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JAMES A. EVANS, Claimant
Malagon & Moore, Claimant's Attorneys
Dan Steelhammer (SAIF), Defense Attorney

WCB 84-09673
April 2, 1987
Order on Review

Reviewed by the Board en banc.

The SAIF Corporation requests review of Referee Seymour's order that awarded claimant permanent total disability in lieu of awards totalling 65 percent (208 degrees) unscheduled permanent partial disability for his low back. The issue is extent of disability, including permanent partial disability.

Claimant originally injured his low back in 1970 while working for a previous employer. After this injury, claimant underwent a laminectomy at L3-4 and his claim was closed with an award of 20 percent unscheduled permanent partial disability. The current claim began in May 1975 when claimant reinjured his low back in a lifting incident in the course of his employment as a welder. Claimant treated with Dr. McHolick, an orthopedic surgeon, and underwent a laminectomy at L5-S1. The claim was closed by Determination Order in January 1978 with a 20 percent unscheduled award. The award was later increased to 45 percent by stipulation.

Claimant returned to work as a welder and then, in June 1980, returned to Dr. McHolick complaining of increased low back pain and pain in his left leg. Later the same month, Dr. Hockey, a neurosurgeon, performed another laminectomy, this time at L4-5. Claimant recovered well after surgery and returned to his regular work in October 1980. Claimant's claim was closed by Determination Order in January 1981 with no award of permanent partial disability in addition to the 45 percent previously awarded. The award was later increased to 65 percent by stipulation.

In November 1982, claimant returned to Dr. Hockey complaining of increased low back pain and pain in his right leg. He underwent another laminectomy at L4-5 in February 1983. Claimant recovered slowly after this surgery and received vocational assistance through the Vocational Rehabilitation Division (VRD). In January 1984, VRD recommended that claimant attend classes in order to obtain a GED. Claimant began attending classes, but dropped out within a couple of weeks with complaints of back pain. When his vocational counselor contacted him and discussed the matter with him, claimant told her that he "didn't see any reason" to attend the classes and obtain a GED.

In May 1984, Dr. Hockey declared claimant medically stationary and rated his permanent impairment as moderately severe. He added that claimant would not be able to return to heavy work. A panel of the Orthopaedic Consultants examined claimant in July 1984. They rated claimant's overall impairment as severe and that due to the May 1975 injury as moderate.

In November 1985, Dr. Hockey approved claimant's participation in a vocational training program for employment as an optical technician. After a number of months in the program, claimant complained that his back pain was being aggravated by the amount of sitting required. Dr. Hockey recommended pain center treatment.

Claimant was evaluated by the staff of the Northwest Pain Center in June 1985. Dr. Rich, the staff neurologist, noted few objective findings and gave his impression as "chronic mechanical low back pain" with minimal signs of nerve root irritation. Dr. Labs, the staff psychologist, interviewed claimant and administered psychological tests. She stated her findings as follows:

> "Results of the psychological screening evaluation reveal an emotionally denying individual who appears to be well adjusted to his pain problem. He appears to be well ensconced in the disabled role and appears to be reinforced for such a view by his wife. He does not believe a self-management approach to his pain problems would be helpful to him as he does not believe himself to have a chronic pain problem. Thus, he appears to be rejecting of any attempts to change his manner of coping with his pain in any significant way. This is truly an unfortunate situation as [claimant] appears to be an intellectually capable individual who is relatively free of significant psychological pathology. It does appear that his disability is being maintained by secondary gains in the areas of relief from work pressures, financial compensation, and the meeting of underlying dependency needs. Until [claimant] becomes motivated to take a more active role in his own rehabilitation, the prognosis for his improvement is, most unfortunately, poor. Thus, he does not appear to be a candidate for pain center admission at this time."

After the staff completed its evaluation, Dr. Newman, the associate Director of the center, wrote Dr. Hockey stating that he appreciated the referral but that he did not recommend admission of claimant to the pain center "because of [claimant's] firm conviction that he is permanently and totally disabled." Claimant did not return to the optician technician training program. His claim was closed by Determination Order in November 1985 with no award of permanent partial disability in addition to the 65 percent previously awarded.

After claim closure, claimant received further vocational assistance and a number of potential jobs were considered. On December 31, 1985, claimant's vocational consultant learned of an opening at a local company for a "maintenance supervisor." The position reportedly would have involved purchasing supplies, keeping inventory and budgeting in addition to supervisory duties. The deadline for submitting applications for the position was January 10, 1986. On January 6, 1986, the counselor forwarded an application form to claimant with instructions to complete it and return it to the counselor in time to submit it by the deadline. When the deadline arrived and claimant had not returned the application, the vocational counselor telephoned claimant. Claimant told the counselor that he had discussed the matter with his attorney and his attorney had

advised him not to complete the application. A few days later, the counselor received a letter from claimant's attorney which stated in pertinent part:

> "The job description for maintenance supervisor includes specific duties that are obviously beyond [claimant's] physical capacity. Therefore, I am advising him not to complete the application. If you have some vocational ideas that are well within [claimant's] physical capacities, please let him know. But if you want him to apply for every job that may be available in this community, no matter what the job duties and physical qualifications necessary for the job, I think your vocational assistance merely amounts to harassment and constitutes a hardship on my client."

In early 1986, claimant's vocational consultant began exploring clerical and accounting positions as a possible vocational alternative and recommended that claimant obtain a GED as the first step toward such a possibility. Claimant refused, stating that he saw no reason to obtain a GED certificate. When sales was suggested as a possible vocational alternative, claimant stated he would not "be a salesman".

At the hearing, which was held in March 1986, a vocational specialist, Mr. McNaught, testified on claimant's behalf. Based upon physical limitations described to him by claimant and the various social and vocational factors involved in the case, Mr. McNaught did not think that claimant was capable of gainful and suitable employment without some form of vocational training. On cross-examination, Mr. McNaught conceded that if the physical limitations described to him by claimant were significantly inaccurate, his opinion regarding claimant's employability would be different.

Claimant did not testify as part of his case in chief. He was, however, called as a witness by SAIF. Claimant testified that his physical abilities were very limited and denied participating recently in any significant physical activity. When asked specifically about whether he had done any painting recently, claimant unequivocally stated that he had not. Counsel for SAIF then asked claimant whether he had in fact painted the interior of a particular residence during the previous two weeks. Claimant admitted that he had, but stated that his wife had done most of the work.

SAIF then called an investigator to the stand. The investigator described activities which suggested that claimant had painted the interior of two different structures over a period of several days by himself.

Emphasizing the testimony of the vocational specialist, Mr. McNaught, the Referee concluded that claimant was entitled to an award of permanent total disability. He dismissed the testimony of SAIF's investigator as nothing more than evidence of "puttering" by claimant. He made no credibility findings.

A worker who seeks an award of permanent total disability must establish that he is permanently incapacitated

from regularly performing work at a gainful and suitable occupation. ORS 656.206(1)(a). He must also establish that he is willing to seek regular gainful employment and that he has made reasonable efforts in that direction. ORS 656.206(3).

After our de novo review of the record, we conclude that claimant has failed to establish entitlement to the award of permanent total disability granted by the Referee. The medical evidence does not support such a conclusion. Dr. Hockey rated claimant's impairment due to the 1975 industrial injury as moderately severe and stated that claimant was incapable of heavy work, but gave no hint that he considered claimant incapable of performing work in some lighter category.

Neither does the vocational evidence provide a basis for the Referee's award. Claimant has failed to cooperate with vocational rehabilitation efforts since his most recent aggravation. He has made no reasonable effort to search for work. As for the testimony of Mr. McNaught to the effect that claimant is permanently and totally disabled without further vocational training, that testimony was based upon physical limitations described by claimant. For the reasons discussed earlier, we question claimant's statements regarding his physical limitations. We conclude, therefore, that claimant has failed to establish entitlement to an award of permanent total disability. Hence, we proceed to a determination of the extent of claimant's permanent partial disability.

In rating the extent of claimant's unscheduled permanent partial disability for his low back, we consider his physical impairment as reflected in the medical record and the testimony at the hearing and all of the relevant social and vocational factors set forth in OAR 436-30-380 et seq. We apply these rules as guidelines, not as restrictive mechanical formulas. See Harwell v. Argonaut Insurance Co., 296 Or 505, 510 (1984); Howerton v. SAIF, 70 Or App 99, 102 (1984).

Claimant was 51 years old at the time of the hearing. He is of average intelligence and has a sixth grade education. The evidence indicates that despite his limited education, claimant reads at high school level and is capable of learning new information and skills. His work history is mainly in the area of welding, but includes considerable supervisory experience.

Following our review of the medical and lay evidence relating to claimant's May 1975 injury, we conclude that claimant's low back impairment is in the lower portion of the moderately severe range. Exercising our independent judgment in light of this impairment and the relevant social and vocational factors, we conclude that an award of 75 percent (240 degrees) adequately and appropriately compensates claimant for the permanent loss of earning capacity due to his industrial injury of May 1975. To date, claimant has been awarded a total of 65 percent (208 degrees) for his 1975 injury. Claimant, therefore, is currently entitled to an additional 10 percent (32 degrees). See ORS 656.222.

SAIF is not authorized to offset compensation paid pursuant to the Referee's award of permanent total disability against the additional compensation granted by this order. United Medical Laboratories v. Bohnke, 81 Or Ap 144, 146 (1986).

ORDER

The Referee's order dated April 15, 1986 is modified. In lieu of permanent total disability, claimant is awarded 10 percent (32 degrees) unscheduled permanent partial disability in addition to the 65 percent (208 degrees) previously awarded for his May 1975 injury. Claimant's attorneys fee shall be adjusted accordingly.

Board Member Lewis dissenting:

I respectfully dissent. Claimant has undergone four back surgeries since the 1975 injury. Orthopaedic Consultants rated his impairment as severe. His limitations preclude him from sitting more than a half hour and standing for shorter periods. He must also periodically lie down. At the time of hearing, claimant was 51 years old with a sixth grade education. He has no transferable skills.

Claimant has the burden to establish that he is willing to seek regular gainful employment and that he has made reasonable efforts to obtain such employment. ORS 656.206(3). However, he may be excused from this requirement of seeking regular gainful employment if he establishes it would be futile. Butcher v. SAIF, 45 Or App 146 (1983).

Based on a combination of claimant's severe disability, his age, education, adaptability to nonphysical labor and other nonmedical factors, I would find him permanently and totally disabled. Therefore, I would affirm the well reasoned opinion of the Referee.

BARRY A. HOWARTH, Claimant
Horton & Koenig, Claimant's Attorneys
Moscato & Byerly, Defense Attorneys

WCB 86-06650
April 2, 1987
Order on Review

The insurer has moved the Board for an order dismissing claimant's request for Board review on the ground that a copy of the request was not timely mailed to the parties. The motion is granted.

The Referee's order issued December 17, 1986. Claimant timely mailed his request for Board review on January 15, 1987. The Board received the request on January 16, 1987. No acknowledgement of service nor a certificate of personal service by mail was provided with the request. A computer generated letter acknowledging the request for Board review was mailed on January 21, 1987. This letter was received by the insurer's counsel on January 22, 1987. This was the insurer's first notice of claimant's request for review. After contacting claimant's counsel, the insurer's counsel received a copy of the request for review on February 4, 1987.

In response to the insurer's motion, claimant's attorney states that "to the best of [his] knowledge and belief," appropriate notice of the request for Board review was provided to the insurer by mail. In addition, claimant's attorney asserts that it is his office's policy to send copies of all correspondence to all interested parties. Recognizing that problems arise in the reception of mail, claimant submits that it "would work a substantial injustice" to have the appeal dismissed.

A Referee's order is final unless, within 30 days after the date on which a copy of the order is mailed to the parties, one of the parties requests Board review under ORS 656.295. ORS 656.289(3). Requests for Board review shall be mailed to the Board and copies of the request shall be mailed to all parties to the proceeding before the Referee. ORS 656.295(2)(4).

In Argonaut Insurance v. King, 63 Or App 847, 852 (1983), the court held that "compliance with ORS 656.295 requires that statutory notice of the request for review be mailed or actual notice be received within the statutory period." In King, the request for review was timely, but copies of the request were never sent to the other parties. The "actual notice" referred to by the court was the Board's computer generated acknowledgment letter, which the evidence established was received by the insurer more than 30 days after the Referee's order was mailed. Inasmuch as the notice of the request for review was untimely, the court found that the Board lacked jurisdiction to consider the appeal.

Here, no contention is made that the insurer received actual notice of the request for Board review within the statutory period. Therefore, in order to comply with the requirements of ORS 656.295, the record must establish that notice of the request for review was timely mailed to the insurer. This record fails to do so.

It is apparently the office policy of claimant's counsel to submit copies of all correspondence to the insurers. Yet, neither an acknowledgement of service nor proof of service by mail accompanied claimant's request for Board review. See OAR 438-11-035(2)(b). Moreover, other than by affidavit, claimant's counsel has submitted no documents that would support his contention that a copy of the request for Board review was mailed to the insurer. When this sparse evidence is compared to the insurer's representation that it did not timely receive a copy of the request for review and the lack of proof of service, we are forced to conclude that claimant has failed to timely comply with the notice requirements of ORS 656.295.

Accordingly, claimant's request for Board review is dismissed for lack of jurisdiction. The Referee's order is final by operation of law.

IT IS SO ORDERED.

JANET K. JACKSON, Claimant
Pozzi, et al., Claimant's Attorneys
Gretchen Wolfe (SAIF), Defense Attorney

WCB 85-03945
April 2, 1987
Order on Reconsideration

Claimant has requested reconsideration of that portion of our Order on Review dated March 4, 1987 that awarded no penalty and attorney fee for the SAIF Corporation's late denial of claimant's aggravation claim. We reversed the Referee's award of a penalty and attorney fee as SAIF had paid interim compensation between the date that the aggravation claim was filed and the date the denial issued. We concluded that there was no compensation then due upon which to base a penalty. EBI Companies v. Thomas, 66 Or App 105 (1983).

Claimant requests that an additional penalty be assessed against outstanding medical expenses existing when the claim was

found compensable. Claimant admits that the insurer has no duty to pay interim compensation for medical services pending acceptance or denial of the aggravation claim. See Anderson v. SAIF, 79 Or Ap 345 (1986); Poole v. SAIF, 69 Or App 503 (1984). However, she asserts that the medical expenses became due and payable at the time the denial was set aside. We acknowledge the argument, but find it unnecessary to reach this issue.

Here, there is no evidence that medical services were unpaid before or after the denial. Thus, the record fails to establish the existence of unpaid medical bills upon which to base the award of an additional penalty.

Furthermore, claimant was awarded a 25 percent penalty and a related attorney fee assessed upon the temporary total disability due from March 25, 1985 to April 17, 1986. We are constrained by statute to award only a single maximum penalty consisting of 25 percent of the compensation then due. ORS 656.262(10); Marlene W. Ritchie, 37 Van Natta 1088, 1097 (1985). The record establishes that the maximum penalty was assessed against all the compensation to be then one. Therefore, even if a second penalty were appropriate, there are no additional amounts upon which to assess it.

Accordingly, claimant's request for reconsideration is granted. Our prior order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our prior order, effective this date.

IT IS SO ORDERED

FREDERICK E. OZAN, Claimant
Dennis H. Henninger, Claimant's Attorney
Ruth Cinniger (SAIF), Defense Attorney
David O. Horne, Defense Attorney

WCB 85-02750, 85-03094, 85-11360 & 85-11361
April 2, 1987
Order on Review

Reviewed by Board Members McMurdo and Lewis.

The SAIF Corporation requests review of that portion of Referee Pferdner's order that awarded claimant a $750 attorney fee. The issue is attorney fees.

Claimant suffered an aggravation of his low back condition in late 1984. As a result, he filed claims with two prior employers. The Wausau Insurance Company denied responsibility for the condition on behalf of the first employer in February 1985. SAIF denied responsibility on behalf of the second employer in June 1985. Claimant timely appealed both denials. In September 1985 an order was issued pursuant to ORS 656.307 designating SAIF as the paying agent. This claim came to hearing solely on the issue of responsibility for the aggravation of claimant's low back condition.

We modify the Referee's award of attorney fees. Responsibility was the sole issue at hearing. Claimant, therefore, was a nominal party and not entitled to an insurer-paid attorney fee. Petshow v. Farm Bureau Ins. Co., 76 Or App 563 (1985); Pamela R. Stovall, 38 Van Natta 41 (1986). However, claimant's attorney took affirmative and substantive steps to have a paying agent named pursuant to ORS 656.307. Consequently, his attorney is entitled to an attorney fee for his services in

obtaining the .307 order to be paid from claimant's compensation. See Mark L. Queener, 38 Van Natta 882 (1986); Bruce Hatelli, 38 Van Natta 1024 (1986). Our review of the file indicates that $250 is a reasonable attorney fee for services in obtaining the .307 order.

ORDER

The Referee's order dated August 15, 1986 is modified. In lieu of that portion of the order that awarded claimant an insurer-paid attorney fee, claimant's attorney is allowed 25 percent of claimant's compensation, not to exceed $250 for services prior to hearing in procuring an order designating a paying agent under ORS 656.307. The remainder of the order is affirmed.

BARBARA T. CHILLA, Claimant
Malagon & Moore, Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 85-05506
April 3, 1987
Order on Review

Reviewed by Board Members Ferris and McMurdo.

The insurer requests review of Referee Seymour's order that set aside its denial of claimant's occupational disease claim for a stress-related condition and awarded a $10,000 attorney fee. The issues are compensability and attorney fees.

The Board adopts the Referee's findings of fact as summarized and augmented by this order.

Claimant worked as a school teacher for the Coos Bay School District since 1971. The record reflects that she first treated for her mental disorder in the early seventies. Dr. Holland, a psychiatrist, treated claimant from October 1977 to January 1979 and diagnosed a personality disorder. The personality disorder was related to a variety of different sources of stress, but no claim was filed with the school district. In the fall of 1981, claimant had an exacerbation of her mental condition and, following the advice of her family physician Dr. Potter, began working only three-fourths time.

During the period claimant worked for the school district she was transferred numerous times. In 1982 she was assigned to an elementary school where she continued to work three-fourths time. Soon after her assignment to the elementary school, claimant learned that the new principal was to be Ms. Marchant. Claimant had experienced difficulties with Ms. Marchant earlier in her career and perceived her to be "against her." Despite her fears, the 1982-83 and 1983-84 school years passed smoothly. Claimant testified that Ms. Marchant had treated her fairly over the two-year period. Eventually, at the request of Ms. Marchant, claimant returned to working full time, beginning in the fall of 1984.

At the start of the 1984 school year, a change was made in the way claimant was to teach her remedial reading students. In the past, the remedial students had come to claimant's classroom for her assistance. Under the new plan, claimant was to attend the classroom of the student needing the help. The change necessitated the coordination of claimant's schedule with that of

the other teachers. Consequently, claimant was asked by Ms. Marchant to make a schedule. Claimant found the making of this schedule to be a frustrating and stressful event. It was only after Ms. Marchant had set a deadline that the schedule was made.

In November 1984, Ms. Marchant submitted a counseling memo concerning claimant's three tardies. After a discussion, claimant insisted that a meeting be held between the principal, herself, and her union representative. The result of the meeting was that claimant was to have no additional "unexcused" tardies and was required, like the other teachers, to sign the attendance book daily. Unlike the other teachers, however, she was required to sign the book upon entering the school building. She was also required to have weekly meetings with Ms. Marchant. Claimant perceived this incident as part of a general scheme of harassment to force her from her position. This conclusion was reinforced by claimant's observation of a question mark written in next to the word "ill" by the assistant principal after she had called in sick. She felt the validity of her excuse was being questioned.

Shortly before Christmas, claimant had another encounter with Ms. Marchant. The students were given a treat of watching a movie. Claimant had released her remedial reading students also to watch the movie. Ms. Marchant did not agree with claimant's decision and a confrontation ensued. At this point, claimant became very upset and called her supervisor to ask for a transfer. He told her not to worry about the situation and that things would be better after the Christmas break.

Following the Christmas break, claimant continued to believe that she was under close scrutiny with an underlying conspiracy to remove her from her job. In late January claimant returned to her family physician, Dr. Potter, and reported that she was suffering considerable stress from her work at school. Dr. Potter referred claimant to Dr. Davis, a psychiatrist. Dr. Davis authorized a medical leave of absence on February 5, 1985. Claimant filed an occupational disease claim for a stress related condition in April 1985. The insurer denied this claim in May 1985 and claimant timely requested a hearing.

Claimant treated for her condition with psychiatrists Davis and Martin. She was examined at the insurer's request by Dr. Parvaresh, also a psychiatrist. Based on the medical evidence, Dr. Parvaresh persuasively concluded that claimant suffered from a preexisting chronic anxiety tension state, dating back to 1970, which is aggravated whenever she is exposed to any degree of stress. Further, claimant's makeup results in her misperceiving herself and the way in which other people assess her. Although not suffering true paranoia, claimant was described by Dr. Parvaresh as having a "suspicious" nature causing her to view her surrounding environment as hostile.

Dr. Parvaresh opined that claimant reacts to anything adverse in her environment whether it is at home, in a personal situation or at work. He stated that the three sources were pretty much inseparable in terms of contribution to the condition. Dr. Parvaresh was asked the ideal way for an employer to deal with a person like claimant. He stated that she would need a very structured job that left little room for miscalculation or misperception. Further, she would need a clear

chain of authority. Ideally, her immediate authority would be one person who is a good communicator. The goal of these changes would be to limit claimant's ability to misperceive her environment and avoid aggravating her anxiety tension state.

In order to establish the compensability of a mental disorder, claimant must prove that: (1) the real events or conditions of her work, when viewed objectively, were capable of producing stress; and (2) the real stressful conditions of her employment were the major contributing cause of her mental disorder. McGarrah v. SAIF, 296 Or 145 (1983); Leary v. Pacific Northwest Bell, 67 Or App 766 (1984). The stressful conditions must be objective in that they must be real, however, the medical effect on the worker is measured by the worker's actual reaction, rather than by an objective standard of whether the conditions would have caused disability in the average worker. Petersen v. SAIF, 78 Or App 167, 170 (1986).

The source of claimant's stress centers around the misperception of her work environment. Claimant viewed many of the events surrounding her work as part of a larger conspiracy to remove her from her job. However, the Referee listened to 12 witnesses and 14 hours of claimant's testimony and came to the opposite conclusion. He stated:

> "I do not believe that anyone in the school district was "out to get" the claimant. Contrary to the claimant's beliefs, her principal, Mrs. Marchant, was not only not "out to get" her, but was making an effort to have her befriended by some of the other teachers."

Like the Referee, we conclude that claimant's misperception of a conspiracy at work was the major contributing cause of the aggravation of her preexisting anxiety tension state. However, we do not conclude that the real events and conditions of her work, when viewed objectively, were capable of producing stress. Consequently, we reverse the Referee.

Claimant cites numerous events taking place over her entire career at the Coos Bay School District that, combined with her preexisting condition, caused her to incorrectly believe that a conspiracy existed to remove her from her teaching position. These included: an effort in 1974 to prevent her from obtaining tenure; her repeated transfer to different schools within the school district; the appointment of her perceived nemesis, Ms. Marchant, as principal; difficulties coordinating her school schedule with the other teachers; the counseling memo concerning her lateness; and the altercation with the principal over allowing her students to view a movie. Claimant asserts that all of these are "real" events that caused the worsening of her preexisting anxiety tension state.

Relying on Petersen, supra., claimant argues that whether these events, when viewed objectively, are capable of causing stress depends upon her reaction. Claimant apparently argues that if she has a reaction caused by real events at work, then those real events are, ipso facto, stressful. We disagree and find that claimant overstated the holding in Petersen.

Acceptance of claimant's position would result in an

objective test viewed through the subjective eyes of the claimant. Such a conclusion creates an entirely subjective test diluting the requirement that events, when viewed objectively by the finder of fact, actually cause the stress. This result would be contrary to the clear two part test established by the McGarrah court.

Claimant's misperception of the events surrounding her job resulted in her detecting a conspiracy where none existed. We conclude that these events, when viewed objectively, are not capable of causing stress. Each of the events described herein are standard fare for an elementary school teacher. Further, many of the events claimant perceived as part of a conspiracy were, in reality, designed to assist claimant in interacting with the other teachers. Claimant's disability is due solely to her misperception of nonstressful work conditions and her imagined conspiracy. Therefore, claimant has failed to establish that her claim is compensable.

ORDER

The Referee's order dated March 25, 1986 is reversed.

BETTY L. JUNEAU, Claimant
Michael B. Dye, Claimant's Attorney
Foss, et al., Defense Attorneys

WCB 85-12126
April 5, 1987
Order on Review

Reviewed by Board Members Lewis and McMurdo.

Claimant requests review of those portions of Referee Howell's order that: (1) declined to award temporary disability for the period October 31, 1983 to May 22, 1986; and (2) refused to assess a penalty and attorney fee for improper claims processing. The issues are temporary disability, penalties and attorney fees.

The Board affirms that portion of the order that declined to award temporary disability between October 31, 1983 and May 22, 1986. However, we reverse that portion of the order that awarded no attorney fee for improper claim closure.

Claimant compensably injured her left knee in December, 1975. She received a Determination Order in 1980 that awarded her 45 percent permanent disability for the loss of the left leg. The award was increased by a 1982 Referee's order.

Subsequently, claimant filed a new claim for back complaints and sensory changes in both arms and legs. In addition she filed separate claims for her right knee and a fibrositis condition. Claimant alleged that all of these claims were related to her industrial injury. The self-insured employer denied the three new claims and claimant requested a hearing.

Hearing was held on July 15, 1985. The issues were: (1) the propriety of the three denials; (2) extent of scheduled disability; (3) entitlement to interim compensation; and (4) the compensability of medical services. Due to the possibility that one of the denials might be set aside, the employer attempted to present evidence that claimant had withdrawn from the labor force and was not entitled to temporary disability benefits consistent

with Cutright v. Weyerhaeuser Co., 299 Or 290 (1985). The Referee concluded that such evidence might be relevant in a future proceeding, but it was not relevant to issues then in dispute.

The Referee set aside the denial of claimant's right knee condition and affirmed the other two denials. The Referee also ordered that interim compensation be paid from August 19, 1983 to October 31, 1983 and that a 25 percent penalty and related attorney fee be assessed for the employer's failure to timely pay this interim compensation. The order further stated that, "filing of an appeal by the employer will not stay payment of compensation to the claimant."

The employer requested review of the order and on May 22, 1986 we reversed the Referee's order finding the right knee compensable, but affirmed the penalty and attorney fee for the failure to pay interim compensation. Betty L. Juneau, 38 Van Natta 553 (1986). Pending review, the employer neither paid compensation nor processed the claim pursuant to ORS 656.268. As a result, claimant sought to enforce the Referee's original order regarding the payment of benefits not stayed pending appeal and the award of penalties and attorney fees affirmed by our order on review. Specifically, claimant asserted entitlement to: (1) temporary disability from October 31, 1983 until the May 22, 1986 Board order; (2) penalties and attorney fees for the employer's failure to pay the interim compensation and an accompanying penalty and attorney fee pursuant to the prior Referee's order; and (3) a penalty and attorney fee due to the employer's failure to submit this claim for closure prior to May 22, 1986.

The Referee concluded that claimant had withdrawn from the labor force in January 1981 or earlier. As a result, he found she was not entitled to additional temporary disability after October 31, 1983. Cutright v. Weyerhaeuser Co., 299 Or 290 (1985); Karr v. SAIF, 79 Or App 250 (1986). We do not disturb that portion of the Referee's order.

The Referee also awarded a 25 percent penalty for the employer's unreasonable refusal to pay interim compensation pursuant to the September 4, 1985 Opinion and Order. We affirm that portion of the Referee's order with the following comment.

After the September 4, 1985 Opinion and Order and pending Board review, the employer was obligated to pay all compensation as required by ORS 656.313(1) and (4). Interim compensation is "compensation" within the meaning of ORS 656.313(4). Jones v. Emanuel Hospital, 280 Or 147 (1977); Howard E. Hughes, 38 Van Natta 434, 436 (1986). In our May 22, 1986 order, we specifically affirmed the award of the penalty and attorney fee for the employer's failure to pay this interim compensation. Betty L. Juneau, 38 Van Natta at 556. Consequently, at the time of hearing, the employer was obligated to pay the penalty, attorney fee and interim compensation directed by the September 4, 1985 order.

The employer offered no explanation for why it has failed to comply with the Referee's prior order or our previous order. The Referee's assessment of an additional 25 percent penalty for the unpaid interim compensation from August 19, 1983 to October 31, 1983 and a related attorney fee is appropriate. See Flora I. Johnston, 38 Van Natta 920 (1986).

We reverse the Referee's failure to award an attorney fee for improper claims processing.

The Referee correctly concluded that after the September 4, 1985 Opinion and Order the employer had an obligation to process the claim to closure pursuant to ORS 656.268. The employer failed to do so. As a result, the Referee concluded that claimant was entitled to a penalty and attorney fee for the unreasonable delay in submitting the claim to closure. See Lester v. Weyerhaeuser Co., 70 Or App 307 (1984); Harold Lester, 37 Van Natta 745 (1985). However, the Referee could find no compensation then due that resulted from the period of the delay. Therefore, the Referee concluded that there was no compensation upon which to base a penalty.

We agree with the Referee's assessment of this issue. However, even when there are no amounts upon which to base the award of a penalty, claimant is still entitled to an attorney fee. Spivey v. SAIF, 79 Or App 568 (1986); Hutchinson v. Lousiana-Pacific Corp., 81 Or App 162 (1986); Wilma K. Anglin, 39 Van Natta 73 (1987); But see Miller v. SAIF, 78 Or App 1258 (1986). In determining a reasonable attorney fee, we consider the factors set out in Barbara A. Wheeler, 37 Van Natta 122 (1985). Applying the Wheeler factors to the facts in our case, we conclude that $400 is a reasonable attorney fee for services rendered through hearing.

ORDER

The Referee's order dated July 21, 1986 is affirmed in part and reversed in part. That portion of the order that declined to award an attorney fee for improper claims processing is reversed. Claimant is awarded a $400 attorney fee to be paid by the self-insured employer. The remainder of the order, as supplemented, is affirmed.

JOHN F. SMITH, Claimant
Susan M. Connolly, Claimant's Attorney
Garrett, et al., Defense Attorneys

WCB 85-13742
April 6, 1987
Order Denying Request to Dismiss

The Board has received the employer's request to dismiss claimant's request for Board review on the grounds claimant has not filed his 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.

IT IS SO ORDERED.

BRUCE BASHAM, Claimant
Jerry Gastineau, Claimant's Attorney
Brian Pocock, Defense Attorney
Art Stevens (SAIF), Defense Attorney

WCB 85-06435 & 86-03198
April 7, 1987
Order on Review

Reviewed by Board Members Ferris and Lewis.

Aetna Technical Services requests review of that portion of Referee Brown's order that: (1) set aside its denial of claimant's aggravation claim for a lower back condition; and (2) upheld the SAIF Corporation's denial of claimant's new injury claim for the aforementioned condition. Claimant cross-requests review of those portions of the Referee's order that: (1) awarded no penalties and attorney fees for Aetna's alleged failure to properly refer the claim for ORS 656.307 processing; and (2) awarded no attorney fee for his attorney services at the hearing. The issues on review are: (1) responsibility; (2) alleged improper claims processing by Aetna; and (3) attorney fees for services at the hearing.

The Board affirms that portion of the Referee's order that: (1) found Aetna responsible for claimant's condition; (2) awarded no penalties and attorney fees for alleged improper claims processing; and (3) awarded no attorney fee for claimant's attorney's services at the hearing.

The Board modifies that portion of the Referee's order that awarded an insurer-paid attorney fee for services rendered by claimant's attorney in procuring the .307 order. Although this issue was not raised by the parties on review, we may make such disposition of the case as we determine to be appropriate. Destael v. Nicolai Co., 80 Or App 596, 600-01 (1986); Miller v. SAIF, 78 Or App 158, 161 (1986).

The Referee's order issued on August 1, 1986. That same day, the Board decided the case of Mark L. Queener, 38 Van Natta 882 (1986). In Queener, we held that attorney fees awarded for services rendered prior to the issuance of a .307 order are payable out of, not in addition to, a claimant's award of compensation. ORS 656.386(1) and (2). Thus, the Referee's award of an $800 attorney fee is modified to reflect an award of 25 percent of claimant's compensation, not to exceed $800.

ORDER

The Referee's order dated August 1, 1986, is affirmed in part and modified in part. In lieu of the Referee's award of an $800 insurer-paid attorney fee, claimant's attorney is awarded 25 percent of claimant's compensation, not to exceed $800, for services rendered prior to hearing in procuring an order designating a paying agent under ORS 656.307. The remainder of the Referee's order is affirmed.

IRENE JENSEN, Claimant
Peter O. Hansen, Claimant's Attorney
Gail M. Gage (SAIF), Defense Attorney

WCB 86-03379
April 7, 1987
Order on Review

Reviewed by Board Members Ferris and McMurdo.

The SAIF Corporation requests review of Referee Galton's order that set aside its "de facto" denial of claimant's occupational disease claim for a "postural or chronic low back strain and cervical strain" and remanded the claim to SAIF for payment of temporary disability compensation. The issues are compensability and temporary disability compensation.

Claimant, 53 years of age at the time of hearing, began working for the Employment Division of the State of Oregon in 1975. For the first five years of her employment, she worked in the Employment Services Department. Her work involved screening unemployed persons and referring them to potential employers. Claimant testified that she experienced no significant back pain during this time.

In late 1980, claimant was transferred to the Unemployment Claims Department. Her job involved the processing of unemployment claims. This work involved a good deal of public contact, sometimes with hostile persons. After a number of months on the job, claimant developed severe low back pain and was hospitalized in mid-1981 under the care of Dr. Cochran, an orthopedic surgeon. Dr. Cochran's initial report stated that claimant had experienced intermittent back pain for four or five years, but that her current episode of back pain represented the most severe flare-up that she had ever experienced. Claimant denied any acute trauma. X-rays revealed marked narrowing of the L5-S1 disc. Dr. Cochran diagnosed degenerative disc disease and recommended conservative treatment.

Claimant was off work for a few weeks and then returned to light duty. After several weeks on light duty, she returned to her regular work. After another several weeks, claimant's back pain began to return. She sought a transfer back to her previous job in the Employment Services Department, but no positions were available. After discussing the situation with Dr. Cochran, claimant decided to quit her job in August 1981.

After leaving her job at the Employment Claims Department, claimant worked with her husband in his nursery business. This work primarily involved the propagation of small plants. Claimant testified that this job was neither physically nor mentally stressful and that she experienced little or no back symptoms during this period.

In January 1983, a year and a half after leaving the Employment Claims Department, claimant returned to work for the same department and performed the same kind of work, but in a different office. After a few months, her low back pain returned and in July 1983 she visited the emergency room and was examined by Dr. Miller, a neurosurgeon. Dr. Miller diagnosed degenerative lumbar disc disease and recommended conservative treatment. After a couple of weeks off, claimant attempted to return to work, but soon began missing work again because of back pain. Claimant briefly reduced her hours to part time and eventually quit her job with the Employment Claims Department in August 1984.

The medical reports indicate that claimant began to complain of neck pain in addition to low back pain several months before quitting. Claimant underwent a myelogram in May 1984 which was indicative of some degenerative arthritis in her neck, but was otherwise negative. Within a few weeks after she left work, claimant's back and neck pain decreased markedly to what appears to be their preexacerbation levels. Claimant ultimately filed her workers' compensation claim in December 1985.

Dr. Hoppert, an orthopedist, began treating claimant in October 1984. His chart notes reflect a number of nonindustrial events which adversely affected claimant's back condition. In October 1984, Dr. Hoppert mentioned that claimant's sister had died and that this had increased claimant's back pain. In August 1985, Dr. Hoppert noted that claimant had experienced an acute flare-up of back pain from doing housework which included canning and washing windows. Later the same month, claimant sustained a mild neck strain when her vehicle was rearended.

The record contains opinions by two physicians regarding the causal connection between claimant's low back and neck conditions and her work activity at the Employment Claims Department. The first of these is Dr. Lahti, a family practitioner who began assisting in claimant's treatment in May 1983. In a report dated January 20, 1986, Dr. Lahti used the terms degenerative cervical disc disease, osteoporosis and chronic low back strain to describe claimant's condition. On the causation question, he remarked: "I can only state that the patient states that what she is required to do on her job makes her pain worse. I doubt the major contributing factor of her condition was due to work. . . . I can only reiterate what I have said before, that [claimant] states that her symptoms are made worse when she is working." In a later report, Dr. Lahti clarified his opinion. He stated his diagnosis at that time as degenerative disc disease and opined that the symptoms of this condition, but not the condition itself, had been worsened by her work activity.

The other physician to give an opinion on the causal connection between claimant's back and neck conditions and her employment was Dr. Langston, a consulting orthopaedic surgeon. He stated:

> "[Claimant] gives a history that is compatible with postural strain superimposed upon degenerative disc disease as a result of her work activities of standing long periods of time, sitting, bending or lifting. . . .
>
> "The occupation she has been able to obtain has not permitted her to vary her positions and the resulting factor is low back pain which is compatible with the physical condition that exists. Her work activity would only make her temporarily symptomatic. I know of no evidence that this would produce any worsening in her degenerative disc disease.

"With respect to the neck area, at this time the examination is entirely normal and she does have degenerative disc disease on her x-ray at a very common level, C5-C6. There is no recommended treatment at this time. The work condition would only make her temporarily symptomatic but not contribute to the cause or development of her neck or back condition. There is no scientific evidence to prove that such work activity would worsen her underlying pathology of degenerative disc disease."

At the hearing, claimant indicated that the standing and especially the stress associated with her work at the Employment Claims Department were the causes of her back pain. Based upon his assessment of claimant's attitude, appearance and demeanor, the Referee found claimant "an entirely credible and reliable witness." We accept the Referee's credibility finding.

The Referee concluded that claimant's degenerative disc disease was not compensable. He went on to find, however, from the reports of Drs. Lahti and Langston, that claimant had sustained a "postural or chronic low back strain and cervical strain." The Referee concluded that claimant's work activity was the major contributing cause of these conditions and ordered SAIF to accept them. As part of his order, the Referee stated: "Upon written verification by Dr. Lahti of claimant's temporary total disability due to her compensable claim, SAIF forthwith shall pay claimant same. Filing a Request for Review shall not stay payment of compensation to claimant. ORS 656.313(1)."

On Board review, SAIF argues that the Referee misconstrued the medical reports by Drs. Lahti and Langston. We agree. Both Dr. Lahti and Dr. Langston used the term "strain" at some point in their reports. From the contexts in which the term was used, however, it is clear that both doctors were referring to the symptoms of claimant's degenerative disc disease and not to some separate condition or conditions. Both doctors also state unequivocally that claimant's degenerative disc disease was not pathologically worsened by her work activity. This conclusion is reinforced by the rest of the medical and lay evidence which indicates nothing more than a symptomatic worsening of claimant's preexisting degernerative disc disease. Under these circumstances, claimant has failed to prove a compensable occupational disease. See Wheeler v. Boise Cascade, 298 Or 452 (1985); Weller v. Union Carbide Co., 288 Or 27, 35 (1979).

SAIF also contends that the Referee erred in ordering it to pay claimant temporary total disability compensation in connection with her "postural or chronic low back strain and cervical strain." SAIF asserts that the only issue raised by claimant at the hearing was compensability and that the Referee exceeded his authority in deciding the issue of temporary disability. We disagree with SAIF on this point. When a Referee orders a claim accepted, the insurer has the duty to process the claim and make payment of the forms of compensation specified in ORS 656.313(4) pending its appeal of the Referee's order. See ORS 656.262; 656.313(1). Temporary total disability compensation is one such form of compensation. The Referee's gratuitous comments

regarding the payment of temporary total disability compensation were unnecessary. They were not, however, improper.

ORDER

The Referee's order dated June 23, 1986 is reversed.

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

WCB 85-03587
April 8, 1987
Order on Reconsideration

Claimant has requested reconsideration of that portion of our Order on Review dated March 16, 1987 that allowed an attorney fee payable out of compensation. Claimant asserts that the attorney fee should have been ordered paid by the insurer. Claimant's attorney asks, in the alternative, that if we should disagree with claimant's argument on reconsideration, that the attorney fee be set aside altogether. The insurer opposes claimant's request that the fee be made payable by the insurer. Claimant's request for reconsideration is allowed. Our prior order is withdrawn for reconsideration. On reconsideration, we modify our prior order to eliminate claimant's attorney fee.

Subsequent to claimant's compensable injury, the insurer began payment of temporary total disability compensation based on a rate later found to be incorrect by the Referee. The Referee found that claimant's rate of compensation should have been greater, and he ordered the insurer to recalculate the rate of claimant's temporary disability. The recalculation resulted in increased temporary total disability compensation for claimant. The Referee inadvertently failed to allow an attorney fee for services at hearing on that issue, however. In our Order on Review, we affirmed the Referee's order and noted that claimant was entitled to an attorney fee for services at hearing. Pursuant to OAR 438-47-030, which provides for attorney fees when a claimant's temporary total disability compensation is increased, we ordered the fee payable out of claimant's compensation.

On reconsideration, claimant argues that the insurer's failure to correctly pay the correct rate of temporary disability from the outset should have been characterized as a "de facto" denial, the setting aside of which should have generated an insurer-paid attorney fee. We disagree. See Wayne D. Cooper, 38 Van Natta 913, 916 (1986). OAR 438-47-030 controls. Claimant's attorney fee was properly ordered payable out of his compensation.

Although we adhere to the reasoning behind the attorney fee allowance in our prior order, we will accommodate claimant's attorney's request that the attorney fee be set aside.

Now, therefore, having granted claimant's request for reconsideration, we modify our prior order to set aside the attorney fee allowed in that order. Except as herein modified, we adhere to and republish our prior order.

IT IS SO ORDERED.

The Beneficiaries of
LAWRENCE W. DIGBY (Deceased), Claimant
Welch, Bruun & Green, Claimant's Attorneys
Richard D. Barber, Jr. (SAIF), Defense Attorney

WCB 85-01620
April 10, 1987
Order on Review

Reviewed by Board Members McMurdo and Lewis.

The SAIF Corporation requests review of Referee Thye's order that found that Judy Digby was entitled to benefits pursuant to ORS 656.226. The issue is whether Judy Digby is a beneficiary.

This claim originally came before us on the question of compensability of the myocardial infarction of Lawrence Digby, deceased. On review, we reversed the Referee's finding of compensability and reinstated SAIF's denial. Lawrence W. Digby, 37 Van Natta 992 (1985). Prior to our order, SAIF denied Judy Digby's claim for benefits. SAIF contended that Judy Digby was not the proper beneficiary. On May 17, 1985, Referee Thye issued an order upholding this denial. Subsequent to that hearing, we reversed the Referee's finding of compensability. Thereafter, claimant requested review by the Court of Appeals.

Pending review by the Court of Appeals, Judy Digby provided new evidence regarding her marital status and asked the Board to remand the case for the taking of additional evidence concerning her status as beneficiary. Concluding that the new evidence warranted remand, we granted the request. However, we acknowledged that the issue would be moot should our order finding the underlying claim noncompensable be upheld. Lawrence W. Digby, 38 Van Natta 92 (1986). Thus, the order on remand was predicated on a subsequent finding of compensability by the Court of Appeals.

Since our remand order, the Court of Appeals has affirmed the Board's finding that the underlying myocardial infarction claim was not compensable and review has been denied by the Supreme Court. Digby v. SAIF, 79 Or App 810 rev den, 302 Or 35 (1986). Therefore, as SAIF correctly points out, the present case is moot and without effect.

Judy Digby concedes that the claim is no longer compensable. However, she asserts that but for the second denial, she would have received benefits until our subsequent finding of noncompensability.

We disagree. SAIF processed this claim according to law. Its denial of Ms. Digby's claim as a beneficiary was reasonable, and all pending benefits were paid correctly.

ORDER

The Referee's order dated July 29, 1986 is vacated and this matter is dismissed.

SALLY J. GOWIN, Claimant
Robert E. Nelson, Claimant's Attorney
Mark Bronstein (SAIF), Defense Attorney

WCB 85-09860
April 10, 1987
Order on Review

The SAIF Corporation has moved the Board for an order dismissing claimant's request for Board review on the ground that the request was untimely filed. The motion is denied.

The Referee's order issued January 16, 1987. Claimant's February 13, 1987 request for review was received by the Board's Portland office on February 17, 1987. The request for review was then forwarded to the Board's Salem office, who received it on February 19, 1987. A proof of mailing, submitted with the request, indicated that a copy of the request had been mailed to SAIF on February 13, 1987. The envelope that contained the request and proof of mailing does not bear a postmark date. The record does not indicate when, or if, the request for Board review was mailed to the Board.

A Referee's order is final unless, within 30 days after the date on which a copy of the order is mailed to the parties, one of the parties requests Board review under ORS 656.295. ORS 656.289(3). Requests for Board review shall be mailed to the Board and copies of the request shall be mailed to all parties to the proceeding before the Referee. ORS 656.295(2).

The time and manner of filing a request for Board review of a Referee's order are set forth in ORS 656.289 and 656.295. OAR 438-11-005(1). Reading the aforementioned statutes together, it is clear that in order for jurisdiction to vest with the Board, a request for review must be mailed to the Board within 30 days of the date the Referee's order is mailed. Although ORS 656.295(2) does not use the word "filing," the Board's administrative rules equate "filing" and "mailing." Cf. ORS 656.298(3) (notice of appeal to court must be "filed" with the court.) Pursuant to the Board's rules, "filing" means either: (1) the receipt of a document by the Board at any office of the Board; or (2) date of mailing. OAR 438-05-040(a), (b); OAR 438-11-005(2).

Here, the Referee's order issued on January 16, 1987. The thirtieth day after January 16, 1987 was February 15, 1987, a Sunday. Monday February 16, 1987 was a legal holiday. Claimant's request for review was physically delivered to the Board's Portland office on Tuesday February 17, 1987.

In computing time periods, if the last day falls on a Saturday, Sunday, or legal holiday, the period runs until the end of the next business day. OAR 438-05-040(4)(c). Therefore, since claimant's request for review was received by one of the Board's offices on the next business day following the end of the statutory 30-day time period, it was timely filed.

We also conclude that SAIF received timely notice of the request for review. The proof of mailing indicates that a copy of the request was mailed to SAIF's attorney on February 13, 1987. SAIF's counsel does not contend otherwise. Furthermore, no assertion is made that either SAIF or its insured has been prejudiced by the lack of timely personal notice of the request for review. In the absence of a showing of prejudice to a party, timely service of a request for Board review on the attorney for a party is adequate compliance with ORS 656.295(2) to vest

jurisdiction in the Board. Argonaut Insurance v. King, 63 Or App 847, 850-51 (1983); Nollen v. SAIF, 23 Or App 420, 423 (1975), rev den (1976); Karen J. Bates, 38 Van Natta 964 (1986).

Accordingly, SAIF's motion to dismiss claimant's request for Board review is denied.

IT IS SO ORDERED.

BARTON M. GROVER, Claimant
Malagon & Moore, Claimant's Attorneys
Davis, Bostwick, et al., Defense Attorneys
H. Thomas Andersen (SAIF), Defense Attorney

WCB 85-14800 & 82-04073
April 10, 1987
Order on Review

Reviewed by Board Members McMurdo and Lewis.

The SAIF Corporation requests review of Referee T. Lavere Johnson's order that: (1) granted claimant permanent total disability; and (2) found it, rather than EBI Companies, responsible for claimant's permanent total disability. The issues are permanent total disability and responsibility for the permanent total disability.

The Board affirms the Referee's finding that claimant is permanently totally disabled. However, we reverse that portion of the order that found SAIF responsible.

In 1979 claimant was employed by EBI insured as a cement mason. Claimant experienced problems with pain, crepitation and limitation of motion in both knees. He filed an occupational disease claim with EBI. The claim was accepted and claimant received a Determination Order in November 1979 awarding him 10 percent (15 degrees) scheduled permanent disability for the loss of function in each leg. Subsequently, claimant returned to his occupation as a mason.

In December 1980, while self-employed, claimant suffered a compensable injury to his low back while lifting. The diagnosis was degenerative joint disease at the L4-5 level aggravated by the industrial accident. In January 1982 claimant underwent a right laminectomy and excision of a bone spur at the L4-5 level. SAIF, the insurer at risk, accepted the claim. Thereafter, a July 1982 Determination Order awarded 25 percent unscheduled permanent disability for claimant's low back and five percent scheduled permanent disability for the loss of use of his right foot. Claimant timely appealed from the Determination Order.

Prior to the issuance of the July 1982 Determination Order, claimant experienced problems with his knees. Following litigation, EBI reopened the claim and in June 1982 claimant underwent surgery for a total left knee replacement. In January 1984 claimant underwent a translocation of the tibial tuberosity for the subluxating patella of his left knee. Knee problems also persisted in the right knee and in October 1984 he had a total right knee replacement. A November 1985 Determination Order awarded claimant an additional 40 percent scheduled permanent disability for the loss of function of the left leg and 45 percent unscheduled permanent disability for the right leg. Claimant timely appealed the Determination Order.

Claimant appealed each Determination Order concerning

his knee conditions as well as his low back condition. In each hearing request, he asserted entitlement to permanent total disability. The requests for hearings were consolidated into a single hearing. The Referee found SAIF responsible for claimant's award of permanent total disability. We disagree.

ORS 656.206(1)(a) requires a claimant's preexisting disability to be considered when determining whether claimant is permanently and totally disabled. Generally, the extent of disability is rated as it exists at the time of hearing. Gettman v. SAIF, 289 Or 609 (1980). However, "[U]nlike a pre-existing disability, see ORS 656.206(1)(a), a subsequent non-compensable injury is not relevant in determining the extent of the worker's permanent disability." Emmons v. SAIF, 34 Or App 603, 605 (1978). See Fowler v. SAIF, 82 Or App 604 (1986). Further, post-industrial injury progression of a preexisting disability cannot be considered in measuring impairment. John D. Kreutzer, 36 Van Natta 285, aff'd mem, 71 Or App 355 (1984); See also Frank Mason, 34 Van Natta 568, aff'd mem, 60 Or App 78 (1982). Therefore, the disability resulting from a preexisting condition is considered as it existed at the time of the injury. John D. Kreutzer, supra.

Viewed as separate claims, this case presents an unusual situation. From EBI's standpoint, claimant's back injury occurred subsequent to his occupational disease claim for his knees. Therefore, in considering whether claimant is permanently totally disabled EBI asserts that the disability from claimant's back cannot be considered. See Fowler, supra. From SAIF's viewpoint, claimant's knee claims are a preexisting condition unrelated to his accepted back condition. Therefore, in determining permanent total disability, the disability resulting from the knee claims can only be considered as it existed at the time of the 1982 low back injury. John D. Kreutzer, supra. In both situations, claimant would be unable to combine the disability from two compensable injuries in determining permanent total disability.

However, preventing claimant from combining the effects of two compensable injuries for the determination of permanent total disability would be contrary to ORS 656.206(1)(a). Therefore, under the unusual circumstances presented in this case, we conclude that disability was properly rated as it existed at the time of the hearing. We also conclude that claimant was not permanently totally disabled until after the aggravation of his knees. See Morris v. Denny's, 53 Or App 863 (1981). The aggravation of the knee claims was the last event to contribute to claimant's disability; and the increased disability due to the aggravation resulted in claimant becoming permanently totally disabled. Therefore, as the last contributor, EBI is responsible for claimant's permanent total disability award.

We find the permanent total disability issue to have been of average difficulty with an ordinary likelihood of success on Board review. A reasonable attorney fee is therefore awarded.

ORDER

The Referee's order dated June 26, 1986 is affirmed in part and reversed in part. That portion of the order that found the SAIF Corporation responsible for claimant's permanent total disability award is reversed. EBI Companies is responsible for

claimant's permanent total disability award. The remainder of the order is affirmed. Claimant's attorney is awarded $600 for services on Board review, to be paid by the SAIF Corporation. EBI Companies shall reimburse the SAIF Corporation for all claim costs incurred since the Referee's order.

ROBERT C. JAQUES, Claimant
Parker, Bowe, et al., Claimant's Attorneys
Davis, Bostwick, et al., Defense Attorneys

WCB 86-15437
April 10, 1987
Order Denying Motion to Dismiss

The insurer has moved the Board for an order dismissing claimant's request for Board review on the ground that a copy of the request was not served upon all parties. See ORS 656.289(3); 656.295(2).

The Referee's order issued January 14, 1987. Claimant's request for Board review was mailed February 9, 1987 and received by the Board February 11, 1987. A certificate of service, submitted with claimant's request, indicated that a copy of the request had been mailed to the insurer's attorney. The insurer's counsel does not contend otherwise. However, neither the insurer nor its insured received a copy of the request for review.

No assertion is made that the insurer has been prejudiced by the lack of timely personal notice of the request for review. In the absence of a showing of prejudice to a party, timely service of a request for Board review on the attorney for a party is adequate compliance with ORS 656.295(2) to vest jurisdiction in the Board. Argonaut Insurance v. King, 63 Or App 847, 850-51 (1983); Nollen v. SAIF, 23 Or App 420, 423 (1975), rev den (1976); Karen J. Bates, 38 Van Natta 964 (1986). Accordingly, the motion is denied.

IT IS SO ORDERED.

ROZALIA MAL, Claimant
Peter O. Hansen, Claimant's Attorney
Cummins, et al., Defense Attorneys

WCB 84-06350 & 85-09396
April 10, 1987
Order on Review

Reviewed by Board Members McMurdo and Lewis.

The insurer requests review of those portions of Referee St. Martin's order that: (1) set aside its denial of claimant's occupational disease claim for bilateral carpal tunnel syndrome; and (2) set aside its denial of claimant's claim for a psychological reaction alleged to be related to her compensable low back injury. The insurer asks that if its denials are upheld, claimant's extent of low back disability be rated. Claimant cross-requests review of those portions of the Referee's order that: (1) denied her request for "interim" compensation for the period of March 2, 1985 through December 24, 1985; and (2) denied her request for penalties and attorney fees for the insurer's alleged failure to timely commence interim compensation payments. The issues are the compensability of claimant's carpal tunnel condition and her psychological reaction, extent of unscheduled permanent partial disability, interim compensation and penalties and attorney fees.

We affirm those portions of the Referee's order that set aside the insurer's denial of claimant's claim for a psychological condition, and denied her request for interim compensation and

associated penalties and attorney fees. We reverse that portion of the order that found claimant's carpal tunnel condition to be compensable.

Claimant sustained a compensable low back injury in June 1983. A Grade I spondylolisthesis was found and a herniated L5-S1 disk was suspected. A subsequent myelogram and CT scan, however, were normal. No permanent impairment was anticipated. The initial claim was closed by Determination Order with an award of temporary disability compensation only.

Claimant came under the care of Dr. Eric Long, a "physical medicine" physician, in March 1984. More than a year after claimant's low back injury, Dr. Long's chart notes contained a reference to claimant's complaints of "coldness" and sensitivity in her upper extremities. Claimant indicated that she was "quite sure" she had no upper extremity complaints while employed as a janitor prior to the low back injury. Long diagnosed bilateral carpal tunnel syndrome and initially found it unrelated to claimant's industrial injury. He reiterated that opinion in a January 1985 chart note. In a report issued approximately the same date, however, Long stated that claimant's carpal tunnel symptoms "appear to relate to work activity while employed by [employer] though not clearly to the low back incident." Claimant filed a claim for bilateral carpal tunnel syndrome on January 14, 1985. The claim was denied nine days later.

On February 6, 1985, Dr. Wilson, a neurologist, disagreed that claimant had carpal tunnel syndrome in the first instance. The next day, Dr. David Long, an orthopedist, reported that when he had first examined claimant in late 1984, she made no complaints of upper extremity discomfort. Two weeks later, he opined that there was no causal relationship between claimant's compensable injury and her carpal tunnel disease. Dr. Nathan, a hand surgeon, testified at hearing that claimant's carpal tunnel condition was ideopathic.

Dr. Eric Long was deposed. He testified that he based his opinion regarding the relationship between claimant's bilateral carpal tunnel condition and her work on claimant's representations regarding her job duties. He also testified, however, that he was unaware of claimant's off-the-job activities and that she was a "poor historian."

Claimant asserts that her work activities while working as a janitor caused her carpal tunnel disease. Claimant's claim appears to be framed, and we feel appropriately, as one for occupational disease. In order to establish her claim, therefore, claimant must prove that her work was the major contributing cause of her condition. Dethlefs v. Hyster Co., 295 Or 298 (1983).

After reviewing the record, we conclude that claimant has failed to sustain her burden of proof. The medical evidence is divided. Dr. Eric Long has concluded that claimant's carpal tunnel condition was, in fact, caused by her work activities. His opinion, however, is unpersuasive for two reasons: First, although his opinion is based largely on claimant's work history, Dr. Long characterized claimant as a poor historian. Second, he admitted that he had no information regarding claimant's off-the-job activities. He could, therefore, not compare claimant's on-the-job activities with those off-the-job for the purpose of reaching an opinion on causation.

The remaining medical evidence does not support the claim. Dr. Wilson found no evidence of carpal tunnel syndrome in the first instance. Dr. David Long found no evidence of the condition during the pertinent claim period. Dr. Nathan acknowledged the presence of the condition, but felt that it was unrelated to claimant's work. We find these opinions persuasive when compared with that of Dr. Eric Long. Claimant has failed to sustain her claim.

ORDER

The Referee's order dated April 10, 1986 is reversed in part and affirmed in part. That portion of the order that set aside the insurer's denial of claimant's claim for bilateral carpal tunnel disease is reversed. The insurer's denial of bilateral carpal tunnel disease is reinstated. The remainder of the order is affirmed. For prevailing against the denial of claimant's psychological claim on Board review, claimant's attorney is awarded a fee of $550, to be paid by the insurer.

IRENE L. MCMANUS, Applicant
Ann Kelley, Ass't. Attorney General

WCB CV-87001
April 10, 1987
Findings of Fact, Conclusions and Proposed Order (Crime Victim Act)

Pursuant to notice, a hearing was conducted and concluded by Roger C. Pearson, special hearings officer, on March 13, 1987 at Salem, Oregon. Applicant, Irene L. McManus, was present and not represented by counsel. The Department of Justice Crime Victim Compensation Fund ("Department") was represented by Ann Kelley, Assistant Attorney General. The court recorder was Charles Fredman. The record was closed March 13, 1987.

Applicant has requested review by the Workers' Compensation Board of the Department's Findings of Fact, Conclusions and Order on Reconsideration dated December 1, 1986. By its order, the Department found that applicant was entitled to benefits as a victim of a crime under ORS 147.005 to 147.365. However, the Department declined applicant's request for waiver of the $250 statutory deductible.

FINDINGS OF FACT

Applicant was physically assaulted and robbed on May 27, 1986 in Portland, Oregon. As a result of this unprovoked attack, she sustained injuries to her left elbow, ribs, and right knee. Applicant was hospitalized for approximately three days. Her period of convalescence ended on June 16, 1986, when she returned to work. While recuperating from her injuries, applicant missed 14 days of work.

Since applicant did not receive a paycheck for some five weeks and was without savings, she was in need of financial assistance. Consequently, she obtained a $400 personal loan from a coworker in June 1986. Repayment began in August, with full satisfaction achieved by December 1986.

Applicant is employed as a salad supervisor for a food service provider. She works 40 hours a week and receives $4.45 per hour. Her gross weekly earnings total $184.75. After federal and state deductions, her weekly earnings total $138.70. This amount is further reduced by applicant's voluntary contribution to a bond and profit sharing plan provided by her employer. Her two-week "take home" pay is approximately $226.

Shortly after the assault, a police detective informed applicant of her potential entitlement to benefits under the Crime Victims' Compensation Program. Applicant was advised that she had six months within which to file her claim. The detective further recommended that she compile all of her hospital bills before submitting her application.

Relying on the detective's suggestion, applicant did not file her claim until August 26, 1986. According to the "Employment and Earnings Information" section of the claim, applicant's net monthly income was $886.50. Her husband was also listed as a dependent. Alleging extreme financial hardship, applicant requested waiver of the $250 statutory deductible.

At the time of the attack, applicant was residing with her husband. Mr. McManus was receiving monthly permanent disability benefits of approximately $416. The couple was without additional sources of income. Their monthly expenses were between $600 and $700. Applicant and her husband separated on July 22, 1986. Applicant insists that she provided the Department with this information. A letter which apparently accompanied her application noted that she was currently residing with her mother. However, the letter does not mention the couple's separation.

Applicant timely filed her claim for benefits under the Compensation of Crime Victims Act. As a result of her injury, she has incurred medical expenses in excess of the $250 statutory minimum and lost wages from her food service position.

The Department accepted the claim. Based on applicant's household income at the time of her application, the Department concluded that she did not qualify for waiver of the $250 statutory deductible. Accordingly, since applicant's net lost earnings were computed to be $388.36, the Department awarded $138.36. Applicant requested reconsideration, contending that her income should have been considered at the time of her injury rather than at the time of her application.

On reconsideration, the Department further explained its calculations of applicant's net income. Relying on its standard formula for computing monthly incomes from weekly wages, the Department concluded that applicant's monthly net income equalled $600.99. With her husband's monthly income of $416, the couple's combined monthly income totalled $1,016. Finding no new evidence reflecting a change in the aforementioned figures, the Department adhered to its prior order.

Applicant testified in a candid and forthright manner. Consequently, based on my personal observation, I find her to be a credible witness.

CONCLUSIONS

The standard of review for cases appealed to the Board under the Act is de novo on the entire record. ORS 147.155(5); Jill M. Gabriel, 35 Van Natta 1224, 1226 (1983).

Pursuant to ORS 147.015, applicant is entitled to an award under the Compensation of Crime Victims Act (Act), if, among other requirements:

> "(1) [She] 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."

In determining the amount of compensation to which an applicant is entitled, the Department shall consider the facts stated on the application for compensation. ORS 147.125. In reaching this determination, the Department shall deduct the sum of $250, unless it finds that the deduction will result in an extreme hardship to the applicant. ORS 147.125(4). A single person without dependents will be eligible for a waiver of the statutory $250 deductible if the person's net monthly income from all sources is $600 a month or less. OAR 137-76-035(1). A married victim without dependents will be eligible for the deductible if the combined income of the victim and spouse is $800 a month or less. OAR 137-76-035(2).

Following my de novo review of the documentary and testimonial evidence, I find that applicant is entitled to benefits from the Crime Victims' Compensation Fund. However, I am not persuaded that the statutory deductible should be waived. Accordingly, I conclude that the Department's Order on Reconsideration should be affirmed.

Applicant has three basic objections to the Department's decision. To begin, she asserts that her net weekly earnings were incorrectly computed. Secondly, she argues that her income should not be considered as of the date of her application, but rather at the time of her injury. Thirdly, she contends that since she is separated from her spouse, his income should not be included as a source of income.

The Department arrived at the $600.99 monthly figure by using a standard formula that converts weekly earnings into equivalent monthly earnings. See generally OAR 137-76-040. This determination was based on information provided by applicant's employer. Applicant neither objects to the gross earning figure nor the federal/statutory deductions. However, she argues that the weekly figure does not accurately depict her actual "take home" pay. Specifically, applicant suggests that her pay is further reduced by her contribution to her employer's bond and profit sharing plan.

This payroll deduction undoubtedly lessens applicant's immediate cash reserves. Yet, it is an investment specifically designed to benefit applicant's personal financial welfare. Moreover, the contribution is strictly voluntary. Although applicant is fully entitled to the aforementioned earnings, she

has chosen to invest these funds in the hopes of realizing additional benefits sometime in the future. This voluntary decision to defer a portion of her income should not be interpreted as a further reduction of her net earnings. Accordingly, I am persuaded that the Department's determination accurately reflects applicant's weekly and monthly net earnings.

Applicant next argues that her income should have been considered as of the date of her injury rather than at the time of her application. I disagree. ORS 147.125 expressly states that the Department shall apply the $250 statutory deductible, unless the deduction will result in an extreme hardship to the applicant. Since such an evaluation cannot be undertaken until an application has been filed, it would follow that the relevant time to determine "extreme hardship" is the date of the application. This conclusion is further supported by the "emergency award" provisions of ORS 147.055. Pursuant to this statute, an emergency award may be made prior to a final decision concerning the claim, if the Department finds that an award will probably be forthcoming and that "undue hardship will result . . . if immediate payment is not made." (Emphasis added).

Had applicant filed her application immediately after the assault, the evidence suggests that she may have qualified for an emergency award, if not a waiver of the statutory deductible. Unfortunately, apparently due to some misleading advice, she refrained from submitting her claim until her physical condition had stabilized. By that time, her financial crisis had eased to a point that could not be considered to be "an extreme hardship" as defined by statutory and administrative guidelines.

Finally, applicant contends that her spouse's monthly disability pension should not have been considered in evaluating her sources of income. She further asserts that she advised the Department of her separation when she filed her claim. The record does not indicate that the Department was ever expressly notified of the couple's separation. Thus, the calculations of applicant's income based on a combined income are understandable. However, even when applicant's claim is analyzed as one for a single person, her monthly income exceeds the $600 "waiver eligibility" requirement as contained in OAR 137-76-035. Accordingly, whether viewed as a single or married person, applicant does not qualify for a waiver of the $250 statutory deductible.

Applicant presented her case in a very polished and informative manner. I recognize her objections and appreciate her frustrations. Yet, the relevant statute clearly requires the Department to apply a statutory deductible, unless the applicant would suffer an extreme hardship. In complying with this mandate, the Department has formulated rules to establish eligibility for waiver of the statutory deductible. Applicant has unquestionably suffered financially as a result of the attack. However, her situation does not satisfy the minimum requirements that would entitle her to a waiver of the deductible.

It may be of some interest to applicant to learn that the Director of the Crime Victims Compensation Program is currently supporting legislation that would eliminate the statutory deductible. It is apparently the goal of the Director to remove "any statutory language which implies that innocent crime victims are in any way responsible for their victimization." Of course, if enacted, this legislation would not

apply to applicant's situation. Yet, hopefully she can take some comfort in knowing that her determination in advocating her position may eventually contribute to the abolition of this statutory requirement.

PROPOSED ORDER

I recommend that the Findings of Fact, Conclusions and Order on Reconsideration of the Department of Justice Crime Victim Compensation Fund dated December 1, 1986 be affirmed.

LARRY L. MOE, Claimant
Vick & Associates, Claimant's Attorneys
Davis, Bostwick, et al., Defense Attorneys

WCB 85-10486
April 10, 1987
Order Withdrawing Order of Dismissal

Claimant has requested reconsideration of the Board's Order of Dismissal dated March 23, 1987 which granted the insurer's motion to dismiss his request for Board review on the ground that a copy of the request was not timely mailed to the parties. We withdraw our prior order.

The Referee's order issued January 29, 1987. Claimant's request for Board review was received by the Board's Portland office on March 2, 1987. A certificate of service, submitted with claimant's request, indicated that copies of the request had been mailed to the insurer and its attorney on March 2, 1987. The insurer's counsel does not contend otherwise. However, the insurer asserts that its insured did not timely receive a copy of the request for review.

A Referee's order is final unless, within 30 days after the date on which a copy of the order is mailed to the parties, one of the parties requests Board review under ORS 656.295. ORS 656.289(3). Requests for Board review shall be mailed to the Board and copies of the request shall be mailed to all parties to the proceeding before the Referee. ORS 656.295(2).

The time and manner of filing a request for Board review of a Referee's order are set forth in ORS 656.289 and 656.295. OAR 438-11-005(1). Reading the aforementioned statutes together, it is clear that in order to vest the Board with jurisdiction, a request for review must be mailed to the Board within 30 days of the date the Referee's order is mailed. Although ORS 656.295(2) does not use the word "filing," the Board's administrative rules equate "filing" and "mailing." Compare ORS 656.298(3) (notice of appeal to court must be "filed" with the court.) Pursuant to the Board's rules, "filing" means either: (1) the receipt of a document by the Board at any office of the Board; or (2) date of mailing. OAR 438-05-040(a), (b); OAR 438-11-005(2).

Here, the Referee's order issued on January 29, 1987. The thirtieth day after January 29, 1987 was February 28, 1987, a Saturday. Claimant's request for review was physically delivered to the Board's Portland office on Monday, March 2, 1987.

In computing time periods, if the last day falls on a Saturday, Sunday, or legal holiday, the period runs until the end of the next business day. OAR 438-05-040(4)(c). Therefore, since

claimant's request for review was received by one of the Board's offices on the next business day following the end of the statutory 30-day time period, it was timely filed.

We also conclude that claimant provided timely notice of his request for review. The certificate of service indicates that copies of the request were mailed to the insurer and its attorney on March 2, 1987, which was the next business day following the expiration of the statutory 30-day period. As discussed above, this notice was timely. See ORS 174.120; 656.289(3); 656.295(2); OAR 438-05-040(4)(c). Furthermore, no assertion is made that the insured has been prejudiced by the lack of timely personal notice of the request for review. In the absence of a showing of prejudice to a party, timely service of a request for Board review on the attorney for a party is adequate compliance with ORS 656.295(2) to vest jurisdiction in the Board. Argonaut Insurance v. King, 63 Or App 847, 850-51 (1983); Nollen v. SAIF, 23 Or App 420, 423 (1975), rev den (1976); Karen J. Bates, 38 Van Natta 964 (1986).

Accordingly, the insurer's motion to dismiss claimant's request for Board review is denied.

IT IS SO ORDERED.

VERNON K. BURR, Claimant
Pozzi, et al., Claimant's Attorneys
Daryll E. Klein, Defense Attorney

WCB 85-10817
April 14, 1987
Order on Review

Reviewed by Board Members McMurdo and Lewis.

Claimant requests review of that portion of Referee Seymour's order that upheld the insurer's denial of claimant's aggravation claim for a neck condition. The issue on review is whether claimant has proven an aggravation.

Claimant, a 53-year-old truck driver, sustained a prior industrial injury to his neck and ribs in January 1983. The claim was closed by Determination Order of June 1983, awarding 10 percent unscheduled permanent disability.

On May 3, 1984, claimant compensably injured his neck, right shoulder, low back, and right wrist. Dr. McMullan, Jr., M.D., diagnosed inter alia neck and back sprain. Later that month, Dr. Schuler, claimant's treating orthopedist, reported neck stiffness and arthritis in the apophyseal joints at C5-6 and 7. Dr. Schuler treated conservatively with emphasis on the right wrist, rather than the neck.

In July 1984, claimant returned to regular work as a long-haul truck driver. Due to neck and right wrist pain, claimant quit his job after approximately two months and began lighter work as a mechanic. His right wrist pain continued and in September 1984, Dr. Schuler took him off work. Claimant felt that Dr. Schuler's treatment was not adequately addressing his neck condition. Consequently, he changed treating physicians in January 1985, and began treatment with Dr. Schmidt, a chiropractor. Dr. Schmidt's treatment was infrequent and sporadic. In March 1985, claimant began work as a short-haul truck driver.

In July 1985, claimant returned to Dr. Schuler for a closing examination. Dr. Schuler noted good range of neck motion and few objective findings, but continued discomfort in the neck. That same month, a Determination Order issued awarding an additional 10 percent unscheduled permanent disability.

Claimant continued working as a short-haul driver until approximately January 28, 1986, when he quit work and reported to Dr. Schmidt with neck pain and headaches. Claimant testified that his neck would get stiff and he would have to stop his truck, take aspirin, and sleep awhile.

In April 1986, the insurer sent claimant to Dr. Thompson, an orthopedist, for an independent medical examination. Dr. Thompson found limited cervical motion in "distinct contrast" to the findings of Dr. Schuler in July 1985. Dr. Thompson concluded his report by stating, "that [claimant's] current problem is within medical probability more due to the underlying spondylosis [at C5-6 and C6-7] than to the accident of May 1984."

In May 1986, the insurer denied claimant's aggravation claim. Shortly thereafter, Dr. Schmidt reported that claimant had experienced a "definite worsening" of his condition and that the May 1984 injury, was the "material contributing factor." Dr. Schmidt further reported lesions at C1-C2 and C2-C3.

The Referee found that Dr. Schmidt was not "convincing," that claimant had not experienced a worsening, and that claimant's neck condition, even if stemming from the upper cervical area, did not relate to the May 1984 injury.

We disagree with the Referee's findings for the following reasons.

It is claimant's burden to prove his case by a preponderance of the evidence. Hutcheson v. Weyerhaeuser Co., 288 Or 51, 56 (1979). In aggravation cases, a claimant must show: (1) a worsening of his condition, which makes him more disabled (i.e., less able to work) than at the time of the last arrangement of compensation; and (2) a causal relationship between the worsened condition and the compensable injury. Stepp v. SAIF, 78 Or App 438 (1986); ORS 656.273(1). Increased symptoms alone do not establish an aggravation claim, unless the worker suffers pain or additional disability that reduces his ability to work thereby resulting in a loss of earning capacity. Smith v. SAIF, 302 Or 396 (1986).

We find that claimant has sustained a worsening of his neck condition, which makes him more disabled and less able to work. The last arrangement of compensation in this case, was the Determination Order of July 31, 1985. Twenty days prior to that date, Dr. Schuler examined claimant for the purpose of a closing examination. As previously noted, the results of Dr. Schuler's examination showed good range of motion and little objective findings. In contrast, Dr. Thompson examined claimant approximately three months after the alleged aggravation and reported, "marked limitation of [cervical] motion * * *." Dr. Thompson, acknowledged that these findings were in "distinct contrast" to those of Dr. Schuler's.

At the hearing, claimant testified that in January 1986, he experienced increased pain and had to quit his job as a truck driver:

Q. "What was it about the work there, that last employer, that you finally decided you couldn't take it anymore and went in for treatment?"

A. "My neck. When I was driving, my neck would get sore, get stiff, and I'd have to stop, take Anacins and Tylenol, sleep. I'd wake up feeling good. I could go again."

Similar complaints of pain are shown in Dr. Schmidt's chart notes of January 28, 1986. The chart notes further show that claimant's frequency of treatment sharply increased after January 28, 1986.

When the medical evidence is divided, we generally assign greater weight to the opinion of the treating physician, unless there are persuasive reasons to do otherwise. Dennis L. Priest, 38 Van Natta 1473 (1986); see also Weiland v. SAIF, 64 Or App 810 (1983). Here, Dr. Schmidt unequivocally reported, as well as testified, that claimant's cervical condition worsened. Dr. Thompson, on the other hand, did nothing to show that claimant did not sustain a worsening. In fact, Dr. Thompson found decreased range of motion since July 1985.

As to the second element of claimant's case (i.e., causation), we find that claimant's current cervical condition is causally related to his May 1984 injury. The focus of the medical experts has been whether claimant's cervical condition relates to the upper cervical spine or the underlying spondylosis in the lower cervical spine. However, the dispositive question is not whether claimant's cervical condition is related to the upper or lower cervical area; but rather, whether the May 1984 injury remains a material contributing cause of the condition.

Here, claimant's cervical condition involves one of the same body parts injured in May 1984. In July 1985, Dr. Schuler noted continuing complaints of pain and stiffness in the neck. Later that month, claimant was awarded 10 percent unscheduled permanent disability. Claimant testified that after the May 1984 injury, his neck pains continued and that he was bothered by the same problems as in the beginning. Claimant continued to treat for his neck condition with Dr. Schmidt; albeit, sporadically until January 1986. Finally, Dr. Schmidt states that the May 1984 injury, is the material contributing cause of the cervical condition.

It is well settled that an industrial injury need not be the sole, or even the principal, cause of a disabling condition. Aquillon v. CNA Insurace, 60 Or App 231 (1982). If the industrial injury contributed to the disability, despite other preexisting conditions, the requisite causal connection is met. Aquillon, 60 Or App at 236. Here, claimant was awarded permanent disability and continued to experience neck pain. Dr. Thompson did not state that claimant's condition resulted solely from the preexisting spondylosis. Rather, he states that claimant's condition is merely "more due" to the preexisting spondylosis. Thus, the evidence shows that claimant's neck injury of May 1984 contributed to his current cervical condition.

ORDER

The Referee's order dated June 25, 1986, is reversed in part and affirmed in part. That portion of the Referee's order that upheld the insurer's denial of claimant's aggravation claim, is reversed. The insurer's denial is set aside and the claim remanded to the insurer for processing according to law. Claimant's attorney is awarded $1,200 for services at the hearing and an additional $500 for services on Board review, to be paid by the insurer. All other portions of the Referee's order are affirmed.

JOSEPH H. FISHER, Claimant
Callahan, et al., Claimant's Attorneys
Peggy Shields (SAIF), Defense Attorney

Own Motion 87-0171M
April 14, 1987
Own Motion Order

SAIF Corporation has submitted to the Board claimant's claim for an alleged worsening of his June 26, 1979 industrial injury. Claimant's aggravation rights have expired. Pursuant to a recent Opinion and Order, SAIF was ordered to accept responsibility for claimant's bilateral carpal tunnel syndrome. SAIF has appealed the Referee's order to the Board for review.

Generally the Board would postpone action on the request for own motion relief until compensability of the claimed condition has been resolved. In this instance, we have concluded that a reversal of the Referee's order would not serve to change our decision and will proceed with a review of the own motion request.

Claimant has not been gainfully employed since his injury. He is apparently receiving Social Security benefits. We note that he has also received permanent disability compensation totalling 320 degrees for 100 percent unscheduled disability. The request for reopening seeks a ruling on claimant's entitlement to compensation for temporary total disability. The Supreme Court in Cutright v. Weyerhaeuser Company, 299 Or 290 (1985), states that temporary total disability benefits "are wage replacement for those persons working or seeking work." It goes on to state that non-workers cannot lose earnings and temporary disability benefits are intended to replace lost income during a worker's period of recovery. Claimant in this case has not lost any earnings as a result of his current condition and, therefore, would not be entitled to temporary total disability even if the bilateral carpal tunnel condition was compensable. The request for own motion relief is hereby denied.

IT IS SO ORDERED.

JOY S. LUCAS, Applicant
Ann Kelley, Ass't. Attorney General

WCB CV-86010
April 14, 1987
Order of Abatement

The Board has received applicant's request for reconsideration of the special hearings officer's proposed order dated March 16, 1987. In her request, applicant expresses her dissatisfaction with the special hearings officer's conclusion that she was not a victim of a "compensable crime."

Applicant further expresses her intention to secure legal representation. This is certainly applicant's prerogative. However, she is advised that the responsibility for retaining legal counsel rests with her. Moreover, there is no statutory provision which requires the Department to pay her attorney's fee should she prevail. Finally, she is reminded that the representation she procures is prohibited from charging her any fee. ORS 147.315; OAR 438-82-055.

Accordingly, in order to allow sufficient time to consider applicant's request, the proposed order is abated. Applicant is given thirty (30) days from the date hereof to obtain legal counsel. If and when she obtains representation, her counsel is directed to file a memorandum in support of applicant's request for reconsideration. Once applicant's response has been filed, the Department shall have fourteen (14) days to file its reply. After each party has presented their respective positions, the Board will take this matter under advisement.

If applicant does not secure legal representation within thirty (30) days from the date hereof, the Board will consider this matter based on the record and arguments as presently presented.

IT IS SO ORDERED.

The Beneficiaries of
ALFRED F. PUGLISI (Deceased), Claimant
Moscato & Byerly, Attorneys
SAIF Corp Legal, Defense Attorneys

WCB 85-11069 & 86-07378
April 14, 1987
Order of Dismissal

The self-insured employer has moved the Board for an order dismissing claimant's alleged beneficiary's request for Board review on the ground that a copy of the request was not timely mailed to the parties. The motion is granted.

The Referee's Order of Dismissal issued January 7, 1987. A request for Board review was timely mailed on February 6, 1987. The Board received the request on February 9, 1987. Neither an acknowledgement of service nor a certificate of personal service by mail was provided with the request. A computer generated letter acknowledging the request for Board review was mailed on February 11, 1987. This letter was received by the employer's counsel on February 13, 1987. This was the employer's first notice of the request for review. After contacting the Board, the employer received a copy of the request for review on March 3, 1987.

A Referee's order is final unless, within 30 days after the date on which a copy of the order is mailed to the parties, one of the parties requests Board review under ORS 656.295. ORS 656.289(3). Requests for Board review shall be mailed to the Board and copies of the request shall be mailed to all parties to the proceeding before the Referee.

In Argonaut Insurance v. King, 63 Or App 847, 852 (1983), the court held that "compliance with ORS 656.295 requires that statutory notice of the request for review be mailed or actual notice be received within the statutory period." In King, the request for review was timely, but copies of the request were never sent to the other parties. The "actual notice" referred to

by the court was the Board's computer generated acknowledgement letter, which the evidence established was received by the insurer more than 30 days after the Referee's order was mailed. Inasmuch as the insurer's notice of the request for review was untimely, the court found that the Board lacked jurisdiction to consider the appeal.

Here, the self-insured employer was not provided with a copy of the request for Board review in a timely manner and did not receive actual knowledge of the request within the statutorily required 30 day period. Consequently, we lack jurisdiction to review the Referee's order, which has become final by operation of law. We are mindful that the alleged beneficiary was not represented by counsel when she requested Board review. We further realize that an unrepresented party is not expected to be familiar with administrative and procedural requirements of the Workers' Compensation Law. However, we are not free to relax a jurisdictional requirement, especially in view of Argonaut Insurance v. King, supra, 63 Or App at 851 n. 2. Julio P. Lopez, 38 Van Natta 862 (1986).

Accordingly, the self-insured employer's motion to dismiss the request for Board review is granted. The request for review is dismissed.

IT IS SO ORDERED.

GARY L. SCHOONOVER, Claimant
Leistner, et al., Claimant's Attorneys
Dennis Ulsted (SAIF), Defense Attorney
Brian Pocock, Defense Attorney

WCB 86-06302
April 14, 1987
Order on Review

Reviewed by Board Members Lewis and McMurdo.

Claimant requests review of Referee Daron's order that increased claimant's award of unscheduled permanent partial disability for his low back from the 75 percent (240 degrees) previously awarded to 95 percent (304 degrees). Claimant contends that he is entitled to an award of permanent total disability. The issue is extent of disability, including permanent total disability.

Claimant injured his low back on January 16, 1980 in the course of his employment as a core feeder at a plywood mill when he slipped and fell, landing on his right buttock. Since the accident, claimant has undergone three low back operations. The first of these, a laminectomy and discectomy at L4-5, was performed by Dr. Stainsby, a neurosurgeon, on January 29, 1980. After the surgery, claimant returned to work part time in June 1980 and to his regular work full time in September 1980. The claim was closed by Determination Order dated October 22, 1980 with a 20 percent unscheduled award.

In July 1981, claimant visited Dr. Rockey, an orthopedic surgeon, complaining of increased pain in his low back and right leg. The claim was reopened and Dr. Rockey performed a laminotomy, disc debridement and decompression at L4-5 on November 4, 1981. This surgery did not alleviate claimant's complaints and on March 26, 1982, Dr. Rockey performed a fusion from L4 through S1. After the third surgery, Dr. Rockey indicated

that claimant was "substantially" impaired and that he should not return to his previous job or other similar employment. He declared claimant medically stationary on January 5, 1983.

On February 1, 1983, claimant was examined by Dr. Holland, a psychiatrist. Dr. Holland diagnosed depression as a result of claimant's industrial injury and recommended psychiatric counseling in association with vocational rehabilitation efforts. He stated, however, that claim closure should not be delayed on account of claimant's psychiatric problems. A second Determination Order was issued on February 3, 1983 which increased claimant's award of unscheduled permanent partial disability to 35 percent.

In April 1983, claimant began an authorized training program (ATP) in electronics assembly. According to the vocational reports, claimant was highly motivated and progressed well until he began working with electronic components. At that time, it was discovered that claimant could not identify certain components accurately because he was color blind. After nearly five months of training, therefore, the program was terminated.

In December 1983, claimant began a second ATP, this time in the area of sales. The ATP involved extensive classroom instruction at a community college and claimant soon began experiencing increased back pain as a result of the sitting required. In mid-January 1984, claimant fell when his right leg suddenly collapsed under him. A couple of weeks later, claimant was examined by Dr. Rockey. Dr. Rockey thought that another surgery might be necessary and recommended that claimant discontinue his schooling. A short time later, claimant's second ATP was terminated.

In April 1984, claimant was examined by a panel of the Orthopaedic Consultants. They recommended against further surgery, but did recommend treatment at a pain center. Dr. Rockey later concurred in these recommendations. Claimant was evaluated and accepted by the Northwest Pain Center and participated in its program during June and July 1984. He reportedly made significant progress during the program. Upon discharge, the staff indicated that claimant was capable of performing work in the light and sedentary categories.

In November 1984, claimant began a work tolerance assessment program to determine his suitability for another ATP. Claimant experienced increased back pain during this program. In April 1985, Dr. Holland opined that claimant would have permanent psychological impairment in the range of 50 to 95 percent. The following month he stated that he doubted, realistically, whether claimant would ever be able to return to work. Another Determination Order issued on May 7, 1985 which increased claimant's total unscheduled award to 75 percent.

After claim closure, claimant was again referred for vocational rehabilitation. The vocational counselor and claimant discussed various vocational alternatives and settled on a vocational goal of leather work in a saddle shop. The counselor then contacted a leather shop and arranged for a three-week, four-hour per day work evaluation. Claimant began the evaluation on

December 3, 1985. Within a week, he experienced a marked increase in low back pain and right leg weakness and had to seek medical treatment. After a couple of days off, claimant returned on a reduced schedule, gradually worked his way back to four hours per day and completed the evaluation.

After the evaluation, the owner of the leather shop filled out a questionnaire provided by the vocational counselor. The owner stated that claimant had put forth "a 100 percent effort" during the entire evaluation. His ultimate conclusion, however, was that claimant was not suitable for leather work. He stated:

> "I feel that it would be a waste of time and money for [claimant] to continue in saddle making course. Partly due to his ability to produce a quality product. But mainly due to his lack of physical ability to stand, sit, or bend over to work on things. I feel that [claimant] would never be able to go at a fast enough pace, or put the hours in to make a living at saddle making."

Soon thereafter, claimant's vocational file was closed. In April 1986, Dr. Holland stated that he would rate claimant's permanent psychological impairment at 60 percent. On April 29, 1986, another Determination Order issued which granted no permanent disability in addition to that previously awarded. Claimant requested a hearing.

The case came to hearing on June 30, 1986. Claimant was 46 years old at the time of the hearing. He had 12 years of formal education, but did not graduate. He later obtained a GED, however. Nearly his entire employment history was in heavy plywood mill work. He testified in a candid and credible manner concerning his physical limitations, daily activities and personal work search activities.

Claimant's most recent vocational counselor also testified. He indicated that claimant would never be able to return to full-time employment in any capacity and stated that he was uncertain whether claimant was capable of employment on a half-time basis. When pressed, he did suggest three possibilities for part-time employment: security guard, night motel clerk and ticket taker. Even these possibilities, however, were acknowledged as very uncertain. Near the end of his testimony, the vocational counselor stated that he thought that claimant had given a maximum effort in vocational rehabilitation.

The Referee concluded that claimant was not entitled to an award of permanent total disability on the basis of the testimony of the vocational counselor regarding claimant's possible ability to work part time in a limited number of jobs. The Referee did conclude, however, that claimant was entitled to additional permanent partial disability and increased the award to 95 percent.

In order to establish entitlement to an award of permanent total disability, a claimant must establish that he is permanently incapacitated from regularly performing work at a gainful and suitable occupation. ORS 656.206(1)(a). He must also establish that he is willing to seek regular gainful employment

and that he has made reasonable efforts to obtain such employment. ORS 656.206(3).

We conclude that claimant has carried his burden in this case. He is seriously impaired, both physically and psychologically, because of his industrial injury. He has participated enthusiastically and to the best of his ability in multiple vocational rehabilitation programs. He has attempted to find employment on his own. Although there is some indication in the record that claimant may be able to work part time in a limited number of jobs, claimant's ability to do so was acknowleged as speculative at best. Speculation cannot be substituted for current reality. See Gettman v. SAIF, 289 Or 609, 614 (1980).

Claimant is awarded permanent total disability effective June 30, 1986, the date of the hearing. See Robert F. Hileman, 38 Van Natta 1522 (1986). The SAIF Corporation is authorized to offset unscheduled permanent partial disability compensation paid pursuant to the Referee's order against the compensation granted by this order. See Pacific Motor Trucking Co. v. Yeager, 64 Or App 28, 31-32 (1983); Donald V. Wilkinson, 37 Van Natta 937 (1985).

ORDER

The Referee's order dated July 24, 1986 is modified. Claimant is awarded permanent total disability effective June 30, 1986. In lieu of the attorney fee awarded by the Referee, claimant's attorney is awarded 25 percent of the increased compensation granted by this order, not to exceed a total fee of $3,000 for services at the hearing and on Board review.

ROBERT L. TRUMP, Claimant
Wade P. Bettis, Jr., Claimant's Attorney
Mitchell, et al., Defense Attorneys
SAIF Corp Legal, Defense Attorney

Own Motion 84-0505M & 84-506M
April 14, 1987
Own Motion Order

Claimant has had two compensable low back injury claims. The first, a 1969 injury claim was processed by Scott Wetzel Services and resulted in a 15 percent unscheduled permanent disability award. The second occurred in 1975 and was the responsibility of the SAIF Corporation. This injury culminated in a 10 percent award. Claimant's aggravation rights have expired.

In 1984, claimant's symptoms increased, prompting additional surgery. Both insurers denied responsibility for his medical services claim. Because of pending hearing requests concerning the denials, we referred claimant's request for own motion relief to the Referee. On February 15, 1985, Referee Wasley recommended that: (1) the Board find that claimant's condition had worsened; and (2) claimant's 1975 injury claim with SAIF be reopened. SAIF requested Board review of that portion of Referee Wasley's order which set aside its denial of the medical services claim.

Pending the appeal, we directed SAIF to pay temporary total disability benefits beginning August 5, 1984 and to continue until closure pursuant to ORS 656.278. Robert L. Trump, Own Motion Order, March 20, 1985. On August 23, 1985, we reversed the Referee's order and found Scott Wetzel responsible for the medical

services claim. Robert L. Trump, 37 Van Natta 1115 (1986). In addition, we issued an Own Motion order reopening claimant's 1969 injury claim with Scott Wetzel and subsequently rescinded our prior Own Motion Order that had directed SAIF to pay claimant's temporary disability benefits. Our Order on Review was appealed to the Court of Appeals.

On May 15, 1986, we issued an Own Motion Determination closing claimant's 1969 injury claim with Scott Wetzel. Claimant was awarded temporary total disability from August 5, 1984 through February 24, 1986, less time worked. Scott Wetzel was further authorized to offset any overpaid temporary disability against unpaid temporary or permanent disability awards. Based on this authorization, Scott Wetzel notified claimant that a $2,208.22 overpayment existed for temporary disability benefits made beyond February 24, 1986, the effective date of claim closure.

On July 30, 1986, claimant advised the Board that he had recently completed his vocational rehabilitation and training program. Considering this event, claimant was desirious of obtaining a Determination Order and a permanent disability award. As a final matter, claimant contested the overpayment. On August 19, 1986, we granted Scott Wetzel an opportunity to respond to claimant's requests. To date, no response has been forthcoming from either Scott Wetzel or SAIF.

On September 10, 1986, the Court of Appeals issued its decision reversing the Board's Order on Review. See Hallmark Furniture v. SAIF, 81 Or App 316 (1986). Pursuant to the court's mandate, we reinstated the Referee's order. Robert L. Trump, 38 Van Natta 1416 (1986). Accordingly, SAIF has ultimately been found responsible for claimant's medical services claim.

Based on the foregoing summary, we make the following findings and determinations. We continue to find that claimant's compensable condition worsened so as to warrant the reopening of his claim. Furthermore, we are persuaded that his condition became medically stationary, resulting in the closure of his claim effective February 24, 1986. However, in accordance with the court's ultimate finding, SAIF is responsible for claimant's current condition. Thus, claimant should have received benefits under his 1975 injury claim with SAIF rather than under his 1969 injury claim with Scott Wetzel.

Consequently, we withdraw our previous Own Motion Orders insofar as Scott Wetzel was directed to reopen and process claimant's 1969 injury claim. We conclude that SAIF is responsible for the processing of the claim. Furthermore, should this decision result in an increase of temporary disability compensation, (i.e, if claimant's 1975 wages were higher than his 1969 wages), SAIF is directed to pay any increased compensation to claimant. Finally, that portion of our Own Motion Determination that authorized an offset for overpaid temporary total disability compensation should not apply to benefits paid after February 24, 1986 while claimant was participating in an authorized training program.

As a result of our decision, Scott Wetzel has paid temporary disability benefits that have been found to be the responsibility of SAIF. Had this been a case under ORS 656.307, designation of a paying agent would have enabled the parties to

obtain reimbursement from each other. Yet, since jurisdiction over this matter arose solely under ORS 656.278, the formal procedure available under ORS 656.307 was not applicable. OAR 436-60-180(3); William C. Dilworth, 38 Van Natta 1283, 1284 (1986). Thus, no authority presently exists to grant Scott Wetzel reimbursement for its claim costs. On the other hand, there is no statutory restriction prohibiting the insurers from agreeing to a process of reimbursement similar to a formal ".307" procedure.

Accordingly, we recommend that SAIF reimburse Scott Wetzel for the temporary disability compensation it paid pursuant to our prior Own Motion orders. This reimbursement would include any temporary disability benefits paid to claimant beyond February 24, 1986, the date of claim closure.

Finally, the record suggests that claimant has completed an authorized training program. If this is the case and claimant's condition is considered medically stationary, he is entitled to have his claim redetermined by the Evaluation Division. ORS 656.268(5); Wayne D. Cooper, 38 Van Natta 913 (1986). Consequently, claimant's 1975 injury claim is remanded to SAIF for processing pursuant to ORS 656.268(5). Once the claim is submitted to the Evaluation Division for closure, claimant's request for additional permanent disability and the request for permission to offset any alleged overpayment will be considered.

IT IS SO ORDERED.

FIDELA O. DURGAN, Claimant
Nick Chaivoe, Claimant's Attorney
Jeff Gerner (SAIF), Defense Attorney

WCB 85-01170
April 16, 1987
Order on Review

Reviewed by Board Members Ferris and McMurdo.

The SAIF Corporation requests review of Referee Lipton's order, as twice adhered to on reconsideration, that set aside SAIF's denial of claimant's occupational disease claim for mental stress. The issue is compensability. We reverse.

At the time of the hearing, claimant had been employed by various agencies of the State of Oregon for approximately ten years. She had suffered from emotional problems since 1977, when she began treating with Dr. Parvaresh, a psychiatrist. Initial psychiatric treatment was for problems unrelated to claimant's employment.

In December 1979, claimant began work as a receptionist for an agency of the State Department of Human Resources. Ultimately, she was promoted to the position of Welfare Assistance Worker and was assigned to the agency's East Portland branch. Claimant's duties included making determinations of eligibility for welfare assistance. She testified that the branch manager for whom she worked was exacting, demanding and "para-military." Claimant attempted to meet the manager's expectations by increasing her workload.

In 1982, after denying several applicants' requests for welfare assistance, claimant came under fire from a local legal aid service. The controversy ultimately reached the Governor's office and an investigation ensued. Claimant perceived no support from her supervisor during the inquiry. She soon experienced a

return of emotional problems, manifested primarily in the form of headaches, depression and anxiety. Claimant returned to Dr. Parvaresh and was hospitalized. A claim for workers' compensation followed on November 30, 1982. Dr. Parvaresh diagnosed claimant's condition as a "psychoneurotic depressive reaction." In a subsequent independent psychiatric examination, Dr. Holland found claimant to have experienced a "major depressive episode," superimposed on a preexisting paranoid personality disorder. He did not find claimant's employment to be the major cause of her reaction.

On February 9, 1983, SAIF issued a denial of the November 1982 claim. In June 1983, claimant returned to work part time. Ultimately, on October 25, 1983, the parties entered into a Disputed Claim Settlement, whereby claimant was paid $6,185 in exchange for a full and final settlement of her psychological claim.

Claimant returned to full-time employment in April 1984. She again came under the influence of her prior supervisor and her feelings of anxiety and depression returned. She resumed treatment with Dr. Parvaresh, who advised her to seek other employment. On August 31, 1984, claimant filed a claim for compensation, alleging that her work had caused "anxiety buildup and apprehension resulting in debilitating headaches."

On September 12, 1984, Dr. Parvaresh submitted a Form 827, noting that claimant had been his patient for years and that her "problems are not new." He again diagnosed "anxiety tension, feelings of depression and somatic disorder." Dr. Parvaresh opined that claimant's preexisting psychiatric disorder was made more symptomatic by the most recent stress on the job.

Dr. Holland reexamined claimant in early November 1984. He found claimant to be exhibiting a "dysthemic disorder," which Dr. Parvaresh later characterized as "new terminology for the previous diagnosis of psychoneurotic depressive reaction." Dr. Holland found claimant's complaints similar to those she described at the time of the prior claim. He again found claimant's work not to be a major contributing cause of the return of her symptoms. He agreed with Dr. Parvaresh that claimant's underlying condition was not caused nor worsened by events occurring on the job.

SAIF issued a denial of claimant's claim on November 15, 1984, asserting that her employment was not the major contributing cause of her return of symptoms. Claimant requested a hearing.

The Referee found that in order to prevail, claimant would need to prove that her work activity was a major contributing cause of a worsening of her preexisting emotional disorder. See Weller v. Union Carbide, 288 Or 27 (1979). The Referee found that claimant had met her burden of proof. In doing so, he took administrative notice of the Diagnostic and Statistical Manual of Mental Disorders (3d. Ed., 1982) (hereinafter DSM III) and its definition of "dysthemic disorder." The Referee's interpreted "dysthemic disorder" to be a condition defined by its symptoms. He then concluded:

"A change in the severity of the symptoms of

> the disease, must, by definition, signal a change, even if only temporary, in the severity of the disease itself."

The Referee thus concluded that claimant's increased symptoms in 1984 constituted a worsening of her underlying condition under Weller, supra, and he found the claim compensable. The Referee did not analyze the effect of the parties' 1983 Disputed Claim Settlement.

SAIF argues on review that the Referee's taking of administrative notice of the DSM III was inappropriate. We agree. In Groshong v. Montgomery Ward Co., 73 Or App 403 (1985), the court stated that the trier of fact in an administrative hearing is limited to the use of evidence actually admitted into the record. In the present case, the Referee took administrative notice of a portion of a scientific treatise that was not made part of the record. No physician specifically discussed or interpreted the treatise and neither party sought its entry into evidence. The Referee's conclusions, therefore, appear to have been his own. The case should have been decided from evidence contained in the record.

With regard to the merits, we find that we need not determine whether claimant's claim is compensable, for even if it is, it is barred by the 1983 Disputed Claim Settlement. The 1983 Settlement purported to pay claimant a sum of money in exchange for her agreement to release SAIF from further liability on the mental stress claim. The Settlement may be viewed as a private contractual agreement between the parties, and the clear and unambiguous language of the contract controls. Steve W. Burke, 37 Van Natta 1018 (1985); Mary Lou Claypool, 34 Van Natta 943 (1982).

The present case is similar to Proctor v. SAIF, 68 Or App 333 (1984), in which the claimant sustained a compensable arm and shoulder injury and subsequently asserted entitlement to compensation for an allegedly related psychological reaction. The parties entered into a Disputed Claim Settlement whereby the claimant agreed to fully compromise and settle his psychological claim in exchange for a sum of money. In a later attempt to avoid the effect of the Settlement, the claimant filed a new psychological claim, contending that the condition previously settled was different from the one most recently diagnosed.

The court noted that had claimant established that he suffered from a new and different psychological condition, he would have been entitled to recover. The court found, however, that the condition for which the claimant sought additional compensation was the same as the one he exhibited prior to the Settlement. It held, therefore:

> "Granted, there is medical evidence that claimant 'has experienced a worsening of his psychological and emotional condition.' . . . We find [however] no evidence that claimant suffers a new psychological disability . . . which is not the natural result of the psychological disability that existed at the time of the stipulation. . . . To rule in claimant's favor would be to require [the insurer] to pay again for what it has already paid." Id. at 336

In the present case, claimant compromised her claim for anxiety tension and depression in October 1983. Approximately ten months later, she filed a second claim with the same employer for the same condition, asserting that it arose out of job stressors nearly identical to the ones she had experienced before. On these facts, we find that the second claim is essentially the same as the first and that it has been fully compromised by the 1983 Disputed Claim Settlement.

ORDER

The Referee's order dated March 5, 1986, as adhered to on reconsideration on March 20, 1986 and March 31, 1986, is reversed. The SAIF Corporation's denial is reinstated.

JOHN D. ELLIS, Claimant
Steven C. Yates, Claimant's Attorney
Thomas Johnson (SAIF), Defense Attorney

WCB 85-03981
April 16, 1987
Order on Review

Reviewed by Board Members McMurdo and Lewis.

The SAIF Corporation requests review of Referee Fink's order that directed it to pay chiropractic billings, as well as a penalty and an attorney fee. On review, SAIF contends that the chiropractic treatments are not compensable and that penalties and attorney fees are not warranted. Claimant has filed no brief on Board review.

Claimant, 29 at the time of hearing, compensably injured his mid-back in December 1979, resulting in an acute thoracic strain. Treatment was conservative, primarily chiropractic as administered by Dr. Buttler. A Determination Order issued in May 1980, awarding temporary disability only. Claimant appealed the Determination Order, and was awarded 10 percent unscheduled permanent disability on Board review.

SAIF disagreed with the frequency of claimant's chiropractic treatment. In 1980, claimant underwent 13 treatments in January, 15 in February, 13 in March, and 9 in April. Nonetheless, SAIF paid all of Dr. Buttler's bills until December 1984, when it paid for only three of 15 treatments. Thereafter, SAIF either refused all payment or paid for only two treatments a month. SAIF failed, however, to issue a denial of claimant's ongoing chiropractic treatment. In July 1985, claimant changed chiropractors and began treatment with Dr. Robinson. None of Dr. Robinson's bills were paid by SAIF.

Dr. Buttler opined that claimant's treatments are causally related to the December 1979 injury, as well as necessary to prevent a worsening of claimant's spinal condition. Drs. Fechtel, Gatterman, and Pasquesi, however, opine that chiropractic care is no longer causally related to claimant's compensable injury.

Claimant's attorney requested a hearing on the issue of penalties and attorney fees, for "failure to pay medical bills timely." At the hearing, claimant's attorney sought to litigate only the issue of penalties and attorney fees; not the compensability of continuing chiropractic treatment. SAIF, however, sought to raise inter alia: (1) whether the chiropractic treatments were causally related to the December 1979, injury; and

(2) whether the frequency of the chiropractic treatments were reasonable and necessary.

In his order, the Referee stated:

> "Were the issues of causal connection, and frequency of treatment, before me I would rule in SAIF's favor. However, those issues are not before me because of SAIF's failure to follow appropriate procedure. What is before me is refusal to pay bills, without formal denial. With regard to the chiropractic treatment, I conclude that the $4,329 of unpaid bills should be paid forthwith. Claimant is also entitled to penalties and attorney fees."

After de novo review, we find that the Referee erred in ordering SAIF to pay the unpaid chiropractic bills. Under ORS 656.245, medical services must only be provided "for conditions resulting from the [compensable] injury * * *." Here, the Referee stated that claimant's continuing need for chiropractic treatment was not causally related to his injury of December 1979. We agree with this statement. In effect, the Referee upheld SAIF's "de facto" denial of claimant's chiropractic treatment. It was, therefore, error for the Referee to order payment of the unpaid chiropractic bills.

The Referee further erred in awarding a penalty. A penalty may appropriately be assessed against an insurer when it fails to timely respond to a claim or unreasonably refuses to pay compensation. ORS 656.262(10). SAIF did not timely deny payment of claimant's chiropractic bills. However, a penalty can only be assessed against "amounts then due." Hutchinson v. Louisiana-Pacific Corp., 81 Or App 162 (1986); ORS 656.262(10). Here, there are no "amounts then due" because claimant's chiropractic treatments were not related to the injury of December 1979. ORS 656.245.

Unlike a penalty, an attorney fee may be awarded even though there are no "amounts then due." Spivey v. SAIF, 79 Or App 568, 572 (1986); Wilma K. Anglin, 39 Van Natta 73 (February 26, 1987); but see Miller v. SAIF, 78 Or App 158, 162 (1986). However, considering the efforts expended and the results obtained, we modify the award from $400 to $100.

ORDER

The Referee's order of July 29, 1986 is affirmed, reversed, and modified. That portion of the order that upheld the SAIF Corporation's "de facto" denial of claimant's chiropractic treatment is affirmed. That portion of the order that directed SAIF to pay the unpaid chiropractic bills, a penalty, and a $1,000 attorney fee for services rendered by claimants's attorney at the hearing, is reversed. That portion of the order that awarded a $400 attorney fee concerning the penalty issue is modified to $100.

CAROLYN ETTINGER, Claimant
Malagon & Moore, Claimant's Attorneys
Cowling & Heysell, Defense Attorneys

WCB 85-02785
April 16, 1987
Corrected Order on Review

Reviewed by Board Members McMurdo and Lewis.

The self-insured employer requests review of that portion of Referee Mongrain's order that set aside its denial of claimant's multiple sclerosis claim. Claimant cross-requests review of those portions of the order that rejected her requests for: (1) interim compensation; (2) additional temporary disability compensation; and (3) an attorney fee in connection with bills for medical services which were disputed pending a complaint to the Medical Director of the Workers' Compensation Department, but then were voluntarily paid. The issues are compensability, interim compensation, temporary disability compensation and attorney fees.

The Board affirms the order of the Referee on the issues of compensability, temporary disability compensation and attorney fees. On the issue of interim compensation, we reverse. The Referee found that claimant was not entitled to interim compensation because her aggravation claim was not compensable on the merits. This was error. Under certain circumstances, interim compensation is due whether or not a claim ultimately is ruled compensable. Jones v. Emaunuel Hospital, 280 Or 147, 151-52 (1977).

Dr. Dunn's report of May 21, 1985 indicated a need for medical treatment relating to claimant's compensable condition and that claimant was unable to work because of that condition. The employer's adjusting agency received a copy of this report on May 28, 1985. Claimant is entitled to interim compensation from the date that the adjusting agency received the report until it issued an aggravation denial on behalf of the employer on August 28, 1985. See ORS 656.273(6).

ORDER

The Referee's order dated July 28, 1986 is reversed in part. That portion of the order that denied claimant's request for interim compensation is reversed. Claimant is awarded interim compensation for the period of May 28, 1985 through August 28, 1985. Claimant's attorney is awarded 25 percent of this additional compensation, up to $2,000, as a reasonable attorney fee. Claimant's attorney is also awarded $600 for services on Board review on the compensability issue, to be paid by the self-insured employer.

FORREST A. LAFFIN, Claimant
Pozzi, et al., Claimant's Attorneys
Davis, Bostwick, et al., Defense Attorneys
Norm Kelley, Ass't. Attorney General

WCB 86-03387
April 16, 1987
Order of Dismissal

The Workers' Compensation Department has moved for an order dismissing the requests for Board review filed by Argonaut Insurance Company and claimant insofar as the requests pertain to WCB Case No. 86-03387. The motion is granted.

WCB Case No. 86-03387 concerns the issue of whether Argonaut is entitled to reimbursement from the Workers'

Compensation Department for temporary total disability benefits paid claimant while he pursued an out-of-state vocational assistance program. Inasmuch as this issue is not a matter concerning a claim, judicial review of this portion of the Referee's order is not subject to ORS 656.289 and 656.295. ORS 656.704(1). Rather, judicial review is subject to ORS 183.310 to 183.550. ORS 656.704(2); OAR 436-120-250(7), (8). Consequently, jurisdiction for judicial review of the Referee's decision in WCB Case No. 86-03387 is conferred upon the Court of Appeals. ORS 183.482.

Accordingly, Argonaut Insurance Company's request for Board review is dismissed for lack of jurisdiction. Furthermore, claimant's request for Board review is also dismissed for lack of jurisdiction insofar as the request concerns WCB Case No. 86-03387. The Board retains jurisdiction over those portions of claimant's request for Board review which pertain to WCB Case Nos. 82-01857 and 84-07454.

IT IS SO ORDERED.

KAREN M. PARTRIDGE (WELCK), Claimant
Peter O. Hansen, Claimant's Attorney
Thomas Sheridan (SAIF), Defense Attorney

WCB 85-07711
April 16, 1987
Order on Reconsideration

The SAIF Corporation has requested reconsideration of the Board's Order on Review dated March 23, 1987. The request is granted and our previous order is withdrawn for reconsideration.

SAIF contends that the Board erred in concluding that it had failed to carry its burden of establishing that the March 24, 1983 denial fell within the scope of the cause of action adjudicated before Referee Menashe in September 1983. SAIF recites our statement to the effect that if claimant had "failed to raise the denial as an issue at the hearing or put on evidence to contest the denial," Referee Menashe would have expressly upheld the denial in his order. SAIF contends that if claimant had not raised the issue at the hearing, Referee Menashe would not have had authority to rule on the denial. SAIF, therefore, contends that we drew an improper inference from Referee Menashe's statement: "The March 24, 1983 denial was not litigated."

SAIF has misconstrued our statement. By the words, "failed to raise the denial as an issue at the hearing," we meant to convey the idea of failing orally to remind Referee Menashe of the issue at the beginning of the hearing, i.e. ignoring the issue. Claimant had requested a hearing on the March 24, 1983 denial and the request was properly before the Referee. The Referee, therefore, was bound either to rule on the denial or preserve it for later litigation. Because the Referee stated in his opinion that the denial was not litigated, but did not rule on the denial in his order, we construed the Referee's statement to mean that the denial had been preserved for later litigation.

It is possible, of course, that the Referee intended the statement in his opinion as a ruling on the denial. We have no way of telling from the record as developed in this case whether this was the Referee's intention. The most that can be said, therefore, is that the record suggests two plausible interpretations of the Referee's statement. Even assuming,

however, that both interpretations are equally plausible, SAIF nonetheless has failed to carry its burden of proof. We still think that the interpretation which we adopted in our previous order is the most plausible under the circumstances.

Therefore, as supplemented by this order, we adhere to and republish our previous order, effective this date.

IT IS SO ORDERED.

RICHARD H. SHRADER, Claimant
Bischoff & Strooband, Claimant's Attorneys
Charles Lisle (SAIF), Defense Attorney

WCB 85-15490
April 16, 1987
Order on Review

Reviewed by Board Members Lewis and McMurdo.

Claimant requests review of Referee Quillinan's order that increased his unscheduled permanent disability award for a right shoulder injury from 20 percent (64 degrees), as awarded by a Determination Order, to 30 percent (96 degrees). Claimant seeks additional unscheduled permanent disability.

In November 1984 claimant was working as a clerk for a bus terminal. He attempted to lift a box weighing 80 to 90 pounds and suffered a compensable injury to his right shoulder. Claimant continued to work, but because of continued shoulder pain saw Dr. Brummer, internist. At Dr. Brummer's request, electrical studies were performed by Dr. Byers who diagnosed a musculocutaneous neuropathy. Claimant experienced severe symptoms, but continued to work using primarily his left hand until November 1985 when Dr. Brummer and Dr. Byers both concluded that claimant should not return to work at the bus terminal.

In December 1985, Dr. Brummer referred claimant to Dr. James, orthopedist. Dr. James concluded that claimant's symptoms were primarily due to inflammatory disease and subacromial bursitis rather than the muscular cutaneous nerve compression. Dr. James noted that claimant had preexisting degenerative arthritis aggravated by his injury. The aggravation of the degenerative arthritis contributed to claimant's permanent impairment.

In January 1986 Dr. Brummer found claimant medically stationary. Claimant was restricted from repetitive use of the arm for pushing, pulling, lifting or carrying. Dr. Brummer further limited claimant's lifting or carrying to no more than 20 pounds occasionally. Vocational retraining was recommended. In April, claimant sought to return to work at the bus terminal. The employer advised that his position had been filled and that no work within his 20 pound lifting limitation was available. Subsequently, vocational efforts were initiated.

In May 1986, claimant received a Determination Order that awarded him 20 percent (64 degrees) unscheduled permanent disability. Claimant timely appealed the Determination Order.

At the time of hearing, claimant was 60 years old with a 12th grade education. He spent almost 26 years working as a clerk for the bus terminal. His duties included loading and unloading freight, selling tickets, handling the books and all activities associated with operating a bus terminal. He has no special training. Claimant testified that he still experiences

significant pain when moving his arm. The pain often wakes him at night. Claimant is right-handed. He has difficulty writing and is limited in performing housework. He agreed with his physician's assessment of his condition precluding him from repetitive use of his right arm or lifting more than 20 pounds. Claimant has contacted approximately 95 employers regarding potential job opportunities. At the time of hearing, he remained unemployed. The Referee concluded that claimant was credible and motivated to return to work.

In rating the extent of claimant's permanent disability, we consider his physical impairment, which includes his credible testimony concerning his pain, physical limitations and relevant social and vocational factors set forth in OAR 436-30-380 et. seq. 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). Following our de novo review of the medical and lay evidence, and considering the aforementioned guidelines, we conclude that claimant is entitled to additional unscheduled permanent disability beyond that awarded by the Referee. In lieu of the Referee's award, we conclude that claimant is entitled to an additional 30 percent (96 degrees) permanent disability for a total of 50 percent (160 degrees) unscheduled permanent disability.

ORDER

The Referee's order dated August 22, 1986 is modified. In lieu of the Referee's award of an additional 10 percent (32 degrees) permanent disability, claimant is awarded an additional 30 percent (96 degrees) permanent disability for a total of 50 percent (160 degrees) unscheduled permanent disability. Claimant's attorney is allowed 25 percent of the additional compensation granted by this order, not to exceed $3,000 as a reasonable attorney's fee.

THERESA L. SIEFER, Claimant
Roll, et al., Claimant's Attorneys
Dianne Sawyer (SAIF), Defense Attorney

WCB 86-00554
April 16, 1987
Order on Review

Reviewed by Board Members Lewis and McMurdo.

The SAIF Corporation requests review of that portion of Referee Leahy's order that set aside its denial of claimant's occupational disease claim for bilateral carpal tunnel syndrome. The issue on review is compensability.

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

We find that the causation of claimant's bilateral carpal tunnel syndrome is a complex medical question requiring expert medical analysis. Uris v. Compensation Dept., 247 Or 420 (1967). A treating physician's opinion is generally accorded greater weight. Weiland v. SAIF, 64 Or App 810 (1983). However, when the medical evidence is divided, we give more weight to those opinions that are well reasoned, complete, and based on an accurate history. Somers v. SAIF, 77 Or App 259, 263 (1986). A physician's conclusory statement regarding causation is entitled to little weight. Moe v. Ceiling Systems, 44 Or App 429 (1980).

After our de novo review of the medical and lay evidence, we find that the preponderance of the persuasive evidence establishes that claimant's work activities were the major contributing cause of her bilateral carpal tunnel syndrome. Accordingly, we agree with the Referee that claimant's condition is compensable.

Furthermore, we find that this is a case of ordinary difficulty with the usual probability of success for claimant. Consequently, a reasonable attorney fee is awarded.

ORDER

The Referee's order of June 5, 1986, is affirmed. Claimant's attorney is awarded $450 for services on Board review, to be paid by the SAIF Corporation.

GUY J. STEPP, Claimant
Pozzi, et al., Claimant's Attorneys
Merrily McCabe (SAIF), Defense Attorney
Rankin, VavRosky, et al., Defense Attorneys
Davis, Bostwick, et al., Defense Attorneys

WCB 85-08493, 85-12079, 85-12080 & 85-13808
April 20, 1987
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of Referee Pferdner's order that upheld three insurers' denials of claimant's occupational disease claim for hearing loss. Should we reverse the finding of noncompensability, the insurers individually assert that they are not responsible. The issues are compensability and responsibility.

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

The facts surrounding claimant's hearing loss are relatively undisputed. The issue of whether claimant's loss of hearing is due to his work exposure or "osteogenesis imperfecta" is a medical question. We therefore rely on expert medical opinion to resolve the issue. See Uris v. compensation Department, 247 Or 420 (1967). As was the Referee, we are persuaded by the well-reasoned opinion of Dr. Wilson that claimant's hearing loss is due to his noncompensable "osteogenesis imperfecta." Consequently, the insurers denials of compensability are upheld.

ORDER

The Referee's order dated August 27, 1986, as supplemented, is affirmed.

WAYNE D. COOPER, Claimant
Peter O. Hansen, Claimant's Attorney
Gretchen Wolfe (SAIF), Defense Attorney

WCB 86-03233
April 24, 1987
Order on Review (Remanding)

Reviewed by Board Members McMurdo and Lewis.

Claimant requests review of Referee Podnar's order that dismissed claimant's request for hearing for lack of jurisdiction. The issue is whether the request for hearing should have been dismissed.

Claimant was compensably injured in February 1978. The claim was closed by Determination Order in September 1978. Claimant's aggravation rights expired five years later. In December 1983, he requested Own Motion relief pursuant to ORS 656.278(1). He also filed a request for hearing on the September 1983 Determination Order, asserting entitlement to additional permanent partial disability compensation. In February 1984, we issued an order deferring action on claimant's request for Own Motion relief, pending resolution of claimant's request for hearing.

In June 1985, claimant entered an authorized training program. SAIF notified him that it would pay temporary disability compensation during training. Shortly after the program began, however, claimant's low back pain forced him out of training. SAIF thereafter discontinued compensation payments because of claimant's nonparticipation in training. The claim, however, was not closed, although SAIF did request an Own Motion determination.

Claimant then filed an amended request for hearing to include SAIF's termination of compensation payments. In his November 25, 1985 Opinion and Order, Referee William Peterson found that claimant's compensation should not have been terminated because he was not medically stationary and the claim was not otherwise appropriate for closure at the time he left vocational training.

Two days before the Referee's order issued, we issued an "Own Motion Determination" wherein claimant was awarded temporary disability compensation for the period in which he was in training. On receipt of our Own Motion order, SAIF requested reconsideration of Referee Peterson's order, asserting that our order precluded claimant from the receipt of further compensation. The Referee disagreed. SAIF requested Board review. On August 12, 1986, we affirmed the Referee's order, finding that claimant's entitlement to compensation during vocational training was independent of his aggravation rights. Wayne D. Cooper, 38 Van Natta 913 (1986). We also found that our prior Own Motion Determination had no effect on the Referee's order and was, in fact, contrary to the administrative rules governing payment of temporary disability compensation. We, therefore, vacated our Own Motion Determination. Wayne D. Cooper, 38 Van Natta 916 (1986).

Some time before our August 1986 Order on Review, SAIF submitted claimant's claim to the Evaluation Division for closure in an apparent attempt to comply with Referee Peterson's order. The Division subsequently issued its Determination Order on February 28, 1986. Claimant appealed from that Order, asserting entitlement to additional permanent partial disability. The issue went to hearing before Referee Podnar, who found that he was without jurisdiction to hear claimant's request. The Referee's order issued before we vacated our prior Own Motion Determination. Apparently relying on our Determination, he stated:

> "A Board's Own Motion Determination gives very specific appeal rights, and these are to the Court of Appeals. I am not persuaded that a Department Determination Order serves to resurrect any rights claimant had prior to the expiration of his aggravation rights."

On review, claimant argues that, given the series of developments in this case, his claim should be remanded to the Referee for a hearing on the extent of disability. We agree. Claimant's right to a hearing on a Determination Order within one year of its issuance is independent of his aggravation rights. ORS 656.268(6). This case will be remanded.

ORDER

The Referee's order dated May 15, 1986 is vacated. This case is remanded to the Referee for a hearing on the merits of claimant's appeal from the February 28, 1986 Determination Order.

LISA R. DAWSON, Claimant
Gatti, et al., Claimant's Attorneys
SAIF Corp Legal (Portland West), Defense Attorney

WCB 85-11984
April 24, 1987
Order on Review

Reviewed by Board Members McMurdo and Lewis.

The SAIF Corporation requests review of Referee Leahy's order that: (1) set aside its denial of claimant's industrial injury claim for the low back; (2) awarded "interim" compensation for the period of July 1, 1985 to August 28, 1985; and (3) assessed a penalty and an associated attorney fee for SAIF's alleged failure to pay interim compensation pending its denial of claimant's claim. The issues are compensability, interim compensation, penalties and attorney fees.

We affirm that portion of the Referee's order regarding compensability. We reverse the Referee's award of interim compensation and his assessment of penalties and attorney fees.

In her request for hearing, claimant asserted entitlement to penalties and attorney fees for SAIF's alleged failure to pay interim compensation. The Referee acknowledged the interim compensation issue at the commencement of the hearing. Thereafter, however, no testimonial evidence was elicited regarding claimant's alleged nonreceipt of interim compensation. No documentary evidence was produced, except for a set of SAIF payment records indicating that claimant had received payment for two periods of temporary total disability. The Referee found that "No TTD at all was paid," although he did not discuss the evidence upon which he relied in reaching his decision.

It is claimant's burden to prove entitlement to additional compensation. See Hutcheson v. Weyerhaeuser, 288 Or 51 (1979). Inherent in meeting that burden is the production of evidence sufficent to support the claim. After reviewing the record, we find that claimant has failed to sustain her burden. There is simply insufficient evidence that claimant was not paid the compensation she seeks. Claimant is, therefore, entitled to neither the interim compensation nor the penalties and attorney fees assessed by the Referee.

ORDER

The Referee's order dated April 17, 1986, as adhered to on reconsideration on May 23, 1986, is reversed in part and affirmed in part. Those portions of the order that awarded claimant interim compensation for the period of July 1, 1985 to

August 28, 1985 and that assessed a penalty and associated attorney fee are reversed. The remainder of the order is affirmed. For prevailing on the compensability issue, claimant's attorney is awarded $600 for services on Board review, to be paid by the SAIF Corporation.

LYNDA J. DEAN, Applicant
Peter W. Preston (Pozzi, et al.), Applicant's Attorney
Ann Kelley, Assistant Attorney General

WCB CV-87003
April 24, 1987
Crime Victim Compensation
Order of Remand

This matter is before the Board on the applicant's request for review and hearing concerning the Department of Justice's Findings of Fact, Conclusions and Order on Reconsideration dated December 30, 1986. By its order, the Department denied compensation to the applicant under the Victims of Crime Compensation Act (ORS Chapter 147).

The record provided to the Board by the Department contains a psychiatric evaluation report from Dr. Price. Dr. Price's report is based on an examination that was conducted before the date of the Department's Order on Reconsideration. However, the report was not furnished to applicant's counsel prior to her appeal. Although this report was not considered by the Department, it has been forwarded to the Board as part of "the entire Department record." See OAR 438-82-025.

The Department has requested that this report be excluded from consideration. The Department relies on ORS 147.155(5), which states that no evidence is admissible at a hearing before the Board that has not previously been considered by the Department. We agree that we are presently unable to consider this report. However, we are also empowered to conduct proceedings in any manner that will achieve substantial justice.

The current record neither contains a report from Dr. Price nor any other psychiatrist. Furthermore, we are persuaded that Dr. Price's report could not have been provided to the Department with due diligence prior to the issuance of its Order on Reconsideration. Under these circumstances and considering the report's relevancy to the issue currently on appeal, we conclude that substantial justice would be served by the Department's consideration of this report.

Accordingly, this matter is remanded to the Department of Justice Crime Victims' Compensation Fund for further consideration of this record, consistent with this order.

IT IS SO ORDERED.

FELIZ ENRIQUEZ, Claimant
Kenneth R. Peterson, Claimant's Attorney
Schwabe, et al., Defense Attorneys

WCB 85-04350
April 24, 1987
Order on Review

Reviewed by Board Members McMurdo and Lewis.

Claimant requests review of Referee St. Martin's order that: (1) refused to continue the case until such date as claimant could appear at the hearing; (2) admitted certain exhibits over claimant's objection; and (3) upheld the insurer's denial of claimant's industrial injury claim. On review, claimant asserts

that the insurer's denial was impermissible under the principle of Bauman v. SAIF, 295 Or 788 (1983). In the alternative, claimant asserts that this claim should be remanded to the Hearings Division for the taking of claimant's testimony.

We find that the Referee's admission of exhibits over claimant's objection was not an abuse of the Referee's discretion. We also find remand to be inappropriate, for this case has not been improperly, incompletely, or otherwise insufficiently developed. ORS 656.295(5). On the merits, however, we find that the insurer's denial was an impermissible "back-up" denial that must be set aside.

On June 12, 1984, claimant and David Gentry were among those persons attending a three-day "weatherization" seminar at a central Oregon resort. On that date, claimant was struck in the face and back of the head by Gentry. The resulting injuries required medical treatment. The facts surrounding the incident are in dispute. Although neither claimant nor Gentry were present at the hearing, each had previously submitted written statements. Those statements were admitted into evidence.

According to claimant's statement, Gentry knocked on claimant's motel room door and asked him if he would exchange two one dollar bills for eight quarters. Claimant agreed to the exchange, the exchange was made, and Gentry left. Later, however, Gentry demanded eight quarters from claimant, as if no exchange had occurred. Following a discussion, claimant was assaulted by Gentry.

According to Gentry's written statement, he and his roommate had retired for the night when, at approximately 2:00 a.m., claimant entered Gentry's room and began removing a large amount of change from the top of a dresser. After observing claimant for a few moments, Gentry left his bed and confronted claimant. A discussion ensued and Gentry ultimately struck claimant, forcing him from the room.

Ron Willocks was present when the altercation occurred and was the only witness to the incident who testified at hearing. Willocks testified that he saw Gentry place approximately $30 in change on the motel room dresser several hours before the altercation. Later, after spending approximately three hours with claimant and Gentry in the motel bar, Willocks retired for the night. He awakened to the sounds of the animated discussion between claimant and Gentry and he observed claimant being struck by Gentry. According to Willocks, when he awoke, he saw claimant standing in front of the dresser with change in his hands. When struck, claimant dropped a significant amount of change. Willocks further testified that approximately five minutes after the altercation, claimant returned to the room and handed Willocks a $20 bill.

On cross-examination, Willocks admitted that he did not awaken until just moments before claimant was struck. Therefore, he did not know whether Gentry had invited claimant into the room or whether claimant had earlier loaned Gentry money. He did not know what had transpired between claimant and Gentry during the period after Willocks left them in the bar. He did know that both claimant and Gentry had been involved in a poker game earlier in the day.

According to Willocks, both he and Gentry were interviewed by three or four persons Willocks believed to be supervisors soon after the altercation occurred. Willocks also testified that he explained his version of the facts to his supervisor (an agent of the present employer) within approximately one week after returning to work from the seminar.

Mr. Boileau, a claims supervisor for the insurer, testified that claimant's claim was initially placed in deferred status, and then accepted in August 1984. When asked if an investigation had been conducted between the filing of the claim and its acceptance, Boileau responded:

> "No. There really doesn't look like there was much of any investigation . . . [the claims examiner] did not do a particularly thorough job on going through this."

According to Boileau, the insurer had only claimant's written statement and medical reports tying claimant's injuries to an assault at the time it accepted the claim. In January 1985, however, the insurer received additional information, including Gentry's written statement, that raised suspicion regarding the claim's compensability. Although the insurer received this information in January 1985, it did not issue a denial of the claim until March 8, 1985. The denial came approximately seven months after the claim was accepted. The basis of the denial was that claimant's injury had occurred under circumstances different from those he represented at the time he filed his claim.

In Bauman v. SAIF, 295 Or 788 (1983), the Court held that after an insurer officially notifies the claimant that the claim has been accepted, the insurer may not, after 60 days have elapsed, deny the compensability of the claim unless there is a showing of fraud, misrepresentation or other illegal activity. Id. at 794. In the present case, claimant was officially notified that his claim had been accepted in August 1984. Approximately seven months later, the insurer "backed up" and issued a denial of compensability. Claimant asserts that the denial was impermissible under Bauman, supra. The insurer responds, however, that because claimant was engaged in illegal activity, i.e., an alleged attempted theft, the Bauman exception to retroactive denials applies.

In order for an insurer to invoke the "fraud, mispresentation or other illegal activity" exception to the Bauman rule, it must prove one or more of those grounds for its denial by a preponderance of the evidence. Parker v. North Pacific Ins. Co., 73 Or App 790 (1985); Parker v. D.R. Johnson Lumber Co., 70 Or App 683 (1984); Karen Hays, 38 Van Natta 1541 (1986). After reviewing the record, we conclude that the present insurer has failed to meet its burden of proof.

From the outset, we question whether the alleged theft involved in this case is among the "illegal" activities contemplated by Bauman. A review of the case law reveals that where the Bauman exception has been invoked, the employer or insurer has attempted to show that it was induced to accept the claimant's claim by his or her fraudulent statement, affirmative act of misrepresentation or omission. See e.g., Rogers v. Weyerhaeuser Co., 82 Or App 46 (1986); Liberty Northwest Ins.

Corp. v. Powers, 76 Or App 377 (1985); Parker v. North Pacific Ins. Co., supra; Skinner v. SAIF, 66 Or App 467 (1984); Thus, there was a direct causal link between the claimant's act or omission and the insurer's subsequent acceptance of the claim.

In the present case, the alleged "illegal" activity involved is claimant's alleged theft. It was not the alleged theft, however, that led to the acceptance of the claim; it was claimant's misrepresentation, if any, regarding the facts surrounding his injury. Thus, while the compensability of claimant's injury may have been called into question because of the surrounding circumstances, those circumstances may not be relevant to determining whether the Bauman exception applies.

Even if the alleged theft is relevant under Bauman, we find that the insurer has failed to prove that claimant was engaged in an attempted theft at the time of his injury. The material evidence consists of the written statements of claimant and Gentry and the hearing testimony of Willocks. Claimant asserts that he was assaulted without provocation. Gentry claims that claimant was engaged in an attempted theft. Because neither claimant nor Gentry testified at hearing, however, the Referee could make no finding regarding either witness's credibility. Consequently, claimant's and Gentry's written statements are effectively in equipoise.

The remaining material evidence is from Willocks. Willocks, however, witnessed only the actual altercation between claimant and Gentry. Because he was asleep up to the moment of the altercation, he was completely unaware of what had theretofore transpired between the combatants. He did not know if claimant was collecting a debt. He did not know whether claimant had been invited into the room. He could only guess that claimant was involved in an attempted theft based on his observation that claimant was in possession of coins at the time he was assaulted.

Willocks' estimation of what transpired, while probative, is not sufficient to prove that claimant was engaged in illegal activity at the time of his injury. Because there is nothing more on which the insurer can rely, we find that it has failed to meet its burden of proving the justification for its retroactive denial. The denial will be disapproved.

ORDER

The Referee's order is reversed in part and affirmed in part. That portion of the order that upheld the insurer's retroactive denial of claimant's industrial injury claim is reversed. Claimant's claim is remanded to the insurer for processing according to law. The remainder of the Referee's order is affirmed. Claimant's attorney is awarded a fee of $1,400 for services at hearing and $650 for services on Board review. Both fees shall be paid by the insurer.

JOHN D. FRANCISCO, Claimant
Stephen V. Piucci, Claimant's Attorney
Rankin, et al., Defense Attorneys
Davis, et al., Defense Attorneys
SAIF Corp Legal (Portland East), Defense Attorney
Acker, et al., Defense Attorneys
Schwenn, et al., Attorneys

WCB 85-14687, 85-14690, 86-05683, 86-05999 & 86-13059
April 24, 1987
Order Denying Motion to Dismiss

Argonaut Insurance Company has moved the Board for an order dismissing claimant's request for Board review on the ground that not all of the parties or their attorneys were served with a copy of claimant's request within the time provided by law. ORS 656.289(3); 656.295(2).

The Referee's order issued January 30, 1987. Claimant's request for Board review was mailed February 17, 1987 and received by the Board February 18, 1987. A certificate of mailing, submitted with the request, indicated that a copy of the request had been mailed to the attorneys for Argonaut and the SAIF Corporation on February 16, 1987. There was no indication that any of the employers, their insurers, or the other attorneys had been mailed a copy of claimant's request. However, on February 23, 1987 the Board mailed a computer generated letter to all of the employers and their attorneys acknowledging the request for review. No representation has been made that the Board's letters were not received.

In Argonaut Insurance v. King, 63 Or App 847, 852 (1983), the court held that "compliance with ORS 656.295 requires that statutory notice of the request for review be mailed or actual notice be received within the statutory period." (Emphasis added.) The "actual notice" referred to by the court in King was the Board's computer generated acknowledgement letter, which the evidence established was received by the insurer more than 30 days after the Referee's order was mailed. Inasmuch as the notice of the request was untimely, the court found that the Board lacked jurisdiction to consider the appeal.

Although we are not bound by formal rules of evidence, we find the Oregon Evidence Code helpful when dealing with matters such as presumptions and burdens of persuasion. James L. Sampson, 37 Van Natta 1549, 1550 (1985). OEC 311(q) establishes a presumption that, "A letter duly directed and mailed was received in the regular course of the mail." OEC 308 provides that a party against whom a presumption operates has the burden of proving that the nonexistence of the presumed fact is more probable than its existence.

Here, the Board's acknowledgement letter was mailed seven days before the statutory period expired. Given the presumption of regular receipt in the course of the mail and the absence of evidence or a representation that the employers or their representatives did not receive our acknowledgement letter within the statutory period, we conclude that it is more probable than not that the parties did receive actual notice of claimant's request for review within the statutory period. Furthermore, in the absence of prejudice to a party, timely service of a request for review on the attorney for a party, rather than the party, is sufficient compliance with ORS 656.295(2) to vest jurisdiction in the Board. Argonaut Insurance v. King, supra; Nollen v. SAIF, 23 Or App 420, 423 (1975) rev den (1976); Karen J. Bates, 38 Van Natta 964 (1986). Accordingly, the motion to dismiss is denied.

IT IS SO ORDERED.

SHIRLEY M. GEHRKE, Claimant
Welch, et al., Claimant's Attorneys
Cummins, et al., Defense Attorneys

WCB 84-04735
April 24, 1987
Order on Review

Reviewed by Board Members McMurdo and Lewis.

The insurer requests review of Referee Menashe's order that: (1) declined to grant its motion to dismiss claimant's request for hearing; (2) set aside its partial denials of responsibility for claimant's current medical and chiropractic treatments; and (3) affirmed a Determination Order's award of 40 percent (128 degrees) unscheduled permanent disability for a back injury. In her respondent's brief, claimant contends that the Referee erred in rating the extent of her permanent disability when she was not psychologically stationary. On review, the issues are procedure, compensability, and extent.

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

Following our de novo review of the medical and lay evidence, we are persuaded that claimant's compensable injury is a material contributing cause of her current need for treatment. Consequently, we agree with the Referee that the insurer's denials should be set aside.

In addition, the evidence preponderates that claimant's condition was medically stationary at the time of hearing. Thus, a determination concerning the extent of claimant's permanent disability was justified. Dr. Colistro's opinion that claimant was not psychologically stationary was prefaced on his recommendation that she seek pain center treatment. Inasmuch as claimant had consistently declined such counseling in accordance with prior medical advice, we do not consider Dr. Colistro's opinion persuasive regarding the "medically stationary" issue.

Furthermore, we conclude that a 40 percent unscheduled permanent disability award adequately reflects claimant's permanent loss of earning capacity due to her compensable injury. Accordingly, we agree with the Referee's assessment concerning the extent of claimant's permanent disability.

Finally, we find that this is a case of ordinary difficulty with the usual probability of success for claimant. Accordingly, a reasonable attorney fee is awarded.

ORDER

The Referee's order dated April 7, 1986 is affirmed. Claimant's attorney is awarded $600 for services on Board review, to be paid by the insurer.

TROY W. KAUFFMAN, Claimant
HELEN V. and DAVID J. PRATT, Employers
MacAfee, et al., Claimant's Attorneys
Gary L. Jones, Attorney
SAIF Corp Legal, Defense Attorney
Carl M. Davis, Dept. of Justice

WCB 85-03077 & 85-03078
April 24, 1987
Order on Remand

This matter is before the Board on remand from the Court of Appeals. Pursuant to the court's April 14, 1987 order, we have been instructed to effect and approve a disputed claim settlement.

In consideration of the alleged noncomplying employer's promise to pay a stated sum, claimant has agreed to dismiss with prejudice all further proceedings related to WCB Case Nos. 85-03077 and 85-03078. In addition, the parties have agreed to resolve the issues currently pending before the Hearings Division in WCB Case No. 86-00180.

By this order, we approve the parties' settlement, thereby fully and finally settling all issues raised or raisable in WCB Case Nos. 85-03077 and 85-03078. That portion of the settlement which concerns the pending hearing in WCB Case No. 86-00180 has been forwarded to the Hearings Division for consideration by a Referee. Accordingly, this matter is dismissed with prejudice.

IT IS SO ORDERED.

THOMAS R. LUCAS, Claimant
Carney, et al., Claimant's Attorneys
Arthur Stevens, III (SAIF), Defense Attorney

WCB 85-04275
April 24, 1987
Order on Review

Reviewed by Board Members Lewis and McMurdo.

Claimant requests review of Referee Brown's order that upheld the SAIF Corporation's denial of claimant's stress-related occupational disease claim. Should claimant prevail on Board review in overturning SAIF's denial, he requests that his attorney be awarded an extraordinary attorney fee for services at the hearing. The issues are compensability and attorney fees.

This claim concerns the symptomatic worsening of a preexisting personality disorder. The Referee concluded that the claim was not compensable based upon our decision in April L. Martinez, 38 Van Natta 621 (1986). In that case, we held that the claimant's stress-induced somatic symptoms were not, in and of themselves, a mental disorder. Id. at 622. We also held that the symptoms were not indicative of a worsening of a preexisting personality disorder because we found that the claimant had no preexisting personality disorder. Id. We gratuitously added that even if the claimant did have a preexisting personality disorder and that disorder had been symptomatically worsened, this did not necessarily equate with a pathological worsening of the disorder. Id. at 622-23.

Since that time and subsequent to the Referee's order, we ruled in Carol J. Rodeheffer, 38 Van Natta 1399, 1400-01 (1986) that the symptoms of a preexisting personality disorder and the disorder itself are one and the same; if the symptoms worsen, the underlying condition has worsened. Our decision was dictated by

the Court of Appeals holding to that effect in Adsitt v. Clairmont Water District, 79 Or App 1, 6, rev den 301 Or 338, 301 Or 666 (1986). We reaffirm that rule in this case. Claimant, therefore, sustained a compensable worsening of his preexisting personality disorder and SAIF's denial must be set aside.

Because we set aside SAIF's denial, we proceed to the question of whether claimant's attorney is entitled to an extraordinary attorney fee for services at the hearing level. Claimant's attorney has submitted a sworn statement detailing his efforts in this case in accordance with OAR 438-47-010(2). These efforts total 118 hours and include depositions of three psychiatrists and a two-day hearing involving nine witnesses. We conclude that an extraordinary fee is warranted and considering the various factors set forth in Barbara A. Wheeler, 37 Van Natta 122, 123 (1985) conclude that a fee in the amount of $5,000 is appropriate under all of the circumstances of this case for services at the hearing level. We further conclude that a fee of $700 is appropriate for the services of claimant's attorney on Board review.

ORDER

The Referee's order dated July 31, 1986 is reversed and the claim is remanded to the SAIF Corporation for acceptance and processing according to law. Claimant's attorney is awarded $5,000 for services at the hearing level and $700 for services on Board review, to be paid by the SAIF Corporation.

MARSHALL L. MANN, Claimant
SAIF Corp Legal, Defense Attorney

WCB 86-06228 & 86-08885
April 24, 1987
Order on Review

Reviewed by Board Members McMurdo and Lewis.

Claimant requests review of Referee Howell's order that upheld the SAIF Corporation's denial of claimant's claim for bilateral carpal tunnel syndrome. The issue is whether claimant's claim under Oregon Workers' Compensation Law is barred by his receipt of benefits under the Longshoremen's and Harbor Workers' Compensation Act. The parties have filed no briefs. We affirm.

We draw from the Referee's statement of the facts. In 1982, claimant began work as a welder for an employer whose business consisted of building and repairing vessels used on navigable waters. Within a month after beginning work, claimant experienced bilateral stiffness, weakness and tingling in his fingers. He ultimately left work because of these symptoms on March 12, 1982. He did not return to work for the employer.

On March 19, 1982, claimant filed a claim under the Longshoremen's and Harbor Workers' Compensation Act (LSHWCA), alleging that his work duties caused the development of his bilateral hand condition. The SAIF Corporation, which provided both federal and state workers' compensation coverage for the employer, accepted claimant's LSHWCA claim. Temporary total disability compensation was thereafter paid. Claimant's hand symptoms continued and he ultimately underwent bilateral carpal tunnel release surgery in July 1985.

Although claimant's claim under LSHWCA had been accepted, he ultimately filed a claim under the Oregon Workers' Compensation Act, as well, asserting entitlement to additional coverage. SAIF issued a denial, arguing, inter alia, that the remedy afforded under LSHWCA was exclusive. SAIF also asserted that pursuant to ORS 656.027(4), claimant was not an Oregon "subject worker" because of the remedy afforded by federal law.

The Referee found, and we agree, that the LSHWCA does not preclude state jurisdiction over single injuries or occupational diseases. In certain situations, state and federal jurisdiction may be concurrent. Sun Ship, Inc. v. Pennsylvania, 447 U.S. 715 (1980); Herb's Welding, Inc. v. Gray, 105 S. Ct. 1421 (1985). Thus, a state may choose to provide supplementary coverage to a worker whose claim is compensable under federal law.

As the Referee correctly noted, the disposition of this case turns on whether Oregon has chosen to provide supplementary coverage and, if so, whether claimant's condition is compensable under Oregon law. ORS 656.027 provides that all workers are subject to Oregon Workers' Compensation Law except those specifically excluded under the Act. Among those excluded is "a person for whom a rule of liability for injury or death arising out of and in the course of employment is provided by the laws of the United States." ORS 656.027(4).

The present claimant's occupational disease has been accepted as compensable under the LSHWCA, a "law of the United States." He is by definition, therefore, not a "subject worker" for whom compensation is available under Oregon law. See Williamson v. Western Pacific Dredging Corp., 304 F. Supp. 510 (1969). The Referee's order will be affirmed.

ORDER

The Referee's order dated October 14, 1986 is affirmed.

ROSA MARTINEZ, Claimant
Francesconi & Cash, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney
Nelson, et al., Defense Attorneys

WCB 85-08253 & 85-10647
April 24, 1987
Order on Review

Reviewed by Board Members Lewis and McMurdo.

Claimant requests review of Referee Michael Johnson's order that upheld the denials of the SAIF Corporation and Liberty Northwest Insurance Corporation regarding claimant's occupational disease claim for bilateral carpal tunnel syndrome. The issue is compensability, and if the claim is compensable, responsibility between the insurers must be determined.

We affirm the Referee's order with the following comment. In reaching his decision, the Referee relied in part on Dr. Peter Nathan's "syndrome" v. "condition" distinction involving carpal tunnel disease. The Referee then cited Amfac, Inc. v. Ingram, 72 Or App 168 (1985) for the proposition that Nathan's distinction "has been adopted as the 'official' analysis within the State of Oregon."

Our reading of Amfac persuades us that that case was decided on its specific facts, and that Dr. Nathan's analysis was useful to the court in reaching its decision. We do not feel that

Nathan's distinction was adopted as a medical/legal standard to be applied in other cases. See William E. McNichols, 38 Or App 261 (1986). We have, therefore, decided the present case solely on its evidence, which includes reports and testimony from Dr. Nathan.

ORDER

The Referee's order dated May 27, 1986 is affirmed.

ALBERTO V. MONACO, Claimant
Welch, Bruun & Green, Claimant's Attorneys
Beers, Zimmerman & Rice, Defense Attorneys

WCB 85-00723
April 24, 1987
Order on Review

Reviewed by Board Members Lewis and McMurdo.

EBI Companies (EBI) requests review of Referee Tuhy's order on remand that set aside its denial of claimant's low back aggravation claim. The issue is whether an out-of-state work-related injury incurred subsequent to claimant's original claim operates to relieve EBI from further responsibility.

Claimant compensably injured his low back while employed by EBI's insured in 1984. The injury occurred in Oregon. Claimant sought medical treatment and he lost time from work. After he returned to work, a layoff prompted him to leave Oregon in search of other employment. He soon found work in the state of Washington. After two months on the job, however, he sustained a second low back injury.

Claimant filed a claim for aggravation with his Oregon employer. EBI issued a denial on behalf of its insured, asserting that claimant's out-of-state injury represented a "new injury," thereby relieving EBI of further liability. Claimant requested a hearing and the issue went before Referee Tuhy. In his April 12, 1985 Opinion and Order, the Referee found claimant's out-of-state injury to have been no more than an aggravation of his original injury. The Referee, therefore, found that EBI remained responsible. EBI requested review.

Subsequent to Referee Tuhy's 1985 order, but before the case was docketed for our review, the court decided Miville v. SAIF, 76 Or App 603 (1985). In Miville, the claimant sustained a compensable injury in Oregon, followed by subsequent out-of-state injuries. The issue was whether an Oregon employer whose injury remained a material cause of the claimant's condition would remain responsible for that condition despite the independent contribution of the out-of-state injuries. The court held that a determination of an Oregon employer's continuing liability turns, in part, on what steps the claimant has taken in pursuit of compensation out-of-state, and the result thereof. The Oregon employer will remain responsible if the claimant has filed a claim in the out-of-state jurisdiction and the claim has been finally determined to be not compensable. If, on the other hand, the claimant has not filed a claim, or has done so and has been awarded compensation, the Oregon employer will be relieved of further responsibility. Miville, 76 Or App at 607.

At the time we reviewed Referee Tuhy's 1985 order, the record was silent with regard to what steps claimant had taken on his Washington claim. Consequently, we remanded the case to the

Referee for additional evidence taking in that regard. Albert V. Monaco, 38 Van Natta 32 (1986). On remand, the Referee found that claimant had filed a claim for compensation in Washington, that he had received compensation pending a decision on the claim, that the claim had ultimately been denied and that claimant had not appealed the denial. On these facts, the Referee found that claimant's claim had been "finally determined" to be noncompensable and that, pursuant to Miville, the Oregon insurer remained responsible. EBI again requested review.

On review, EBI's argument is two-fold: First, it argues that because claimant received compensation pending the denial of his Washington claim, EBI is no longer responsible under Miville. Second, it argues that because claimant failed to appeal the denial of his Washington claim, there was no "final determination" thereof. EBI argues that it would be against public policy to allow a claimant to effectively control which state pays his compensation by choosing when and when not to appeal adverse decisions.

With regard to EBI's first argument, we disagree that claimant's receipt of Washington payments precludes his recovery in Oregon. The Miville court made clear that an Oregon employer is relieved of liability if a claimant is "awarded" compensation in the foreign jurisdiction. We interpret the court's use of the term "awarded" to be in reference to compensation paid pursuant to a compensable claim. The present claimant's payments were made pending acceptance or denial of his claim. They appear, therefore, to have been the Washington equivalent of Oregon's "interim" compensation. ORS 656.262(4). "Interim" compensation is not "awarded," it is simply paid pending an acceptance or denial of the claim.

As to EBI's second argument, we disagree that there has been no "final determination" of claimant's claim simply by virtue of his election not to appeal the denial. A denial becomes "final" when it is not appealed, and the claim thereby becomes "finally determined" to be not compensable. EBI would apparently require a claimant to contest his denial through a jurisdiction's highest level of appeal in order to receive a "final determination," as that term is used in Miville. The Miville court, however, enunciated no such requirement and, notwithstanding EBI's policy arguments to the contrary, we will not create an obligation not recognized by the court.

EBI shall remain responsible for claimant's claim. It shall also pay claimant a reasonable attorney fee for services on Board review because, although there were elements of responsibility in this case, claimant would have gone uncompensated had EBI's denial been upheld. Compare Stovall v. Sally Salmon Seafood, 84 Or App 612 (April 8, 1987); Petshow v. Farm Bureau Ins. Co., 76 Or App 563 (1985).

ORDER

The Referee's Order on Remand dated April 8, 1986 is affirmed. Claimant's attorney is awarded $650 for services on Board review, to be paid by EBI Companies.

CYNTHIA D. PHELPS, Claimant
Richardson, et al., Claimant's Attorneys
Acker, Underwood, et al., Defense Attorneys

WCB 85-09405
April 24, 1987
Order on Review

Reviewed by Board Members Lewis and McMurdo.

The insurer requests review of Referee Lipton's order that set aside its denial of claimant's industrial injury claim for the right elbow. The issue is whether claimant's injury arose out of and in the course of her employment.

We affirm the Referee's order with the following comment. In finding this claim compensable, the Referee found claimant to be credible "with respect to those facts which are relevant and material to the issue before me." He also found the employer's witness to be essentially credible. He refused to rely on the witness' testimony, however, because of his finding that she was "clearly biased in favor of the employer." The Referee made no finding with regard to claimant's probable bias in favor of her own claim.

Because it is likely that the direct and interested parties to a claim will be biased in favor of their own interests, a reliability finding based on those parties' biases is probably of little value. See John K. Schurz, 38 Van Natta 1454, 1459-60 (1986).

We find this claim to have been of average difficulty with the usual probability of success for claimant. A reasonable attorney fee is therefore awarded for services on Board review.

ORDER

The Referee's order dated April 24, 1986 is affirmed. Claimant's attorney is awarded $600 for services on Board review, to be paid by the insurer.

JAMES R. STAMPS, Claimant
Vick & Associates, Claimant's Attorneys
Schwabe, et al., Defense Attorneys
David Horne, Defense Attorney
Cowling & Heysell, Defense Attorneys

WCB 85-10857, 85-15875 & 85-15876
April 24, 1987
Order on Review

Reviewed by Board Members Lewis and McMurdo.

Wausau Insurance Companies (Wausau) requests review of Referee Quillinan's order that set aside its denial of claimant's new injury claim for the low back and, by implication, upheld Boise Cascade Corporation's (Boise Cascade) denial of claimant's aggravation claim for the same condition. The sole issue on review is responsibility.

Claimant suffered a compensable low back strain while employed by Boise Cascade in May 1983. After conservative treatment, claimant returned to work. A January 1984 Determination Order awarded five percent unscheduled permanent partial disability for the low back.

Claimant began working for another employer in April 1984 and his low back symptoms returned. Dr. Holton, a chiropractor, became the treating physician and provided conservative treatment. Claimant filed claims with Boise Cascade

and the later employer, asserting that the return of his symptoms constituted either an aggravation or a new injury. Both employers issued denials and the claims went to hearing. By Opinion and Order dated August 22, 1985, Referee Howell found Boise Cascade responsible for what was determined to be a compensable aggravation. The Board affirmed the Referee's order on April 30, 1986.

Prior to the 1985 Opinion and Order, claimant began work for a third employer, a distributing company insured by Wausau. Claimant worked as a beer and wine route salesman, taking orders and occasionally stocking shelves. He continued to receive conservative chiropractic care from Dr. Holton, but tolerated his initial job duties well. After a short layoff, however, claimant's duties changed. He was required to lift and deliver kegs of beer weighing 25 to 30 pounds and, according to claimant, the new job was much heavier and faster-paced. Claimant was taken off work after a few weeks by Dr. Holton due to his inability to tolerate the physical demands of his job. Increased pain, rather than a specific injurious incident, resulted in claimant's leaving work. Claimant has not worked since August 1985.

Claimant filed claims with Boise Cascade and Wausau for his most recent period of disability. Each issued a denial of responsibility. Claimant was thereafter sent to Dr. Stanford, an orthopedist, who opined that claimant's most recent employment was not a material factor in his return of symptoms. Dr. Holton also repeatedly reported that claimant's underlying condition was not worsened by the later employment.

Claimant testified that his symptoms greatly increased during his last employment. The symptoms were of the same quality as they had previously been, but they were of greater intensity. Claimant had never been symptom-free following the 1983 injury at Boise Cascade. He testified, however, that in his opinion, his condition had worsened as a result of the last job, primarily because he was now unable to work, whereas he had been able to continue working up to August 1985.

Dr. Holton also testified. It remained his opinion that claimant had essentially the same degree of underlying pathology throughout his several employments; only the severity of symptoms had fluctuated. His opinion was bolstered by x-ray images showing little, if any, pathological change since the original injury. According to Dr. Holton, while claimant's "impairment" may have increased, the fluctuating symptoms were to be expected following the initial injury.

The Referee framed the issue before her as whether claimant's last employment "contributed to his current disability." She further found:

> "An increase in symptoms above and beyond what would reasonably be expected from a waxing and waning type injury can constitute an increased disability even if there is no change in the underlying condition."

Finding that claimant's last employment had resulted in increased symptoms to the point that he was more disabled, the Referee concluded that the last insurer, Wausau, was responsible.

Subsequent to the Referee's order, the court decided Hensel Phelps Const Co. v. Mirich, 81 Or App 290 (1986), in which it held that a worsening of symptoms alone during the later employment does not shift liability from the initial employer to the latter. Rather, in order to shift liability away from the first employer, the later employment must have independently contributed to the causation of the disabling condition, i.e., to a worsening of the underlying condition. Id. at 294.

The present case is similar to Mirich. Claimant's last employment led to increased symptoms, resulting in a renewed period of disability. According to the treating and consulting physicians, however, there was no change in the underlying low back condition and no independent contribution to the causation of the disabling condition. Under Mirich, the first employer, Boise Cascade, remains responsible for claimant's current condition. The Referee's holding to the contrary will be reversed.

ORDER

The Referee's order dated June 9, 1986 is reversed. Wausau Insurance Companies' denial of claimant's new injury claim is reinstated. Boise Cascade Corporation's denial of claimant's aggravation claim is set aside and Boise Cascade is ordered to accept and process claimant's claim according to law.

TIMOTHY J. SWODECK, Claimant
Welch, Bruun & Green, Claimant's Attorneys
Edward C. Olson, Defense Attorney

WCB 85-09687
April 24, 1987
Order on Review

Reviewed by Board Members Ferris and McMurdo.

The insurer requests review of Referee Lipton's order that set aside its "back up" denial of claimant's low back injury claim. The issue on review is compensability.

Claimant, 38 years old at the time of the hearing, drove a U-Haul truck from Oklahoma to Oregon in November 1984. Upon his arrival, he complained of low back pain and exhibited symptoms thereof. The following day, he traveled to Seattle for Thanksgiving weekend. Claimant's sister-in-law drove part of the way because his back hurt. While in Seattle, claimant saw Dr. Tindall, a chiropractor. Dr. Tindall noted bilateral lower back pain, but found no signs of any disc involvement.

In December 1984, still complaining of back pain, claimant began work as a general laborer for a battery manufacturer. On December 11, 1984, he allegedly sustained a slip-and-fall injury while bending over to pick up an old battery. There were no witnesses. He immediately reported the alleged injury to his supervisor and was seen by Drs. Revell and Segur, chiropractors. Dr. Revell noted, "probable acute lumbar strain [and] possible lumbar disc involvement." On Dr. Segur's initial medical report, claimant denied any previous injuries to his lower back. One week later, the insurer accepted the claim.

In January 1985, claimant saw Dr. Hill, a neurologist, who initially diagnosed back strain. However, subsequent myelograms revealed a herniated disc and he underwent two lumbar laminectomies.

Some time thereafter, the insurer received a phone call from claimant's sister-in-law. She informed the insurer that claimant had suffered prior low back problems and that his condition was not due to the alleged December 1984 injury. As a result, the insurer took a recorded statement wherein claimant stated:

> "Q. Prior to employment with our employer, had you ever been injured before, with a low back problem?
>
> "A. No. I never had back problems before. No, I've never been troubled by my back, and for a person driving the miles I drove, it was a wonder. I drove 300, 350 miles a day on my job.
>
> "Q. What about the haul from Oklahoma?
>
> "A. There was a lot of tension cause I had a lot of things I was worrying about, I had a home I'm losing, I'm still trying to fight with that, and I'm trying to fight to keep my car, and right now my financial problems are real bad, just trying to stay above water.
>
> "Q. Have you seen any physicians for any previous back problems?
>
> "A. [unnamed person answers] He saw a chiropractor before he went to Dr. Hill on this one, this injury.
>
> "Q. Where was this?
>
> "A. It's an organization with the University of Oregon, they're students learning, it's on Flavel."

Subsequently, the insurer issued a "back up" denial of claimant's low back condition.

Dr. Hill was deposed. He testified that claimant never informed him of any prior history of back problems. Only after the denial issued did he finally become aware of claimant's prior history. He further testified that claimant's herniated disc could be explained by either the December 1984 injury, or claimant's history of back problems excluding the alleged injury.

The Referee found that claimant failed to disclose his previous back problems and, therefore, the insurer's "back up" denial was permissible. However, the Referee ultimately found the claim compensable stating:

> "Claimant's description of the 'slip and fall' incident is, according to Dr. Hill, classic for an incident resulting in disc herniation. Therefore, even if the process was begun before claimant's employment with Standard Battery, his employment contributed to the condition. Thus, the condition is compensable."

We agree that claimant withheld material information from the insurer and that its "back up" denial was permissible. Bauman v. SAIF, 295 Or 788, 794 (1983); Skinner v. SAIF, 66 Or App 467, 470 (1984). We do not agree, however, that claimant compensably injured his low back.

To establish compensability, claimant must prove that the alleged December 1984 incident at work was a material contributing cause of his need for medical treatment. Summit v. Weyerhaeuser Co., 25 Or App 851, 856 (1976). Compensability must be proven by a preponderance of the evidence (i.e., more likely than not). Hutcheson v. Weyerhaeuser Co., 288 Or 51, 56 (1979). Lay testimony concerning causation is probative evidence. Garbutt v. SAIF, 297 Or 148 (1984). However, it may not be persuasive when the claim involves a complex medical question. Uris v. Compensation Department, 247 Or 420, 424 (1967).

Here, the only medical expert to render an opinion regarding the cause of claimant's herniated disc, is Dr. Hill. However, an examination of Dr. Hill's testimony shows that his opinion is based entirely on the history provided. Accordingly, when asked by claimant's attorney whether the alleged December 1984 injury was a material contributing cause of the herniated disc, Dr. Hill testified:

> "Yes. Given that history, you know, it's really consistent with -- if, you know, this was a documented accident, he did fall, and this is not some -- sort of contrived thing, I would say that that would be the incident that caused his herniated -- caused his disc to herniate."

Similarly, when asked by the insurer's attorney whether claimant's herniated disc could be caused by his history of back problems excluding the alleged December 1984 injury, Dr. Hill stated:

> "Oh. I see. Certainly you could get a history like that. Certainly."

Therefore, claimant's case ultimately rests upon his credibility as an historian.

When a Referee's credibility findings are based upon his observation of a witness' demeanor at hearing, we will ordinarily defer to them. Humphrey v. SAIF, 58 Or App 360 (1982). However, when credibility of a witness is based upon the substance of the witness' testimony, a reviewing body is just as capable of evaluating the witness as is the Referee. Coastal Farm Supply v. Hultberg, 84 Or App 282 (March 11, 1987); Davies v. Hanel Lbr. Co., 67 Or App 35, 38 (1984); Andrew Simer, 37 Van Natta 118 (1985). Here, the Referee made the following credibility finding:

> "Based upon my close and careful observations of the attitude, appearance, demeanor and testimony of the several witnesses, I find that they were all credible and reliable while noting that [claimant's] testimony was somewhat evasive in his distinction between strains, injury and the onset of symptomatology."

Inasmuch as the Referee found claimant "evasive," we do not find that we must ipso facto defer to his general credibility finding. This is especially true when, as here, expert medical opinion is based entirely upon whether claimant did, in fact, sustain a slip-and-fall injury. After our de novo review, we are not persuaded that a compensable injury occurred in December 1984.

On direct examination by the insurer's attorney, claimant was impeached as follows:

> "Q. Did you tell Dr. Revell or Dr. Segur at the chiropractic office about your medical treatment in Seattle?
>
> "A. No, I didn't."

Claimant witheld information regarding his prior back problem when initially filing his claim and subsequently during his recorded statement. Moreover, he failed to inform his doctors of such history and was impeached at the hearing. Under such circumstances, we are highly suspect of claimant's credibility. When, as here, claimant's case is based almost entirely upon his veracity, we do not find that the evidence preponderates in favor of compensability.

ORDER

The Referee's order dated April 23, 1986, is reversed. The insurer's denial of claimant's low back condition is reinstated and upheld.

JOHN A. TALLANT, Claimant
TROJAN CONCRETE & EXCAVATING, Employer
Robert L. Chapman, Claimant's Attorney
Cowling & Heysell, Attorneys
Merrily McCabe (SAIF), Defense Attorney
David Horne, Defense Attorney

WCB 86-08967 & 86-02121
April 24, 1987
Order on Review (Remanding)

Reviewed by Board Members Ferris and Lewis.

The Workers' Compensation Department and the SAIF Corporation have requested Board review of Referee Brown's approval of two Disputed Claim Settlements. These settlements were entered into between claimant and Trojan Concrete & Excavating Co., Inc., a noncomplying employer; and between claimant and Green Holdings, Inc., a potentially responsible employer under ORS 656.029. The Department and SAIF contend that they were neither consulted nor made a party to these agreements. Trojan and Green Holdings have asked that the requests for Board review be dismissed for lack of standing.

Pursuant to ORS 656.295(5), should we determine that a case has been improperly, incompletely, or otherwise insufficiently developed, we may remand to the Referee for further evidence taking, correction, or other necessary action. Inasmuch as the record is silent concerning the events surrounding the execution of these agreements, we conclude that remand is appropriate.

Accordingly, this matter is remanded to the Referee with instructions to convene a hearing. At this hearing, evidence and

further argument may be presented regarding the issue of the Department's and SAIF's standing to question each of the settlements. Furthermore, each of the parties may present evidence addressing the contention that the settlements should be set aside. The Department and SAIF shall present evidence first. Finally, in the event that either settlement is set aside, the parties shall also present evidence concerning the compensability of, and responsibility for, claimant's injury claim.

Following the hearing, the Referee shall issue an order addressing the "standing" question, as well as the requests to set aside the disputed claim settlements. If either, or both, of the settlements are set aside, the Referee shall also address the compensability and responsibility issues.

IT IS SO ORDERED.

HAROLD D. TALLENT, Claimant
Davis, et al., Defense Attorneys

WCB 85-09741
April 24, 1987
Order Denying Motion to Abate Referee's Order

The insurer has moved the Board for an interim order staying payment of unscheduled permanent disability compensation ordered by Referee Lipton, pending consideration of the insurer's motion for remand. We conclude that we must deny the motion for abatement of the Referee's order.

Should we determine that a case has been improperly, incompletely, or otherwise insufficiently developed, we remand for further evidence. ORS 656.295(5). Inasmuch as such an analysis necessarily requires a complete evaluation of the record, it is the Board's policy to defer ruling on motions for remand until Board review.

The insurer's request for abatement of the Referee's order pending our consideration of the motion for remand is contrary to law. ORS 656.313(1) expressly states that the filing of an insurer's request for review shall not stay payment of compensation to a claimant. We recognize the insurer's frustration in being compelled to either pay the compensation pending our review of the Referee's order or risk a substantial penalty if it elects not to pay. Yet, we are bound by legislative constraints. Myron W. Rencehausen, Sr., 38 Van Natta 613 (1986).

Accordingly, the insurer's motion to stay payment of compensation pending our consideration of the motion for remand is denied. We defer ruling on the motion for remand until Board review. Any supplemental documents which are submitted in support of the motion will be reviewed solely for the purpose of determining whether the motion should be granted and will not be made part of the record on review. See ORS 656.295(5).

IT IS SO ORDERED.

IBRAHIM G. TRAD, Claimant WCB 85-04879
Carney, et al., Claimant's Attorneys April 24, 1987
SAIF Corp Legal (Portland East), Defense Attorney Order on Review

Reviewed by Board Members McMurdo and Lewis.

The SAIF Corporation requests review of that portion of Referee Fink's order that granted claimant permanent total disability. The issue on review is permanent total disability.

Claimant, 53 years of age at the hearing, sustained a compensable injury to his low back in December 1980. He was eventually diagnosed as having bulging degenerative discs at L4-5 associated with nerve root irritation. All physicians agree that there is a psychological component to claimant's condition. Drs. Hadeed and Schuler noted signs of functional overlay. Dr. Franks reported some psychological component. Dr. Gambee and the Orthopaedic Consultants detected conversion hysteria.

Dr. Franks, a consulting neurosurgeon, initially recommended decompressive surgery. Subsequently, it was learned that claimant feared surgery. Since there was no fixed deficit at L4-5, Dr. Franks later recommended against surgery.

Claimant was born and raised in Syria. He has a fifth grade Syrian education and is relatively fluent in his native language. Prior to migrating to the United States in 1973, he worked in concrete and cement work. Thereafter, he began working for SAIF's insured, manufacturing concrete pipes. The job required little ability to speak or understand English. After his compensable injury, claimant attempted to return to modified work on two occasions. However, he has not worked since January 1982.

Claimant has received a total of 50 percent unscheduled permanent disability by way of Stipulation and Determination Order.

Vocational rehabilitation services were undertaken in February 1983. Claimant refused two job offers in light-duty repair work and showed little motivation to contact employers. This resulted in the near termination of vocational services in April 1984. Thereafter, he contacted approximately 17 different employers. In February 1985, a three week course in electronics assembly was completed, but claimant was unable to understand fundamental electronic theory and employment efforts proved fruitless.

Claimant's English skills are minimal. He reads at only the third grade level, he has trouble comprehending anything more than simple sentences, and he speaks rather poorly. Further, his IQ is rated at 81.

Several doctors have rendered opinions regarding the extent of claimant's physical impairment. Dr. Schuler, the initial treating physician, opined that there was no "significant evidence of permanent partial disability as the patient does not cooperate and overreacts and shows evidence of emotional overlay." The Orthopaedic Consultants examined claimant on three occasions and concluded that, "[claimant's] impairment, if any, is minimal to mild * * * ." They further stated that "there is certainly no reason to suggest [claimant] is totally disabled."

Dr. Hadeed, claimant's treating chiropractor, concurred with an earlier report of Orthopaedic Consultants rating claimant's impairment as mild. Dr. Franks felt claimant could lift up to 35 pounds and that he was not totally disabled. Finally, Dr. Gambee, an orthopedist, rated claimant's impairment as "minimal or mild."

Claimant testified that his physical condition has not improved since the original injury. He begins to feel faint and tired after only a couple hours of work. His daily activities are minimal. However, he felt he could perform light work such as answering telephones.

The Referee was "ambivalent" concerning claimant's credibility. He remarked that he had struggled in deciding the instant case and that, given the medical and vocational evidence, he would normally not even consider awarding permanent total disability. However, he deemed this case to be "exceptional" and concluded that claimant fit within the "odd-lot" doctrine. We disagree with the Referee for the following reasons.

A worker may prove permanent total disability by showing that he is totally physically or medically incapable of performing regular gainful and suitable employment. See Brech v. SAIF, 72 Or App 388 (1985). Permanent total disability need not, however, derive solely from the worker's medical or physical incapacity alone. Emerson v. ITT Continental Baking Co., 45 Or App 1089 (1980). Accordingly, under the "odd-lot" doctrine, a worker's physical impairment as well as contributing nonmedical factors such as age, education, adaptability to nonphysical labor, and emotional conditions can establish permanent total disability. Clark v. Boise Cascade Co., 72 Or App 397 (1985). An award of permanent total disability cannot be based on speculative assumptions regarding a worker's future employment prospects; that is, disability must be rated as it exists at the time of the hearing. See Gettman v. SAIF, 289 Or 609 (1980). Finally, unless the "futility" exception applies, the worker has the burden of proving that he sought regular gainful employment and that he made reasonable efforts to obtain such employment. Butcher v. SAIF, 45 Or App 313, 318 (1983); ORS 656.206(3).

We find that claimant has failed to establish that he is permanently incapacitated from regularly performing work at a gainful and suitable occupation. Consequently, he is not entitled to an award of permanent total disability.

Although claimant has suffered some permanent physical impairment, we are not persuaded that he is totally physically incapacitated from working. All the medical experts opine that claimant's physical impairment is only minimal to mild. Dr. Franks opined that claimant could lift up to 35 pounds and was "certainly" not totally disabled. Dr. Schuler indicated a lack of significant permanent partial disability. Lastly, the Orthopaedic Consultants felt claimant could return to his former type of work.

We further conclude that when claimant's physical disabilities are combined with his social and vocational factors, he has not established permanent total disability under the "odd-lot" doctrine. We are persuaded that he possesses sufficient physical capabilities, work experience, and vocational training to achieve a successful return to the work force.

In reaching this decision, we note that it is difficult to reconcile claimant's contention that he is permanently and totally disabled, when he refused to accept two job offers in light duty repair work. The vocational rehabilitation reports indicate that claimant completed a two month skills course aimed at improving his English communication skills, as well as training in the electronics field. Given claimant's minimal physical disability, two job offers in light-duty repair work, and his electronics training, we find that he has the ability to regularly perform gainful and suitable employment.

Furthermore, an essential element to claimant's case is the "seek work" requirement under ORS 656.206(3). Here, claimant did little to assist attempts at retraining and reemployment. The several vocational counselors were continually frustrated with claimant's lack of motivation and refusal to develop any vocational goals. After de novo review, we are not persuaded that claimant was willing to seek regular gainful employment or that he made reasonable efforts to obtain such employment. Further, we do not consider claimant to be so disabled that such efforts would have been futile. None of the medical experts felt claimant was so disabled that he could not return to, at least, light-duty work.

It is claimant's burden to prove his case by a preponderance of the evidence. Hutcheson v. Weyerhaeuser Co., 288 Or 51, 56 (1979). Following our de novo review of the medical, vocational, and lay evidence, we find that the record fails to preponderate in favor of permanent total disability. Furthermore, we conclude that a 50 percent unscheduled permanent disability award adequately compensates claimant for his permanent loss of earning capacity due to the compensable injury. ORS 656.214(5).

ORDER

That portion of the Referee's order dated March 31, 1986, that granted claimant permanent total disability and awarded an accompanying attorney fee, is reversed. The Determination Order's award of March 18, 1985, is reinstated. The remainder of the Referee's order is affirmed.

Beneficiaries of
JONG J. AHN, Claimant
Peter O. Hansen, Claimant's Attorney
Meyers & Terrall, Defense Attorneys

WCB 85-00438
April 27, 1987
Order on Review

Reviewed by Board Members Ferris and Lewis.

The self-insured employer requests review of those portions of Referee Galton's order, as amended on reconsideration, that: (1) awarded decedent's beneficiaries temporary total disability benefits for the period of November 29, 1984 through June 28, 1985; (2) assessed penalties and attorney fees for the employer's alleged unreasonable resistance to the payment of temporary total disability compensation; (3) awarded decedent's beneficiaries interim death benefits for the period of June 29 through August 6, 1985; (4) assessed penalties and attorney fees for the employer's alleged unreasonable resistance to the payment of interim death benefits; (5) allowed decedent's beneficiaries to appeal the October 9, 1986 Determination Order; (6) allowed decedent's beneficiaries to withdraw their request for permanent

total disability after the Referee had granted that award; and (7) awarded 256 degrees for 80 percent unscheduled permanent partial disability, bringing decedent's total award to 100 percent (320 degrees). Decedent's children, Gieme and Johnny Ahn, cross-request review of that portion of the order that denied them survivors' benefits under ORS 656.204. The issues are: (1) temporary total disability; (2) interim death benefits; (3) penalties and attorney fees; (4) whether decedent's beneficiaries could appeal the October 1986 Determination Order; (5) whether the beneficiaries could withdraw their request for permanent total disability; (6) extent of unscheduled permanent partial disability; and (7) the beneficiaries' entitlement to benefits under ORS 656.204.

Decedent immigrated to the United States in 1978 and began working as a cookie packer. She eventually was injured three times on the job, the last of which was a right shoulder injury occurring on August 25, 1982. Decedent was treated conservatively by Dr. Sultany for a diagnosed fibrositis condition. She attempted to return to work, but was unsuccessful due to pain. Psychological evaluation was recommended.

Decedent was examined by Dr. Christensen, a psychologist, to whom decedent complained of familial as well as injury-related tension. She was unable to accept Christensen's suggestion that the residuals of her injury had abated and that any ongoing problem she was experiencing might be emotional. Dr. Sultany agreed with Christensen that decedent's injury was no longer the cause of her apparent disability. Based on the reports of Christensen, Sultany and an independent examination by Dr. Parvaresh, psychiatrist, the employer issued a partial denial of decedent's psychological condition. That denial went to hearing before Referee Neal, whose June 12, 1984 Opinion and Order set aside the denial and remanded decedent's psychological claim for processing. We affirmed the Referee's order without opinion on July 24, 1985.

In October 1984, decedent began work as a drapery salesperson for her brother. Her right shoulder pain soon returned, however, and her brother notified decedent's vocational counselor that she was incapable of continuing. Decedent ultimately left work on November 28, 1984. She continued to receive outpatient therapy for her compensable psychological condition.

Decedent came under the care of Dr. Johnson, a psychiatrist, in June 1985. She was treated four times, the last being approximately three weeks after she was initially seen. Johnson noted decedent's ongoing depression and suicidal ideation. Approximately one week after decedent's last treatment, her body was found in her vehicle. The cause of death was later determined to have been a self-inflicted overdose of prescription medication.

Approximately one month after decedent's death, Dr. Johnson reported that decedent had attempted suicide on two prior occasions, once by taking drugs and another by walking into the ocean. He also noted that decedent had discussed on numerous occasions the emotional and financial benefit to be gained by the members of her family if she were to die. Decedent worried about how one of her children would adjust to her death. She felt that her other child, however, was strong enough to withstand the

adjustment. Based on his conversations with decedent, Dr. Johnson offered the following observation regarding her state of mind prior to her death:

> ". . . [I]t appears to me that [decedent] planned her suicide, with the expectation that those left behind would be better off because of the insurance money and she would no longer have the problems she had. "There seems to be more of a rational plan, to the extent that suicide can be rational, than a response to 'an irresistible impulse.'
>
> "Certainly she did have a good understanding of her act and the consequences of her act."

Dr. Johnson later stated that decedent was a danger to herself at the time of her death and that she probably met the admission criteria for commitment to an institution. He further stated, however, that while decedent considered suicide to be her last alternative, she did, in fact, make a decision to carry it out.

One defense theory proposed at hearing was that decedent's death was the result of a "deliberate intention," thereby precluding her beneficiaries from receiving benefits of any kind pursuant to ORS 656.156. The employer has renewed that defense on review and, because the remainder of this case depends on the success or failure of that defense, we will address it first. ORS 656.156 provides:

> "If injury or death results to a worker from the deliberate intention of the worker to produce such injury or death, neither the worker nor the widow, widower, child or dependent of the worker shall receive any payment whatsoever under ORS 656.001 to 656.794."

The Referee agreed with the employer that death benefits were not payable in this case under ORS 656.204. He disagreed, however, that decedent's beneficiaries were precluded entirely from receiving compensation generated during decedent's lifetime. The Referee cited as authority the then-current case of Betty McGill, 36 Van Natta 1692 (1984), in which we held the decedent's occupational claim to be compensable, despite our finding that the decedent had deliberately and intentionally taken his own life. The Referee reasoned that by finding the underlying occupational disease claim compensable, we implicitly allowed decedent's beneficiary to take any temporary disability benefits, medical billings and prescription reimbursements that would have been paid had decedent survived. The Referee, therefore, found that although we had denied the beneficiary's request for death benefits, we had implicitly allowed her to take other benefits available under the workers' compensation law.

While we understand the Referee's reasoning, we did not have occasion in McGill to specifically address the question now before us, i.e., whether a beneficiary can receive nondeath-related benefits when the decedent's death has occurred through suicide. We merely found the decedent's stress-related disease to be compensable without commenting on the beneficiary's entitlement to benefits accumulated during decedent's lifetime.

Prior to McGill, there had been only one case dealing with the compensability of death by suicide. In Jones v. Cascade Wood Products, 21 Or App 86 (1975), the decedent had suffered a compensable low back injury, followed by a psychological reaction that ultimately led to the decedent's suicide. The evidence, however, was that the decedent was neither insane, unable to control his actions nor unable to form a deliberate intent to kill himself at the time of his death. The court acknowledged three standards employed by various jurisdictions, the most liberal of which is the "but for" test. Under that test, a suicide is compensable if "but for" the injury the suicide would not have occurred. See e.g., Beauchamp v. Workmen's Comp. App. Bd., 259 Cal App2d 147 (1968). Another standard is the "irresistible impulse" test, under which the suicide is compensable only if the decedent was acting under the influence of an irresistible impulse that completely dominated his will, and the impulse resulted from the compensable injury. See e.g., United States v. Biami, 243 F Supp 917 (ED Wis 1965). The third and most restrictive standard requires that the suicide take place when the actor is so deranged that the suicide is not the result of any conscious volition to produce death, and the actor has no knowledge of the consequences of his act. See e.g., Sponatski's Case, 220 Mass 526, 108 NE 466 (1915).

The Jones court found that because the decedent was neither insane nor deluded at the time of his death, his suicide would be compensable only if the liberal "but for" test were employed. The court rejected that test, however, finding that its application would render ORS 656.156 meaningless. The court did not have reason to determine which of the remaining tests was applicable in Oregon, for under either standard, recovery would be barred. Jones, 21 Or App at 89.

In McGill, supra, 36 Van Natta 1692, we were faced with determining which of the two remaining standards was applicable in this jurisdiction. The decedent was a physician against whom two malpractice actions had been filed. As a result, the decedent became despondent and sought psychiatric treatment. He was ultimately hospitalized. During a weekend pass from the hospital, the decedent took his own life. The medical evidence was that his psychiatric condition was the direct result of the malpractice actions filed against him. After reviewing the record, we found the decedent's condition to be a compensable occupational disease. Id. at 1693.

The remaining issue was whether the decedent's widow was precluded from receiving death benefits because of ORS 656.156. That issue turned on which of the two viable suicide standards remaining after Jones was applicable. We found that the decedent was acting under an "irresistible impulse," but found that standard too elusive to be consistently applied. We, therefore, found the "insanity" test, under which the decedent must act with no conscious volition to produce death, to be more in line with the intent of the legislature. Finding the decedent in McGill to have acted with deliberate intent, we denied his widow's claim for death benefits. Id. at 1695.

The Court of Appeals reversed, McGill v. SAIF, 81 Or App 210 (1986), and followed the "chain of causation" standard set forth in Larson, The Law of Workmen's Compensation 6-140, Sec. 36.00 (1985), as interpreted by the Supreme Court of Texas in

Saunders v. Texas Employers' Ins. Ass'n, 526 SW2d 515 (Tex 1975). The McGill court stated:

> "We hold that a worker's suicide resulting from work-related stress which produced a mental derangement that impaired his ability to resist the compulsion to take his own life cannot be said to have arisen from a 'deliberate intention' under ORS 656.156(1)." McGill, 81 Or App at 215.

The court found that the decedent in McGill was mentally deranged as a result of his compensable stress condition, and that he was thereby rendered incapable of forming a deliberate intent to take his own life. Id. at 215.

Applying the "chain of causation" test to the present case, we find that decedent committed suicide as a result of "deliberate intention," as that phrase is used in ORS 656.156(1). The pertinent medical evidence comes from Dr. Johnson, decedent's most recent treating psychiatrist. According to Johnson, decedent formulated a "rational plan" to commit suicide and had a "good understanding of her act" and the consequences thereof. While it is also true that claimant was probably commitable because of her danger to herself, there is no persuasive evidence that she was mentally deranged to the extent that she was incapable of formulating a rational plan to commit suicide. In fact, the evidence is to the contrary.

Because we find that decedent acted with deliberate intent, we must decide whether ORS 656.156 precludes decedent's beneficiaries' from taking any and all benefits under Oregon compensation law. As noted, supra, the statute provides that when suicide is the result of deliberate intent, neither the surviving spouse, children nor other dependent of the decedent shall receive any payment whatsoever under any workers' compensation law. The statute is clear and unambiguous and we are required to apply it according to its plain meaning. See Satterfield v. Satterfield, 292 Or 780 (1982). We, therefore, find that decedent's beneficiaries are precluded from receiving benefits under the workers' compensation law. This finding moots the remaining issues in this case, all of which involve the extent of compensation to which the beneficiaries may have been entitled had our aforementioned findings been otherwise.

ORDER

The Referee's order dated May 30, 1986, as amended on July 15, 1986, is affirmed in part and reversed in part. That portion of the order that denied decedent's beneficiaries' request for benefits under ORS 656.204 is affirmed. The remainder of the order is reversed.

KENNETH W. HEIL, Claimant
Pozzi, et al., Claimant's Attorneys
Rankin, VavRosky, et al., Defense Attorneys

WCB 85-11285
April 27, 1987
Order on Review (Remanding)

Reviewed by Board Members McMurdo and Lewis.

Claimant requests review of those portions of Referee Fink's order that upheld the self-insured employer's denial of claimant's claim for aggravation relating to his low back and its denial of claimant's request for authorization for further surgery on his low back. Claimant also requests that the Board remand the case for receipt of evidence developed subsequent to the date of the Referee's order. The issues are remand, aggravation and medical services.

On January 23, 1987, claimant filed a motion for remand with the Board. Attached to the motion for remand were documents relating to a surgical operation to claimant's low back which was performed on January 7, 1987. These documents were not available prior to the hearing and are highly probative in relation to claimant's aggravation and medical services claims. Under these circumstances, we conclude that the case should be remanded for further development and reconsideration by the Referee. See ORS 656.295(5); Duckett v. SAIF, 79 Or App 749, 750 (1986).

ORDER

The Referee's order dated June 13, 1986 is vacated and the case is remanded to the Referee for further development and reconsideration.

DENNIS WILSON, Claimant
Michael B. Dye, Claimant's Attorney
Schwabe, et al., Defense Attorneys

WCB 86-04147
April 27, 1987
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of Referee Podnar's order that upheld the self-insured employer's denial of claimant's medical services claim. The issue is compensability.

We affirm the Referee's order with the following comment. Although we agree that claimant's claim is not compensable, we disagree with the Referee that the claim is barred by the parties' May 5, 1980 Disputed Claim Settlement. That settlement purported to deny the compensability of all future medical services that might arise from claimant's compensable injury. Such a settlement has no effect on claimant's ongoing right to reasonable and necessary medical services. See ORS 656.236(1); EBI Companies v. Freschette, 71 Or App 526 (1984).

ORDER

The Referee's order dated August 27, 1986 is affirmed.

CALVIN K. HENDRIX, Claimant
Douglas D. Hagen, Claimant's Attorney
Lester Huntsinger (SAIF), Defense Attorney
Meyers & Terrall, Defense Attorneys

WCB 85-12561 & 86-01052
April 28, 1987
Order on Review

Reviewed by Board Members McMurdo and Lewis.

Claimant requests review of those portions of Referee Fink's order that upheld the insurers' denials of claimant's industrial injury claim relating to his low back and rejected his claims for interim compensation, penalties and attorney fees. The issues are the timeliness of claimant's claim, compensability, interim compensation, penalties and attorney fees.

On the timeliness and compensability issues, the Board affirms and adopts the order of the Referee. On the interim compensation, penalty and attorney fee issues, we reverse.

Claimant filed an 801 form with the employer on September 27, 1985 claiming that he had injured his low back on July 4, 1985. The employer indicated on the 801 form that it first knew of claimant's alleged injury on September 23, 1985. The insurer issued its first compensability denial on October 4, 1985, within 14 days of September 23, 1985. The insurer, therefore, was not liable for interim compensation based upon the information contained in the 801 form. See ORS 656.262(4); Jones v. Emanuel Hospital, 280 Or 147, 151 (1977).

The record contains evidence of two other events, however, which may have triggered the insurer's duty to pay interim compensation prior to September 23, 1985. The first of these events came from claimant's testimony. He testified that he orally reported the accident to his employer the morning after it allegedly occurred. If believed, this report would satisfy the definition of a "claim" under the last clause of ORS 656.005(7) and would trigger the insurer's duty to begin paying interim compensation. We, however, do not accept claimant's testimony. The Referee expressly found claimant not credible based upon his observations of claimant's demeanor and several internal inconsistencies in claimant's testimony. We accept the Referee's credibility finding and reject claimant's alleged oral report as a basis for ordering the payment of interim compensation.

The second event which may have triggered the insurer's duty to pay interim compensation was an 827 form addressed to the insurer, signed by claimant's treating chiropractor and dated September 6, 1985. The form contained a description of claimant's alleged injury, gave a number of diagnoses relating to claimant's low back and stated that claimant was unable to work. On Board review, the insurer concedes that this form was sufficient to trigger its duty to begin paying interim compensation, but contends that there is no evidence in the record concerning when it received the form. Careful examination of the exhibit reveals a perforation-type date stamp at the bottom of the document. When reviewed upside down, the date stamp reads in pertinent part: "9-17-85 . . . EBI." In light of this date stamp, we conclude that the insurer, EBI Companies, received the document on September 17, 1985. The denial was not issued until 17 days later. The insurer, therefore, should have begun paying interim compensation three days before it issued its denial. See ORS 656.262(4); Jones v. Emanuel Hospital, supra. It has provided no explanation for failing to do so. Under these circumstances, the insurer will be ordered to pay

interim compensation from September 17 through October 4, 1985, a five percent penalty and a $50 attorney fee. See ORS 656.262(10); 656.382(1); George J. Kovarik, 38 Van Natta 1381 (1986); Barbara A. Wheeler, 37 Van Natta 122, 123 (1985).

ORDER

The Referee's order dated April 4, 1986 is affirmed in part and reversed in part. Those portions of the Referee's order that rejected claimant's claims for interim compensation, penalties and attorney fees are reversed. Claimant is awarded interim compensation from September 17 through October 4, 1985. EBI Companies shall also pay to claimant a penalty of five percent of this compensation. Claimant's attorney is awarded 25 percent of the interim compensation awarded by this order, not to exceed $500, and is also awarded an insurer-paid attorney fee of $50 in connection with the penalty issue. The remainder of the Referee's order is affirmed.

CORNELIUS JONES, Claimant
Doblie & Associates, Claimant's Attorneys
Alice M. Bartelt, Defense Attorney

WCB 86-06403
April 28, 1987
Order of Dismissal

Claimant has moved the Board for an order dismissing the insurer's request for Board review on the ground that the request was untimely filed. The motion is granted.

The Referee's order issued December 23, 1986. On January 14, 1987, claimant requested clarification of the Referee's order. On January 21, 1987, the Referee withdrew and abated his December 23, 1986 order. On January 22, 1987, the insurer requested Board review of the Referee's December 23, 1986 order. On February 9, 1987, the Referee issued an amended order, reaffirming and republishing his former order. To date, no request for Board review of this order has been filed.

A Referee's order is final unless, within 30 days after the date on which a copy of the order is mailed to the parties, one of the parties requests Board review under ORS 656.295. ORS 656.289(3). The time within which to appeal an order continues to run, unless the order has been abated, stayed, or "republished." International Paper Co. v. Wright, 80 Or App 444 (1986). To abate and allow reconsideration of an order issued under ORS 656.289(1), the second order must contain specific language. Farmers Insurance Group v. SAIF, 301 Or 612, 619 (1986).

Here, the insurer requested review of the Referee's December 23, 1986 within 30 days of its issuance. However, on the date the insurer mailed its appeal, the Referee's order had already been expressly withdrawn and abated. Thus, the insurer's request for Board review of a nonexistent Referee's order is a nullity.

The Referee's February 9, 1987 order, with some additions, reaffirmed and republished his former order. Inasmuch as this order was not appealed within 30 days of its issuance, it has become final by operation of law. ORS 656.289(3). Accordingly, the insurer's request for Board review is dismissed for lack of jurisdiction.

Inasmuch as the insurer's request for Board review has been dismissed prior to a decision on the merits, claimant is not entitled to an attorney fee. Agripac, Inc. v. Kitchel, 73 Or App 132 (1985); Rodney C. Strauss, 37 Van Natta 1212, 1214 (1985).

IT IS SO ORDERED.

SALVADORE M. MENDOZA, Claimant
E-Z FARMS, Employer
Kenneth D. Peterson, Claimant's Attorney
Joseph T. McNaught, Attorney
Richard Barber (SAIF), Defense Attorney
Carl M. Davis, Assistant Attorney General

WCB 85-10029 & 85-04406
April 28, 1987
Order on Review

Reviewed by Board Members Lewis and Ferris.

Claimant requests review of those portions of Referee Neal's order, as amended on reconsideration, that: (1) found that the Hearings Division was without jurisdiction to reclassify claimant's claim from nondisabling to disabling; and (2) denied claimant's request for penalties and attorney fees for the SAIF Corporation's allegedly unreasonable failure to originally classify the claim as disabling. The issues are jurisdiction and penalties and attorney fees.

We agree with the Referee that penalties and attorney fees are not appropriate in this case. On the jurisdictional issue, however, we reverse.

Claimant incurred a compensable chest injury in August 1984 while employed by a noncomplying employer. In December 1984, SAIF accepted the claim as nondisabling. It issued a Notice of Acceptance, explaining to claimant that his claim had been accepted as nondisabling and that he had certain rights. The claim was never closed. On April 9, 1985, claimant requested a hearing, seeking a reclassification of his claim from nondisabling to disabling.

The Referee found that she was without jurisdiction to entertain claimant's request for reclassification. Citing the then current case of Garland Combs, 37 Van Natta 756 (1985), she found that claimant had failed to timely request reclassification of his claim and that his only remaining remedy was to establish an aggravation under ORS 656.273.

Subsequent to the Referee's order, the court decided Davison v. SAIF, 80 Or App 541 (1986). In Davison, the claimant suffered a scheduled injury and his claim was later accepted as nondisabling. The claimant did not request reclassification of his claim, as allowed by ORS 656.268(12). He asserted, however, that his claim had been misclassified as nondisabling from the outset and that it was still viable because it had never been closed. The insurer argued that the Notice of Acceptance sent to the claimant also operated to close the claim. The court agreed with the claimant, holding that because the claim had never been closed, the time within which the claimant could seek a Determination Order had not expired. The court then remanded the claim for closure pursuant to ORS 656.268. Id. at 544.

We find Davison to be directly applicable to the present case, for after reviewing the medical evidence, we are persuaded

that claimant's claim should have been classified as disabling from the outset. Because his claim was never closed, the claim is still viable and must be remanded for closure pursuant to ORS 656.268.

ORDER

The Referee's order dated August 11, 1986 is reversed in part and affirmed in part. That portion of the order that dismissed claimant's request for hearing is reversed. Claimant's claim is remanded to the SAIF Corporation for processing and closure pursuant to ORS 656.268. The remainder of the Referee's order is affirmed. Claimant's attorney is awarded 25 percent of the increased compensation resulting from this order, not to exceed $3,000.

ADELIE M. WEBB, Claimant
Stephen Behrends, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 83-00463
April 28, 1987
Order on Remand

This matter is before the Board on remand from the Court of Appeals. Webb v. SAIF, 83 Or App 386 (1987). The court has directed the SAIF Corporation to pay claimant's medical benefits from December 2, 1982 to April 26, 1984. The court has also mandated that we award penalties and attorney fees for SAIF's unreasonable denial.

Accordingly, this claim is remanded to SAIF for the payment of claimant's medical benefits for his low back condition from December 2, 1982 to April 26, 1984. In addition, SAIF is directed to pay to claimant a penalty in a sum equal to 25 percent of these benefits. SAIF is further directed to pay to claimant's attorney a fee in the amount of $500, in addition to the penalty.

IT IS SO ORDERED.

NOLAND I. BENDER, Claimant
Malagon & Moore, Claimant's Attorneys
Cowling & Heysell, Defense Attorneys

WCB 86-04788
April 30, 1987
Order on Review

Reviewed by Board Members Ferris and Lewis.

The insurer requests review of Referee Daron's order that increased claimant's award of unscheduled permanent partial disability for his low back from the five percent (16 degrees) awarded by Determination Order to 50 percent (160 degrees). The issue is extent of disability.

Claimant injured his low back in October 1984 in a lifting incident in the course of his employment as a choker setter for a logging company. At the time of this injury, he was earning $9.00 per hour. He sought treatment from a chiropractor, Dr. Adams.

In December 1984, Dr. Adams reported that she had discovered a number of congenital and developmental anomalies in claimant's low back which made him "prone to instability in the lumbosacral motor unit." She stated that she was ready to release him to regular work, but cautioned: "[I]t seems wise to keep the instability of [claimant's] low back in mind." Claimant did not immediately return to work.

The following month, Dr. Adams reported that she felt uncomfortable releasing claimant to "full duties" and referred him to a consulting chiropractor, Dr. McCrory, for another opinion. Dr. McCrory noted a number of congenital and developmental abnormalities in addition to those identified by Dr. Adams and stated: "It is my impression, based on the underlying congenital anomalies found on x-ray examination, that [claimant] is most definitely not suited to heavy labor." (Emphasis in original). This view was echoed in July 1985 by Dr. Becker, a specialist in physical medicine and rehabilitation. Dr. Becker later commented that even considering the congenital and developmental anomalies, claimant could safely perform "medium-heavy" work, which he defined as repetitive lifting of objects weighing 50 pounds.

Claimant received vocational assistance in the form of a direct employment program from January to September 1985. The vocational counselor located a potential job in the medium or light category in a local plywood mill. The wages were nearly as much as those of a choker setter and mill management expressed strong interest in hiring claimant. Before any openings were available in the mill, the time limit for the provision of vocational services expired and vocational services were terminated on the ground that claimant's lack of employability was due to economic conditions rather than to his industrial injury. Nonetheless, mill management indicated that they were anticipating openings in the near future and that they would contact claimant when such openings did occur. Claimant's claim was closed by Determination Order in March 1986 with a five percent unscheduled award.

Claimant requested a hearing which was held in August 1986. He testified that he continued to experience occasional periods of back pain and received one or two chiropractic treatments per month. He indicated that he had turned down six or seven offers of heavy employment which paid as much as or more than he was making as a choker setter, because he no longer felt able to perform that kind of work. He also testified that he had never been contacted by the plywood mill but that he had located a job as a gas station attendant about four months prior to the hearing. The job paid about $4.30 per hour and usually required him to work 60 hours per week. During the four months that claimant had worked at the gas station, he had not missed any work because of back pain.

The Referee emphasized claimant's inability to engage in heavy labor and the difference between the wage that claimant was earning at the time of the injury ($9.00 per hour) and the wage that he was earning at the time of the hearing ($4.30 per hour). The Referee then stated that he considered the aforementioned wage differential a reliable indicator of the severity of claimant's loss of earning capacity. Consequently, the Referee increased claimant's unscheduled award from five to 50 percent.

We disagree with the Referee's analysis. The purpose of an award of unscheduled permanent partial disability is to compensate a claimant for "the permanent loss of earning capacity due to the compensable injury." ORS 656.214(5). Our first point of disagreement with the Referee's analysis is that the record does not support the conclusion that claimant is unable to perform heavy work "due to" the compensable injury. The recommendations

against engaging in heavy labor were based upon the presence of congenital and developmental anomalies in claimant's spine which were discovered during his course of treatment. These anomalies made claimant more susceptible to future low back injuries. There is no indication in the record, however, that the anomalies were either caused or worsened by the industrial injury or that they were producing symptoms as a result of the industrial injury which disabled claimant from heavy work. Under these circumstances, it was inappropriate for the Referee to consider limitations attributable to the congenital and developmental anomalies in rating the extent of claimant's disability. See Barrett v. D & H Drywall, 300 Or 553, 555-56 (1986).

Our second point of disagreement with the Referee's analysis concerns his heavy reliance upon the difference between the wage claimant earned at the time of the industrial injury and the wage he was earning at the time of the hearing. "Earning capacity" is defined as "the ability to obtain and hold gainful employment in the broad field of occupations, taking into consideration such factors as age, education, training, skills and work experience." ORS 656.214(5). Evidence of a worker's earnings may sometimes be relevant to a determination of extent of disability. See Watkins v. Fred Meyer, Inc., 79 Or App 521, 525-26 (1986); Jacobs v. Louisiana-Pacific, 59 Or App 1, 3 (1982). Such evidence, however, is not an accurate direct measure of earning capacity. See Ford v. SAIF, 7 Or App 549, 552-53 (1972).

In the present case, we fail to see how the difference between what claimant was earning at the time of his injury and at the time of the hearing has any significance in rating the extent of his disability. Claimant testified that, because he had been advised not to engage in heavy labor, he had turned down a number of offers of employment which paid at least as much as he was earning at the time of his injury. In light of our previous conclusion regarding the cause of claimant's inability to perform heavy labor, this indicates that claimant could earn just as much as he did at the time of his injury were it not for his congenital and developmental anomalies. In addition, even considering claimant's congenital and developmental anomalies, the vocational assistance record in this case establishes that employment with pay comparable to what claimant was earning at the time of his injury does exist within claimant's physical, social and vocational limitations. For these reasons, we conclude that the Referee's reliance upon claimant's wages as a measure of his earning capacity was misplaced.

We proceed, therefore, to rate the extent of claimant's disability. In so doing, we consider the impairment due to the compensable injury as reflected in the medical record and the testimony at the hearing and all of the relevant social and vocational factors set forth in OAR 436-30-380 et seq. We apply these rules as guidelines, not as restrictive mechanical formulas. See Harwell v. Argonaut Insurance Co., 296 Or 505, 510 (1984); Howerton v. SAIF, 70 Or App 99, 102 (1984).

Claimant was 21 years old at the time of the hearing. He is of average intelligence and is a high school graduate. His work history includes jobs as a janitor, a laborer for a city maintenance department, a laborer for a commercial fisherman, a veneer puller in a plywood mill and a choker setter for a logging company.

Following our de novo review of the medical and lay evidence, we conclude that claimant's low back impairment due to the industrial injury is in the minimal range. Exercising our independent judgment in light of claimant's level of impairment and the relevant social and vocational factors, we conclude that an award of 16 degrees for five percent unscheduled permanent partial disability adequately and appropriately compensates claimant for the permanent loss of earning capacity due to his industrial injury. We, therefore, reinstate and affirm the Determination Order award.

ORDER

The Referee's order dated September 5, 1986 is reversed. The award of unscheduled permanent partial disability granted by the Determination Order dated March 26, 1986 is reinstated and affirmed.

RUSSELL W. CARLEZON, Claimant
Bischoff & Strooband, Claimant's Attorneys
Cliff, Snarskis & Yager, Defense Attorneys

WCB 86-04612
April 30, 1987
Order on Review

Reviewed by Board Members Lewis and Ferris.

Claimant requests review of Referee Daron's order that upheld the insurer's denial of claimant's aggravation and medical services claims for the low back. The issues are aggravation and medical services.

We affirm that portion of the Referee's order that upheld the insurer's denial of claimant's aggravation claim. However, we find claimant's claim for medical services compensable. Consequently, we reverse the Referee's contrary finding.

Claimant suffered a compensable low back strain in 1984. The claim was accepted as disabling and claimant treated with Dr. Feld, a chiropractor, for two months before returning to work. The claim was closed by Determination Order in April 1984 with an award of temporary total disability.

Claimant continued to work for his employer for approximately 18 months before seeking additional treatment. According to his credible testimony, however, claimant continued to suffer intermittent low back pain throughout the term of his employment. In February 1986, he returned to Dr. Feld complaining of severe low back pain. He received regular treatments until the insurer denied his claim for medical services in March 1986.

The insurer sent claimant to Dr. Woolpert for an independent medical examination in June 1986. Woolpert found no objective signs of disability and felt that, given the 18 months between claimant's medical treatments, it was unlikely that his current condition was related to the original injury. Dr. Feld, on the other hand, felt that claimant's original problem had never resolved and that the 1984 back injury was responsible for the most recent flare up of symptoms.

Claimant testified that he had "a lot of discomfort" during the 18 months between chiropractic treatments, but that his work schedule made it difficult to see a doctor. He had suffered no intervening trauma and when he revisited Dr. Feld, his symptoms were in the same area of the low back. The pain, however, had simply increased to the point that additional treatment was

needed. Claimant testified that Feld's chiropractic manipulations greatly decreased his pain and improved his mobility.

Claimant is entitled to medical services necessitated by the original injury. ORS 656.245. Like curative treatment, palliative medical services are compensable, so long as they are proven to be both reasonable and necessary. Wetzel v. Goodwin Bros., 50 Or App 101 (1981). After reviewing this record, we are persuaded that claimant's claimed medical services are both reasonable and necessitated by the injury. The treating physician has stated that claimant's current condition is a continuation of his original injury, and that intermittent chiropractic treatments are needed to maintain claimant's employability. Claimant's credible testimony is consistent with his physician's reports; his symptoms have been recurrent, consistently located in the same area of the low back, and have been relieved by intermittent chiropractic adjustments.

The only contrary medical evidence comes from Dr. Woolpert, who opines that claimant's current condition is not related to the original injury. Woolpert, however, saw claimant for the first time nearly two and a half years after the injury. Unlike Dr. Feld, he did not have the advantage of following claimant's case from the outset. Neither has he suggested an alternative cause for claimant's recurrent low back pain. We find Dr. Woolpert's opinion less persuasive than that of the treating physician.

ORDER

The Referee's order dated September 5, 1986 is reversed in part and affirmed in part. That portion of the order that upheld the insurer's denial of claimant's claim for medical services is reversed. The remainder of the order is affirmed. Claimant's attorney is awarded $500 for services at hearing and $400 for services on Board review, to be paid by the insurer.

ARTHUR E. MATTHEWS, Claimant
J. Michael Casey, Claimant's Attorney
Charles Lisle (SAIF), Defense Attorney

WCB 85-07796
April 30, 1987
Order on Review

Reviewed by Board Members McMurdo and Lewis.

Claimant requests review of Referee Brown's order that: (1) upheld the SAIF Corporation's "de facto" denial of his aggravation claim for a right hip condition; and (2) declined to award temporary disability benefits, penalties, and accompanying attorney fees for allegedly unreasonable claims processing. On review, claimant contends that: (1) his original claim was never properly closed; (2) his aggravation claim is compensable; and (3) he is entitled to temporary disability, penalties, and accompanying attorney fees.

Claimant was 55 years of age at the time of hearing. In September 1980, he sought medical treatment for right hip pain from Dr. Weinman, orthopedist. Claimant attributed his pain to his 11-year employment as a route salesman for a beer distributorship. He further reported that his problem had progressively developed since January 1980. An arthrogram and bone scan were normal. Conceding that diagnostic possibilities remained, Dr. Weinman concluded that early avascular necrosis or degenerative joint disease of the hip could not be shown by objective examination or diagnostic tests.

In November 1980 claimant filed an occupational disease claim for "unknown damage" to his right hip. His claim listed the date of onset as January 8, 1979. Claimant has no recollection of giving the 1979 date. Rather, he dates the onset of his symptoms to the fall of 1980. Claimant apparently did not miss any time from work. Classifying the claim as a disabling occupational disease, SAIF issued its denial.

In January 1981 Dr. Weinman opined that claimant was medically stationary and that the claim should be closed. In March 1981 Dr. Woolpert, orthopedist, noted that claimant had obvious synovitis of the right hip that was most likely due to rheumatoid arthritis which was presently undetectable by blood studies. Although the problem remained ill-defined, Dr. Woolpert opined that claimant's work activities would appear to have aggravated the process.

The compensability of claimant's right hip claim was considered at a June 1981 hearing. A prior Referee found that claimant's work activity had aggravated his right hip condition. Consequently, SAIF's denial was set aside. However, SAIF did not notify claimant that his claim had been accepted either as disabling or nondisabling. Moreover, the claim was never closed by Notice of Closure or through the Evaluation Division.

Although his hip pain never resolved, claimant continued to work as a route salesman until May 1984. At that time, he was transferred to a less strenuous job as a "pre-writer." There is no indication that this transfer affected his wages. In August 1984, claimant returned for medical treatment. X-rays raised the possibility of a rheumatoid variant arthritis. In October 1984, Dr. Thompson, orthopedist, diagnosed degenerative arthritis. Since claimant had been laid off in September 1984, he began receiving unemployment benefits in October 1984 and continued to do so for the following six months. During this period, claimant felt that the duties of a route salesman exceeded his physical limitations.

On May 13, 1985, claimant's attorney advised SAIF that claimant's compensable condition had materially worsened. Since claimant was unable to pursue his regular employment, he was in need of temporary disability benefits. Claimant's attorney suggested that the claim could be processed either as an aggravation or as a new claim.

On May 29, 1985, SAIF notified claimant that his aggravation rights had expired. Thus, SAIF concluded that claimant was not entitled to interim benefits while a decision concerning the reopening of his claim was pending. SAIF was apparently using the January 1979 date as the date of onset. Claimant was advised that in order to "perfect" his aggravation claim he should present medical reports relating his current worsened condition and need for medical treatment to his compensable claim. SAIF had ceased its coverage of the employer in March 1981. SAIF neither issued a denial nor processed claimant's request as a new claim.

Since claimant began seeking medical treatment in September 1980, his attorney contended that his aggravation rights had not expired. Moreover, claimant's counsel asserted that claimant's condition had continued to worsen until his eventual retirement.

Dr. McCafferty, radiologist, compared claimant's September 1980 x-rays with August 1984 x-rays. In Dr. McCafferty's opinion, the 1984 films demonstrated a more pronounced joint space narrowing. However, Dr. McCafferty did not have sufficient facts to establish that claimant's condition was worsened by work-related conditions. Dr. Cervi-Skinner, endocrinologist, agreed that claimant's condition had worsened between 1980 and 1984. Yet, Dr. Cervi-Skinner did not discuss the condition's relationship to the compensable claim or claimant's work activities.

Dr. Thompson reported that claimant was able to continue his regular duties in September and October 1984. Furthermore, Dr. Thompson concluded that claimant's problem represented a natural progression of degenerative arthritis. In Dr. Thompson's opinion, any activity involving the hip, whether at work or at home, would contribute to the problem.

In July 1985 claimant obtained employment with another distributorship. He primarily worked in public relations, but occasionally performed deliveries. He was laid off in October 1985. Since that time he has been unemployed, drawing a pension and working on his small farm. However, he does not regard himself as retired.

The Referee found that claimant had failed to establish a causal relationship between his current condition and his compensable claim. Consequently, SAIF's "de facto" denial was upheld. The Referee further concluded that claimant was not entitled to interim compensation whether his claim was analyzed as an aggravation or new injury. Since no medical verification of an inability to work as a result of a worsened condition had been provided, the Referee found that claimant was not entitled to interim compensation under ORS 656.273(6). In addition, if viewed as a new injury claim, the Referee found no indication that claimant was required to leave work as a result of the need for treatment for a compensable condition. Rather, the evidence suggested that he was no longer in the work force. Finally, considering the confusion surrounding the onset date for claimant's compensable claim, the Referee did not find SAIF's response unreasonable.

We affirm those portions of the Referee's order that found that claimant was not entitled to interim compensation, penalties, and attorney fees. However, we reverse that portion of the order that found that claimant's current condition was not causally related to his compensable claim.

Pursuant to ORS 656.268(3), claims for nondisabling injuries or disabling injuries without permanent disability may be closed either through a Notice of Closure or by means of a Determination Order. This statute was in effect in September 1980, when claimant first sought treatment for his compensable condition. See Or Laws 1979, ch 839, §§4(3) and 33. In Davison v. SAIF, 80 Or App 541 (1986), recon 82 Or App 546 (1986), the court concluded that claims for nondisabling injuries must be closed before the time within which a claimant may seek a Determination Order begins to run.

Here, it is not entirely clear whether the claim was classified as nondisabling or disabling. However, it is clear that the claim was compensable and should have been processed to

closure, either through administrative means or through the Evaluation Division. SAIF cannot circumvent the closure process by attempting to terminate future responsibility before the extent of the compensable condition has been determined. Webb v. SAIF, 83 Or App 386, 391 (1987); Roller v. Weyerhaeuser Co., 67 Or App 583, amplified 68 Or App 743, rev den 297 Or 601 (1984). Inasmuch as the claim has never been closed, SAIF's "de facto" denial is invalid. Accordingly, the claim is remanded to SAIF for closure pursuant to ORS 656.268.

ORDER

The Referee's order dated February 6, 1986 is affirmed in part and reversed in part. Claimant's 1980 "right hip" claim is remanded to the SAIF Corporation for closure pursuant to ORS 656.268. The remainder of the Referee's order is affirmed. Claimant's attorney is awarded 25 percent of the increased compensation awarded when the claim is closed, not to exceed $3,000.

J.C. OLIVER, Claimant
Galton, et al., Claimant's Attorneys

Own Motion 87-0055M
April 30, 1987
Own Motion Determination Rescinded

On January 28, 1987, we issued an Own Motion Determination closing claimant's claim for a December 16, 1980 injury. Asserting that his claim has never been closed either by means of a Notice of Closure or Determination Order, claimant questions our jurisdiction to consider this matter. Following further review, we find that we lack jurisdiction.

The self-insured employer accepted claimant's 1980 left knee injury claim. Although claimant sought medical treatment, he apparently continued to work. It is unclear whether the claim was accepted as disabling or nondisabling. In any event, there is no indication that the claim was closed either administratively or through the Evaluation Division. See ORS 656.268(3).

In May 1986, the employer voluntarily reopened the claim and paid temporary disability benefits. Once claimant's condition became medically stationary, the claim was submitted to the Board for "Own Motion" closure. Thereafter, we issued our Own Motion Determination. Claimant has now presented additional materials in support of his contention that his claim has never been closed.

Pursuant to ORS 656.268(3), claims for nondisabling injuries or disabling injuries without permanent disability may be closed either through a Notice of Closure or by means of a Determination Order. In Davison v. SAIF, 80 Or App 541 (1986), recon 82 Or App 546 (1986), the court concluded that claims for nondisabling injuries must be closed before the time within which a claimant may seek a Determination Order begins to run.

Here, it is not entirely clear whether claimant's injury claim was accepted as nondisabling or disabling. However, regardless of the claim's classification, the record fails to establish that the claim has ever been closed. Consequently, we conclude that claimant's 1980 injury claim remains open because it was never closed by a Notice of Closure or Determination Order. See ORS 656.268(3); Davison v. SAIF, supra.

Inasmuch as the claim has never been closed, we lack jurisdiction to consider this matter under ORS 656.278. Accordingly, we rescind our prior determination and remand this matter to the Evaluation Division for claim closure pursuant to ORS 656.268(3).

IT IS SO ORDERED.

WILLIAM H. WILSON, Claimant
Coons & Cole, Claimant's Attorneys
EBI Companies, Defense Attorney

Own Motion 87-0068M
April 30, 1987
Own Motion Order

EBI Companies has submitted claimant's request for reopening of his August 1978 right foot and leg injury claim to the Board for consideration pursuant to its own motion authority under ORS 656.278. Claimant's aggravation rights have expired.

As of January 1980, the last arrangement of compensation, claimant has received scheduled permanent disability awards totalling 20 percent for the right foot and 20 percent for the right leg. In addition, claimant has been awarded 34 degrees of the right foot stemming from a 1971 injury for which the SAIF Corporation was the responsible insurer. This 1971 injury also apparently resulted in the amputation of his left leg below the knee.

Following our review of this record, we find that there has been a worsening of claimant's compensable right foot and ankle condition. The record preponderates that claimant is experiencing increased pain and further restricted motion as a result of a significant progressive degenerative condition. We are further persuaded that claimant's 1978 compensable injury is a material and independent contributing cause of this condition. Accordingly, we conclude that his claim with EBI should be reopened.

On November 26, 1986, we issued an Own Motion order reopening claimant's 1971 left leg and right foot injury claim with SAIF. See WCB Case No. 86-0639M. Pursuant to that order, SAIF was directed to pay temporary total disability compensation beginning October 22, 1986, and to continue, less time worked, until closure pursuant to ORS 656.278. To date, this claim remains open and SAIF has apparently continued to pay claimant's compensation.

From November 11, 1986 through January 12, 1987, EBI also paid temporary disability compensation. EBI took this action although it had not submitted the claim to the Board for formal reopening. Once EBI learned of SAIF's payments, it stopped paying compensation and referred the matter to the Board for consideration.

As discussed above, we are persuaded that EBI is responsible for claimant's current right foot and ankle condition. Therefore, claimant's 1978 injury claim shall be reopened. Temporary disability compensation should commence October 22, 1986 and continue, less time worked, until closure pursuant to ORS 656.278. These benefits shall be further reduced by the compensation claimant has previously received from EBI and SAIF.

The goal of this order is to award claimant the equivalent of temporary disability compensation under his 1978 injury claim with EBI from October 22, 1986 until claim closure. Nothing more and nothing less. Thus, from this date, EBI shall be responsible for the payment of claimant's temporary disability compensation and the processing of the 1978 right foot and ankle injury claim. However, to avoid claimant's double recovery of temporary disability compensation, EBI may offset its initial payments of benefits against the compensation it paid between November 11, 1986 and January 12, 1987.

SAIF shall continue to be responsible for the processing to closure of claimant's 1971 left leg injury claim, but it will no longer be responsible for the payment of temporary disability benefits as we previously directed. An interim order to this effect has been issued this date in WCB Case No. 86-0639M.

As a result of our decision, SAIF has paid temporary disability benefits that have been found to be the responsibility of EBI. Had this been a case under ORS 656.307, designation of a paying agent would have enabled SAIF to obtain reimbursement from EBI. Yet, since jurisdiction over this matter arose solely under ORS 656.278, the formal procedure available under ORS 656.307 was not applicable. OAR 436-60-180(3); William C. Dilworth, 38 Van Natta 1283, 1284 (1986). Thus, no statutory procedures presently exist to grant SAIF reimbursement of its claim costs. Likewise, there are no statutory restrictions that would prohibit the insurers from accomplishing the goal of a ".307" procedure. Consequently, we recommend that EBI reimburse SAIF for the temporary disability compensation it paid pursuant to our November 26, 1986 order in WCB Case No. 86-0639M.

IT IS SO ORDERED.

WILMA A. MOORE, Claimant
Malagon & Moore, Claimant's Attorneys
Arthur Stevens (SAIF), Defense Attorney

WCB 86-06466
May 6, 1987
Order on Review

Reviewed by Board Members en banc.

Claimant requests review of Referee T. Lavere Johnson's order that upheld the SAIF Corporation's denial of claimant's claim for Hepatitis B. The issue is compensability.

The Board affirms the order of the Referee.

ORDER

The Referee's order dated September 8, 1986 is affirmed.

Board Member Lewis Dissenting:

Because I believe that claimant has established the compensability of her hepatitis condition, I respectfully dissent from the majority's opinion.

Claimant is a registered nurse at a county correctional facility. Her work duties include assisting physicians and dentists in their care of prisoners. She routinely comes in contact with prisoners' bodily fluids in the course of her employment.

In February 1986, claimant was diagnosed as having contracted Hepatitis B, an infectious disease that affects the liver. As a result of her illness, claimant received medical treatment and lost time from work. She filed a claim for compensation the day after learning of her diagnosis. She alleged that she contracted hepatitis as a result of her general exposure to prisoners who may have had or carried the disease, and/or from a specific incident in October 1985 in which she was pricked by an unsterile hypodermic needle used in a prisoner's dental procedure. Claimant's testimony regarding her exposures was corroborated by that of another correctional facility nurse.

Claimant's treating physician's June 1986 report is the only medical opinion in evidence. He noted that as a correctional facility nurse, claimant was likely exposed to numerous individuals who were potential carriers of the hepatitis virus. He also noted that the incubation period for the disease, while variable, is generally from two to three months. With regard to causation, he stated

> " . . . it is only logical to assume that [claimant] did contract hepatitis at her place of employment. There is no question that health professionals are at a higher risk of contracting hepatitis B."

The Referee found, and I agree, that claimant's off-the-job activities did not expose her to the hepatitis virus during the months preceding her diagnosis. Despite that finding, the Referee found the claim noncompensable, concluding that the treating physician's opinion was merely speculative rather than framed in terms of medical probability. The majority apparently agrees with this finding.

I recognize that claimant has the burden of proof and that because this claim involves a complex medical question, proof must at least include expert medical opinion. Medical certainty is not required, however. Neither must the medical opinion be phrased in a particular form. McClendon v. Nabisco Brands, 77 Or App 412 (1986). In addition, claimant's testimony, as well as that of the other witnesses, is probative. Garbutt v. SAIF, 297 Or 148 (1984).

After thoroughly reviewing this record, I am persuaded that claimant's claim is compensable. Admittedly, the treating doctor's opinion that "it is only logical to assume" a medical causal connection is not the strongest statement of causation. The remainder of the record so clearly supports compensability, however, I do not find the doctor's opinion fatal to the claim. It is uncontroverted that claimant routinely came in contact with prisoners' bodily fluids and that the hepatitis virus can be transmitted by such contact. It is further uncontroverted that prisoners at claimant's workplace have, in fact, developed hepatitis in the past, and that one such case was reported during the year that claimant developed the disease. There is no dispute that the incubation period for hepatitis is approximately three months, and that claimant was punctured with an unsterile needle approximately three months prior to her diagnosis. There is no evidence to suggest that claimant was exposed off the job.

Claimant's treating physician was aware of all of the aforegoing facts and he felt that an assumption could be made regarding claimant's exposure on the job. I agree. For that reason, I respectfully dissent from the majority's opinion.

JOHN SCHILLER, Claimant
Quintin B. Estell, Claimant's Attorney
Jill Bork (SAIF), Defense Attorney

Own Motion 87-0257M
May 6, 1987
Own Motion Order

SAIF Corporation has submitted to the Board claimant's claim for an alleged worsening of his February 29, 1980 industrial injury. Claimant's aggravation rights have expired. SAIF does not oppose reopening of this claim, but asks the Board to rule on the commencement date for temporary total disability compensation.

In order to obtain claim reopening under ORS 656.278, claimant must show that his compensable condition has materially worsened since the last arrangement of compensation. The last arrangement of compensation in this matter is a stipulation signed by the Referee on March 10, 1987. Claimant seeks benefits from February 11, 1987. In Timothy Dugan, Own Motion Order dated February 26, 1987, the Board determined that the last arrangement of compensation was actually the date claimant signed the stipulation. In this case, claimant signed the stipulation on February 13, 1987, thereby stating in effect that he was medically stationary on that date.

Claimant apparently first saw Dr. Melgard on February 17, 1987. At that time, he indicated that claimant's condition had worsened and claimant should remain at bedrest. After a myelogram, surgery was done in early April 1987.

After thorough review of the evidence, the Board concludes claimant's claim should be reopened for the payment of temporary total disability compensation commencing February 17, 1987 and continuing until closure pursuant to ORS 656.278.

IT IS SO ORDERED.

BRUCE A. BASHAM, Claimant
Jerry Gastineau, Claimant's Attorney
Brian Pocock, Defense Attorney
Art Stevens (SAIF), Defense Attorney

WCB 85-06435 & 86-03198
May 7, 1987
Order on Reconsideration

Aetna Technical Services has requested reconsideration of the Board's Order on Review dated April 7, 1987. By our order, we agreed with the Referee's conclusion that Aetna, rather than the SAIF Corporation, was responsible for claimant's current lower back condition. However, we modified the Referee's attorney fee award. Instead of receiving an insurer-paid attorney fee, claimant was awarded a 25 percent attorney fee, payable from his compensation, not to exceed $800. Contending that our decision has created a "processing problem," Aetna has suggested that we "adjust" our prior order.

The situation can be explained as follows. Pending the resolution of the responsibility issue, SAIF apparently paid claimant's compensation as a paying agent under ORS 656.307. Since Aetna is responsible for the claim, it is preparing to reimburse SAIF for its claim costs. However, SAIF has paid claimant's compensation without deducting claimant's attorney's fee. Thus, if Aetna deducts the attorney fee from claimant's compensation as directed by our order, SAIF will not be fully reimbursed.

Following further consideration of this matter, we conclude that our prior order should be supplemented. Consequently, Aetna is directed to fully reimburse SAIF for its claim costs. In addition, Aetna shall pay claimant's attorney a fee equal to 25 percent of claimant's compensation, not to exceed $800. Finally, Aetna is authorized to offset against future compensation an amount equal to the sum it pays to claimant's attorney.

Accordingly, Aetna's request for reconsideration is granted and our prior order is withdrawn. On reconsideration, as supplemented herein, the Board adheres to and republishes its former order, effective this date.

IT IS SO ORDERED.

DEL SEITZINGER, Applicant
Ann Kelley, Ass't. Attorney General

WCB CV-86007
May 7, 1987
Order of Remand (Crime Victim Compensation Act)

This matter is before the Board on the applicant's request for review and hearing concerning the Department of Justice's Findings of Fact, Conclusions and Order on Reconsideration dated November 24, 1986. By its order, the Department found that applicant was entitled to compensation for lost income in the amount of $298.89. Applicant had originally requested compensation for lost wages in the amount of $660.40.

Applicant's request for Board review asserts entitlement to additional compensation not sought at the time of his original application. The additional sums sought include compensation for alleged lost wages from a second job held by applicant at the time of the crime leading to his application, credit card finance charges allegedly incurred as a result of the Department's delay in processing his claim, and alleged lost income from a private business venture. The Department has not had the opportunity to consider or respond to applicant's request for additional compensation.

We believe that substantial justice would best be served by the Department's consideration of applicant's most recent assertions. Accordingly, this matter is remanded to the Department of Justice Crime Victims' Compensation Fund for further consideration of this record, consistent with this order.

IT IS SO ORDERED.

ROBERT T. MOON, Claimant
Bernt A. Hansen, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 85-07258
May 8, 1987
Order on Review

Reviewed by Board Members McMurdo and Lewis.

Claimant requests review of Referee Myers' order that: (1) found claimant to have been medically stationary on January 7, 1985; (2) awarded claimant 32 degrees for 10 percent unscheduled permanent partial disability for the low back, whereas the Determination Order had awarded temporary disability only; (3) determined that claimant's rate of temporary total disability should have been calculated by way of OAR 436-60-020(4)(c); (4) authorized an offset of overpaid temporary total disability compensation resulting from what the Referee determined to have been an incorrect calculation of the rate of claimant's compensation; and (5) denied claimant's request for penalties and attorney fees for the SAIF Corporation's alleged late payment of certain medical bills. The issues are claimant's medically stationary date, extent of unscheduled permanent partial disability, the rate of claimant's temporary total disability compensation, offset and penalties and attorney fees.

We affirm those portions of the Referee's order regarding claimant's medically stationary date, extent of unscheduled disability and penalties and attorney fees. We conclude, however, that claimant was "regularly employed," ORS 656.210(2), at the time of his injury, and that the rate of his temporary disability compensation should have been calculated pursuant to the wage he was receiving at the time of his injury. On that issue, and the resulting offset issue, therefore, we reverse.

Claimant began work as a utility worker for the employer in mid-1984. He soon changed jobs to that of a packer, and he eventually bid for a position as a baker. Before ultimately securing the baker job in late October 1984, claimant served as a baker trainee. He became a full baker on October 21, 1984. He served in that capacity until November 29, 1984, when he was compensably injured. Thus, during the approximately 18 weeks that claimant worked for the employer, he held five positions, each paying a different hourly wage. Claimant's hourly wage rose with each progressive job change. On the date of injury, claimant was earning $7.69 per hour.

SAIF initially calculated claimant's temporary disability based on a $7.69-per-hour, 40-hour work week. When it later discovered that claimant had held varying positions at varying wages within the employer's company, however, SAIF proposed a recalculation of the rate of compensation to reflect the entire 18 weeks claimant worked for the employer.

ORS 656.210 provides that when a claimant's disability is temporary, he shall receive compensation equal to 66-2/3 percent of wages. For purposes of the statute, the weekly wage is ascertained by use of a multiplier reflecting the daily wage the "regularly employed" worker was receiving at the time of the injury. As used in the statute, "'regularly employed' means actual employment or availability for such employment." As to workers not "regularly employed," the statute authorizes the Director of the Workers' Compensation Department to promulgate

rules establishing such workers' weekly wages. ORS 656.210(2). The Director has done so in OAR 436-60-020.

OAR 436-60-020(4)(c) provides that for workers employed for "varying hours, shifts or wages," the rate of compensation shall be calculated from average weekly earnings for the past 26 weeks of employment, if available. Reasoning that the present claimant had worked "varying hours, shifts or wages," during his employment, the Referee approved SAIF's proposed method of calculation. Inherent in the Referee's decision was a finding that claimant was not "regularly employed," as that term is used in ORS 656.210(2).

After reviewing the circumstances of claimant's employment, we find that he was "regularly employed" under the pertinent statute. OAR 436-60-020 was, therefore, not applicable. The concept of "regular" employment is not a static one; whether or not a worker was regularly employed at the time of his injury will vary, depending on the circumstances. In Saiville v. EBI Companies, 81 Or 469 (1986), for example, the court found a worker "regularly employed" despite his being an "on call" employee who did not work regular hours for an hourly wage. The fact that the claimant had worked five of the six days between the date of his hiring and the date of his injury was sufficient, in the court's opinion, to find the worker regularly employed. Id. at 472.

The present claimant initially worked for the employer as a utility worker, earning $5.30 per hour. He continued to seek more desirable employment within the company, however, ultimately attaining a baker's job at $7.69 per hour. Claimant's job changes did, in fact, result in differing hours and wages during his tenure. However, at the time of his injury, claimant had been employed for nearly five weeks as a baker, regularly receiving the $7.69-per-hour wage. There was no persuasive evidence that claimant's most recent position would not be permanent. Unlike what we interpret to be an "irregularly" employed worker, claimant did not report to work each day not knowing in what job, for what pay, or for how many hours he would be employed. Thus, in our view, claimant was "regularly employed" as a baker at the time of his injury, and the rate of his compensation should have been calculated based on the wage he was receiving at the time of his injury.

The Referee authorized SAIF to offset amounts deemed to have been overpaid as a result of SAIF's initial calculation of claimant's compensation rate. Because we have found that SAIF's initial method of computation was, in fact, the correct one, there is no overpayment. The offset will be set aside.

ORDER

The Referee's order dated March 11, 1986 is reversed in part and affirmed in part. Those portions of the order that ordered that the rate of claimant's temporary disability compensation be computed pursuant to OAR 436-60-020(4)(c) and allowed SAIF to offset any resulting overpayment are reversed. SAIF is ordered to calculate claimant's compensation based on the wage he earned at the time of his compensable injury. Claimant's attorney is allowed 25 percent of claimant's increased compensation, not to exceed $3,000. The attorney fee shall be paid out of compensation. The remainder of the Referee's order is affirmed.

YVONNE P. ROBERTS, Claimant
Vick & Gutzler, Claimant's Attorneys
SAIF Corp Legal (Portland West), Defense Attorney

WCB 84-07983 & 85-07289
May 8, 1987
Order on Review

Reviewed by Board Members McMurdo and Lewis.

Claimant requests review of Referee Leahy's order that: (1) upheld the SAIF Corporation's denial of chiropractic treatment; and (2) declined to award any unscheduled permanent disability for her back condition. The issues are medical services and extent of unscheduled permanent disability.

Claimant was working as a machine operator on July 22, 1983 when she slipped and fell. She was taken to the hospital by ambulance and diagnosed as having a contusion to her left side. She treated with Dr. Dougan for a cracked left rib and left low thoracic strain. The claim was accepted as a disabling injury, and claimant was released to regular work. Subsequently, she treated with Dr. Scott, chiropractor, for acute lumbar, thoracic and cervical sprain/strain. Dr. Scott released claimant to regular duty on August 8, 1983. Thereafter, claimant continued to treat with Dr. Scott at regular intervals.

In April 1984 claimant was examined by Dr. Tilden, chiropractor. Dr. Tilden concluded that claimant had preexisting multiple level degenerative joint disease, which accounted for her symptoms and minimal loss of function. Noting that claimant's injury had not worsened her preexisting degenerative joint disease, Dr. Tilden opined that her current condition was unrelated to her thoracolumbar musculoligamentous strain. Dr. Scott disagreed. Subsequently, SAIF issued a denial of claimant's current chiropractic treatment, stating that claimant's current condition was related to her degenerative joint disease and not her accepted injury. In June 1984 a Determination Order issued, awarding no permanent disability.

In September 1984 claimant was examined by the Orthopaedic Consultants. The panel of physicians diagnosed preexisting C5-6 spondylosis with degenerative joint disease in the lumbar spine. The physicians noted claimant's history of a cervical, thoracic, lumbar strain, but found no objective evidence to support her complaints. Dr. Gambee, an orthopedist on the panel, further stated that the etiology of her condition was her fall. However, at the time of the September 1984 examination, claimant was having no symptoms related to either her injury or osteoarthritis.

Also in September 1984 Dr. Scott concluded that claimant had sustained permanent impairment as a result of her injury. Claimant was restricted from lifting more than 20 to 25 pounds and would experience pain with excessive walking or sitting.

In December 1984 claimant experienced an exacerbation of pain in her low back and left leg. She filed an aggravation claim which was accepted. Claimant was released from work for approximately a month and found medically stationary in January 1985. In April 1985 claimant was examined by Dr. Ho, osteopath. He suggested that claimant's low back discomfort may be due to inflammatory disease and recommended medication. Dr. Scott reported that claimant had experienced no additional impairment as a result of this aggravation. A May 1985 Determination Order issued, awarding no permanent disability.

In July 1985, claimant was examined by Western Medical Consultants. An orthopedist and neurologist diagnosed chronic lumbar and dorsal strain with a possible left trochanteric bursitis. Claimant's cervical strain was felt to have resolved without impairment. Her continued complaints of discomfort in the neck area were felt to be due to her degenerative cervical disc disease. The Consultants stated that her 1984 aggravation was an exacerbation of her 1983 injury. She was medically stationary. Based on claimant's complaints of symptoms in the thoracic and lumbar spine, they concluded she had minimal impairment. Subsequent to the report, a deposition was taken of the panel neurologist, Dr. Snodgrass. He could find no degenerative disc disease in the lumbar spine and attributed claimant's symptoms in that area to her strain. Dr. Snodgrass detected almost no objective findings of impairment.

Claimant is 49 years old and has worked for her current employer for 11 years operating a variety of machines. Prior to her 1983 fall, she had never experienced any back problems. Her current job is the operation of an automatic chain assembly machine. The operation of this machine involves mostly sitting, which she feels increases her symptoms. She treats with Dr. Scott at sufficient intervals to relieve her symptoms. She feels his treatments are essential to enable her to continue working.

The Referee concluded that claimant had failed to establish that her 1983 fall had resulted in impairment requiring treatment. We disagree.

After de novo review of the lay and medical evidence, we conclude that the chiropractic treatment for claimant's low back and left leg pain is related to her industrial injury. However, we are not persuaded that her compensable injury is a material contributing cause of her current cervical condition. Like the Referee, we also conclude that claimant has suffered no lost earning capacity as a result of either her original injury or the aggravation.

For every compensable injury, the insurer shall provide medical services for conditions resulting from the injury for such period as the nature of the injury or the process of the recovery requires. ORS 656.245(1). Palliative treatment is compensable when necessary to relieve pain and allow claimant to continue working. West v. SAIF, 74 Or App 317 (1985).

We are persuaded that claimant's low back and leg pain is related to her industrial injury. This conclusion is supported by the reports of her treating physician, Dr. Scott, who has regularly treated her since the 1983 injury. Consistent with Dr. Scott's opinion is Western Medical Consultants' conclusion that claimant suffers a lumbar and dorsal strain with minimal impairment. Furthermore, Dr. Snodgrass stated that he could detect no degenerative disc disease in the lumbar spine that would account for her low back discomfort. We are persuaded by that opinion and reject Dr. Tilden's conclusion that her symptoms are due to lumbar degenerative disc disease. In addition, we are not persuaded by the Orthopaedic Consultants' report that offered no explanation for claimant's continued symptoms. Finally, claimant's testimony persuasively establishes that she never had back pain prior to the falling incident. Therefore, we conclude that claimant's chiropractic treatment for her low back and leg pain is compensable.

Claimant testified that she currently had only minimal discomfort in the upper cervical area. All the physicians are in agreement that she had preexisting degenerative cervical disc disease. Moreover, Dr. Snodgrass persuasively opined that the cervical disc disease accounted for her minimal discomfort and that the strain she suffered had resolved. We also are persuaded that claimant's cervical strain had resolved. Consequently, we affirm the denial of chiropractic care insofar as it relates to the treatment of her cervical condition.

At the time of hearing claimant was working at her same occupation at the same wage as before the injury. Although post-injury earnings are but one factor that may or may not be significant to an individual case, Jacobs v. Louisiana-Pacific, 59 Or App 1, 3 (1982), the record as a whole fails to establish that claimant's compensable injury has resulted in a loss of earning capacity. She has a 12th grade education. Dr. Snodgrass found almost no objective evidence of impairment and described it as minimal. Even considering the reports of Dr. Scott and the testimony of claimant, we are not persuaded that the injury has resulted in restricting her from holding gainful employment in the broad field of general industrial occupations. See Ford v. SAIF, 7 Or App 549, 552 (1972). Consequently, we agree with the Referee that claimant is not entitled to an award of permanent disability.

ORDER

The Referee's order dated June 27, 1986 is reversed in part and affirmed in part. That portion of the order that upheld the denial of chiropractic treatment of claimant's cervical condition is affirmed. The denial of chiropractic care as it relates to claimant's low back and leg condition is reversed. The remainder of the order is affirmed. Claimant is awarded an $1,100 attorney fee for services at hearing and $500 for services on Board review, to be paid by the SAIF Corporation.

CHARLES R. WRIGHT, Claimant
Aspell, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB RH-84002
May 8, 1987
Order on Review

Reviewed by Board Members McMurdo and Lewis.

The SAIF Corporation requests review of Referee Daron's order on reconsideration that: (1) set aside its denial of claimant's aggravation claim; (2) declined to exclude exhibits pursuant to OAR 438-07-005(3)(b); and (3) awarded claimant a $2,000 attorney fee for services at hearing. The issues are aggravation, the admission of exhibits and attorney fees.

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

This case comes before us following our Order on Review (Remanding). Charles R. Wright, 36 Van Natta 892 (1984). That order provides a thorough chronological summary of the claim up to 1983. The portion of the case not remanded to the Referee was appealed by claimant to the Court of Appeals. The court affirmed our order. Wright v. SAIF, 76 Or App 479 (1985), rev den, 300 Or 605 (1986). The sole issue before the Referee in this proceeding was the validity of an aggravation claim.

The Referee found that SAIF could not deny the claim because of Bauman v. SAIF, 295 Or 788 (1983), and subsequent cases prohibiting retroactive denials. We need not address the Referee's conclusion because, on the merits, we find the claimant has sustained an aggravation of his compensable condition.

Claimant suffers from a compensable pleuritis condition characterized by inflammation of the pleura. Dr. Bervens, the treating physician, stated that when the pleura is inflamed the surface of the lung touches the pleura sac, resulting in severe chest pain. In December 1981, after cutting wood, claimant was admitted to the hospital for severe chest pains. Initially, SAIF accepted the claim as an aggravation of his compensable pleuritis condition. Subsequently, however, Dr. Bervens stated that claimant's chest pains may be related to Addison's disease. Addison's disease would be unrelated to the compensable pleuritis condition. Thereafter, SAIF issued a denial of the aggravation claim, stating that claimant's condition was unrelated to his compensable injury.

In September 1983 claimant was sent to the Stanford University School of Medicine. After diagnostic tests ruled out Addison's disease, Dr. Bervens stated that his current working diagnosis of claimant's condition was "[b]asically, recurrent pluritis [sic], with an element of bronchitis and . . . a diagnosis of possible coronary artery spasm." These findings persuasively eliminated the basis of SAIF's denial, while supporting the conclusion that claimant's chest pains were related to his compensable condition. Further, claimant has established that his December 1981 hospitalization for severe chest pains resulted in more disability and lessened his ability to work. See Smith v. SAIF, 302 Or 396 (1986). Consequently, claimant has proven that he suffered a compensable aggravation.

We find this case to have been of average difficulty with an ordinary likelihood of success on Board review. A reasonable attorney fee is therefore awarded.

ORDER

The Referee's order on reconsideration dated May 9, 1986, as supplemented, is affirmed. Claimant's attorney is awarded $500 for services on Board review, to be paid by the SAIF Corporation.

JOSEPH H. FISHER, Claimant
Callahan, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

Own Motion 87-0171M
May 12, 1987
Own Motion Order Rescinded

The Board issued an Own Motion Order on April 14, 1987 whereby the request for own motion relief was denied. Claimant has requested that the Board vacate its order, contending the matter was improperly before the Board and should be processed under ORS 656.273.

The aggravation rights in this claim commenced to run on October 8, 1981, thereby expiring on October 8, 1986. Claimant's request for aggravation was made several months prior to the expiration of his aggravation rights. We conclude that the

request for reopening should be processed pursuant to ORS 656.273 and that our April 14, 1987 Own Motion Order should be rescinded in its entirety.

IT IS SO ORDERED.

WILBUR W. NEAL, Claimant
Morley, et al., Claimant's Attorneys
Beers, et al., Defense Attorneys
Cummins, et al., Defense Attorneys

WCB 85-13719 & 85-09711
May 12, 1987
Order on Review

Reviewed by Board Members Lewis and McMurdo.

Claimant requests review of Referee Wilson's order that upheld the denials of both EBI Companies and the self-insured employer regarding the compensability of claimant's occupational disease claim for bilateral hearing loss. The threshold issue is whether claimant's claim is compensable. If it is, we must determine which insurer is responsible.

Claimant began work for a lumber mill in 1969. A few years later, EBI's insured purchased the mill. Claimant remained there through March 1979. He worked the trim and hula saws, which he described as "pretty noisy." After working in the mill for approximately five years, he was provided with hearing protection devices. Despite the hearing protection, claimant testified that the noise level remained "somewhat loud."

Claimant testified that hearing tests were routinely performed at the mill on an annual basis. A 1976 audiogram showed that claimant had high tone hearing loss. In October 1978, EBI's insured received a citation for excessive noise and was given one month to correct the situation.

From March 1979 to January 1980, claimant worked for another lumber mill. He does not remember wearing any hearing protection while there. He next worked a few months for a farming outfit. There was no loud noise associated with this job.

Claimant began working for the self-insured employer, a canning company, in July 1981 and remained employed there through November 1984. The work was only seasonal from July through November. Claimant performed inspection and sanitation duties at or near an inspection belt. He testified that there was quite a bit of noise exposure emitting from the belt machinery. Furthermore, he felt that his hearing loss had worsened during his employment with the self-insured employer. After November 1984, claimant began employment with a janitorial service. He was not exposed to loud noise on this job and did not notice any worsening of his hearing.

As to claimant's off-the-job noise exposure, he performed combat duty in Korea, but showed no signs of hearing loss when discharged. Outside of one occasion in 1984, he has not hunted in approximately 20 years. He has engaged in household and yard work activities such as occasionally operating a bench grinder, electric drill, power lawn mower, and weed eater. He fishes about two or three weekends each summer using an 18 horsepower motor boat. Lastly, his father experienced a loss of hearing, but his three brothers have not.

Dr. Cooper, an otolaryngologist, performed an independent medical examination in May 1985. Dr. Cooper concluded that claimant had a 22 percent bilateral hearing loss sustained from "acoustic trauma." Dr. Cooper further opined that it was difficult to determine at which employment claimant sustained the acoustic trauma. However, Dr. Cooper stated that claimant's last exposure to "excessive noise" was at the self-insured employer.

A second independent medical examination was performed in June 1986 by Dr. Panian, a hearing specialist. Dr. Panian opined that claimant's hearing loss was secondary to noise exposure over the years as well as presbycusis. After reviewing an audiogram of claimant taken at the self-insured employer in March 1982, Dr Panian stated:

> ". . . one can say in two years of [claimant's] employment from 1982 to 1984, that his hearing did progressively worsen, more in the high frequencies. On that basis, one must accept then that noise exposure while on the job at [the self-insured employer] may very well have been the etiology of more hearing loss."

Dr. Panian did note, however, that the 1982 audiogram was very cursory and it was not known whether claimant had been noise free for 24 to 36 hours prior thereto.

The Referee found that both the medical and non-medical evidence was insufficient to establish compensability. We disagree for the following reasons.

In order to prove entitlement to compensation for an occupational disease, a worker must prove that he has developed a disease or infection which arose out of and in the scope of his employment. ORS 656.802(1)(a). He must also prove that his exposure was of the type to which he was not ordinarily subjected other than during working hours. Finally, he must prove that his work was the major contributing cause of his disease. Dethlefs v. Hyster Co., 295 Or 298 (1983).

The Referee cited the case of Williams v. SAIF, 22 Or App 350 (1975), as controlling authority. He found Williams to present "the evidentiary situation here." The medical evidence in Williams consisted of only two audiograms, a letter, and a report from the treating doctor. The treating doctor went no further than to opine that, "The hearing loss that [the claimant] has is compatible with that caused by noise exposure." (Emphasis in original.) The non-medical evidence in Williams consisted entirely of claimant's testimony that he was exposed to tremendous noise levels. Further, the claimant successfully objected at the hearing to the introduction of noise level studies. Consequently, the Williams court held that there was insufficient evidence to establish that the claimant's hearing loss was related to his employment.

Unlike Williams, the medical evidence here shows a causal relationship between claimant's hearing loss and his employment. Dr. Cooper opined that "acoustic trauma" caused claimant's hearing loss, but was uncertain at which time or place

the acoustic trauma occurred because of claimant's multiple jobs. The uncertainty of Dr. Cooper pertained solely to the question of responsibility; not whether claimant's hearing loss was work related. Dr. Panian opined that claimant's hearing loss was consistent with noise exposure and presbycusis, and that it may very well have been caused by noise exposure sustained at the self-insured employer. Although neither doctor stated the magic words, "the major contributing cause," we are persuaded that their opinions read together show the requisite causal connection between claimant's employment and his hearing loss. See McClendon v. Nabisco Brands, Inc., 77 Or App 412, 416-17 (1986).

The Referee also found that the opinions of both Dr. Cooper and Dr. Panian were unpersuasive because neither doctor had "information as to the actual noise levels present." We disagree. The Referee did not find claimant's testimony not credible, nor do we. In fact, the citation for excessive noise exposure issued to EBI's insured in October 1978 corroborates claimant's testimony. Thus, we do not find the medical evidence unpersuasive simply because the doctors relied on claimant's history in forming their opinions.

Regarding the non-medical evidence, in Williams there was no evidence of noise level studies. Here, however, the evidence shows that in October 1978, which was approximately five months prior to claimant's departure from EBI's insured, the employer was cited for excessive noise exposure. Moreover, claimant testified that he was exposed to loud noise at both EBI's insured and the self-insured employer. As we found in Vincent M. Bird, 37 Van Natta 1245, 1246 (1985), a claimant may prove the compensability of a hearing loss claim based on his subjective testimony without the aid of noise level studies. See Herb Ferris, 34 Van Natta 470 (1982); Ferris v. Willamette Industries, 61 Or App 227 (1982).

Finally, we find that claimant's work-related noise exposure was of the type to which he was not ordinarily subjected during off-work hours. The evidence shows that claimant engaged in routine household and yard work activities requiring the occasional use of power tools. He also operated a motor boat from two to three times a year. We are not persuaded that these occasional activities ordinarily subjected claimant to the kind of noise exposure he sustained at work. Therefore, we conclude that the preponderance of the medical and non-medical evidence establishes the compensability of claimant's claim.

Turning to the question of responsibility, the last injurious exposure rule provides that, if a worker proves that the disease could have been caused by work conditions that existed over some indefinite period of time, the last employment providing potentially causal conditions is deemed to have caused the disease. Boise Cascade Corp. v. Starbuck, 296 Or 238, 241 (1984); Meyer v. SAIF, 71 Or App 371, 373 (1984). In order to shift responsibility to an earlier employer, the last employer where conditions existed that could have caused the disease must establish that the conditions at the earlier employer were the sole cause or that it was impossible for conditions at the last employer to have caused the disease. FMC Corp v. Liberty Mutual Ins. Co., 70 Or App 370 (1984), clarified, 73 Or App 223 (1985).

Here, the evidence establishes that conditions at the self-insured employer were of a kind that could have caused

claimant's hearing loss. Meyer v. SAIF, 71 Or App at 374-75 (1984). Dr. Panian opined that claimant's hearing loss progressively worsened during his employment at the self-insured employer. Moreover, claimant testified that he was subjected to excessive noise while working near the inspection belt. Therefore, we conclude that the last injurious exposure rule operates to place responsibility for claimant's hearing loss on the self-insured employer.

ORDER

The Referee's order dated August 6, 1986, is reversed part and affirmed in part. That portion of the Referee's order that upheld the self-insured employer's denial is reversed. The employer's denial is set aside and the claim is remanded to the employer for processing according to law. That portion of the Referee's order that upheld EBI Companies' denial is affirmed. Claimant's attorney is awarded $1,200 for services at the hearin and $600 for services on Board review, to be paid by the self-insured employer.

MARY L. BROWN & CHARLES G. BROWN, Applicants
Ann Kelley, Ass't. Attorney General

WCB CV-87002
May 13, 1987
FINDINGS OF FACT, CONCLUSIONS
PROPOSED ORDER (CRIME VICTI

Pursuant to notice, a hearing was conducted and concluc by Roger C. Pearson, special hearings officer, on April 17, 1987 at Salem, Oregon. Applicant, Mary L. Brown and Charles G. Brown, on behalf of their minor child, Charles Ryan Brown, were present and not represented by counsel. The Department of Justice Crime Victim Compensation Fund ("Department") was represented by Ann Kelley, Assistant Attorney General. The court recorder was Charles Fredman. The record was closed April 17, 1987.

Applicant has requested review by the Workers' Compensation Board of the Department's Findings of Fact, Conclusions and Order on Reconsideration dated December 15, 1986. By its order, the Department denied applicant's claim for compensation as a victim of a crime under ORS 147.005 to 147.365. The Department based its denial on: (1) applicant's failure to file a claim for benefits within one year from the date of the criminal injury; and (2) a lack of evidence that applicant was mentally or physically incapable of filing the claim within one year of the injury, as a direct result of the criminal injury.

FINDINGS OF FACT

Applicant, Mary L. Brown and Charles G. Brown, are parents of a seven year old boy, Charles Ryan Brown (hereafter referred to as "Ryan"). Ryan was the innocent victim of the crim of sexual abuse. The attack, which apparently occurred in early 1985, was committed by the son of applicant's former babysitter.

Applicant first learned that Ryan had been victimized i the latter part of April 1985. On April 26, 1985, with Mrs. Brow in attendance, Ryan was interviewed by Officer Grisham of the Tigard Police Department. At this interview, the officer mentioned the Crime Victim Compensation Program. Since applicant had incurred no medical expenses and because no criminal charges

had yet been initiated, Mr. Grisham recommended that applicant postpone filing an application for benefits. Applicant was further advised to await a conviction before filing her son's claim. This was also the advice offered by Ms. Adair, a grade school principal.

Apparently due to "hearsay" evidence and a lack of medical documentation, the suspect was not charged for attacking Ryan. However, in July 1985 the suspect was arrested for molesting another child. While a January 1986 trial was pending, applicant spoke with Mr. Herman, the Deputy District Attorney who was prosecuting the case for Washington County. After explaining why the accused was not being prosecuted for attacking Ryan, Mr. Herman placed applicant in touch with the Victim Assistance Program for Washington County.

In September 1985 applicant talked with Ms. Suzanne Dudy of the Washington County Victim Assistance Program. Once again, applicant was advised to await a conviction before filing for benefits. At no time during this conversation was applicant told of "time deadlines" regarding the claim's filing. Instead, several questions concerned the family's financial status. Following this discussion, Ms. Dudy sent applicant information concerning the Crime Victim Compensation Program. Included with these materials was an application. Considering the professional advice they had received and since no medical expenses had been incurred, applicant did not file a claim.

Beginning in the fall of 1985, Ryan received individual counseling from Dr. Ed Wilgus, a psychologist at Charles F. Tigard Grade School. These sessions occurred on a weekly basis. By the spring of 1986, Dr. Wilgus recommended that the family seek private psychiatric counseling for Ryan. In May 1986 applicant recontacted Ms. Dudy. Noting that Ryan was seeking a specialist's attention, applicant again inquired into filing a claim for benefits. Ms. Dudy advised applicant to wait until Ryan's sessions were completed. Once the treatments had ended, Ms. Dudy proposed that the application be submitted along with her letter of explanation.

Thereafter, the family retained the services of Dr. Eugene Borkan, a psychiatrist with the Oregon Health Sciences University. Ryan treated with Dr. Borkan on approximately eight occasions between May and July 1986. These treatments proved successful. Private insurance paid for a portion of Dr. Borkan's bill. However, a $410 balance presently exists.

Following Dr. Borkan's treatments, applicant completed the claim and forwarded it to Ms. Dudy. Applicant signed the claim on August 5, 1986. On August 8, 1986, the application was sent to the Crime Victims Compensation Program, accompanied by Ms. Dudy's letter. Ms. Dudy explained that applicant had been given misleading information concerning the filing of a claim. Ms. Dudy requested that the application be given "your <u>most careful consideration</u>, realizing that the parents were <u>told</u> they had to wait until the suspect was convicted before applying." (Emphasis in original.) The Department received the application on August 12, 1986.

Following its investigation, the Department found that applicant had established "good cause" for failing to file a claim within six months of learning of the attack. Therefore, the

filing deadline was extended an additional six months to April 26 1986. However, the claim had not been filed until August 12, 1986. Since no claim could be accepted over one year from the date of injury, except for mental or physical incapacity directly resulting from the criminal injury, the Department denied the claim "with regret." The Department concluded as follows:

> "It is very unfortunate that the claimant, during the course of his involvement with the criminal justice system, was given incorrect information about the Crime Victims Compensation Program and the statutory requirements. It is with regret that this claim must be denied, [but] the applicable rules do not provide the opportunity for this department to accept the claim."

On December 15, 1986, the Department reconsidered its prior order. Finding no basis for reversing its previous decision, the Department "confirmed" its prior order.

Applicant asked that Attorney General Frohnmayer review this matter. Two letters from the Attorney General are present in this record. Mr. Frohnmayer expressed his sorrow that applicant had "suffered a second trauma as a result of an imperfect justice system." However, after discussing the applicable statutes and supporting administrative rules, Mr. Frohnmayer advised applicant that the Department was required to deny the claim. The Attorney General closed as follows:

> "Ms. Brown, I wish I could tell you the criminal justice system does not make mistakes, but errors are made. The tragedy in your situation is that, due to a breakdown in the criminal justice system, you suffer as an innocent victim of circumstances beyond your control."

Mary L. Brown, the sole witness at the hearing, testified in a candid and forthright manner. Consequently, based on my personal observation, I find her to be an entirely credible witness.

CONCLUSIONS

The standard of review for cases appealed to the Board under the Compensation of Crime Victims Act (Act) is de novo on the entire record. ORS 147.155(5); Jill M. Gabriel, 35 Van Natta 1224, 1226 (1983).

Pursuant to ORS 147.015, applicant is entitled to an award under the Act, if, among other requirements:

> "(6) The application for an award of compensation under ORS 147.005 to 147.365 is filed with the department:
> " (a) Within six months of the date of the injury to the victim; or
> " (b) Within such further extension of time as the department for good cause shown, allows."

Lack of knowledge of the Fund or failure of an investigating officer to provide information as provided for in ORS 147.365 shall be deemed to be "good cause" for extension of the time in which a claim must be filed. OAR 137-76-030(1). The extension consists of an additional six months from the date of the injury. Id. In the interest of orderly and consistent administration, no extension of time within which a claim must be filed will be granted beyond one year from the date of the criminal injury for any cause except for mental or physical incapacity directly resulting from the criminal injury sustained. OAR 137-76-030(2).

Following my de novo review of the documentary and testimonial evidence, I find that the preponderance of the evidence establishes that applicant's claim for benefits was filed more than one year after the date of injury. Therefore, the application was untimely. Furthermore, I am not persuaded that applicant's failure to file the claim within one year of the injury was attributable to mental or physical incapacity directly resulting from the injury. Consequently, I conclude that the Department's Order on Reconsideration should be affirmed.

OAR 436-76-030 was apparently enacted in response to several Board decisions concerning the issue of good cause for late claim filings. These decisions were discussed in Lori Beghtol, 38 Van Natta 1003 (1986). A review of these decisions follows.

In Ronald E. Bass, 35 Van Natta 1679 (1983), the claim was filed nearly two years after the injury. The claim had not been filed earlier as a result of incorrect information furnished by the local District Attorney's office. The Justice Department denied the application relying on "administrative policy" as set forth in OAR 436-76-030 (formerly OAR 436-76-105), which at that time was merely a proposed rule. Finding that the Department had not shown that it was prejudiced in processing the claim by the late filing, the Board reversed the Department's denial of benefits. The Board relied on Jill M. Gabriel, supra., and Ivan Ouchinnikov, 34 Van Natta 579 (1982), which also involved claims filed in excess of one year from the date of injury. These late filings were both attributable to law enforcement officials' failures to provide information of potential benefits. In reversing the Department's denial, the Board stated in Gabriel:

> "We believe that the denial of a claim because of late filing (where good cause has been shown) without first making a showing that it was prejudiced by the late filing is an abuse of discretion. We hold, therefore, that the Department abused its discretion in denying this claim." 35 Van Natta 1228.

The Board in Gabriel reasoned that by failing to adopt administrative rules, the Department had failed to provide notice that there was an absolute deadline of one year for filing claims. This reasoning was also applied in the Board's subsequent decision in Bass. However, the Board noted in Bass as follows:

"Although we agree with the Department that

it has the power to adopt such rules to define 'good cause,' in the absence of properly promulgated rules to that effect, we decline to limit our review on the basis of 'administrative policy' and proposed rules." 35 Van Natta 1681.

Since these decisions, the Department has properly promulgated rules defining "good cause." See OAR 137-76-030. These rules became effective on September 1, 1983. See ORS Chapter 147; JD 4-1983. Thus, these rules are directly applicable in determining whether good cause exists to allow the present applicant's late claim for benefits.

In April 1985, after learning of the attack upon Ryan, applicant received a brief description of the Crime Victim Compensation Program. In addition, an application was forwarded to them in September 1985, five months after they were advised of the criminal injury. Thus, applicant had the necessary materials with which to file a claim for benefits. However, law enforcement officials, as well as a grade school principal, unanimously suggested postponement of the claim until a conviction was obtained and medical expenses were incurred. Under these circumstances, I find that applicant has established "good cause" for a six month extension. See OAR 137-76-030(1).

Inasmuch as applicant first learned of the criminal injury on April 26, 1985, this "good cause" extension would lapse on April 26, 1986. The application was not filed until August 12, 1986. According to OAR 137-76-030(2), no further extension of time will be granted except for mental or physical incapacity directly resulting from the criminal injury. Although applicant unquestionably experienced a great deal of stress as a result of this incident, the preponderance of the evidence fails to establish the requisite mental or physical incapacity necessary to further extend the time for filing a claim for benefits. Therefore, I conclude that the claim must fail as untimely.

This is a most regrettable situation. After learning of the existence of the victim's assistance program, applicant endeavored to obtain further information. Materials and an application were eventually secured. Had the claim been filed at this point, it likely would have been accepted. However, because of misleading advice, primarily from local law enforcement officials, the claim was not filed until approximately 16 months after applicant learned of the criminal injury.

Applicant's reliance upon the representations from these professionals is understandable. In response to this type of situation, OAR 137-76-030 has been promulgated. Thus, because of the incomplete and misleading information provided by law enforcement officials, applicant is granted an additional six month "grace period" to file for benefits. OAR 137-76-030(1). Thereafter, "in the interest of orderly and consistent administration further extensions can only be granted under very specific circumstances. OAR 137-76-030(2). As discussed above, the application unfortunately was filed beyond the six month extension and the requirements for a further extension have not been satisfied. Consequently, the application was impermissibly untimely.

Applicant presented Ryan's case in a very impressive and impassioned manner. I fully recognize their contentions and

appreciate their frustrations. Yet, the relevant statute and accompanying administrative rules are clear. To paraphrase Attorney General Frohnmayer, due to a breakdown in the criminal justice system, the Brown family must suffer as an innocent victim of circumstances that were beyond their control. Although applicant will not receive any monetary benefit resulting from this claim, they can take pride in knowing that their actions will likely assist subsequent victims of crime. Because the determination exhibited by their efforts to advance Ryan's cause through state channels and to the ultimate level of appeal will undoubtedly prompt local officials to further emphasize the victim's assistance program and the requirements thereunder.

PROPOSED ORDER

I recommend that the Findings of Fact, Conclusions and Order on Reconsideration of the Department of Justice Crime Victim Compensation Fund dated December 15, 1986 be affirmed.

CATHERINE A. MEDINA, Claimant
Peter O. Hansen, Claimant's Attorney
Judy Johnson (SAIF), Defense Attorney

WCB 85-15044
May 13, 1987
Order on Review

Reviewed by Board Members Lewis and McMurdo.

Claimant requests review of Referee Tenenbaum's order that awarded a 15 percent penalty and a $150 attorney fee for the insurer's failure to pay temporary disability in a timely manner. The issues on review are penalties and attorney fees.

The parties stipulated to the following facts. Temporary disability payments made on October 19 and November 2, 1984, and March 6 and April 3, 1986, were paid for a period that ended seven days earlier. Payments made on February 7 and 21, 1986 were made for a period that ended eight days earlier. A payment made in November 1984, was paid for a period that ended 11 days earlier.

At issue is the interpretation of OAR 436-60-150(4), which provides (in part):

> "[c]ontinued temporary disability due shall be paid to within seven days of the date of payment at least once each fourteen days thereafter . . . ."

The Referee found that only the payment made 11 days late was unreasonable. The others were not. Accordingly, she concluded that a 15 percent penalty was warranted. However, the Referee assessed the penalty against only the four days of late temporary disability compensation.

We recently addressed this issue in Billy A. Springs, 38 Van Natta 1475 (1986), stating:

> "OAR 436-60-150 permitted SAIF to be seven days behind in the payment of temporary disability. Thus, SAIF should be penalized only for each payment which was over seven days late between the period May 20, 1985 through April 7, 1986. We also conclude

that the 25 percent penalty assessed by the Referee is warranted as SAIF repeatedly and consistently made late payments for almost a year and provided no excuse for the lateness of these payments."

Similarly, in the case presently before us, SAIF offers no explanation or justification for its late payments. The late payments began in November 1984 and continued in April 1986. Under such circumstances, we conclude that a 25 percent penalty should be assessed against each temporary disability payment paid beyond seven days.

Under ORS 656.262(10), a penalty is to be assessed against "amounts then due." Here, the entire amount of each late temporary disability payment is the "amount then due;" not simply the number of days beyond the seven day grace period in which payment was finally made.

Lastly, in determining the reasonableness of attorney fees, the following factors are 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. Barbara A. Wheeler, 37 Van Natta 122 (1985). After considering these factors, we find that a total award of $450 is a reasonable attorney fee for services rendered concerning the penalty issue. Accordingly, we modify the Referee's attorney fee award.

ORDER

The Referee's order dated July 17, 1986, is modified. In lieu of the Referee's assessment of a penalty, the SAIF Corporation is ordered to pay a 25 percent penalty assessed against the entire amount of the temporary disability benefits paid on November 4, 1984, March 6, 1986, and April 3, 1986. Claimant's attorney is awarded $450 for services rendered concerning the penalty issue, to be paid by the SAIF Corporation.

MICHAEL A. NEWELL, Claimant
Olson Law Firm, Claimant's Attorney
Roberts, et al., Defense Attorneys

WCB 84-10498
May 13, 1987
Order Denying Motion to Dismiss

Claimant has moved the Board for an order dismissing the insurer's amended request for Board review. The motion is denied.

The Referee's order issued February 27, 1987. On March 3, 1987, in response to claimant's request for an extraordinary attorney fee, the Referee abated his order. That same day, the insurer requested Board review of the February 27, 1987 order. On April 7, 1987, the Referee issued an Order on Reconsideration. On April 14, 1987, the Board received the insurer's amended request for review, the same day the Referee issued an Amended Order on Reconsideration. On May 4, 1987, the insurer requested review of the Referee's amended order.

Claimant contends that the Board lacks jurisdiction to hear any appeal because the Referee's April 14, 1987 amended order has not been properly appealed. Assuming, without deciding, that claimant's contention is accurate, the insurer has now specifically and timely requested review of the amended order.

Therefore, the Board has jurisdiction to consider this matter in its entirety. See James D. Whitney, 37 Van Natta 1463 (1985) (When simultaneous acts affect the vesting of jurisdiction in this forum, in the interest of administrative economy and substantial justice, we give effect to the act that results in the resolution of the controversy at the lowest possible level.)

IT IS SO ORDERED.

MIKE D. RICE, Claimant
Michael G. & Merry D. Bracco dba
EQUITY DEVELOPMENT, INC., Employer
Ginsburg, et al., Claimant's Attorneys
Henderson & Assoc., Attorneys
SAIF Corp Legal, Defense Attorneys
Carl M. Davis, Ass't. Attorney General

WCB 85-10303
May 13, 1987
Order Denying Motion for Attorney Fees

On January 27, 1987, in response to the noncomplying employer's notice of withdrawal, we dismissed its request for Board review. On March 23, 1987, claimant moved for an attorney fee award for services rendered prior to the withdrawal of the employer's appeal.

Pursuant to ORS 656.295(8), a Board order is final unless within 30 days after the date of mailing of copies of such order, one of the parties appeals to the Court of Appeals for judicial review. The time within which to appeal an order continues to run, unless the order has been abated, stayed, or "republished." International Paper Co. v. Wright, 80 Or App 444 (1986). Inasmuch as the Board's January 27, 1987 order has neither been appealed, abated, stayed, nor "republished" within the statutory 30-day period, it has become final by operation of law. Consequently, we lack jurisdiction to consider claimant's motion.

Furthermore, assuming for the sake of argument that we could consider the motion, it would be denied. Where an insurer's or employer's request for Board review is dismissed prior to a decision on the merits, claimant is not entitled to an attorney fee. Agripac, Inc. v. Kitchel, 73 Or App 132 (1985); Leland O. Bales, 38 Van Natta 25 (1986); Rodney C. Strauss, 37 Van Natta 1212, 1214 (1985).

IT IS SO ORDERED.

SUSAN D. CHAPMAN (Deceased), Claimant
Cottle, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 85-02929
May 15, 1987
Order of Remand

This matter is before the Board on remand from the Court of Appeals. Pursuant to the court's April 15, 1987 order, claimant's petition for an allowance of attorney fees payable out of compensation has been remanded to the Board for determination.

Claimant was awarded 15 percent (48 degrees) unscheduled permanent disability by a Determination Order. A Referee's order increased this award to 50 percent (160 degrees). Claimant's attorney was granted a fee of 25 percent of this 35 percent (112 degrees) increase, not to exceed $2,000, payable out of claimant's compensation. Thereafter, the Board reduced claimant's increased award from 35 percent (112 degrees) to 10 percent (32 degrees). Susan D. Chapman, 37 Van Natta 1687 (1985). Commensurate with this reduction, claimant's attorney's fee was adjusted

accordingly. Therefore, claimant's attorney fee was reduced to 25 percent of the 10 percent (32 degrees) increase in claimant's permanent disability compensation.

The Court of Appeals modified the Board's order to award 40 percent (128 degrees) unscheduled permanent disability. Chapman v. EBI Companies, 83 Or App 518 (1987). Thus, claimant's permanent disability award was increased by 15 percent (48 degrees), bringing her total award to 40 percent (128 degrees). Claimant's attorney petitioned the court for an attorney fee award and the court has remanded to the Board for determination of a fee. See ORS 656.382(2); 656.386(2).

When claimant appeals the extent of permanent disability to the Court of Appeals and prevails, an additional fee of 25 percent of any increase awarded by the appellate court shall be approved. OAR 438-47-045(1); Zoi Sarantis, 36 Van Natta 1634 (1984). Fees awarded under our rules are not established in any mandatory amount; the rules are suggestive. OAR 438-47-005; Morris v. Denny's, 53 Or App 863, 866 (1981). Claimant's attorney's fee shall be paid from the increased compensation awarded by the court. ORS 656.386(2); Gainer v. SAIF, 51 Or App 869 (1981); Zoi Sarantis, supra.

The Board has sufficient information to form the basis for awarding fees before the Court of Appeals. Accordingly, claimant's attorney is allowed 25 percent of the additional 15 percent (48 degrees) of permanent disability compensation awarded by the court, payable out of claimant's compensation. ORS 656.386(2); 656.388(4); OAR 438-47-045.

IT IS SO ORDERED.

EUGENE I. CORLISS, Claimant
Emmons, et al., Claimant's Attorneys
Dennis Ulsted (SAIF), Defense Attorney

WCB 85-15703
May 19, 1987
Order on Review

Reviewed by Board Members Lewis and McMurdo.

Claimant requests review of Referee Seifert's order that awarded 80 degrees for 25 percent unscheduled permanent partial disability, in lieu of a Determination Order award of 48 degrees for 15 percent unscheduled disability for a hernia condition. The issue is extent of unscheduled disability. Claimant asserts entitlement to a greater award.

Claimant suffered a compensable hernia in June 1982 and underwent surgery for that condition two months later. He returned to work and did well until May 1983, when a recurrent right inguinal hernia was discovered. A second surgery was performed in October 1983 by Dr. Hudson. Thereafter, claimant experienced ongoing pain, particularly with heavy exertion.

Because of continuing pain, claimant underwent an ilioinguinal nerve block and cryogenic neurolysis of the right ilioinguinal nerve in January 1984. Although claimant experienced a brief period of relief, his pain returned in February 1984, resulting in a fourth surgical procedure a month later. When that surgery did not effect relief, Dr. Innes performed a right inguinal orchiectomy with a Cooper's ligament repair. Again, surgery was not successful. In a final attempt to alleviate

claimant's symptoms, Dr. Maley performed a genital femoral nerve block. When that procedure essentially failed, Dr. Hudson concluded that further nerve block procedures would not be indicated.

Claimant testified that he experiences ongoing, debilitating pain. Prolonged standing, sitting or walking produce severe symptoms. Claimant is unable to lift more than 20 pounds without a burning sensation in his right thigh. His testimony regarding his limitations was corroborated by that of Mr. Evans, a friend, and claimant's wife.

Claimant was 49 years of age at the time of the hearing. He had a tenth grade education and no GED. His prior employments have all been manual and heavy. His vocational counselor has noted that he has transferable skills only in areas that exceed his physical limitations. The evidence is that claimant is now precluded from all but sedentary to light employment. Testing reveals below average intellectual ability.

The Referee awarded claimant 10 percent unscheduled disability in addition to the 15 percent previously awarded by Determination Order. After reviewing the record, we conclude that claimant's disability exceeds 25 percent. Taking into consideration his permanent impairment, education, work history, age and other pertinent social and vocational factors, we conclude that claimant is entitled to an additional 10 percent unscheduled disability, bringing his total award to 35 percent. The Referee's award will be so modified.

ORDER

The Referee's order dated June 6, 1986 is modified. In lieu of the Referee's award, and in addition to the Determination Order's award of 15 percent (48 degrees), claimant is awarded 20 percent (64 degrees) unscheduled permanent partial disability for his hernia condition. Claimant's attorney is allowed 25 percent of claimant's increased permanent disability compensation created by this order, not to exceed $3,000.

TIMOTHY DUGAN, Claimant
Malagon & Moore, Claimant's Attorneys
Jeff Tyvol (SAIF)

Own Motion 86-0662M
May 19, 1987
Own Motion Order

On February 26, 1987, we issued an Own Motion Order reopening claimant's 1980 injury claim. Pursuant to our order, the SAIF Corporation was directed to commence paying temporary total disability compensation effective from December 9, 1986 and to continue until closure pursuant to ORS 656.278. We further directed SAIF to pay claimant's attorney 25 percent of the additional compensation granted by our order, not to exceed $600.

On March 19, 1987, claimant requested a hearing. Contending that SAIF had failed to timely comply with our February 26, 1987 order, claimant sought penalties and accompanying attorney fees. Inasmuch as claimant's request emanated from an own motion order, we retain jurisdiction over this matter. See David L. Waasdorp, 38 Van Natta 81 (1986).

SAIF has submitted a copy of its summary sheet detailing the date of payments concerning this claim. On March 10, 1987, SAIF made a payment which covered the period from December 9, 1986

through March 2, 1987. However, claimant's $600 attorney fee was not paid until March 19, 1987. Since its initial temporary disability payment, SAIF has continued to pay claimant's compensation in two week intervals.

Temporary disability benefits are due within 14 days of any determination or litigation order directing the payment of temporary disability. OAR 436-60-150(3)(e). If the insurer unreasonably delays paying compensation, it 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. ORS 656.262(10). Attorney fees awarded out of claimant's compensation retain their identity as "compensation." Candy J. Hess, 37 Van Natta 12 (1985); Robert G. Perkins, 36 Van Natta 1050, 1051 (1984). Failure to timely pay an attorney fee award payable from claimant's compensation is improper and can result in the assessment of a penalty and additional attorney fee. Candy J. Hess, supra.

Here, SAIF timely paid claimant's temporary disability compensation as directed by our February 26, 1987 order. Thus, SAIF's response to this portion of our order was not unreasonable. However, claimant's attorney fee was not paid until March 19, 1987, some seven days late. SAIF offers no explanation for its late compliance with this portion of our order.

Following our review of this matter, we conclude that SAIF unreasonably failed to timely pay claimant's attorney's fee as directed by our prior order. Consequently, a penalty and accompanying attorney fee will be assessed. Accordingly, claimant shall receive 15 percent of the "amount then due." ie; the $600 attorney fee award. In addition, claimant's attorney is awarded $50 for services concerning this issue.

IT IS SO ORDERED.

TIMOTHY R. FREEMAN, Claimant
Brian R. Whitehead, Claimant's Attorney
Alan Ludwick (SAIF), Defense Attorney

WCB 85-05481
May 19, 1987
Order on Review

Reviewed by Board Members Lewis and McMurdo.

Claimant requests review of Referee Leahy's order that dismissed claimant's request for hearing as untimely and, alternatively, upheld the SAIF Corporation's back-up denial of claimant's industrial injury claim relating to his left knee. Claimant concedes that the back-up denial was proper, but requests that the Board decide an issue raised by the parties at the hearing but not decided by the Referee. That issue concerns monies SAIF paid for medical services prior to the issuance of its back-up denial which were voluntarily repaid to SAIF by certain medical service providers after the issuance of the back-up denial. The issues are jurisdiction and medical services.

Claimant filed a claim in August 1984 for an injury to his left knee that allegedly occurred in the course of his employment as a forestry worker. The claim was accepted by SAIF. Claimant underwent two arthroscopic surgeries on his left knee, one in August and one in October. SAIF timely paid all bills submitted for claimant's medical services.

A short time later, SAIF obtained information which led

it to believe that claimant had misrepresented the circumstances of his injury. On January 15, 1985, SAIF issued a back-up denial of claimant's claim. SAIF then contacted a number of medical service providers and requested that they return monies paid on the claim. Several medical service providers complied with this request. On May 2, 1985, SAIF credited payments from medical services providers totalling $1,762.20. On August 1, 1985, SAIF credited an additional $13.20. Presumably, the medical service providers then rebilled claimant for these services.

On May 1, 1985, the Hearings Division in Salem received a letter from claimant's former attorney. The letter stated in pertinent part:

> "[Claimant] came to me on 2/27/85 showing me a copy of the enclosed letter that he assured me that he mailed, on the date stated, 2/27/85, to your Board, as addressed. He struck me as quite credible and the letter itself reveals at least a modicum of efficiency [sic]. The SAIF denial letter is also enclosed.
>
> ". . . .
>
> "Upon speaking with the Board last week, a file or the letter sent by [claimant] cannot be located. In any event I enclose a request for hearing to be processed in this matter."

The day after receiving this letter, the Hearings Division wrote claimant's attorney stating that the only enclosure with the letter had been an attorney fee agreement. Claimant's attorney then forwarded a completed request for hearing form, a copy of SAIF's back-up denial and a copy of a typewritten letter which ostensibly was composed by claimant on February 27, 1985. The letter began with claimant's name and address and then gave the address of the Hearings Division in Salem. The body of the letter contained a request for hearing on SAIF's back-up denial and concluded with a typewritten signature. The Hearings Division received these documents on May 7, 1985. In its answer to claimant's request for hearing, SAIF alleged that the Hearings Division was without jurisdiction to review the denial because claimant had not timely requested a hearing and also alleged that the denial was proper on the merits.

The case came to hearing before Referee Leahy on October 22, 1985. One of the issues raised at the beginning of the hearing by claimant's attorney related to the medical services for which SAIF had been reimbursed by the medical service providers. The record was held open for evidence on this issue as well as written closing arguments.

Regarding the request for hearing dated February 27, 1985, claimant testified that he typed the request, put it in an envelope addressed to the Hearings Division, put a stamp on the envelope and placed the envelope in a mailbox. He also testified that he provided a copy of this letter to his former attorney.

In December 1985, the parties submitted their closing arguments and a claim summary sheet produced by SAIF showing the amounts reimbursed to SAIF by the medical service providers. In

his opinion, Referee Leahy discussed the merits of the back-up denial at length and ruled that the denial should be upheld. The Referee expressly found claimant not credible based upon his demeanor and conflicts between his testimony and that of the other witnesses. In a two-sentence paragraph near the end of the order, the Referee stated as an alternative ground for upholding the denial that claimant had not shown good cause for requesting a hearing after 60 days but within 180 days. See ORS 656.283(1); 656.319(1). The Referee did not directly address the issue involving the medical services reimbursed to SAIF. Claimant requested reconsideration or clarification of the Referee's order. The request was denied.

On Board review, claimant ignores the jurisdictional issue and simply argues that the Referee erred in not ordering SAIF to repay the monies it received from the medical service providers after it issued its back-up denial. Before addressing the merits of the issue raised by claimant, we must determine whether we have jurisdiction to do so.

In his closing arguments before the Referee, claimant contended that his request for hearing dated February 27, 1985 vested jurisdiction in the Hearings Division by virtue of the alleged fact that claimant had mailed the request to the Board within 60 days of the date of the back-up denial. Claimant went on to argue on several bases that the fact that the Board did not actually receive the request until after the expiration of the 60-day deadline was not fatal to the jurisdiction of the Hearings Division. We do not find any of these arguments convincing. In the first place, claimant did not address the applicable administrative rules: OAR 438-06-005 and 438-05-040(4). Claimant has not provided sufficient evidence of the date of mailing under the latter rule. Second, claimant's arguments were based upon testimony which the Referee found not credible. After our de novo review of the record, we accept the Referee's negative credibility assessment. As for the statements of claimant's former attorney in his letter of April 29, 1985, we do not find them reliable. The letter indicated reliance upon the accuracy of information provided by claimant.

For the above reasons, we conclude that the Referee properly dismissed claimant's request for hearing as untimely. We, therefore, do not have jurisdiction to address the matter argued by the parties on Board review.

ORDER

The Referee's order dated December 30, 1985 is affirmed on the ground that claimant's request for hearing was not timely filed.

KEVIN J. GEYER, Claimant
Bischoff & Strooband, Claimant's Attorneys
Cowling & Heysell, Defense Attorneys

WCB 86-03642
May 19, 1987
Order on Review

Reviewed by Board Members McMurdo and Lewis.

The insurer requests review of Referee Mongrain's order that set aside its denial of an aggravation claim relating to claimant's neck and low back. The issue is aggravation.

Claimant compensably injured his head, neck and low back in November 1983 when a piece of lumber fell from a stack, hit him

on the head and neck and knocked him to the ground. He received treatment initially from Dr. Buonocore, a general practitioner, and then began treating with a chiropractor, Dr. Wehinger, in January 1984. Dr. Wehinger released claimant for modified work in April 1984.

Claimant returned to work, but continued to complain of pain throughout his head, neck, shoulders, arms, low back and legs. In May 1984, Dr. Wehinger referred claimant to Dr. Campagna, a neurosurgeon, for evaluation. After listing claimant's complaints and conducting a physical examination, Dr. Campagna suspected protruded cervical and lumbar discs and recommended a myelogram. A myelogram was carried out, but revealed no abnormalities.

In August 1984, claimant was examined by Dr. Maukonen, a neurologist. Claimant complained of pain throughout his head, neck, shoulders, arms, low back and right leg. In obtaining claimant's medical history, Dr. Maukonen asked claimant whether he had ever experienced problems with his head, neck or back prior to the industrial accident. Claimant replied that he had not. Dr. Maukonen then reminded claimant that he had treated him about nine months prior to the industrial accident for a neck injury sustained in an auto accident. Claimant stated that he had forgotten about this accident. Concerning this alleged lapse of memory, Dr. Maukonen skeptically commented, "It should be noted that at the time he saw me initially he reported that the [auto] accident had occurred because he had to run his car off the road because he was being held at knife-point." The physical examination which followed revealed no abnormalities. Dr. Maukonen stated that he considered claimant an unreliable historian and opined that claimant could return to work without restrictions.

Dr. Campagna released claimant for regular work on September 7, 1984. Within four days of returning to work, however, claimant left work again complaining of increased pain in his head, neck, shoulders, low back and right leg. After a physical examination which revealed no abnormalities, Dr. Campagna nonetheless authorized time loss and recommended vocational assistance.

Claimant was examined by a panel of the Orthopaedic Consultants in October 1984. We note that when questioned regarding his medical history, claimant again denied previous injuries to his neck or back. After a physical examination which revealed no objective abnormalities, the panel found claimant medically stationary and rated his impairment at zero. They did note moderate to severe "functional overlay," however, and recommended a psychiatric evaluation.

The following month, claimant was examined by Dr. Stolzberg, a psychiatrist. After interviewing claimant and administering an MMPI, Dr. Stolzberg found no significant psychological pathology. She commented, however, that claimant had withheld "appropriate information about many aspects of his current functioning and financial situation" and that he "appeared to be a somewhat unreliable historian."

The claim was closed by Determination Order dated December 13, 1984 with no award of permanent partial disability.

Claimant requested a hearing. In a report issued a few days after claim closure, Dr. Campagna rated claimant's neck and low back impairment as minimal. When the insurer requested a clarification of the basis of Dr. Campagna's impairment rating, he replied simply, "He has subjective pain."

Claimant returned to Dr. Campagna in May 1985 with complaints of pain in his left shoulder, low back and left leg. Claimant stated that he had begun to experience these symptoms since his previous visit on December 17, 1984. Dr. Campagna noted that claimant was working full time as a timber faller. After a physical examination which revealed no significant abnormalities, Dr. Campagna diagnosed "chronic cervical and lumbar sprain" secondary to claimant's 1983 industrial accident and gave him a prescription for medication.

In an Opinion and Order issued on June 18, 1985, Referee Mongrain awarded claimant five percent unscheduled permanent partial disability for his neck and low back. The Referee indicated that he shared the skepticism expressed in Dr. Maukonen's report regarding claimant's reliability as a historian. Neither party appealed the order.

On June 20, 1985, claimant returned to Dr. Campagna complaining of numbness and weakness in his arms and legs. Claimant indicated that he had experienced similar symptoms for some time, but that the symptoms had worsened after he began full-time employment as a construction worker on June 17, 1985. Dr. Campagna ordered x-rays of the cervical region and an EMG of the right upper extremity. Neither of these procedures revealed any abnormalities. Dr. Campagna stated his impression as "chronic neck sprain with functional overlay."

On July 23, 1985, claimant again returned to Dr. Campagna complaining of continuing pain in his head, neck and shoulders. Dr. Campagna noted that claimant was working as a truck driver. After a physical examination which revealed no objective abnormalities, Dr. Campagna stated that claimant remained medically stationary and that only symptomatic treatment was indicated.

In December 1985, claimant began treating with Dr. Schefstrom, a chiropractor. Claimant complained of pain throughout his back with radiation into his left leg. Dr. Schefstrom diagnosed chronic cervical, dorsal and lumbar strains and began a course of frequent manipulations.

In February 1986, claimant was again examined by Dr. Campagna at the request of the insurer. Dr. Campagna noted complaints of pain throughout claimant's head, neck, shoulders, arms, low back and both legs. Claimant indicated that he had left work in January 1986. After a physical examination which revealed no objective abnormalities, Dr. Campagna diagnosed chronic cervical and lumbar sprains secondary to the 1983 industrial injury, opined that claimant's condition had not worsened and stated that only symptomatic treatment was indicated. The insurer issued an aggravation denial later the same month and claimant requested a hearing.

In April 1986, Dr. Schefstrom reported that when claimant had first sought treatment from him on December 30, 1985, claimant "was completely disabled [and] unable to perform or

sustain any physical activity." He went on to state that claimant had made "moderate progress" under his care and estimated that claimant would probably be medically stationary in another two or three months.

The aggravation denial came to hearing before Referee Mongrain on June 19, 1986. Claimant testified that a short time after he was examined by Dr. Campagna in July 1985, he lost his job as a truck driver for reasons unrelated to his compensable condition and had not worked since that time until about two weeks prior to the hearing. This was contrary to what he told Dr. Campagna in February 1986. Claimant then testified that, beginning in July 1985, the pain in his neck, shoulders and especially his low back gradually increased until December 1985, when he "could hardly walk." He then sought treatment from Dr. Schefstrom. When asked to compare how he felt in December 1985 with how he felt at the time of the hearing, claimant stated that he felt "50 percent better, at least."

On cross-examination, claimant acknowledged that the symptoms he had described on direct examination were very similar to the symptoms to which he had testified at the previous hearing before Referee Mongrain. He insisted, however, that his symptoms had worsened since the issuance of the Referee's previous Opinion and Order. Regarding his employment as a truck driver, claimant stated that he would have continued working had he not been laid off.

The Referee reaffirmed his impression that claimant was "not . . . a completely reliable historian." He also found that there had been "no significant change in claimant's underlying condition." He went on to find, however, that claimant's symptoms had worsened since the last arrangement of compensation to the point that he was less able to work and set aside the aggravation denial on that basis.

Since the Referee issued his order, the Supreme Court has discussed the proof required to establish a "worsened condition" under ORS 656.273(1). In Smith v. SAIF, 302 Or 396 (1986), the court indicated that in order to prove a worsened condition, a claimant must establish a change in condition and entitlement to additional compensation under ORS 656.206, 656.210, 656.212 or 656.214. Regarding aggravation claims based upon worsened symptoms, the court commented:

> "Increased symptoms in and of themselves are not compensable and not sufficient to require the payment of additional compensation, unless the worker suffers pain or additional disability that results in loss of the worker's ability to work and the worker thereby suffers a loss of earning capacity."

From this statement, it is clear that a worsening of symptoms can be a "worsened condition" within the meaning of ORS 656.273(1), but only if the trier of fact is convinced: (1) that the symptoms actually have increased since the last arrangement of compensation; and (2) that the increase in symptoms has resulted in additional disability within the meaning of one of the four sections cited earlier. With regard to the first of these elements, we see nothing in the court's opinion that would detract from our statement in Vonda Atwell, 38 Van Natta 57, 59 (1986) and other cases that if a claimant has received an award of permanent

partial disability, he must show a fluctuation of symptoms beyond that expected of the waxing and waning of the compensable condition. In such cases, future symptomatic flare-ups and associated periods of temporary disability have been anticipated and compensated. A claimant, therefore, may be temporarily disabled after the last arrangement of compensation because of a fluctuation in the level of his symptoms and still not be able to establish a "worsened condition" within the meaning of ORS 656.273(1). See International Paper Co. v. Turner, 84 Or App 248, 250-51 (1987); Gwynn v. SAIF, 84 Or App 67 (1987).

On our de novo review of this case, we are not convinced that claimant has established a fluctuation of his symptoms beyond that anticipated and compensated in his award of permanent partial disability. The medical evidence reflects periodic symptomatic flare-ups both before and after the last arrangement of compensation, depending on claimant's level of activity. Dr. Campagna, claimant's long-time treating physician, saw nothing unusual in this and, in February 1986, expressly stated that claimant's condition had not changed. Dr. Schefstrom appears to hold a different opinion. By virtue of Dr. Campagna's advantage in observing claimant over a longer period of time and the fact that Dr. Schefstrom's opinions are based upon history and complaints which the Referee found unreliable and which we expressly find not credible, we conclude that claimant has failed to establish a fluctuation of symptoms of sufficient magnitude to constitute a "worsened condition" within the meaning of ORS 656.273(1).

ORDER

The Referee's order dated August 15, 1986 is reversed. The insurer's denial dated February 24, 1986 is reinstated and upheld.

KENNETH T. JONES, Claimant
Coons & Cole, Claimant's Attorneys
Garrett, et al., Defense Attorneys

Own Motion 85-0614M
May 19, 1987
Own Motion Determination on Reconsideration

Claimant has requested reconsideration of the Board's November 18, 1985 Own Motion Determination, which closed claimant's June 18, 1976 injury claim. Contending that his claim was misclassified as nondisabling and has never been closed, claimant asserts that this matter should be submitted to the Evaluation Division for the issuance of a Determination Order.

On June 21, 1976, claimant filed a claim, alleging that he had injured his "left back muscles" on June 18, 1976 when he "stepped backward off the green chain dock." On June 24, 1976, claimant sought treatment from Dr. Hagen, chiropractor. Diagnosing severe sprain to the cervical and upper dorsal area, Dr. Hagen prescribed chiropractic adjustments and physiotherapy. Dr. Hagen further recommended that claimant not return to work, unless lighter work was available.

Although Dr. Hagen suggested the reopening of claimant's previous nondisabling injury claim, the self-insured employer accepted this 1976 episode as a new injury. The claim was classified as nondisabling. There is no indication that claimant either missed time from work or received temporary disability compensation as a result of this injury

In January 1978, Dr. Bryson, claimant's treating chiropractor, reported that claimant had last received treatment on December 7, 1977. Concluding that claimant's condition was medically stationary, Dr. Bryson determined that he had suffered no permanent impairment. There is no indication that the claim was closed either administratively or through the Evaluation Division.

Since his compensable injury, claimant has periodically sought treatment for his back complaints. The treatments have been conservative in nature and have enabled claimant to remain working with no time loss.

In August 1985 Dr. Smith, orthopedist, performed an independent medical examination. X-rays of the cervical and thoracic spine revealed osteoarthritis. Claimant's permanent impairment as a result of this condition was rated as 15 percent. However, Dr. Smith did not feel that these degenerative changes were necessarily related to claimant's compensable injuries.

In October 1985 the employer requested closure of the claim. In its request, the employer noted that claimant had not received temporary disability compensation nor was any such compensation due. Thereafter, the Board issued its Own Motion Determination, closing the claim.

Claimant objects to our determination, contending that we lacked jurisdiction to consider the matter. He argues that his injury was disabling from the outset. Consequently, asserting that his claim has never been closed, claimant requests rescission of the Board's determination and submission of the claim to the Evaluation Division. We conclude that we have jurisdiction.

At the time of claimant's compensable injury, no statute required closure of a claim for a nondisabling injury. ORS 656.268(3), which requires carrier closure of a nondisabling claim, became effective on January 1, 1980. Or Laws 1979, ch 839 § 4(3) and 33; Webb v. SAIF, 83 Or App 386 (1987). In addition, ORS 656.262(11) (now ORS 656.262(12)) provided that if within one year after the injury, a worker claimed that a nondisabling injury had become disabling, the insurer/employer should immediately report the claim to the director. If the claim that a nondisabling injury had become disabling was made more than one year after the date of injury, the claim was to be treated as an aggravation claim pursuant to ORS 656.268. id. If the injury was nondisabling and no determination had been made, a claim for aggravation had to be filed within five years after the date of injury. ORS 656.273(4)(b).

The interplay of these statutes was discussed in Davison v. SAIF, 80 Or App 541, opinion modified on recon 82 Or App 546 (1986). In Davison, the claimant lost a small portion of his little finger. His 1982 injury claim was accepted as nondisabling. The claimant did not seek reclassification of the injury within the required one year period. Eventually, the claimant sought reclassification, contending that his claim had never been formally closed either administratively or by Determination Order. The Davison court found that the claim had been misclassified from the outset. Thus, ORS 656.262(12) did not apply. Furthermore, the court concluded that SAIF's notice of acceptance did not comply with the notice of closure requirements

of ORS 656.268(3). Since the claim had never been closed, the court reasoned that the claimant's right to seek a determination order had not expired.

This case is distinguishable from Davison. Here, unlike Davison, there was no statutory requirement for the closure of a nondisabling injury claim. Moreover, although claimant contends that his claim was misclassified from the outset, the record fails to establish that he missed any time from work or sustained any permanent impairment as a result of his compensable injury. Thus, unlike Davison, the provisions of ORS 656.262(11) (now 656.262(12)) and 656.273(4)(b) are directly applicable.

Because claimant's injury was nondisabling and no determination had been made, his five-year aggravation rights were statutorily required to have commenced June 18, 1976, the date of his injury. ORS 656.273(4)(b). Inasmuch as claimant's aggravation rights had expired at the time the employer voluntarily reopened his claim and submitted it for closure, we conclude that we had jurisdiction to issue our own motion determination pursuant to ORS 656.278.

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our prior order, effective this date.

IT IS SO ORDERED.

MICHAEL B. KINSLOW, Claimant
Imperati, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 86-00988
May 19, 1987
Order on Review

Reviewed by Board Members McMurdo and Lewis.

The insurer requests review of that portion of Referee Pferdner's order that declined to grant an offset for a stipulated overpayment of temporary disability compensation. Claimant cross-requests review of that portion of the Referee's order that declined to assess penalties and attorney fees for the insurer's failure to timely comply with claimant's discovery requests. The issues are offset, penalties and attorney fees.

The Board affirms the Referee with the following comment.

The insurer requests that the Board either approve the stipulated overpayment of temporary disability, or allow it to assert the overpayment in a future proceeding. Any issue relating to the stipulated overpayment of compensation may be raised and decided when, and if, claimant receives a disability award against which an offset may be allowed. ORS 656.268(4); Milton O. Burson, 36 Van Natta 282, 284 (1984); George E. Johnson, 37 Van Natta 547, 548 (1985).

ORDER

The Referee's order dated August 22, 1986 is affirmed.

SHARON K. McGINLEY, Claimant
Cash Perrine, Claimant's Attorney
Alan Ludwick (SAIF), Defense Attorney

WCB 86-00345
May 19, 1987
Order on Review

Reviewed by Board Members Lewis and McMurdo.

The SAIF Corporation requests review of Referee Daron's order that awarded claimant 176 degrees for 55 percent unscheduled permanent partial disability, in lieu of a Determination Order award of 48 degrees for 15 percent unscheduled disability for the low back. The issue is extent of unscheduled permanent partial disability. We modify.

Claimant incurred two compensable injuries to the low back, the last of which occurred in August 1984. She was diagnosed as suffering from a chronic lumbosacral strain, superimposed on degenerative disk disease. At the time of her most recent injury, claimant was employed as a cook one day per week at $3.45 per hour. All treatment has been conservative and claimant's physical impairment has been rated as between "mild" and "moderate."

At the time of the hearing, claimant was 44 years of age. She had an 11th grade education and no GED. She cannot return to the job she was performing at time of injury, but she is capable of light-duty employment. According to claimant, her condition has remained essentially constant since the time of her original injury in late 1983.

The Referee noted that even after her injury, claimant remained capable of the same work schedule she had when she was injured. He also noted that claimant's testimony and complaints were inconsistent with the degree of activity she had engaged in subsequent to her injury. Despite these observations, the Referee found claimant to be permanently partially disabled to the extent of 55 percent of the maximum allowable by law.

We find the Referee's award to have been excessive. Although claimant's injury did result in permanent impairment, she is not seriously disabled and has had no radical medical treatment. Neither her age nor her education present substantial barriers to her reemployment. Taking these and other pertinent factors into consideration, we find that claimant will be adequately compensated for her industrial injuries by an award of 96 degrees for 30 percent unscheduled permanent partial disability. The Referee's order is, therefore, modified.

ORDER

The Referee's order dated August 7, 1986 is modified. In lieu of the Referee's award, and in addition to the Determination Order's award of 15 percent (48 degrees) unscheduled permanent disability, claimant is awarded 15 percent (48 degrees) unscheduled permanent disability for the low back. Claimant's attorney fee shall be adjusted accordingly.

RONALD L. MCMAHILL, Claimant
Brian R. Whitehead, Claimant's Attorney
Garrett, et al., Defense Attorneys

WCB 85-04851
May 19, 1987
Order on Review

Reviewed by Board Members McMurdo and Lewis.

Claimant requests review of those portions of Referee Myers' order that: (1) found that his compensable right knee condition had not worsened before the expiration of his aggravation rights; and (2) declined to assess a penalty and accompanying attorney fees for the employer's alleged unreasonable unilateral termination of temporary disability benefits. In its respondent's brief, the employer contends that the Referee erred in assessing penalties and accompanying attorney fees for an allegedly unreasonable delay in responding to a request for authorization of surgery. On review, the issues are perfecting an aggravation claim, compensability of an aggravation claim, penalties, and attorney fees.

Claimant was 38 years of age at the time of hearing. In February 1980 he suffered a right knee injury while working as a city maintenance worker. In May 1980, Dr. Tiley, claimant's treating orthopedist, performed surgery for a torn, degenerated medial meniscus. In July 1980, Dr. Tiley released claimant to return to his regular employment, indicating that he had suffered no permanent impairment. The claim was closed by an August 8, 1980 Notice of Closure.

In January 1983, claimant returned to Dr. Tiley, complaining of a "little achiness" and crepitation in the knee. Although these difficulties arose at the end of claimant's workdays, they were not interfering with his job. X-rays were taken. Concluding that claimant's problem was chondromalacia of the patella and inadequate rehabilitation of the quadricep muscle, Dr. Tiley recommended a rehabilitation program. Claimant apparently continued to work.

In June 1983, Dr. Tiley reported that further investigation of the knee would be necessary. Dr. Tiley also stated that claimant would be admitted "in the near future as an outpatient" for an arthroscopic evaluation.

In October 1983, Dr. Phifer, orthopedist, performed an independent medical examination. Dr. Phifer concluded that claimant had chronic mild laxity of the ligament structure of his right knee with probable mild traumatic arthritis. No significant crepitus, which would be consistent with chondromalacia of the patella, was detected. Dr. Phifer recommended medication, but in the event such treatment proved ineffective, opined that an "arthroscopy would certainly be appropriate." Expressing disagreement with Dr. Phifer's evaluation, Dr. Tiley continued to recommend surgery.

In November 1983, the employer's claims supervisor requested an "updated medical report" from Dr. Tiley. The employer was particularly interested in obtaining the following information: (1) was claimant's condition related to his compensable injury; (2) had there been a material worsening of his condition since prior closure; and (3) had claimant sustained any permanent disability. Rather than respond to the employer's specific inquiries, Dr. Tiley forwarded duplicate copies of his chart notes. The employer made no further response to Dr. Tiley's surgery recommendation.

In February 1984, Dr. Tiley reported that claimant had last been treated in June 1983. At that time, claimant continued to be released for regular work. Dr. Tiley further noted that he was still awaiting authorization for an arthroscopy and possible shaving. The employer neither authorized nor denied this request.

In December 1984, Dr. Tiley reported that claimant's symptoms were continuing. Noting that an independent examiner had agreed with the surgery recommendation, Dr. Tiley repeated his request for authorization to proceed.

In January 1985, claimant was reexamined by Dr. Phifer. Claimant apparently had been unemployed since August 1984. He engaged in exercises, but had not taken any medication for his knee discomfort. Dr. Phifer repeated his previous opinion that an arthroscopy would be appropriate if medication did not adequately control claimant's symptoms.

In February 1985, the employer forwarded a copy of Dr. Phifer's report to Dr. Tiley. The employer stated that a third opinion would be obtained if Dr. Tiley continued to recommend surgery. Noting that medication had previously been ineffective, Dr. Tiley repeated his surgery request. Dr. Tiley also reported that, "at this point," the arthroscopy was diagnostic to confirm the existence of a suspected mechanical problem.

In April 1985, claimant filed a request for hearing. As issues, claimant raised a "de facto" denial of his medical services claim, penalties, and attorney fees.

In July 1985, claimant was seen by Dr. Shaw, orthopedist. In Dr. Shaw's opinion, an arthroscopy would provide a clearer diagnosis and prognosis. Accordingly, Dr. Shaw agreed with Dr. Tiley's diagnosis and surgery recommendation.

On August 26, 1985, the employer approved the request for surgery. Dr. Tiley performed the arthroscopy on September 18, 1985. The surgery demonstrated some degenerative changes where the prior surgery had occurred. Recommending an exercise program, Dr. Tiley suggested that claimant return in six weeks for a routine follow-up.

On December 10, 1985, Dr. Tiley opined that claimant was stable with some mild impairment. Foreseeing the probability of degenerative arthrosis, Dr. Tiley concluded that claimant was free to pursue any occupational activity, provided he avoided "a lot of kneeling or a lot of impact loading or where he has to have the risk of a lot of twisting the knee."

The employer paid temporary disability from September 18, 1985 through December 10, 1985. These dates coincided with claimant's surgery and Dr. Tiley's statement that claimant was free to pursue any occupational activity. Since claimant's five-year aggravation rights had expired on August 8, 1985, the employer considered this compensation to be voluntary.

Claimant testified that his right knee condition worsened in 1983. However, he continued to perform his regular work activities until August 1984, when he was laid off. For the following six months he worked on "odd jobs" and received

unemployment benefits. In February 1985 he obtained a temporary position which ended in July 1985. At the time of hearing, claimant had not returned to work since his September 1985 surgery.

The Referee reasoned that Dr. Tiley's January and June 1983 chart notes might be considered aggravation claims. However, the Referee concluded that claimant had failed to prove that his condition had, in fact, aggravated prior to the expiration of his aggravation rights. The Referee was not persuaded that claimant's compensable condition had become either permanently or temporarily more disabled until he submitted to the September 1985 surgery. Because the claim had been reopened after claimant's aggravation rights had expired, the Referee found that the "unilateral termination" issue was within the Board's Own Motion jurisdiction. Finally, finding that the employer's response to the surgery request had been unreasonable, the Referee assessed a penalty and accompanying attorney fee.

We agree with the Referee that the employer's conduct in processing the series of surgery requests was dilatory. However, we disagree with the assessment of a penalty for unreasonable claims processing. In Lester Carman, 37 Van Natta 1686 (1985), 38 Van Natta 8 (1986), we concluded that payments for medical services were not due until the surgery had been performed. Consequently, no penalty could be assessed for an unreasonable delay in providing authorization for surgery because there were "no amounts then due." In reaching this decision, we relied on Paige v. SAIF, 75 Or App 160 (1985).

Here, as in Carman, no penalty will be assessed because there are no amounts then due upon which to base the penalty. However, claimant is entitled to an attorney fee. See Wilma K. Anglin, 39 Van Natta 73, 76 (1987). Under these circumstances and in light of the factors enumerated in Barbara A. Wheeler, 37 Van Natta 122, 123 (1985), we conclude that an appropriate fee is $300. Consequently, the Referee's award of attorney fees concerning this issue is modified.

We also agree with the Referee that claimant perfected an aggravation claim. Either one of Dr. Tiley's 1983 chart notes constituted a need for further medical services as required by ORS 656.273(3). When read together, the chart notes certainly provided notice to the employer that claimant was in need of additional medical treatment for a condition apparently attributable to his compensable injury.

Subsequent to the Referee's order, the Court of Appeals discussed the requirements for perfecting an aggravation claim. See Krajacic v. Blazing Orchards, 84 Or App 127 (1987). In Krajacic, the claimant had received ongoing treatment and consultations for a chronic lumbosacral strain since his nondisabling compensable injury. He contended that two reports from his treating chiropractor constituted an aggravation claim. One of the reports requested more monthly treatment for his continuing symptoms. The other suggested a referral to a neurosurgeon. Concluding that the notice of an aggravation claim must show more than a need for palliative treatment for continuing conditions, the court found that claimant had not perfected an aggravation claim.

The Krajacic court cited Haret v. SAIF, 72 Or App 668, 672, rev den 299 Or 313 (1985), for the proposition that the purpose of ORS 656.273(3) is to allow an aggravation claim to be

made by a physician's report requesting additional services. The court reasoned that "additional services" must be read together with ORS 656.273(1) which makes it clear that the additional medical services referred to are for "worsened conditions." Although it conceded that the report itself does not need to prove the worsened condition, the court held that the report must put the insurer on notice that treatment for more than continuing conditions is indicated. (Emphasis in original). When viewed in the context of the ongoing treatment, the Krajacic court concluded that the reports did not show anything new. The court distinguished Haret, where the claimant had not seen a physician for a year and the claim indicated an ailment which was different from that which the claimant had previously received disability.

Here, as in Haret, claimant had not been receiving ongoing treatment for a chronic condition. When he returned to Dr. Tiley in January 1983, claimant had not sought medical treatment for his right knee condition for more than two years. Following this examination, Dr. Tiley diagnosed a new condition, chondromalacia, and recommended additional services, a rehabilitation program. Moreover, following claimant's June 1983 examination, Dr. Tiley recommended an arthroscopic evaluation. Unlike the reports in Krajacic, Dr. Tiley's reports establish that claimant was suffering from a different ailment which required more than palliative treatment. Accordingly, we find that claimant perfected an aggravation claim within the statutory five-year period.

Having found that a claim for aggravation was perfected, we next consider whether claimant's condition resulting from his compensable injury has worsened since the last award of compensation. ORS 656.273(1); Gwynn v. SAIF, 84 Or App 67 (1987); Consolidated Freightways v. Foushee, 78 Or App 509, rev den 301 Or 338 (1986). In Smith v. SAIF, 302 Or 396 (1986), the Supreme Court agreed with the Court of Appeals' analysis, 78 Or App 443 (1986), that "worsened conditions" means a change in condition which makes a claimant "more disabled," either temporarily or permanently, than he was when the original claim was closed. Because compensation for a scheduled disability is for loss of use of a scheduled body part, "more disabled" means increased loss of use of that body part. International Paper Co. v. Turner, 84 Or App 248 (March 11, 1987).

Utilizing the aforementioned analysis, we conclude that claimant's compensable condition has worsened. At the time of the August 1980 Notice of Closure, claimant had been released to his regular work. In addition, Dr. Tiley, his treating physician, had concluded that claimant had suffered no permanent impairment. When claimant returned to Dr. Tiley in 1983, he was experiencing consistent difficulty with the knee. Dr. Tiley diagnosed a different condition and prescribed additional medical services. Eventually, claimant's contention that his condition had worsened was confirmed by the September 1985 arthroscopy. Following the arthroscopy, Dr. Tiley diagnosed degenerative changes in the knee and concluded that claimant had suffered mild impairment. Moreover, Dr. Tiley suggested that claimant refrain from stressful work activities involving the knee.

The foregoing medical and lay evidence establishes that claimant sustained an increased loss of use of his right knee

since the last award of compensation. See International Paper Co. v. Turner, supra. Therefore, we are persuaded that claimant is "more disabled" than he was when his original claim was closed. Consequently, we conclude that claimant's condition has worsened since the last award of compensation. See Smith v. SAIF, supra; Gwynn v. SAIF, supra. Accordingly, claimant has established the compensability of his aggravation claim. See ORS 656.273(1), (7).

Much of the evidence, particularly the results from the September 1985 arthroscopy, was generated after the expiration of claimant's five-year aggravation rights. See ORS 656.273(4)(b). However, since claimant's aggravation claim was timely filed, we are not foreclosed from considering this subsequent evidence. If our decision was otherwise, medical examinations conducted after the five-year period and all testimony concerning claimant's current condition would be prohibited. Such reasoning would be contrary to the language of ORS 656.273(4)(b), which states only that the claim for aggravation must be filed within five years after the date of the nondisabling injury. (Emphasis added).

Thus, we conclude that, because the aggravation claim was timely perfected, the evidence generated in support of the claim need not only pertain to claimant's condition prior to the expiration of his aggravation rights, but can also include evidence produced thereafter. Our conclusion is supported by ORS 656.273(7), which provides for hearings in accordance with ORS 656.283 on any issue involving aggravation claims. Furthermore, ORS 656.273(7) states that if the evidence as a whole shows a worsening of claimant's condition, the claim shall be allowed. (Emphasis added). Such language would encompass evidence formulated subsequent to the expiration of a claimant's aggravation rights, as well as testimony given at hearing. Finally, our reasoning compares favorably with the general scheme of evaluating a claimant's condition as of the date of hearing. Gettman v. SAIF, 289 Or 609 (1980); Jeffrey Barnett, 36 Van Natta 1636 (1984).

We turn to the employer's unilateral termination of claimant's temporary disability benefits. Temporary disability benefits should continue until a Determination Order issues, unless claimant has returned, or been released to return, to regular work. Jackson v. SAIF, 7 Or App 109 (1971). In order to justify terminating temporary benefits, the release for a return to work should be clear and unambiguous. Ramon Robledo, 36 Van Natta 632 (1984); John R. Daniel, 34 Van Natta 1020 (1982). If the release is unclear, further clarification is necessary. Neva W. Brehmer, 36 Van Natta 1603 (1984).

Claimant received temporary disability benefits commencing with his September 1985 surgery. Reasoning that claimant's aggravation rights had expired, the employer concluded that he was no longer entitled to temporary disability benefits. Thus, the employer considered its payments strictly voluntary in nature. As discussed above, the employer's reasoning was incorrect. Consequently, once the employer began paying temporary disability compensation, it was obligated to continue the payment of these benefits until one of the Jackson requirements was met.

The employer apparently terminated claimant's benefits after receiving Dr. Tiley's December 10, 1985 chart note. Dr. Tiley reported that claimant was free to pursue any occupational activity he desired. However, concluding that

claimant had suffered mild impairment, Dr. Tiley also recommended that claimant avoid certain physical activities. This latter statement suggests that claimant was not released to his regular work activities. If nothing else, this statement made it unclear whether claimant had, in fact, been released to his regular work.

Under these circumstances, we conclude that the employer was obligated to continue paying temporary disability compensation, pending further clarification of Dr. Tiley's opinion. Thus, we find that the employer should pay temporary disability benefits until one of the following events has occurred: (1) the date claimant was released to his regular work; (2) the date claimant returned to his regular work; or (3) the issuance of a Determination Order. These benefits should be reduced by any wages paid to claimant or any unemployment benefits received during this period.

Considering the procedural complexities present in this matter, we do not find the employer's unilateral termination of benefits to have been unreasonable. Accordingly, no penalty and accompanying attorney fees will be assessed for this conduct.

ORDER

The Referee's order dated July 29, 1986 is affirmed, modified, and reversed. The SAIF Corporation's "de facto" denial of claimant's aggravation claim is set aside and this matter is remanded to SAIF for processing according to law. Claimant's attorney is awarded $1,200 for services at hearing and $600 for services on Board review, concerning this aggravation issue, to be paid by SAIF. In addition, SAIF is directed to pay temporary disability benefits effective December 11, 1985, with payments to continue until the date claimant returned to his regular work, was released to return to his regular work, or until the issuance of a Determination Order. These benefits shall be reduced by any wages paid to claimant or any unemployment benefits received during this period. Claimant's attorney is awarded 25 percent of this increased compensation, not to exceed $3,000. The Referee's assessment of a penalty for an unreasonable response to claimant's surgery request is reversed. In lieu of the Referee's attorney fee award concerning this issue, claimant's attorney is awarded $300, to be paid by the SAIF Corporation. The remainder of the Referee's order is affirmed.

THOMAS J. MILLER, Claimant
Malagon & Moore, Claimant's Attorneys
Pamela Schultz (SAIF), Defense Attorney

WCB 86-02720
May 19, 1987
Order on Review

Reviewed by Board Members McMurdo and Lewis.

The SAIF Corporation requests review of Referee Baker's order that awarded claimant 15 percent (48 degrees) unscheduled permanent disability for the back, whereas a Determination Order had awarded no permanent disability. The issue on review, is extent of unscheduled permanent disability.

Claimant, 54 years of age, has an eighth grade education and has worked as a logger for nearly 37 years. He has performed virtually all jobs associated with logging. During the last 20 years, however, he has worked solely as a hook tender.

In June 1985, claimant suffered a compensable injury to

his left shoulder, right chest, low back, and left hip. Claimant attempted to return to work in July 1985, but quit after only one day because of right body pain. Dr. O'Fallon, claimant's family physician, treated conservatively with rest and muscle relaxants. Surgery was not required.

In September 1985, claimant entered the Injured Workers' Program. After only 11 days of occupational therapy, claimant was able to lift 75 pounds once per hour and to stand for four hours per eight-hour workday. In November 1985, claimant indicated that he felt very good physically and was ready to return to work. Accordingly, Dr. Becker, the Injured Workers' Program physician, released claimant to regular work without restriction.

A Determination Order issued in January 1986, awarding no permanent partial disability.

In March 1986, claimant returned to regular work as a full-time hook tender. He has not missed any work since May 1986. At the time of the hearing, claimant was working for $13.00 an hour, which was 50 cents an hour more than his wage at the time of his compensable injury.

The Referee found claimant a sincere and credible witness. Claimant testified that his back is stiff and sore in the mornings, but resolves during the day. He takes two or three aspirin before going to work. His job as a hook tender, which is mainly supervisory, occasionally requires him to work a saw or set chokers. These activities cause pain. However, claimant fills in as a choker setter when needed. He feels he can no longer climb trees or work as a choker setter on a full-time basis. Yet, he has not worked full-time at such jobs in approximately 15 years. Since his release to regular work, he has not sought any medical treatment for his work injury.

In May 1986, claimant was seen by Dr. Schacner, a physician and surgeon, for an independent medical examination. Dr. Schacner found no evidence of permanent impairment. As to claimant's complaints of back soreness, Dr. Schacner opined that these complaints were related solely to preexisting degenerative arthritis in the lumbar spine. Subsequently, Dr. O'Fallon stated that he agreed "completely" with Dr. Schacner's assessment.

The Referee awarded claimant 15 percent unscheduled permanent disability. We disagree with the Referee's award for the following reasons.

It is claimant's burden to prove that he has incurred a permanent loss of earning capacity as a result of the June 1985 injury. Hutcheson v. Weyerhaeuser Co., 288 Or 51, 56 (1979). Depending on the circumstances, post-injury earnings may be of great, little, or no importance in determining loss of earning capacity. Jacobs v. Louisiana-Pacific, 59 Or App 1, 3 (1982). Accordingly, we have not considered claimant's eventual successful return to work at an increased wage as determinative evidence that he did not sustain permanent disability.

Further, we are aware that medical evidence is not statutorily required to establish the extent of permanent disability. Garbutt v. SAIF, 297 Or 148 (1984). However, if we find a worker's testimony insufficient to resolve a complicated medical issue, we are not bound by it; that is, we may require

expert medical opinion to resolve the issue presented. Kassahn v. Publishers Paper Co., 76 Or App 105 (1985). Complex medical causation questions require expert medical analysis. Uris v. Compensation Dept., 247 Or 420 (1967).

Here, both Dr. Schacner and Dr. O'Fallon opine that claimant has no permanent impairment. More importantly, both doctors relate claimant's complaints to a preexisting condition; not the June 1985 work injury. Neither doctor opines that the preexisting condition was worsened by the compensable injury. Thus, while we do not ignore either the Referee's credibility finding or claimant's testimony, we find the medical evidence more persuasive regarding the cause of claimant's alleged disability. See Uris, supra; Kassahn, supra.

After our de novo review of the medical and lay evidence, the preponderance of the evidence fails to establish a causal relationship between claimant's complaints of pain and his compensable injury. Therefore, we find that claimant is not entitled to an award of unscheduled permanent disability.

SAIF argues for permission to offset any reduction in the Referee's award of permanent disability against any future payments of permanent or temporary disability. It is well settled, however, that such an offset is impermissible. See Hutchinson v. Louisiana-Pacific, 67 Or App 577, 581, rev. den., 297 Or 340 (1984); Carol J. Levesque, 38 Van Natta 230 (1986); ORS 656.313(2). Accordingly, SAIF's request is denied.

ORDER

The Referee's order dated August 29, 1986, is reversed.

CARL D. PITTS, Claimant
Emmons, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

Own Motion 86-0508M
May 19, 1987
Own Motion Determination on Reconsideration

Claimant has requested reconsideration of the Board's April 29, 1987 Own Motion Determination on Reconsideration. Pursuant to our order, claimant was awarded an additional 10 percent (32 degrees) unscheduled permanent disability for his left shoulder injury. In addition, claimant's attorney was awarded 25 percent of the additional compensation granted by our order, not to exceed $350. Claimant objects to our "arbitrary" award of attorney fees, contending that he should receive an award of $560, i.e., 25 percent of the $2,240 increase in his unscheduled permanent disability award.

We grant claimant's request for reconsideration. Consequently, our prior order is withdrawn.

If a proceeding is initiated on the Board's own motion because of a request from a claimant and an increase in compensation is awarded, the Board shall approve for claimant's attorney a reasonable fee payable out of any increase awarded by the Board. OAR 438-47-070(2). The amount of a reasonable attorney fee shall be based on the efforts of the attorney and the results obtained, subject to any applicable maximum fee provided by 47-000 to 47-095. OAR 438-47-010(2). Fees awarded under the Board's rules are not established in any mandatory amount; the

rules are suggestive. ORS 656.388(4); OAR 438-47-005; Morris v. Denny's, 53 Or App 863, 866 (1981); Charles W. Roller, 38 Van Natta 158 (1986).

In determining the reasonableness of attorney fees, several factors are generally considered. These factors include: (1) the time devoted to the case; (2) the complexity of the factual and legal issues presented; (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. Barbara A. Wheeler, 37 Van Natta 122, 123 (1985). Our failure to discuss or analyze an attorney fee award or allowance should not be taken to mean that all of the aforementioned factors are not carefully considered. Kenneth E. Choquette, 37 Van Natta 927, 928 (1985).

The efforts of claimant's attorney have resulted in an increase in claimant's unscheduled permanent disability compensation. Therefore, claimant is entitled to a reasonable attorney fee payable out of his increased award. See OAR 438-47-070(2). Yet, the amount of claimant's attorney's fee is not based on his contingent fee arrangement with his attorney. Rather, the amount of his fee is based on his attorney's efforts and the results obtained. See OAR 438-47-010(2).

After conducting our review of the record and considering the aforementioned guidelines, we conclude that $350 is a reasonable attorney's fee for claimant's attorney's services concerning this own motion matter. In reaching this conclusion, we have also considered the Wheeler factors, as well as the potential ramifications resulting from our decision as mentioned in claimant's reconsideration request.

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our April 29, 1987 Own Motion Determination on Reconsideration in its entirety, effective this date.

IT IS SO ORDERED.

CHARLES H. WHIDDON, Claimant
Pozzi, et al., Claimant's Attorneys
Mark Bronstein (SAIF), Defense Attorney
Rankin, VavRosky, et al., Defense Attorneys

WCB 85-14106 & 85-14801
May 19, 1987
Order on Review

Reviewed by Board Members McMurdo and Lewis.

The SAIF Corporation requests review of Referee Pferdner's order that found it responsible for an injury to claimant's low back. Should the self-insured employer be found responsible, it contends that claimant did not timely appeal its denial of his aggravation claim. The issues are responsibility and timeliness.

Claimant injured his low back in February 1981, while working for the self-insured employer. In June 1981 Dr. Duff, orthopedist, diagnosed a herniated disc at the L4-5 level. Dr. Duff performed a discectomy and laminectomy at that level. An October 1982 Determination Order awarded claimant 15 percent unscheduled permanent disability for his low back condition and 15 percent scheduled permanent disability for the loss of the right foot. Following the Determination Order, claimant periodically sought treatment for his low back condition. Subsequently, a stipulation increased claimant's award to 25 percent unscheduled disability and 25 percent scheduled disability.

In June 1985 claimant was working for SAIF's insured as a gas station attendant. While bending over to put gas in a car, he felt a pop and an "electrical feeling" down his back and left leg. The following day, claimant reported to the emergency room with severe pain in his low back and left leg. X-rays were interpreted as unchanged from those taken in 1982. A CT scan was performed that revealed mild bulging at the L4-5 level and slight bulging at the L5-S1 level. The scan revealed no disc herniation or spinal stenosis.

In August 1985 claimant filed an aggravation claim with the self-insured employer. The employer issued a denial on August 29, 1985. The denial was sent to claimant by certified mail. In September the denial was returned to the employer unclaimed. On November 7, 1985, the denial was resent by means of ordinary mail. Claimant appealed the denial on November 14, 1985. Claimant also filed a claim for new injury with SAIF, which issued a denial of responsibility in October 1985. Claimant timely appealed SAIF's denial. Subsequently, SAIF requested the issuance of an order pursuant to 656.307(1) designating a paying agent. However, the self-insured employer opposed the issuance of an order, seeking to preserve the issue of whether claimant had timely appealed the denial.

In April 1986 Dr. Duff concluded that claimant's injury had resulted in a "considerable, but temporary worsening of his situation." He felt claimant was medically stationary on July 23, 1985 and that he had suffered no additional impairment. Inasmuch as claimant had previously complained of right sciatic pain and now complained of left sciatic pain, Dr. Duff concluded that the 1985 incident was a new injury.

In June 1986 claimant was examined by the Orthopaedic Consultants. The Consultants found claimant's symptoms far out of proportion to the stresses applied during the exam. Noting that claimant's description of radiating pain was nonanatomic, the Consultants concluded that his pain level bore no relation to his degree of disability. The Consultants felt strongly that the 1985 incident was only an aggravation of symptoms and not a new injury.

In July 1986 claimant was examined by Western Medical Consultants. The interference of psychological factors prevented the Consultants from assessing claimant's impairment. However, the Consultants concluded that it did not appear that claimant had suffered significant new injury to his low back in 1985, "but that he had at least a transient exacerbation of symptoms."

The Referee concluded that the 1985 incident was a new injury. Consequently, he found SAIF responsible. We disagree.

To shift responsibility in successive injury cases, the burden is on the first employer, whose employment caused the initial disability, to prove that the second employment independently contributed to claimant's disability. Eva L. (Doner) Staley, 37 Van Natta 731 (1985) on reconsideration 38 Van Natta 1280 (1986). The second injury must "independently contribute to the causation of the disabling condition, i.e., to a worsening of the underlying condition." Hensel Phelps Construction Co. V. Mirich, 81 Or App 290 (1986).

The Referee relied upon Dr. Duff's conclusion that

claimant had sustained a new injury. However, Dr. Duff based this conclusion on claimant's complaints of new symptoms. He provides no explanation of the pathology for these new complaints and describes the 1985 injury as a "temporary worsening of his situation." We are not persuaded that Dr. Duff's description of the incident as a "new injury" is the same as a worsening of the underlying condition for the purposes of shifting responsibility. This conclusion is supported by the brief period of disability resulting from this incident and claimant's lack of additional impairment. Further, neither medical consulting group could conclude that the 1985 incident was anything more than an aggravation of symptoms. Consequently, the self-insured employer has failed to establish that the 1985 incident independently contributed to the causation of claimant's condition. Responsibility for the 1985 incident rests with the self-insured employer.

Having established that responsibility did not shift, we next consider the timeliness of claimant's appeal from the self-insured employer's denial. The Referee concluded that claimant's failure to receive actual notice of the denial constituted good cause for his failing to request a hearing within 60 days. We affirm the Referee's finding that the denial was timely appealed, but with the following comment.

ORS 656.319 requires claimant to request a hearing on a denial "not later than the 60th day after the claimant was notified of the denial" nor later than the 180th day if claimant establishes good cause for his failure to file within 60 days. Further, OAR 438-05-065 states:

> "Notice of denial or other notice from which statutory time runs against a claimant shall be in writing and should in every case be delivered by registered or certified mail with return receipt requested. Notice by personal service meeting the requirements for service of a summons may be substituted for mailed notice."

The only attempt to provide notice to claimant within 60 days of issuance of the denial was the self-insured employer's certified mailing. This denial was returned unclaimed. Our rule clearly requires that the denial be "delivered," not just sent. We are unwilling to infer notice based on a denial that never reached the claimant. We recognize that, under limited circumstances, delivery (notice) can be inferred by mailing. See Margaret J. Sugden, 35 Van Natta 1251 (1983). However, in the present situation, we conclude that claimant did not have notice of the denial until it was sent through regular mail delivery in November 1985. Claimant appealed that denial a week after it was sent. Consequently, claimant's appeal was timely.

Claimant is entitled to an attorney fee on Board review for his active participation in these proceedings to protect his right to compensation. See Stovall v. Sally Salmon Seafood, 84 Or App 612 (April 8, 1987). Petshow v. Farm Bureau Ins. Co., 76 Or App 563 (1985). We find this issue to have been of average difficulty with an ordinary likelihood of success on Board review. A reasonable attorney fee is therefore awarded.

ORDER

The Referee's order dated August 20, 1986 is reversed in part and affirmed in part. That portion of the order that found the SAIF Corporation responsible for claimant's low back injury is reversed. SAIF's denial is reinstated. The self-insured employer's denial is set aside. The claim is remanded to the employer for processing according to law. The self-insured employer shall reimburse SAIF for claim costs paid in accordance with the Referee's order. Claimant is awarded a $400 attorney fee for services on Board review, to be paid by the self-insured employer. The remainder of the Referee's order, as supplemented, is affirmed.

ELGAN AMIDON, Claimant
Robert Grant, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

Own Motion 82-0249M
May 21, 1987
Own Motion Determination

The SAIF Corporation requested that the Board exercise its Own Motion authority and overturn claimant's permanent total disability award resulting from a March 8, 1964 low back injury. Following a series of procedural issues, we previously concluded that we had jurisdiction to reevaluate claimant's permanent total disability award. Elgan E. Amidon, 36 Van Natta 612 (1985). However, we found it necessary to refer this matter to the Hearings Division. id. The Referee was instructed to take evidence concerning the extent of claimant's permanent disability and to forward the record to us, along with a recommendation.

Following a hearing, Referee Mongrain found that SAIF had failed to establish that claimant's condition had improved or that he was presently able to perform a gainful and suitable occupation. See Kytola v. Boise Cascade Corp., 78 Or App 108 (1986). Consequently, Referee Mongrain recommended that we enter an order maintaining claimant's award of permanent total disability. In addition, based upon the protracted litigation process and the complexity of the issues involved, the Referee recommended that we allow an extraordinary attorney's fee of $4,000.

After conducting our review of the record and the respective contentions of the parties, we agree with the findings and conclusions reached by the Referee. Accordingly, we adopt the Referee's June 25, 1986 recommended order, as supplemented July 15, 1986, as our own. In addition, for services rendered in researching and preparing claimant's respondent's brief before the Board, claimant is awarded a reasonable attorney fee of $500. As with the extraordinary attorney fee, this fee shall be paid by the SAIF Corporation in addition to claimant's compensation. ORS 656.382(2); OAR 438-47-070(1).

IT IS SO ORDERED.

AUDREY M. CONSER, Claimant
Emmons, et al., Claimant's Attorneys
Jeff Gerner (SAIF), Defense Attorney

WCB 85-11674
May 21, 1987
Order on Review

Reviewed by Board Members Ferris and Lewis.

The SAIF Corporation requests review of Referee Seifert's order that set aside its denial of claimant's low back injury claim. The issue is compensability. We reverse.

Claimant alleges that she injured her low back on June 21, 1985 while employed by the Parks and Recreation Division of the Oregon Department of Transportation. According to claimant, she was removing sand and other debris from some steps with a back pack air blower when she misjudged a step, spun around, struck the blower against a railing, and was hit in the low back by the rebounding blower. There were no witnesses, although one of claimant's coworkers was working in the general vicinity when the accident allegedly occurred. The coworker did not testify. Claimant testified that she told a park ranger, Mr. Vaughn, of the incident. Vaughn did not appear at hearing either, however.

Claimant testified that she returned to park headquarters at the end of her shift. Claimant's supervisor, Mr. Tutor, was at the headquarters. However, he was not informed of claimant's accident at the time because, according to claimant, he "told everybody to get out because it was quitting time." Claimant worked for three more days before her next regularly-scheduled day off. On the third day, she worked in close proximity with her supervisor. Again, however, claimant did not inform him of the alleged work incident because, according to claimant, she "forgot" to mention it.

Claimant ultimately sought medical attention four days after the alleged incident. A June 25, 1985 hospital chartnote reads as follows: "Pain runs down back of neck to her back . . . Working [at a] park, lifting daily . . ."

The note does not mention claimant's low back or a specific trauma to that area. Another chartnote entered four days later continues to refer to chronic cervical pain resulting from a motor vehicle accident. Again, however, no mention of the low back or a specific work incident appears. Claimant asserts that the motor vehicle accident occurred as a result of an injury-related low back spasm that made her lose control of her vehicle. She did not return to work after the accident.

Claimant testified that she contacted Mr. Tutor's secretary on June 25, 1985, indicated that she was going to a physician and asked the secretary to pass the message to Tutor. She phoned once again on June 27th and spoke directly with Tutor. According to claimant's testimony, she specifically informed Tutor that she had injured her low back while using the blower. Tutor's contemporary documentation of the conversation, however, indicates that claimant mentioned going to a doctor for back pain, but said nothing regarding a work incident. Tutor telephoned claimant later the same day and informed her that she should pick up and fill out a claim form if she felt that her injury was related to her work. According to Tutor, claimant indicated that she would first consult with her attorney. She ultimately did file a claim form on June 30, 1985, alleging that she had incurred either an aggravation of a 1983 back injury, or a new injury in June 1985 while using the back pack blower.

Claimant's son generally corroborated claimant's version of the facts, although his testimony regarding the alleged accident was necessarily dependent on claimant's history. He testified that following the accident, claimant needed assistance in doing even minor tasks, such as getting out of bed. His recollection was that it was he, rather than claimant, who telephoned Mr. Tutor, but he could not remember whether Tutor was informed of claimant's alleged work-related incident.

Tutor testified that he saw claimant at the end of the workday in which she was allegedly injured, and that she exhibited no signs of injury. He also saw her several times approximately four days later, and she appeared healthy. No mention of a work incident was ever made to him in person or over the phone. According to Tutor, claimant called him on June 27, 1985 and indicated she was "sick" and that her doctor had told her to stay home for two days. Again, no mention was made of an alleged work incident.

Tutor testified that before the hearing, he had never heard claimant's current rendition of the circumstances surrounding her injury. He indicated that when she filed her claim form, she suggested that the injury may have originated in 1983, may have occurred from "sweeping sand," or may have resulted from packing the air blower. According to Tutor, claimant had never before represented that she was struck in the low back by the blower.

The Referee found the claim compensable, despite his observance that "claimant's recollection is less than precise, and the evidence is in some ways contradictory that she suffered the injury as alleged . . ." Despite his concerns, the Referee found claimant's version of the facts "sufficiently corroborated by the witnesses."

It is claimant's burden to prove her claim by a preponderance of the evidence, i.e., that it is more probable than not that her injury occurred as described. See Hutcheson v. Weyerhaeuser, 289 Or 51 (1979). After reviewing the record, we find that claimant has failed to sustain her burden. The evidence is in conflict. Whereas claimant says she told her supervisor and at least one other coworker of her injury soon after it occurred, the supervisor directly refutes that and the other coworker did not testify. Under such circumstances, the documentary record is of great importance.

The medical records authored soon after claimant's alleged work incident are essentially silent with regard to the low back. Neither do those records mention a work incident. Mr. Tutor's records entered a few days after the alleged incident are also silent with regard to a work related injury. Claimant's son did corroborate her testimony, but because he was not a witness to the alleged accident, his testimony was necessarily dependent on claimant's history. These factors, coupled with Mr. Tutor's testimony, leaves us unpersuaded that claimant's low back condition resulted from an accident at work. The Referee's order will be reversed.

ORDER

The Referee's order dated July 25, 1986 is reversed.

LAWRENCE E. OLDS, Claimant
Susan M. Connolly, Claimant's Attorney
Kate Donnelly (SAIF), Defense Attorney

WCB 86-05073
May 21, 1987
Order on Review

Reviewed by Board Members McMurdo and Lewis.

The SAIF Corporation requests review of that portion of Referee Myers' order that awarded claimant 160 degrees for 50 percent unscheduled permanent partial disability in lieu of a Determination Order award of 32 degrees for 10 percent unscheduled disability for a pulmonary condition. The issue is extent of unscheduled disability. We modify.

Claimant had been employed at a lumber mill for approximately 13 years when, in early 1985, he experienced breathing difficulties and other problems at work. He filed a claim for those problems, which was initially denied and ultimately accepted by SAIF. Claimant came under the care of Dr. Fowler, an internist. Fowler diagnosed hypersensitivity bronchitis/pharyngitis as a result of exposure to toxic chemicals.

In the fall of 1985, claimant was seen by Dr. Kirkpatrick, a psychiatrist, who opined that claimant's occupational exposure had resulted in considerable psychiatric conflicts and depression. Kirkpatrick did not believe, however, that claimant's psychiatric difficulties would affect his ability to work. It appears, however, that claimant's psychological reaction eventually resulted in physical manifestations, largely in the form of an ulcer condition. Dr. Fowler found that condition to be a sequela of the compensable occupational exposure.

In March 1986, claimant was seen by a second psychiatrist, Dr. Gardner. Gardner found neither physical pathology nor evidence of psychological problems. The claim was subsequently closed by Determination Order with an award of 10 percent unscheduled disability. The Referee raised claimant's award to 50 percent, finding that claimant was precluded not only from his regular work at the lumber mill, but also from all work involving chemical irritants.

Although we agree with the Referee that claimant has disability exceeding the 10 percent awarded by the Determination Order, we find the award of 50 percent to have been excessive. Claimant was 42 years of age at the time of the hearing and was a high school graduate. He had a wide range of prior work experience, including retail sales, bookkeeping, light mechanical work, warehousing, work at a service station, welding, and general labor. In addition, a vocational evaluation revealed that claimant had transferable skills in the areas of management, personnel, advertising and inventory. He has at least average intellectual ability and above-average verbal skills. The vocational counselor felt that claimant had excellent potential for reemployment, although he noted that claimant appeared hesitant to rejoin the work force.

We recognize that claimant's occupational exposure and its sequelae have resulted in physical disability. Claimant's problem, however, is fairly specific, i.e., he has a sensitivity to noxious chemicals. There is no persuasive evidence that he cannot return to his many prior employments, so long as he avoids noxious environments. Considering claimant's varied work history, transferable skills and other positive social/vocational factors, we conclude that claimant will be adequately compensated by an award of 30 percent unscheduled disability. The Referee's order will be modified accordingly.

ORDER

The Referee's order dated September 10, 1986 is modified. In lieu of the Referee's award, and in addition to the Determination Order's award of 10 percent (32 degrees) unscheduled permanent disability, claimant is awarded 20 percent (64 degrees) permanent disability, for a total to date of 30 percent (96 degrees) unscheduled permanent disability for his pulmonary condition. Claimant's attorney's fee shall be adjusted accordingly.

LYNDA J. PRICHARD, Claimant
Vick & Gutzler, Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 85-09793
May 21, 1987
Order on Review

Reviewed by Board Members Lewis and McMurdo.

Claimant requests review of Referee Seymour's order that upheld the self-insured employer's denial of claimant's industrial injury claim for the low back. The issue is compensability. We reverse.

Claimant is a former cannery worker who alleges that she strained her low back at work on July 17, 1985. Claimant testified that on that date she was working on a conveyor belt, sorting beans, when the belt malfunctioned and stopped. The beans, however, continued to be sent to the belt and soon a large pile developed. According to claimant, she attempted to move a large pile of beans off the belt when her back strain occurred.

Within an hour of the alleged injurious event, claimant reported to her supervisor that her back was hurting. The supervisor directed claimant to the company first aid station, where claimant received aspirin and was sent back to work. She continued to work until lunchtime, when she decided that she needed medical treatment. Later that evening, claimant reported to a hospital emergency room, where she was directed to Dr. Strum. Strum took claimant's history of an on-the-job accident and noted "marked muscle spasm" and tenderness in the lumbosacral area. The diagnosis was acute lumbosacral strain. Claimant's low back spasms continued into early August, 1985. A subsequent CT scan revealed objective findings.

The employer produced the testimony of three of claimant's coworkers. One was claimant's supervisor, who testified that claimant exhibited no pain behavior after reporting her injury. The supervisor also testified that on the day in question, few beans were being processed and that, while she was not always in a position to view claimant's work station, she had not observed an abnormal buildup of beans at anytime during the day. Two more coworkers also testified that the day in question was particularly slow and that a build up of beans would have been unlikely.

Dr. Strum was deposed. He felt claimant's condition was consistent with the history she gave regarding her injury, and that the magnitude of her symptoms suggested that a traumatic event had, in fact, occurred.

The Referee made no specific credibility finding, although he suggested that no witness was more or less credible than any other. He found the evidence to be in equipoise and upheld the insurer's denial.

It is claimant's burden to prove the compensability of her injury. Hutcheson v. Weyerhaeuser, 288 Or 51 (1979). In order to do so, she must persuade us that it is more likely than not that her injury occurred as she describes. After reviewing the record, we are persuaded that claimant sustained a compensable injury on July 17, 1985. No one disputes that she was suffering from a back strain on the day in question. The alleged injury was reported to claimant's supervisor within approximately an hour after it occurred. The medical evidence is persuasive that claimant suffered a traumatic event. No off-the-job causes have been suggested by the employer. Only the mechanism of the injury is in direct dispute. Claimant says it occurred when she moved a large pile of beans. Three other witnesses say that if there was a pile of beans at all, it was small.

We find that we are more persuaded by claimant's consistent history of an acute, trauma-related low back strain, as well as the supporting medical evidence, than we are concerned about the size of a hill of beans. We find that claimant was injured as she alleges and that the employer's denial must be set aside. This case was of ordinary difficulty and the usual probability of success for claimant at hearing and on review. A reasonable attorney fee is, therefore, awarded.

ORDER

The Referee's order dated May 6, 1986 is reversed. Claimant's claim is remanded to the self-insured employer for processing according to law. Claimant's attorney is awarded $1,250 for services at hearing and $600 for services on Board review, both fees to be paid by the self-insured employer.

JUDITH L. ROTELLA, Claimant
Pozzi, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 86-03731
May 21, 1987
Order on Review

Reviewed by Board Members Ferris and Lewis.

The insurer requests review of Referee Lipton's order that set aside its denial of claimant's claim for accidental injury or occupational disease for a situational stress reaction. The insurer also asks that we review the Referee's finding that its denial was unreasonable. The issues are compensability and the reasonableness of the insurer's denial.

We affirm the Referee's order on the merits. We find, however, that the insurer's denial was not unreasonable. The Referee appears to have found that the insurer did not have sufficient information upon which to base its denial. Finding, however, that there were "no amounts due" from which to calculate a penalty, the Referee did not assess one.

Our review of the record persuades us that at the time the insurer issued its denial, it had a legitimate doubt as to its liability. The resulting denial was, therefore, not unreasonable. See Emery v. Adjustco, et. al., 82 Or App 101 (1986).

ORDER

The Referee's order dated June 25, 1986 is reversed in

part and affirmed in part. That portion of the order that found the insurer's denial to have been unreasonable is reversed. The remainder of the order is affirmed. Claimant's attorney is awarded $600 for services on Board review, to be paid by the insurer.

GEORGE E. HODGES, Claimant
Darrell L. Cornelius, Claimant's Attorney
Davis, Bostwick, et al., Defense Attorneys

WCB 86-02834
May 22, 1987
Order on Review

Reviewed by Board Members McMurdo and Lewis.

Claimant requests review of Referee Menashe's order that: (1) upheld the insurer's denial of his aggravation and medical services claims for a back condition; and (2) declined to assess penalties and attorney fees for an allegedly unreasonable refusal to pay compensation. The issues on review are aggravation, penalties and attorney fees.

The Board affirms the Referee with the following comments. The treating physician's opportunity to observe claimant is a relevant factor, which is considered by the Board. Weiland v. SAIF, 64 Or App 810 (1983); Hamlin v. Roseburg Lumber, 30 Or App 615 (1977); but see Harris v. Farmers Co-op Creamery, 53 Or App 618 (1981). However, after our de novo review of claimant's lay testimony and the medical evidence, we find that the preponderance of the evidence fails to establish that claimant's compensable injury was a material contributing cause of any alleged worsening of his back condition.

ORDER

The Referee's order dated September 24, 1986 is affirmed.

KENNETH K. KESSEL, Claimant
Michael B. Dye, Claimant's Attorney
Brian R. Whitehead, Attorney
Merrily McCabe (SAIF), Defense Attorney

WCB 85-03895
May 22, 1987
Order on Review (Remanding)

Reviewed by Board Members McMurdo and Lewis.

Claimant requests review of those portions of Referee Nichols' order that upheld the SAIF Corporation's denial of claimant's industrial injury and occupational disease claims relating to his low back and rejected claimant's request for interim compensation. Claimant also contends that the Board should remand the case to the Referee with instructions to order the production of certain documents for possible inclusion in the record. The issues are remand, compensability and interim compensation.

Claimant's request for remand is granted. Prior to the hearing, claimant requested disclosure of claims information by SAIF in accordance with OAR 438-07-015(2), which provides:

> "(2) Documents pertaining to claims are obtained by mailing a copy of the Request for Hearing, or a written demand, to the insurer. Within fifteen (15) days of said mailing the insurer shall furnish the claimant, without cost, copies of all

> medical and vocational reports, records of compensation paid, and other documents pertaining to the claim(s) which are then or come to be in the possession of the insurer, except that evidence offered solely for impeachment need not be so disclosed. Failure to comply with this section may be considered unreasonable delay or refusal under ORS 656.262(10)."

SAIF generally complied with this request and forwarded a number of documents to claimant. One of these documents was a SAIF investigative report. The report mentioned six pages of typed notes provided by the employer. Claimant's attorney noticed that these notes were not included in the documents forwarded by SAIF and requested the Referee to order production of the documents. SAIF objected to the request on the ground that the documents constituted "impeachment evidence" under the rule.

The Referee reviewed the disputed documents prior to the hearing and ruled at the beginning of the hearing that claimant was not entitled to the documents at that time, stating: "[T]heir sole purpose in this hearing would be for impeachment . . . . The document will be returned to SAIF Corporation." SAIF did not introduce or otherwise reveal the contents of the documents during the course of the hearing.

In his brief on Board review, claimant contends that SAIF improperly used the "impeachment evidence" exception to the disclosure rule to withhold potentially relevant information from him. We agree. The rule requires an employer or insurer to disclose to the claimant prior to the hearing all documents pertaining to the claim, "except evidence offered solely for impeachment." The language of the rule requires either that the evidence be disclosed prior to the hearing or be offered at the time of the hearing. SAIF did neither in this case and effectively prevented claimant from examining the documents. Use of the impeachment evidence exception in this way could lead to obvious abuses which go to the very heart of the hearings process. We note that claimants have similar disclosure duties under subsection (3) of OAR 438-07-015.

We conclude, therefore, that this case should be remanded to the Referee and that SAIF should be required to provide the disputed documents to claimant unless it can convince the Referee that some other valid reason exists for their nondisclosure. Assuming that claimant is provided the documents, he should be allowed a reasonable time to examine them and to offer all or part of them for inclusion in the record. The Referee should then proceed to reconsider claimant's claim in light of the new evidence, if any.

ORDER

The Referee's order dated March 24, 1986 is vacated and the case is remanded to the Referee for further proceedings consistent with this order.

FRED L. SHEPPARD, Claimant
Yturri, et al., Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB 85-02300
May 22, 1987
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of Referee Leahy's order that: (1) declined to grant claimant permanent total disability; and (2) upheld a Determination Order's award of 65 percent (208 degrees) unscheduled permanent disability for a right shoulder injury. The issue on review is extent of disability, including permanent total disability.

Claimant was 62 years of age at the time of the hearing. He has a sixth grade education and no GED certificate. His work experience consists solely of general labor farm work and he has no training in other occupations.

Claimant has multiple preexisting disabilities. First, many years ago he sustained a right knee injury. According to claimant's testimony, the right knee "gives out" nearly every day and is painful when walking. Dr. Dahlin, the treating orthopedist, reported:

> "This [right knee] injury has resulted in persistent pain following the initial swelling. The pain is located medially and [is] related to weight bearing."

Second, in either 1959 or 1963 claimant sustained extensive soft tissue injuries of the left upper extremity, including a broken left wrist. Claimant testified that the wrist bothers him "quite a lot" and that he wears a leather wrist band "all the time." Claimant first began wearing the leather band in 1959. Again, Dr. Dahlin observed:

> "[Claimant] has weakness of his grip on the left as well as a popping sensation in the wrist and intermittent numbness of the left fingers."

Lastly, in August 1974 claimant suffered a myocardial infarction. A few months later, he was examined by Dr. Scott, who noted that claimant had made a good recovery, but that "his ability to do work is impaired." Nitroglycerine was prescribed. In 1979, claimant reported a recurrence of chest pain and was seen by Dr. Sanders. Dr. Sanders reported that claimant's chest pain was produced by work activity, such as lifting bales of hay. It was further noted that claimant had never used the previously prescribed nitroglycerin. Dr. Sanders advised claimant to stop smoking and rest a couple of days.

In September 1982, claimant sustained a compensable injury to his right shoulder. Thereafter, he treated with both Dr. Dahlin, and Dr. Squires, chiropractor. Dr. Squires diagnosed rotator cuff syndrome and treated with ultra sound therapy. Dr. Dahlin diagnosed, "[a]dhesive capsulitis, probably on the basis of a shoulder dislocation." Dr. Dahlin treated with steroid injection and intensive physical therapy.

In September 1983, claimant was referred to Dr. O'Brien, neurologist. Dr. O'Brien recommended right shoulder surgery. The

next month, claimant was seen by Dr. Stott, cardiologist. Dr. Stott diagnosed, "severe generalized arterosclerosis [sic]" with a recent increase in anginal symptoms. Because of claimant's precarious cardiac condition, Dr. Stott advised against surgical repair of the right shoulder.

Vocational rehabilitation was undertaken in January 1983. The vocational counselor testified that she worked hard to get claimant back to work. The counselor felt that claimant was generally highly motivated to return to work, although he had become briefly discouraged when in August 1983 Dr. Dahlin advised that he not return to modified work. Claimant's former employer testified that claimant could not perform his old job, but there might be some chores or tasks claimant could still perform.

The counselor initially testified that claimant was employable as a labor contractor, an inspector at a bottling plant, and a cashier at a service station. On cross-examination, however, she conceded that none of the aforementioned jobs had ever been proposed to claimant. In fact, she had not checked with any employers concerning any of these jobs to see if a person with claimant's qualifications would be a suitable candidate. Finally, she agreed that some of the proposed jobs were unrealistic given claimant's physical restrictions.

In September 1983, claimant's physical therapist opined that claimant's right shoulder condition had caused him to become a "one-handed person." The therapist concluded that any employment would have to be limited to one-handed activity.

That same month, Dr. Dahlin performed a closing examination. Dr. Dahlin reported that claimant had a permanent impairment of "18 percent to the whole man," and that he could perform any job not requiring repetitive prolonged motions of the right shoulder. However, Dr. Dahlin explained that the foregoing impairment rating pertained solely to claimant's right shoulder. That is, claimant's preexisting heart and left arm conditions contributed to a "greater" disability and qualified him for handicapped workers' reserve benefits.

In September 1983, Dr. O'Brien reported "many difficulties" pertaining to claimant's right shoulder, including a rotator cuff tear, bicipital tendinitis, mild fascitis, and sternoclavicular capsulitis. Dr. O'Brien recommended right shoulder surgery and concluded:

> "[G]iven the [claimant's] present state of condition, he certainly would not be employable. The only hope that he has to go through his life in an uncrippled condition would be to aggressively attempt to rehabilitate that shoulder in not only a medical but a physical therapy sense after surgery . . . ."

In October 1983, Dr. Stott examined claimant and diagnosed, "severe generalized arterosclerosis. [sic]" Dr. Stott reported:

> "[Claimant] has symptomatic coronary artery disease with recent progression of symptoms, symptomatic peripheral vascular

> disease with claudication, and he is markedly limited with his ability to exercise."

In November 1983, claimant's vocational counselor advised him to apply for Social Security Disability Income. Claimant did so, and was receiving such benefits at the time of the hearing. In July 1984, the counselor determined that vocational services were no longer appropriate given claimant's advanced age, his medical condition, his receipt of social security benefits, and his belief that he was totally disabled.

Dr. Johnson, orthopedist, performed an independent medical examination in May 1984. Dr. Johnson found that claimant had virtually no use of his right shoulder. Dr. Johnson concluded:

> "I feel this man has a fifty percent permanent partial impairment with loss of physical function as compared to the whole arm."

Lastly, in October 1985, Dr. O'Brien reexamined claimant. Dr. O'Brien reported that claimant's rotator cuff tear had worsened, that it was exquisitely tender, and that range of motion was rather limited. Dr. O'Brien concluded:

> "This [claimant] probably has a maximum impairment rangeing [sic] somewhat in the area of 18% but I feel that the important part of his rating will be in the disability factors which is an administrative function and not a medical function. I feel that one has to take into consideration his age of 62 and his precarious cardiac position. When one ponders about whether this patient should go back to work they can see that this is going to be impossible so again in his disability factors one has to consider his employability. . . . Were he not to have the cardiac condition the shoulder would be fixed and if it were fixed his employability would depend upon the type of recovery that he makes."

The Referee found that claimant was not permanently totally disabled. We disagree.

A worker may prove permanent total disability by showing that he is totally physically or medically incapable of performing regular gainful and suitable employment. See Brech v. SAIF, 72 Or App 388 (1985). Permanent total disability need not, however, derive solely from the worker's medical or physical incapacity. Emerson v. ITT Continental Baking Co., 45 Or App 1089 (1980). Accordingly, under the "odd-lot" doctrine, a worker's physical impairment as well as contributing nonmedical factors such as age, education, adaptability to nonphysical labor, and emotional conditions can establish permanent total disability. Clark v. Boise Cascade Co., 72 Or App 397 (1985).

A worker's preexisting disability is a relevant consideration. ORS 656.206(1)(a). Generally, disability must be

rated as it exists at the time of the hearing; that is, speculative assumptions regarding a worker's return to work prospects are not considered. Gettman v. SAIF, 289 Or 609 (1980). However, when a preexisting disability continues to worsen after the compensable injury, and the worsening is not related to the compensable injury, the preexisting disability is considered only as it existed at the time of the compensable injury. See Emmons v. SAIF, 34 Or App 603 (1978); Frank Mason, 34 Van Natta 568, aff'd mem, 60 Or App 786 (1982); John D. Kreutzer, 36 Van Natta 284 aff'd mem, 71 Or App 355 (1984). Lastly, under ORS 656.206(3), a worker is required to make reasonable efforts to obtain regular gainful employment, unless it would be "futile" to do so. Butcher v. SAIF, 45 Or App 318 (1983).

Here, the Referee found that claimant's preexisting heart disability was a "subsequent noncompensable condition." Therefore, the Referee considered only claimant's right shoulder injury in determining whether he was permanently totally disabled. The Referee did find, however, that claimant was permanently totally disabled because of his angina condition.

We find that claimant's disability, including all of his preexisting disabilities save for his heart condition, should be considered as it existed at the time of the hearing. See Gettman, supra. The heart condition, however, must be viewed as it existed at the time of claimant's compensable injury, disregarding any worsening of the condition thereafter. See Emmons, supra.

Here, claimant's compensable right shoulder injury resulted in a rotator cuff tear. In September 1983, Dr. O'Brien found claimant's shoulder extremely tender and opined that he was not employable. That same month, the physical therapist reported that employment opportunities would have to be limited to one-handed activity.

Claimant also has multiple preexisting disabilities. His right knee gives out frequently and he cannot walk without pain. His left wrist impairs his ability to grip and results in finger numbness. Lastly, claimant's heart condition arose in 1974. Shortly thereafter, Dr. Scott noted that claimant's ability to work was impaired. Five years later, work activity produced a recurrence of chest pain. Although it is not clear whether claimant medicated with nitroglycerin since that time, it is clear that he routinely carried nitroglycerin either on his person or in his car prior to October 1983. Furthermore, in October 1983, Dr. Scott diagnosed severe generalized arteriosclerosis.

The evidence establishes that claimant's preexisting heart disability worsened after the compensable right shoulder injury. The precise onset date, however, is not altogether clear. Claimant testified that he suffered a heart attack in "September" 1983, and that he was seen by Dr. Johnson, thereafter. Dr. Johnson did not examine claimant until October 18, 1983. That same day, claimant was seen by Dr. Stott who subsequently reported increased chest pain "[o]ver the last two weeks . . ." Consequently, we find that the worsening of claimant's preexisting heart disability, occurred some time after September 1983. On September 20, 1983, Dr. O'Brien did not refer to any increased chest pain or heart symptoms. However, at that time, Dr. O'Brien concluded that claimant "certainly would not be employable."

On Board review, the insurer argues that claimant was unable to have shoulder surgery solely because of his worsened heart condition. The insurer cites William J. Robinson, 38 Van Natta 1325 (1986), for the proposition that the claimant's disability must be judged "as though he had undergone surgery and retraining . . . ." The insurer has overstated our holding in Robinson. Although we do not consider the subsequent worsening of claimant's preexisting heart disability, we are unwilling to speculate about the results of both surgery and vocational retraining. See Gettman, 289 Or at 614.

Finally, the preponderance of the evidence establishes that claimant was willing to seek regular gainful employment and that he made reasonable efforts to obtain such employment. ORS 656.206(3). The vocational counselor testified that claimant was highly motivated to return to work and never refused to apply for any job. Only after Dr. Dahlin refused to release claimant to modified work, did he temporarily become pessimistic. Further, in July 1984 the vocational counselor, not claimant, recommended termination of further vocational services due to claimant's age, his shoulder condition, his worsened heart condition, his receipt of Social Security disability income, and his belief that he was totally disabled.

Accordingly, after conducting our de novo review, we find that claimant's multiple preexisting disabilities, his compensable right shoulder injury, his advanced age, his lack of education or training, and his work experience solely in heavy labor farm work, establish that he is permanently totally disabled under the "odd-lot" doctrine.

The insurer is allowed to offset the amount of permanent partial disability already paid pursuant to the Referee's order, as prepayment of claimant's permanent total disability award. Pacific Motor Trucking Co. v. Yeager, 64 Or App 28 (1983); Donald W. Wilkinson, 37 Van Natta 938 (1985).

ORDER

The Referee's order dated November 25, 1985, is reversed. Claimant is awarded permanent total disability benefits effective May 9, 1984. For his attorney's services at the hearing level and on Board review, claimant's attorney is awarded 25 percent of the increased compensation awarded by this order, not to exceed $3,000.

CHARLES T. BRENCE, Claimant
Michael B. Dye, Claimant's Attorney
Cowling & Heysell, Defense Attorneys
Arthur Stevens III (SAIF), Defense Attorney

WCB 85-14936, 85-15871 & 85-16044
May 28, 1987
Interim Order

Claimant has requested review of Referee Howell's order dated August 19, 1986. The primary issue before the Referee was responsibility between two insurers for claimant's low back condition. In addition, however, claimant represents that during the closing arguments following the hearing, the parties verbally stipulated that claimant's attorney fees, if any, would be paid in addition to, rather than out of, his compensation. Although claimant requested that the closing arguments be recorded, no party asked that they be transcribed. Claimant now asks that the Board order and bear the cost of a transcription of closing arguments.

Claimant's request is denied. However, should claimant wish to obtain a transcription, bearing the cost thereof, this case will be remanded to the Referee for consideration of the transcript and a determination of attorney fees. If claimant does not wish to obtain a transcription, the Board will review the case in the normal course. Claimant is hereby requested to inform the Board of his pleasure within ten days from the date of this order.

IT IS SO ORDERED.

KATHY K. CALKINS, Claimant
Tamblyn & Bush, Claimant's Attorneys
Edward C. Olson, Defense Attorney

WCB 84-02419
May 28, 1987
Order on Remand (Remanding)

This matter is before the Board on remand from the Court of Appeals. Calkins v. Westcraft Chair, Inc., 84 Or App 320 (1987). The court held that the doctrine of res judicata did not bar claimant's right hip claim. Consequently, the court reversed our order that had upheld the Referee's dismissal of the claim.

Inasmuch as the insurer's motion to dismiss was granted, the Referee did not have the opportunity to analyze and consider the merits of claimant's right hip claim. Under these circumstances, we conclude that this case should be remanded to the Referee for a decision on the claim's merits. See ORS 656.295(5). Accordingly, this matter is remanded to Referee Shebley for action consistent with the court's opinion and this order.

IT IS SO ORDERED.

EARL F. COOK, Claimant
Hayner, et al., Claimant's Attorneys
Cummins, et al., Defense Attorneys

WCB 85-00439
May 28, 1987
Order on Review

Reviewed by Board Members Ferris and McMurdo.

The self-insured employer requests review of Referee Quillinan's order, as adhered to on reconsideration, that found claimant to be permanently and totally disabled. The issue is whether claimant is entitled to that award. We reverse.

Claimant worked for the employer for many years, doing primarily heavy labor. His first injury, however, occurred in 1958 during work for another employer. That injury, which involved the low back, eventually required surgery. Claimant continued working as a log truck driver for several years thereafter. In 1974 he underwent noncompensable ulcer surgery. Three years later, he had surgery to repair the left tympanic membrane. In January 1979, claimant suffered a neck injury after hitting his head on an overhead crossbeam. The previous back injury aggravated in 1982, and in June 1983 a right shoulder bursitis condition was diagnosed.

In November 1983, while employed by the present employer, claimant suffered his last industrial injury. He fell approximately ten feet off of a platform, suffering injuries to his left arm, right hip and low back. Claimant was prescribed medication, physical therapy and a cervical collar. It was later determined that he had injured his kidneys in the accident, as well.

In December 1983, claimant saw Dr. Holbert for right shoulder pain. Holbert discovered a large tear of the right rotator cuff and surgery was performed. In April 1984, claimant was ultimately released to work not involving tasks above shoulder level. He returned to work for the present employer, but after eight days the mill shut down and resulted in his being laid off. At the same time, Dr. Holbert declared claimant medically stationary with regard to the right shoulder. Claimant then began to complain to Dr. Lindsay that his back pain had returned, prohibiting any kind of work.

In August 1984, claimant was examined by an Orthopaedic Consultants panel, who found him to have "mildly moderate" neck and low back impairment and "mild" impairment of the right shoulder. The panel felt that the impairment resulting from claimant's most recent injury was "minimal." Dr. Lindsay agreed with the panel's assessment, but opined that claimant would likely be unable to return to gainful employment. A December 13, 1984 Determination Order thereafter awarded claimant 50 percent unscheduled permanent partial disability.

One year later, Dr. Lindsay completed a physical capacities form in which he indicated that claimant could sit, stand and walk up to three hours per workday, and lift and carry up to 10 pounds. It was further his opinion that claimant could not bend, climb, reach, work in high places or work around moving machinery. By January 1986, Lindsay noted that claimant continued to have pain in his legs, arms and shoulders, but appeared to be doing relatively well.

Ms. Shell, a certified rehabilitation counselor, testified that she provided vocational assistance to claimant in 1984. She found him to have transferable skills and a good work record. Although she did not feel that claimant was capable of working 40 hours per week, she found from Dr. Lindsay's December 1985 physical capacities report that he could work part-time. She had tentatively identified several positions for which claimant had apparent interest and capabilities at the time the vocational file was closed. According to Ms. Shell, closure was effected because of claimant's express interest in pursuing self-employment.

Claimant testified that he was 61 years of age at the time of the hearing and that he had completed the eighth grade. He had been a dryer feeder for the employer for approximately 15 years at the time of the November 1983 accident. He testified that his back is constantly painful, restricting the amount of time he can sit. He indicated that his right shoulder is painful to the extent that it is difficult for him to hammer a nail without contracting his arm into a bent position. He stated that he does not bend at all because of pain and that he cannot do overhead work. He indicated that he can ride in an auto "if I don't ride too far," and if he can make frequent stops. He has not worked since attempting a short return to the mill after the 1983 injury. Neither does it appear that he has actively sought work.

Claimant testified that during the summer of 1985 he took a fishing trip to Crane Prairie Reservoir in the Cascade Mountains. He stated that it was necessary for him to stop his motor home and rest every 40 to 50 miles. He further indicated that he never drives if there is someone with him who can do the

driving. He indicated that he avoids heights because of balance problems, does not bend or jump, and does no carpentry work because of pain. He stated that he cannot climb and cannot reach out in front of him.

The employer then produced the testimony of Mr. Pearne, a private investigator retained by the employer to conduct surveillance of claimant during the summer and fall of 1985. Pearne's surveillance covered several days during the period. According to Pearne, claimant was generally actively engaged in various tasks during the time he was observed. Pearne testified that claimant engaged in the following activities during the period of investigation: He drove his travel home 218 miles from Coos Bay to Crane Prairie Reservoir, making only one stop for lunch and a second brief stop to confer with another driver. He assisted in positioning a boat used for fishing near the reservoir. He performed carpentry work on a utility trailer at his home, using hammers, nails and saws, once working for an hour and forty minutes without a break. He used a gasoline-powered weed trimmer around his premises. He used a broom to sweep the area around his house and garage for approximately 35 minutes without a break. He went under his porch to do carpentry repairs and was observed carrying two ten foot planks and sheets of plywood across his yard.

The investigator also produced two unedited surveillance films of claimant engaged in various activities. In one film, he is seen jumping down onto a trailer hitch in an attempt to get it properly seated. He is seen at work on the utility trailer, hammering nails with no apparent difficulty. He is observed carrying what appears to be a barrel with another man. Claimant later explained that the barrel contained dirt and weighed approximately 50 pounds. Claimant is seen using the weed trimmer and climbing a side hill near his home to do trimming. He is seen on top of his travel home, securing a boat to the roof.

The films do not depict a man who can complete tasks in a vigorous fashion. They do, however, depict someone who is active and who is obviously capable of doing a number of physical tasks. We find claimant's testimony and the rather severe physical restrictions suggested by Dr. Lindsay to be somewhat inconsistent with the level of claimant's activity depicted in the surveillance films. We agree with Ms. Shell's opinion that claimant likely can work part-time. Accordingly, claimant has not proved that he is permanently and totally disabled, as that phrase is used in ORS 656.206(1).

Although claimant is not permanently totally disabled, we find that he is entitled to an increased award of unscheduled disability over the 50 percent provided by way of the December 1984 Determination Order. After considering claimant's age, education, work history, physical impairment, preexisting disabilities and other social and vocational factors, we find that he will be adequately compensated by an award of 75 percent unscheduled permanent partial disability. This award is in lieu of and not in addition to any previous award or awards. The insurer is allowed to offset award payments made to date against the 75 percent granted by this order.

ORDER

The Referee's order dated May 30, 1986, as amended on

June 11, 1986 and adhered to on reconsideration on September 8, 1986, is reversed. In lieu of the Referee's award of permanent total disability and not in addition to any previous awards, claimant is awarded 240 degrees for 75 percent unscheduled permanent partial disability. Claimant's attorney's fee shall be adjusted accordingly.

JAMES W. HAHN, Claimant
Huffman, et al., Claimant's Attorneys
Stoel, et al., Defense Attorneys

WCB 85-15376
May 28, 1987
Order on Review

Reviewed by Board Members McMurdo and Lewis.

The self-insured employer requests review of Referee Lipton's order, as adhered to on reconsideration, that: (1) awarded claimant 192 degrees for 60 percent unscheduled permanent partial disability, in lieu of prior awards of 96 degrees for 30 percent unscheduled disability for the left shoulder; and (2) denied the employer's request that the record be reopened for the taking of additional evidence. The issues are extent of unscheduled disability and the employer's request that the record be reopened. The employer requests that we remand this case to the Referee in the event that we affirm his award of unscheduled disability. We reverse the Referee's award.

Claimant is a former machinist who compensably injured his left shoulder in March 1981. Dr. Fry diagnosed a shoulder strain and impingement syndrome, for which claimant underwent an acromionectomy approximately six weeks after his injury. Prior to the injury, claimant had been treated for recurrent left shoulder pain. Following surgery, he returned to his pre-injury job, but experienced pain when lifting his arms above the shoulder level. In July 1981, Dr. Fry suggested that claimant not do overhead work, although he added: "All-in-all, I believe he is getting along quite well at this point."

In April 1982, claimant was examined by Dr. Puziss, an orthopedic surgeon. Puziss found claimant to have "minimal" permanent impairment with respect to the left shoulder, although he agreed with Dr. Fry that claimant should not do overhead work with the left arm. Claimant was then seen by Dr. Platt, a neurologist whose studies showed no "significant neurologic components of the patient's complaints." A Determination Order issued on May 13, 1982, awarding claimant periods of temporary disability and 10 percent unscheduled permanent disability for the left shoulder.

Claimant thereafter continued to experience shoulder symptoms and was taken off work for a brief period in early 1983. He was then examined by Dr. Langston, an orthopedist, who opined that claimant's left shoulder impairment was in the "mild" range. Langston did not feel that further treatment was needed. Once claimant's claim was again closed, a second Determination Order awarded an additional five percent unscheduled disability. Thereafter, claimant was referred for vocational assistance. He was ultimately reemployed by his employer as a machinist and model-maker technician.

By way of an April 27, 1984 Stipulated Order of Dismissal, claimant was awarded an additional 10 percent unscheduled disability. An October 18, 1985 Determination Order

increased the award by another five percent, bringing the total award to 30 percent. Following yet another reopening, the claim was closed without an additional award of permanent disability. Claimant requested a hearing.

Claimant was the only witness at hearing. He testified that at the time of his injury, he was earning approximately $21,800 per year. At the time of the hearing, his salary was $21,000. He was 41 years of age, had a 12th grade education and two years of college credit. Although he testified that he was functionally illiterate upon graduation from high school, he achieved a 6th grade reading level through post-injury adult education. He drives a car and does his own auto repairs. Claimant testified that a week before hearing, he had undergone a semi-annual performance review of his work. He characterized it as "great," describing the above-average quality and quantity of his work, as well as his "perfect" attendance.

The Referee found claimant's current employment "highly specialized," and arranged largely through the employer's cooperation. He also found claimant to suffer from "physical restrictions and educational deficits [that] significantly restrict his opportunities to perform jobs paying anything comparable to his present wage, much less his wage at injury." Based on these factors, the Referee doubled claimant's existing award, bringing his total award to 60 percent.

We find the Referee's award to have been excessive. While claimant has clearly suffered permanent disability as a result of his compensable injury, we find that he was adequately compensated by the awards he had received prior to the hearing. At 41, claimant is relatively young. While he has problems reading, he has a high school diploma and two years of post-graduation community college instruction. He was successfully employed at the time of the hearing in a job whose wage approximated that which he was earning at the time of his injury. There is no persuasive evidence that claimant's current job was specially created for him, and it is noteworthy that despite the employer's 2,000 layoffs shortly before the hearing, claimant's position survived. These factors, coupled with the medical evidence that claimant's permanent impairment is "mild" at most, lead us to conclude that the 30 percent unscheduled disability awarded him prior to the hearing was adequate. The Referee's award of additional unscheduled disability will be reversed.

ORDER

The Referee's order dated September 10, 1986 is reversed.

CLIFFORD L. HAINES, Claimant
Pozzi, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 85-14168
May 28, 1987
Order on Review

Reviewed by Board Members McMurdo and Ferris.

Claimant requests review of Referee Podnar's order that dismissed his hearing request for lack of jurisdiction. Claimant requests that: (1) the case be remanded to allow the Referee to hear all relevant evidence concerning jurisdiction; or (2) should we reverse the Referee's jurisdictional finding, the case be

remanded for the taking of additional evidence concerning extent of unscheduled permanent disability, penalties and attorney fees. The issues are jurisdiction and remand.

In July and September 1983 claimant filed occupational disease claims for asbestos exposure against Kaiser Shipbuilding Company and Commercial Iron Works. SAIF Corporation, insurer for both employers, denied the claims. Claimant timely appealed the denials. In May 1984 SAIF entered into a stipulation with claimant that accepted the claim against Commercial Iron Works and dismissed the claim against Kaiser Shipbuilding.

On June 20, 1984 SAIF issued a Notice of Closure, stating that claimant had suffered no permanent disability as a result of his occupational disease. The notice fully complied with the requirements of ORS 656.268(3) and included claimant's right to request a determination from the Evaluation Division within one year of the mailing date. In July 1985 claimant requested and received discovery from SAIF. In addition to a copy of the June 20, 1984 Notice of Closure, the discovery contained copies of four different Notices of Closure. The four copies all had issuance dates of August 22, 1984.

On July 26, 1985 claimant asked the Evaluation Division to issue a Determination Order concerning the August 1984 Notice of Closure. Initially, the Evaluation Division denied the request as it had not been made within one year of the original June 20, 1984 Notice of Closure. Subsequently, the Evaluation Division reconsidered its position and issued a Determination Order on November 8, 1985. The Determination Order awarded claimant 75 percent unscheduled permanent disability. On March 5, 1986, a second Determination Order was issued rescinding the first. The new Determination Order stated that the correct date of the Notice of Closure was June 20, 1984 and that the request for review was beyond one year. Consequently, the Evaluation Division concluded that it lacked jurisdiction.

Claimant sought penalties and attorney fees for improper claims processing and additional unscheduled permanent disability beyond that awarded by the November 8, 1985 Determination Order. SAIF moved to dismiss claimant's request for hearing, contending that the November 8, 1985 Determination Order was invalid and that the Referee lacked jurisdiction.

After hearing the first witness testify, the Referee requested information from the parties. The attorneys acknowledged that claimant had never directly received any of the August 22, 1984 Notices of Closure. Claimant knew of the notices only after his attorney received discovery from SAIF in July 1985. Consequently, the Referee concluded that only the June 20, 1984 Notice of Closure was valid. Despite claimant's request to present additional evidence, the Referee granted SAIF's motion and dismissed the hearing. Following the ruling, the Referee left the hearing room. The record was left open for claimant to make an offer of proof.

Without the aid of a Referee, the parties presented additional evidence from numerous witnesses. The testimony focused on the source of the altered Notices of Closure. A thorough review of the testimony indicates that the altered copies were neither new nor amended Notices of Closure. Further, the

evidence suggests that the alterations were made by the Compliance Division, after receipt of its copy of the June 20, 1984 Notice of Closure.

We agree that the Referee erred in not allowing claimant to present all relevant evidence concerning the source of the Notices of Closure. We also acknowledge that the Referee should have remained at the hearing to rule on evidentiary matters arising from the testimony of the subsequent witnesses, after allowing claimant to make an offer of proof. However, claimant was able to fully present all evidence regarding the Notices of Closure. After the close of hearing, SAIF submitted an additional exhibit and affidavit for supplemental inclusion in the record. The affidavit and supplemental exhibit were not properly submitted and therefore have not been considered on review. Furthermore, after considering the record in its entirety, we conclude that the record is sufficiently developed that remand is not necessary. See ORS 656.295(5).

On the merits, we agree with the Referee that only the June 20, 1984 Notice of Closure was valid. Consequently, the Referee properly granted SAIF's motion to dismiss.

ORS 656.268(3) states that "[t]he insurer or self-insured employer shall issue a notice of closure of such a claim to the worker and to the Workers' Compensation Department." Only the June 20, 1984 Notice of Closure was sent to claimant as provided by statute. Further, no evidence was presented that claimant's claim was ever reopened or an amended Notice of Closure issued after June 20, 1984. As a result, the altered copies of the Notices of Closure were not valid and claimant had only until June 20, 1985 to request a Determination Order. Since the request for a Determination Order was not made until July 1985, the resulting November 8, 1985 Determination Order was invalid. Consequently, the Referee properly granted SAIF's motion to dismiss.

Claimant asserts that even if the June 20, 1984 Notice of Closure is valid, SAIF still had an affirmative duty to submit the claim to the Evaluations Division pursuant to ORS 656.262(12) as claimant had apparent permanent disability. However, ORS 656.262(12) only applies to claims that are nondisabling and subsequently become disabling. See Davison v. SAIF, 80 Or App 541 (1986). Here, claimant's claim was accepted as a disabling injury by the May 1984 stipulation and properly closed pursuant to ORS 656.283(3) with the June 20, 1984 Notice of Closure. Thus, claimant had one year from June 20, 1984 to challenge that determination.

ORDER

The Referee's order date June 27, 1986, as supplemented, is affirmed.

ROY J. HOLLOWAY, Claimant
WILFORD MAIN dba WILFORD L. MAIN TRUCKING, Employer
W.D. Bates, Claimant's Attorney
David C. Force, Attorney
Lester Huntsinger (SAIF), Defense Attorney
Carl Davis, Ass't. Attorney General

WCB 85-09258 & 85-05017
May 28, 1987
Order on Review

Reviewed by Board Members Lewis and McMurdo.

Wilford L. Main (Main), doing business as Wilford L. Main Trucking, the noncomplying employer, requests review of that portion of Referee Myers' order that dismissed his request for hearing for lack of jurisdiction. On review, Main contends that the Referee had jurisdiction to grant his request to prohibit the Workers' Compensation Department from seeking reimbursement from him pursuant to ORS 656.054(3).

The Workers' Compensation Department has requested that this matter be remanded for hearing. We deny the request. After conducting our de novo review, we find that the record has not been "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(5). Furthermore, it has not been shown that material evidence was unobtainable with due diligence before the hearing. Delfina P. Lopez, 37 Van Natta 164, 170 (1985).

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

The Board and the Hearings Division are empowered to decide all cases, disputes and controversies regarding matters concerning a claim under ORS 656.001 to 656.794, and for conducting such other hearings and proceedings as may be prescribed by law. ORS 656.708(3); 656.726(2). The Board is also authorized to determine those matters concerning a claim in which "a worker's right to receive compensation, or the amount thereof, are directly in issue." ORS 656.704(3); Petshow v. Portland Bottling Co., 62 Or App 614, 617 (1983). Finally, a noncomplying employer is entitled to request a hearing to challenge the compensability of a claim accepted by the SAIF Corporation on its behalf. OAR 436-80-060(1)(c), (d).

Main did not challenge the order issued by the Workers' Compensation Department which found him to be a noncomplying employer. Since this order became final by operation of law, he cannot dispute its ultimate findings. However, Main did avail himself of his right to request a hearing concerning SAIF's acceptance of the claim. Yet, since his objection was more than 60 days from the date the claim was referred to SAIF, his retroactive denial would be permissible only if SAIF's acceptance had been prompted by the illegal activities referred to in Bauman v. SAIF, 295 Or 788 (1983). See Stephen L. Dokey, 38 Van Natta 1560 (1986).

Thus, Main was furnished an opportunity to contest the claim's compensability. However, because of SAIF's prior acceptance, he was required to prove that the approval resulted from fraud, misrepresentation, or illegal activity. See Bauman v. SAIF, supra; Stephen L. Dokey, supra. Inasmuch as the record does not establish that SAIF's acceptance was attributable to any of these illegal activities, the claim is considered compensable as a matter of law.

Admittedly, Main's burden of proof was complicated by SAIF's apparently dilatory claims processing. Furthermore, we are mindful of the potential due process ramifications which arise from this situation. Yet, as we stated in Dokey, Bauman does not distinguish between retroactive denials made by private insurers and those made by insurers assigned by operation of law. Accordingly, we conclude that we must apply Bauman to this case as we would any other.

Contending that SAIF's claims processing effectively revoked his rights to contest the claim's compensability, Main requested an order prohibiting the Department from seeking reimbursement pursuant to ORS 656.054(3). The Referee correctly held that the Hearings Division lacked jurisdiction to consider this request. Once the Department's noncompliance order became final and the claim was referred to SAIF, it assumed responsibility for all processing matters. See ORS 656.054(1). Therefore, we conclude that Main is foreclosed from raising objections to SAIF's processing decision in this forum. However, the reasonableness of SAIF's administrative costs could eventually be litigated through civil proceedings should the Director subsequently attempt to recover these costs. See ORS 656.054(3).

ORDER

The Referee's order dated June 10, 1986, as supplemented herein, is affirmed.

RICHARD G. KASPER, Claimant
Emmons, et al., Claimant's Attorneys
Merrily McCabe (SAIF), Defense Attorney

WCB 84-08210
May 28, 1987
Order on Review

Reviewed by the Board en banc.

The SAIF Corporation requests review of Referee Howell's order that: (1) set aside the disputed claim settlement portion of a stipulation agreement; and (2) set aside its denial of claimant's aggravation claim for a back condition. On review, SAIF contends that the settlement should be reinstated and that claimant's compensable condition has not worsened. We agree and reverse.

Claimant was 55 years of age at the time of hearing. He has a lengthy history of back problems, dating from 1952. In 1962, he suffered a low back injury while working for a prior employer. This injury resulted in a low back fusion, for which he received permanent disability equivalent to 65 percent of an arm. By 1974, claimant was suffering from degenerative changes in the cervical and lumbar spine. In July 1974, he was injured in a motor vehicle accident while working for a previous employer. Following conservative treatment, he received 15 percent unscheduled permanent disability for his cervical and dorsal spine by virtue of an October 1976 stipulation.

In 1977 claimant began working for SAIF's insured as a truck driver. He continued to receive periodic chiropractic treatments from Dr. Schmidt. In December 1980 and March 1981, claimant filed claims concerning his back and neck pain. A hearing concerning the claims was convened in February 1982. After consolidating the two claims, a prior Referee found SAIF

responsible. The Referee stated that the degeneration in claimant's cervical, dorsal, and lumbar spine had been accelerated by his work exposure for SAIF's insured. In reaching this decision, the Referee was persuaded by Dr. Schmidt's opinion that the symptoms of claimant's preexisting condition had worsened.

In May 1982, claimant was examined by a panel of physicians from BBV Medical Services. In the panel's opinion, claimant's symptoms were a natural progression of his preexisting osteoarthritis and a residual of his prior injuries and fusion. The panel concluded that claimant's permanent disability would persist because of his on-going arthritic problem. Dr. Schmidt generally concurred with the panel's report.

A June 1982 Determination Order closed the claim, awarding claimant 10 percent unscheduled permanent disability for his low back. Claimant briefly returned to work. However, his symptoms soon increased, prompting Dr. Schmidt to take him off work.

In November 1982 Dr. Degge, orthopedist, performed an independent medical examination. Concluding that claimant's recent exacerbation represented a low back strain which had resolved, Dr. Degge attributed the ongoing symptoms to the progression of degenerative arthritis throughout the cervical, dorsal, and lumbar areas. In Dr. Degge's opinion, no increase in claimant's permanent disability award was indicated, although the total loss of lower back function was moderately severe due to the degenerative arthritic condition.

Thereafter, SAIF denied claimant's aggravation claim. Yet, by virtue of a March 1983 stipulation, the claim was reopened and claimant's appeal from the June 1982 Determination Order was dismissed.

In April 1983 claimant was examined by Dr. Tilden, chiropractor. Dr. Tilden essentially agreed with Dr. Degge's assessment. In Dr. Tilden's opinion, claimant's symptoms were entirely related to his ongoing degenerative joint disease. Furthermore, Dr. Tilden concluded that claimant's arthritic condition had not been materially worsened as a result of his 1980 compensable injury.

Dr. Schmidt did not agree with the reports of Drs. Degge and Tilden. Specifically, Dr. Schmidt opined that claimant's problem was definitely related to his occupation and the multiple injuries that he had sustained. In addition, Dr. Schmidt did not recommend that claimant return to work, even in a modified position.

The claim was reclosed in May 1983. Claimant received no additional permanent disability award. He did not return to work and continued to treat with Dr. Schmidt.

In August 1983 claimant was examined by Dr. Burr, orthopedist. Claimant attributed his 1962 low back fusion to a 1960 truck-train accident. He also mentioned a 1969 incident, where a heavy weight had dropped on his shoulders causing upper shoulder and neck pain. Claimant related his 1981 problems to driving on logging roads in a "bad cab." Dr. Burr diagnosed degenerative arthritis in the cervical and lumbar spine. In

Dr. Burr's opinion, claimant's symptoms were due to this arthritic condition. Thereafter, SAIF denied responsibility for claimant's osteoarthritis.

In February 1984, at Dr. Schmidt's request, claimant was examined by Dr. Cash, chiropractor. Dr. Cash reported that claimant suffered from a degenerative joint condition and arthritic syndrome. Dr. Cash opined that this condition had been materially worsened by claimant's 1980 and 1981 truck driving activities and low back incidents. Consequently, Dr. Cash concluded that a portion of claimant's ongoing pain syndrome was attributable to his compensable claim.

In March 1984 the parties entered into a "Settlement Stipulation." The parties acknowledged that a bona fide dispute existed concerning the compensability of claimant's osteoarthritis. Therefore, in return for $7,720, claimant agreed that SAIF's denial remained in full force and effect. Furthermore, claimant agreed that he would be responsible for medical treatment for his osteoarthritic condition, both in the past and in the future. However, the parties agreed that SAIF remained responsible for any conditions related to the 1980 compensable injury. Finally, in return for the dismissal of his request for hearing concerning the May 1983 Determination Order, claimant received 40 percent unscheduled permanent disability for his low back.

Within one month of this agreement, Dr. Schmidt reported that claimant's low back pain had increased. Dr. Schmidt related this "aggravation" to claimant's 1980 industrial injury. In April 1984 Dr. Cash reexamined claimant. Contrary to his February 1984 report, Dr. Cash attributed claimant's discomfort to a biomechanical imbalance rather than an arthritic syndrome. Dr. Cash did not discuss the relationship, if any, between claimant's discomfort and the compensable injury.

In July 1984 Dr. Rosenbaum performed an independent medical examination. Claimant's condition was diagnosed as degenerative osteoarthritis of the cervical, lumbar, and dorsal spine. Finding no evidence that claimant's preexisting arthritis had been worsened by the July 1980 injury, Dr. Rosenbaum concluded that claimant's current condition and ongoing treatment were entirely the result of the natural progression of his arthritis. In addition, Dr. Rosenbaum opined that there had been no change in claimant's arthritic disease since the March 1984 settlement.

Thereafter, SAIF denied responsibility for claimant's aggravation claim. Relying on its October 1983 denial and the March 1984 settlement, SAIF contended that claimant's current treatment was related to the noncompensable osteoarthritis.

In September 1984 Dr. Schmidt opined that claimant's condition "did indeed worsen following his compensation agreement on 3-13-83 [sic]." Dr. Schmidt further concluded that claimant's compensable injury had compounded his previous problem and caused further aggravation to the spine. Contrary to his earlier opinions, Dr. Schmidt later stated that claimant's recent acute episodes were related to irritations to the nerve roots rather than to osteoarthritis.

In February 1985 claimant was examined by Dr. Llewellyn, chiropractor. Dr. Llewellyn concluded that claimant was suffering from a degenerative process which was a by-product of his multiple low back injuries. However, in Dr. Llewellyn's opinion, this degeneration was not the cause of claimant's need for treatment. Rather, claimant's severe low back impairment and continued need for treatment was attributable to his 1980-81 industrial injuries.

The Referee found that the prior Referee had held that claimant's work worsened his preexisting degenerative condition. Thus, the Referee concluded that to the extent the March 1984 settlement attempted to settle a dispute concerning that issue, it was invalid. Consequently, the disputed claim settlement portion of the March 1984 stipulation was set aside. The Referee reasoned that whether claimant's osteoarthritis remained related to his employment and whether that condition supported an aggravation claim was a viable issue of fact.

Turning to the aggravation claim, the Referee had "very serious reservations" concerning the apparent reversals of opinion contained in the recent reports of Drs. Cash and Schmidt. However, the contrary opinions, which attributed claimant's symptoms to his degenerative condition, were based on the premise that claimant's arthritis was unrelated to the compensable injury. The Referee reasoned that this premise had been contradicted by the prior Referee's findings. Accordingly, the Referee was "forced to find that a preponderance of the evidence as a whole shows that claimant's condition worsened as a result either of his industrial strain or his industrially advanced/accelerated degenerative condition."

In any case where there is a bona fide dispute over compensability of a claim, the parties may, with the approval of a Referee, the Board or the court, by agreement make such disposition of the claim as is considered reasonable. ORS 656.289(4). The legislature must have intended that we exercise our own independent judgment in determining whether a bona fide dispute over compensability exists between the parties. Arlie Johns, 32 Van Natta 88 (1981), aff'd mem. 58 Or App 534 (1982). We regard vacating prior settlements to be an extraordinary remedy to be granted sparingly only in the most extreme situations. Mary Lou Claypool, 34 Van Natta 943, 946 (1982); James Leppe, 31 Van Natta 130 (1981).

The record fails to establish that the dispute settled by the March 1984 settlement was not bona fide. See Roberts v. Willamette Industries, 82 Or App 188 (1986). Consequently, we conclude that the disputed claim settlement should not have been set aside.

The prior Referee was persuaded that claimant's work exposure had worsened his preexisting degenerative condition in that the condition's symptoms had been accelerated. Thus, claimant's then-existing symptoms from his preexisting condition were found attributable to his compensable claim for "neck and lower back pain." This conclusion did not formally resolve SAIF's continuing responsibility for claimant's underlying degenerative condition or its symptoms. Moreover, the Referee's finding did not foreclose the theoretical possibility that a future issue would arise regarding whether the compensable injury remained a material contributing cause of claimant's symptoms from his

preexisting degenerative condition. See e.g., Aldrich v. SAIF, 71 Or App 168, 172-73 (1984).

The aforementioned issue apparently arose and eventually culminated in the March 1984 disputed claim settlement. Pursuant to the settlement's terms, SAIF did not forsake its continuing responsibility for conditions materially related to claimant's compensable claim. Instead, the parties stipulated that the past, present, and future symptoms attributable to claimant's preexisting osteoarthritic condition were not materially related to his compensable 1980 claim.

We turn to the aggravation claim. To establish a claim for aggravation, claimant must prove that the condition resulting from his compensable injury has worsened since the last award or arrangement of compensation. ORS 656.273(1). Claimant is not required to prove a worsening of his underlying condition, as opposed to symptoms. Consolidated Freightways v. Foushee, 78 Or App 509, rev den 301 Or 338 (1986). However, he is required to prove that this flare-up of symptomatic pain rendered him more disabled than he was at the time of the last arrangement of compensation. ORS 656.273; Smith v. SAIF, 302 Or 396 (1986); Gwynn v. SAIF, 84 Or App 67 (1987).

Following our de novo review of the medical and lay evidence, we are not persuaded that claimant's condition resulting from his 1980 compensable injury has worsened since the March 1984 arrangement of compensation. The preponderance of the persuasive medical evidence suggests that claimant's current condition is attributable to his underlying osteoarthritic condition. As discussed above, this condition is not compensable. Furthermore, assuming for the sake of argument that claimant's current symptoms are related to his compensable injury, we find that this episode merely represents a recurrence of symptoms which was anticipated at the time of the last arrangement of compensation. Accordingly, we conclude that his aggravation claim is not compensable.

ORDER

The Referee's orders dated May 28, 1985 and June 18, 1985 are reversed. The March 16, 1984 "Stipulated Settlement" is reinstated in its entirety. The SAIF Corporation's July 26, 1984 denial is reinstated and upheld.

Board Member Lewis Dissenting:

I respectfully dissent.

Claimant suffered an injury on July 15, 1980 for which he filed a claim. The claim was initially denied. In February 1982, the denial was set aside. In his Opinion and Order the Referee stated "[t]here seems little doubt that the claimant's multiple back injuries have caused or accelerated the conditions he now has: spondylosis, osteoarthritis and degenerative disc disease." He further stated "I am persuaded . . . that the degeneration in the claimant's back -- in the cervical, dorsal and lumbar areas -- was accelerated by the claimant's work for Santiam [employer] in 1980 and in March 1981." The Referee's 1982 order left no room for subsequent speculation concerning the compensability of claimant's osteoarthritis condition. The order was not appealed.

A worker cannot release any rights under ORS 656.001 to ORS 656.794. ORS 656.236(1). However, "in any case where there is a bona fide dispute over compensability of a claim, the parties may, with the approval of a referee, the board or the court, by agreement make such disposition of the claim as is considered reasonable." ORS 656.289(4).

Like the Referee, I am unable to conclude that a bona fide dispute over the compensability of claimant's osteoarthritis condition could exist in light of the February 1982 Opinion and Order. I conclude that the May 1984 "Settlement and Stipulation" was a release not permitted by ORS 656.236(1). Consequently, with regard to the compensability of the osteoarthritis condition, the Referee correctly found the settlement invalid.

Further, the majority's reliance on Roberts v. Willamette Industries, 82 Or App 188 (1986) to find a bona fide dispute is misplaced. In Roberts, claimant suffered a back injury for which the insurer paid benefits. Subsequently, claimant received a Determination Order awarding permanent total disability. However, at least one physician reported that claimant's compensable back injury was merely a sprain that resolved causing no permanent disability. The insurer denied the compensability of a portion of claimant's claim. Based on this denial, the parties entered into a settlement that disputed out the compensability of the majority of claimant's claim. However, the original back sprain specifically remained compensable. Significantly, a dispute existed as no determination had ever been made regarding the extent or permanency of claimant's back injury.

Here, unlike Roberts, a determination was made by a Referee that claimant's osteoarthritis and degenerative back condition was compensable. Therefore, claimant could not enter into an agreement releasing his rights for benefits with regard to that condition.

I would affirm the well reasoned order of the Referee.

RITA MITCHELL, Claimant
Dorothee Moore & Marvin Rhine dba
FREELOADER TAVERN, Employee
Charles Maier, Claimant's Attorney
Jeff Gerner (SAIF), Defense Attorney
Carl Davis, Ass't. Attorney General

WCB 85-15344 & 85-14563
May 28, 1987
Order on Review

Reviewed by Board Members Ferris and McMurdo.

The noncomplying employer requests review of Referee Foster's order that: (1) dismissed its hearing request concerning the issue of whether claimant sustained a compensable low back injury; and (2) increased claimant's award of unscheduled permanent partial disability for this injury from the 10 percent (32 degrees) granted by Determination Order to 25 percent (80 degrees). On review, the issues are jurisdiction, compensability and extent of disability. The parties have filed no briefs.

Following our de novo review of the record, we agree with the Referee's conclusion that the noncomplying employer's objection to the SAIF Corporation's prior acceptance of the claim, which was raised more than 60 days from the date the claim was

referred to SAIF, would be permissible only if the acceptance had been prompted by the illegal activities referred to in Bauman v. SAIF, 295 Or 788 (1983). See Stephen L. Dokey, 38 Van Natta 1560 (1986). Accordingly, with the aforementioned clarification, the Board affirms the order of the Referee.

Although the parties filed no briefs, claimant's attorney shall be awarded a nominal attorney fee for technically prevailing against the noncomplying employer's request for review. See ORS 656.382(2); Myron W. Rencehausen, 39 Van Natta 56 (1987).

ORDER

The Referee's order dated August 11, 1986 is affirmed. Claimant's attorney is awarded $100 on Board review, to be paid by the SAIF Corporation on behalf of the noncomplying employer.

NANCY J. SCHELIN, Claimant
Francesconi & Cash, Claimant's Attorneys
Gail Gage (SAIF), Defense Attorney
Roberts, et al., Defense Attorneys

WCB 86-09012 & 86-09011
May 28, 1987
Order of Dismissal

The self-insured employer and the SAIF Corporation have moved the Board for an order dismissing claimant's request for Board review on the ground that a copy of the request was not timely mailed to the parties. The motion is granted.

The Referee's order issued March 18, 1987. A request for Board review was timely mailed on April 16, 1987. The Board received the request on April 17, 1987. Neither an acknowledgement of service nor a certificate of personal service by mail was provided with the request. A computer generated letter acknowledging the request for Board review was mailed to the parties on April 21, 1987. This was the employer's and SAIF's first notice of the request for review.

A Referee's order is final unless, within 30 days after the date on which a copy of the order is mailed to the parties, one of the parties requests Board review under ORS 656.295. ORS 656.289(3). Requests for Board review shall be mailed to the Board and copies of the request shall be mailed to all parties to the proceeding before the Referee. ORS 656.295(2).

In Argonaut Insurance Co. v. King, 63 Or App 847, 852 (1983), the court held that "compliance with ORS 656.295 requires that statutory notice of the request for review be mailed or actual notice be received within the statutory period." In King, the request for review was timely, but copies of the request were never sent to the other parties. The "actual notice" referred to by the court was the Board's computer generated acknowledgement letter, which the evidence established was received by the insurer more than 30 days after the Referee's order was mailed. Inasmuch as the insurer's notice of the request for review was untimely, the court found that the Board lacked jurisdiction to consider the appeal.

Here, neither the employer nor SAIF was provided a copy of the request for Board review. Moreover, neither party received actual knowledge of the request within the statutorily required 30-day period. Consequently, we lack jurisdiction to review the Referee's order, which has become final by operation of law. See ORS 656.289(3).

We are mindful that claimant was apparently unrepresented by counsel when she requested Board review. We further realize that an unrepresented party is not expected to be familiar with administrative and procedural requirements of the Workers' Compensation Law. However, we are not free to relax a jurisdictional requirement, particularly in view of Argonaut Insurance Co. v. King, supra. Alfred F. Puglisi, 39 Van Natta 310 (1987); Julio P. Lopez, 38 Van Natta 862 (1986).

Accordingly, the request for Board review is dismissed.

IT IS SO ORDERED.

BENNY F. SEAY, Claimant
Coons & Cole, Claimant's Attorneys
Davis, Bostwick, et al., Defense Attorneys

WCB 84-02040 & 85-08209
May 28, 1987
Order of Dismissal

The insurer requested Board review of Referee Quillinan's amended order and Order on Reconsideration in WCB Case Nos. 84-02040 and 85-08209. The parties have submitted for our approval a proposed Disputed Claim Settlement. The settlement is designed to resolve the issues currently raised or raisable on Board review. In addition, the parties have agreed to resolve the issues presently pending before the Hearings Division in WCB Case Nos. 86-15994 and 87-01525.

In consideration of the insurer's promise to pay a stated sum, claimant has agreed to withdraw his two 1984 claims which form the basis of the issues raised or raisable in the current request for Board review. We have approved the parties' settlement, thereby fully and finally settling this matter. Those portions of the settlement which concern the pending hearing requests have been forwarded to the Hearings Division for consideration by a Referee. Accordingly, the request for Board review is dismissed with prejudice.

IT IS SO ORDERED.

BRIAN J. SHAW, Claimant
Blyth, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 85-07440
May 28, 1987
Order on Review

Reviewed by Board Members Ferris and McMurdo.

Claimant requests review of those portions of Referee Shebley's order that: (1) found claimant's claim to have been properly closed by the March 28, 1984 Determination Order; and (2) affirmed the Determination Order awards of 80 degrees for 25 percent unscheduled permanent partial disability for the right shoulder and 9.6 degrees for five percent scheduled disability for the right arm. In addition, claimant asserts entitlement to medical services for the right arm. The Referee's order did not address that issue.

We affirm the Referee's order with the following comment. The Referee did not address, and could not have addressed, the issue of claimant's entitlement to medical services for the right arm because the issue was not raised at hearing. We will not consider it on review. See e.g., Jerry Ussery, 37 Van Natta 1642 (1985).

ORDER

The Referee's order dated September 2, 1986 is affirmed.

ANNELIESE SOMMERS, Claimant
Pozzi, et al., Claimant's Attorneys
Thomas Johnson (SAIF), Defense Attorney

WCB 85-01458
May 28, 1987
Order on Review

Reviewed by Board Members Ferris and McMurdo.

The SAIF Corporation requests review of Referee Galton's order that granted claimant an award of permanent total disability in lieu of an award by Determination Order of 25 percent (80 degrees) unscheduled permanent partial disability for her low back, neck and psychological conditions. The issue is extent of permanent disability, including permanent total disability.

Claimant compensably injured her low back and neck on May 26, 1981 when she tripped and fell backwards while carrying one end of a heavy wooden panel over her head. Claimant sought treatment initially from Dr. Hebert, a chiropractor, and then from Dr. Melnick, a family practitioner. She complained of severe low back pain with tingling and other neurological symptoms in her lower extremities. Dr. Melnick diagnosed an acute cervical and low back strain and ordered an EMG to rule out more serious pathology. The EMG was normal. Conservative treatment was continued and claimant continued to complain of severe back and neck pain.

In late June 1981, Dr. Hebert reported that he thought claimant's condition was being exacerbated by what he termed "the stress of her home environment." Claimant lived with her husband and four sons in a large home in a rural setting on approximately one acre of land. Claimant had been raised in Holland in a regimented environment and had a rigid conception of how her household should be run. She bought food in bulk and cooked nearly everything, including bread, from scratch. She maintained a large garden and canned, froze and sun-dried her own vegetables. She tended a number of animals including chickens and a goat. She insisted that her family eat meals in relatively formal fashion at a table covered with a linen tablecloth and set with full place settings. She washed and dried all dishes by hand immediately after each meal. She scrubbed the floors and washed the windows by hand on a weekly basis. She bought only cotton and wool clothes for her family and washed, air-dried and ironed the clothes at least once per week. Claimant attempted to maintain this rigorous schedule after her injury. Dr. Hebert thought that "a more controlled environment" would be conducive to claimant's recuperation and recommended an orthopedic evaluation of claimant's condition. SAIF assigned a registered nurse to provide home care for claimant and scheduled an appointment with the Orthopaedic Consultants.

The notes recorded by the registered nurse indicate that claimant had some misconceptions concerning the nature of the workers' compensation system. At one point, claimant requested that she be sent on a cruise at SAIF's expense. On another occasion, claimant requested that she be flown to Holland to be with her mother or that her mother be flown from Holland to Oregon. The nurse's notes and later medical reports also indicate that claimant exhibited a strong desire to control the nature and course of her medical treatment. Claimant refused medications, ignored the advice of her doctors, resisted the taking of x-rays and failed to cooperate during physical examinations.

Claimant was examined by a panel of the Orthopaedic Consultants in September 1981. The panel diagnosed resolving cervical and lumbar strains and noted functional interference during the examination. A psychological evaluation was recommended.

Claimant was examined by a neurologist, Dr. Smith, in October 1981. Dr. Smith diagnosed cervical and low back strains with the possibility of a herniated disc at L4-5 or L5-S1, myofascial pain syndrome involving the neck and low back, muscle contraction headaches, right-sided muscular weakness and reactive depression, all related to claimant's industrial injury. Dr. Smith thereafter became claimant's treating physician.

Later in October 1981, claimant was examined by a psychiatrist, Dr. Stolzberg, at SAIF's request. Claimant complained of back pain, headaches and a depressed mood and again requested that SAIF fly her to Holland so that she could be with her mother. After interviewing claimant and administering psychological tests, Dr. Stolzberg concluded that claimant had "life-long neurotic problems revolving around dependency." She stated that claimant's ongoing physical complaints were accommodating these dependency needs and predicted that claimant would become entrenched in a disabled role. She recommended a course of psychotherapy.

Claimant began treating with a clinical psychologist, Dr. Ude, in December 1981. Dr. Ude concluded that claimant was experiencing a "grief reaction" to the curtailment of her activities by her chronic pain syndrome and diagnosed depression. Dr. Ude began a series of counseling sessions designed to increase claimant's relaxation skills and enhance claimant's understanding of her situation.

Claimant was examined a second time by the Orthopaedic Consultants in April 1982. The panel found little objective evidence of pathology, but noted marked functional overlay. The panel concluded that claimant was medically stationary and rated her permanent impairment as a result of the industrial accident as minimal for the low back and none for the neck.

Later the same day, claimant was reexamined by Dr. Stolzberg. Dr. Stolzberg recommended that claimant continue receiving psychotherapy for her long-standing personality problems, but stated that the claim could be closed because these personality problems had no causal connection to claimant's industrial injury. Dr. Stolzberg noted that claimant's treating psychologist, Dr. Ude, personally observed both the Orthopaedic Consultants examination and the examination by Dr. Stolzberg. Dr. Ude later conceded in a letter to SAIF that she had assumed the role of an advocate for claimant.

Dr. Smith reviewed the Orthopaedic Consultants' report and agreed with its conclusions except to the extent that it found claimant medically stationary. Dr. Ude reviewed the report and stated that the panel had failed to recognize the true extent of claimant's physical limitations. She stated that claimant was fearful of traditional medical practices and was terrified that the panel would find something wrong with her that would require more examinations by doctors, more x-rays and perhaps even

surgery. Claimant, therefore, had downplayed the frequency, duration and intensity of her symptoms during the examination. Dr. Ude disagreed with the panel's conclusion that claimant was medically stationary. In a subsequent report, Dr. Ude also stated that claimant's psychological condition was not stationary and urged SAIF not to close the claim.

Claimant began receiving vocational assistance in early 1982 and was soon at loggerheads with her vocational counselor. Claimant insisted that she be trained as a foreign language teacher, a goal which would require at least two years of schooling. The counselor told claimant that she was not eligible for such a lengthy training program under the administrative rules in force at the time, but agreed to recommend that claimant receive clerical training. Claimant became agitated, demanded that she be trained as a language teacher and insisted that the administrative rules did not apply to her.

Later in 1982, claimant changed her mind temporarily and demanded that she be trained as a registered nurse. When claimant's vocational counselor again stated that claimant was not eligible for such a lengthy training program under the administrative rules, claimant again became agitated and stated that she would not consider being "a typist." Soon thereafter, claimant threatened to "give up" if her desires were not met.

During late 1982, the vocational counselor began to consider closing claimant's vocational file for failure to cooperate. When this was brought to claimant's attention, claimant finally agreed to enroll in a clerical training program. Claimant began the program in January 1983, but continued to express bitterness that her desire to be a language teacher had not been realized and soon began to complain of increased back pain. In August 1983, Dr. Smith stated that claimant was unable to continue her clerical classes because of her complaints of back pain. The following month, Dr. Smith noted in a report to SAIF that claimant did not really want to become a clerk or secretary and suggested that something be done to accommodate claimant's desire for training as a language teacher. Claimant's vocational training program ultimately was terminated because of "medical problems."

In September 1983, claimant was evaluated at a pain center and was quite uncooperative with the staff. She refused to allow a physical examination, refused to take an MMPI and refused to answer many questions, stating that these procedures and questions were intrusions of her privacy. She repeatedly stated that she did not want to be at the pain center and that the insurer's funds would be better spent if applied toward her education as a language teacher. Dr. Yospe, the center's clinical psychologist noted in his report, "[Claimant] initially displayed many dramatic forms of pain behavior, but this lessened considerably as she became more engrossed in the interview." At one point in his report, the pain center director, Dr. Seres, commented: "We have a distinct feeling that one of the patient's major goal [sic] seems to be to defeat authority rather than to deal constructively with her problems. This is not seen as a psychological illness, but clearly actively defeats any efforts for trying to help her." Claimant was discharged as unsuitable for pain center treatment.

In December 1983, Dr. Smith stated that claimant was

nearing a medically stationary status, but indicated that he would like to examine her once more before making a final determination. In March 1984, Dr. Smith reported that he had reexamined claimant and that claimant was medically stationary as of the date of his previous examination in December 1983. With regard to claimant's permanent impairment, Dr. Smith stated that he was unable to give an impairment rating, but commented: "I still feel that she has a significant degree of permanent impairment resulting from her chronic low back and neck pain. Her chronic pain will greatly limit her in any future endeavors at work."

Claimant was scheduled for another examination by the Orthopaedic Consultants in May 1984. Claimant appeared for her appointment, but then refused to allow the doctors to examine her.

Dr. Smith reexamined claimant in August 1984. He indicated that claimant was still medically stationary and stated that he considered her "to be rather severely disabled given the combination of her chronic headaches, neck pain, depression and back pain." He stated that she was "at least 75 [percent] disabled, possibly being able to do very light parttime [sic] work." In October 1984, Dr. Ude declared claimant psychologically stationary and stated that claimant would have some unspecified level of permanent psychological impairment.

Claimant finally submitted to another examination by the Orthopaedic Consultants in November 1984. Claimant was uncooperative during the examination and refused to perform many tests. The panel diagnosed a marked functional overlay and stated that claimant had no permanent physical impairment as a result of the industrial injury.

Dr. Stolzberg reexamined claimant the same day. Dr. Stolzberg stated that claimant did not have any permanent psychological impairment which could be attributed to the industrial injury. At one point in her report, Dr. Stolzberg commented: "[Claimant] does have multiple complaints of anxiety and depression but I have the feeling that these, as her physical problems are, frequently form a method of solving underlying psychological conflicts and manipulating her environment."

Dr. Smith expressed disagreement with the Orthopaedic Consultants report, stating that he believed claimant did have a physical problem in the form of chronic myofascial pain syndrome. In a later report, Dr. Smith commented on the etiology of this syndrome, stating:

> "The etiology of [myofascial pain syndrome] has not been fully delineated, but is felt to be due to disordered physiology in spinal cord and brain pain pathways. There is often a large emotional component with the situation being complicated by chronic depression and anxiety. This type of chronic pain is often very difficult to overcome and can have a devastating impact upon the patient's life. Although my subspecialty is epilepsy, I also have a large general neurology practice. I have had considerable experience treating

individuals with chronic myofascial pain. I believe that these individuals have an organically based disorder of abnormal neurophysiology, the basis of which is not yet fully defined."

Dr. Ude reviewed the reports by the Orthopaedic Consultants and Dr. Stolzberg and stated that she disagreed with the conclusion that claimant's psychological problems were not attributable to the industrial accident.

Claimant's claim was closed by Determination Order dated January 18, 1985 with an award of 25 percent unscheduled permanent partial disability "resulting primarily from injury to [her] low back."

After claim closure, claimant agreed to undergo a CT scan. The scan was normal except for a slightly bulging disc at L5-S1 which Dr. Smith conceded was insufficient to account for claimant's complaints. Nonetheless, it continued to be Dr. Smith's "feeling that [claimant did] indeed have a permanent partial disability as a result of her chronic myofascial pain."

Shortly before the hearing in a letter to claimant's attorney, Dr. Ude reported that she had now assigned claimant a diagnosis of "major depression." She repeated her conclusion that claimant's condition was causally related to the industrial accident and stated that claimant would have "significant" permanent psychological impairment. Dr. Ude's report notes that claimant had been taking classes since the autumn of 1985 at a local college to become a language teacher.

Claimant testified that she experienced constant severe pain in her lower back, neck and between her shoulder blades that dramatically increased with nearly any movement of her trunk or neck. She stated that she was incapable of bending over, of lifting more than a few pounds or of sitting, standing or walking for more than a few minutes. Claimant also stated that she had difficulty driving for more than 20 minutes and had difficulty getting in and out of her car.

SAIF called an investigator who presented a videotape of some of claimant's activities less than a week prior to the hearing. The beginning of the tape shows claimant at her home hanging laundry on an outside clothesline. Claimant's movements during this activity included bending over at the waist, twisting her neck and torso, shaking out clothes, partially squatting to walk under the clothesline and reaching above her head to hang clothes on the line. Claimant's movements appeared fluid, uninhibited and painless. Later in the tape, claimant is shown walking through a parking lot carrying a large tote bag and getting into her car. Claimant walked at a rapid pace, up a slight incline at one point, twisted her neck to look for traffic, walked to her car, opened the car door and got swiftly behind the wheel. Claimant's movements again appeared fluid, uninhibited and painless.

The Referee accepted the reports of Drs. Smith and Ude as "thoughtful, complete, persuasive and well reasoned" and rejected the reports of the Orthopaedic Consultants and Dr. Stolzberg as "far less well-reasoned and thus less persuasive." The Referee expressly found claimant credible based

on her demeanor which, according to the Referee, included a number of pain behaviors, and accepted her testimony regarding her physical limitations. He dismissed the videotape as "no smoking gun." The Referee concluded that claimant was entitled to an award of permanent total disability on the basis of medical disability alone or, in the alternative, under the "odd-lot" doctrine. Under the latter theory, the Referee found that claimant was excused from the "seek work" requirement of ORS 656.206(3) by the "futility doctrine" or, in the alternative, had demonstrated "very reasonable efforts to become rehabilitated and find employment."

After our de novo review of the record, we reverse the Referee's award of permanent total disability. The record is replete with reports, not only by the Orthopaedic Consultants and Dr. Stolzberg, but also by a number of other medical professionals, that preponderate in favor of the conclusion that much of claimant's impairment is voluntary in nature. Claimant repeatedly has refused to be examined or has failed to cooperate in examinations performed by anyone except the doctors who support her perception of her limitations. Claimant has placed unrealistic and unreasonable demands on the insurer and vocational assistance provider and has employed complaints of pain in an attempt to force them to accommodate her demands or to frustrate their efforts. Claimant repeatedly has failed to cooperate with reasonable efforts to provide vocational assistance and training. For these reasons, we conclude that claimant has failed to carry her burden of proving that she is willing, but permanently unable, to regularly perform work at a gainful and suitable occupation. ORS 656.206(1)(a) & (3).

We do not find the conclusions of Drs. Ude and Smith persuasive. Dr. Ude conceded that she had become claimant's advocate and thus had lost her objectivity. Dr. Smith gave no objective basis for his diagnosis of "myofascial pain syndrome" and, in fact, indicated that this syndrome was not understood by the medical community.

As for claimant's testimony regarding her physical limitations, we find it inconsistent with the medical record and with the videotape introduced at the hearing. Although we usually defer to a credibility finding of a Hearings Referee, especially when based upon the demeanor of a witness, we do not accept the Referee's credibility finding in this case. That finding was based primarily upon pain behaviors which Dr. Yospe, a trained psychological professional, indicated were subject to considerable exaggeration.

In rating the extent of claimant's unscheduled permanent partial disability, we consider her impairment as reflected in the medical record and the testimony at the hearing and all of the relevant social and vocational factors set forth in OAR 436-30-380 et seq. We apply these rules as guidelines, not as restrictive mechanical formulas. See Harwell v. Argonaut Insurance Co., 296 Or 505, 510 (1984); Howerton v. SAIF, 70 Or App 99, 102 (1984).

Claimant was 37 years old at the time of the hearing. She is of above average intelligence, graduated from the European equivalent of high school and also attended the University of Amsterdam for two years studying language. She speaks Dutch, French, German and English fluently and also speaks some Spanish. Before moving to the United States in 1966, claimant worked as an

aide in a Montessori school and as a dental hygienist. Since her move to this country, claimant has worked as a housewife, as a laborer on a Christmas tree farm and as a woodworker.

Following our de novo review of the medical and lay evidence, we conclude that claimant's total physical and psychological impairment as a result of the industrial accident does not exceed the mild range. Exercising our independent judgment in light of claimant's level of impairment and the relevant social and vocational factors, we conclude that claimant's permanent loss of earning capacity does not exceed the the Determination Order award of 25 percent (80 degrees) unscheduled permanent partial disability. The Determination Order award, therefore, shall be reinstated and affirmed.

ORDER

The Referee's order dated June 18, 1986 is reversed. The award by the Determination Order dated January 18, 1985 of 25 percent (80 degrees) unscheduled permanent partial disability is reinstated and affirmed.

LARRY L. TURPIN, Claimant
Coons & Cole, Claimant's Attorneys
Cowling & Heysell, Defense Attorneys

WCB 86-01787
May 28, 1987
Order on Review

Reviewed by Board Members Lewis and McMurdo.

The insurer requests review of Referee Foster's order that awarded claimant a $300 attorney fee in connection with the late payment of certain medical bills and the payment of a penalty. The insurer unreasonably delayed payment of the bills, but then paid them the same day that claimant's attorney filed a request for hearing. The insurer was not aware that claimant had filed a request for hearing when it issued payment. After receiving the request for hearing, the insurer also agreed to pay a 25 percent penalty, but refused to pay claimant's attorney a fee. The issue is attorney fees.

The Board affirms the order of the Referee with the following comment. Authority for the attorney fee awarded in this case was provided by ORS 656.262(10), 656.382(1) and Spivey v. SAIF, 79 Or App 568, 572 (1986).

ORDER

The Referee's order dated October 20, 1986 is affirmed.

OTIS W. WATERS, Claimant
Squires & Lopez, Claimant's Attorneys
Rankin, et al., Defense Attorneys

WCB 85-15924
May 28, 1987
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of Referee Shebley's order that found that his left shoulder and back injury claim had not been prematurely closed. On review, the issue is premature closure.

In deciding whether a claim has been prematurely closed, we determine whether claimant's condition was medically stationary on the date of closure, without considering subsequent changes in

his condition. Sullivan v. Argonaut Ins. Co., 73 Or App 694 (1985); Alvarez v. GAB Business Services, 72 Or App 524 (1985). However, in conducting our analysis, we may consider medical evidence that was not available to the Evaluation Division at the time of closure. Schuening v. J. R. Simplot, 84 Or App 622 (April 8, 1987); Brown v. Jeld-Wen, Inc., 52 Or App 191 (1981).

Following our de novo review of the record, including evidence that was unavailable to the Evaluation Division, we are persuaded that claimant's compensable condition was medically stationary at the time his claim was closed. Accordingly, we agree with the Referee that the claim was not prematurely closed.

ORDER

The Referee's order dated August 27, 1986 is affirmed.

ROSALIE A. WELCH, Claimant
Michael B. Dye, Claimant's Attorney
Garrett, et al., Defense Attorneys

WCB 85-14992
May 28, 1987
Order on Review

Reviewed by Board Members McMurdo and Lewis.

The insurer requests review of Referee Podnar's order that awarded: (1) 35 percent (52.5 degrees) scheduled permanent disability for the left wrist; and (2) 30 percent (45 degrees) scheduled permanent disability for the right wrist. These awards were in lieu of Determination Order awards of five percent (7.5 degrees) for each wrist. The issue on review is extent of scheduled permanent disability.

Claimant, a 51 year old sewing machine operator, sustained a compensable bilateral carpal tunnel disease in February 1983. Carpal tunnel release surgeries were performed in March and April 1983. Following a period of physical therapy, claimant returned to her former job in July 1983. She initially worked full time, but later worked only part time due to pain and swelling in her hands. Claimant's discomfort continued, and after approximately one year she quit her job.

In November 1984, claimant was examined by the Orthopaedic Consultants. The Consultants reported "residual symptoms" and felt that claimant was unable to return to her former occupation. The Consultants concluded that claimant's impairment was "minimal." In April 1984, the Consultants reexamined claimant. The Consultants found claimant's ongoing symptoms unsupported by objective findings and opined that pyschological factors were affecting her recovery. The Consultants rated claimant's impairment as "mild."

A Determination Order issued in May 1985, awarding five percent scheduled permanent disability for each wrist.

In February 1986, claimant secured employment as a meat packer. She worked only a few days and then sought emergency medical treatment for pain and swelling in her hands. The following month she was examined by Dr. Tesar, her treating physician and hand surgeon. Dr. Tesar felt that the February 1986 incident was an aggravation of claimant's compensable disease. The next month, Dr. Tesar explained that claimant had experienced

only a temporary aggravation and that her condition had not worsened. Dr. Tesar concluded that claimant "continues with 5% permanent partial disability * * *."

Claimant credibly testified that she suffers a constant dull pain in her hands. Overuse causes tingling and swelling. She can lift only small or light-weight objects. Moreover, she lifts by gripping with her forearms, rather than her hands.

In awarding increased permanent disability, the Referee stated that claimant's loss of function was "clear." He considered Dr. Tesar's assessment "meager." Likewise, he considered the Consultants' assessment "[in] accurate." We do not agree.

It is claimant's burden to prove her case by a preponderance of the evidence. Hutcheson v. Weyerhaeuser Co., 288 Or 51, 56 (1979). Here, the medical evidence is in agreement. The Consultants examined claimant on two separate occasions and rated her impairment from minimal to mild. Likewise, Dr. Tesar reported that claimant's level of disability continues with that awarded by the May 1985 Determination Order. Therefore, the medical evidence does not support an award of increased permanent disability.

The criteria for rating the extent of scheduled permanent disability is the loss of use or function of the injured member. ORS 656.214(2). We do not apply the Workers' Compensation Department's admininstrative rules governing extent of disability in a rigid mechanistic fashion, but rather as guidelines. Fraijo v. Fred N. Bay News Co., 59 Or App 260 (1982). In the instant case, claimant's testimony indicates that she can no longer perform work requiring consistent use of her hands and wrists without experiencing pain and swelling. However, the medical evidence establishes that her impairment is in the minimal to mild range. After conducting our de novo review of the lay evidence, including claimant's credible testimony, and the medical evidence, we consider an award of 15 percent scheduled permanent disability to adequately compensate claimant.

ORDER

The Referee's order dated September 17, 1986, is modified. In lieu of the Referee's award, and in addition to the Determination Order's award of five percent (7.5 degrees) scheduled permanent disability for each wrist, claimant is awarded 10 percent (15 degrees) for each wrist, giving her a total to date of 15 percent (22.5 degrees) scheduled permanent disability for loss of use or function of each wrist. Claimant's attorney's fees shall be adjusted accordingly.

DAVID MARTIN, Claimant
Galton, et al., Claimant's Attorneys
Gretchen Wolfe (SAIF), Defense Attorney

Own Motion 84-0207M
May 29, 1987
Own Motion Order

On July 21, 1986, we rescinded a prior Own Motion Determination, thereby reopening claimant's August 9, 1971 injury claim. Pursuant to our order, the SAIF Corporation was directed to commence paying temporary total disability compensation from April 10, 1986 and to continue until closure pursuant to ORS 656.278. We further directed SAIF to pay claimant's attorney 25 percent of the additional compensation granted by our order, not to exceed $400. Pursuant to our July 31, 1986 supplemental order, this maximum attorney fee award was increased to $750.

Contending that SAIF has failed to timely comply with our prior orders, claimant seeks penalties and accompanying attorney fees. Specifically, claimant asserts that SAIF failed to timely pay his attorney fee award. Inasmuch as claimant's request emanated from an own motion order, we retain jurisdiction over this matter. See David L. Waasdorp, 38 Van Natta 81 (1986).

The relevant facts are as follows. On August 4, 1986, SAIF paid temporary total disability benefits totalling $3,143.58. In addition, claimant's attorney was paid $280.50. Thereafter, SAIF continued to provide biweekly payments of temporary disability. However, claimant's attorney received no further payment until October 16, 1986, when SAIF paid $129.69. The remainder of claimant's attorney fee was not paid until November 5, 1986.

SAIF states that the initial attorney fee payment represents its portion, as opposed to the Retroactive Reserve Fund's portion, of claimant's initial award of temporary total disability benefits. Yet, SAIF offers no explanation for its failure to fully and timely pay the remaining portion of claimant's attorney fee. Rather, it contends that there is no basis for a penalty since there is no compensation due. Furthermore, SAIF argues that claimant's attorney could have obtained his fee directly from claimant or from future benefits.

Temporary disability benefits are due within 14 days of any determination or litigation order directing the payment of temporary disability. OAR 436-60-150(3)(e). If the insurer unreasonably delays paying compensation, it 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. ORS 656.262(10).

Attorney fees awarded out of claimant's compensation retain their identity as "compensation." Candy J. Hess, 37 Van Natta 12 (1985); Robert G. Perkins, 36 Van Natta 1050, 1051 (1984). Failure to timely pay an attorney fee award payable from claimant's compensation is improper and can result in the assessment of a penalty and an additional attorney fee. Candy J. Hess, supra.

Here, SAIF timely paid a portion of claimant's attorney fee award as directed by our July 31, 1986 order; i.e., $280.50. Thus, SAIF's response to a portion of our order was not unreasonable. However, no additional payment was made to claimant's attorney for more than two months. Moreover, the remainder of claimant's attorney fee was not paid until November 5, 1986. SAIF offers no reasonable explanation for its failure to fully and timely comply with our order.

Following our review of this matter, we conclude that SAIF unreasonably failed to fully and timely pay claimant's attorney fee as directed by our prior order. Consequently, a penalty and accompanying attorney fee will be assessed against that portion of the fee that was untimely paid; i.e., $469.50. Accordingly, as a penalty, claimant shall receive 25 percent of this amount.

In addition, as a reasonable attorney's fee concerning this issue, claimant's counsel is awarded $200. In reaching this

determination, we are mindful that claimant's attorney has expended several hours of research and preparation regarding this matter. However, we note that a significant portion of this time concerned a request for hearing that was ultimately dismissed for lack of jurisdiction. Thus, claimant's reasonable attorney fee is based on the services rendered and the results obtained in this proceeding.

IT IS SO ORDERED.

ERNESTO H. RAVETTO, Claimant
Malagon & Moore, Claimant's Attorneys
Luvaas, et al., Defense Attorneys

WCB 86-02324
May 29, 1987
Order on Review

Reviewed by Board Members Ferris and McMurdo.

The insurer requests review of Referee Seymour's order that awarded claimant 64 degrees for 20 percent unscheduled permanent partial disability for the low back, in lieu of a Determination Order awarding temporary total disability only. The issue is extent of unscheduled permanent partial disability. We reverse.

Claimant compensably injured his low back on August 26, 1985 while employed as a part-time soccer coach for a public school. He visited Dr. Larson, an osteopath, who diagnosed a lumbar muscle spasm. Larson indicated his uncertainty with regard to whether claimant would experience permanent disability as a result of his injury. X-rays conducted soon thereafter revealed a degenerative L5-S1 disk with air in the disk space. The films were otherwise normal.

After claimant filed his claim, he came under the treatment of Dr. Serbu. In his September 16, 1985 report, Serbu noted the inconsistencies between claimant's claimed injury and his behavior during the examination. Whereas claimant complained of left leg sciatic pain, he favored his right leg and sat on his left hip. Dr. Serbu found both behaviors to be inconsistent with a left sciatic condition. He also noted:

> " . . . [S]evere pain in someone who has straight leg raising at 80° is very unusual."

On September 26, 1985, Serbu reported that claimant had returned for a followup visit and was "totally asymptomatic." All objective tests were normal. Serbu stated:

> "I believe this man has a mild lumbar strain. I believe he overly exaggerated his symptoms . . . I feel he is totally recovered . . . I do not feel he has any permanent partial disability."

A month later, claimant visited Dr. Roy at a sports clinic. Roy felt that claimant had limitations, but that they were only temporary. The insurer then sent claimant to Dr. Macritchie, who also felt that claimant's physical capacity was mildly limited. She found no evidence of permanent neurologic impairment, however. On January 9, 1986, Dr. Roy concurred with Macritchie's report.

In late January 1986, claimant changed treating

physicians to Dr. Bamforth, a chiropractor. Bamforth immediately found claimant to be not medically stationary and he began regular chiropractic treatments. On February 26, 1986, however, Bamforth stated, "I feel [claimant] can continue with his regular work activities." Then, three months later, Bamforth issued a brief statement in which he suggested that claimant had suffered "moderate" permanent impairment as a result of his injury. The February 6, 1986 Determination Order awarded claimant a period of temporary total disability, but made no permanent disability award.

Claimant testified that he had taken the part-time coaching job to supplement the irregular income he received from acting, his primary profession. He stated that since his injury, he has had great difficulty in completing some of the movements and other tasks needed to participate in repertory theatre, commercials and acting workshops. Claimant believes that he is permanently impaired.

The Referee awarded claimant 20 percent unscheduled disability, apparently finding that he was significantly disabled. We disagree. In fact, we find that claimant has failed to prove that he has suffered any permanent disability.

The medical record is nearly unanimous that claimant has suffered no permanent impairment as a result of his injury. Dr. Serbu has found none. Dr. Macritchie sees no permanent neurological deficit. Dr. Roy has stated that whatever limitations claimant has are temporary. Dr. Larson simply doesn't know. Only Dr. Bamforth has stated that claimant has suffered permanent impairment. Inexplicably, however, that statement was preceded by his opinion rendered three months later that indicated claimant could return to his regular work activities. Dr. Bamforth has not explained those seemingly inconsistent statements, nor has he elaborated on his conclusion that claimant suffers permanent disability. Thus, notwithstanding claimant's probative testimony, Garbutt v. SAIF, 297 Or 148 (1984), we find the record as a whole to preponderate against an award of permanent disability. See Kassahn v. Publishers Paper Co., 76 Or App 105 (1985).

ORDER

The Referee's order dated September 10, 1986 is reversed.

PEDRO G. ALCALA, Claimant
Michael B. Dye, Claimant's Attorney
Garrett, et al., Defense Attorneys

WCB 86-05800
June 1, 1987
Order Denying Motion to Consider Respondent's Brief

The insurer has objected to the Board's refusal to accept the insurer's respondent's brief as untimely. On reconsideration, we adhere to our prior decision.

On March 26, 1987, the Board forwarded a transcript of the proceedings to the parties. Included with the transcript was the briefing schedule. Claimant's appellant's brief was due April 16, 1987, which was 21 days after the date of mailing of the transcript. See OAR 438-11-015(2), (Effective November 1, 1986, WCB Admin. Order 5-1986). Pursuant to the aforementioned rule, the insurer's respondent's brief was due within 21 days after the date of mailing of the appellant's brief.

Claimant's appellant's brief was mailed on April 16,

1987. The insurer's respondent's brief was mailed on May 11, 1987, 25 days after the date of mailing of the appellant's brief. No written request for an extension of time within which to file its brief had been received.

The insurer asserts that its brief was due within 20 days after it was served with appellant's brief. Since the 20th day fell on a Sunday and the insurer mailed its brief the following Monday, it contends that its brief was timely filed. In support of this contention, the insurer relies on a former Board rule (OAR 438-11-010(3)) which concerned the filing of briefs on Board review.

The rule upon which the insurer relies was amended on November 5, 1985. WCB Admin. Order 1-1985. Among other modifications, the filing date for a respondent's brief was changed from 20 days of service to 21 days from the date of mailing of the appellant's brief. The rule has since been renumbered and was recently replaced. See OAR 438-11-015(2), (Effective November 1, 1986, WCB Admin. Order 5-1986); OAR 438-11-015(2), (Effective April 15, 1987, WCB Admin. Order 2-1987). Yet, the "21-day rule" has remained intact since the November 1985 amendment.

Consequently, when claimant requested Board review, our rules provided that the insurer's respondent's brief was due within 21 days after the date of mailing of claimant's appellant's brief. See OAR 438-11-015(2), (Effective November 1, 1986, WCB Admin. Order 5-1986). Inasmuch as the insurer's brief was not filed within 21 days after the date claimant's brief was mailed, it is untimely. Accordingly, we continue to conclude that the brief shall not be considered on Board review.

IT IS SO ORDERED.

KATHRYN J. GEE, Claimant
Roll, et al., Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB 85-03818
June 1, 1987
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of those portions of Referee Nichols' order that: (1) declined to grant permanent total disability; (2) declined to grant an additional award of unscheduled permanent disability for her low back condition, in excess of the 55 percent (176 degrees) previously awarded for a prior compensable injury by multiple Determination Orders and a stipulation; (3) awarded 15 percent (48 degrees) unscheduled permanent disability for her neck condition, in addition to a previous award by Determination Order of 10 percent (32 degrees); and (4) awarded five percent (9.6 degrees) scheduled permanent disability for loss of use of her right arm. Claimant has also moved the Board for inclusion of additional evidence on review. The issues are permanent total disability, extent of both unscheduled and scheduled disability, and the inclusion of additional evidence on review.

The Board affirms the order of the Referee.

The Board also denies claimant's motion for inclusion of additional evidence on review. In her motion, claimant states,

"[r]emand is not necessary in this instance." However, the only mechanism allowing a party to move the Board for supplementation of the record, is a motion for remand. ORS 656.295(5). Consequently, we treat claimant's motion as one for remand.

We may remand to the Referee should we find that the record has been "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(5). Here, claimant seeks to admit an additional report from Dr. Leveque, further explaining claimant's employment at his office. Under such circumstances, we find that the record was neither improperly nor incompletely developed at the time of the hearing. Furthermore, claimant has not shown that Dr. Leveque's opinion was unobtainable with due diligence before or at the hearing. Kienow Food Stores v. Lyster, 79 Or App 416 (1986); Delfina P. Lopez, 37 Van Natta 164 (1985).

ORDER

The Referee's order dated June 6, 1986 is affirmed.

LAWRENCE J. KAFORSKI, Claimant
J. Rion Bourgeois, Claimant's Attorney
Nancy Meserow, Defense Attorney
Miller, et al., Defense Attorneys

WCB 85-07144 & 85-15602
June 1, 1987
Order on Review (Remanding)

Reviewed by Board Members McMurdo and Lewis.

Wausau Insurance Company requests review of those portions of Referee Thye's order that set aside its denials of compensability and responsibility relating to claimant's bilateral carpal tunnel syndrome. Claimant cross-requests review of that portion of the order that assessed a penalty for various claims processing violations based only upon compensation due prior to the hearing and also contends that an attorney fee awarded on the penalty issue should be increased. Should the Board reverse the Referee's finding of compensability on the record developed at the hearing, claimant also requests that the case be remanded for further development in light of a post-hearing surgical operation. The issues are compensability, remand, responsibility, penalties and attorney fees.

Based upon the record as currently developed, the Board does not find claimant's carpal tunnel condition compensable. Dr. Salumbides, the physician whose opinion is the most favorable to claimant, indicated that claimant's condition was caused by an ideopathic thickening of the carpal tunnel ligament and that subsequent inflammation of the median nerve with activity did not represent a worsening of the underlying condition. Given our finding on the compensability issue, we remand to the Referee for further development in light of claimant's post-hearing surgical operation. See Parmer v. Plaid Pantry # 54, 76 Or App 405, 409 (1985).

ORDER

The Referee's order dated April 9, 1986 is vacated and the case is remanded to the Referee for further development.

MERLE F. PARKS, Claimant
Steven C. Yates, Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 86-03139
June 1, 1987
Order Denying Motion to Dismiss

The self-insured employer has moved the Board for an order dismissing claimant's request for Board review on the ground that the request was untimely filed. The motion is denied.

The Referee's Order of Dismissal issued December 9, 1986. The order did not contain a statement explaining the parties' rights of appeal as required by ORS 656.289(3). Instead, claimant was specifically advised that the Referee would reconsider the order, if, within 30 days, he provided a "good and sufficient explanation of his failure to appear" at the scheduled hearing. On December 18, 1986, claimant provided an explanation and requested that the hearing be rescheduled.

On January 5, 1987, the Referee issued an Order on Reconsideration. After reviewing the explanation, the Referee found that claimant had failed to establish "good cause" for his failure to appear at the hearing. Accordingly, the motion to set aside the dismissal order was denied. On January 12, 1987, claimant requested Board review of the Referee's January 5, 1987 order.

A Referee's order is final unless, within 30 days after the date on which a copy of the order is mailed to the parties, one of the parties requests Board review under ORS 656.295. ORS 656.289(3). The time within which to appeal an order continues to run, unless the order has been "stayed," withdrawn, or modified. International Paper Co. v. Wright, 80 Or App 444 (1986); Fischer v. SAIF, 76 Or App 656, 659 (1986). In order to abate and allow reconsideration of an order issued under ORS 656.289(1), at the very least, the language of the second order must be specific. Farmers Insurance Group v. SAIF, 301 Or 612, 619 (1986).

Here, the Referee's December 9, 1987 Order of Dismissal did not advise the parties of their rights of appeal as required by ORS 656.289(3). Furthermore, the Referee specifically advised claimant that the order would be reconsidered if a "good and sufficient explanation" was provided within 30 days. Upon reception of claimant's explanation, in accordance with the dismissal order, the Referee issued a January 5, 1987 Order on Reconsideration. Claimant's excuse was reviewed, but found insufficient to establish "good cause."

The Referee's December 9, 1987 order was neither expressly "stayed" nor withdrawn. Yet, since the January 5, 1987 order specifically considered claimant's explanation, the previous order was modified. Moreover, the January 5, 1987 order was expressly labeled "Order on Reconsideration" and was in direct response to claimant's compliance with the Referee's previous directive to provide an explanation for the failure to appear at the scheduled hearing.

Under these circumstances, we find that the Referee's December 9, 1987 Order of Dismissal was modified and reconsidered by the January 5, 1987 Order on Reconsideration. Consequently, because claimant timely requested Board review of the Order on Reconsideration, we conclude that we have jurisdiction to consider this matter. Accordingly, the motion to dismiss is denied. The

employer's respondent's brief shall be due within 21 days from the date of this order, with claimant's reply brief, if any, due in accordance with Board filing procedures. See OAR 438-11-020; 438-11-015(2).

IT IS SO ORDERED.

FLOAREA PERVA, Claimant
Peter O. Hansen, Claimant's Attorney
Mark Bronstein (SAIF), Defense Attorney

WCB 86-12262
June 1, 1987
Order of Dismissal

Reviewed by Board Members Lewis and McMurdo.

The SAIF Corporation has moved the Board for an order dismissing claimant's request for Board review on the ground that the request was untimely filed. The motion is granted.

The Referee's order issued March 16, 1987. On March 26, 1987, claimant requested reconsideration. On April 8, 1987, the Referee issued an "Order Denying Reconsideration." The order provided as follows:

> "After review claimant's motion for reconsideration is not allowed. The appeal time shall run from the date of this Order Denying Reconsideration."

The March 16, 1987 order was neither abated, stayed, nor republished. On April 27, 1987, claimant requested Board review of the Referee's order dated "April 9, 1987 [sic]."

A Referee's order is final unless, within 30 days after the date on which a copy of the order is mailed to the parties, one of the parties requests Board review under ORS 656.295. ORS 656.289(3). The time within which to appeal an order continues to run, unless the order has been "stayed," withdrawn, or modified. International Paper Co. v. Wright, 80 Or App 444 (1986); Fischer v. SAIF, 76 Or App 656, 659 (1986). In order to abate and allow reconsideration of an order issued under ORS 656.289(1), at the very least, the language of the second order must be specific. Farmers Insurance Group v. SAIF, 301 Or 612, 619 (1986).

In specifically denying the motion for reconsideration, the Referee attempted to grant the parties an additional 30 days within which to appeal his prior decision. Yet, a Referee cannot by letter or order extend the appeal period beyond the time permitted by statute. Farmers Insurance Group v. SAIF, supra. Moreover, the Referee's March 16, 1987 order has neither been modified, withdrawn, stayed, "republished," nor appealed within the statutorily required 30-day period.

Consequently, we lack jurisdiction to consider the matters determined by the March 16, 1987 order, which has become final by operation of law. See ORS 656.289(3). Inasmuch as the Referee's subsequent order refused to reconsider matters that have since become final by operation of law, no issues remain for us to consider. Accordingly, claimant's request for Board review is dismissed.

IT IS SO ORDERED.

LEE E. SHORT, Claimant
Bloom, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorneys

WCB 83-00025
June 1, 1987
Order on Remand

This matter is before the Board on remand from the Court of Appeals. Pursuant to the court's order, we have been directed to determine claimant's petition for an allowance of attorney fees payable out of compensation.

The court held that claimant had established a worsening of her psychological condition as of September 1, 1982. Short v. SAIF, 79 Or App 423, 428 (1986). Inasmuch as the Board had previously found that claimant's condition worsened as of March 30, 1983, the Board's order was modified. Thus, the claim was reopened as of September 1, 1982, thereby potentially entitling claimant to additional temporary total disability benefits. See ORS 656.273(6).

If a claimant appeals the extent of temporary or permanent disability to the Court of Appeals, an additional fee of 25 percent of any increase awarded by the appellate court shall be approved. OAR 438-47-045(1). This award shall be paid from claimant's award of compensation. ORS 656.386(2); OAR 438-47-010(5); OAR 438-47-045(1). Accordingly, claimant's attorney is allowed 25 percent of any additional temporary total disability compensation resulting from the court's decision, payable out of, and not in addition to, claimant's compensation.

IT IS SO ORDERED.

ERNEST E. THOMPSON, Claimant
Hayner, et al., Claimant's Attorneys
Foss, et al., Defense Attorneys

WCB 85-07828
June 1, 1987
Order on Reconsideration

Claimant requested reconsideration of the Board's Order on Review dated March 10, 1987. We abated our order on April 3, 1987 to allow the self-insured employer opportunity to respond to claimant's request.

The issue at the hearing was extent of disability for claimant's low back and left shoulder. Prior to the hearing, the employer wrote claimant stating that it had reason to believe that he had sustained a new injury to his shoulder while working for a subsequent employer. The parties proceeded to hearing and the insurer defended against claimant's request for a permanent disability award for his shoulder on responsibility grounds. Neither party joined the allegedly responsible subsequent employer. The Referee accepted the employer's arguments and concluded that any disability relating to claimant's shoulder was the responsibility of a subsequent employer. We affirmed the Referee's order without comment.

In his request for reconsideration, claimant asserts that the employer is treating the Board's order as a denial of claimant's shoulder condition. He contends that the Referee and the Board were without authority "to issue orders denying [his shoulder] condition . . . where no formal written denial has been entered [by the employer]."

We disagree with claimant's characterization of our order as a "denial" of his shoulder condition. The issue before

the Board was extent of disability for the shoulder condition. On that issue, claimant had the burden of proving a material causal connection between his shoulder disability and his compensable injury. David E. Sitton, 36 Van Natta 773 (1984). The basis of our order was our conclusion that claimant had failed to carry that burden.

As supplemented herein, the Board adheres to and republishes its previous order, effective this date.

IT IS SO ORDERED.

MICKY A. THRESHER, Claimant
Brian R. Whitehead, Claimant's Attorney
Schwabe, et al., Defense Attorneys

WCB 85-10230
June 1, 1987
Order on Review

Reviewed by Board Members McMurdo and Lewis.

Claimant requests review of that portion of Referee Baker's order which declined: (1) to award temporary disability compensation from July 24, 1985 through December 11, 1985; and (2) to assess penalties and attorney fees for unreasonable claims processing. The insurer cross-requests review of that portion of the Referee's order which: (1) declined to authorize an offset for temporary disability benefits paid while claimant was incarcerated; and (2) awarded temporary disability from December 12, 1985 through February 11, 1986, as well as penalties and attorney fees for unreasonable delay or refusal to pay compensation.

In September 1983, claimant compensably injured his right knee. His treating physician, Dr. O'Fallon, diagnosed a possible torn cartilage associated with chondromalacia. Conservative treatment was not successful. Consequently, arthroscopic surgery was performed by Dr. Spady, orthopedist, in February 1984. Claimant's recovery was uneventful. In April 1984, a Determination Order closed the claim, awarding five percent scheduled permanent disability.

In May 1984, claimant came under the care of Dr. Poulson, orthopedist. Because of continuing knee symptoms, Dr. Poulson performed a repeat arthroscopy in August 1984. Shortly thereafter, a Stipulation rescinded the April 1984 Determination Order, and temporary disability benefits were reinstituted. Claimant was incarcerated in October 1984.

The insurer submitted the claim for closure on July 18, 1985, stating: "[claimant] is currently in prison . . . . We are requesting administrative closure." At that time, no physician had considered claimant medically stationary nor had Dr. Poulson released him to return to regular work. Later that month, the Evaluation Division issued a Determination Order finding that claimant was medically stationary as of July 23, 1985.

Prior to the Determination Order, the insurer unilaterally terminated payment of temporary disability compensation, as of July 16, 1985. Consequently, after the issuance of the Determination Order, the insurer ceased paying any further temporary disability beyond July 16, 1985. At the hearing, the insurer conceded that temporary disability benefits were due and owing for the period July 17, 1985 through July 23,

1985, and that its failure to pay such benefits was a mere oversight.

Claimant was released from prison on December 1, 1985. On December 12, 1985, he returned to Dr. Poulson, complaining of right knee pain. Dr. Poulson ordered an arthrogram, recommended surgery, and indicated that claimant had not returned to work. On December 24, 1985, Dr. Poulson advised the insurer of claimant's condition and requested authorization for another arthroscopy. The insurer received Dr. Poulson's letter on December 27, 1985, and apparently approved of the surgery thereafter.

The arthroscopy was eventually performed on February 12, 1986. The surgery revealed that claimant's cruciate ligaments had been torn for some time. Accordingly, the insurer reopened claimant's claim and began paying temporary disability on February 12, 1986.

The Referee found that the claim was prematurely closed. We agree. However, the Referee also found that the termination of claimant's temporary disability benefits after July 23, 1985, was not improper. We disagree.

When a claimant's compensable condition becomes medically stationary, unless he is enrolled in an authorized training program, an insurer shall so notify inter alia the Evaluation Division, and request claim closure. ORS 656.268(2). When medical reports indicate that a claimant's condition has become medically stationary and the insurer decides that the claim is disabling, but without permanent disability, it must issue a proper notice of closure to the claimant and the Department. ORS 656.268(3). Claims shall not be closed nor temporary disability benefits terminated if a claimant has not become medically stationary or is enrolled in an authorized training program. ORS 656.268(1). Further, if a claimant's attending physician has not approved the claimant's return to regular work, the insurer must continue to pay temporary disability benefits until the termination of such benefits is authorized by claim closure. ORS 656.268(2); see also Volk v. SAIF, 73 Or App 643, 646 (1985); Jackson v. SAIF, 7 Or App 109 (1971).

Here, claimant underwent right knee surgery in August 1984. Thereafter, neither Dr. Poulson nor any other physician considered claimant medically stationary. The insurer then submitted the claim for closure in July 1985, without any medical evidence to indicate that claimant had become medically stationary. Nonetheless, the Evaluation Division concluded that claimant was medically stationary on July 23, 1985.

Under such circumstances, we are persuaded by the preponderance of the evidence that claimant was not medically stationary on July 23, 1985. Accordingly, we agree with the Referee's finding that claimant's claim was prematurely closed.

Regarding the termination of claimant's temporary disability benefits, none of the statutory requirements for such termination have been met. On July 25, 1985, the date the Determination Order issued, claimant had not become medically stationary nor had Dr. Poulson released him to return to regular work. The insurer argues that it "properly" terminated claimant's temporary disability benefits, "because the July 25, 1985 Determination Order authorized it to do so." However, the

insurer's argument ignores the fact that the Determination Order issued prematurely. Whether the insurer's termination of claimant's temporary disability benefits was "proper" is a question of reasonableness, and pertains solely to the issue of penalties and attorney fees. Therefore, we find that the claimant's temporary disability benefits should have continued after July 23, 1985.

Recently, we faced a similar situation in the case of Lloyd O. Fisher, 39 Van Natta 5 (1987). There, the insurer unilaterally terminated the claimant's temporary disability benefits while he was incarcerated and his claim was still in open status. We stated as follows:

> "At the time of the insurer's unilateral termination of temporary disability benefits, claimant's condition was not medically stationary and his claim had neither been closed administratively nor by Determination Order. Furthermore, he had neither returned, nor been released, to regular work. Under these circumstances, we agree with the Referee's conclusion that the insurer's unilateral termination of benefits was improper. [Citation omitted.]
>
> * * * * *
>
> "In affirming the Referee's order, we wish to stress that this is not a finding that claimant is entitled to temporary disability benefits during his incarceration. Rather, we are finding that the insurer's unilateral termination of benefits, although not unreasonable, was invalid." 39 Van Natta at 6.

Like Fisher, the instant claimant's temporary disability benefits were unilaterally terminated. Although a Determination Order issued here, it prematurely closed claimant's claim and is therefore set aside. Consequently, claimant is entitled to temporary disability benefits after July 23, 1985. Again, however, we wish to make clear that this is not a finding that claimant is entitled to temporary disability benefits while incarcerated. Rather, we are finding that the insurer's unilateral termination of claimant's existing temporary disability benefits followed by the premature closing of his claim during his incarceration, was invalid.

Claimant also requests penalties and attorney fees for the insurer's "blatantly unreasonable" conduct in requesting claim closure without supporting medical evidence. We do not find that the insurer either unreasonably delayed or unreasonably refused to pay compensation under ORS 656.262(10). The record reveals that the insurer had difficulty in locating claimant and in arranging a closing medical examination. Further, prior to our decision in Fisher, it was unclear whether an incarcerated worker had a continuing right to existing temporary disability benefits.

On cross-appeal, the insurer requests authorization to offset temporary disability benefits paid while claimant was

incarcerated. As in Fisher, we find that such a request should be addressed by the Evaluation Division at the time of proper claim closure.

The insurer also raises the issue of claimant's entitlement to temporary disability from December 12, 1985 through February 11, 1986, and accompanying penalties and attorney fees. The Referee found that claimant had established an aggravation claim based upon Dr. Poulson's chart notes of December 12 and 19, 1985. Thus, the Referee found that claimant was entitled to temporary disability benefits commencing on December 12, 1985, plus penalties and attorney fees for the insurer's failure to timely reopen the claim and pay temporary disability benefits.

We have found, however, that claimant's claim was prematurely closed by the Determination Order of July 25, 1985. Therefore, claimant's claim was still in open status when he saw Dr. Poulson on December 12, 1985. Accordingly, we find that claimant was entitled to continuing temporary disability benefits after July 23, 1985 through February 11, 1986.

Lastly, we agree with the Referee's finding that the insurer's failure to pay temporary disability benefits until February 12, 1986, and its failure to pay such benefits retrospectively to December 12, 1985, was unreasonable. ORS 656.273(6).

ORDER

The Referee's order is affirmed, reversed, and modified. That portion of the Referee's order that failed to award temporary disability compensation after July 23, 1985, is reversed. That portion of the Referee's order that awarded temporary disability from December 12, 1985 through February 11, 1986, plus accompanying penalties and attorney fees is modified. The insurer shall pay temporary disability benefits from July 24, 1985 through February 11, 1986. Claimant's attorney is awarded an attorney fee equal to 25 percent of the increased compensation granted by this order, not to exceed $3,000. All other portions of the Referee's order are affirmed.

MICHAEL H. TURNER, Claimant
Gary J. Susak, Claimant's Attorney

WCB 86-03882
June 1, 1987
Order on Review

Reviewed by Board Members Lewis and McMurdo.

Claimant requests review of Referee Fink's order that upheld the self-insured employer's denial of his occupational disease claim for left ear hearing loss and tinnitus. No briefs have been filed on review. The issue is compensability.

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

Lay testimony on medical issues may be persuasive, but if we find the lay testimony unpersuasive or insufficient to resolve complex medical issues, we may require expert medical opinion to resolve the issue. Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985); Uris v. Compensation Department, 247 Or 420, 424 (1967). Here, claimant attempted to prove his case by relying on audiograms, which he termed "relatively self-explanatory." He offered no medical opinion regarding the

causation of his alleged occupational disease. Whether or not the audiograms are "self-explanatory," we find that the causal relationship between claimant's alleged occupational disease and his employment with the self-insured employer requires expert medical analysis. Kassahn, supra; Uris, supra. Claimant, however, failed to present any expert medical opinion on the issue of causation. Consequently, we find that the evidence does not preponderate in favor of compensability.

ORDER

The Referee's order dated October 22, 1986, as supplemented, is affirmed.

ANTONIO URREA, Claimant
Tharp & Van Atta, Claimant's Attorneys
Butler & Looney, Attorneys
Lester Huntsinger (SAIF), Defense Attorney
Carl M. Davis, Ass't. Attorney General

WCB 85-06541
June 1, 1987
Order on Review

Reviewed by Board Members McMurdo and Lewis.

Claimant requests review of Referee Leahy's order that upheld the SAIF Corporation's denial, on the noncomplying employer's behalf, of his back injury claim. The issue is whether claimant was a subject employe.

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

After de novo review, we conclude that claimant has failed to sustain his burden of proof. Claimant testified that the injury occurred on December 12, 1985 after working two days. He told Dr. Bills that the injury occurred around December 23, 1984, but was seen in the Emergency Room on December 21, 1984. Further, claimant initially reported the claim to the employer's liability insurer stating in a recorded statement that the injury occurred while visiting his brother at the employer's dairy. His explanation of why he did not initially file his claim through workers' compensation system is not persuasive.

We recognize that the testimony of Gilbert and Hodges lends support to claimant's claim. However, neither witness observed claimant working at the dairy during the period he claimed he was injured. Furthermore, claimant's brother was an employe of the dairy. The testimony of the employer indicates that claimant voluntarily assisted his brother with his work at the dairy. Both co-workers observed claimant working with his brother. Based upon this record, we cannot conclude that it is more likely than not that claimant's injury occurred while working for the employer. Consequently, we conclude that claimant has failed to prove that he was a subject employe at the time of his injury.

ORDER

The Referee's order dated February 11, 1986 is affirmed.

BRUCE A. BASHAM, Claimant
Jerry Gastineau, Claimant's Attorney
Brian Pocock, Defense Attorney
Art Stevens (SAIF), Defense Attorney

WCB 85-06435 & 86-03198
June 2, 1987
Second Order on Reconsideration

Claimant has requested reconsideration of the Board's April 7, 1987 Order on Review, as supplemented and republished in its May 7, 1987 Order on Reconsideration. Specifically, claimant contends that he is entitled to an attorney fee for services on Board review.

In our previous orders, we agreed with the Referee's conclusion that claimant was entitled to an attorney fee for services rendered prior to hearing in procuring an order designating a paying agent under ORS 656.307. However, we modified the Referee's attorney fee award. Instead of an insurer-paid fee, claimant was awarded an attorney fee payable from his compensation. We relied on Mark L. Queener, 38 Van Natta 882 (1986). Inasmuch as responsibility was the sole issue raised by the insurers, and claimant did not prevail on his cross-request, he was not awarded an attorney fee for services on Board review.

In support of his contention that he should receive an attorney fee for services on review, claimant relies on Stovall v. Sally Salmon Seafood, 84 Or App 612 (April 8, 1987). In Stovall, the court concluded that claimant was entitled to attorney fees under ORS 656.386(1) for prevailing finally on her claim against a specific employer in a responsibility case. Although neither employer had questioned the claim's compensability, one employer had raised a defense that, if successful, would have prevented claimant from receiving compensation from either employer. Furthermore, no paying agent had been designated under ORS 656.307. Since claimant had actively participated in the proceedings and was justified in doing so to protect her right to compensation, the Stovall court held that she was entitled to an attorney fee award under ORS 656.386(1).

This case is distinguishable from Stovall. Here, neither insurer contested the claim's compensability. Moreover, unlike Stovall, compensability had been conceded by the insurers upon the issuance of an order designating a paying agent pursuant to ORS 656.307. Thus, claimant's participation was not necessary to protect his right to compensation. Furthermore, on review, claimant took no position concerning which of the insurers was responsible. Under these circumstances, an award of attorney fees for services at the hearing level and on Board review is inappropriate. OAR 438-47-090; Petshow v. Farm Bureau Ins. Co., 76 Or App 563, 569 (1985), rev den 300 Or 722 (1986); SAIF v. Phipps, 85 Or App 436 (May 20, 1987).

Accordingly, claimant's request for reconsideration is granted and our prior orders are withdrawn. On reconsideration, as supplemented herein, the Board adheres to and republishes our former orders, effective this date.

IT IS SO ORDERED.

THERESA SKOYEN, Claimant
Richard O. Nesting, Claimant's Attorney
Roberts, et al., Defense Attorneys

WCB 83-11958
June 2, 1987
Order on Review

Reviewed by Board Members Lewis and McMurdo.

The insurer requests review of that portion of Referee Knapp's order that set aside its partial denial of claimant's psychiatric condition and remanded the claim for processing to closure pursuant to ORS 656.268. Claimant cross-requests review, contending that she is entitled to an award of permanent total disability.

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

An insurer's acceptance of a claim includes only those injuries or conditions specifically accepted in writing pursuant to ORS 656.262(6). Johnson v. Spectra Physics, 303 Or 49, 58 (1987). Mere payment of compensation does not constitute acceptance of a claim. ORS 656.262(9); Gregg v. SAIF, 81 Or App 395 (1986). An insurer may partially deny a claim if it specifies which injuries or conditions it accepts and which it denies. Johnson v. Spectra Physics, supra.

After applying the aforementioned precedent to the present case, we conclude that the insurer's payments for a portion of claimant's psychiatric treatments did not foreclose it from subsequently denying responsibility for her psychiatric condition. Inasmuch as the insurer had not specifically accepted responsibility for claimant's psychiatric condition, its partial denial was not prohibited under Bauman v. SAIF, 295 Or 788 (1983). Johnson v. Spectra Physics, supra.

However, following our de novo review of the medical and lay evidence, we are persuaded that claimant's compensable injury was a material contributing cause of her psychiatric condition, or its worsening. Jeld-Wen, Inc. v. Page, 73 Or App 136 (1985); Partridge v. SAIF, 57 Or App 163 (1982). Consequently, we agree with the Referee's conclusion that claimant's current psychiatric condition is compensable.

Furthermore, since claimant's psychological claim has been found compensable, it has been remanded to the insurer for processing to claim closure pursuant to ORS 656.268. Thus, it would be inappropriate to determine claimant's permanent disability, until her claim has been properly closed. Kociemba v. SAIF, 63 Or App 557, 559-60 (1983); Gary A. Freier, 34 Van Natta 543, 545 (1982).

Finally, we consider the compensability issue to have been of ordinary difficulty with the usual probability of success for claimant. Accordingly, a reasonable attorney fee is awarded.

ORDER

The Referee's order dated March 24, 1986 is affirmed. Claimant's attorney is awarded $500 for services on Board review, to be paid by the insurer.

RANDY D. JOHNSON, Claimant
Coons & Cole, Claimant's Attorneys
Nelson, et al., Defense Attorneys

WCB 85-09413
June 4, 1987
Order on Review

Reviewed by Board Members Ferris and Lewis.

Claimant requests review of that portion of Referee Michael Johnson's order that: (1) declined to set aside a Determination Order as premature; (2) upheld the insurer's "de facto" denial of claimant's aggravation claim for a back condition; and (3) declined to rate the extent of claimant's unscheduled permanent disability. The insurer cross-requests review, but has filed no brief. The insurer has also moved the Board for remand pursuant to ORS 656.295(5). The issues on review are premature claim closure, aggravation, extent of unscheduled disability, and remand.

Claimant compensably injured his mid-back in October 1984, while working for a meat packing company. Claimant continued working until December 1984, when he saw Dr. Bamforth, chiropractor. Dr. Bamforth diagnosed a muscle spasm and treated conservatively. In June 1985, claimant underwent an independent medical examination performed by Dr. Howell, osteopath. Howell found no signs of objective abnormalities and declared claimant medically stationary on that date. That same month, Dr. Bamforth agreed that claimant was medically stationary, but opined that he suffered some permanent disability. Shortly thereafter, claimant's claim was closed with an award of five percent unscheduled permanent disability.

In September 1985, Dr. Bamforth rated claimant's physical impairment as "mild to moderate." Subsequently, Dr. Howell reported that he could find no evidence to support an increased award of permanent disability.

At the hearing held on February 20, 1986, the sole issue was extent of unscheduled disability. There was no evidence presented on any other issues. Neither party moved to leave the record open nor objected when the Referee stated, "the record will not be held open for anything further."

Claimant testified that his employment history included work as a sound technician, carpenter, grave digger, and waiter. After his 1984 compensable injury, he worked a few months each as a service station attendant and a delicatessen clerk. At the time of the hearing, he had been employed full time as an auto salesman for approximately six weeks. He could no longer perform many of his former jobs and had recently refused a job loading trucks because of his back condition. His back worsens in cold weather, he has trouble sleeping, and he takes prescription medication to reduce inflammation.

Four days after the hearing, the insurer asked that the Referee reopen the record. The basis of the insurer's motion was a February 13, 1986 report from Dr. Randle, neurologist. According to the insurer, the report was received after the hearing and was relevant to the issue of extent of permanent disability. Dr. Randle, who examined claimant on referral from Dr. Bamforth, reported that claimant's pain did not produce any permanent impairment. However, Dr. Randle further reported that claimant's 1984 compensable injury had resulted in scarring near

the T-7 level, which was causing nerve entrapment. If conservative treatment was not successful, Dr. Randle recommended either local injections or surgical exploration.

Claimant objected to the insurer's motion and argued that if Dr. Randle's report were received into evidence, the insurer should voluntarily set aside the Determination Order and pay retroactive temporary disability benefits. The Referee allowed the insurer's motion and admitted Dr. Randle's report into evidence. The Referee stated that "good cause" had been shown for late submission of the report inasmuch as claimant had missed his first appointment with Dr. Randle, resulting in the rescheduling of the examination one week prior to the hearing. The Referee went on to state that claimant's attorney could cross-examine Dr. Randle, as well as formally raise the issue of premature claim closure. Claimant's attorney responded affirmatively on both counts. The Referee then issued an order in May 1986 that: (1) left the record open for Dr. Randle's deposition; and (2) added the additional issue of premature claim closure.

Following Dr. Randle's deposition, the parties submitted written closing arguments. In so doing, each party briefly argued the merits of whether claimant had sustained an aggravation. Consequently, the Referee's final order addressed the further issue of aggravation. The Referee ultimately found that claimant had proven neither an aggravation nor premature claim closure. However, based on Dr. Randle's opinion, the Referee concluded that claimant was not medically stationary. Thus, the Referee ordered the insurer to reopen claimant's claim and submit it for closure when his condition became medically stationary.

We disagree with the Referee's reopening of the record after the hearing. OAR 438-07-025 provides:

> "(1) The Referee may reopen the record and reconsider his or her decision before a notice of appeal is filed or, if none is filed, before the appeal period expires. Reconsideration may be upon the referee's own motion or upon a motion by a party showing error, omission, misconstruction of an applicable statute or the discovery of new material evidence.
>
> "(2) A motion to reconsider shall be served on the opposite parties by the movant and, if based on newly discovered evidence, shall state:
>
> "(a) The nature of the new evidence; and
>
> "(b) An explanation why the evidence could not reasonably have been discovered and produced at the hearing."

Here, the insurer was aware that claimant had been referred to Dr. Randle as early as July 1985. Moreover, prior to the hearing, the insurer sent a letter to Dr. Randle specifically requesting a report for litigation purposes. Pursuant to OAR 438-06-090, "[e]ach party shall be prepared to produce at hearing all evidence to establish their case." At the hearing, however,

the insurer failed either to subpoena Dr. Randle or to move to hold the record open for receipt of his February 1986 report. Under such circumstances, we find that Dr. Randle's opinion could reasonably have been discovered and produced at the time of, if not before, the hearing. OAR 438-07-025(2)(b). Therefore, we do not consider either Dr. Randle's report or his testimony on review.

We further disagree with the Referee's adjudication of additional issues that were not raised at the hearing. We wish to make clear, that when the record was closed at the end of the hearing the only issue raised was the extent of claimant's unscheduled permanent disability. See Carr v. Allied Plating Co., 81 Or App 306, 309 (1986); Million v. SAIF, 45 Or App 1097, 1102, rev den 289 Or 337 (1980); Thomas E. Harlow, 38 Van Natta 1406 (1986); Pamela R. Rard, 38 Van Natta 1524 (1986). Thus, the issues of premature claim closure and aggravation were not properly before the Referee.

The insurer requests remand to allow the Referee to take further evidence of a February 1987 report authored by Dr. Randle, as well as a March 1987 Determination Order. We may remand to the Referee should we find that the record has been "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(5). To merit remand it must be clearly shown that material evidence was not obtainable with due diligence at the time of the hearing. Kienow's Food Stores v. Lyster, 79 Or App 416 (1986); Delfina P. Lopez, 37 Van Natta 164 (1985).

Here, the record pertaining to the extent of claimant's unscheduled permanent disability was properly, completely, and sufficiently developed at the close of the hearing. Moreover, as we previously stated, Dr. Randle's opinion was obtainable with due diligence at the hearing. Accordingly, after de novo review, we find that remand is not warranted.

Having excluded Dr. Randle's opinion, the record before us establishes that claimant was medically stationary at the time of the hearing. We therefore proceed to rate the extent of claimant's unscheduled permanent disability. In rating the extent of claimant's unscheduled permanent disability for his mid-back, we consider his physical impairment as reflected in the medical record, the testimony at the hearing, and all of the relevant social and vocational factors set forth in OAR 436-30-380 et seq. We apply these rules as guidelines, not as restrictive mechanical formulas. See Harwell v. Argonaut Insurance Co., 296 Or 505, 510 (1984); Howerton v. SAIF, 70 Or App 99, 102 (1984).

At the time of hearing, claimant was 23 years old and successfully employed full time as an auto salesman. He lacks one semester from obtaining a high school diploma and has completed two terms of college course work. Dr. Howell opined that claimant had no permanent impairment. Dr. Bamforth opined that claimant had mild to moderate impairment. Claimant testified to bending and lifting restrictions, as well as pain.

Following our de novo review of the medical and lay evidence, we conclude that the Determination Order's award of five percent unscheduled permanent disability adequately and appropriately compensates claimant for his permanent loss of earning capacity due to the industrial injury. Therefore, we decline to award any additional permanent disability.

ORDER

The Referee's order dated September 5, 1986 is reversed. The Determination Order dated July 18, 1985 is affirmed insofar as it pertains to claimant's award of unscheduled permanent disability.

MARIO ALVAREZ, Applicant
Ann Kelley, Ass't. Attorney General

WCB CV-87005
June 5, 1987
Crime Victim Compensation
Order of Remand

This matter is before the Board on the applicant's request for review and hearing concerning the Department of Justice's Findings of Fact, Conclusions and Order on Reconsideration dated February 26, 1987. By its order, the Department denied compensation to the applicant under the Victims of Crime Compensation Act (ORS Chapter 147).

Applicant has requested that the Board consider medical records from Good Samaritan Hospital and Medical Center that were recently provided by the hospital to the Department. These hospital records were not received by the Department prior to the issuance of its February 26, 1987 Order on Reconsideration. According to applicant, these records "detail [his] injury and subsequent treatment." The Department was granted an opportunity to reply to applicant's request, but no response has been received.

Pursuant to ORS 147.155(5), no evidence is admissible at a hearing before the Board that has not previously been considered by the Department. However, the Board is also empowered to conduct proceedings in any manner that will achieve substantial justice. Lynda J. Dean, 39 Van Natta 328 (April 24, 1987).

The current record contains several medical reports from attending physicians. Yet, the record apparently does not contain applicant's "complete" hospital record, "including emergency room reports," as the Department had previously requested from the hospital. Under these circumstances and considering the potential relevance of these materials, we conclude that substantial justice would best be served by the Department's consideration of applicant's entire hospital record.

Accordingly, this matter is remanded to the Department of Justice Crime Victims' Compensation Fund for further consideration of the record, consistent with this order.

IT IS SO ORDERED.

RAYMOND E. RUSCHER, Claimant
Charles Maier, Claimant's Attorney
Edward C. Olson, Defense Attorney

WCB 85-14299
June 5, 1987
Order on Review

Reviewed by Board Members Lewis and McMurdo.

Claimant requests review of those portions of Referee Nichols' order that: (1) awarded claimant 160 degrees for 50 percent unscheduled permanent partial disability in lieu of a Determination Order award of 96 degrees for 30 percent unscheduled disability for the cervical and dorsal spine; and (2) denied

claimant's request for penalties and attorney fees for the insurer's alleged failure to timely submit payment for certain medical bills. The issues are extent of unscheduled disability, including permanent total disability, and penalties and attorney fees.

We affirm that portion of the Referee's order that awarded claimant 50 percent unscheduled permanent partial disability. We reverse, however, that portion of the order denying claimant penalties and attorney fees.

There is evidence that the insurer failed to pay certain compensable medical billings in a timely fashion. The insurer has offered no explanation for the late payment. The Referee acknowledged that payments had not been timely submitted. She found, however, that because there was no evidence that claimant had been denied medical services as a result of the untimely payments, the resulting dispute would be a matter for resolution by the Workers' Compensation Department. She therefore concluded that there was no basis for the imposition of penalties and attorney fees. We disagree.

One purpose for requiring timely payment of compensable medical billings is to give claimant notice as to whether claimed services are being accepted or denied. See Billy J. Eubanks, 35 Van Natta 131 (1983). As to that purpose, whether claimant actually receives services while awaiting acceptance or denial is largely irrelevant. The insurer's duty to timely pay for compensable medical services is clear. Its failure to do so without explanation is unreasonable. Consequently, penalties and attorney fees are appropriate.

ORDER

The Referee's order dated September 16, 1986 is reversed in part and affirmed in part. That portion of the order that denied claimant's request for penalties and attorney fees is reversed. As a penalty for its failure to timely pay certain compensable medical billings, the insurer is assessed a penalty equal to 25 percent of the amount of those billings. For prevailing on the penalty issue, claimant's attorney is awarded a fee of $400, to be paid by the insurer. The remainder of the Referee's order is affirmed.

SHARON E. KELLEY (VanGORDER), Claimant
Roll, et al., Claimant's Attorneys
Bottini & Bottini, Defense Attorneys

WCB 86-01948, 86-13153 & 86-15802
June 10, 1987
Order Withdrawing Order of Dismissal

On May 7, 1987, we abated our April 10, 1987 Order of Dismissal to consider claimant's motion to vacate. Our dismissal order had been issued in response to claimant's prior request that her appeal from a Referee's order be withdrawn. Contending that she neither understood the nature nor the consequence of her previous withdrawal request, claimant has asked that her "appeal proceed because it was filed on time initially." In response to claimant's motion, the insurer contends that the Board lacks jurisdiction to allow the appeal to proceed. Claimant's request is granted.

Claimant's motion for withdrawal of her request for Board review is written in what appears to be her own handwriting. Although she was represented by legal counsel, there is no

indication that her counsel received a copy of this request. Our dismissal order specifically advised the parties of their "30-day" rights of appeal pursuant to ORS 656.295(8) and 656.298. Within this statutory period, claimant, through her attorney, requested reconsideration. With the request, claimant submitted her affidavit describing her emotional problems and general confusion with the review process. In addition, she included a report from her mental health therapist stating that claimant did not fully understand her rights of appeal. Prior to the expiration of the 30-day period, we abated our dismissal order.

Following our review of this matter, we are persuaded that claimant's appeal should proceed. The materials specifically submitted in support of the motion for reconsideration establish that claimant's withdrawal request was taken without benefit of counsel and in a state of mental and emotional confusion. Since her request for review and request for reconsideration were timely filed and considering the circumstances surrounding her withdrawal request, we conclude that claimant should be entitled to have the issues raised in her request for Board review considered. See Eduardo Ybarra, 35 Van Natta 1343 (1983).

Accordingly, upon issuance of this order, a hearing transcript shall be ordered. Once copies of the transcript are forwarded to the parties, a briefing schedule will be implemented.

IT IS SO ORDERED.

DAVID F. WEICH, Claimant
Peter O. Hansen, Claimant's Attorney
Acker, Underwood, et al., Defense Attorneys
Schwenn, Bradley, et al., Defense Attorneys
Barbara Brainard (SAIF), Defense Attorney

WCB 86-05419, 86-04681 & 86-04682
June 10, 1987
Order Denying Motion to Strike Brief

The SAIF Corporation, on behalf of its insured, Kach Machine Works, has moved the Board for an order striking claimant's appellant's brief on the ground that it was not served upon all parties to the hearing. SAIF contends, and the record indicates, that claimant mailed a copy of his appellant's brief to only one of three potentially responsible insurers.

Our rules of procedure do not expressly provide that a brief not served on all other parties may be stricken. See OAR 438-11-035(2). However, we conclude that such a remedy is implied and is within our discretion. James M. Kleffner, 38 Van Natta 1413 (1986).

The record establishes that claimant did not immediately provide SAIF (Kach) or another insurer with a copy of his appellant's brief. Yet, each insurer obviously obtained a copy because they have filed respondent's briefs specifically addressing the arguments raised in claimant's brief. Thus, no party has been aggrieved by claimant's failure to fully comply with our rules of procedure. Under these circumstances, we conclude that his appellant's brief should not be stricken.

Accordingly, the motion to strike claimant's appellant's brief is denied. Claimant's reply brief, if any, shall be due 14 days from the date hereof. OAR 438-11-015(2); 438-11-020.

IT IS SO ORDERED.

ROBERT L. MONTGOMERY, Claimant
Welch, Bruun & Green, Claimant's Attorneys
Leah Sideras (SAIF), Defense Attorney
Schwabe, et al., Defense Attorneys

WCB 85-10101, 85-03595, 85-03596 & 86-07797
Order on Reconsideration

Claimant has requested reconsideration of the Board's February 24, 1987 Order on Review in which we affirmed the Referee's finding that United Employers Insurance, rather than the SAIF Corporation, was responsible for claimant's low back, right hip, and right leg condition. Specifically, claimant requests an attorney fee for his counsel's services on Board review. On March 17, 1986, we abated our prior order and invited additional argument. After further consideration, we conclude that claimant is entitled to an attorney's fee.

At hearing, the issue was framed as "responsibility for claimant's low back, right hip and leg condition." Yet, the issue of compensability had not been formally conceded because no paying agent had been designated under ORS 656.307. Consequently, claimant was awarded an insurer-paid attorney fee for his participation at the hearing in setting aside United Employers' denial.

The issue of compensability was raised in United Employers' request for Board review. However, in its brief, United Employers did not question the claim's compensability. Rather, it asserted that SAIF was responsible for claimant's back, right hip and leg condition. In response to United Employers' assertions, claimant recommended that the Referee's responsibility finding be affirmed. Following our de novo review, we affirmed the Referee's order.

Pursuant to ORS 656.382(2), if a request for Board review is initiated by an employer/insurer, and the Board finds that the compensation awarded to claimant should not be disallowed or reduced, the employer/insurer shall be required to pay a reasonable attorney fee. However, unless claimant takes a position concerning which of the insurers is responsible and actively litigates that point, an award of attorney fees is inappropriate. SAIF v. Phipps, 85 Or App 436 (May 20, 1987); Petshow v. Farm Bureau Ins. Co., 76 Or App 563, 569 (1985), rev den 300 Or 722 (1986). Furthermore, where no paying agent has been designated under ORS 656.307 and claimant has actively participated in the proceedings to protect his right to compensation, he is entitled to an attorney fee award under ORS 656.386(1). Stovall v. Sally Salmon Seafood, 84 Or App 612 (April 8, 1987).

Here, no paying agent has been designated under ORS 656.307. Thus, although the primary issue addressed on review has been responsibility, the issue of compensability has not formally been conceded. Moreover, claimant has successfully defended the Referee's finding that United Employers is responsible for his low back, right hip, and right leg condition. Under these circumstances, we conclude that claimant has actively participated in these proceedings in order to protect his right to compensation. Accordingly, he is entitled to a reasonable attorney fee for services on Board review.

We have previously held that when compensability is merely a potential issue on Board review, claimant is not entitled

to an attorney fee. See Wayne A. Hawke, 39 Van Natta 31 (1987); Karen J. Bates, 39 Van Natta 100 (1987). Thus, to the extent the reasoning expressed in those cases is contrary to this holding, that reasoning is rejected.

Finally, we consider this issue to have been of ordinary difficulty with the usual probability of success for claimant. Consequently, a reasonable attorney fee is awarded.

ORDER

Our February 24, 1987 Order on Review is withdrawn. On reconsideration, as modified herein, we republish and adhere to our February 24, 1987 order, effective this date. Claimant's attorney is awarded $400 for services on Board review, to be paid by United Employers Insurance Company.

JACK D. RICHARDSON, Claimant
Emmons, et al., Claimant's Attorneys
Acker, Underwood, et al., Defense Attorneys
Roberts, et al., Defense Attorneys

WCB 84-13066 & 85-00971
June 11, 1987
Order Denying Motion for Reconsideration

Claimant has moved the Board for an order granting him an award of attorney fees payable from claimant's compensation. We conclude that we lack jurisdiction to consider the motion.

The relevant facts are as follows. Following an insurer's request for Board review, we reversed the Referee's finding concerning responsibility for claimant's carpal tunnel syndrome. Jack D. Richardson, 38 Van Natta 270, 470 (1986). In addition, we reversed the Referee's award of attorney fees, finding that claimant was not entitled to an attorney fee for services at hearing pursuant to ORS 656.386(1) or on Board review pursuant to ORS 656.382(2). Jack D. Richardson, supra, 38 Van Natta at 273. Claimant timely requested appellate review, asserting entitlement to attorney fees at the hearings level and on review. On March 11, 1987, the Court of Appeals affirmed our order without opinion. Richardson v. National Fruit Canning, 84 Or App 427 (1987).

Claimant contends that the court merely ruled that he was not entitled to an insurer-paid attorney fee. Consequently, for his counsel's services in procuring an order designating a paying agent under ORS 656.307 and for otherwise protecting his right to compensation, claimant now requests that his attorney be allowed a fee payable from his compensation.

The Board has jurisdiction to consider timely requests for review of Referee orders. See ORS 656.289; 656.295. Furthermore, pursuant to ORS 656.278, the Board has continuing jurisdiction to modify, change, or terminate former findings, orders or awards. However, such action must be justified and cannot be undertaken while claimant has the right to request a hearing on aggravation under ORS 656.273. See ORS 656.278(1) and (2).

Here, claimant timely appealed the Board's orders. With this appeal, jurisdiction left the Board and became vested with the Court of Appeals. See ORS 656.295(8); 656.298. The court's subsequent affirmation of the Board's order has now become final by operation of law. Thus, the Board lacks jurisdiction to consider any issue emanating from either the Referee's, its own, or the

court's prior orders. The issue of claimant's entitlement to attorney fees, whether insurer-paid or payable from compensation, would naturally be encompassed within these orders. Moreover, since claimant continues to retain his aggravation rights, his request is an inappropriate matter for the exercise of the Board's Own Motion authority. See ORS 656.278(2).

Accordingly, for the foregoing reasons, we conclude that we lack jurisdiction to consider claimant's request. Claimant's motion is therefore denied.

IT IS SO ORDERED.

CAROLYN J. GANT, Claimant
Merrill Schneider, Claimant's Attorney

WCB TP-87004
June 12, 1987
Third Party Order

Claimant has petitioned the Board to resolve a dispute as to the just and proper distribution of the proceeds of a settlement of an action against a third party. We have jurisdiction pursuant to ORS 656.593(3). Denton v. EBI Companies, 67 Or App 339 (1984). The sole issue is whether the cost of two independent medical examinations are included within the insurer's statutory lien under ORS 656.580(2).

The independent medical examinations were performed by Dr. Mandiberg, orthopedist. One occurred in August 1986 and the other in March 1987. The insurer describes these examinations as a necessary part of the management of the claim. Noting that these examinations were initially prompted by claimant's quest for additional information, the insurer asserts that the examinations were beneficial to claimant since she obtained an orthopedic explanation for her condition and treatment. We conclude that the expenses from these examinations should not be included within the insurer's lien.

The insurer contends that the August 1986 examination was the direct result of claimant's dissatisfaction with her current treatment and her request for a second opinion. In addition, the insurer suggests that the purpose of this examination was three-fold: (1) to secure a more specific diagnosis; (2) to recommend future treatment, if any; and (3) to evaluate any permanent impairment. Yet, the insurer acknowledges that claimant expressed her concerns on May 1, 1986, some four months prior to Dr. Mandiberg's examination.

In August 1986 Dr. Mandiberg diagnosed a cervical strain and a "frozen" left shoulder. The cervical strain was considered stationary. However, Dr. Mandiberg recommended physical therapy, under an orthopedist's supervision, for claimant's shoulder. Dr. Mullins, claimant's treating chiropractor, generally concurred with Dr. Mandiberg's findings. Yet, other than periodic chiropractic treatments, no further therapy was apparently forthcoming.

On November 26, 1986, the insurer submitted the claim for closure. However, on December 24, 1986, the Evaluation Division refused to close the claim without additional information concerning claimant's current left shoulder condition. Thereafter, arrangements were made for claimant to be reexamined by Dr. Mandiberg. Concluding that claimant's shoulder was stationary, Dr. Mandiberg did not feel that further treatment was

needed. Once Dr. Mandiberg's March 1987 report was submitted to the Evaluation Division, the claim was closed.

Although the insurer characterizes Dr. Mandiberg's examinations as a necessary part of the management of the claim, we consider the examinations and subsequent reports to have been obtained for claim evaluation purposes. The insurer's receipt of each report was not followed by inquiries into further treatment options. Rather, each report precipitated actions designed to submit the claim for closure and evaluation.

We have previously held that claim evaluation reports are analogous to litigation reports and, as such, not properly includable in a paying agency's lien against a third party recovery. Darrell L. Rambeau, 37 Van Natta 144 (1986); Shawn Cutsforth, 35 Van Natta 515, 517 (1983). In keeping with the Cutsforth rationale, we conclude that Dr. Mandiberg's bills are not an expenditure for "compensation, first aid or other medical, surgical or hospital service." See ORS 656.593(1). Consequently, these expenses are not properly a part of the insurer's lien.

Accordingly, we hold that the insurer is entitled to be paid and retain the sum of $2,496.12 from the proceeds of claimant's third party settlement in full satisfaction of its lien for expenditures for compensation, including its expected future expenditures. Thus, the parties shall make the necessary financial adjustments and effect distribution of the settlement proceeds in compliance with ORS 656.593 and this order.

IT IS SO ORDERED.

BETTY L. ZIEMER, Claimant
Kenneth D. Peterson, Claimant's Attorney
Alan Ludwick (SAIF), Defense Attorney

WCB 85-11899
June 12, 1987
Order on Review

Reviewed by Board Members Lewis and McMurdo.

Claimant requests review of Referee Leahy's order that upheld the SAIF Corporation's denial of claimant's aggravation claim for the low back. Claimant also asserts that the Referee erred by admitting a certain medical report into evidence. Finally, claimant asks that we admit into evidence a medical report authored on May 2, 1986. The issues are compensability and whether certain exhibits should have been admitted into the record.

We affirm the Referee's order with the following comment. Claimant asks that a May 2, 1986 report from Dr. Ford be admitted into the record. We treat claimant's request as one for remand. We find remand to be inappropriate, however, because the record does not reflect that such a report exists or that it was ever offered by any party. Claimant represents that the report was discussed by the parties and the Referee and that it was tacitly agreed that it would become part of the record. Any discussion that occurred must have been off the record, however, for nowhere in the record does the report or a discussion thereof appear.

ORDER

The Referee's order dated August 28, 1986 is affirmed.

LINDA DYER KARNA, Claimant
Roll, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys

Own Motion 86-0306M
June 16, 1987
Own Motion Order

The Board issued an Own Motion Order on June 16, 1986 whereby claimant's claim was reopened with temporary total disability compensation to commence September 12, 1985 and continue until closure pursuant to ORS 656.278. The insurer subsequently requested that the Board abate its order and reconsider its decision. The order was abated and both parties have now submitted their respective arguments and reports.

Claimant originally saw Dr. Davis, an osteopath, on September 12, 1985. However, his only report was not written until February 7, 1986. In that report he indicated he was unaware that claimant was filing a work-related injury claim. He felt her condition was not medically stationary and was unable to state how much treatment would be necessary. Claimant subsequently saw Dr. Schostal on September 27, 1985. He referred her to Dr. Berkeley for evaluation. On October 17, 1985, Dr. Berkeley stated that claimant appeared to be developing more radicular symptoms in her right arm, although she was experiencing sensory impairment on the left side. On December 26, 1985 he wrote directly to claimant, advising her that the recent myelogram showed very minor changes at C4-5 and C6-7. He did find some nerve root problems, but they did not require surgery. In conclusion, Dr. Berkeley stated ". . . I feel that if you are continuing to have severe pain, certainly you should abstain from working. . . . I can keep you off work as long as you hurt and I would expect you to let me know when you would be able to return to some sort of employment." No further reports were submitted from Drs. Davis, Schostel or Berkeley.

Claimant is now treating with Dr. Heatherington, who, in August 1986, indicated that her condition was not yet stationary, although it was much improved. He indicated that claimant was able to return to work in August 1986. The Orthopaedic Consultants, in September 1986, found claimant's condition to be medically stationary and no treatment recommended.

After thorough review of the evidence, the Board concludes the decision reached in its June 16, 1986 order must be reversed. The doctor upon whose report we relied earlier did not indicate claimant was disabled from work and, as far as we can ascertain, did not continue to see her. Dr. Berkeley provided only palliative treatment, if he treated her at all. Again, we have only one report from him. We have no report from Dr. Heatherington which would indicate his diagnosis of the problem and whether or not he intends to provide curative treatment. Based on the record before us, we find claimant saw at least five doctors during a one-year period, underwent curative treatment with none of them, and returned to gainful employment on her own initiative. We conclude claimant's symptoms did increase during that time; however, there is no evidence that her condition worsened beyond that which would be expected with the 45 percent disability award she has already been granted. The June 16, 1986 Own Motion Order is hereby reversed. The request for own motion relief is denied.

IT IS SO ORDERED.

RONALD L. McMAHILL, Claimant
Brian R. Whitehead, Claimant's Attorney
Garrett, et al., Defense Attorneys

WCB 85-04851
June 16, 1987
Amended Order on Review

Reviewed by Board Members McMurdo and Lewis.

The Board has learned that the "Order" portion of its May 19, 1987 Order on Review has misidentified the insurer. Our order directs the SAIF Corporation to process claimant's aggravation claim, including the payment of compensation and attorney fees. However, the employer is not represented by SAIF, but instead is self-insured.

Therefore, in the interests of substantial justice, we conclude that our prior order should be withdrawn and replaced with this amended order. Accordingly, by this reference, our prior order is adhered to and republished in its entirety, with the following amendment. All references to the "SAIF Corporation" should be deleted and replaced with the words "self-insured employer." Rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

ARNOLD G. WHEELER, Claimant
Joseph T. McNaught, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

Own Motion 87-0276M
June 16, 1987
Interim Own Motion Order

The SAIF Corporation has requested that the Board exercise its Own Motion authority pursuant to ORS 656.278 and reevaluate claimant's permanent total disability award. Inasmuch as claimant's 1960 injury predated the 1965 amendments to the Workers' Compensation Act (1965 Or Laws, Ch. 285), we have jurisdiction to consider SAIF's request. Elgan E. Amidon, 37 Van Natta 612, 614 (1985).

Following our review of the documents submitted by SAIF, we conclude that it would be appropriate to refer this matter to the Hearings Division. See OAR 438-12-005(1)(d); 438-12-010. At the hearing, any additional documentary and testimonial evidence shall be taken concerning whether claimant remains entitled to an award of permanent total disability. Should the Referee find that claimant is no longer entitled to such an award, the extent of his permanent disability shall also be rated.

After conducting the hearing, the Referee is instructed to forward to us the entire documentary record, including a transcript of the hearing. In addition, the Referee shall provide us with proposed findings and recommendations concerning SAIF's request.

IT IS SO ORDERED.

MICKY A. THRESHER, Claimant
Max Rae, Claimant's Attorney
Schwabe, et al., Defense Attorneys

WCB 85-10230
June 23, 1987
Order Denying Reconsideration

Claimant has requested reconsideration of the Board's Order on Review dated June 1, 1987. Specifically, claimant asserts that he is entitled to a reasonable attorney fee award for prevailing on two issues raised in the insurer's cross-request for Board review.

Claimant's request for reconsideration was mailed on June 10, 1987. Yet, on or about June 9, 1987, the insurer had petitioned for judicial review. We have previously held that we are authorized to withdraw an Order for Reconsideration after the filing of a petition for judicial review with the Court of Appeals. Dan W. Hedrick, 38 Van Natta 208, 209 (1986). However, we choose not to exercise our authority in this instance. In any event, had we reconsidered this matter, it is unlikely that we would have found that claimant was entitled to an insurer-paid attorney fee for responding to the insurer's cross-appeal. See Richard M. Deskins, 38 Van Natta 825, 826 (1986).

Accordingly, the request is denied. Instead, we adhere to our prior order. Furthermore, the issuance of this order neither "stays" our prior order nor extends the time for seeking review. International Paper Company v. Wright, 80 Or App 444 (1986); Fischer v. SAIF, 76 Or App 656 (1985).

IT IS SO ORDERED.

LINDA L. BEARD, Claimant
Bottini, et al., Claimant's Attorneys
Acker, Underwood, et al., Defense Attorneys

WCB 86-00068
June 24, 1987
Order on Review

Reviewed by Board Members Lewis and McMurdo.

Claimant requests review of Referee Shebley's order that upheld the insurer's denial of claimant's occupational disease claim for mental stress. The issue is compensability. We reverse.

Claimant sustained a compensable shoulder injury while employed by a hospital in February 1977. The injury ultimately required three surgeries, finally precluding claimant from returning to her regular work as a nurse's aide. She received vocational assistance in the form of two light-duty-job placements. Both failed and claimant became depressed. She then came under the care of Dr. Colistro, a psychologist. His active treatment of claimant began in September 1982, and it continued up to the time of the present hearing.

On July 14, 1983, claimant went to work on a wage subsidy basis for the present employer, Dr. Gregory Shipp, a chiropractor. At the time she began, claimant continued to seek treatment from Dr. Colistro for anger and depression associated with her prior failed employment experiences. After a brief period of adjustment, claimant felt comfortable with her new receptionist job. She discontinued her medication for several months and reported feeling that her prior depression had come to an end.

As Dr. Shipp's receptionist, claimant was responsible

for screening all phone calls, receiving up to 70 patients per day, making up new files, scheduling appointments, effecting bill collections and working on the computer. As time went on, claimant began to feel overwhelmed by the volume of work for which she was responsible. She kept in close contact with Dr. Colistro, and occasionally complained of the stresses associated with her work load. In addition to her work load, claimant complained of having to pay $1,600 for a mandatory training seminar, while other employes' tuition was paid by the employer. According to claimant, Dr. Shipp also showed general favoritism toward certain employes while others appeared to receive more work and fewer benefits.

Claimant also complained that her employer regularly listened in on her telephone conversations. She indicated that she felt ethically compromised by billing insurance companies twice for a single treatment and by charging patients for therapies they did not receive. She was also given the duty of calling patients who failed to keep appointments and reminding them of the importance of coming in for therapy. Claimant found this duty uncomfortable. She also found disturbing the job of collecting money from patients, including an apparent $5.00 surcharge from each patient to cover the "research" involved in putting together disability forms.

Claimant testified that Dr. Shipp was issued a check for $235.00 by the Workers' Compensation Department Rehabilitation Fund to purchase a mat to be used under her chair. According to claimant, Shipp cashed the check but did not purchase the mat. Instead, he provided claimant with a used mat from the office. Claimant's other complaints included her allegation that some part-time employes were being paid more than certain full-time workers, that Dr. Shipp wanted all conversations at the front desk tape recorded, that he released patients' confidential files to other patients who worked for insurance companies, and that claimant and other employes were required to pay Dr. Shipp 25 cents each time they uttered something negative about their employment.

Claimant testified that she received two offers of employment from other medical offices during her tenure. She declined both, however, after being told by Dr. Shipp that she was indispensable as an employe. Then, on October 15, 1985, claimant was called into Shipp's office where, according to claimant, she was told by him: " . . . I've got some good news and I've got some bad news for you . . . the first news is 'I love you.' The second news is that I'm letting you go . . ."

Claimant testified that she had received no warning of her impending termination and that Dr. Shipp did not attempt to explain the reasons for it during their conversation. According to claimant, Shipp indicated that he had arranged a part-time position for her in another clinic, but when she later inquired, there was no job available. Claimant testified that the method of her firing, coupled with the fact that she was again unemployed, caused her depression to return. She began seeking additional treatment from Dr. Colistro, and filed a stress-related claim for occupational disease in late October 1985.

Ms. Gill, who was employed by Dr. Shipp during a portion of the time claimant worked there, also testified. She corroborated claimant's testimony with regard to her allegations

of a heavy work load, favoritism, double billing, and the generally stressful working environment in Dr. Shipp's office.

Dr. Shipp also testified. He denied that claimant was required to participate in the collection of delinquent accounts. He also denied that he participated in favoritism. He admitted that some of claimant's telephone calls were monitored for the purpose of ensuring that she was providing the right information to callers. With regard to the allegation of double billing, Dr. Shipp asserted that two insurers would be billed only if a patient had incurred injuries to two parts of the body in different accidents, and treatments were provided separately for each injury in one visit. He admitted that he released patients' files to a certain insurer's claims examiner, who reviewed files for him as payment for her personal chiropractic care.

Dr. Shipp testified that during the last few months of claimant's employment, she did not complain of being overworked and, in fact, seemed quite satisfied with her employment. With regard to the events surrounding claimant's termination, Shipp indicated that because of claimant's ongoing shoulder therapy, she was unable to assist an associate chiropractor in manipulating patients for the purpose of taking x-rays. As a result, claimant's usefulness at the office declined and he considered terminating her. With regard to the event that led to the actual termination, Dr. Shipp testified:

> "As far as the termination went . . . my wife was eight months pregnant at the time, it turned out that the Hawaii trip [a bonus offered to employes who performed well] was due, and she basically said she didn't want to go . . . So I had a patient . . . who was going to go in her place. When I let [claimant] know that, she basically said that it was unfair and didn't want to go to Hawaii. Then I was posed with well, why is she here, why am I keeping her here, because now she's said that she's not going to go to the Hawaii trip and she's going to stay home."

Shipp then called claimant into his office and offered the "good news - bad news" scenario. He testified that he did not indicate to claimant that he had arranged another job placement for her. He admitted that he did not discuss with claimant the reasons for her firing prior to the termination, and that claimant probably felt she was doing an adequate job up to the time of the firing.

Claimant was recalled as a witness and testified that she was unaware that Dr. Shipp was dissatisfied with her work product prior to her firing. Although she was not a trained x-ray technologist, Shipp did not suggest that she acquire training in that regard. According to claimant, her termination came as a complete surprise.

Dr. Colistro, the treating psychologist, was deposed. He testified that he began treating claimant on a regular basis in 1982, but that her depression had largely resolved at the time she began working for Dr. Shipp. In Colistro's opinion, claimant's depression gradually increased during her tenure with Shipp

because of her work load, long hours and several incidents in which she felt ethically compromised by Shipp's billing policies. Then, with the unexpected termination, claimant's condition markedly worsened, resulting in greater depression and suicidal ideations.

Dr. Turco, a consulting psychiatrist, also was deposed. He testified that he saw claimant on two occasions and that, in his opinion, claimant's termination was a far greater stressor than her working environment in general. He also indicated that, in his opinion, claimant's problem was primarily the result of her emotional make-up. He also indicated, however, that if claimant's representations regarding her working environment were true, the work would have been a contributory factor leading to her emotional disturbance.

The Referee found no reason to disbelieve claimant's account of her working conditions. In fact, he found claimant's version of the facts "much more convincing and believable than her employer's." Despite this finding, the Referee concluded that claimant's claim was not compensable. He found that it was claimant's termination, rather than the conditions of her employment, that resulted in her psycholgical condition. The Referee cited Elwood v. SAIF, 298 Or 429 (1985), for the proposition that job termination itself is not compensable. While we agree with the Referee that stress resulting from job termination alone is not compensable, we find that his analysis of Elwood was incomplete.

It is claimant's burden to prove the compensability of this claim for occupational disease. In order to satisfy that burden, she must prove that stressful conditions, viewed objectively, existed on the job. McGarrah v. SAIF, 296 Or 145, 166 (1983). She must also prove that the employment conditions, when compared with nonemployment conditions, were the major contributing cause of her mental disorder. Dethlefs v. Hyster Co., 295 Or 298 (1983). Finally, because claimant's psychological condition preceded her employment, she must prove that her employment exposure was the major cause of a worsening of her underlying condition. Weller v. Union Carbide, 288 Or 27 (1979).

In Elwood v. SAIF, supra, the Supreme Court discussed the effects of job termination and whether or not it is compensable. The Court concluded:

> " . . . [T]he occupational disease law did not make illness from losing a job a compensable risk of the job . . . The line, we think, runs between illness resulting from the stress of actual or anticipated unemployment, which is not compensable, and illness resulting from the circumstances and manner of discharge, which can be regarded as events still intrinsic to the employment relationship before termination and can lead to compensation." Id. 298 Or at 433 (emphasis added).

We interpret the Court's holding to be that, while stress resulting from the isolated act of job termination is not compensable, the circumstances surrounding the termination, including the manner of the discharge, are to be considered when

determining compensability. After reviewing this record, we are persuaded that the working conditions preceding claimant's termination, and particularly the circumstances and manner of her discharge, were the major contributing cause of a worsening of her underlying psychological condition.

Like the Referee, we find claimant's version of the facts more persuasive than that of her employer. From her testimony, as corroborated by that of Ms. Gill, we find that claimant's pretermination working conditions were objectively capable of producing stress in this claimant. The termination itself was clearly stress-producing in that it came without warning and followed a period in which claimant was apparently led to believe that she was performing satisfactorily.

The medical evidence also preponderates in claimant's favor. Dr. Colistro, the long-time treating psychologist, has repeatedly and unequivocally stated that claimant's work exposure was the major cause of her worsened condition. While he believes that claimant's termination was the final precipitating factor in her need for additional treatment, he has also cited numerous pretermination events that "gradually worsened" her condition. Dr. Turco, the consulting psychiatrist, believes that claimant's condition is largely the result of her emotional make-up. He has conceded, however, that if claimant's version of the facts was accurate, the work exposure would be stress-producing.

Claimant's claim is compensable. The Referee's order will be reversed.

ORDER

The Referee's order dated July 23, 1986 is reversed. Claimant's attorney is awarded $1,850 for services at hearing and $700 for services on Board review. Both fees shall be paid by the insurer.

ROBERT J. BEATY, Claimant
Malagon & Moore, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

Own Motion 84-0198M
June 24, 1987
Second Own Motion Order on Reconsideration

Claimant has requested reconsideration of our October 1, 1986 Own Motion Order on Reconsideration that declined to grant permanent total disability. With his request, claimant has submitted another report from his treating psychiatrist which provides clarification of his previous opinion. On April 28, 1987, the SAIF Corporation was granted an opportunity to respond to claimant's request. However, no response has been received.

Following our further review of this matter, we are persuaded that, as a result of his compensable conditions, claimant is permanently incapacitated from regularly performing work at a gainful and suitable occupation. ORS 656.206(1)(a). Consequently, we conclude that he is entitled to an award of permanent total disability.

Accordingly, claimant is awarded permanent total disability, effective this date. As a reasonable attorney's fee, claimant's attorney is awarded 25 percent of this increased compensation, not to exceed $800.

IT IS SO ORDERED.

ELLA M. HOLLAND, Claimant
Steven C. Yates, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

Own Motion 86-0489M
June 24, 1987
Own Motion Order

Claimant has requested that the Board exercise its own motion authority and reopen her claim for an alleged worsening of her April 17, 1970 industrial injury. Claimant's aggravation rights have expired. SAIF Corporation has recently accepted responsibility for claimant's 1983 knee surgery, but opposes the payment of temporary total disability compensation as claimant is receiving Social Security benefits. Claimant argues that these benefits are disability benefits and not retirement.

Based on Cutright v. Weyerhaeuser Company, 299 Or 290 (1985), the Board must deny claimant's request for temporary total disability compensation. Cutright states:

> "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.

Claimant has been living on Social Security disability benefits since 1975. The evidence does not show that she lost any wages as a result of the surgery in 1983.

Claimant also seeks an increased award for permanent disability. The Board's records indicate claimant has received awards totalling 90 degrees for 60 percent loss of function of the left leg. We find no medical evidence which would aid the Board in rating claimant's disability at the time her condition became medically stationary after the 1983 surgery.

The request for own motion relief is hereby denied.

IT IS SO ORDERED.

JOHN LOSINGER, Claimant
Elliott Lynn, Claimant's Attorney
Tooze, et al., Defense Attorneys

WCB 82-10633
June 24, 1987
Order on Review

Reviewed by Board Members Ferris and McMurdo.

The insurer requests review of that portion of Referee Knapp's order that set aside its denial of claimant's industrial injury claim for his right shoulder. The issues are res judicata and compensability.

The res judicata issue in this case was the subject of a previous Board order remanding the case to the Referee for a hearing on the merits. John Losinger, 36 Van Natta 239 (1984). The insurer urges us to reconsider our previous decision on the res judicata issue and find claimant's claim for his shoulder barred under this doctrine. We conclude that our previous decision on the res judicata issue was correct and thus proceed to the issue of compensability.

Claimant injured his right hand and allegedly his right shoulder in September 1980 when his right hand became entangled in

the gears of a piece of machinery that he was operating. Claimant's hand was severely lacerated and required several surgical operations including a skin graft and hence was the focus of claimant's early medical treatment. The 801 form mentions only a hand injury. One step in the skin graft surgery required that claimant's hand be sewn to his chest wall for about two and a half weeks. During this period, claimant's entire right upper extremity including his shoulder was immobilized. The initial treating physician was Dr. Jewett, a plastic and reconstructive surgeon with a subspecialty in hand surgery. The insurer accepted the claim within two and a half weeks of the accident.

During the two years prior to the industrial accident, claimant was involved in three automobile accidents. Claimant sought treatment after these accidents from Dr. Burke, an osteopath. According to Dr. Burke's chart notes, the first accident occurred on February 22, 1979 and resulted in complaints of headaches and pain in the right side of claimant's neck. The second accident occurred on January 14, 1980 and resulted in complaints of headaches and pain in claimant's neck, left shoulder and low back. The third accident occurred two days later, on January 16, 1980, and resulted in complaints of pain in the right shoulder and tingling in the right arm in addition to the complaints associated with the second accident. Dr. Burke treated all of claimant's injuries conservatively.

The first mention of problems with claimant's right shoulder after the industrial injury was in early October 1980 when claimant began undergoing physical therapy for his hand. Claimant complained of pain and weakness in his shoulder and was encouraged to exercise it. Claimant continued to receive physical therapy for his hand for about four months until February 1981, but the last mention of shoulder complaints in the physical therapy notes occurred in early November 1980.

Dr. Jewett released claimant to return to modified work in February 1981, but after a week claimant was unable to continue. Dr. Jewett's reports mention only hand problems as the cause of claimant's inability to continue working. Dr. Jewett declared claimant medically stationary in July 1981 and rated the impairment of claimant's hand.

Claimant was examined by Dr. Schwan, an osteopath at the Callahan Center, in August 1981. At that time, claimant complained of pain, stiffness and weakness in his right hand, arm, shoulder and neck and attributed all of these symptoms to the September 1980 industrial accident. Dr. Schwan noted complaints of pain on various passive movements of the right shoulder, although he also commented that claimant was grossly overfocusing on physical complaints. One of the diagnoses recorded by Dr. Schwan after his examination was "possible capsulitis of the right shoulder." In a separate physical capacities assessment form, Dr. Schwan commented, "Needs some home exercises for his right shoulder and neck."

The same day, claimant was examined by Dr. Johnson, the psychologist at the Callahan Center. Dr. Johnson's report contains the first statement regarding the mechanism of claimant's alleged shoulder injury. Claimant told Dr. Johnson that he had wrenched his shoulder when he yanked his hand out of the gears of the machine.

Elsewhere in his report, Dr. Johnson noted that claimant was grossly overfocused on physical problems. Claimant indicated that he experienced daily problems with headaches, his hearing, pain in his neck, arm, back and hands, areas of numbness, unusual skin sensations, skin problems, gastrointestinal difficulties and visual problems. Claimant also reported experiencing frequent problems with fatigue, muscular weakness, tension and breathing and weekly problems with shakiness, insomnia, urination, excessive gas, vomiting and chest pain. In pain drawings, claimant indicated aching of the head, neck, both shoulders, upper back, buttocks, right arm, hand and thumb. Dr. Johnson's diagnoses of claimant's psychological state were inadequate personality, hysterical personality, schizoid personality and anxiety neurosis. He did not think, however, that these problems required treatment at that time.

A few days later, a member of the Callahan Center staff who instructed claimant in home exercises for his right shoulder noted that claimant complained of pain in his shoulder, but stated that claimant was able to perform all of the exercises requested of him. The instructor also noted that claimant's right arm movements appeared weak when he attempted to lift weights on the universal gym.

Claimant's claim was closed by Determination Order dated September 1, 1981 with a scheduled award of 55 percent for the right forearm. Later in September, claimant underwent a work tolerance evaluation at the Callahan Center. The evaluator noted that claimant exhibited considerable pain behavior relating to his right shoulder. Claimant rubbed his shoulder vigorously and sighed loudly when the evaluator entered the room. Later, during a portion of the evaluation which involved the use of a ten-key adding machine, claimant stopped, rubbed and moved his shoulder and, "with a bright tone and a smile," stated, "Are we allowed to rest? My shoulder just gave out." The evaluator noted that claimant resumed the evaluation in four minutes without further pain behavior.

Claimant was involved in a fourth automobile accident on February 19, 1982. He again sought treatment from Dr. Burke, complaining, among other symptoms, of headaches and pain in the right side of his neck and right shoulder. Dr. Burke prescribed conservative treatment.

In March 1982, claimant's claim was reopened when he began an authorized training program in electronics assembly. Claimant completed the program in June 1982 and his claim was again closed by Determination Order with additional temporary disability compensation, but with no additional award of permanent disability.

Claimant went to work for an electronics company in June 1982, worked for about one month and was then laid off. Claimant found a job with another electronics company and began working for that employer in early August 1982. In late October 1982, claimant reported to Dr. Grimm, a neurologist, complaining of increasing pain and numbness in his right arm and shoulder among other symptoms. Dr. Grimm noted a right shoulder droop and atrophy and weakness of the right shoulder musculature among other neurological symptoms involving the face, right ear, right upper

extremity and right lower extremity. Mild disorientation was also noted. Dr. Grimm suspected a tumor of some kind and hospitalized claimant for tests. A brain scan, x-rays of the right shoulder and an EMG involving the upper extremities, shoulder and chest revealed no abnormalities. Claimant was then referred for an evaluation by Dr. Binder, a psychologist.

Dr. Binder diagnosed a "somatization reaction" secondary to concerns by claimant that he would be unable to continue working at his job as an electronics assembler and also suspected a chronic dysfunction of the left hemisphere of claimant's brain. Dr. Binder recommended that claimant be given emotional support and reassurance about his condition. Claimant did not return to work as an electronics assembler.

In December 1982, claimant began receiving osteopathic manipulations of his shoulder from Dr. Burke. Dr. Burke reported to the insurer that claimant's symptoms apparently were related to the September 1980 industrial accident when claimant jerked his hand out of the gears of the machine. At about the same time, Dr. Grimm opined in a letter to claimant's attorney that claimant's right arm and shoulder pain was "directly attributable" to claimant's September 1980 industrial accident. The insurer issued a denial of claimant's shoulder problems later the same month and claimant requested a hearing.

In January 1983, counsel for the insurer met with Dr. Grimm and discussed possible alternative explanations for claimant's right shoulder complaints. They went over Dr. Burke's chart notes which showed complaints of neck and right shoulder pain attributable to some of claimant's auto accidents. Dr. Grimm was not aware of the auto accidents before this time. In a report issued after the meeting, Dr. Grimm retracted his former opinion and stated that, in view of the previous injuries to claimant's shoulder and neck, there was no way of proving which of claimant's multiple injuries was the cause of his ongoing complaints.

Claimant was involved in a fifth automobile accident on March 7, 1984. He was treated for this accident by Dr. Gray, specialty unknown, and spent about one week in the hospital with his neck in traction.

After issuing his second opinion, Dr. Grimm was contacted by claimant's attorney and also spoke directly with Dr. Burke concerning the effects of claimant's auto accidents on his right shoulder. In May 1984, Dr. Burke wrote Dr. Grimm stating, "Treatment of [claimant] prior to September 1980 industrial injury [sic] revealed no right shoulder dysfunction or loss of muscle mass. In addition, I have never treated [claimant] for a shoulder condition." Later the same month, Dr. Grimm issued a third opinion in which he stated that claimant's ongoing complaints of right shoulder pain were "a direct consequence" of the September 1980 industrial accident.

Claimant's case came to hearing later in May 1984. Claimant testified that when he caught his hand in the gears it had taken him three pulls to get his hand free. The last of these pulls, claimant testified, was with all of his might and weight and when his hand finally tore free, he fell backwards onto the ground. Claimant indicated that he felt his shoulder separate on the third pull.

Dr. Burke testified that until about a year prior to the hearing he did not think that claimant's September 1980 industrial accident had played any material role in claimant's ongoing complaints of right shoulder pain. Before that time, Dr. Burke had attributed claimant's complaints to the automobile accidents and, indirectly, to the effects of anatomical anomalies in claimant's spine and one leg. At the time of the hearing, however, Dr. Burke testified that it was his "guess" that claimant's shoulder complaints were 40 percent attributable to the industrial accident and 60 percent attributable to other, noncompensable factors. Dr. Burke indicated that he had changed his mind concerning the cause of claimant's shoulder complaints based upon the reports and conclusions of Dr. Grimm.

Dr. Burke also commented on the letter he had sent to Dr. Grimm in May 1984. When asked to explain his statement in the letter that he had never treated claimant for a shoulder condition, he conceded that he had treated claimant repeatedly for complaints of right shoulder pain. He testified, however, that he had not characterized these complaints as a "shoulder condition" because he reserved that phrase for conditions brought about by direct trauma to the shoulder. When questioned regarding his statement that prior to the September 1980 industrial accident he had never noticed any dysfunction or loss of muscle mass in claimant's shoulder, Dr. Burke conceded that he had not noticed any such dysfunction or atrophy in claimant's shoulder at any time after the industrial injury either, including the time after Dr. Grimm identified these symptoms in October 1983.

Dr. Grimm also testified at the hearing. He diagnosed claimant's condition as paralysis of one of the nerves servicing the shoulder (the "eleventh nerve") and reiterated his opinion that this injury was attributable to claimant's September 1980 industrial accident. When questioned further, Dr. Grimm indicated that his opinion was based upon two facts stated in the letter he received from Dr. Burke in May 1984: (1) that claimant had never been treated for a shoulder condition prior to the industrial accident; and (2) that claimant had no symptoms of shoulder dysfunction or atrophy prior to the industrial accident. When informed regarding the content of Dr. Burke's testimony, Dr. Grimm conceded that both of the major bases of his opinion were invalid. He continued to hold his opinion regarding the cause of claimant's shoulder complaints, however, on the ground that the pulling motion described by claimant was compatible with the kind of injury he had diagnosed.

Dr. Jewett, the physician who treated claimant's hand injury, was deposed after the hearing. He stated that he saw no relationship between claimant's hand injury and the alleged shoulder condition. Dr. Jewett stated that his opinion was based primarily upon the fact that claimant did not complain of pain in his shoulder until long after the industrial accident. When shown the early physical therapy notes for claimant's hand which mentioned complaints of right shoulder pain, Dr. Jewett explained these complaints as due to and typical of the kind of skin graft procedure which claimant had undergone. He also indicated that claimant's complaints of shoulder pain were rather nonspecific and that he did not take them too seriously in light of claimant's hysterical kind of personality.

After our de novo review of the record, we conclude that

claimant has failed to prove by a preponderance of the evidence that the industrial accident in September 1980 was a material contributing factor to his ongoing complaints of right shoulder pain. There are a number of potential noncompensable explanations for claimant's complaints including his multiple automobile accidents, his documented psychological conditions and perhaps even an undiagnosed brain or nervous disorder. Although Dr. Burke and Dr. Grimm both thought there was a causal connection between the industrial injury and claimant's shoulder complaints, we do not find their opinions persuasive. Dr. Burke's opinion was based primarily upon the conclusions of Dr. Grimm. Dr. Grimm's conclusions were based upon facts provided by Dr. Burke -- facts which were later demonstrated to be inaccurate. Under these circumstances, both opinions are without sufficient foundation to support a finding of compensability. See Somers v. SAIF, 77 Or App 259, 263 (1986). In addition, given claimant's diagnosed psychological conditions involving overfocusing on physical complaints, we do not find his testimony alone sufficient to carry his burden of proof. Consequently, we conclude that the insurer's denial of claimant's right shoulder condition should be reinstated and affirmed.

ORDER

The Referee's order dated October 4, 1984 is reversed in part. That portion of the order that set aside the insurer's denial dated December 30, 1982 of claimant's right shoulder condition is reversed. The insurer's denial is reinstated and affirmed. The remainder of the Referee's order is affirmed.

MIGUEL A. RAMIREZ, Claimant
Goldberg & Mechanic, Claimant's Attorneys
Nelson, et al., Defense Attorneys
Norman Cole (SAIF), Defense Attorney
Noreen K. Saltveit, Defense Attorney

WCB 86-08067, 85-12858 & 85-13343
June 24, 1987
Order on Reconsideration

Claimant has requested reconsideration of our Order on Review dated June 1, 1987. The request is granted and the order is withdrawn for reconsideration.

Claimant contends that the Board erred in not ordering both the SAIF Corporation and Liberty Northwest Insurance Corporation to pay his attorney a fee for services on Board review. He contends that his attorney is entitled to a fee from SAIF under ORS 656.382(2) and OAR 438-47-055 on the responsibility issue because he "took an active position and was more than a nominal participant regarding SAIF's appeal." He contends that his attorney is entitled to a fee from Liberty Northwest under the same provisions because "Liberty Northwest continued to contest the compensability of the claim on appeal." No order pursuant to ORS 656.307 has been issued in this case.

We reject claimant's argument with regard to SAIF. Claimant presented alternative arguments on Board review on the responsibility issue, one in line with the position taken by SAIF and the other in line with the Referee's order. Claimant, therefore, did not take a position on the responsibility issue and is not entitled to an attorney fee for that reason. See SAIF v. Phipps, 85 Or App 436 (May 20, 1987); Petshow v. Farm Bureau Insurance Co., 76 Or App 563, 569 (1985), rev den 300 Or 722 (1986).

We accept claimant's argument with regard to Liberty

Northwest. Although responsibility was the focus of the parties' briefs, Liberty Northwest did raise the issue of compensability and claimant submitted a short reply. Under these circumstances, we find that claimant has actively participated to protect his right to compensation. See Robert L. Montgomery, 39 Van Natta 469 (June 11, 1987). Consequently, he is entitled to a reasonable attorney fee for services on Board review. Considering the factors enunciated in Barbara A. Wheeler, 37 Van Natta 122, 123 (1985), we conclude that a fee of $100 is appropriate.

Liberty Northwest Insurance Corporation shall pay claimant's attorney a fee of $100 for services on Board review. Except as herein modified, the Board adheres to and republishes its previous order, effective this date.

IT IS SO ORDERED.

EVERETT S. STANDLEY, Claimant
Peter O. Hansen, Claimant's Attorney
Spears, Lubersky, et al., Defense Attorneys

WCB 85-13382 & 86-02530
June 24, 1987
Order on Review

Reviewed by the Board en banc.

The self-insured employer requests review of that portion of Referee Myers' order that increased claimant's award of unscheduled permanent partial disability for the neck from 40 percent (128 degrees) to 65 percent (208 degrees). The issue is extent of disability.

We affirm the Referee's order with the following comments. In its brief before the Board, the employer argues that a worker who has retired from the work force is not entitled to permanent partial disability benefits. The dissenting opinion agrees. The employer argues that the principles set forth in Cutright v. Weyerhaueser Co., 299 Or 290 (1985) are applicable to cases involving unscheduled permanent partial disability. We disagree.

First, as the employer acknowledges, the Cutright court did not have occasion to discuss the effect of retirement on a claimant's entitlement to permanent partial disability. Cutright was specific in its discussion of temporary total disability, and its holding is necessarily limited to that benefit. Second, the basic principles underlying temporary total disability are fundamentally different from those of permanent partial disability. Whereas the benefit to be gained from temporary total disability is compensation for lost wages, ORS 656.210(1); Cutright, supra, 299 Or at 298, the statutory benefit surrounding unscheduled permanent partial disability is compensation for lost capacity to earn. ORS 656.214(5).

The Cutright holding that a retired worker is not entitled to temporary total disability compensation is logical. While retired, the claimant makes no attempt to earn and, therefore, by definition, he suffers no loss of wages as a result of his injury. By contrast, a claimant who has incurred a permanent injury to an unscheduled body part suffers more than a temporary loss of wages, he permanently loses a portion of his wage-earning capacity. Whether he is retired or actively seeking work, his lost earning capacity remains.

The resolution of this controversy may at least partially depend on one's view of retirement. If the act of retiring is viewed as permanent and absolute, the present employer's argument is strengthened. Arguably, a claimant whose absolute retirement is guaranteed has no earning capacity to lose; as a worker he or she is a nonentity. In our view, however, the concept of retirement in modern society is a dynamic one. A claimant may retire with the sincere hope of never having to return to work. Yet, later, because of changed financial or personal circumstances a claimant may decide that a return to work is necessary or desirable. At that point, his or her earning capacity, which has been permanently reduced as a result of a prior compensable injury, becomes a very real factor in a claimant's return to work. The worker is willing, but his or her capacity for work is limited.

Because of what we find to be fundamental differences between the purposes of compensation for temporary total and permanent partial disability, we find Cutright, supra, inapplicable to the present case. We, therefore, affirm the order of the Referee.

ORDER

The Referee's order dated August 14, 1986 is affirmed. Claimant's attorney is awarded $600 for services on Board review, to be paid by the self-insured employer.

Board Chairperson Ferris dissenting:

Because I do not believe that a claimant who has retired is entitled to additional permanent partial disability compensation subsequent to his retirement, I respectfully dissent from the majority opinion.

Claimant was compensably injured in April 1980. After a brief recovery period, he returned to his job and worked regularly until voluntary retirement removed him from the work force on May 1, 1983. Claimant receives both a Teamster's pension and Social Security. Claimant was medically stationary at the time of his retirement and he was not seeking medical attention. Approximately seven months after he retired, however, claimant returned to his physician, complaining of increased symptoms. He thereafter sought reopening of his claim. The employer responded by reopening the claim for medical services only. It refused to pay claimant additional temporary total disability compensation because of his retired status. Claimant requested a hearing and the employer's denial was upheld by Referee Richard Knapp on January 31, 1986. Both the Board, Everett S. Standley, 37 Van Natta 1844 (1985), and the Court of Appeals, Standley v. Pacific Motor Trucking, 80 Or App 791 (1986), affirmed without opinion.

In the interim, claimant was awarded 40 percent unscheduled permanent partial disability by a November 1985 Determination Order. He requested a hearing, seeking an additional award of permanent disability. The employer contended that claimant was entitled to no permanent disability compensation because he had retired before the aggravation claim giving rise to the most recent Determination Order. The employer cited Cutright v. Weyerhaeuser Co., 299 Or 290 (1985), inter alia, as authority.

In his August 1986 Opinion and Order, Referee Raymond

Myers rejected the employer's contention, believing that the rationale of the Cutright decision was not applicable to a case involving entitlement to permanent disability. Finding claimant more disabled than the 40 percent awarded by Determination Order, the Referee granted claimant an additional 25 percent. The employer sought Board review. The majority has affirmed the Referee's order.

I agree with the employer's arguments on review and would, therefore, reverse the Referee's order. It is acknowledged from the outset that Cutright, supra, specifically involved a retired claimant's entitlement to temporary total disability compensation and is, therefore, not directly on point with the case at bar. In reading Cutright, however, I find it instructive with regard to the Court's interpretation of the entire scheme of the Workers' Compensation Law, and I believe that its concepts are applicable to cases involving both permanent partial and temporary total disability.

In Cutright, the claimant sought additional temporary total disability compensation pursuant to an aggravation claim filed subsequent to his retirement. The Court's majority found that a retired claimant is no longer a "worker" for purposes of the Oregon Workers' Compensation Law, and is, therefore, not entitled to receive compensation for lost wages. The Court noted:

> "The entire scheme of the 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 . . . The name of the act itself . . . indicates who is to be covered - 'workers.' . . . 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 from the workforce is no longer a 'worker' as defined." 299 Or at 296-7 (emphasis in original).

Although the Court did not have occasion to rule with regard to cases involving permanent partial or permanent total disability, it offered the following observations:

> "ORS 656.268(1), which sets forth the procedure for determining awards of 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." 299 Or at 298.

With regard to awards of permanent total disability, the Court noted: " . . . 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." Id. at 300.

From these and other statements in Cutright, I perceive the Court's interpretation of the Workers' Compensation Law to be that only those persons who statutorily qualify as "workers" are entitled to receive compensation, be it for temporary or permanent disability, under the Act. As the Court has noted, a retired person is not a "worker" because he or she no longer offers his or her services for a remuneration. Whereas the compensation law is designed to compensate an injured worker for a "loss," there can be no loss, by definition, when the former worker has completely withdrawn from the work force.

For the aforementioned reasons, I respectfully dissent.

VERNON J. TENBUSH, Claimant
Peter O. Hansen, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

Own Motion 87-0309M
June 24, 1987
Own Motion Order

SAIF Corporation has submitted to the Board claimant's claim for an alleged worsening of his April 10, 1967 industrial injury. Claimant's aggravation rights have expired. SAIF has authorized the requested surgery, but opposes reopening of the claim for temporary total disability compensation.

Claimant last worked in the winter of 1982. In March 1983 Dr. Hamilton recommended claimant undergo surgery. SAIF Corporation refused to authorize the surgery and claimant requested a hearing. Referee Mulder, on July 2, 1985, issued an Opinion and Order which ordered SAIF Corporation to allow the surgery. As far as we know, the surgery still has not taken place.

We presume that claimant contends he could not perform gainful employment over the past 4-1/2 years due to the condition for which surgery was recommended. However, he has offered no explanation for the two year wait after the surgery was approved by the Referee. We can only conclude claimant's unemployed status for at least the past two years was by his own choice. The purpose of temporary total disability benefits are to replace lost wages. Claimant will not lose any wages even if he undergoes the recommended surgery. Cutright v. Weyerhaeuser Company, 299 Or 290 (1985). The request for own motion relief is hereby denied.

IT IS SO ORDERED.

LISA A. WILSON, Claimant
Gatti, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 85-15555
June 24, 1987
Order on Review

Reviewed by Board Members Ferris and Lewis.

The SAIF Corporation requests review of that portion of Referee T. Lavere Johnson's order that granted claimant's attorney a $2,000 attorney fee for overturning its denial of claimant's cervical condition and related medical services. Claimant cross-requests review, seeking a penalty and attorney fee for SAIF's alleged "back-up" and unreasonable denial of her cervical condition. The issues are attorney fees and penalties.

Claimant was 25 years of age at the time of the hearing. In July 1984, she sustained a compensable "dorsal-lumbar

strain" injury. Dr. Kahn, her initial treating chiropractor, diagnosed a dorsal and lumbar sprain with myofascitis. In November 1984, claimant came under the care of Dr. Tilchin, chiropractor. Tilchin immediately informed SAIF, by way of a Change Of Attending Physician form, that claimant complained of back, neck and headache pain. One month later, Tilchin wrote SAIF a letter causally relating claimant's cervical condition to the compensable injury.

In December 1985, claimant came under the care of Dr. McCrory, chiropractor. In March 1986, McCrory referred claimant back to Dr. Kahn for limited treatment of her "cranial suture fixation and pterygoid rotation due to residual cervical spine instability." Kahn treated claimant four times in March/April 1986. In June 1986, McCrory referred claimant to a licensed massage therapist for "massage therapy." Shortly thereafter, SAIF issued a partial denial of claimant's cervical condition, payment of Dr. Kahn's treatment, and payment of the massage therapist's treatment.

Prior to the hearing, SAIF withdrew that portion of its partial denial relating to the massage therapy and agreed to pay for the therapist's treatment. The Referee found that SAIF had knowledge of claimant's cervical condition no later than December 1984, and that it continued to pay for chiropractic treatment of that condition until a year-and-a-half later. He considered this an "acceptance" of the claim and found that SAIF had, therefore, issued a "back-up" denial. He also found that claimant's cervical condition as well as Dr. Kahn's four treatments were compensable on the merits. In so doing, he awarded claimant's attorney a $2,000 attorney fee. We modify.

In determining a reasonable attorney fee, we look to the efforts of the attorney and the results obtained. OAR 438-47-010(2); see also Arthur D. Roppe, 38 Van Natta 118, 119 (1986); Barbara A. Wheeler, 37 Van Natta 122, 123 (1985). Exercising our independent judgment, we find that a reasonable attorney fee would be $1,400.

Claimant has cross-requested review on the issue of penalties and attorney fees for SAIF's alleged "back-up" and unreasonable denial of claimant's cervical condition. Although the Referee found that SAIF had issued a "back-up" denial, he declined to award a penalty and attorney fee because SAIF, "had valid reasons . . . to issue the denial." We affirm with the following comments.

Applying the recent case of Johnson v. Spectra Physics, 303 Or 49 (1987), to the instant case, we find that SAIF's mere silence and payment of medical services was not an "acceptance" of claimant's cervical condition. Thus, we do not find that SAIF's partial denial constitutes an impermissible "back-up" denial. See Bauman v. SAIF, 295 Or 788 (1983). In any event, we agree with the Referee that SAIF did not act unreasonably in denying claimant's cervical condition. ORS 656.262(10). After Dr. Tilchin's December 1984 report, there is very little indication that claimant was receiving treatment for anything other than her mid and low back condition.

ORDER

The Referee's order dated October 24, 1986 is modified

in part and affirmed in part. That portion of the Referee's order that awarded claimant's attorney an attorney fee of $2,000 for overturning the SAIF Corporation's partial denial, is modified to $1,400. The remainder of the Referee's order, as supplemented herein, is affirmed.

RICHARD L. WINE, Claimant
Olson Law Firm, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

Own Motion 85-0548M
June 24, 1987
Own Motion Order

On February 5, 1987, we issued a Second Own Motion Determination on Reconsideration in which we found that the SAIF Corporation had unreasonably failed to timely comply with our September 24, 1986 Own Motion Determination. Pursuant to our order, SAIF was directed to pay a penalty of 25 percent of the permanent disability compensation due as a result of our September 24, 1986 Own Motion Determination. We further directed SAIF to pay a reasonable attorney's fee of $150.

Contending that SAIF failed to timely comply with our February 5, 1987 order, claimant has requested additional penalties and attorney fees. Inasmuch as claimant's request emanates from an own motion order, we retain jurisdiction over this matter. See David L. Waasdorp, 38 Van Natta 81 (1986).

In response to claimant's contention, SAIF has provided a copy of its claim summary sheet. The sheet indicates that the penalty and attorney fee were paid on March 10, 1987.

Pursuant to ORS 656.295(8), SAIF had 30 days from the date of our February 5, 1987 order within which to appeal to the Court of Appeals. See also ORS 656.278(3). If an appeal had been filed, neither the penalty nor the attorney fee would have been payable pending review. See ORS 656.313(4). Thus, the penalty and attorney fee became due upon the expiration of the statutory appeal period. The 30th day after February 5, 1987 was March 7, 1987, a Saturday. Consequently, SAIF had until Monday, March 9, 1987, to file its appeal. See OAR 438-05-040(4)(c). No appeal was filed. The following day, March 10, 1987, SAIF paid the penalty and attorney fee.

Our review of the record suggests that SAIF complied with our February 5, 1987 order on the first day it no longer had the option of requesting judicial review of the order. Since SAIF paid the penalty and attorney fee upon the expiration of its rights of appeal, we do not consider its conduct unreasonable. Accordingly, we decline to grant claimant's request for additional penalties and attorney fees.

IT IS SO ORDERED.

CLIFFORD L. HAINES, Claimant
Pozzi, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 85-14168
June 26, 1987
Order on Reconsideration

Claimant has requested reconsideration of the Board's Order on Review dated May 28, 1987. Specifically, claimant asserts that the SAIF Corporation had an affirmative duty pursuant to ORS 656.268(3), to submit the claim to the Evaluation Division for the issuance of a Determination Order. SAIF had issued a

Notice of Closure stating that claimant had suffered no permanent disability. We disagree with claimant's assertion.

Following the issuance of a Notice of Closure by an insurer, ORS 656.268(3) in relevant part states:

> "The notice must inform the worker of the the decision that no permanent disability results from the injury; of the amount and duration of temporary total disability compensation; of the right of the worker to request a determination order from the Evaluation Division within one year of the date of the notice of claim closure; of the aggravation rights; and of such other information as the director may require. Within one year of the date of the notice of closure, a determination order subsequently shall be issued on the claim at the request of the claimant or may be issued by the Evaluation Division upon review of the claim if the division finds that the claim was closed improperly. If an insurer or self-insured employer has closed a claim pursuant to this subsection and thereafter decides that the claim has permanency, the insurer or self-insured employer shall request a determination order as provided in subsection (2) of this section. If an insurer or self-insured employer has closed a claim pursuant to this subsection, if the reasonableness of that closure decision is at issue in a hearing on the claim and if a finding is made at the hearing that the closure decision was not supported by substantial evidence, a penalty shall be assessed against the insurer or self-insured employer and paid to the worker in an amount equal to 25 percent of all compensation determined to be owing between the date of original closure and the date upon which the claim is closed by determinaton order." (Emphasis added.)

Thus, before becoming obligated to submit the claim to the Evaluation Division following the Notice of Closure, SAIF first had to determine whether the claim had permanency. The statute indicates that this decision is discretionary, subject to a standard of reasonableness. Consequently, SAIF was not mandated to submit the claim to the Evaluation Division for issuance of a Determination Order.

The statute does provide claimant a method by which to dispute the reasonableness of the Notice of Closure. Initially, the Evaluation Division is vested with jurisdiction to review the propriety of the insurer closure. Prior to this review, the Hearings Division is without jurisdiction to consider the closure's reasonableness. See Barbara Gilbert, 36 Van Natta 1485 (1984). Therefore, in order to contest a Notice of Claim Closure, claimant must request a Determination Order from the Evaluation

Division within one year of the Notice. Since claimant did not timely request a Determination Order, the Referee was without jurisdiction to consider the issues surrounding closure or the extent of permanent disability.

Accordingly, the request for reconsideration is granted and our prior order withdrawn. On reconsideration, the Board adheres to and republishes its former order of May 28, 1987, effective this date.

IT IS SO ORDERED.

ROBERT D. ARMSTRONG, Claimant
Brian R. Whitehead, Claimant's Attorney
Acker, et al., Defense Attorneys

WCB 86-02776
June 30, 1987
Order on Review

Reviewed by Board Members McMurdo and Lewis.

The insurer requests review of Referee Garaventa's order, as amended on reconsideration, that set aside its denial of claimant's occupational disease claim for chronic rhinitis. The issue is compensability. We reverse.

Claimant is a former textile mill worker who asserts that his exposure to textile dust and fibers was the major cause of a chronic rhinitis condition. He filed a claim for nosebleeds and headaches on January 24, 1986 after working for the mill for approximately ten years.

For about six months prior to filing his claim, claimant complained of harassment by his supervisors, as well as by other workers. He was disciplined on several occasions for outbursts of temper, being away from his work station and absenteeism. He received a "final warning" from the employer in December 1985. Shortly thereafter, claimant took a two-week vacation and never returned to work. After the vacation, he sought medical attention from Dr. Minard, a psychiatrist, for headaches. Minard authorized a 30-day release from work and referred claimant to Dr. Parosa, an internist, for respiratory complaints.

Among other things, Parosa diagnosed "rhinosinusitis," which is an infection of the nasal passages. In Parosa's opinion, claimant's recent flare-ups were probably caused or sustained by what Parosa believed to be marked irritant exposures at claimant's work. After antibiotics and other treatment failed, Parosa referred claimant to Dr. Eschelman, an ear, nose and throat specialist. Eschelman diagnosed a deviated septum and a mucosal cyst, but found no evidence of sinusitis. The treatment suggested by Eschelman ultimately corrected claimant's problem.

In March 1986, the employer arranged for an independent medical examination by Dr. Montanaro, Assistant Professor of Medicine at the Oregon Health Sciences University. Montanaro is an allergist and immunologist. He took a history from claimant of a "very dusty" and poorly ventilated working environment. Claimant also related preexisting hay fever, asthma and chronic rhinitis. Based on claimant's history and other factors, including an allergy test that revealed sensitivity only to house dust, Montanaro opined that claimant's work had caused a temporary aggravation of symptoms, that the symptoms had resolved, and that they were not related to his current condition.

Following Montanaro's report, Dr. Parosa was asked once again to render an opinion regarding causation. In his March 24, 1986 report, Parosa stated:

> "The work environment is responsible for all or part of the rhinosinusitis due to marked irritant exposures around [claimant's] weaving loom. [Claimant] was quite unprotected at times from heavy dusts."

Parosa felt that there were no significant off-the-job exposures that could have caused claimant's irritation.

Claimant testified that he first sought treatment from Dr. Minard for stress-related symptoms and that he was unaware that he had sinus problems at that time. He admitted that prior to leaving work at the end of December 1985, he told coworkers that he was going to pursue some sort of action against the employer for what he perceived to be unfair treatment. He described his working environment as very dusty, but admitted that his symptoms did not improve after he left the job. It was not until Dr. Eschelman treated him in March 1986 that he improved.

Three of claimant's coworkers testified under subpoena on his behalf. They essentially corroborated his testimony with regard to the dusty conditions at work, although all three witnesses indicated that dust could be seen in the air only on occasion.

Mr. Scott, an industrial hygienist employed by the insurer, conducted an air quality study of the work place in May 1986. For approximately five hours, particulates were gathered from the air and were later measured. According to Scott, the work place particulate values were approximately 1/100th to 1/30th of allowable OSHA levels. This finding, and Scott's personal observation of the work place, led him to conclude that the use of safety masks would be unnecessary at the work site.

Dr. Parosa testified that he is an internist who specializes in pulmonary medicine, although he is not Board certified in that specialty. Parosa remained of the opinion that claimant's work exposure was the major cause of what Parosa felt was a new, rather than preexisting condition. He admitted, however, that several other irritants could be factors in the development of that condition. They included claimant's family history, an allergy to house dust, a deviated septum, wood stove smoke, claimant's practice of riding his bicycle in cold weather, the fact that his house has no humidification or air filtration system, and increased exposure to colds and flu from claimant's seven children. Parosa also admitted that the signs and symptoms claimant demonstrated were those triggered by many different irritants in a wide variety of people.

Dr. Montanaro also testified. He is a Board certified allergist and immunologist. He stated that claimant suffers from perennial allergic rhinitis that preexisted his work exposure. He disagreed with Dr. Parosa's diagnosis of sinusitis, finding no evidence of infection on examination. Montanaro visited the work site and found it to be clean. He saw no airborne particulates and, in his opinion, the site's low particulate count would be unlikely to produce symptoms. In any event, according to Montanaro, claimant's work exposure did no more than trigger

symptoms, without creating a pathological change in claimant's underlying condition. He also indicated that when one suffers from irritant rhinitis, his symptoms will usually subside once the irritant is removed. Claimant was seen by Dr. Montanaro three months after he left work, but he remained symptomatic.

The Referee was more persuaded by the testimony of the workers who described the conditions at the work place than by Dr. Montanaro's personal observations. She, therefore, concluded that claimant was exposed to substantially greater concentrations of airborne particulates at work than he was off the job. The Referee also found Dr. Parosa's opinion more persuasive than that of Dr. Montanaro, concluding that claimant suffered from a condition composed of a complex of symptoms, and that the condition had been worsened by claimant's industrial exposure. Thus, the Referee found claimant's claim compensable.

This claim is one for occupational disease. Claimant must, therefore, prove that his work exposure was the major contributing cause of his condition. Dethlefs v. Hyster Co., 295 Or 298 (1983). Because his rhinitis condition preexisted his employment, claimant must also prove that his work exposure was the major cause of a worsening of his underlying condition. Weller v. Union Carbide, 288 Or 27 (1979). A worsening of symptoms alone, without a concomitant worsening of the condition, is not compensable.

After reviewing the record, we find that claimant has failed to sustain his burden of proof. This case is sufficiently medically complex that we find its resolution to be largely dependent on expert medical opinion. See Kassahn v. Publishers Co., 76 Or App 105 (1985). We also find that the medical evidence, even viewing it in a way most favorable to claimant, is at most in equipoise. The medical opinions are in conflict, not only with regard to whether claimant's work was the major cause of his condition, but also as to whether he experienced a mere symptomatic reaction or an actual worsening of his underlying condition.

After reviewing the opinions of Drs. Parosa and Montanaro, we find Montanaro's more persuasive. First, he is a Board certified allergist and immunologist. Dr. Parosa is not Board certified and, although he specializes in pulmonary medicine, he has indicated that claimant does not have a pulmonary disease. Second, Parosa did not personally observe the work site. Yet, his opinion appears to be dependent on his impression that claimant's work place was consistently "very dusty." The remainder of the record, however, does not support that impression. The documentary studies of the work site's particulate levels suggest that claimant's place of employment was not "very dusty." That was also the impression of Mr. Scott and Dr. Montanaro, both of whom personally observed the site and found it to be clean. Third, in our view, Dr. Parosa did not satisfactorily explain why he felt that claimant's work place was the major cause of his condition when he admitted that claimant was regularly exposed to a wide variety of irritants off the job. Neither has Dr. Parosa offered an explanation regarding why claimant's symptoms continued for three months after he left the work site.

Dr. Montanaro, on the other hand, identified many environmental irritants to which claimant is regularly exposed.

The work site was merely one of them and, in Montanaro's opinion, not the major one. In any event, Montanaro stated that at most, claimant's work exposure generated a mere flare-up of symptoms; the underlying chronic rhinitis remained unchanged.

Our reading of the record leaves us unpersuaded that claimant's employment caused or worsened his underlying chronic rhinitis condition. His claim for occupational disease, therefore, is not compensable.

ORDER

The Referee's order dated October 21, 1986, as amended on November 7, 1986, is reversed.

EDWARD J. EBBESEN, Claimant
Dwyer, Simpson & Wold, Claimant's Attorneys
Bottini & Bottini, Defense Attorneys

WCB 85-14023
June 30, 1987
Order on Review

Reviewed by Board Members Lewis and McMurdo.

Claimant requests review of that portion of Referee Nichols' order, as amended, that upheld a Determination Order awarding 32 degrees for 10 percent unscheduled permanent partial disability for the low back. The self-insured employer cross-requests review, seeking a reduction in claimant's award of unscheduled disability and the elimination of the attorney fee awarded by the Referee for claimant's defense against the employer's cross-request for hearing regarding the extent of claimant's disability. The issues are extent of unscheduled disability and attorney fees.

We affirm that portion of the Referee's order that upheld the Determination Order award of unscheduled disability. We reverse, however, the Referee's award of attorney fees.

Claimant compensably injured his back in May 1985. He ultimately received 10 percent unscheduled disability by way of Determination Order. He requested a hearing from the Order, seeking an additional award. The employer cross-requested a hearing, seeking a reduction of claimant's award. The Referee affirmed the Determination Order award and, based on Travis v. Liberty Mutual Insurance, 79 Or App 126 (1986), awarded claimant an attorney fee for prevailing on the employer's cross-request.

The Travis court concluded that an insurer's cross-appeal on the issue of extent of permanent disability constituted a request "initiated" by the insurer. It held, therefore, that a successful defense against such a request entitled the claimant to an attorney fee pursuant to ORS 656.382(2). As we have since noted, however, the Travis court did not discuss OAR 438-47-075 in reaching its decision. Richard M. Deskins, 38 Van Natta 494, on reconsideration, 38 Van Natta 825 (1986). That rule provides:

> "In the event of a cross appeal by either party, 47-000 to 47-095 shall be applied as if no cross appeal was taken, unless the party initiating the appeal withdraws his appeal and the cross appellant proceeds; in which case the cross appellant shall be considered the initiating party."

The present claimant did not withdraw his appeal. The employer, therefore, simply responded to it rather than initiating its own. As we noted in Deskins, supra, we are bound to follow our own administrative rules. Our rules provide that, in the current situation, no attorney fee is to be awarded.

ORDER

The Referee's order dated September 10, 1986, as amended on October 1, 1986, is reversed in part and affirmed in part. That portion of the order that awarded claimant an insurer-paid attorney fee is reversed. The remainder of the order is affirmed.

SHAREN L. EVANS, Claimant
Vick & Gutzler, Claimant's Attorneys
Meyers & Terrall, Defense Attorneys
Tooze, et al., Defense Attorneys

WCB 85-14990 & 86-00724
June 30, 1987
Order on Review

Reviewed by Board Members Lewis and McMurdo.

The Hartford Insurance Company (Hartford) requests review of Referee Shebley's order that upheld Frito-Lay's denial of claimant's aggravation claim for the low back and set aside Hartford's denial of claimant's new injury claim for the same condition. The sole issue on review is responsibility. Claimant has not submitted a brief on review and has taken no position with regard to responsibility. We draw from the Referee's statement of the facts.

Claimant had worked for Frito-Lay, a self-insured employer, for approximately five years at the time she suffered a compensable injury to her left lower back, hip and leg. The injury occurred in March 1984. Claimant's resulting claim was eventually closed with an award of 20 percent unscheduled disability for the low back. Claimant remained symptomatic following the 1984 injury and occasionally sought medical treatment.

In September 1985, claimant began work for Hartford's insured as a waitress. She was required to lift and carry heavy objects as part of her job duties, and she suffered increased pain and discomfort as a result. Approximately one month after she began, claimant left work due to increasing pain. She also sought medical treatment from Dr. Seifert, a chiropractor who became the treating physician. Seifert opined that claimant had aggravated or exacerbated her prior condition. He later stated:

> " . . . [I]t is my considered opinion that the [most recent] injury . . . is the material contributing cause of the present condition and that the job duties at [Hartford's insured's] in late September - mid-October 1985 temporarily aggravated her condition symptomatically."

Claimant was also examined by two consulting chiropractors, who reported that the later employment may have effected a "minor re-injury to the lumbar spine." They also reported, however, that there appeared to be "no significant material worsening of [claimant's] condition at this time . . ."

Claimant testified that following her original injury,

she remained symptomatic up to and including her employment with Hartford's insured. She further testified that the worsening of her symptoms on the last job came on gradually over the one-month period in which she was employed. Her pain was in the same area of the low back and was of approximately the same quality as that following her original injury.

The Referee correctly identified this case as one involving successive injuries. In finding the last employer responsible, however, the Referee stated:

> "In successive injury, as opposed to occupational disease, cases '[i]t is not necessary to establish a worsening of the underlying compensable condition,' only that 'the symptomatology of the condition has worsened so that the claimant is more disabled than at the time of the last arrangement of compensation.' Consolidated Freightways v. Foushee, 78 Or App 509, 512 (1986). Moreover, 'a rebuttable presumption exists that a claimant's last industrial injury contributed independently to the worsened condition and that the insurer at the time is responsible.' Industrial Indemnity Co. v. Kearns, 70 Or App 583, 587 (1984)."

The Referee then concluded that because the last employment progressively increased claimant's symptoms to the point that she required additional medical attention and was unable to continue working, the last insurer was responsible.

We disagree with the Referee's analysis. The cases he relied upon are inapplicable to the specific facts of this case. The primary issue in Foushee, supra, was whether a symptomatic worsening following the last arrangement of compensation is sufficient to establish a compensable aggravation. The issue of responsibility was merely peripheral in Foushee, and that case has little application to the case at bar. Neither does Kearns, supra, apply. Unlike the present case, which consists of two successive, denied claims for injury, Kearns involved multiple accepted claims.

Contemporaneous with the Referee's order, the Court of Appeals decided Hensel Phelps Const. Co. v. Mirich, 81 Or App 290 (1986). Mirich is similar to the present case in that it involves successive employments and successive periods of disability. In both Mirich and the present case, the second period of disability was precipitated by several weeks of activity, as opposed to an identifiable traumatic event. In both cases, the claimants experienced increased symptoms during the last employment, without suffering a worsening of the underlying condition.

The Mirich court found the first employer responsible, holding:

> "If worsened symptoms alone were enough to place responsibility on the second employer, then the first employer would never be responsible . . . There must be a worsening

of the underlying condition." Mirich, 81 Or App at 294.

Mirich controls the case at bar. The Referee's order will be reversed.

ORDER

The Referee's order is reversed in part and affirmed in part. That portion of the order that set aside the Hartford's "new injury" denial and upheld Frito-Lay's aggravation denial is reversed. Frito-Lay is ordered to process claimant's claim according to law. Frito-Lay is also ordered to reimburse the Hartford Insurance Company for costs incurred thus far in processing this claim. The remainder of the Referee's order is affirmed.

STEVEN B. GRAVES, Claimant
S. David Eves, Claimant's Attorney
Acker, et al., Defense Attorneys

WCB 86-10104
June 30, 1987
Order on Review

Reviewed by Board Members McMurdo and Lewis.

The insurer requests review of that portion of Referee Myers' order that awarded claimant a $200 attorney fee for successfully defending against the insurer's cross-request for hearing. The issue on review is attorney fees.

Claimant sustained a compensable asthmatic condition. His claim was closed by a Determination Order, which awarded five percent unscheduled permanent disability. He timely requested a hearing, raising the issue of extent of unscheduled permanent disability. The insurer cross-requested, alleging that the Determination Order's award was excessive.

The Referee awarded claimant an additional five percent unscheduled permanent disability. He also awarded claimant a $200 attorney fee for prevailing against the insurer's cross-appeal. The insurer requested reconsideration on the attorney fee issue, but the Referee issued an order denying its motion. The Referee cited Travis v. Liberty Mutual Insurance, 79 Or App 126 (1986), as authority for the attorney fee.

As we discussed in Richard M. Deskins, 38 Van Natta 494, on reconsideration, 38 Van Natta 825, 826 (1986), the Travis court did not address OAR 438-47-075, which provides:

> "In the event of a cross appeal by either party, 47-000 to 47-095 shall be applied as if no cross appeal was taken, unless the party initiating the appeal withdraws his appeal and the cross appellant proceeds; in which case the cross appellant shall be considered the initiating party."

We are bound to follow the dictates of our administrative rules. Emmett P. Curtis, 39 Van Natta 123, 124 (1987). Here, the insurer cross-appealed and claimant did not withdraw his appeal. Therefore, pursuant to OAR 438-47-075, the insurer is not the initiating party and claimant is not entitled to an insurer-paid attorney fee.

ORDER

The Referee's order dated October 20, 1986, is reversed in part and affirmed in part. The Referee's award of a $200 insurer-paid attorney fee is reversed. The remainder of the Referee's order is affirmed.

SOCRATIS N. KATSIKIS, Claimant
Hayner, et al., Claimant's Attorneys
Cummins, et al., Defense Attorneys

WCB 86-03193
June 30, 1987
Order on Review

Reviewed by Board Members McMurdo and Lewis.

The self-insured employer requests review of those portions of Referee Foster's order that: (1) found claimant's claim for left ear tinnitus and hearing loss to have been timely filed; (2) found the claim compensable as one for occupational disease; and (3) assessed an attorney fee against the employer for its alleged unreasonable failure to provide certain documents. The issues are whether claimant's claim was timely filed, if so, whether the claim is compensable, and attorney fees.

We affirm that portion of the Referee's order that awarded attorney fees. While we disagree with the Referee's characterization of this claim as one for occupational disease, we find that claimant's claim for injury was timely filed. Our review of the record persuades us that although the claim was filed after the statutory 30-day filing period had expired, ORS 656.265(1), the employer failed to prove that it was prejudiced by the late filing. ORS 656.265(4)(a); See Satterfield v. Comp. Dept., 1 Or App 524 (1970). Despite our finding with regard to the claim's timeliness, we find it not compensable.

Claimant has been employed by the employer since 1964. He has performed a number of jobs during his tenure. He alleges that on or about March 1, 1984 he incurred left ear tinnitus and hearing loss as a result of an on-the-job incident. Claimant testified that he was working inside a metal enclosure when a fellow worker pounded on the exterior with a hammer, causing a great deal of noise. According to claimant, his left ear began ringing at the time and has continued to ring ever since. He did not recall wearing ear protection at the time of the alleged incident, although he testified that he routinely wore protection while on the job.

Claimant testified that he told his supervisor of the incident on the day it occurred. The supervisor did not testify at the hearing. Claimant did visit the company nurse approximately one week after the incident. He testified that he could not recall discussing the cause of his ear problems with the nurse. The nurse also testified, and could not recall discussing a work incident with claimant. Her notes, made contemporaneously with her discussion with claimant, reflect only that claimant had been experiencing ear problems for five months prior to the date of his visit.

Claimant did not see a doctor until August 29, 1984, or approximately six months after the alleged incident. He testified that he waited to seek medical attention because of his belief that his problem would simply go away. When the problem did not subside, he visited Dr. Echavarria, an otolaryngologist.

Echavarria noted a five-to-six month history of high pitched left ear ringing and a mild left ear hearing loss dating back to 1982. Although claimant testified that he told Dr. Echavarria of the March 1984 work incident, the doctor's chart notes say only: " . . . perhaps [a] welding injury of 3-4 years ago played a role [in the hearing loss]." Echavarria offered no specific treatment plan.

In December 1984, claimant was examined by Dr. Ediger, an audiologist. Claimant explained the 1984 work incident and indicated that he had had ringing in his left ear since that time. Ediger's audiometric tests revealed a hearing loss of "zero." In his opinion, it was "unlikely" that any hearing loss claimant might have experienced would have been caused by the incident he described. With regard to the left ear tinnitus, Ediger suggested it was "possible" that a single exceptionally loud noise could cause the problem. He explained, however, that noise generally causes tinnitus in both ears, as opposed to the monaural loss of which claimant complained.

In January 1985, claimant was examined by Dr. Panian, an otolaryngologist. Claimant described the 1984 incident. He also gave a history of shooting high powered rifles and working with unmuffled chain saws. Claimant's brain stem test was normal and Dr. Panian was unable to offer an opinion regarding causation. On March 19, 1986, the employer issued a denial of claimant's claim.

Claimant was examined by Dr. Tate, an otolaryngologist, in June 1986, more than two years after claimant's alleged work incident. In a brief report that followed, Tate stated: "I think at this time we can attribute his hearing loss to the noise exposure." In an August 1986 follow-up report, Tate stated that the March 1984 incident "contributed" to claimant's left ear tinnitus. He further stated that the incident "probably materially" contributed to the left ear hearing loss. In the same report, however, Tate stated that it was only "possible" that the 1984 incident materially contributed to a worsening of claimant's left ear hearing loss.

The Referee made the following findings:

> "The evidence preponderates that claimant's hearing loss and tinnitus condition are a result of his work exposure. I conclude claimant's condition is an occupational disease and that his request for hearing appealing the denial was timely."

The Referee did not discuss the evidence upon which he relied or his reasoning for finding claimant's claim to be one for occupational disease.

We disagree with the Referee's findings. First, we find that claimant's claim is properly characterized as one for accidental injury rather than occupational disease. An occupational disease is of gradual onset and is generally not unexpected, given the nature of a claimant's continuing work exposure. See James v. SAIF, 290 Or 343 (1981). An accidental injury, on the other hand, is generally the unexpected result of either an identifiable incident, or an onset traceable to a discrete time period. See Valtinson v. SAIF, 56 Or App 184 (1982).

Claimant alleges that his left ear problems arose from a single and identifiable incident, i.e., an accidental injury. We note peripherally that if claimant's claim were one for occupational disease, it would fail. In order to prove the compensability of a disease, claimant would have to prove that his work exposure, when compared with off the job factors, was the major cause of the development of his tinnitus and of the worsening of his underlying hearing loss condition. See Dethlefs v. Hyster Co. 295 Or 298 (1983); Weller v. Union Carbide, 288 Or 27 (1979). Considering claimant's preexisting hearing loss, the test results suggesting little in the way of post-exposure loss, and the several off-the-job factors to which he was apparently routinely exposed, his claim for occupational disease thereby fails.

In order to prove the compensability of his claim for accidental injury, claimant must prove that his work incident was a material cause of his tinnitus and hearing loss. Summit v. Weyerhaeuser Co., 25 Or App 851 (1976). Although his testimony is probative in that regard, Garbutt v. SAIF, 297 Or 148 (1984), we find claimant's conditions to be of sufficient medical complexity that expert medical opinion is required to prove the claim. Kassahn v. Publishers Paper Co., 76 Or App 105 (1985).

There is insufficient medical support for claimant's claim. Dr. Echavarria, who apparently was unaware of claimant's alleged 1984 incident, stated only that an unspecified "welding injury" of several years prior might have been a cause. Dr. Ediger stated that the 1984 incident was unlikely to have caused hearing loss and only "possibly" contributed to claimant's tinnitus. Dr. Panian had no opinion with regard to causation.

Only Dr. Tate appears to support the claim. Tate's opinion, however, is flawed for two reasons: First it is conclusory and lacks medical analysis. See Moe v. Ceiling Systems, 44 Or App 429 (1980). Second, although Tate did not examine claimant for more than two years after the March 1984 incident, his report fails to discuss the effects, if any, of claimant's off-the-job activities. Those activities were identified by Dr. Panian and discussed at length by claimant at hearing. Without a more definitive report from Dr. Tate, we are unable to rely upon his opinion to sustain claimant's claim.

Accordingly, we find on this record that claimant has failed to sustain his burden of proof. The Referee's contrary holding will be reversed.

ORDER

The Referee's order dated October 7, 1986 is reversed in part and affirmed in part. That portion of the order that set aside the self-insured employer's denial of claimant's claim for tinnitus and hearing loss is reversed. The employer's denial is reinstated. The remainder of the order is affirmed.

STEVEN C. LOVELL, Claimant
Malagon & Moore, Claimant's Attorneys
Brian L. Pocock, Defense Attorney

WCB 85-15364
June 30, 1987
Order on Review

Reviewed by Board Members Ferris and McMurdo.

Claimant requests review of that portion of Referee Seifert's order that rejected his request for an attorney fee in connection with a request for an offset raised orally by the self-insured employer at the beginning of the hearing. The Referee rejected the employer's request for an offset in his Opinion and Order and expressly rejected claimant's request for an attorney fee in an Order on Reconsideration. The issue is attorney fees.

The Board affirms the orders of the Referee with the following comment. In refusing to award an attorney fee, the Referee cited and relied upon Richard M. Deskins, 38 Van Natta 494, 629, 825, 908 (1986). Deskins, in turn, was based upon OAR 438-47-075. By its terms, OAR 438-47-075 applies only to formal cross appeals. The offset issue in this case was raised informally by the employer at the beginning of the hearing. OAR 438-47-075 and Deskins, therefore, are inapplicable. We nonetheless affirm the Referee because an offset does not represent a disallowance or reduction of compensation within the meaning of ORS 656.382(2). See Lawrence N. Sullivan, 39 Van Natta 88, 97 (1987); cf. Forney v. Western States Plywood, 297 Or 628, 633 (1984); Nonda G. Henderson, 37 Van Natta 425 (1985).

ORDER

The Referee's Opinion and Order dated July 30, 1986 and the Order on Reconsideration dated September 23, 1986 are affirmed.

ROBERT T. MOON, Claimant
Bernt A. Hansen, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 85-07258
June 2, 1987
Order of Abatement

Claimant has requested that we reconsider that portion of our Order on Review dated May 8, 1987 that deals with the rate of temporary total disability to which he is entitled. Claimant asserts that our order failed to consider his argument that overtime pay should have been included in the calculation of his benefits.

In order to allow sufficient time to consider claimant's motion and any response thereto from the SAIF Corporation, we hereby abate our May 8, 1987 Order on Review. SAIF is asked to submit its response, if any, within 21 days of the date of this order.

IT IS SO ORDERED.

ROBERT T. MOON, Claimant
Bernt A. Hansen, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 85-07258
June 30, 1987
Order on Reconsideration

On May 26, 1987, we received claimant's request for reconsideration of our Order on Review dated May 8, 1987. Specifically, claimant asked that we clarify whether our findings regarding his rate of temporary total disability compensation included overtime pay.

On June 2, 1987 we abated our prior order to allow time to consider claimant's request and the SAIF Corporation's response thereto. We have now received and considered the parties' positions on this issue.

Claimant's request for reconsideration is granted. We withdraw our prior order for reconsideration. On reconsideration, we find that claimant's overtime should not be included in the calculation of his temporary total disability compensation. Our conclusion is based on our finding that claimant did not work overtime on a regular basis. Pursuant to OAR 436-60-020(4)(i), overtime is to be considered only when it is regularly worked. Except as modified herein, therefore, we adhere to and republish our prior order, effective this date.

IT IS SO ORDERED.

CHARLES W. ROLLER, Claimant
Michael Bruce, Claimant's Attorney
Schwabe, et al., Defense Attorneys

WCB 86-03475
June 30, 1987
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 denial of continuing responsibility for claimant's diabetic condition. The Referee concluded that the employer's denial was barred by res judicata because claimant had been granted an award of unscheduled permanent partial disability for his diabetic condition and the employer had not timely appealed that award. If the Board affirms the Referee on the res judicata issue, the employer requests that the Board exercise its own motion authority to eliminate the permanent disability award previously granted to claimant. This request will be decided separately under WCB Case No. 87-0337M. The issues are res judicata and the continuing compensability of claimant's diabetic condition.

We affirm the order of the Referee with the following comment. The Referee stated in his order that in light of the res judicata effect of the previous award of permanent partial disability, the only conceivable way that the employer could be relieved of liability for claimant's diabetic condition would be through an independent contribution to the worsening of the condition as a result of subsequent employment. On Board review, the employer contends that the Referee failed consider ORS 656.325(3) which provides:

> "A worker who has received an award for unscheduled permanent total or unscheduled partial disability should be encouraged to make a reasonable effort to reduce the disability; and the award shall be subject to periodic examination and adjustment in conformity with ORS 656.268."

Based upon this subsection, the employer argues that an award of permanent partial disability is not necessarily permanent and contends, therefore, that its denial was not barred by res judicata. Regardless of the employer's argument, to achieve a reduction of permanent disability under ORS 656.325(3), the employer must begin by petitioning the Evaluation Division under the provisions of ORS 656.268. The employer's denial of further

responsibility for claimant's condition short-circuited this statutory procedure and was thus invalid. Cf. Roller v. Weyerhaeuser, 67 Or App 583, 587, amplified on reconsideration, 68 Or App 743, rev den 297 Or 601 (1984).

ORDER

The Referee's order dated September 26, 1986 is affirmed. Claimant's attorney is awarded $650 for services on Board review, to be paid by the self-insured employer.

JERRY FRUICHANTIE, Claimant
Michael B. Dye, Claimant's Attorney

WCB 87-0025M
May 6, 1987
Own Motion Order on Reconsideration

The insurer has requested reconsideration of the Board's February 24, 1987 Own Motion Order. Pursuant to our order, the insurer was directed to reopen claimant's 1978 injury claim and pay temporary disability compensation from October 17, 1986 until claim closure. We further directed the insurer to pay claimant's attorney 25 percent of the compensation granted by our order, not to exceed $500.

The insurer has asked that we abate and reconsider our order. The insurer continues to assert that claimant's condition has not materially worsened since the last arrangement of compensation. Alternatively, the insurer contends that a subsequent employer should be held responsible for claimant's condition.

Claimant responds that the insurer paid a single lump sum payment on March 11, 1987. This payment apparently covered the period from October 17, 1986 through the date of payment. Except for this payment, claimant alleges that the insurer has failed to comply with our order. Specifically, claimant contends that he has neither received his attorney's fee nor any additional temporary disability benefits. Consequently, he requests the assessment of a penalty and accompanying attorney fees for the insurer's failure to comply with our prior order.

After further considering this matter, we reach the following conclusions. The insurer's request for abatement and reconsideration of our prior order is denied. Inasmuch as our prior order was neither appealed, abated, withdrawn, nor republished, it has become final by operation of law. ORS 656.278(3); 656.295(8); International Paper Co. v. Wright, 80 Or App 444 (1986). Furthermore, we remain persuaded that claimant's compensable condition has worsened since the last arrangement of compensation. Therefore, we conclude that modification of our prior order is not justified. See ORS 656.278(1).

Finally, the Board, rather the Hearings Division, is the appropriate forum to consider issues emanating from an own motion matter. David L. Waasdorp, 38 Van Natta 81 (1986). Thus, we have jurisdiction to consider claimant's contention that the insurer has unreasonably failed to comply with our prior order. However, before we address this issue, the insurer is allowed an opportunity to provide an explanation for its conduct. If no response has been received within 20 days from the date of this order, we shall take this matter under advisement based on the present record.

IT IS SO ORDERED.

KENNETH W. HEIL, Claimant
Pozzi, et al., Claimant's Attorneys
Rankin, VavRosky, et al., Defense Attorneys

WCB 85-11285
May 19, 1987
Order of Abatement

Pursuant to the Board's April 27, 1987 Order on Review, this matter was remanded to Referee Fink for consideration of additional evidence which was not available at the time of hearing. The issues presented at that hearing included the self-insured employer's denials of an aggravation claim and a request for authorization for surgery. Since the issuance of our order, we have learned that the documents which form the basis of claimant's request for remand have also recently been considered by Referee Mulder in WCB Case No. 87-01322. The case before Referee Mulder apparently involves claimant's hearing request from the employer's denial of an aggravation claim filed subsequent to the hearing in this case.

Under these circumstances, we conclude that our April 27, 1987 order should be abated pending the outcome of Referee Mulder's order in WCB Case No. 87-01322. Upon the issuance of Referee Mulder's order, the parties are requested to advise the Board of their respective positions concerning the motion for remand which remains pending in this case. If no response is forthcoming within 21 days of Referee Mulder's order, the Board shall assume that the motion for remand has been withdrawn and will proceed to consider this case based on the present record.

IT IS SO ORDERED.

CHARLES H. WHIDDON, Claimant
Pozzi, et al., Claimant's Attorneys
Mark Bronstein (SAIF), Defense Attorney
Rankin, VavRosky, et al., Defense Attorneys

WCB 85-14106 & 85-14081
June 16, 1987
Order of Abatement

The Board has received the self-insured employer's motion for reconsideration of our Order on Review dated May 19, 1987. The issue raised in the employer's motion is identical to the issue presented in a motion for reconsideration which is currently pending in another case.

Therefore, in order to allow sufficient time to consider the motions, 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.

CHARLES W. ROLLER, Claimant
Michael Bruce, Claimant's Attorney
Schwabe, et al., Defense Attorneys

Own Motion 87-0337M
June 30, 1987
Own Motion Order

The self-insured employer requests that the Board exercise its own motion authority to eliminate an award of unscheduled permanent partial disability relating to claimant's diabetic condition. The award was granted by a Determination Order and, for the reasons disclosed in Weyerhaeuser Co. v. Roller, 85 Or App 500 (May 27, 1987), was not timely appealed by the employer.

We have this date ruled in WCB Case No. 86-03475, that the employer has an administrative remedy under ORS 656.325(3) in the matter for which it has requested own motion relief. In light of this administrative remedy, the employer's request for own motion relief is denied. See OAR 438-12-005(1)(a).

IT IS SO ORDERED.

WORKERS' COMPENSATION CASES

Decided in the Oregon Supreme Court:

Decided in the Oregon Court of Appeals:

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Nibby J. Seabeck (Deceased), Claimant.
COTTRELL,
Petitioner,
v.
EBI COMPANIES et al,
Respondents.
(WCB 84-12966; CA A38940)

Judicial Review from Workers' Compensation Board.

Argued and submitted December 11, 1986.

Michael M. Bruce, Eugene, argued the cause for petitioner. On the brief was Richard A. Lee, Eugene.

Jerald P. Keene, Portland, argued the cause for respondents. On the brief were Gordon T. Clark and Roberts, Reinisch & Klor, P.C., Portland.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

WARREN, J.

Affirmed.

Rossman, J., dissenting.

WARREN, J.

Claimant filed a claim for death benefits under ORS 656.226, alleging that she is entitled to benefits because she is a surviving cohabitant. She seeks review of the Workers' Compensation Board's affirmance and adoption of the referee's order denying her claim.

Claimant and decedent had cohabited for approximately three years before the job-related accident that caused decedent's death, and they had a child together. A month before the accident, decedent moved out of claimant's home into an apartment 15 to 20 minutes away. He returned to visit four or five times, and claimant visited him at his apartment twice, both for short periods of time. During the visits to claimant's home, decedent helped around the house and yard. Claimant testified that decedent had moved out because they "needed space" to work out some problems and that she hoped that they would get back together.

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 relation, 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."

In *Amos v. SAIF*, 72 Or App 145, 694 P2d 998 (1985), we said

that a claimant must be cohabiting with the insured at the time of the compensable injury in order to be entitled to survivor's benefits under the statute. Thus, unless the arrangement between claimant and decedent was cohabitation, her claim must be denied.

"Cohabitation" is determined in each case by the nature of the relationship:

> "[T]he essence of cohabitation is the living together and the sexual relations, and there may be some degree of living apart and an occasional trip away without destroying the relation * * *." *Bowlin v. SAIF*, 81 Or App 527, 531, 726 P2d 1186 (1986), quoting from *Wadsworth v. Brigham*, 125 Or 428, 482, 259 P 299, 266 P 875 (1928).

Here, decedent moved out of claimant's house and into an

apartment in another part of the city, because they were having problems with their relationship. Although claimant and decedent continued to talk about working out their problems and to make plans for future improvements to claimant's home, it is speculative whether he would have ever returned to live with her and their child. Unlike in *Bowlin*, here the change in living arrangements was caused by a change in the nature of the relationship. Although claimant testified that she hoped the previous relationship would resume, that does not amount to cohabitation. Benefits were properly denied.

Affirmed.

ROSSMAN, J., dissenting.

Beginning with the premise that, for purposes of survivor's benefits, cohabitation is analogous to marriage, the central inquiry becomes: What is to cohabitation what divorce is to marriage? A divorce, or a "dissolution" as it is referred to in this state, is generally defined as the *termination* of the marriage relationship. The law treats it as a complete severance of the husband and wife unit.

Thus, our function in this kind of case (in which we are required to conduct a *de novo* review) is to examine all of the evidence and to decide *whether the parties ever intended to terminate their relationship. Bowlin v. SAIF*, 81 Or App 527, 532, 726 P2d 1186 (1986). I have read the record and I have considered the same facts as has the majority. I believe that the greater weight of that evidence is not on the side where the majority, in mirroring the Board's evaluation, unfortunately puts it.

Granted, decedent had moved out of the house. However, a mere physical absence from the family home—standing alone—does not establish that the parties intended to terminate their relationship. The reasons are limitless why a spouse or domestic associate might leave the house for an extended, temporary period of time, *i.e.*, illness requiring hospitalization, vacation travel, employment and the like. Even accepting that decedent's reason for leaving the house was the discord between claimant and himself, I do not see, based on that evidence alone, why claimant must lose this case.

The evidence on claimant's side of the scale is much weightier. Decedent visited her, worked in the yard and made plans for painting and repairing the house. He continued to receive his mail at her address. Many of his personal possessions, including his tools, clothing and toiletry items remained in the house. The parties had been temporarily separated once previously during their relationship. Claimant testified that she and decedent had intended, with the current physical separation, "[t]o give each of us space and time to work things out * * * to where we could be back together again and raise our son and have a happy life together." Viewing claimant's and decedent's relationship as akin to a marriage, the evidence does not paint a picture of two people bent on divorce.

The majority concludes that the evidence is "speculative" as to whether decedent would have ever returned to claimant and their son. I cannot accept that appraisal of the record. I realize that the evidence comes from claimant, but there is nothing to suggest that her testimony is not credible. Employer does not contradict what she says.

Because the evidence preponderates in claimant's favor, and because, as claimant points out,

> "it would be contrary to the purposes of the Workers' Compensation law to deny her survivor's benefits solely because of a temporary separation that did not effect [*sic*] the underlying existence of her substantial relationship with the deceased,"

we should reverse the Board. Accordingly, I respectfully dissent.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Gayle A. Jaynes, Claimant.

JAYNES,
Petitioner,

v.

WEYERHAEUSER COMPANY,
Respondent.

(86-0673M; CA A42732)

Judicial Review from Workers' Compensation Board.

On respondent's motion to dismiss filed January 19, 1987.

Ridgway K. Foley, Jr., Portland, for the motion.

Judith H. Uherbelau, Ashland, contra.

Before Young, Presiding Judge, and Warren and Deits, Judges.

PER CURIAM

Motion denied.

PER CURIAM

Claimant petitions for judicial review in a workers' compensation case from what is styled an "Own Motion Determination." Employer moves to dismiss the petition on the ground that a claimant may not have review of an own motion determination which does not diminish or terminate a former award. ORS 656.278(3).

Claimant sustained a compensable injury on September 25, 1980. A determination order was entered on May 18, 1981. On December 13, 1985, employer voluntarily reopened the claim as an aggravation. On December 4, 1986, employer moved for an own motion closure. The claim was closed on December 11, 1986, by the "Own Motion Determination," awarding claimant additional compensation.

Claimant's last award of compensation was on May 18, 1981, and the aggravation claim was timely. That was within five years after the last award, and claimant was entitled to have the claim closed pursuant to ORS 656.268. Her right to a hearing on that determination order is independent of the Board's own motion jurisdiction. *See Owen v. SAIF*, 77 Or App 368, 713 P2d 628 (1986). The Board's order was, therefore, not an own motion order from which claimant may not seek review. ORS 656.278(2).

Motion to dismiss denied.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

PORTLAND MAILING SERVICES, INC.,
Petitioner,

v.

STATE ACCIDENT
INSURANCE FUND CORPORATION,
Respondent.

(CA A40258)

On petitioner's motion to present additional evidence filed October 2, 1986.

Lew E. Delo, Nancy B. Dickerson and Delo, Kantor and Stamm, Portland, for the motion.

Dave Frohnmayer, Attorney General, and Ann Kelley, Assistant Attorney General, Salem, contra.

Before Young, Presiding Judge, and Warren and Deits, Judges.

YOUNG, P. J.

Motion to present additional evidence denied; petition for judicial review dismissed for lack of jurisdiction.

YOUNG, P. J.

This matter is before us on petitioner's motion to present additional evidence. In SAIF's answer to the motion, it contends that the court lacks jurisdiction of the petition.

Petitioner seeks judicial review of a "determination" by SAIF that petitioner owed a premium for workers' compensation insurance for Nancy Torres who, it argues, is not a subject employe under ORS 656.027(9). The determination is a letter from SAIF, which petitioner argues is a final order by a state agency and subject to review as an order in a contested case.

ORS 183.315(1) provides:

> "(1) The provisions of ORS 183.410, 183.415, 183.425, 183.440, 183.450, 183.460, 183.470 and 183.480 do not apply to local government boundary commissions created pursuant to ORS 199.425 or 199.430, the Department of Revenue, State Accident Insurance Fund Corporation, Public Utility Commissioner, Workers' Compensation Department, Psychiatric Security Review Board or State Board of Parole."

SAIF is expressly exempted from ORS 183.480, which provides for judicial review of certain agency orders:

> "(1) Any person adversely affected or aggrieved by an order or any party to an agency proceeding is entitled to judicial review of a final order, whether such order is affirmative or negative in form. A petition for rehearing or reconsideration need not be filed as a condition of judicial review unless specifically otherwise provided by statute or agency rule.

"(2) Judicial review of final orders of agencies shall be solely as provided by ORS 183.482, 183.484, 183.490 and 183.500.

"(3) No action or suit shall be maintained as to the validity of any agency order except a final order as provided in this section and ORS 183.482, 183.484, 183.490 and 183.500 or except upon showing that the agency is proceeding without probable cause, or that the party will suffer substantial and irreparable harm if interlocutory relief is not granted.

"(4) Judicial review of orders issued pursuant to ORS 813.410 shall be as provided by ORS 813.410."

Petitioner argues, however, that ORS 183.482[1] alone confers jurisdiction to review SAIF's determination. ORS 183.315(1) does not exclude SAIF from ORS 183.482. SAIF contends that ORS 183.482 merely governs the scope of our review once jurisdiction is acquired under ORS 183.480. We agree. ORS 183.480(2) would not be necessary, if ORS 183.482 itself conferred jurisdiction. Because SAIF is exempt from ORS 183.480, authority for judicial review of its determinations is not provided for by the APA.

Moreover, workers' compensation law specifically addresses SAIF's premium demands. ORS 656.560(2) provides:

"If any employer insured with the State Accident Insurance Fund Corporation * * * fails to make payment of premiums * * * required within 30 days after a written demand by the State Accident Insurance Fund Corporation, such employer is in default and is also subject to a penalty * * *. The written demand shall be mailed to the employer * * *. A copy of the demand shall at the same time be sent to the director [of the Workers' Compensation Department]. ORS 656.005(12)."

If an employer defaults as described, SAIF may impose a lien on the employer's property by filing a lien notice with the county clerk in which the property is located. ORS 656.566(2). The lien may be foreclosed only if SAIF establishes its validity by an action in circuit court. ORS 656.566(3) and (4). The employer could challenge the premium demand at that point, or it could seek a declaratory ruling under ORS 28.010. Either way, SAIF's action is not reviewable under APA provisions.

Motion to present additional evidence denied; petition for judicial review dismissed for lack of jurisdiction.

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[1] ORS 183.482 provides, in part:

"(1) Jurisdiction for judicial review of contested cases is conferred upon the Court of Appeals. Proceedings for review shall be instituted by filing a petition in the Court of Appeals. The petition shall be filed within 60 days only following the date the order upon which the petition is based is served unless otherwise provided by statute. If a petition for rehearing has been filed, then the petition for review shall be filed within 60 days only following the date the order denying the petition for rehearing is served. If the agency does not otherwise act, a petition for rehearing or reconsideration shall be deemed denied the 60th day following the date the petition was filed, and in such cases, petition for judicial review shall be filed within 60 days only following such date. Date of service shall be the date on which the agency delivered or mailed its order in accordance with ORS 183.470."

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Pamela R. Stovall, Claimant.
STOVALL,
Petitioner - Cross-Respondent,
v.
SALLY SALMON SEAFOOD et al
Respondents - Cross-Respondents,
and
HALLMARK FISHERIES et al,
Respondents - Cross-Petitioners.
(WCB 84-13447, 85-01254; CA A38730)

Judicial Review from Workers' Compensation Board.

Argued and submitted December 19, 1986.

James L. Edmunson, Eugene, argued the cause for petitioner - cross-respondent. With him on the briefs was Malagon & Moore, Eugene.

Jerald P. Keene, Portland, argued the cause for respondents - cross-respondents Sally Salmon Seafood and EBI Companies. With him on the brief was Roberts, Reinisch & Klor, P.C., Portland.

Paul L. Roess, Coos Bay, argued the cause for respondents - cross-petitioners Hallmark Fisheries and Liberty Northwest Insurance Corporation, Coos Bay. With him on the brief was Foss, Whitty & Roess, Coos Bay.

Before Buttler, Presiding Judge, and Joseph, Chief Judge, and Warren, Judge.

BUTTLER, P. J.

Reversed on petition and remanded for an award of attorney fees; affirmed on cross-petition.

BUTTLER, P. J.

In this Workers' Compensation case, claimant seeks insurer-paid attorney fees for prevailing finally against Hallmark before the Workers' Compensation Board on a claim for an occupational disease involving carpal tunnel syndrome. The Board declined to award fees, stating that claimant was a nominal party only. Hallmark cross-petitions, arguing that Sally Salmon Seafood should be responsible for the claim. In the alternative, Hallmark asserts that, if it is responsible, claimant should be equitably estopped from receiving benefits, because she provided misleading information concerning her health on her employment application.

We address the cross-petition first. Claimant first

experienced pain and swelling in her hand while working at Sally Salmon as a crab shaker. She did not seek medical treatment or lose time from work, but treated herself at home. She left Sally Salmon on June 5, 1985, and, after an interim job shucking oysters, began work at Hallmark on June 28, 1985, as a cod scraper. Between the jobs at Sally Salmon and Hallmark, she had no symptoms and did not seek medical treatment. After two weeks at Hallmark, she began to experience pain and swelling in her hand again and consulted Dr. Smith, who diagnosed carpal tunnel syndrome.

Hallmark contends that claimant's exposure while working for it merely activated the symptoms of a condition that was caused by the work at Sally Salmon but did not contribute to the underlying condition. Dr. Melson examined claimant at Sally Salmon's request and concluded that her condition arose as a consequence of her work at Sally Salmon but that the work at Hallmark resulted in the need for surgery:

> "I feel that her carpal tunnel syndrome first made its clinical appearance while she was working at Sally Salmon Seafood, and was exacerbated by her activities at Hallmark Fisheries, resulting in need for surgical intervention."

We read Melson's report to mean that claimant would not have required surgery had she not worked at Hallmark. The working conditions at both employers could have caused the disease; however, claimant did not become disabled until she sought medical treatment while working at Hallmark. The Board properly assigned responsibility to Hallmark for the

cumulative effect of the exposures at the two employments. *Bracke v. Baza'r*, 293 Or 239, 646 P2d 1330 (1982).

When claimant completed her employment application with Hallmark, she represented that she had not suffered any previous hand, wrist or arm trouble. She admitted at the hearing that that statement was false. Hallmark asserts that it should be entitled to raise "estoppel by conduct" as an affirmative defense to responsibility for the claim, because it relied on claimant's representation concerning her health in hiring her and would not have hired her had she provided the correct history of her hand problem. Although claimant was less than candid, she had not sought medical treatment for her condition or lost any work as a result of it. We are not persuaded that, even if equitable estoppel is applicable in the Workers' Compensation context to free an employer of responsibility for a work-related condition, it would be appropriate to invoke it here.

On claimant's petition, we conclude that she is entitled to attorney fees for prevailing finally on her claim against Hallmark. No paying agent was designated under ORS 656.307.[1] Although neither employer questioned the compensability of the carpal tunnel syndrome at the hearing, if Hallmark had been successful in its estoppel "defense," claimant would not have been entitled to compensation from either employer. She actively participated in the proceedings and was justified in doing so to protect her right to compensation. She prevailed finally before the Board on her claim

[1] Hallmark requested an order under ORS 656.307, but none was issued, presumably because Sally Salmon contested the compensability of the claim until the time of the hearing.

against Hallmark and, for that reason, is entitled to attorney fees under ORS 656.386(1), payable by Hallmark. *Petshow v. Farm Bureau Ins. Co.*, 76 Or App 563, 710 P2d 781 (1985), *rev den* 300 Or 722 (1986); *see* OAR 438-47-090(1).

On the petition, reversed and remanded for an award of attorney fees; affirmed on cross-petition.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of
Robert B. Williams, Claimant.
ESTATE OF TROY VANCE, JR. et al,
Petitioners,
v.
WILLIAMS,
Respondent.
(WCB TP-85007; CA A39127)

Judicial Review from Workers' Compensation Board.

Argued and submitted December 19, 1986.

Kenneth Kleinsmith, Portland, argued the cause for petitioners. On the brief was Scott H. Terrall, Portland.

Michael McClinton, Salem, argued the cause for respondent. On the brief were Tim J. Helfrich and Yturri, Rose, Burnham, Ebert & Bentz, Ontario.

Before Buttler, Presiding Judge, and Joseph, Chief Judge, and Warren, Judge.

BUTTLER, P. J.

Affirmed.

BUTTLER, P. J.

This workers' compensation case concerns the right of a paying agency to assert a lien for future expenditures against the proceeds of a settlement reached by claimant with a third party.

Claimant sustained a compensable injury and filed a claim for benefits, which employer accepted. He also elected to seek damages from a third party pursuant to ORS 656.578. His attorney negotiated a settlement with the third party's insurance carrier. During negotiations, the attorney corresponded with employer's workers' compensation carrier, the paying agency (agency), to ascertain the amount of its expenditures. Beginning in June, 1984, the agency advised claimant regularly of its costs.

On March 28, 1985, claimant's attorney telephoned the agency's adjuster and advised her that he had received an offer of $80,000 to settle the third-party claim. He was advised that the adjuster would approve the settlement if claimant would agree to pay the agency's lien of $19,467.55. The next

day, March 29, 1985, the adjuster sent claimant's attorney a letter confirming the agency's approval of the settlement, and advising: "As you know, we have a workers' compensation lien in the amount of $19,467.55 to be considered."

On April 4, 1985, claimant executed a release of the third-party claim, and on the same day his attorney sent a form to the agency entitled "Approval of Settlement by Paying Agency," asking the agency to approve the settlement and a distribution providing for payment to the agency of $19,467.55. On April 11, 1985, the agency's attorney telephoned claimant's attorney and advised him that it was not agreeing to the distribution and that, in addition to the $19,467.55, it was claiming a lien on the settlement proceeds for the present value of anticipated future costs. Claimant's attorney did not agree to the additional lien.

On motion of the agency, the Board considered the matter under ORS 656.593(3). It determined that the agency's just and proper share of the settlement proceeds was $19,467.55 and that the agency was not entitled to claim an additional amount for expected future claim costs, because claimant had relied on the agency's representation that its

lien was $19,467.55 in negotiating and settling the claim with the third party.

An injured worker may elect to sue a negligent third party who is not protected by ORS 656.018. ORS 656.578. If the worker elects to sue, the proceeds of any damages recovered are subject to a lien of the agency for an amount equal to any compensation benefits paid and "the present value of its reasonably to be expected future expenditures." ORS 656.580(2); ORS 656.593(1).[1] If, however, the claimant

[1] ORS 656.593 provides, in part:

"(1) If the worker or the beneficiaries of the worker elect to recover damages from the employer or third person, notice of such election shall be given the paying agency by personal service or by registered or certified mail. The paying agency likewise shall be given notice of the name of the court in which such action is brought, and a return showing service of such notice on the paying agency shall be filed with the clerk of the court but shall not be a part of the record except to give notice to the defendant of the lien of the paying agency, as provided in this section. The proceeds of any *damages recovered* from an employer or third person by the worker or beneficiaries shall be subject to a lien of the paying agency for its share of the proceeds as set forth in this section and the total proceeds shall be distributed as follows:

"(a) Costs and attorney fees incurred shall be paid, such attorney fees in no event to exceed the advisory schedule of fees established by the board for such actions.

"(b) The worker or the beneficiaries of the worker shall receive at least 33-1/3 percent of the balance of such recovery.

"(c) The paying agency shall be paid and retain the balance of the recovery, but only to the extent that it is compensated for its expenditures for compensation, first aid or other medical, surgical or hospital service, *and for the present value of its reasonably to be expected future expenditures for compensation and other costs of the worker's claim under ORS 656.001 to 656.794.* Such other costs include assessments for reserves in the Administrative Fund, but do not include any compensation which may be payable under ORS 656.273 or 656.278.

"(d) The balance of the recovery shall be paid to the worker or the beneficiaries of the worker forthwith. Any conflict as to the amount of the balance which may be retained by the paying agency shall be resolved by the board.

"(2) The amount retained by the worker or the beneficiaries of the worker shall be in addition to the compensation or other benefits to which such worker or beneficiaries are entitled under ORS 656.001 to 656.794.

"(3) *A claimant may settle any third party case* with the approval of the paying agency, in which event the *paying agency is authorized to accept such a share of the proceeds as may be just and proper* and the worker or the beneficiaries of the worker shall receive the amount to which the worker would be entitled for a recovery under subsection (1) and (2) of this section. Any conflict as to what may be a just and proper distribution shall be resolved by the board." (Emphasis supplied.)

settles the third-party claim with the approval of the agency, ORS 656.578, the agency is authorized to accept as its share of

the proceeds "an amount which is just and proper," provided the worker receives at least the amount to which he is entitled under ORS 656.593(1) and (2). ORS 656.593(3).

In other words, if the third-party claim is settled, the compensation carrier may accept as its "just and proper" share an amount which is less than or equal to, but not more than, the amount of the lien to which it would be entitled if the claim had not been settled. Even under subsection (1), when the judgment is paid to the agency, its lien is lost if it does not retain enough to satisfy its lien. *SAIF v. Parker*, 61 Or App 47, 656 P2d 335 (1982). That is true, too, when the claimant discusses a proposed settlement of a third-party claim with the agency and obtains its approval, ORS 656.587, and is advised of the amount which the agency claims under ORS 656.593(3). The amount that the agency is "authorized to accept" is less precise than the amount of its lien under ORS 656.593(1)(c): "just and proper," as opposed to "its expenditures for compensation * * * and * * * the present value of its reasonably to be expected future expenditures for compensation." The question here is whether the agency fixed the "just and proper" amount it claimed when it gave claimant's attorney a figure.

We held in *SAIF v. Cowart*, 65 Or App 733, 672 P2d 389 (1983), that an insurer is entitled to rely on a claimant's representation that the amount he is to receive is in settlement of the claimant's third-party action and that the Board lacked authority to restructure the settlement to pay a portion of the proceeds to the claimant's wife on her claim of loss of consortium. In *Denton v. EBI Companies*, 67 Or App 339, 679 P2d 301 (1984), we noted that, in negotiating a settlement, a claimant has a vital interest in knowing the exact amount of the agency's claimed lien. We held there that the agency could not recover time loss costs which were incurred before settlement but which had not been included in the originally asserted lien. Both *Cowart* and *Denton* support the conclusion that, when either a worker or an agency, in the course of negotiating a third-party settlement, makes a representation to the other which could affect the other's position on the amount of the settlement, the other is entitled to rely on that representation. The requirement that the agency approve any settlement necessitates full disclosure by both parties.

Schlecht v. SAIF, 60 Or App 449, 653 P2d 1284 (1982), on which the agency relies, is not to the contrary. There, the agency had not agreed to the settlement at the time it was executed and did not do so until after the initial proceeds had been distributed. There was no reliance by the worker on the agency's representations as to the amount of its lien. We held that the insurer was not required to make a claim at the time of the settlement for the costs incurred between the time of settlement and the time of the distribution of proceeds and could be compensated for actual expenses incurred before the time of distribution out of the settlement proceeds.

We find that in the process of negotiating the third-party settlement, claimant asked for, and the agency provided, a statement of its lien claim. Claimant expressly sought and received prior approval of the settlement. He relied on the agency's representation of its lien in negotiating and settling the third-party action and was entitled to do so. We hold that, when a agency represents the amount of its claimed lien to a worker, knowing that the worker is in the process of negotiating a third-party settlement, the agency may not claim as its "just and proper" share of the settlement any more than the originally asserted lien, even if the total amount claimed is not in excess of the lien authorized by ORS 656.593(1) and (2). We affirm the Board's holding that the agency's just and proper share of the settlement proceeds is $19,467.55.

Affirmed.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of John D. Schuening, Claimant.

SCHUENING,
Petitioner,

v.

J.R. SIMPLOT & COMPANY,
Respondent.

(85-00949; CA A40423)

Judicial Review from Workers' Compensation Board.

Argued and submitted March 16, 1987.

David C. Force, Eugene, argued the cause for petitioner. On the brief was Kenneth D. Peterson, Jr., Hermiston.

Kenneth L. Kleinsmith, Portland, argued the cause for respondent. On the brief was Daniel L. Meyers, Portland.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

BUTTLER, P. J.

Reversed and remanded to the Board for determination of benefits payable for October 1, 1984, to April 1, 1985.

BUTTLER, P. J.

Claimant seeks review of a Workers' Compensation Board order affirming the referee's decision that claimant's aggravation claim had not been prematurely closed.

Claimant suffered a compensable right ankle injury in July, 1983. The claim was closed by a determination order on May 4, 1984, and then reopened on June 1, 1984, on an aggravation claim. On October 1, 1984, Dr. Smith advised that, although claimant was still in pain and had other symptoms, there was nothing more that could be done for him from a medical standpoint. He stated that the ankle was

medically stationary and recommended claim closure. Claimant was not satisfied that nothing more could be done and saw Smith's partner, Dr. Weeks. Weeks referred claimant to Dr. Graham, who examined him in January, 1985, and, after consultation with a radiologist and one of claimant's treating doctors, reported that claimant could either accept his disabling condition or try more aggressive treatment, which would involve surgery:

> "The patient has a choice, in my opinion of making the decision whether to accept his ankle as it is or to be aggressive in dealing with it. If he accepts it as it is, I think it is unlikely to show further improvement. Whether or not he will eventually grow worse is not clear to me. I think he would find it difficult, however, under his present circumstances to try to continue to work at jobs requiring long periods on his feet, working on rough or irregular ground and doing a lot of kneeling, squatting and carrying and lifting heavy loads.
>
> "Aggressive treatment, in my opinion, would consist of repeat surgery with adequate exposure of the medical dome of the talus and x-ray localization of the lesion within the talus with its removal and subsequent bone grafting. I believe this can only be accomplished by an osteotomy of the medial malleolus. Surgery itself may produce some additional stiffness and would produce a relatively long recovery and rehabilitation phase. In addition it is not completely clear that he could expect pain relief and I think this would depend to a certain extent on what, if anything, was found at the time of surgery and whether or not collapse of the dome of the talus, if resection is of sufficient size, could be prevented. It is possible this patient may eventually need to have an arthrodesis of the ankle."

In the meantime, the Evaluation Division closed the claim with a medically stationary date of October 1, 1984. Claimant elected to have the surgery, which employer authorized as reasonable and necessary. Employer reopened the claim as of April 1, 1985, the date of the surgery. On the theory that the claim was closed prematurely, claimant seeks temporary total disability from October 1, 1984, to the date when the claim was reopened.

Claimant testified at the hearing that his condition did not change from October 1, 1984, to the date of the surgery. The parties stipulated that, if Smith were to testify, he would state that he was "unaware of any factors that would have made surgery more necessary in January, 1985, than it was in October, 1984."

ORS 656.005(17) provides that "medically stationary" means that "no further material improvement would reasonably be expected from medical treatment, or the passage of time." In determining whether a claim was prematurely closed, we determine whether the claimant's condition was medically stationary on the date of closure, without considering subsequent changes in his condition. *Sullivan v. Argonaut Ins. Co.*, 73 Or App 694, 700 P2d 274 (1985); *Alvarez v. GAB Business Services*, 72 Or App 524, 696 P2d 1131 (1985). Here, the evidence indicates that claimant's condition did not change between the date of closure and the date of surgery. The only question, therefore, is whether the evidence before the referee shows that he was medically stationary on the date

of closure.[1] Contrary to employer's contention, the referee and the Board properly considered medical evidence on that issue that was not available to the Evaluation Division at the time of closure. *See, e.g., Brown v. Jeld-Wen, Inc.*, 52 Or App 191, 627 P2d 1291 (1981).[2]

The referee stated that Graham's report supported

the finding that claimant was medically stationary at the time of closure. We read the report differently. Graham was the first doctor to suggest that claimant might benefit from surgery. That treatment was not palliative, but was suggested for the purpose of improving claimant's ankle problem. Although, as the referee stated, there is no evidence that Weeks had "misdiagnosed" claimant's condition, Graham offered treatment that had not been proposed before and did so with a reasonable hope of further medical improvement. We conclude that claimant's condition was not medically stationary on the date of closure.

Reversed and remanded to the Board for a determination of benefits payable for October 1, 1984, to April 1, 1985.

[1] This issue is not to be confused with whether penalties should be imposed for an "unreasonable" premature closure. That determination is based on the medical evidence available to the employer at the time of the alleged unreasonable closure. *Mt. Mazama Plywood Co. v. Beattie*, 62 Or App 355, 661 P2d 109 (1983).

[2] *But see Martin v. SAIF*, 77 Or App 640, 713 P2d 640, *rev den* 301 Or 240 (1986), which held that medical evidence submitted after closure is not considered. *Martin* relied on *Alvarez v. GAB Business Services, supra*. As we have said, *Alvarez* holds only that subsequent changes in the development of the claimant's condition are not considered.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Ernest W. Botefur, Claimant.

BOTEFUR,
Petitioner,

v.

CITY OF CRESWELL et al,
Respondents.

(WCB 85-00470; CA A38414)

Judicial Review from Workers' Compensation Board.

Argued and submitted January 9, 1987.

James L. Edmunson, Eugene, argued the cause for petitioner. With him on the brief was Malagon & Moore, Eugene.

Darrell E. Bewley, Assistant Attorney General, Salem, argued the cause for respondent. With him on the brief were Dave Frohnmayer, Attorney General, Virginia L. Linder, Solicitor General, and Keith Kekauoha, Certified Law Clerk, Salem.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

Reversed and remanded to referee for award of temporary total disability from December 14, 1984, to February 5, 1985; for determination of penalty and attorney fees; for determination of whether claimant is entitled to temporary total disability for period between filing of claim and December 14, 1984.

WARREN, J.

Claimant was injured at work in December, 1981, when he was struck in the chest by a backhoe. His workers' compensation claim was accepted, and he received an award of 60 percent permanent partial disability. He filed an aggravation claim in April, 1984, which SAIF denied on September 17, 1984. A hearing was held in November, 1984, and on December 7, 1984, the referee ordered the claim accepted but held that claimant is not entitled to interim compensation, because there had been no medical verification, "prior to denial," of inability to work.

On December 14, one week after the referee's order, Dr. Wichser, claimant's treating pysician, wrote to SAIF "urgently" requesting that claimant be allowed to participate in a pain clinic and that he receive temporary total disability from April 26, 1984. Wichser concluded his letter by stating that pain treatment "is the only way this man will ever return to gainful employment." Wichser reported on February 14, 1985, that claimant had been unable "to return to his regular form of employment or any other form of employment * * * since April 1984." SAIF began paying temporary total disability benefits immediately thereafter, for the period beginning February 5, 1985. Claimant seeks review of an order of the Workers' Compensation Board which held that he was not entitled to temporary total disability for any time before February 5, 1985.

The Board concluded that claimant was barred by *res judicata* and collateral estoppel from claiming any benefits for time loss for the period before the first referee's order in December, 1984. It reasoned that the question of claimant's entitlement to temporary total disability could have been, but was not, presented at the November, 1984, hearing.

The Board misunderstood the issues before the first referee. Claimant had sought a hearing on SAIF's denial of the claim. The only issues before the referee were the compensability of the claim and claimant's entitlement to interim compensation for the period before the denial of September 17, 1984. The referee found that there had been an aggravation but held that no interim compensation was due because there had been no medical verification, *before the denial*, of an

inability to work. The referee set aside the denial and ordered the claim accepted and processed to closure.

The referee was not presented with and did not decide any question related to claimant's substantive right to temporary total disability. Claimant's entitlement to interim

compensation depended only on the procedural question of whether, before the denial, there had been medical verification of inability to work. *Silsby v. SAIF*, 30 Or App 555, 592 P2d 1074 (1979). At the time of the 1984 hearing, SAIF still denied the claim, and there was no reason for claimant to present evidence on the question of his right to temporary total disability for the period after the denial, which would not be owed unless the claim were determined to be compensable. Evidence of medical verification obtained after the denial would have been irrelevant to the question of interim compensation and premature as to the question of temporary total disability. The referee's finding that there had been no medical verification, before the denial, of an inability to work did not preclude claimant from later providing verification of an inability to work and proof of temporary total disability.

The Board affirmed the referee's alternative holding that claimant had not shown that he was entitled on the merits to additional temporary total disability. It resolved the issue solely by concluding that claimant had not provided "medical verification of inability to work," as required by ORS 656.273(6). We find that Wichser's December 14, 1984, report, stating that the only way claimant would return to work is with pain therapy, was medical verification of his inability to work and triggered SAIF's duty to pay temporary total disability. Claimant is entitled to a penalty on the amount due from December 14, 1984, and attorney fees pursuant to ORS 656.262, because SAIF's failure to pay benefits was not based on a legitimate doubt as to the compensability of the time loss. *Norgard v. Rawlinsons*, 30 Or App 999, 569 P2d 49 (1977).

Whether claimant is entitled to temporary total disability for any time before December 14, 1984, depends on whether a preponderance of the evidence shows that he was disabled during that period due to the compensable claim. ORS 656.210. A doctor's verification of an inability to work is certainly evidence of disability, but it is not necessarily the only relevant evidence. *See Garbutt v. SAIF*, 297 Or 148, 681

P2d 1149 (1984). The entire record is relevant to whether claimant was entitled to additional temporary total disability.

We reverse and remand to the referee for an award of temporary total disability from December 14, 1984, to February 5, 1985; for a determination of penalty and attorney fees; and for a determination of whether claimant is entitled to temporary total disability for any time between the filing of the claim and December 14, 1984.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Rodney D. Phelan, Claimant, and In the Matter of the Complying Status of H.S.C. Logging, Inc., a Washington Corporation, Employer, Ottis Holwegnar, Individually, and Gerald Stump, Individually.

PHELAN,
Petitioner,
v.
H.S.C. LOGGING, INC. et al,
Respondents.

(WCB 84-08850; CA A39944)

Judicial Review from Workers' Compensation Board.

Argued and submitted February 11, 1987.

Garry L. Kahn, P.C., Portland, argued the cause for petitioner. With him on the brief was Emerson G. Fisher, Portland.

Thomas M. Christ, Portland, argued the cause for respondents H.S.C. Logging, Inc., Ottis Holwegnar and Gerald Stump. With him on the brief were Jas Adams and Mitchell, Lang & Smith, Portland.

Dave Frohnmayer, Attorney General, Virginia L. Linder, Solicitor General, and Darrell E. Bewley, Assistant Attorney General, Salem, filed the brief for respondent SAIF Corporation.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

WARREN, J.

Affirmed.

WARREN, J.

Claimant seeks review of an order of the Workers' Compensation Board which affirmed the referee's denial of benefits because claimant was not an Oregon subject worker at the time of his industrial injury. We affirm.

Claimant is an Oregon resident. In July, 1982, he was unemployed. While attending his place of worship in Washington, he spoke with a friend, Maxwell, about the possibility of working for Maxwell's employer, H.S.C. Logging, Inc. (HSC). Maxwell checked with his boss at HSC's office in Carson, Washington, and received permission to hire claimant. Claimant spoke with Maxwell by telephone from his home and accepted the job.

Claimant performed all of his work for HSC at an Oregon logging site near Hood River. He rode to the work site with HSC workers who drove across the river from Washington and picked him up in Oregon. He completed a W-4 form and gave it to his supervisor at the Oregon site. All paychecks were issued from HSC's Washington office. The job site supervisor received direction from the company's Washington office. Approximately 80 percent of HSC's logging operations were conducted in Washington; the other 20 percent were in Oregon. HSC furnished workers' compensation coverage under Washington law for all its employes, whether they worked in Oregon or Washington. It did not cover its employes under Oregon's workers' compensation laws. It withheld Oregon income tax from the paychecks of workers who either lived in Oregon or were working there.

The issue is whether claimant was a "worker from another state" temporarily working in Oregon and thereby exempted from coverage under Oregon's workers' compensation law by ORS 656.126(2).[1] In *Kolar v. B & C Contractors*, 36

Or App 65, 583 P2d 562 (1978), we adopted a permanent employment relation test to determine whether a worker is "employed in this state" under ORS 656.126(1) for purposes of providing benefits when the worker is injured on a temporary assignment in another state for an Oregon employer. We reaffirmed the use of the test in *Langston v. K-Mart*, 56 Or App 709, 711, 642 P2d 1205, *rev den* 293 Or 235 (1982), where we stated that "[t]he inquiry is focused on the extent to which claimant's work outside the state was *temporary*." (Emphasis in original.) ORS 656.126(1) is the mirror image of ORS 656.126(2), *i.e.*, the inquiry is whether claimant's work in Oregon was temporary.

Here, the evidence establishes that Maxwell hired claimant after he received authorization from HSC's office in Washington. HSC's operations were run from the Washington office, and paychecks were issued from there. Although claimant's first job was at an Oregon logging site, he and Maxwell had discussed the probability that the next logging site would be in the Mt. St. Helens area of Washington. HSC had no temporary employes as such, but it did have short term jobs like the one at which claimant was employed. All

[1] ORS 656.126(2) provides:

"Any worker from another state and the employer of the worker in that other state are exempted from the provisions of ORS 656.001 to 656.794 while that worker is temporarily within this state doing work for the employer:

"(a) If that employer has furnished workers' compensation insurance coverage under the workers' compensation insurance or similar laws of a state other than Oregon so as to cover that worker's employment while in this state;

"(b) If the extraterritorial provisions of ORS 656.001 to 656.794 are recognized in that other state; and

"(c) If employers and workers who are covered in this state are likewise exempted from the application of the workers' compensation insurance or similar laws of the other state.

"The benefits under the workers' compensation insurance Act or similar laws of the other state, or other remedies under a like Act or laws, are the exclusive remedy against the employer for any injury, whether resulting in death or not, received by the worker while working for that employer in this state."

If claimant is a "worker from another state," HSC is exempted, because it has complied with ORS 656.126(2)(a), and the state of Washington fits the criteria of subsections (2)(b) and (c). *See Bowers v. Mathis*, 280 Or 367, 571 P2d 489 (1977).

employes were hired on the expectation that, if they performed adequately, they could remain employed. Claimant knew that, if he "worked out" as a new employe, he could continue working for HSC if he chose to do so. He testified that, in the six weeks he worked for HSC, employer seemed pleased with him. Although he had never worked in the state of Washington before his injury, we conclude that he was a Washington worker temporarily working in Oregon and that he was a Washington employe exempt from coverage under Oregon's workers' compensation law. Accordingly, we affirm the Board's denial of benefits.

Affirmed.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Rene Van Woesik, Claimant.

VAN WOESIK,
Petitioner,

v.

PACIFIC COCA-COLA CO. et al,
Respondents.

(WCB 84-09431; CA A36863)

Judicial Review from Workers' Compensation Board.

Argued and submitted June 18, 1986.

James L. Edmunson, Eugene, argued the cause for petitioner. With him on the brief was Malagon & Associates, Eugene. Peter O. Hansen, Portland, filed an association of counsel.

Craig A. Staples, Portland, argued the cause for respondents. With him on the brief was Roberts, Reinisch & Klor, P.C., Portland.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

RICHARDSON, P. J.

Affirmed.

RICHARDSON, P. J.

Claimant seeks review of a Workers' Compensation Board order that denied his claim for aggravation of his lower back injury. We affirm.

Claimant suffered a compensable low back injury on May 5, 1980. Dr. Johnson performed a lumbar laminectomy, nerve decompression and excision of a herniated disc. The claim was closed on May 12, 1981, with an award of unscheduled disability. A second determination order was issued on August 11, 1982, awarding additional unscheduled disability. Claimant's condition worsened, and on February 3, 1983, a stipulation was approved granting additional unscheduled disability, for a total award of 30 percent. Claimant later filed an aggravation claim, which the insurance

carrier denied on May 3, 1983. A hearing was held in June, 1984, on his appeal of that denial and it was upheld.

After the June hearing, claimant was examined again by Dr. Johnson, who performed a myelogram and a CT scan in July. Both were negative. On August 1, 1984, claimant experienced shooting low back pain after reaching for a cup of coffee and was treated at the hospital emergency room for what was diagnosed as "chronic low back pain."

Claimant sought a second opinion from Dr. Geist, who noted that he was in severe pain and had difficulty moving, that he had a reversal of his lumbar lordosis and a lumbar kyphosis, little movement in his low back and muscle spasms in the lumbar area. He recommended muscle relaxants and rest. Dr. Johnson examined him again in mid-August and observed that he had recurrent back and leg pain with camptocormia and referred him to Dr. Waldram. Claimant filed an aggravation claim and the carrier denied it in August, 1984. Dr. Waldram examined him in September, noted significant somatization of symptoms and camptocormia and recommended therapy. In October, Dr. Johnson concluded that further neurological or orthopedic procedures would not be beneficial and recommended retraining for lighter employment. In November, claimant was examined by Dr. Erickson, an osteopath, who observed an increase in pain and recommended intensive physical therapy, pain medication and muscle relaxants, which he believed would reduce the pain to the level existing before June, 1984.

A hearing was held on November 15, 1984, and the referee concluded that claimant had failed to prove that his underlying condition had worsened since the last arrangement of compensation and affirmed the denial. The Board affirmed the referee's opinion and order.

The issue is whether claimant proved an aggravation of his low back injury since the last arrangement of compensation in June, 1984. We agree with his argument that the Board erred in saying that it was necessary for him to prove that his underlying condition had worsened. Although increased symptoms in themselves are not compensable as an aggravation, pain that results in additional loss of earning capacity is. *Smith v. SAIF*, 302 Or 396, 730 P2d 30 (1986). However, we conclude that claimant has failed to prove that increased symptoms and pain resulted in an increased loss of earning capacity.

Claimant contends that his condition has worsened since the last hearing. However, the testimony that he gave regarding his symptoms at the June and November hearings was similar. He stated at both hearings that he has trouble walking, bending and sitting and needs medication to sleep. He stated further that he has constant back and leg pain, extending into his ankles, and that his leg often gives out, causing him to fall. Although the camptocormia appears to be a new condition, claimant had previously experienced several of the other conditions which he now describes. Reduced lumbar range of motion, loss of lumbar lordosis, positive straight leg raising tests and muscle spasms were present before June, 1984. Three of the doctors who examined him

after June were seeing him for the first time and had nothing with which to compare his status.

Claimant also contends that there is evidence of an aggravation, because Dr. Johnson responded "yes" on a questionnaire asking whether his condition had worsened since February, 1983. In the light of the other medical opinions, we find this unpersuasive; it is merely a conclusion that is not supported by any explanation.

Even if claimant has demonstrated increased pain, he has failed to show a loss of earning capacity. He relies on Dr. Johnson's letter stating that he was incapacitated from work during June and July, 1984, yet he fails to note that the period

of incapacitation extended only until after evaluation of his medical condition. Although Dr. Johnson recommended in October that claimant be retrained for lighter work, he did not suggest that claimant has been unable to work or that his earning capacity has been reduced since June, 1984. Further, his employment status was the same at the time of both the June and November hearings: he was not working. He was employed for only brief periods three or four times between 1980 and 1984 and quit each job because of pain. He currently takes care of two young children and has applied for several jobs that he admitted he would be unable to perform. We conclude that he has failed to prove that an increase in symptoms has resulted in a loss of earning capacity.

Claimant also contends that he is entitled to attorney fees for services rendered before the Board on review. However, there is no statutory authorization for an award. ORS 656.382(2) provides for fees to be awarded to a claimant *if* the insurer or employer appeals and compensation is not reduced or disallowed. *Shoulders v. SAIF*, 300 Or 606, 615, 716 P2d 751 (1986). Claimant appealed from the referee's order, and his claim for aggravation was denied. Similarly, ORS 656.386(1) is inapplicable, because it requires that a claimant "finally prevail" on the issue of compensation.

Affirmed.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

YOUNG,
Plaintiffs,

v.

MOBIL OIL CORPORATION,
Appellant - Cross-Respondent,

v.

MYERS DRUM COMPANY,
Respondent - Cross-Appellant.

(A8203-01737; CA A36144)

Appeal from Circuit Court, Multnomah County.

Robert P. Jones, Judge.

Argued and submitted October 22, 1986.

James N. Westwood, Portland, argued the cause for appellant - cross-respondent. With him on the briefs were John D. Burns, C. Edward Fletcher, III, and Miller, Nash, Wiener, Hager & Carlsen, Portland.

James H. Marvin, Portland, argued the cause for respondent - cross-appellant. With him on the brief were Richard H. Divine and Schouboe, Marvin & Furniss, Portland.

Before Warden, Presiding Judge, and Van Hoomissen and Young, Judges.

WARDEN, P. J.

Affirmed on appeal and on cross-appeal.

WARDEN, P. J.

The only issue presented by this appeal[1] is whether third-party defendant Myers Drum Company (Myers) has a contractual duty to indemnify defendant/third-party plaintiff Mobil Oil Corporation (Mobil) for a payment made to plaintiffs in settlement of their claims against Mobil.[2] The trial court held that the indemnity provision in Myers' contract with Mobil is void. We affirm.

The facts are not disputed. Mobil is a New York corporation with headquarters in that state, and Myers, until 1985, was a subsidiary of a California corporation. On November 1, 1979, Mobil entered into a contract with Myers that was negotiated in California. It provided that Myers would pick up used 55-gallon oil drums from Mobil's plant in Portland, recondition them at its Portland plant and return the drums to Mobil's plant. An indemnity provision in the contract provided that Myers would

[1] Because we affirm the trial court, we need not address the issues raised by Myers in its cross-appeal. We therefore affirm on the cross-appeal.

[2] The claim of plaintiffs against Mobil has been settled and their complaint dismissed; the third-party claims of Mobil against A. J. Bayer Company, Truck Insurance Exchange and Elmer L. Hamm have all been dismissed. Appropriate judgments were entered.

"indemnify and hold Mobil harmless against all losses, expenses, liability and claims * * * for death, personal injury or property damage arising out of the work hereunder by [Myers] or any subcontractor or their agents or employes."

The contract also provided that New York law was to govern the agreement.

On April 15, 1980, plaintiff, an employe of Myers, suffered injuries at Mobil's plant while delivering reconditioned drums. As permitted by the workers' compensation system, ORS 656.001 to ORS 656.794, he and his wife brought an action against Mobil, alleging negligence and seeking damages for his injuries and for loss of consortium. Mobil filed a third-party complaint against Myers and others for indemnity. Mobil later settled with plaintiffs on all of their claims, paying them $30,000. When Myers declined to participate in the settlement, Mobil pursued its contractual indemnity claim. After trial, the court granted Myers' motion to dismiss

the third-party complaint on the basis of ORS 656.018(1) and *Roberts v. Gray's Crane & Rigging*, 73 Or App 29, 697 P2d 985, *rev den* 299 Or 443 (1985). Mobil appeals.

Mobil contends that the trial court erred by not enforcing the choice-of-law clause in the contract, which would apply New York law and, Mobil contends, result in enforcement of the indemnity provision. Myers argues that ORS 656.018(1)[3] sets forth a fundamental public policy of Oregon that operates to void the indemnity provision *despite* the choice-of-law clause and that our holding in *Roberts v. Gray's Crane & Rigging, supra*, compels that result. Myers alternatively urges that if New York law is applied, it would defer to Oregon law under the facts of this case and that, therefore, under ORS 656.018(1), the indemnity provision is void. We address in turn how Oregon law and New York law resolve the issue.

In construing contracts, Oregon adheres to the rule that the intention of the parties prevails. *Miller v. Miller*, 276 Or 639, 555 P2d 1246 (1976). That rule gives parties the autonomy to choose the law that is to govern their contracts. *Sterrett v. Stoddard Lbr. Co.*, 150 Or 491, 46 P2d 1023 (1935); *see Warm Springs Forest Products Ind. v. EBI Co.*, 300 Or 617, 716 P2d 740 (1986). There are, however, limits to parties' autonomy in choosing that law. Restatement (Second) Conflict of Laws § 187(2) (1971) provides:

"The law of the state chosen by the parties to govern their contractual rights and duties will be applied * * * unless either

"(a) the chosen state has no substantial relationship to the parties or the transaction and there is no other reasonable basis for the parties' choice, or

"(b) application of the law of the chosen state would be contrary to a fundamental policy of a state which has a

[3] ORS 656.018(1) provides, in relevant part:

"The liability of every employer who satisfies the duty required by ORS 656.017(1) [to maintain assurance that workers and their beneficiaries will receive compensation for compensable injuries] is exclusive and in the place of all other liability arising out of compensable injuries to the subject workers, the workers' beneficiaries and anyone otherwise entitled to recover damages from the employer on account of such injuries or claims resulting therefrom, specifically including claims for contribution or indemnity asserted by third persons from whom damages are sought on account of such injuries * * *."

> materially greater interest than the chosen state in the determination of the particular issue and which * * * would be the state of the applicable law in the absence of an effective choice of law by the parties."

Oregon cases have dealt with choice of law issues in contract actions, but none of them has concerned contracts containing choice of law clauses. *See Lilienthal v. Kaufman*, 239 Or 1, 395 P2d 543 (1964); *Citizens First Bank v. Intercontinental Express*, 77 Or App 655, 713 P2d 1097 (1986); *Seattle-First National Bank v. Schriber*, 51 Or App 441, 625 P2d 1370 (1981). *Lilienthal* adopted the principle that the law applied should be that of the state having the most significant relationship to the parties and the transaction. Later cases have followed the *Lilienthal* approach, citing Restatement (Second) Conflict of Laws § 188 (1971) as additional authority. *Citizens First Bank v. Intercontinental Express, supra; Seattle-First National Bank v. Schriber, supra.* Our cases also have implicitly followed the methodology of § 187(2). In *Seattle-First National Bank v. Schriber, supra*, where the issue was whether Oregon law or Washington law was to apply, we stated that, "even if Washington were to have more and closer contacts with this transaction, [*the*] *public policy expressed in* [*the Oregon statute*] *is so important that Oregon law should be applied.*" 51 Or App at 446. (Emphasis supplied.) We follow the analysis set forth in § 187(2) of the Restatement to resolve the issue in this case under Oregon law.

New York law also follows the principle that the parties may choose the law that is to govern their contracts. *See A.S. Rampell, Inc. v. Hyster Co.*, 3 NY2d 369, 144 NE2d 371, 165 NYS2d 475 (1957); *Compania de Inversiones Internacionales v. Industrial Mortgage Bank of Finland*, 269 NY 22, 198 NE 617 (1935). The parties' choice of law may include the conflict of laws principles applied under that law. *Carlos v. Philips Business Systems, Inc.*, 556 F Supp 769, *aff'd* 742 F2d 1432 (2d Cir 1983) (applying New York law). The parties' freedom of choice, however, is not absolute. *See Nakleh v. Chemical Construction Corp.*, 359 F Supp 357 (SD NY 1973) (applying New York law). Although the parties' choice of law is to be given considerable weight, the law of the jurisdiction with the most significant contacts is the law to be applied. *Haag v. Barnes*, 9 NY2d 554, 175 NE2d 441, 216 NYS2d 65

(1961). Section 187(2) (1971) sets forth the significant relationship test adopted by New York courts. *S. Leo Harmonay, Inc. v. Binks Mfg. Co.*, 597 F Supp 1014 (SD NY 1984); *Nakleh v. Chemical Construction Corp., supra; see Bank Itec N.V. v. J. Henry Schroder Bank & Trust*, 612 F Supp 134 (SD NY 1935). New York law, therefore, like Oregon law, applies section 187 methodology in cases where the parties have contractually chosen the law that is to govern.[4]

Because both Oregon and New York apply the same

[4] New York applies § 187 methodology even when the parties choose New York law to govern. In *Business Incentives, Inc. v. Sony Corp. of Amer.*, 397 F Supp 63 (SD NY 1975), New Jersey law was applied despite a New York choice-of-law clause, because New Jersey had a strong public policy at stake, greater contacts with the transaction and a materially greater interest in applying its law.

methodology and would, presumably arrive at the same result, a false conflict is presented. The dispositive issue is, therefore, whether ORS 656.018(1) sets forth a fundamental public policy of this state.[5] If, as we conclude, the statute states such a policy, the indemnity provision is void.

We must first determine what constitutes a "fundamental public policy." *Comment* g to § 187 explains:

> "The forum will apply its own legal principles in determining whether a given policy is a fundamental one within the meaning of [§ 187(2)(b)] * * *.
>
> "* * * * *
>
> "To be 'fundamental,' a policy must * * * be a substantial one. * * * [A] fundamental policy may be embodied in a statute which makes one or more kinds of contracts illegal * * *."

Oregon requires that a public policy be clear and "overpowering" before a court will interfere with the parties' freedom to contract on the ground of public policy. *See Harrell v. Travelers Indemnity Company*, 279 Or 199, 567 P2d 1013 (1977). In *Schultz v. First Nat. Bk. of Portland*, 220 Or 350, 358, 348 P2d 22 (1959), the Supreme Court stated that a foreign contract is invalid in Oregon if it is "offensive to our moral standards or here regarded as injurious to the public welfare." The court, quoting from *Loucks v. Standard Oil Co.*, 224 NY 99, 120 NE 198, 202 (1918), also stated that such a contract is enforceable

unless it " 'would violate some fundamental principle of justice, some prevalent conception of good morals [or] some deep-rooted tradition of the common weal.' " 220 Or at 360. We turn then to the policy expressed in ORS 656.018(1).

In *Roberts v. Gray's Crane & Rigging, supra*, we decided that, under ORS 656.018(1), the indemnity agreements between the parties involved were void. In that case, an allegedly negligent third-party had sought indemnity from a employer who was subject to the Workers' Compensation Act. We analyzed ORS 656.018(1):

> "Under the Workers' Compensation Act, a subject employer's duty to maintain coverage for its subject workers, ORS 656.017(1), is its exclusive liability for injuries to those workers. ORS 656.018. Before amendment in 1977, ORS 656.018(1) provided:
>
> " 'Every employer who satisfies the duty required by subsection (1) of ORS 656.017 is relieved of all other liability for compensable injuries to his subject workmen, the workmen's beneficiaries and anyone otherwise entitled to recover damages from the employer on account of such injuries, except as specifically provided otherwise in ORS 656.001 to 656.794.'
>
> "In *U.S. Fidelity v. Kaiser Gypsum*, 273 Or 162, 539 P2d 1065 (1975), the Supreme Court held that the statute did not bar an action for common law indemnity by a third party against an employer, when the third party's liability to an injured worker had resulted from a breach of an express or implied independent duty owed by the employer to the third

[5] Myers does not assert that subsection (a) of § 187(2) applies here (*i.e.*, that there is no reasonable basis for choosing New York law).

party. On the same day that *Kaiser Gypsum* was decided, the Supreme Court held that the statute did not bar an indemnity action by a third party against an employer under an express contract of indemnity. *Gordon H. Ball v. Oregon Erect. Co.*, 273 Or 179, 539 P2d 1059 (1975). The court noted that '[t]here is no indication that the legislature in enacting ORS 656.018(1) intended to preclude an employer from *voluntarily* contracting with a third party to indemnify it for damages paid to an injured employee.' 273 Or at 185. (Emphasis in original.)

"In 1977, ORS 656.018 was amended. Or Laws 1977, ch 804, § 3a. The statute now provides:

"'(1)(a) The liability of every employer who satisfies the duty required by ORS 656.017(1) is exclusive and in place of all other liability arising out of compensable

injuries to his subject workers, the workers' beneficiaries and anyone otherwise entitled to recover damages from the employer on account of such injuries or claims resulting therefrom, *specifically including claims for contribution or indemnity asserted by third persons from whom damages are sought on account of such injures*, except as specifically provided otherwise in ORS 656.001 to 656.794.

"'(b) This subsection shall not apply to claims for indemnity or contribution asserted by a corporation, individual or association of individuals which is subject to regulation pursuant to ORS chapter 757 or 760.

"'(c) *Except as provided in paragraph (b) of this subsection, all agreements or warranties contrary to the provisions of paragraph (a) of this subsection entered into after July 19, 1977, are void.*

"'* * * * *.' (Emphasis supplied.)

"The statute was amended to overturn the holding of *U. S. Fidelity v. Kaiser Gypsum, supra. Boldman v. Mt. Hood Chemical Corporation*, 288 Or 121, 124, n 1, 602 P2d 1072 (1979). The legislative history of the amendment indicates that it was equally intended to abrogate the holding of *Gordon H. Ball v. Oregon Erect. Co., supra.*

"Contrary to [third-party plaintiff's] contention that 'there is nothing on the face of the language of ORS 656.018(1)(a) which bars *express* indemnity agreements,' the statute clearly bars such agreements. The best evidence of the purpose of a statute is its language. * * * Subsection (1)(a) provides that the employer's duty to provide workers' compensation coverage shall be its exclusive liability for injuries to its workers and specifically protects the employer from third-party claims for contribution or indemnity. Subsection (1)(c) provides that *all* agreements or warranties to the contrary entered into after July 19, 1977, are void.

"* * * * *

"[W]e hold that ORS 656.018 * * * is reasonably necessary to maintain the balance in the Workers' Compensation Act. The legislative history of the 1977 amendments to ORS 656.018 reveals that the legislature amended the statute to restore the exclusive liability protection former ORS 656.018(1) was understood to afford the employer before *U.S. Fidelity v. Kaiser Gypsum, supra*, and *Gordon H. Ball v. Oregon Erect. Co., supra*. The legislature was concerned that

third-party indemnity claims against employers would circumvent and undermine the exclusive liability provision. Obviously, if employers were liable for such claims, workers' compensation would no longer be their exclusive liability. The legislature also expressed concern about the costs and prolonged litigation threatened by such claims." 73 Or App at 32-36. (Citation omitted; emphasis in original.)

Oregon's workers' compensation laws "provide the overall social benefits deriving from a uniform workmen's compensation system." *Giltner v. Commodore Con. Carriers*, 14 Or App 340, 345, 513 P2d 541 (1973). As *Roberts* says, the exclusive liability provision forms an essential part of this state's workers' compensation system. That the 1977 amendments were enacted in immediate response to *U.S. Fidelity v. Kaiser Gypsum, supra*, and *Gordon H. Ball v. Oregon Erect. Co., supra*, indicates a strong legislative intent to void *all* indemnity agreements subjecting an employer to additional liability. The legislative response also indicates that it considered the policy granting employers exclusive liability to be a compelling and "overpowering" one. Neither the statute nor its legislative history leads us to think that the legislature intended not to provide a subject employer like Myers with the same protection afforded by ORS 656.018(1) to the injured worker's employer in *Roberts* or to protect a negligent third-party merely because the parties chose another state's law to govern their agreement.

If parties to a contract could circumvent the workers compensation laws by choosing the law of another jurisdiction to govern their agreement, the statutory scheme would break down, thereby causing "injury to the public welfare." To allow a negligent third party in Mobil's position to be indemnified totally for its negligence would subvert the policy stated in ORS 656.012(2)(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."

That policy essentially encourages the employer to provide a safe workplace. However, if Mobil is indemnified by other companies for injuries to those companies' employes that occur on Mobil's premises because of hazards there, then Mobil has less incentive to provide a safe workplace than

when no indemnity is allowed. The exclusive liability provision is therefore a cornerstone of the fundamental policy stated in ORS 656.012(2)(d). For those reasons, we hold that ORS 656.018(1) evinces a fundamental public policy of this state that voids the indemnity provision in the agreement between Myers and Mobil.[6] The trial court did not err in dismissing Mobil's third-party complaint against Myers.

Affirmed on appeal and on cross-appeal.

[6] We do not find Mobil's arguments to the contrary convincing. It argues that the statute does not state a fundamental public policy, because it "is riddled with exceptions." The only exceptions found in the statute are for railroads and regulated public utilities. Another "exception" merely prevents any retroactive effect of the amendments. Mobil also urges that a single statute does not constitute a fundamental public policy, relying on *Schultz v. First Nat. Bk. of Portland, supra*. That reliance is misplaced. *Schultz* states the principle that a statute will invalidate a foreign contract if the statute expresses some fundamental public policy and the foreign contract is regarded as injurious to the public welfare, because it violates that public policy. In this case, we have just such a policy set forth by the statute and just such a contract.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Elizabeth M. White, Claimant.
WAREMART, INC.,
Petitioner,
v.
WHITE,
Respondent.
(WCB 84-03175; CA A38694)

Judicial Review from Workers' Compensation Board.

Argued and submitted December 1, 1986.

Kenneth L. Kleinsmith, Portland, argued the cause for petitioner. On the brief was Daniel L. Meyers, Portland.

Nelson R. Hall, Portland, argued the cause for respondent. With him on the brief were Pozzi, Wilson, Atchison, O'Leary & Conboy, Portland, and Diana Craine, Portland.

Before Warden, Presiding Judge, and Van Hoomissen and Young, Judges.

VAN HOOMISSEN, J.

Affirmed.

VAN HOOMISSEN, J.

Employer seeks judicial review of a Workers' Compensation Board order awarding claimant permanent total disability.[1] The dispositive issue is whether medical conditions preexisting claimant's compensable injuries may be considered in determining the extent of her disability. The Board concluded that they may be considered. On *de novo* review, we affirm.

In March, 1983, claimant slipped on a wet floor at work and injured her back. In April, she again fell at work, reinjuring her back. She was seen by Dr. Bristol, who initially diagnosed a bruised sciatic nerve. He noted arthritic disc degeneration in her spinal column and decreased sensation to pinpricks in her right leg and foot. She returned ten days later, complaining of continued low back pain. He changed his initial diagnosis to lumbar sprain. He also noted that the numbness in her right leg and foot were more extensive and that her right arm responded variably to pinpricks. She could not return to work at that time. Employer accepted her claim and began paying time loss and medical benefits.

[1] ORS 656.206(1)(a) provides, in relevant part:

"'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."

[2] The record is unclear whether the fracture occurred in April or August. However, it has been treated as a work injury by all parties.

Claimant continued to suffer low back pain. In August, 1983, a back spasm caused her to fall, resulting in a fracture of her left ankle.[2] Her neurological symptoms persisted, and Bristol referred her to several specialists. By early 1984, the specialists had diagnosed primary amyloidosis and secondary peripheral neuropathy.

In March, 1984, employer sought closure on the ground that claimant's work-related disability had become medically stationary and that it was not the cause of her medical impairment. It also denied benefits for the amyloidosis and peripheral neuropathy. The determination order upheld the denial; it awarded claimant 45 percent unscheduled disability resulting from her back condition and

10 percent disability for the loss of function of her ankle. Claimant requested a hearing.

The referee found that claimant and Bristol were credible witnesses. He concluded that "the conditions diagnosed as amyloidosis, peripheral neuropathy secondary to amyloidosis, and diabetes were not preexisting conditions, nor were they preexisting disabling conditions.* * * I am of the opinion claimant is not permanently and totally disabled." He awarded claimant 60 percent unscheduled permanent partial disability for her back condition and 10 percent disability for her ankle. Claimant requested review. The Board found that, although the amyloidosis and peripheral neuropathy were unrelated to claimant's work injury and, therefore, were noncompensable, their combination with her compensable injury justifies an award of permanent total disability:

> "Claimant had preexisting degenerative disc disease and a prior industrial injury to her right ankle. The unrelated polyneuropathy condition was discovered coincidentally at the time of claimant's industrial injury in April 1983. Treatment of the neuropathy induced the subsequent diabetic condition. The diabetes and the polyneuropathy interfered with the healing of claimant's left ankle. Claimant's treating doctor reported that claimant was totally disabled by the effects of her low back injury alone, but that she would also be totally disabled by the polyneuropathy. Subsequent testing established that the neuropathy condition was a sign of severe primary amyloidosis. Although primary amyloidosis was previously unsuspected and undetected, we are persuaded by the treating doctor's ultimate opinion that the condition preexisted claimant's industrial injury.
>
> "* * * * *
>
> "We find that the synergistic combination of claimant's preexisting primary amyloidosis with industrial injuries to claimant's low back and left ankle results in permanent total disability."

Employer contends that the weight of the medical evidence establishes that claimant's amyloidosis and neuropathy arose only coincidentally at the time of her injury. It argues that those conditions should not be considered in determining the extent of her disability, because they were not caused by her work injury, and that, even if the conditions preexisted her work injury, they were asymptomatic and not

disabling before the injury. Therefore, they should not be considered as preexisting disabilities in determining benefits.[3]

The medical evidence establishes that claimant's amyloidosis and neuropathy are unrelated to her work injury. The work injury did not cause, or worsen, those conditions. Bristol testified that the conditions preexisted the injury. He based his opinion on the fact that claimant exhibited decreased sensation to pinpricks during her first treatment for her work injury. The decreased sensation was the clinical manifestation of the amyloidosis and neuropathy. Nothing in the record contradicts that opinion. However, Bristol also testified that those conditions have prevented claimant's strained back from healing and that her back injuries continue to cause muscle spasms and pain radiating through her hips and legs. Claimant's amyloidosis and neuropathy have interfered with his treatment for her ankle and back injuries. Because she now moves only with a wheelchair or walker, physical therapy may not be used to treat her back.

The preexisting conditions are preventing recovery from her work injuries. Bristol testified that the back and

ankle injuries sustained by claimant at work are totally disabling because of the effect of the amyloidosis *on them, i.e.,* they will not heal, because of the amyloidosis. Although the preexisting conditions themselves are not compensable, their synergistic effect on her compensable injuries must be considered if she is permanently and totally disabled because of the injuries. *See Arndt v. Nation Appliance,* 74 Or App 20, 701 P2d 474 (1985); *see also Aquillon v. CNA Insurance, supra* n 3. Claimant is entitled to compensation for permanent and total disability. *See Taylor v. SAIF,* 75 Or App 583, 586, 706 P2d 1023 (1985).[4]

Affirmed.

[3] In *Aquillon v. CNA Insurance,* 60 Or app 231, 653 P2d 264 (1982), *rev den* 294 Or 460 (1983), a physician treating the claimant for a work injury noted cloudy fluid in the claimant's knee joint. The fluid was the first clinical manifestation of what was later diagnosed as tuberculosis. The employer denied benefits for the work injury and for the tuberculosis, contending that the injury would have resolved itself *but for* the tuberculosis. On review, we held the denial improper:

> "In this case claimant challenges what purports to be a partial denial of his claim insofar as it relates to the tuberculosis, viewed as a separate condition, as well as a denial of further responsibility for benefits as a result of the accepted industrial injury claim. In the abstract, that kind of denial might not be unreasonable where there is a noncompensable, separate condition and where the claimant has fully recovered from his compensable injury. Here, the preponderance of the medical evidence is that the tuberculosis itself was not worsened by the industrial injury and hence, is not itself compensable. The problem is that it is difficult, if not impossible, on this record to separate the effects of the tuberculosis from those of the traumatic injury.
>
> "* * * * *
>
> "There is, however, no medical evidence in the record supporting the position that all effects of the industrial injury had ceased. No doctor states the claimant's current condition stems solely from the tuberculosis. To the contrary, the undisputed medical evidence is that the two conditions are inextricably intertwined, in that the traumatic injury was superimposed on the tubercular infection, and the presence of the tubercular infection prolonged the effects of the traumatic injury to the synovium." 60 Or App at 235.

The same analysis applies here.

[4] The oft-expressed maxim still applies: an employer takes the worker as it finds her. *Barrett v. D & H Drywall,* 300 Or 325, 328, 709 P2d 1083 (1985), *adhered to on reconsideration,* 300 Or 553, 715 P2d 90 (1986).

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
James E. Duckett, Claimant.

DUCKETT,
Petitioner,

v.

ALASKA STEEL CO. et al,
Respondents.

(WCB 83-07023, 83-07022, 83-06855, 83-06854; CA A37341)

Judicial Review from Workers' Compensation Board.

Argued and submitted September 15, 1986.

Nelson R. Hall, Portland, argued the cause for petitioner. With him on the brief was Pozzi, Wilson, Atchison, O'Leary & Conboy, Portland.

Kenneth Kleinsmith, Portland, argued the cause for respondents Schnitzer Steel and Scott Wetzel Services. On the brief were Meyers & Terrall, and Daniel L. Meyers, Portland.

David O. Horne, Beaverton, argued the cause and filed the brief for respondent Wausau Insurance.

Darrell E. Bewley, Assistant Attorney General, Salem, argued the cause for respondent SAIF. With him on the brief were Dave Frohnmayer, Attorney General, and James E. Mountain, Jr., Solicitor General, Salem.

No appearance for respondents Alaska Steel Co. and Scrap Processors.

Before Joseph, Chief Judge, and Newman and Deits, Judges.

DEITS, J.

Affirmed.

DEITS, J.

Claimant seeks review of a Workers' Compensation Board order denying claimant's occupational disease claim. We affirm.

From 1960 until 1979, claimant worked in scrap yards operated by Alaska Steel Co. and Scrap Processors, where he was exposed to asbestos fibers. In 1980, physicians diagnosed a lung carcinoma, and his left lung was removed. In 1981, he filed a claim with SAIF and the two employers. The claim was denied. In July, 1982, a hearing was held, but the record was held open. In October, 1982, SAIF moved to join Employer's

Insurance of Wausau and El Dorado Insurance,[1] because those carriers were on the risk between 1969 and 1976. Claimant objected to the joinder, and by an order in December, 1982, the referee denied SAIF's motion.

In March, 1983, the referee issued an opinion and order holding claimant's condition compensable. However, the referee also held that claimant's work after 1975, when SAIF was the insurer, did not contribute to the condition. The referee concluded that the claim had to be filed within five years after the last exposure in an employment and that, because it was not filed with the insurers on the risk before 1975, claimant could not prevail. ORS 656.807(1).

Claimant moved for reconsideration, arguing that he had met the requirements for filing.[2] The referee issued an order holding his initial opinion and order in abeyance. SAIF then moved to reconsider and renewed its argument for joinder of the other insurers. The referee issued an order allowing joinder and holding that claimant had correctly filed

his claim with the then direct responsibility employer, who had the duty to notify its former insurers. ORS 656.403(1). The referee then vacated all of the proceedings on the claim to allow the other insurers to have an opportunity to participate and remanded the case to be reset.

Claimant sought Board review of the order allowing joinder and vacating the proceedings. The Board denied jurisdiction, because the orders were not final, and we dismissed claimant's petition for judicial review. There followed two hearings[3] before a second referee in which claimant took the position that the issue of compensability had already been determined, that the order of joinder was for resolution of the issue of responsibility only and that claimant had no involvement in the subsequent proceedings. The referee determined that the earlier orders were properly vacated, that compensability was presently at issue and that claimant had not proved a compensable occupational disease. The Board agreed.

Claimant argues that the referee at the first hearing lacked authority to vacate the portion of the order holding the claim compensable, because neither claimant nor SAIF's motion for reconsideration raised the issue of compensability. Claimant argues that the referee was limited to ruling on whether claimant had properly filed the original claim and then to entering a finding of responsibility against employer and SAIF under the last injurious exposure rule. Claimant

[1] El Dorado Insurance is defunct. The company was represented in the proceeding through Scott Wetzel Services, Inc. Scott Wetzel argued that, after the referee had ordered joinder, it had denied the compensability of the claim and claimant never appealed that denial. We agree with the referee that jurisdiction was established by the referee's order of joinder.

[2] At the time, ORS 656.807(1) provided:

"Except as otherwise limited for silicosis, all occupational disease claims shall be void unless a claim is filed with the State Accident Insurance Fund Corporation or direct responsibility employer within five years after the last exposure in employment subject to the Workers' Compensation Law and within 180 days from the date the claimant becomes disabled or is informed by a physician that he is suffering from an occupational disease whichever is later."

[3] The first of the hearings was discontinued when the question of a conflict of interest was raised regarding SAIF's representation of two employers with adverse interests.

argues that SAIF's motion must have related to statutory considerations or discovery of new evidence and, because SAIF made no statutory arguments and gave no explanations for any new evidence, it provided no grounds for vacation or reconsideration of the compensability issue.

The pertinent rule, OAR 436-83-480,[4] provides:

> "The referee may reopen the record and reconsider his decision before a notice of appeal is filed or, if none is filed, before the appeal period expires. Reconsideration may be upon the

> referee's own motion, or upon a motion by a party showing error, omission, misconstruction of an applicable statute or the discovery of new material evidence.
>
> "(2) A motion to reconsider shall be served on the opposite parties by the movant and, if based on newly discovered evidence, shall state:
>
> "(a) The nature of the new evidence; and
>
> "(b) An explanation of why the evidence could not reasonably have been discovered and produced at the hearing."

We do not agree with claimant's narrow interpretation of the rule. The rule is designed to be a flexible aid in the search for accurate facts and just conclusions. *Bailey v. SAIF*, 296 Or 41, 46, 672 P2d 333 (1983). Under the rule, the referee could reconsider the joinder issue on his own motion. His reconsideration of the joinder issue allowed him also to reconsider other aspects of the case affected by his determination that the additional insurers were necessary parties. The referee's determination that his order should be vacated in its entirety, because parties not joined at the time of the first hearing should have the chance to participate, was within his authority.

Claimant next argues that the Board erred in finding that his carcinoma is not an occupational disease. The referee at the third hearing concluded that claimant had been exposed to above-normal levels of asbestos in his employment. However, she concluded that the preponderance of the medical evidence established that claimant's exposure to asbestos was not the major contributing cause of the lung cancer. Rather, the more likely cause was claimant's smoking two to three packs of cigarettes a week for approximately 30 years.

Claimant argues that the evidence does not support the conclusion that the major contributing cause of the cancer was his smoking. He is particularly critical of the testimony of Dr. Hammar, a lung cancer specialist. Plaintiff argues that Hammar's conclusion is not persuasive, because his testimony concerning the location of the cancer was incorrect. He testified that the cancer was centrally located in the lung, an area usually associated with cancer caused by smoking, whereas medical reports contemporaneous with claimant's surgery show a tumor of the lower left lobe.

Although Hammar's testimony on the location of the cancer was incorrect, his conclusion that the cancer was caused by claimant's smoking was not based solely on that

[4] OAR 436-83-480 has been amended and renumbered OAR 438-07-025(1). The changes are not material to this review.

fact. He also based his conclusion on the facts that there were no fibrosis, plaques or thickening present in claimant's lungs. That conclusion is confirmed by other medical reports. In addition, four other physicians concluded that smoking was the most likely cause of the cancer. Only claimant's family physician and Dr. Lawyer, a pulmonary specialist, concluded that the major contributing cause of claimant's carcinoma was the working conditions. However, Lawyer's conclusion is subject to some question because his opinion was based on a report by Dr. Churg, an expert in asbestos-related lung diseases, who said that he was unable to conclude that asbestos caused the tumor.

Affirmed.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Adolph T. Huhnholz, Claimant.

WAUSAU INSURANCE COMPANY et al,
Petitioners,

v.

HUHNHOLZ,
Respondent.

(WCB 85-00963; CA A38134)

Judicial Review from Workers' Compensation Board.

Argued and submitted September 15, 1986.

David Horne, Beaverton, argued the cause and filed the brief for petitioner Wausau Insurance Company.

No appearance for petitioner Thomas Industries.

Barbara Woodford, Portland, argued the cause for respondent. With her on the brief was Haugh & Foote, P.C., Portland.

Before Joseph, Chief Judge, and Newman and Deits, Judges.

DEITS, J.

Reversed.

DEITS, J.

Employer and its insurer petition for review of an order of the Workers' Compensation Board holding that claimant had suffered a compensable injury. We reverse.

Claimant is 61 years old and has worked for employer almost continuously for 18 years as a painter. He prepared and painted firescreens and fireplace accessories, handling and lifting the parts before and after painting. In 1962, he was treated for low back problems. He again experienced back problems in the late 1970's. In the summer of 1984, a reduction in the workforce resulted in an increase in claimant's workload. He testified that on June 6, 1984, his back significantly

worsened after he had lifted large racks of Teflon all day. After that, the pain in his back worsened. He was off work in June and July with kidney stone problems, returned to work in the fall, but he left work finally in October.

Claimant's treating physician, Dr. Rideout, diagnosed degenerative disc disease, osteoarthritis and chronic low back strain. He testified that claimant's work activities caused the symptoms to increase, but that it could not be determined objectively whether the degenerative process had been accelerated by the work activities.

Dr. Rosenbaum, a specialist in rheumatology, examined claimant at the request of insurer. He testified that osteoarthritis is an ongoing process, which may be made symptomatic by repetitive lifting but which will not be worsened by such activity. He stated that osteoarthritis could be worsened by a direct injury. Rosenbaum was not aware of the change in claimant's workload in 1984 but stated that, if claimant had had to do a lot of lifting and moving, he would have more pain symptoms without a change in the underlying condition. The medical evidence shows that claimant's pain is caused by the osteoarthritis.

The Board concluded that, although there had been an increase in symptoms, claimant had not established a compensable occupational disease, because there was no persuasive evidence that the pre-existing condition was worsened by his employment. *See Weller v. Union Carbide*, 288 Or 27, 602 P2d 259 (1979). However, the Board, relying on *Valtinson v. SAIF*, 56 Or App 184, 641 P2d 598 (1982), held that

claimant had shown a connection between the specific June 6 work and the onset of his disability and, thus, had shown a compensable injury.

In *Valtinson*, the claimant had been free of back pain before he drove a jail van from Grants Pass to Portland and back. He began to suffer low back pain on the return trip. We held that the claimant had suffered a compensable injury. Although the onset of his pinched nerves was not "instantaneous," it had occurred in a matter of hours. Here, unlike in *Valtinson*, there was no sudden onset of pain over a discrete period. Although claimant testified that after lifting the racks of Teflon his back hurt "real bad," he also testified, and the medical evidence showed, that his back had hurt periodically before the June incident. He did not seek medical treatment for low back pain until September, 1984, and even then continued to work, except for time off for his kidney stone problems.

We agree with insurer that, at most, claimant's work made his pre-existing condition symptomatic. Both physicians agreed that activity could cause a worsening of the symptoms but that they could not conclude that the osteoarthritis itself was affected by the work activities. Claimant did not show that the June 6 work, rather than the pre-existing osteoarthritis, resulted in the need for medical attention. The evidence does not support the conclusion that claimant suffered a compensable injury or an occupational disease. *See Cooper v. SAIF*, 54 Or App 659, 635 P2d 1067 (1981), *rev den* 292 Or 356 (1982).

Reversed.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Timothy W. Evans, Claimant.

EVANS,
Petitioner - Cross-Respondent,

v.

ROOKARD, INC. et al,
Respondents - Cross-Petitioners,
MITCHELL & SONS LOGGING et al,
Respondents - Cross-Respondents.

(WCB 85-01835 and 85-01838; CA A38729)

Judicial Review from Workers' Compensation Board.

Argued and submitted February 17, 1987.

James L. Edmunson, Eugene, argued the cause for petitioner. With him on the brief was Malagon & Moore, Eugene.

Jerald P. Keene, Portland, argued the cause for respondents - cross-petitioners EBI Companies and Rookard, Inc. With him on the brief was Roberts, Reinisch & Klor, P.C., Portland.

John Snarskis, Portland, argued the cause and filed the brief for respondents - cross-respondents Mitchell & Sons Logging and Industrial Indemnity.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

PER CURIAM

On petition, order amended to allow $700 in attorney fees at Board level; affirmed on cross-petition.

PER CURIAM

In this workers' compensation case, claimant seeks review of a Board decision which refused to honor the parties' stipulation that, in the event that EBI was held to be responsible for the claim, it would pay claimant attorney fees of $700 for his attorney's participation at the hearing. EBI cross-petitions, challenging the Board's holding that it, and not Industrial Indemnity, is responsible for the claim.

We affirm on the cross-petition. The medical evidence persuades us that claimant's knee condition is the responsibility of EBI as an aggravation of an earlier compensable injury and is not a new injury which would justify a shifting of responsibility to the subsequent employer.

EBI made the fees stipulation pending review by the Board on the question of responsibility, and stands by that stipulation. The Board reasoned that it was not bound because, as a matter of law, claimant would not be entitled to insurer-paid attorney fees in a case where the only issue is responsibility and claimant did not participate meaningfully

in the hearing. Whether or not claimant would have been entitled to an award for his participation in the hearing under the pertinent law, EBI agreed that he did participate meaningfully and was entitled to attorney fees if he prevailed against it. It was not for the Board to question the parties' agreement.

On petition, the Board order is amended to allow $700 in attorney fees at the Board level; affirmed on cross-petition.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Patricia A. Rees, Claimant.

WEYERHAEUSER COMPANY,
Petitioner,

v.

REES,
Respondent.

(WCB 84-09458; CA A38993)

Judicial Review from Workers' Compensation Board.

Argued and submitted November 14, 1986.

Ridgway K. Foley, Portland, argued the cause for petitioner. With him on the brief were Mildred J. Carmack and Schwabe, Williamson, Wyatt, Moore & Roberts, Portland.

David C. Force, Eugene, argued the cause and filed the brief for respondent.

Before Warden, Presiding Judge, and Van Hoomissen and Young, Judges.

YOUNG, J.

Affirmed.

YOUNG, J.

Employer seeks review of a Workers' Compensation Board order awarding claimant permanent total disability benefits. At issue is the extent of her disability. We affirm.

In August, 1982, claimant sustained a compensable back strain while shoveling sawdust. Dr. Schachner immediately treated her, characterized the injury as an aggravation of her underlying degenerative disc disease and recommended that she not return to work at that time. Before the injury, Schachner had been treating claimant for degenerative disc disease, degenerative arthritis in her hips, a diseased rotator cuff in her right shoulder and degenerative arthritis in her right knee. She was also recovering from a compensable bilateral carpal tunnel release procedure.

In September, 1982, Schachner reported that claimant could not perform work requiring continued sitting or

standing, bending, lifting, twisting, kneeling, crawling, climbing or button pushing. Dr. Lorenz concurred in Schachner's conclusions. Despite her efforts at rehabilitation, claimant has not worked since the injury.

The referee found that claimant's disability was caused by progressive preexisting disease and that the compensable injury made only a small permanent contribution to that disability. The referee awarded 20 percent unscheduled back disability. The Board reversed, finding that the compensable injury was a material contributing factor to claimant's permanent total disability.

ORS 656.206(1)(a), in part, provides:

> "'Permanent total disability' means the loss, including preexisting disability, of use or function of any scheduled or unscheduled portion of the body which permanently incapacitates the worker from regularly performing work at a gainful and suitable occupation."

Employer concedes that claimant is permanently and totally disabled. It contends, however, that the compensable injury only temporarily aggravated claimant's pre-existing disc disease and that none of her disability is due to the 1982 injury. All of her disability, it argues, is attibutable to the natural course of the pre-existing degenerative disc disease and to other noncompensable conditions arising after the injury.

Employer also argues that, because Schachner could not attribute a distinct increment of claimant's disability to the compensable injury, none of the disability is compensable. We disagree with all of those contentions.

In determining whether claimant is permanently and totally disabled, we consider all of her medical impairment, including pre-existing noncompensable disability. *Lohr v. SAIF*, 48 Or App 979, 983, 618 P2d 468 (1980); ORS 656.206(1)(a). The extent of diability is determined from the conditions existing at the time of the hearing. *Gettman v. SAIF*, 289 Or 609, 614, 616 P2d 473 (1980).

We turn to whether claimant's disability is causally related to the 1982 injury. The determining factor is whether the injury is a material contributing cause of claimant's disability. *Destael v. Nicolai Co.*, 80 Or App 596, 600, 723 P2d 348 (1986). We find that claimant's disability is attributable to *both* her pre-existing disabling disease and her compensable injury. In February, 1985, Schachner reported:

> "In respect to whether the manual labor performed by [claimant] materially accelerated the progression of her underlying degenerative disease, I cannot categorically state that as a fact as findings to date reveal that her deterioration is of a virulent nature and that the deterioration is taking place at a rate too rapid to relate to manual labor or natural progression.
>
> "Lastly I do feel that there is restriction referrable to this individual's back in regard to stiffness and limited range of motion related to the degenerative disk disease that preexisted the August 10, 1982, injury. However, it is not possible for me to separate how much restriction existed prior to August 10, 1982, as a component of further limitation is related to her hip disease which would of itself restrict low back motion."

That report indicates that the compensable injury was a material contibuting cause of claimant's disability. Schachner attributed the extent of her disability to *more* than that which would be caused by the natural progression of her pre-existing disease alone.

The inability of Schachner to assign separate increments of disability to pre-existing disability, to the compensable injury and to post-injury worsening of the pre-existing

conditions is not fatal to compensability. In the context of permanent total disability, we consider the extent of claimant's total impairment, including that caused by all disabling conditions, regardless of compensability, that pre-existed the injury and the impairment resulting from the injury itself. In *Arndt v. National Appliance Company*, 74 Or App 20, 701 P2d 474 (1985), we noted that the synergistic effect of an injury's contribution to a worker's pre-existing impairment "makes it pointless to speak in terms of 'incremental impairment.' " 74 Or App at 26. Cause and effect between discrete contributing causes and discrete portions of disability cannot always be traced. Whether some portion of claimant's disability is caused by post-injury natural worsening of her pre-existing condition is immaterial, because we find that the compensable injury materially contributed to claimant's present medical impairment.[1]

Affirmed.

[1] Employer correctly argues that noncompensable conditions arising after the injury cannot be considered in determining the extent of disability. *Emmons v. SAIF*, 34 Or App 603, 605, 579 P2d 305 (1978). However, on *de novo* review, we do not find that any new conditions affect claimant's disability.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Howard E. Hughes, Claimant.

GEORGIA-PACIFIC CORPORATION,
Petitioner - Cross-Respondent,

v.

HUGHES,
Respondent - Cross-Petitioner.

(WCB No. 84-12107; CA A39769)

Judicial Review from Workers' Compensation Board.

Argued and submitted February 11, 1987.

George Goodman, McMinnville, argued the cause for petitioner - cross-respondent. On the briefs were Jerry K. Brown, and Cummins, Cummins, Brown & Goodman, P.C., McMinnville.

Ronald L. Bohy, Salem, argued the cause and filed the brief for respondent - cross-petitioner.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

ROSSMAN, J.

Affirmed on petition; reversed on cross-petition; referee's penalty order reinstated.

ROSSMAN, J.

The first question raised in this workers' compensation case is whether the payment of interim compensation is stayed pending an employer's or insurer's appeal to the Board or petition for judicial review by the Court of Appeals.

The general rule is that payment of compensation is not stayed pending appeal. ORS 656.313(1) provides:

> "Filing by an employer or the insurer of a request for review or court appeal shall not stay payment of compensation to a claimant."

ORS 656.313(4) defines "compensation" as used in that section as

> "benefits payable pursuant to the provisions of ORS 656.204 to 656.208, 656.210 and 656.214 and does not include the payment of medical services."

Employer asserts that interim compensation should be stayed pending appeal or review, because it is not a benefit payable pursuant to any of the sections referred to in ORS 656.313(4). Specifically, employer contends that the significant cases require the conclusion that, although interim compensation is calculated similarly to temporary total disability benefits, which are payable pursuant to ORS 656.210, it is different from temporary total disability in that it is payable pursuant to ORS 656.262.[1]

Employer relies principally on selected language from *Jones v. Emanuel Hospital*, 280 Or 147, 470 P2d 70 (1977), and *Bono v. SAIF*, 298 Or 405, 410, 692 P2d 606 (1984). The Supreme Court coined the term "interim compensation" in *Jones* to describe the benefits that are payable to a claimant

no later than 14 days after a claim is filed but before acceptance or denial of the claim:

> "Subsection (2) [of ORS 656.262], construed together with subsections (4) and (5), requires the employer to pay what may for convenience be called interim compensation payments until the employer denies the claim." 280 Or at 151.

Employer also quotes language from *Bono v. SAIF*, *supra*, 298 Or at 407: " '[I]nterim compensation' under ORS

[1] ORS 656.262 provides, in part:

"(2) The compensation due under this chapter shall be paid periodically, promptly and directly to the person entitled thereto upon the employer's receiving notice or knowledge of a claim, except where the right to compensation is denied by the insurer or self-insured employer.

"* * * * *

"(4) The first instalment of compensation shall be paid no later than the 14th day after the subject employer has notice or knowledge of the claim. Thereafter, compensation shall be paid at least once each two weeks, except where the director determines that payment in instalments should be made at some other interval. The director may by rule convert monthly benefit schedules to weekly or other periodic schedules."

656.262(4) is at issue." (Footnote omitted.) Language later in the opinion is also cited:

> "In *Jones v. Emanuel Hospital, supra,* we interpreted ORS 656.262(2) to include interim compensation within the scope of 'compensation due' to an injured worker. We held that under ORS 656.262(4), interim compensation must be paid * * *.
>
> *Jones* equated interim compensation with total disability benefits. *The opinion stated that Ms. Jones had 'requested interim compensation payments (called temporary total disability)* * * *.'* We did not express that interim compensation payments were to be made pursuant to the benefits calculation of ORS 656.210, but this follows from the quoted statement. There is no independent interim compensation benefits calculation in ORS 656.262(4). The amount of interim compensation payments is determined in the same manner as the amount of temporary total disability benefits.
>
> "Interim compensation and temporary total disability are also linked in another way.* * *" 298 Or at 408-09. (Emphasized portion not quoted by employer; footnote omitted.)

Employer draws the conclusion from the quoted language that the Supreme Court does not consider interim compensation to be precisely the same thing as temporary total disability.

The Supreme Court's language could support employer's interpretation, but we do not agree with employer. Our reading of ORS 656.262 leads us to conclude that it governs only the *procedure* for payment of compensation due under chapter 656. ORS 656.262(4) provides that "the first instalment of compensation [due under chapter 656] shall be paid no later than the 14th day after * * * notice or knowledge of the claim." "Compensation" under chapter 656 consists of all the benefits provided to a worker for a compensable condition, including temporary total disability. ORS 656.005(9). Compensation, including benefits for temporary

total disability, is *due* if the claim has not been denied. ORS 656.262(2). We understand the language quoted from *Jones v. Emanuel Hospital, supra,* merely to *describe* as "interim compensation" the temporary total disability benefits which are payable before the denial of a claim. That understanding is consistent with the cases that have considered on the issue. Even in *Jones v. Emanuel Hospital, supra,* 280 Or at 149, the court stated: "[Claimant] requested interim compensation payments (called temporary total disability)." In *Likens v. SAIF,* 56 Or App 498, 501, 642 P2d 342 (1982), we stated that we understood *Jones* "to require payment of temporary total disability compensation no later than the 14th day after the employer has notice of the claim." No case suggests that ORS 656.262 provides for a distinct set of benefits. It merely establishes when compensation due under the other sections becomes payable. We conclude that the judicially created term "interim compensation" describes temporary total disability benefits due not later than 14 days after notice of an injury and before acceptance or denial of the claim. It is payable pursuant to both ORS 656.210 and ORS 656.262. We hold that payment is not stayed pending appeal or judicial review.

Employer asserts that, in any event, the claim was void *ab initio,* because it was not asserted in a timely manner.

We do not reach that contention, because employer does not explain here why the claim was untimely.

On cross-petition, claimant asserts that the Board erred in reducing a penalty awarded for employer's failure to pay the previously awarded interim compensation. The referee initially awarded claimant interim compensation for all the time between 14 days after employer received notice of the claim and the date of the denial. That award was made, in view of our decision in *Bono v. SAIF,* 66 Or App 138, 673 P2d 558 (1983), *reversed* 298 Or 405, 692 P2d 606 (1984), without consideration of whether claimant had lost time from work. Pending review by the Board, employer refused to pay interim compensation. At claimant's request, a second referee, enforcing the first referee's decision, assessed a penalty on the full amount of interim compensation that had been withheld. The Board reduced the penalty to reflect the reduced amount of interim compensation that was due on application of the Supreme Court's decision in *Bono v. SAIF, supra,* which had come down after the second referee's decision.

ORS 656.262(10) authorizes a penalty for an unreasonable delay or refusal to pay compensation on amounts "then due." At the time when the second referee assessed a penalty, the amount "then due" was the full amount of interim compensation. The fact that that amount was later reduced by the Board due to a change in the law does not alter the fact that, when the compensation was due, employer refused to pay it. Therefore, the second referee properly assessed a penalty on the full amount of interim compensation which had been awarded by the first referee.

Affirmed on petition; reversed on cross-petition; referee's penalty order reinstated.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Stanley C. Phipps, Claimant.
STATE ACCIDENT INSURANCE
FUND CORPORATION et al,
Petitioners - Cross-Respondents,
v.
PHIPPS,
Respondent - Cross-Petitioner,
INDUSTRIAL INDEMNITY et al,
Respondents - Cross-Respondents.
(WCB Nos. 84-01838 and 84-02301; CA A38833)

Judicial Review from Workers' Compensation Board.

Argued and submitted January 26, 1987.

Darrell E. Bewley, Assistant Attorney General, Salem, argued the cause for petitioners - cross-respondents. With him on the brief were Dave Frohnmayer, Attorney General, and James E. Mountain, Jr., Solicitor General.

James S. Coon, Portland, argued the cause for respondent - cross-petitioner. With him on the brief was Aitchison, Imperati, Barnett & Sherwood, P.C., Portland.

John E. Snarskis, Portland, argued the cause and filed the brief for respondents - cross-respondents.

Before Joseph, Chief Judge, and Newman and Deits, Judges.

JOSEPH, C. J.

Affirmed on petition for review; reversed on cross-petition and remanded for determination of attorney fees payable by SAIF.

JOSEPH, C. J.

SAIF seeks review of a Workers' Compensation Board order which reversed the referee's determination that claimant had suffered a new injury and assigned SAIF responsibility for claimant's back condition. SAIF argues that, even though there is "no question [but] that there has been an aggravation in the medical sense," claimant did not suffer an aggravation in the "legal sense." SAIF contends that the Board misunderstood and misapplied the rules governing successive injuries. We disagree and affirm.

Claimant first compensably injured his back in 1979 while employed as an electrician by American Ship Dismantlers, SAIF's insured. After the 1980 award of compensation, low back pain continued; there were periods of hospitalization as well as periods of relief. Claimant was working as a maintenance man for Amber Foods Corporation in September, 1983, when he picked up a machine part weighing 75-100 pounds and felt "something pop" in his back. He con-

tinued to work for about a week, but the pain then became too debilitating. As SAIF concedes, the four doctors who testified all concluded that claimant has suffered an aggravation by reason of disabling symptoms of his underlying compensable condition. None of the doctors suggested that the September, 1983, incident contributed independently to claimant's low back disability. Without that contribution, the first employer remains liable. *Hensel Phelps Const. v. Mirich*, 81 Or App 290, 724 P2d 919 (1986).[1]

Claimant also seeks review of the Board's order, because it determined that he was only a nominal party at the hearing and on Board review and that he is therefore not entitled to attorney fees. The Board relied on *Petshow v. Farm Bureau Ins. Co.*, 76 Or App 563, 710 P2d 781 (1985), *rev den* 300 Or 722 (1986), which involved a proceeding to determine which insurer was responsible for a compensable injury. We

concluded that "unless the claimant takes a position concerning which of the insurers is responsible and actively litigates that point," an award of attorney fees is inappropriate. 76 Or App at 569.

This case also arose from a proceeding to determine responsibility between two insurers, but claimant took the position at the hearing and on Board review that he had suffered an aggravation, not a new injury. Claimant's stake in the outcome of that determination amounts to $120 more per week for time loss over a long period of time. Claimant's attorney participated in the proceeding and also filed a brief before the Board. We conclude that claimant is entitled to attorney fees. ORS 656.386.

Affirmed on petition for review; reversed on cross-petition and remanded for determination of attorney fees payable by SAIF.

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[1] In *Hensel Phelps Const.* we said: "If worsened symptoms alone were enough to place responsibility on the second employer, then the first employer would never be responsible.* * * There must be a worsening of the underlying condition." 81 Or App at 294. The last sentence is correct in its context but is misleading as a general rule. A disabling worsening of the underlying condition *or* a disabling worsening of the symptoms of that condition is an *aggravation*. *See Consolidated Freightways v. Foushee*, 78 Or App 509, 717 P2d 633, *rev den* 301 Or 338 (1986). The issue of independent contribution relates to whether there is a *new injury*.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Daryl G. Richmond, Claimant.

RICHMOND,
Petitioner,

v.

SAIF CORPORATION et al,
Respondents.

(WCB 83-08780; CA A39405)

Judicial Review from Workers' Compensation Board.

Argued and submitted January 5, 1987.

Philip H. Garrow, Bend, argued the cause and filed the brief for petitioner.

Darrell E. Bewley, Assistant Attorney General, Salem, argued the cause for respondents. With him on the brief were Dave Frohnmayer, Attorney General, and James E. Mountain, Jr., Solicitor General, Salem.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

RICHARDSON, P. J.

Affirmed.

RICHARDSON, P. J.

Claimant seeks review of a Workers' Compensation Board order which upheld a disputed claim settlement between claimant and SAIF. We affirm.

Claimant suffered a compensable back injury in 1980, and in October, 1981, the claim was closed by a determination order which awarded permanent partial disability. In December, 1981, the parties stipulated to reopen the claim for payment of medical benefits and temporary total disability. SAIF also began paying claimant's medical bills for psychiatric treatment but did not accept or deny responsibility for the psychological or psychiatric condition. The claim was closed again by a determination order in February, 1983; claimant was awarded temporary total disability but no additional permanent partial disability. On April 26, 1983, claimant signed a stipulation and order by which he agreed to settle the claim for his psychological or psychiatric condition for $15,000. It provided, in part:

> "7) The parties are desirous of settling their differences without incurring the cost of litigation and it is therefore stipulated and agreed, subject to the approval of the Workers' Compensation Board, pursuant to the provisions of ORS 656.289(4), that this matter may be fully and finally settled by the payment by the SAIF Corporation and the acceptance by the Claimant of $15,000.00 in full and final settlement of any and all claims for any psychiatric or psychological disabilities.
>
> "8) Claimant understands that this is a settlement of a

doubtful and disputed claim and that there is no acceptance of the denied conditions either expressed or implied and that the same shall remain in their denied status forever. Claimant further understands that in the event of a subsequent closure of his claim after completion of an approved program of vocational rehabilitation he may only contest the permanent partial disability given him if he can demonstrate a change in his physical condition since this arrangement for compensation."

In a separate section of the agreement, SAIF specifically denied responsibility for claimant's psychological or psychiatric condition. The settlement was approved by the Hearings Division on May 23, 1983.

A hearing was held on December 5, 1984, on claimant's appeal from the 1983 determination order. The hearing

also addressed the validity of the disputed claim settlement. The referee set aside the settlement and ordered claimant to repay the $15,000 that SAIF had paid under the agreement. The Board affirmed on appeal. However, on reconsideration, the Board withdrew its previous order and reversed that portion of the referee's order that set aside the settlement.

On judicial review, claimant first contends that the Board erred in reinstating the settlement, because SAIF had already accepted petitioner's psychological condition when it stipulated to a reopening of the claim. In December, 1981, when the claim was reopened, the stipulation was that SAIF would reopen the "claim for temporary total disability and medical service benefits effective November 9, 1981, and continuing until closed." Claimant asserts that, because SAIF agreed to reopen the claim and paid for claimant's psychological care from December, 1981, through May 23, 1983, it has accepted the psychological condition. Claimant is incorrect. ORS 656.262(9) provides in part:

"Merely paying or providing compensation shall not be considered acceptance of a claim or an admission of liability * * *."

Additionally, it has been established that payments made by an insurer in compliance with ORS 656.262(4)[1] are not to be interpreted as acceptance of a claim. *Bauman v. SAIF*, 295 Or 788, 670 P2d 1027 (1983); *Frasure v. Agripac*, 290 Or 99, 619 P2d 274 (1980); *Gregg v. SAIF*, 81 Or App 395, 725 P2d 930 (1986).

Claimant also argues that ORS 656.262(6)[2] required SAIF to deny the psychological claim within 60 days and that,

[1] ORS 656.262(4) provides in part:

"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. * * *"

[2] ORS 656.262(6) provides in part:

"Written notice of acceptance or denial of the claim shall be furnished to the claimant by the insurer or self-insured employer within 60 days after the employer has notice or knowledge of the claim. Pending acceptance or denial of a claim, compensation payable to a claimant does not include the costs of medical benefits or burial expenses. The insurer shall also furnish the employer a copy of the notice of acceptance. * * *"

because it did not, the claim should be deemed accepted. Contrary to claimant's assertion, the failure to deny a claim within the time limitation does not preclude a subsequent denial. We stated in *Townsend v. Argonaut Ins. Co.*, 60 Or App 32, 36, 652 P2d 828 (1982), that "the penalty for a late denial is not a waiver of the right to deny; the penalty is specified in [ORS 656.262(10)]."[3]

Claimant next asserts that the settlement should have been set aside because there was no bona fide dispute. ORS 656.289(4)[4] allows the resolution of a claim by a disputed claim settlement when there is a bona fide dispute as to compensability. *Roberts v. Willamette Industries*, 82 Or App 188, 728 P2d 60, *rev den* 302 Or 461 (1986). Claimant contends that there was no dispute over the compensability of his psychological condition, because all the medical evidence indicates that his psychological condition either arose out of or was aggravated by his back injury. SAIF did not accept claimant's psychological condition as compensable; it follows that there was a dispute between SAIF and claimant about the compensability of that condition. It was SAIF's position either that the psychological condition preexisted the injury and was not aggravated by it or that it arose independently of the injury.

The medical evidence reveals disagreement as to the cause of the psychological condition. One doctor stated that

claimant's depression was a result of his inability to find a successful rehabilitation program and job; another concluded that depression was a deeply ingrained part of his personality and that it was difficult to determine how much of his discontent was caused from his preexisting personality and how much was due to his work situation. There is also evidence that claimant's problem was caused by anger at his employer, concern about his wife's health problems and by financial problems that pre-dated the injury. Finally, there is evidence that the depression and anxiety were a result of the injury. We conclude that there was a bona fide dispute and that it was the proper subject of a settlement.

Affirmed.

[3] ORS 656.262(10) provides:

"If the insurer or self-insured employer unreasonably delays or unreasonably refuses to pay compensation, or unreasonably delays acceptance or denial of a claim, the insurer or self-insured employer shall be liable for an additional amount up to 25 percent of the amounts then due plus any attorney fees which may be assessed under ORS 656.382."

[4] ORS 656.289(4) provides:

"Notwithstanding ORS 656.236, in any case where there is a bona fide dispute over compensability of a claim, the parties may, with the approval of a referee, the board or the court by agreement make such disposition of the claim as is considered reasonable. If disposition of a claim referred to in ORS 656.313(3) is made pursuant to this subsection and the insurer or self-insured employer and the affected medical service and health insurance providers are unable to agree on the issues of liability or the amount of reimbursement to the medical service and health insurance providers, and the amount in dispute is $2,000 or more, those matters shall be settled among the parties by arbitration in proceedings conducted independent of the provisions of this chapter. If the amount in dispute is less than $2,000, the insurer or self-insured employer shall pay to the medical service and health insurance provider one-half the disputed amount. As used in this subsection 'health insurance' has the meaning for that term provided in ORS 731.162."

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Steve Krajacic, Claimant.

KRAJACIC,
Petitioner,

v.

BLAZING ORCHARDS et al,
Respondents.

(WCB 84-02476; CA A37693)

Judicial Review from Workers' Compensation Board.

On petitioner's petition for reconsideration filed April 2, 1987. Former opinion filed February 25, 1987.

James L. Edmunson, Karen M. Werner, and Malagon & Moore, Eugene, for petition.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

DEITS, J.

Reconsideration allowed; former opinion modified and adhered to as modified.

DEITS, J.

Claimant has filed a petition for review, which we treat as a petition for reconsideration. ORAP 10.10. In our opinion, *Krajacic v. Blazing Orchards*, 84 Or App 127, 733 P2d 113 (1987), we said:

> "[The doctor's] statement that claimant's injury is permanent only indicates a waxing and waning of symptoms of the chronic condition for which he had received an award."

We grant reconsideration only to correct a factual error. Petitioner correctly points out that he had not received an award on his claim. As noted in our opinion, 84 Or App at 131, the claim was classified as nondisabling. We still hold that claimant did not perfect his aggravation claim within the statutory period.

Reconsideration allowed; former opinion modified and adhered to as modified.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Charles W. Roller, Claimant.

WEYERHAEUSER COMPANY,
Petitioner - Cross-Respondent,

v.

ROLLER,
Respondent - Cross-Petitioner.

(WCB 82-08886, 83-07686; CA A38972)

Judicial Review from Workers' Compensation Board.

Argued and submitted January 30, 1987.

Allan M. Muir, Portland, argued the cause for petitioner - cross-respondent. On the brief were Cynthia S.C. Shanahan, Lawrence L. Paulson and Schwabe, Williamson, Wyatt, Moore & Roberts, Portland.

Michael M. Bruce, Eugene, argued the cause and filed the brief for respondent - cross-petitioner.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

BUTTLER, P. J.

Affirmed on petition and on cross-petition.

BUTTLER, P. J.

Employer seeks review of an order of the Workers' Compensation Board holding that the referee did not have jurisdiction to review a determination of the Evaluation Division on the extent of claimant's disability. Claimant cross-petitions, contending that the Board erred in not allowing him attorney fees. We affirm.

Claimant was injured in a mill accident in January, 1980. Employer accepted the claim. Shortly thereafter, claimant was found to be suffering from diabetes melitis, which was ultimately found to be related to the injury and was held compensable. However, in January, 1982, employer denied further responsibility for the diabetes, contending that that condition was no longer related to the compensable injury. A referee set aside the denial, and employer appealed to the Board. While that appeal was pending, the Workers' Compensation Department issued a determination order on August 17, 1982, awarding 20 percent unscheduled permanent partial disability. Claimant requested a hearing on that determination. On September 28, 1982, the same date on which the Board received claimant's hearing request, it issued an order on employer's appeal disallowing the claim. On claimant's petition for review, we reversed the Board on April 11, 1984, and remanded the case for reinstatement of the referee's order. *Roller v. Weyerhaeuser Co.*, 67 Or App 583, 679 P2d 341 (1984). Claimant's request for hearing on the determination order of August 17, 1982, was still pending at that time.

On remand, the Board reinstated the referee's order holding the claim compensable. Employer then wrote a letter to the referee, which it intended to be a cross-appeal from the determination order, in which it asserted that claimant was not entitled to an award of any permanent partial disability. At the beginning of the hearing on the determination order, claimant withdrew his request for a hearing. Over claimant's objection, the referee held that he could consider employer's evidence regarding extent, and determined that claimant was not entitled to any permanent partial disability. The Board reversed the referee on the ground that the referee did not have jurisdiction to consider employer's request for a reduction of the disability award, because employer had not filed a

request for hearing within one year of the determination order, as required by ORS 656.268.

The Board relied in part on *SAIF v. Maddox*, 295 Or 448, 667 P2d 529 (1983). There, the Supreme Court held that a referee has jurisdiction to enter an order rating the extent of disability if the claimant's condition had once been determined to be compensable, even if the issue of compensability is still the subject of a pending appeal. The Supreme Court relied on ORS 656.313 to support its conclusion that an employer may be required to litigate the question of the extent of disability while the issue of compensability is pending. ORS 656.313(1) provides:

> "Filing by an employer or the State Accident Insurance Fund Corporation of a request for review or court appeal shall not stay payment of compensation to a claimant."

Recognizing that "compensation" as used in ORS 656.313(1) and as defined in ORS 656.313(4) includes certain benefits which are awarded only after a determination of the extent of disability, the court concluded that, because the payment of compensation is not stayed pending an appeal by an employer, the litigation of the extent of disability necessarily is not stayed pending the litigation of compensability.

Employer contends that *SAIF v. Maddox, supra*, is limited by its facts and by ORS 656.313 to the case where an *employer* appeals an order upholding the compensability of a claim and should not apply when, as here, the *claimant* has sought review of a Board order disallowing the claim. The court did not so limit its holding, and we are persuaded that that would not be a correct result. Only an employer or insurer would appeal a referee's determination that a claim is compensable and, under *Maddox*, a determination of the extent of disability is not stayed pending that appeal. If the employer then prevailed before the Board on the question of compensability, employer's interpretation would require that the determination of extent be stayed pending the claimant's petition for review by the Court of Appeals. If the claimant prevailed here, the rationale of *Maddox* is that the question of extent may be litigated pending the employer's petition for review to the Supreme Court. Thus, employer's suggested interpretation of *Maddox* would create more chaos in what is already a complicated procedure, leaving uncertain at every

juncture the continuing significance of the existing determination order.

We conclude that the more stable approach, and the one that the rationale of *Maddox* appears to require, is that, once there has been a determination of the extent of disability, that issue may be litigated finally and independently of the continuing litigation on compensability. The requirement of ORS 656.268 that a party seek a hearing within one year of the issuance of a determination order is not tolled pending the claimant's appeal from a Board order finding the claim to be noncompensable, because the determination of extent of disability is not stayed at any point in the litigation of compensability. *See Wright v. SAIF*, 76 Or App 479, 709 P2d 755 (1985), *rev den* 300 Or 605 (1986). We recognize the apparent anomaly of requiring an employer to request a hearing on a determination order after the Board has decided that the claim is not compensable. However, if the employer wishes to challenge the determination order, it has, by statute, only one year within which to do so. The Board correctly reversed the referee.[1]

Claimant contends in his cross-petition that he is entitled to insurer-paid attorney fees under ORS 656.382(2)[2] for prevailing before the Board on employer's challenge of the determination order.

ORS 656.382 authorizes an award of insurer-paid attorney fees if the claimant prevails on an appeal initiated by the insurer or the employer. Here, *claimant* initiated the appeal to the Board. He is not entitled to attorney fees under ORS 656.382, or under any other section.[3]

Affirmed on petition and on cross-petition.

---

[1] We do not decide whether the Board's adjudication of noncompensability stayed employer's obligation *to pay benefits* as ordered by the Department in the determination order.

[2] ORS 656.382(2) provides:

"If a request for hearing, request for review, appeal or cross-appeal to the Court of Appeals or petition for review to the Supreme Court is initiated by an employer or insurer, and the referee, board or court finds that the compensation awarded to a claimant should not be disallowed or reduced, the employer or insurer shall be required to pay to the claimant or the attorney of the claimant a reasonable attorney fee in an amount set by the referee, board or the court for legal representation by an attorney for the claimant at and prior to the hearing, review on appeal or cross-appeal."

[3] Before the Board, claimant asserted that he was entitled to attorney fees under ORS 656.386(1). The Board correctly held that ORS 656.386(1) does not authorize an award of insurer-paid attorney fees when a claimant prevails only on extent of disability.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Dawn White, Claimant.

NORTH CLACKAMAS SCHOOL DIST.,
Petitioner - Cross-Respondent,

v.

WHITE,
Respondent - Cross-Petitioner.

(WCB 83-09151; CA A36411)

Judicial Review from Workers' Compensation Board.

Argued and submitted June 18, 1986.

Jerald P. Keene, Portland, argued the cause for petitioner - cross-respondent. With him on the briefs was Roberts, Reinisch & Klor, P.C., Portland.

Donald E. Beer, Portland, argued the cause for respondent - cross-petitioner. With him on the brief was Galton, Popick & Scott, Portland.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

RICHARDSON, P. J.

Reversed on petition, affirmed on cross-petition.

RICHARDSON, P. J.

Employer seeks review of a Workers' Compensation Board order allowing further medical treatment to claimant for a hip injury. The Board affirmed an October 5, 1984, referee's order providing continued treatment despite employer's assertion that further treatment was barred by *res judicata*. We reverse.

Claimant suffered an industrial injury when she strained her hips on October 26, 1981, while working as a custodian, when she "misstepped" while descending some stairs. She consulted several doctors, who offered various diagnoses. Her claim was closed with an award of time loss only on April 9, 1982. She challenged that award, claiming premature closure or, alternatively, permanent partial disability benefits. On June 15, 1982, a referee affirmed the closure and rejected her claim for permanent partial disability. In relevant part, the referee stated:

> "The relationship of claimant's current disability to her industrial injury is a medical question, and claimant has not sustained her burden of showing a medical connection between her present condition and her industrial injury. I therefore find that her claim was properly closed and she is not entitled to have her claim reopened.
>
> "In the alternative, claimant asks for permanent partial disability award. I find that where none of the medical specialists who have examined claimant have found claimant has

> a permanent impairment as a result of her October 26, 1981 industrial injury and where all of the specialists have found claimant could return to her former job, she has not sustained her burden of proving that she has lost any earning capacity as a result of her industrial injury."

The Board affirmed and adopted the referee's opinion and order.

For four months after the Board's order, claimant continued to receive medical treatment for her hip condition. She also sought treatment for lower back pain. On July 25, 1983, employer's insurer issued a partial denial, disclaiming responsibility for further medical treatment. Claimant challenged that determination before a second referee, asserting aggravation of the original injury. The referee upheld the denial of the aggravation claim and disallowed further medical treatment for her back. However, the referee ruled that

expenses for medical treatment of claimant's hip condition should be continued. The Board affirmed.

Employer argues that its liability for any further medical treatment is barred by the first referee's determination that claimant failed to demonstrate a medical link between her hip condition and the original industrial injury. Alternatively, employer asserts that there is insufficient evidence of a causal relationship between claimant's current hip condition and the original accident. Claimant cross-petitions for review, seeking medical benefits for her back condition. We need to address only the *res judicata* issues.

ORS 656.245(1) provides that medical treatment must be paid for "conditions resulting from the injury." *See SAIF v. Forrest*, 68 Or App 312, 680 P2d 1031 (1984); *Francoeur v. SAIF*, 17 Or App 37, 40, 520 P2d 477, *rev den* (1974). Claimant bears the burden of demonstrating that the need for medical services results from an industrial injury. *SAIF v. Forrest, supra*, 68 Or App at 315; *McGarry v. SAIF*, 24 Or App 883, 889, 547 P2d 654 (1976).

When a referee or the Board makes a determination that a particular medical condition is or is not the result of an industrial injury, and there is no appeal, that determination may not be relitigated. *Kuhn v. SAIF*, 73 Or App 768, 700 P2d 253 (1985); *Aldrich v. SAIF*, 71 Or App 168, 691 P2d 923 (1984); *SAIF v. Forrest, supra*. In *Kuhn*, we reversed, on *res judicata* grounds, a Board determination which denied benefits to the claimant. We held that the Board had impermissibly relied on expert testimony asserting no medical causation when a causal relationship had already been established in a prior proceeding:

> "Although [the expert] was entitled to reiterate his original conclusion, it conflicts with the law of the case, which is that permanent disability resulted from her industrial injury. As a legal matter, it is wrong. * * * Therefore, his conclusion must be discounted." 73 Or App at 772. (Citations omitted.)

Both claimants and employers are subject to *res judicata* prin-

ciples in workers' compensation cases.[1] Claimant cannot use

an aggravation claim as a back door to relitigate underlying causation issues. *Deaton v. SAIF*, 33 Or App 261, 576 P2d 35 (1978).

We do not agree with claimant's assertion that issues raised by her present claim are significantly different from those previously litigated. More than five months after the industrial accident a referee found that her then existing hip condition was unrelated to her initial compensable injury. That determination was affirmed by the Board and never appealed. The present case is unlike our decision in *Kepford v. Weyerhaeuser Co.*, 77 Or App 363, 713 P2d 625, *rev den* 300 Or 722 (1986), where the claimant offered a previously unlitigated theory. Here, the record contains no objective evidence distinguishing claimant's current hip condition from the hip malady which she had asserted in her original disability hearing. Because entitlement to medical treatment and disability benefits result from work-related injuries, the underlying causation issues are essentially identical. The compensability of claimant's hip condition has already been determined.[2]

Reversed on petition, affirmed on cross-petition.

---

[1] *Res judicata* operates somewhat differently in workers' compensation cases than in other types of cases. As we noted in *Farmers Ins. v. Hopson*, 53 Or App 109, 631 P2d 342 (1981), the distinction is sometimes an important one:

> "Generally stated, the doctrine of *res judicata* applies where a subsequent action is brought involving the same parties (or their privies) and the same claim or cause of action. Its effect is to preclude relitigation of any issues which were determined or which could have been determined in the initial case. * * * This terminology is not directly analogous to the administrative proceedings involved here; it is perhaps more useful to inquire whether issues to be determined on reconsideration are identical or necessarily include the issues which would be determined at the hearing on extent of disability." 53 Or App at 114. (Citations omitted.)

[2] Claimant's cross-petition for review of the Board's denial of medical treatment for her low back pain is arguably not barred by *res judicata*. We conclude that her present back condition is the product of a preexisting condition which was not caused or affected by the industrial accident.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Kevin L. Farrell, Claimant.

GORDON et al,
Petitioners,

v.

FARRELL et al,
Respondents.

(WCB 84-08997; CA A38881)

Judicial Review from Workers' Compensation Board.

Argued and submitted January 5, 1987.

Quintin B. Estell, Salem, argued the cause and filed the brief for petitioners.

Rick W. Roll, Astoria, argued the cause for respondent Farrell. With him on the brief was Roll, Westmoreland & Lavis, P.C., Astoria.

Michael D. Reynolds, Assistant Attorney General, Salem, waived appearance for respondent SAIF Corporation.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

DEITS, J.

Affirmed.

DEITS, J.

Employers seek review of a Workers' Compensation Board order holding that respondent Farrell (claimant) was a subject worker at the time of his injury. We affirm.

Employers are husband and wife and partners in the ownership of a five-unit rental complex and a farm on which their home is located.[1] Claimant and his wife began renting one of the units in January, 1984, for $200 per month. Shortly thereafter, the parties agreed that the Farrells would manage the units for a rent deduction of $55 a month plus $5 for each additional hour over 11 hours per month worked by claimant or his wife. Claimant began doing farm work for the Gordons for $5 per hour, and his wife did some housework for the Gordons. Claimant usually called George Gordon in the evening to see if work was available the next day. He averaged about $320 a month. Employers deducted the rent from that amount as well as taxes, Social Security and a Workers' Compensation deduction.[2]

By mid-April, 1984, most of the farm work was done. On the evening of May 7, 1984, claimant called George to inquire about the availability of work for the following day. He

[1] Employers were found to be non-complying employers. ORS 656.017.

[2] Employers claim that Workers' Compensation insurance was not obtained because of a mistake by their accountant.

informed George that he was looking for work to do, because he had a bill to pay. George told him that there was no farm work but Helen had some painting that she wanted done at the house. Claimant agreed to do that. He went to work at the home the next morning and injured himself when he fell off a ladder.

Employers argue that claimant was a nonsubject worker under ORS 656.027, which provides in part:

> "All workers are subject to ORS 656.001 to 656.794 except those nonsubject workers described in the following subsections:
>
> "* * * * *
>
> "(2) A worker employed to do gardening, maintenance, repair, remodeling or similar work in or about the private home of the person employing the worker.

> "(3) A worker whose employment is casual and either:
>
> "(a) The employment is not in the course of the trade, business or profession of the employer; or
>
> "(b) The employment is in the course of the trade, business or profession of a nonsubject employer.
>
> "For the purposes of this subsection, 'casual' refers only to employment where the work in any 30-day period, without regard to the number of workers employed, involves a total labor cost of less than $200."

They concede that, if claimant had been injured while doing farm work or work at the rental units, he would be a subject employe. They argue, however, that his employment was casual and that the work at the house was outside the course of the trade, business or profession of his employer.

We addressed a similar issue in *Anfilofieff v. SAIF*, 52 Or App 127, 627 P2d 1274 (1981), where the claimant worked as a carpenter on a housing project. He was injured while nailing metal siding on a bathhouse located at his employer's home. We held that the claimant was a subject worker:

> " 'The second category of troublesome cases [as to coverage] is that which involves employees who go from one class of work to another. Here, as in the other specific exemptions, it is impractical to construe the act in such a way that employees and employers dart in and out of coverage with every momentary change in activity. The great majority of decisions, therefore, attempt to classify the overall nature of the claimant's duties, disregarding temporary departures from that class of duties even if the injury occurs during one of the departures. * * *'
>
> "* * * * *
>
> "The rationale underlying this rule is that employer has the power to enlarge the scope of an employee's employment by assigning specific tasks. Once that authority is exercised, the employee has no practical choice but to perform as requested. The employee must either comply or face dismissal. To require the employee to decide whether to comply, but forfeit compensation, or refuse, and face dismissal, is impractical and unfair." 52 Or App at 132. (Citation omitted.)

The overall nature of claimant's duties was to perform miscellaneous tasks for employers at the farm and rental units. The work at the house may have been a temporary

departure from claimant's usual duties. However, applying the rationale of *Anfilofieff*, employers did have the authority to expand the scope of his duties, and if claimant wished to continue the work relationship, which he needed to do to make his rent payments, he had a strong incentive to do any work available. In the past, claimant had performed whatever tasks employer had needed done. If he had not done the work at the house, he risked not being given whatever work employers might later have available.

Employers also argue that claimant had to prove that they had labor costs of $200 or more during the 30-day period immediately before the injury. ORS 656.027(3). They rely on *Konell v. Konell*, 48 Or App 551, 617 P2d 313 (1980), *rev den* 290 Or 449 (1981), where there was insufficient evidence to show that the claimant would have earned enough money to result in the employers' costs meeting the statutory minimum. The evidence in that case did not show that the employer had *ever* met the statutory minimum. Here, the referee found that claimant averaged about $320 per month between the end of January and mid-April; therefore, the statutory requirement was met.

Affirmed.

IN THE SUPREME COURT OF THE
STATE OF OREGON

In the Matter of the Compensation of
Edward J. Reel, Claimant.

STATE ACCIDENT
INSURANCE FUND CORPORATION,
Respondent on review,

v.

REEL,
Petitioner on review.

(WCB 84-00293; CA A36984; SC S33331)

In Banc

On review from the Court of Appeals.*

Argued and submitted January 21, 1987.

Ronald L. Bohy, of Rolf Olson, P.C., Salem, argued the cause and filed the petition for petitioner on review.

Darrell E. Bewley, Assistant Attorney General, Salem, argued the cause for respondent on review.

JONES, J.

The Court of Appeals is affirmed, and the Workers' Compensation Board is reversed.

Gillette, J., filed a dissenting opinion in which Linde, J., joined.

*Judicial review from the Workers' Compensation Board. 81 Or App 258, 724 P2d 914 (1986).

JONES, J.

The issue in this workers' compensation case is whether claimant was in the course of his employment at the time of his injury. The Court of Appeals denied claimant benefits for injury he sustained in an explosion in his own camper parked near the construction site where he worked. We affirm.

The Court of Appeals succinctly outlined the events leading up to claimant's injury:

> "Claimant was a dump truck driver for a paving contractor which had its principal place of business in McMinnville, Oregon. His permanent home is in Salem, but his job took him all over the state to various construction sites. At the time of the injury, he was working on a job in Cascade Locks, a distance of 89 miles from Salem. He had decided to drive his pickup and camper to the job site and live there for the duration of the job, four to eight weeks. The night before the injury, claimant discovered that he was out of coffee. He drove to the local store to buy some, but he found it closed. He parked his camper on the other side of the road and spent the night there. The following morning, while claimant was in his camper and was attempting to light a cigarette, fumes from the camper's defective propane tank caused an explosion, and he was badly burned." *SAIF v. Reel,* 81 Or App 258, 260, 724 P2d 914 (1986).

The following facts are undisputed: Claimant's employer, J.C. Compton Company, maintained a principal place of business located in McMinnville. Claimant, who resided in Salem, began working for J.C. Compton Company in 1979 as a dump truck operator and worked continuously for that employer until he was injured in the explosion in October 1983. The employment required employes to travel to remote parts of the state on paving jobs, and employes had short notice when a new job would begin or where it would be. The jobs lasted anywhere from two weeks to three months. The Cascade Locks paving job lasted three months. (The distance from Salem to McMinnville is 26 miles; from McMinnville to Cascade Locks is 99 miles.) Claimant had been on the Cascade Locks job for six weeks when he was injured. Some 41 persons were employed at this site. They were from Salem, Hermiston, Eagle Creek, Aumsville, Bend, Lake Oswego, Gardiner, Florence, Portland, Gresham, Sweet Home, Springfield, Canby,

Klamath Falls, Talent, McMinnville, Carlton, Dallas, Echo (all in Oregon), and Vancouver and Kennewick (both in Washington). Some of the workers commuted to the job from their homes. Others stayed in Cascade Locks in campers, in apartments, and in mobile homes. Some brought their families with them.

Claimant lived in his camper on or near the job site in Cascade Locks during the week but commuted to his home in Salem on weekends. Work schedules were posted daily and differed from one day to the next. Employes were often called on by the employer to report to work early or to work overtime to take advantage of weather conditions. They needed to be close by the job site in case of a suspension or resumption of operations due to a change in weather. Claimant was paid the required wage for federally funded projects, which was the prevailing union scale plus a zone pay differential dependent upon the distance of the job from the nearest union hall. He was not reimbursed for travel, subsistence or lodging, but was paid an additional $3.35 per hour for working in a zone more than 75 miles from Salem.

Although claimant was not working under a collective bargaining agreement, he was paid the extra hourly pay pursuant to the agreement "because of remoteness of area * * * there is a great inequity between living expenses of an employee providing for himself and his family in the major metropolitan areas and those of an employee working in remote areas within the large geographical area of this agreement." No travel time, transportation reimbursement or subsistence was paid to employes by the employer except when transporting equipment. Employes driving equipment away from their "home terminal" to a job site were paid the cost of lodging and meals.

The referee awarded compensation on the ground that claimant was a "traveling employe" and that the activities resulting in his injury reasonably related to his travel status, concluding:

> "In this case claimant may not have been required, as a condition of employment, to temporarily reside in the Cascade Locks area. However, claimant's hours of work varied, overtime was occasionally required and commuting would have involved a 180 mile drive each day. As a practical matter,

claimant's travel status was necessary and that status was due entirely to his employment. He was, therefore, a traveling employee.

"The remaining question is whether claimant's activities at the time of injury were reasonably related to his travel status or whether they represented such a distinct personal departure as to sever the employment relationship.

"Cases in all jurisdictions almost uniformly hold that injuries to traveling employees resulting from sleeping in hotels or motels are compensable. Additionally, a number of cases, including Oregon cases, have held that the mere consumption of alcoholic beverages does not constitute a distinct departure from employment. Here, claimant slept in his camper and, while preparing for work, attempted to light a cigarette. Certainly lighting a cigarette was not sufficient to sever claimant's employment relationship. Nor has any authority been cited or found to distinguish claimant's injury in a mobile 'room' which he owned and controlled from a room in a hotel, owned and controlled by a neutral party.

"I conclude that claimant was a traveling employee, that his activities at the time of injury were reasonably related to his employment necessitated travel status and that, as a result, his injury was sufficiently employment related to be compensable."

The Workers' Compensation Board affirmed, and the State Accident Insurance Fund petitioned for judicial review. The Court of Appeals reversed, finding that claimant was neither a "resident" nor a "traveling" employe and that he was injured "while engaging in a purely personal activity which bore no relationship to his employment." 81 Or App at 260-61.

To be compensable, an injury must arise out of and in the course of employment. ORS 656.005(8)(a). Claimant contends that he was a traveling employe and within the course of his employment at the time of the explosion. This court has never addressed whether the concept of a "traveling employe" should be utilized to interpret ORS 656.005(8)(a). However, the Court of Appeals adopted the concept in *Simons v. SWF Plywood Co.*, 26 Or App 137, 143, 552 P2d 268 (1976), deriving it from Professor Larson's work:

"'Employees whose work entails travel away from the employer's premises are *** within the course of their

employment continuously during the trip, except when a distinct departure on a personal errand is shown. Thus, injuries arising out of the necessity of sleeping in hotels or eating in restaurants away from home are usually held compensable.' 1 Larson, Workmen's Compensation Law 5-172, § 25.00 (1972)."

In this case, the Court of Appeals recognized that "[claimant's] job took him all over the state to various construction sites"; nevertheless, it concluded that claimant was not a "traveling employe" as that court has applied those terms in interpreting ORS 656.005(8)(a), because "[h]is travel brought him *to* and not away from his employer's job site." 81 Or App at 260-61 (emphasis in original). The Court of Appeals stated:

"We would treat claimant as a traveling employe if he were required by the nature of his work to travel 'away from the employer's premises.' 1A Larson, *supra*, at 5-525; *see Slaughter v. SAIF*, 60 Or App 610, 654 P2d 1123 (1982). He would be compensated for injuries arising out of the necessity of traveling, except if a distinct departure on a personal errand were shown. *Beneficiaries of McBroom v. Chamber of Commerce*, 77 Or App 700, 713 P2d 1095 (1986); *Simons v. SWF Plywood Co.*, 26 Or App 137, 552 P2d 268 (1976). His travel brought him *to* and not away from his employer's job site. We conclude that he was not a traveling employe in the sense that the term is used for workers' compensation purposes." 81 Or App at 260-61 (emphasis in original).[1]

We agree that this claimant's injury when he was burned in the explosion did not occur within the course of his employment.

Many cases hold that employes traveling on business of the employer and at the direction of the employer are covered by workers' compensation. *See, e.g., Rogers v. SAIF*, 289 Or 633, 616 P2d 485 (1980) (worker "on call" 24 hours a day at job site as a requirement of employment); *Slaughter v. SAIF*, 60 Or App 610, 654 P2d 1123 (1982) (long-haul truck driver on a layover); *Simons v. SWF Plywood Company, supra* (claimant traveling to various Oregon cities for business meetings injured on the return trip). But here, even though

J.C. Compton Company had its principal place of business in McMinnville, the claimant never worked at McMinnville. Only 2 of the 41 employes were from McMinnville. The employer maintained a business office in McMinnville, but the construction work was carried out by employes at job sites all over the state.

Workers' compensation should be awarded to a worker when the employe has been directed, as part of his duties, to remain at a particular place or locality until directed otherwise or for a specified length of time. The risk inherent in travel may arise out of the employment where such travel is a necessary incident of the employment. That is, when the travel is essentially part of the employment, the risk remains an incident to the employment even though the employe may not actually be working at the time of the injury.

The purpose of the workers' compensation law is to provide benefits for injuries caused by work-related hazards arising from the course of the employment. Under that rule, injuries sustained while driving to and from work normally are not covered, even though it is the work that subjects the worker to the hazard. *Nelson v. Douglas Fir Plywood Co.*, 260 Or 53, 488 P2d 795 (1971). On the other hand, where traveling employes are concerned, because the work sometimes subjects them to the hazards of fire in hotels or food poisoning in restaurants when the employer requires the worker to be traveling, the Court of Appeals has held those hazards covered. *See, e.g., Slaughter v. SAIF, supra; Simons V. SWF Plywood, supra.*

The real issue in this case is not whether this claimant was a traveling employe, but whether he was directed to

[1] We believe that the Court of Appeals has used "employer's premises" and "employer's job site" as being synonymous.

live at or near the job site as an integral part of his employment. This is not a case where an employer sends a worker to a specific location to carry out the work of the employer. This is a difficult case because, for practical purposes, the employes who lived in remote areas of the state could not be available to carry out the employer's work unless they lived near the job site. Thus, although not directed by the employer to live at the job site, most of the workers necessarily had to do so to fulfill their employment obligations.

We believe that the problem is best resolved, not by reference to any "traveling employe rule," but by examining

the contractual relationship of the parties to determine if the claimant's injury "arose out of and in the course of" his employment. ORS 656.005(8)(a). The employes were paid a substantial differential for working in remote areas of the state. They agreed not to be reimbursed for lodging or meals while working in these remote areas unless they were driving company equipment. The working agreement was for them to be paid for five days per week only for hours spent at the job site. They were not paid regular salary for after-hours work. If they worked overtime, they were paid specially for overtime.

There is a line of related cases (the "bunkhouse cases") in which a worker is required to live on the premises in quarters provided by the employer. As to such employes, Larson states that this is the rule:

> "When an employee is required to live on the premises, either by his contract of employment or by the nature of the employment, and is continuously on call (whether or not actually on duty), the entire period of his presence on the premises pursuant to this requirement is deemed included in the course of employment. However, if the employee has fixed hours of work outside of which he is not on call, compensation is awarded usually only if the course of injury was a risk associated with the conditions under which claimant lived because of the requirement of remaining on the premises." 1A Larson, Workmen's Compensation Law 5-212, § 24.00 (1985).

As to such employes who are continually on call, but off the premises, off-premises injuries normally are not covered. 1A Larson, *supra*, at 5-225 to 5-229, § 24.23.

But when the worker has the option of living on or off the premises, Larson's rule is:

> "When residence on the premises is merely permitted, injuries resulting from such residence are not compensable under the broad doctrines built up around employees required to reside on the premises. This distinction has been applied when the source of injury was the burning of the bunkhouse, tent, or other residence furnished by the employer, a fall from a porch, a fall down stairs, injury going toward or coming from the residence, electrocution, collapse of the hut in a high wind, destruction of a trailer by a tornado, and various other hazards not directly associated with the employment. The theory is that when residence is mandatory, it is the constraints and obligations of the employment that subject the

> employee to the risk that injured him, while if the residence is optional, the employee is free to do as he pleases and there is

no continuity of employment obligation of any kind during the time the employee is voluntarily sleeping in a place provided for his convenience by the employer." 1A Larson, *supra*, at 5-244 to 5-248, § 24.40 (footnotes omitted).

Assuming without deciding that we would adopt the same or a similar rule were the case presented, the situation of the claimant at bar is more akin to the worker having the option to live on or off the premises than to the worker required to live on the premises. Here, the claimant, during off-duty hours, was free to do as he pleased, without respect to the employer's job site. The relationship between the injury and the employment is no greater than the risk of injury while going to or from work, a risk which, as stated above, is not covered.

Although an employer cannot contract with an employe not to provide workers' compensation for injuries suffered in the course of employment, ORS 656.018(1)(c), the employment agreement of the parties can be utilized to interpret whether the worker is in the course of his employment. Under the employment agreement in this case, we conclude this worker was not in the course of his employment at the time of his injury, because:

(1) He made the decision to live in his camper at the job site. He was not directed to do so by his employer. He could have rented a house, a motel room, stayed with friends or endured a long commute from his home. The choice was his, not his employer's.

(2) He agreed to be paid an additional $3.35 per hour for working without other subsistence in an area remote from his home.

(3) The employer specially agreed to pay wages and subsistence if the worker was driving the employer's equipment to the job site, but not otherwise.

The Court of Appeals is affirmed, and the Workers' Compensation Board is reversed.

GILLETTE, J., dissenting.

I dissent.

This longstanding, permanent employe worked at various locations around the state as the needs of his employer dictated. Some locations doubtless were sufficiently close to home to permit a reasonable commute. The job under consideration here was not such a job, however, and we ought to acknowledge it.

A job nearly 100 miles from home with varying and unpredictable hours is a job the employer *knows* to be one that will require the employe to find lodging near the job site. The fact that there is (or is not) a pay differential based on distance from a union hiring hall, that the employer pays (or does not) for certain travel but not all or that the employe received (or did not) a subsistence allowance does not settle the matter. The issue is whether the injury arose out of and in the course of his employment.

The majority does not draw a steady bead on this inquiry. It first says (303 Or at ___), "The real issue in this case is not whether this claimant was a traveling employe, but whether he was directed to live at or near the job site as an integral part of his employment." If that is the inquiry, then the state of facts to which I've already referred supplies the answer: The only fair inference from the geographic and other facts is that that is precisely what the employer "directed" (required of) him.

Unfortunately, the next sentence in the majority opinion begins to undo the focus: "This is not a case where an employer sends a worker to a specific location to carry out the work of the employer." 303 Or at ___. Again, with respect, that is not a correct summary of the facts, as the next two sentences of the majority opinion seem to recognize:

> "* * * This is a difficult case because, for practical purposes, the employes who lived in remote areas of the state could not be available to carry out the employer's work unless they lived near the job site. *Thus, although not directed by the employer to live at the job site, most of the workers necessarily had to do so to fulfill their employment obligations.*" 303 Or at ___ (emphasis supplied).

However massaged, these passages fail to let the

majority out of its central dilemma. The majority must insist that there be a specific "direction" to the employe to reside at the job site in order to sustain its view. The majority cites no case law, from this state or elsewhere, which has imposed so formalistic a requirement. To do so allows the employer, by its silence, to contract out of workers' compensation responsibility. This is not permissible in Oregon. ORS 656.018(1)(c). If an employer so arranges the circumstances of a job situation that it *in fact* requires a permanent employe to live at the site for the duration of the job, the employe has been "directed" — assuming that term has any significance in such an analysis — to do so.

Such case law as I have found from around the country supports this view. In *Olinger Const. Co. v. Mosbey*, 427 NE2d 910 (Ind App 1981), Mosbey, an employe of Olinger Construction, was assigned to work at a bridge and road construction site located 150 miles from his home. He lived in a motel while working on the project. One evening, a former employe of Olinger's entered Mosbey's motel room and stabbed Mosbey, who later died from the injuries. The Indiana court concluded that Mosbey's death was compensable under the traveling employe rule. The court rejected the employer's argument that Mosbey was not a traveling employe because his assignment was long-term:

> "[E]ven if Mosbey had been assigned to the site for an extended time, we see no basis for making a distinction between employees, such as salesmen and truck drivers, who travel from city to city and those, such as Mosbey, who travel to one site and remain there until their specific assignment is completed.
>
> "The rationale behind the traveling employee rule is that an employee who is required to travel away from home is furthering the business of his employer as he eats, sleeps, and performs other acts necessary to his health and comfort during his travels. * * * This rationale applies equally to an

employee who travels to a fixed location and stays there to do his job. This type of traveling employee is also away from home or headquarters because of his job, so that, in a sense, his activities, such as eating and sleeping in a distant location, are done for the benefit of the employer." *Olinger Const. Co. v. Mosbey, supra,* 427 NE2d at 915 (citation omitted).

* *Brown v. Palmer Construction Company, Inc.*, 295

A2d 263 (Me 1972), involved two linemen who were assigned to work on a project in Brattleboro, Vermont. The job site was "beyond reasonable commuting distance" from the claimants' homes in Maine. The employer expected the claimants to find lodgings near the Vermont job site and paid them additional compensation to cover their living expenses. The claimants worked regular hours and were not "on call" when off duty. The claimants shared an apartment with kitchen facilities and were injured when the oven of their gas stove exploded. The court concluded that the claimants' injuries were compensable under the traveling employe rule:

"We think the policy of the Maine Act is to protect the employee against risks which are not purely self-created but are created by and incidental to the employment. In the instant case the necessity of lodging and meals in Brattleboro was not merely the necessity of the injured employees = it was a necessity of the employer in furtherance of the work it had contracted to perform in Vermont. These employees slept and ate where they did, not of their own choice or preference, not as a matter of personal comfort or convenience, but to accommodate the necessities of their employment. What they did was within the contemplation of the terms and conditions of that employment. The choice of an apartment with ordinary kitchen facilities, a choice the employees were free to make, did not add such unreasonable or excessive risks and perils as might cast doubt on the right to coverage. We conclude as did the Commissioner below that there is no rational difference between a traveling employee who moves from place to place and one who travels many miles to his employer's job location and can return home only on weekends or when the work is finally completed." *Brown v. Palmer Construction Company, supra,* 295 A2d at 266-67.

In *Leonard v. Dennis*, 465 So 2d 538 (Fla App 1985), the claimant worked as the supervisor of a construction project in Crystal River, Florida. He stayed in a Crystal River motel from Monday through Thursday and returned to his home in Tampa each weekend. The claimant was injured in an automobile accident while driving to a nearby restaurant with the project manager. The court held that, regardless of whether claimant and the project manager were going to dinner for business purposes, claimant was covered under the traveling employe doctrine.

In *Wright v. Industrial Comm'n*, 62 Ill 2d 65, 338

NE2d 379 (1975), Wright supervised the installation of industrial machinery in the purchasers' factories. His job frequently involved travel to out-of-state locations for five to six months at a time. During a trip to Newburn, Tennessee, Wright was killed in a head-on car collision. The employer argued that

"where an employee remains at a specific job location for 5 or 6 months, as in the present case, he becomes, in effect, a 'resident' of that location and can no longer be classified as a traveling employee." *Wright, supra,* 62 Ill 2d at 69. The court found that Wright was a traveling employe, concluding that:

> "We can find no rational basis to distinguish between the employee who is continuously traveling and one who travels to a distant job location only to return when the work is completed. While it is true that the latter type of employee may become more familiar with the risks inherent in his out-of-town employment because he remains in one locale, the risks are still present. It would be inconsistent to deprive an employee of benefits of workmen's compensation simply because he must travel to a specific location for a period of time to fulfill the terms of his employment and yet grant the benefits to another employee because he continuously travels." *Id.*

The unjust outcome of this case is not dictated by statute, prior case law or any identified public policy. Awarding benefits, as the referee and Workers' Compensation Board did, is appropriate.

I respectfully dissent.

LINDE, J., joins in this dissent.

IN THE SUPREME COURT OF THE
STATE OF OREGON

In the Matter of the Compensation of
Lawrence J. Lizotte, Claimant.

LIZOTTE,
Petitioner on Review,

v.

EASTERN OREGON HOSPITAL et al,
Respondents on Review.

(WCB 84-10933; CA A37861; SC S33779)

In Banc

On petition for review filed March 12, 1987.*

James L. Edmunson, Karen M. Werner, and Malagon & Moore, Eugene, for petitioner on review.

PER CURIAM

The petition for review is allowed. The case is remanded to the Court of Appeals in light of the opinions and decisions of the Supreme Court in *Barrett v. D & H Drywall*, 300 Or 325, 709 P2d 1083 (1985), 300 Or 553, 715 P2d 90 (1986).

*On judicial review from an order on review of the Workers' Compensation Board. 83 Or App 524, 732 P2d 91 (1987).

PER CURIAM

The issue in this workers' compensation case involves the effect of symptoms from a pre-existing condition on a claim for loss of earning capacity following a compensable injury. Claimant contends that the referee failed to apply the law properly. The Workers' Compensation Board (Board) affirmed and adopted the opinion of the referee without elaboration. After our decision in *Barrett v. D & H Drywall*, 300 Or 325, 709 P2d 1083 (1985), 300 Or 553, 715 P2d 90 (1986), the Court of Appeals affirmed this case without opinion. It is to be noted that our opinion in *Barrett* reversed the most recent opinion of the Court of Appeals in *Barrett* on the issue in this case.

Because we do not review the evidence to arrive at independent findings of fact in workers' compensation cases, *Sahnow v. Fireman's Fund Ins. Co.*, 260 Or 564, 491 P2d 997 (1971), we would not allow review in this case if we could determine that the Court of Appeals had exercised its fact-finding function by evaluating the evidence under the correct rule of law. *Gettman v. SAIF*, 289 Or 609, 612-13, 616 P2d 473 (1980). However, the circumstances of this case suggest that the Court of Appeals may have affirmed the Board under an erroneous interpretation of the law.

The petition for review is allowed. The case is remanded to the Court of Appeals in light of the opinions and decisions of the Supreme Court in *Barrett v. D & H Drywall*, *supra*.

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