VAN NATTA'S WORKERS' COMPENSATION REPORTER

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

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40 Van Natta ____ (1988)

LESLIE D. CALVIN, Claimant
Gerri L. Christensen, Dept. of Justice

WCB CV-88001
June 10, 1988
Crime Victim Order

Applicant requests review by the Workers' Compensation Board of the Department of Justice's Order on Reconsideration dated December 8, 1987. The Department's order rejected applicant's claim under the Crime Victims' Compensation Act, ORS 147.005 to 147.365, on the ground that the evidence was insufficient to establish applicant's entitlement to benefits.

In lieu of a fact-finding hearing, the parties have agreed to submit the case for review based upon the documentary record provided by the Department of Justice and the parties' written arguments. See OAR 438-82-030(2). The written arguments have been received and fully considered. The standard for our review under the Act is de novo, based on the entire record. ORS 147.155(5); Jill M. Gabriel, 35 Van Natta 1224, 1226 (1983).

FINDINGS OF FACT

Applicant sustained a gunshot wound to the face and neck at approximately 10:20 p.m. on July 4, 1987. He was taken to the hospital where he was interviewed by police. He told the interviewing officer that a friend, Howard England, had driven him to the intersection of North Borthwick and Prescott in Portland to buy some marijuana. Applicant got out of the car and made his purchase. As he began to return to the car, a man wearing a ski mask stepped out from behind some bushes, robbed him of the marijuana and shot him in the face.

The police also interviewed Howard England and another witness, Michele Phillippi. According to England, he and applicant were driving through the area where the injury occurred when applicant stated that he needed to urinate. England pulled the car over in a darkened area and both of them got out. At that point, a man wearing a ski mask stepped out of the shadows and robbed him of his watch and some money. The robber then went around the car and attempted to rob applicant. Applicant and the robber struggled, the robber fired two shots and applicant fell to the ground. The robber then fled.

According to Phillippi, applicant and England were standing on the street near a car. A young man carrying a gun approached them. The young man was not wearing a ski mask. A short time later, the young man shot applicant and then fled. Phillippi lived in the neighborhood and did not know applicant, England or the young man. Phillippi refused to give further information to the police for fear that the young man who shot applicant had seen her and might try to harm her.

Because of the different accounts of the shooting received from applicant and the witnesses, the lack of further cooperation from Phillippi and the absence of information concerning the identity of the young man, the police suspended their investigation of the incident on July 9, 1987. Applicant's mother filed a claim on his behalf under the Crime Victims' Compensation Act on July 13, 1987.

On August 24, 1987, applicant filed a statement with the Department of Justice regarding the shooting which differed

substantially from his original account. The statement indicated that applicant and England were driving around, watching fireworks, when he had England pull over so that he could urinate. He got out of the car, urinated and then purchased some fireworks from a young man standing in an alley. While he was away from the car, a man approached England and robbed him. When applicant returned to the car, the robber was sitting behind the wheel of the car and England was in the passenger seat. As applicant approached, the robber got out of the car, approached applicant and demanded applicant's valuables. Applicant put his hands in his pockets and the robber then shot him and fled.

On November 17, 1987, the Department issued its order denying applicant's claim for victims' compensation on the ground that the differing accounts of the shooting provided by applicant and the witnesses made it impossible to determine the facts of the incident and thus to determine whether applicant was eligible for victims' compensation. The order commented that if applicant was in the process of purchasing illegal drugs at the time of the shooting he would not be eligible for compensation because his injury would be substantially attributable to his own wrongful act within the meaning of ORS 147.015(5).

Applicant requested reconsideration of the Department's order and submitted another written account of the shooting dated November 26, 1987. In this account, applicant stated that England stopped his car to allow applicant to urinate. As he was doing so, a man forced his way into England's car and robbed England. As applicant was returning to the car, the robber got out, approached him and demanded his watch and money. Applicant refused and tried to resist. The robber then shot him. The Department reaffirmed its decision denying applicant's claim for victims' compensation in an Order on Reconsideration dated December 8, 1987.

In light of the varying accounts of the shooting provided by applicant, we find that applicant is not a credible witness. Of the three accounts given by applicant, we find the first the most accurate, although we do not accept it uncritically. Based upon this first account, we find that the shooting was closely associated with an illegal drug transaction. We find Michele Phillippi, a disinterested third party, credible and the information provided by her accurate. We find Howard England not credible based upon differences between his and Ms. Phillippi's accounts of the incident and his failure to mention the drug transaction.

OPINION AND CONCLUSIONS

ORS 147.015 provides that an applicant for victims' compensation is entitled to such compensation if, among other requirements:

> "(5) The death or injury to the victim was not substantially attributable to the wrongful act of the victim or substantial provocation of the victim."

"Substantially attributable to the wrongful act of the victim" means "attributable to an unlawful act voluntarily entered into from which there can be a reasonable inference that, had the

act not been committed, the crime complained of would not have occurred." OAR 137-76-010(7). "Substantial provocation" means "a voluntary act or utterance from which there can be a reasonable inference that, had it not occurred, the crime would not have occurred." OAR 137-76-010(8).

After our de novo review of the record, we conclude that the evidence supports the conclusion that applicant's injury was substantially attributable to his own wrongful act. The shooting occurred in connection with an illegal drug transaction. Such transactions involve a substantial risk of the kind of injury sustained by applicant. In addition, no credible evidence establishes the precise motivation for the shooting and the information provided by Ms. Phillippi is not sufficiently detailed to fill this gap.

For the above reasons, we conclude that the evidence does not establish that applicant is entitled to benefits and that the Department's Order on Reconsideration should be affirmed.

ORDER

The Findings of Fact, Conclusions and Order on Reconsideration of the Department of Justice Crime Victim Compensation Fund dated December 8, 1987 is affirmed.

CLAUDE BAILEY, Claimant
Emmons, et al., Claimant's Attorneys
Cowling & Heysell, Defense Attorneys

Own Motion 88-0158M
July 1, 1988
Own Motion Order

The insurer has submitted to the Board claimant's claim for an alleged worsening of his August 6, 1975 industrial injury. Claimant's aggravation rights have expired. The insurer has accepted responsibility for the current condition, but opposes reopening for the payment of temporary total disability as it contends claimant can continue to do his regular job even while receiving medical treatment.

Pursuant to ORS 656.278(1)(a), we may exercise our "Own Motion" authority when we find that there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. In such cases, we are authorized to award temporary disability compensation commencing from the time the worker is actually hospitalized or undergoes outpatient surgery. (Emphasis added.) Claimant underwent surgery on March 12, 1988. Dr. Peek has indicated that claimant's condition rendered him disabled from work as of January 29, 1988 and that claimant continues to be disabled. We conclude claimant's claim should be reopened with temporary total disability compensation to commence March 12, 1988 and to continue until claimant returns to his regular work at his regular wage or is medically stationary, whichever is earlier. Claimant's attorney is awarded 25% of the additional compensation granted by this order, not to exceed $650 as a reasonable attorney's fee. Reimbursement from the Reopened Claims Reserve is authorized to the extent allowed under ORS 656.625 and OAR 436, Division 45. When appropriate, the claim shall be closed by the insurer pursuant to OAR 438-12-055.

IT IS SO ORDERED.

VIVIAN BARBER, Claimant
Emmons, et al., Claimant's Attorneys
SAIF Corp, Insurance Carrier

Own Motion 88-0209M
July 1, 1988
Own Motion Order

SAIF Corporation has submitted to the Board claimant's claim for an alleged worsening of her January 31, 1971 industrial injury. Claimant's aggravation rights have expired. SAIF opposes reopening of this claim as it contends claimant's back pain represents a waxing and waning of the compensable condition rather than a worsening.

Pursuant to ORS 656.278(1)(a), we may exercise our "Own Motion" authority when we find that there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. In such cases, we are authorized to award temporary disability compensation commencing from the time the worker is actually hospitalized or undergoes outpatient surgery. Claimant was hospitalized on October 5, 1987 for five days of conservative treatment. The evidence indicates that her compensable condition did materially worsen so as to render her temporarily disabled from gainful employment. We conclude she is entitled to compensation for temporary total disability as prescribed by law.

Accordingly, claimant's claim is reopened with temporary total disability compensation to commence October 5, 1987 and to continue until claimant returns to her regular work at her regular wage or is medically stationary, whichever is earlier. Claimant's attorney is awarded 25% of the additional compensation granted by this order, not to exceed $500 as a reasonable attorney's fee. Reimbursement from the Reopened Claims Reserve is authorized to the extent allowed under ORS 656.625 and OAR 436, Division 45. When appropriate, the claim shall be closed by the insurer pursuant to OAR 438-12-055.

IT IS SO ORDERED.

PATRICK HIGGINS, Claimant
Davis & Bostwick, Attorneys

Own Motion 86-0433M
July 1, 1988
Own Motion Order

In August 1986, the Board received a letter from claimant in which he requested temporary total disability compensation from January 1986. This letter was construed to be a request for own motion relief and a Board file was set up. Subsequent to the initial request, we have received evidence that own motion relief may, in fact, not be appropriate as claimant's 1979 claim was in an open status. In December 1987 the Board asked the parties whether there was any reason to keep the own motion file active. Claimant's prior attorney responded, only to state that he no longer represented claimant.

The passage of two years with no further contact from claimant causes us to conclude the own motion file should be dismissed. Claimant can attempt to reactivate his claim at any time should the need arise.

The request for own motion relief is hereby dismissed.

IT IS SO ORDERED.

INA M. JEFFRIES, Claimant
Rosenthal & Greene, Claimant's Attorneys
SAIF Corp, Insurance Carrier

Own Motion 88-0314M
July 1, 1988
Own Motion Order

SAIF Corporation has submitted to the Board claimant's claim for an alleged worsening of her April 5, 1978 industrial injury. Claimant's aggravation rights have expired. SAIF has authorized the surgery, but opposes reopening of this claim as it contends claimant's has not worked sufficient time to justify payment of benefits under Cutright v. Weyerhaeuser Company, 299 Or 290 (1985).

Pursuant to ORS 656.278(1)(a), we may exercise our "Own Motion" authority when we find that there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. In such cases, we are authorized to award temporary disability compensation commencing from the time the worker is actually hospitalized or undergoes outpatient surgery.

Surgery has been authorized by SAIF Corporation and claimant may be entitled to compensation for temporary total disability by the Board. ORS 656.278. The only consideration is claimant's recent work history. Claimant has provided evidence to indicate she made over $2,000 in 1987. There is also evidence of medical treatment throughout 1987, with surgery recommended as early as April 1987. We conclude that claimant did not voluntarily remove herself from the work force and is entitled to compensation for temporary total disability during her recovery from surgery.

Following our review of this record, we are persuaded that claimant's compensable injury has worsened requiring surgery. Accordingly, claimant's claim is reopened with temporary total disability compensation to commence December 18, 1987 and to continue until claimant returns to her regular work at her regular wage or is medically stationary, whichever is earlier. Claimant's attorney is awarded 25% of the additional compensation granted by this order, not to exceed $400 as a reasonable attorney's fee. Reimbursement from the Reopened Claims Reserve is authorized to the extent allowed under ORS 656.625 and OAR 436, Division 45. When appropriate, the claim shall be closed by the insurer pursuant to OAR 438-12-055.

IT IS SO ORDERED.

PAUL LENOCKER, Claimant
Charles D. Maier, Claimant's Attorney
Liberty Northwest, Insurance Carrier

Own Motion 87-0624M
July 1, 1988
Second Own Motion Determination on Reconsideration

The Board issued an Own Motion Determination on November 10, 1987 whereby claimant's claim was closed with no additional award for permanent disability. On reconsideration, the Board denied claimant's request for further disability benefits. Claimant again asks the Board to reconsider its earlier position.

The Board denied permanent disability compensation to claimant as it was persuaded it lacked jurisdiction under the recently enacted own motion law. ORS 656.278 and OAR

438-12-052(2). Claimant contends he is entitled to benefits as was the worker in Gayle L. Fitzgerald, 40 Van Natta 127 (1988). The claim in the Fitzgerald case was opened under the old law in 1987 and, thereafter was closed under the provisions of the old law which did allow for permanent disability compensation. The instant case was also reopened in 1987 and closed in 1987. Four months later claimant requested additional permanent disability compensation. At that point, the request for additional benefits was filed with the Board on a closed claim, distinguishable from Fitzgerald, which was in an open status at the time permanent disability benefits were considered. We conclude our decision on April 14, 1988 was proper and are unwilling to disturb our prior orders. See Orville D. Shipman, 40 Van Natta 537 (June 8, 1988). The request for further permanent disability compensation is denied.

IT IS SO ORDERED.

BONNIE L. OZMENT, Claimant
Kilpatrick & Pope, Claimant's Attorneys
DebraAnn Kronenberg (SAIF), Defense Attorney
Roberts, et al., Defense Attorneys

Own Motion 87-0713M
July 1, 1988
Own Motion Order

SAIF Corporation initially submitted to the Board claimant's claim for an alleged worsening of her March 21, 1978 industrial injury. Claimant's aggravation rights have expired. The Board referred the request for own motion relief to the Hearings Division for consolidation with WCB Case Nos. 85-07074 and 87-014639. WCB Case No. 88-01043 was subsequently added to the proceedings before the Referee. All matters have been resolved by stipulation. SAIF Corporation has agreed to accept responsibility for claimant's condition, rescinding its December 3, 1987 denial. The parties and the Referee have recommended to the Board that claimant's claim be reopened for temporary total disability compensation as of September 14, 1987, the date she was hospitalized for back pain.

Pursuant to ORS 656.278(1)(a), we may exercise our "Own Motion" authority to award temporary disability benefits only when we find that there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. In such cases, we are authorized to award temporary disability compensation commencing from the time the worker is actually hospitalized or undergoes outpatient surgery. We note that the hospitalization on September 14, 1987 was for emergency room care only. After careful consideration, we have determined that emergency room care does not satisfy the statute for purposes of claim reopening under own motion jurisdiction. Later in that same month, claimant was hospitalized for 24 hours; however, we are not satisfied that the treatment provided to her was related to the compensable 1978 injury.

The evidence indicates that claimant's claim can, and should, be reopened with temporary total disability compensation to commence the date of her hospitalization in December 1987 for stress reaction. Temporary disability benefits should continue until claimant returns to her regular work at her regular wage or is medically stationary, whichever is earlier. Reimbursement from the Reopened Claims Reserve is authorized to the extent allowed under ORS 656.625 and OAR 436, Division 45. When appropriate, the claim shall be closed by the insurer pursuant to OAR 438-12-055.

IT IS SO ORDERED.

MICHAEL D. PEDERSON, Claimant
Malagon & Moore, Claimant's Attorneys
SAIF Corp, Insurance Carrier

Own Motion 88-0265M
July 1, 1988
Own Motion Order

SAIF Corporation has submitted to the Board claimant's claim for an alleged worsening of his November 23, 1977 industrial injury. Clamant's aggravation rights have expired. SAIF has accepted responsibility for claimant's recent medical expenses, but recommends the Board deny the request for claim reopening as claimant's condition does not require inpatient or outpatient surgery or hospitalization for treatment at this time. Claimant argues that the Board's decision in this case should be made considering the law in effect at the time of his injury rather than current own motion law.

Claimant's contention that the law in effect at the time of his injury controls in this situation has been discussed in a recent Board order. Andy Webb, 40 Van Natta 586 (June 22, 1988). The Board concludes that the request for own motion relief must be considered under the current own motion law which took effect on January 1, 1988. Pursuant to ORS 656.278(1)(a), we may exercise our "Own Motion" authority only when we find that there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. In such cases, we are authorized to award temporary disability compensation commencing from the time the worker is actually hospitalized or undergoes outpatient surgery. Current treatment involves conservative chiropractic care and would not entitle claimant to claim reopening under ORS 656.278. The request for own motion relief is hereby denied.

IT IS SO ORDERED.

LEROY WYANT, Claimant
SAIF Corp, Insurance Carrier

Own Motion 87-0729M
July 1, 1988
Own Motion Order

Claimant has requested that the Board exercise its own motion authority and reopen his claim for an alleged worsening of his September 29, 1980 industrial injury. Claimant's aggravation rights have expired. SAIF issued a formal denial of the cervical treatment recommended by Dr. Hockey and recommends that the request for own motion relief be denied.

Claimant's 1980 SAIF injury was to his low back. Treatment currently recommended by Dr. Hockey is for his neck. Dr. Hockey does not appear to relate the neck problems to the 1980 injury. We note also that SAIF's denial of treatment has not been appealed by claimant. Pursuant to ORS 656.278(1)(a), we may exercise our own motion authority only when we find that there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. None of the above prerequisites for own motion relief have been met. We conclude we are without authority to reopen this claim and deny the relief claimant seeks.

IT IS SO ORDERED.

The Beneficiaries of
THOMAS J. BERDOT (Deceased), Claimant
Doblie & Associates, Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 85-07225
July 5, 1988
Order Denying Motion for Reconsideration

Claimant has requested reconsideration of the Board's Order on Review dated July 23, 1987 that affirmed the Referee's order upholding the insurer's denial of claimant's claim for death benefits. Specifically, claimant asks that we withdraw our prior order and remand this matter to the Referee for the taking of additional evidence regarding disability which was unobtainable at the time of the hearing. We decline to withdraw our prior order.

FINDINGS

On July 28, 1987, claimant timely appealed the Board's July 23, 1987 Order on Review to the Court of Appeals. Oral argument before the court was scheduled for June 13, 1988.

Claimant recently learned of the existence of an April 1988 medical journal article describing a study which claimant submits has a direct bearing on the case presently pending before the court. Simultaneously with this motion, claimant is also seeking remand from the court pursuant to former ORS 656.298(6).

CONCLUSIONS

We have previously held that it is possible to withdraw an order for reconsideration after the filing of a petition for judicial review with the Court of Appeals. ORS 183.482(6); Dan W. Hedrick, 38 Van Natta 208, 209 (1986), aff'd mem 83 Or App 275 (1987). However, we exercise this authority rarely. Ronald D. Chaffee, 39 Van Natta 1135 (1987).

Inasmuch as nearly one year has passed since the issuance of the Board's order and because the issue raised by claimant's request is presently squarely before the court, we decline to withdraw our order for reconsideration. Consequently, claimant's request is denied.

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.

ROGER T. BROWN, Claimant
Douglas L. Minson, Claimant's Attorney
Daryll E. Klein, Defense Attorney
SAIF Corp Legal, Defense Attorney

Own Motion 87-0130M
July 5, 1988
Own Motion Order

Claimant initially requested that the Board exercise its own motion authority and reopen his claim for an alleged worsening of his February 8, 1980 industrial injury. The Board referred the own motion request to the Hearings Division for consolidation with WCB Case No. 87-03213. At issue before the Referee was which, if any, insurer is responsible for the treatment rendered on and after October 13, 1986. Referee Bethlahmy found SAIF Corporation, the insurer on the risk at the time of claimant's 1980 injury, to be responsible for claimant's condition and recommended to the Board that it exercise its own motion authority and reopen claimant's 1980 SAIF claim.

The Board concurs with the Referee's decision regarding responsibility for claimant's condition. Pursuant to ORS 656.278(1)(a), we may exercise our "Own Motion" authority when we find that there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. In such cases, we are authorized to award temporary disability compensation commencing from the time the worker is actually hospitalized or undergoes outpatient surgery. We find that claimant was hospitalized between October 15, 1987 and October 20, 1987 for medication, physical therapy and diagnostic testing. We conclude claimant has met the requirements in ORS 656.278 and is entitled to compensation for temporary total disability. Accordingly, claimant's claim is reopened with temporary total disability compensation to commence October 15, 1987 and to continue until claimant returns to his regular work at his regular wage or is medically stationary, whichever is earlier. Reimbursement from the Reopened Claims Reserve is authorized to the extent allowed under ORS 656.625 and OAR 436, Division 45. When appropriate, the claim shall be closed by the insurer pursuant to OAR 438-12-055. Claimant's attorney is awarded 25% of the additional compensation granted by this order, not to exceed $400 as a reasonable attorney's fee.

IT IS SO ORDERED.

ROGER T. BROWN, Claimant
Douglas L. Minson, Claimant's Attorney
Daryll E. Klein, Defense Attorney
SAIF Corp Legal, Defense Attorney

Own Motion 87-0130M
July 14, 1988
Amended Own Motion Order

The Board issued an Own Motion Order on July 5, 1988 whereby claimant's claim was reopened for the payment of temporary total disability compensation. The order erroneously commenced payment of benefits from October 15, 1987. The order should be corrected so that all references to the year 1987 in paragraph two actually read "1986". The remainder of the order is affirmed.

IT IS SO ORDERED.

JOAN M. CARRANZA, Claimant
Vick & Gutzler, Claimant's Attorneys
Randolph Harris (SAIF), Defense Attorney

WCB 87-12201
July 5, 1988
Order Denying Motion to Dismiss

The SAIF Corporation 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 on all parties. We deny the motion.

FINDINGS

The Referee's initial order issued February 24, 1988. On March 15, 1988, this order was abated to allow for the Referee's review of claimant's motion for reconsideration. On April 6, 1988, the Referee issued an Order on Reconsideration.

On April 15, 1988, claimant mailed, by certified mail, her request for Board review of the Referee's order. The request included a certificate of personal service by mail, indicating that copies of the request had been mailed to SAIF and its counsel. The employer, SAIF's insured, did not receive a copy of claimant's request for review.

On April 22, 1988, the Board mailed a computer-generated letter acknowledging the request. The acknowledgment was mailed to all parties to the proceeding before the Referee.

We find that the request for Board review was filed and that the parties received notice of the request within 30 days of the Referee's April 6, 1988 order.

CONCLUSIONS

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). 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. Argonaut Insurance Co. v. King, 63 Or App 847, 852 (1983).

"Party" means a claimant for compensation, the employer of the injured worker at the time of injury and the insurer, if any, of such employer. ORS 656.005(19). Attorneys are not included within the statutory definition of "party." Robert Casperson, 38 Van Natta 420, 421 (1986). Yet, 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, supra, page 850-51; Nollen v. SAIF, 23 Or App 420, 423 (1975), rev den (1976); Robert C. Jaques, 39 Van Natta 299 (1987). Furthermore, in the absence of prejudice to a party, timely service of a request for review on the employer's insurer is sufficient compliance with ORS 656.295(2) to vest jurisdiction in the Board. Nollen v. SAIF, supra.

Here, claimant timely filed a request for Board review of the Referee's order. See ORS 656.289(3). Although copies of her request were provided to SAIF and its counsel, she neglected to mail a copy of the request for review to the employer. However, no contention has been made that the employer has been prejudiced by not directly receiving a copy of claimant's request for review. Absent such a finding, we hold that timely service of the request for review on SAIF and its counsel is adequate compliance with ORS 656.295(2) to vest jurisdiction in the Board. See ORS 656.295(2); Argonaut Insurance Co. v. King, supra, page 850-51; Nollen v. SAIF, supra.

Moreover, since the Board's acknowledgment letter was mailed to all parties to the hearing within 16 days after the Referee's order, we conclude that it is more probable than not that the employer received actual notice of claimant's request for review within the statutory 30-day period. See John D. Francisco, 39 Van Natta 332 (1987); James L. Sampson, 37 Van Natta 1549, 1550 (1985).

Accordingly, SAIF's motion to dismiss is denied. SAIF's respondent's brief shall be due 14 days from the date of this order. Claimant's reply brief, if any, shall be due seven days after the date of mailing of SAIF's brief. Thereafter, this case will be docketed for review.

IT IS SO ORDERED.

JACK D. EASLEY, Claimant
Philip H. Garrow, Claimant's Attorney
Cummins, Cummins, et al., Defense Attorneys

WCB 87-08913
July 5, 1988
Interim Order Denying Motion to Offset and Remand

The insurer requested Board review of Referee Howell's March 16, 1988 Order on Reconsideration that granted claimant permanent total disability, whereas Determination Orders had awarded 20 percent (64 degrees) unscheduled permanent disability for a low back injury. Prior to our review of this case, the insurer has moved for authorization to offset permanent partial disability benefits paid pursuant to the Determination Orders against permanent total disability benefits granted by the Referee's order which are apparently payable during the same period. Alternatively, the insurer has asked that this matter be remanded to the Referee for consideration of the request for offset authorization. The motions are denied.

FINDINGS

Claimant requested a hearing concerning, among other issues, Determination Orders dated June 5, 1987 and June 16, 1987, which had awarded a total of 20 percent unscheduled permanent disability for a low back injury. Claimant contended that he was permanently and totally disabled.

The case proceeded to hearing on September 28, 1987. At the hearing, the insurer did not request permission to offset permanent partial disability benefits paid pursuant to the Determination Orders, in the event that claimant was granted permanent total disability benefits payable for the same period. Following the receipt of additional evidence and closing arguments, the record was closed on December 11, 1987.

On December 31, 1987, the Referee issued his order, which among other findings, concluded that claimant was permanently and totally disabled. The Referee further directed that claimant receive permanent total disability benefits effective June 5, 1987. Both parties requested reconsideration. Claimant asserted that the effective date for his permanent total disability benefits should be April 1, 1987. The insurer contended that claimant was not permanently and totally disabled as a result of his compensable injury. The insurer did not request permission to offset.

On January 29, 1988, the Referee abated his December 31, 1987 order. Thereafter, the parties filed their respective responses. In response to claimant's motion, the insurer asserted that, if the Referee chose to find claimant was entitled to permanent and total disability benefits, the benefits should commence as of the date of hearing. Once again, no request for permission to offset was included with the insurer's submission.

On March 16, 1988, the Referee issued an Order on Reconsideration, continuing to find claimant permanently and totally disabled. However, the effective date for the permanent total disability benefits was changed from June 5, 1987, as previously ordered, to April 1, 1987. On March 22, 1988, the insurer requested Board review of the Referee's order.

On April 7, 1988, for the first time, the insurer

requested permission to offset the permanent partial disability benefits paid pursuant to the Determination Orders against the permanent total disability benefits that were due in accordance with the Referee's order. In the event that the Board declined its motion, the insurer asked that the case be remanded to the Referee for consideration of the offset request.

CONCLUSIONS

The issue before us is not whether the insurer is entitled to an offset or who has the authority to authorize offsets. Rather, the issue is when an insurer must request authorization to obtain an offset for an alleged overpayment of workers' compensation benefits when the issues of extent of permanent disability arising out of the claim is before the litigation forum. We conclude that the insurer's request is untimely.

In Wilson v. SAIF, 48 Or App 993 (1980), the court concluded:

> " * * * A policy of requiring the carrier to raise a claim of offset as provided in ORS 656.268(3) will encourage the parties to litigate all of the issues at a single hearing, rather than creating new issues and a necessity for further hearings at a time after a final award of compensation has been determined. * * * " 48 Or App at 998.

In its order on reconsideration in Donald W. Wilkinson, 37 Van Natta 937 (1985), the Board, having increased claimant's award to one of permanent total disability in its first order, granted the insurer permission to offset. Although the insurer had not previously requested an offset, the Board concluded that the insurer's delay did not interfere with the orderly system of compensation. The Board reasoned that the insurer had no cause to ask for an offset after the Referee's order, because until the Board awarded permanent total disability, the effective date of that award was unknown.

The Board's reconsideration order in Wilkinson, as well as the court's determination in Wilson, adhere to the principle which requires the parties to raise all issues presenting a justiciable controversy before the Referee at the time of hearing. Here, the insurer's entitlement to an offset, or credit, resulting from permanent partial disability benefits paid under the Determination Order was such an issue. The insurer knew, or should have known, that the offset issue was properly before the Referee in the event claimant was granted permanent and total disability. Yet, the issue was neither raised at the outset of the hearing, before issuance of the Referee's initial order, nor while the Referee's order was abated for reconsideration. Instead, the insurer raised the offset issue only after it had requested Board review of the Referee's order.

In order to further the policy considerations set forth in Wilson and Wilkinson, we conclude the "raise or waive" rule is applicable to this case. See also Mavis v. SAIF, 45 Or App 1059 (1980). Inasmuch as we hold that the offset issue is not properly

before us, we decline to grant the insurer's requests for either offset authorization or remand.

IT IS SO ORDERED.

ROBERT GATES, Claimant
John C. O'Brien, Claimant's Attorney
SAIF Corp, Insurance Carrier

Own Motion 86-0197M
July 5, 1988
Own Motion Determination on Reconsideration

The Board issued an Own Motion Determination on December 18, 1987 whereby claimant's claim was closed with temporary total disability compensation terminating as of November 25, 1987. Claimant has submitted two new reports from Dr. Berselli to the Board for consideration of possible claim reopening. SAIF opposes the relief claimant seeks.

Dr. Berselli, on February 1, 1988, indicated that claimant was not medically stationary and temporary total disability compensation should continue. Claimant was, at that time, being tried in a flexion jacket body cast. On February 22, 1988, Dr. Berselli stated that claimant continues to be medically stationary, time loss was not authorized and the cast treatment was palliative in nature.

The evidence persuades us that claimant's condition remains medically stationary and the December 18, 1987 closure was proper. Pursuant to ORS 656.278(1)(a), we may exercise our "Own Motion" authority when we find that there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. Such is not the case here. We conclude claim reopening would be inappropriate on this record. The request for further own motion relief is denied.

IT IS SO ORDERED.

PETER M. GROCKI, Claimant
Bernardi & Spencer, Claimant's Attorneys
Davis & Bostwick, Defense Attorneys

WCB 87-12390
July 5, 1988
Order of Dismissal

On November 16, 1987, Referee Lipton issued an order dismissing claimant's hearing request without prejudice. The Referee issued the dismissal order based on claimant's attorney's representation that his hearing request had been prematurely filed and that he required additional time to determine what issues to pursue. Claimant's attorney further noted that the insurer's counsel had no objection to a dismissal without prejudice.

Contending that he subsequently came into possession of materials which ripened the issues in this matter, claimant filed an application to schedule another hearing. The application carried this same WCB Case Number. Yet, simultaneously with the filing of his application, claimant timely requested Board review of the Referee's dismissal order. Thus, jurisdiction to consider this case shifted from the Hearings Division to the Board.

Claimant has now filed another request for hearing. This recent hearing request, which has received WCB Case No. 88-06159, is currently scheduled for hearing on July 11, 1988 in Portland.

Inasmuch as the relief sought by claimant's request for Board review in this case has now been realized through the scheduling of his hearing request in WCB Case No. 88-06159, his request for review has been effectively withdrawn. Accordingly, the request for review is dismissed.

IT IS SO ORDERED.

ELSIE L. HOBKIRK, Claimant
Roberts, et al., Claimant's Attorneys
Rick Barber (SAIF), Defense Attorney

WCB 85-12353
July 5, 1988
Order on Reconsideration

Claimant requested reconsideration of our Order on Review dated November 10, 1987, which granted the insurer's request for authorization to offset permanent partial disability benefits previously paid pursuant to a Determination Order against permanent total disability benefits payable for the same period pursuant to a Referee's order. We abated our order to allow time for the SAIF Corporation to respond and for us to adequately consider the request. Having received SAIF's response, we are prepared to reconsider the matter.

The Referee's order provided that claimant was entitled to permanent total disability. The award resulted in concurrent payments of permanent partial and permanent total disability benefits. The Referee framed the issue at hearing as extent of claimant's permanent disability, including permanent total disability. SAIF did not raise the issue of its entitlement to an offset, or credit, for the previously paid permanent partial disability benefits against the potential award for permanent total disability benefits, which in fact came about after litigation. SAIF did not file a motion for reconsideration, after issuance of the Referee's order, raising the issue of its entitlement to an offset or credit. SAIF requested Board review and apparently began offsetting the benefits unilaterally. SAIF requested authorization for offset in its brief on Board review.

Claimant requested a hearing concerning SAIF's unilateral offset. The issue raised in that request and the subsequent Referee's order is not presently before us. The issue of whether SAIF is entitled to offset unilaterally the previously paid permanent partial disability benefits, including penalties and attorney fees based on alleged misconduct in making a unilateral offset, is presently before the Hearings Division in WCB Case No. 87-04327.

Initially, we granted SAIF's request. Citing Guy M. Shorb, 39 Van Natta 1038 (1987), we stated that SAIF was entitled to an offset of permanent partial disability benefits paid between the effective date of the permanent total disability award and the date of the Referee's order.

After further consideration we conclude that the issue before us is not whether SAIF is entitled to an offset or who has the authority to authorize offsets. Rather, the issue is when an insurer, in this case the SAIF Corporation, must request authorization to obtain an offset for an alleged overpayment of workers' compensation benefits when the issue of extent of permanent disability arising out of the claim is before the litigation forum.

In Wilson v. SAIF, 48 Or App 993 (1980), the court concluded:

> " * * * A policy of requiring the carrier to raise a claim of offset as provided in ORS 656.268(3) will encourage the parties to litigate all of the issues at a single hearing, rather than creating new issues and a necessity for further hearings at a time after a final award of compensation has been determined. * * * " 48 Or App at 998.

In its order on reconsideration in Donald W. Wilkinson, 37 Van Natta 937 (1985), the Board, having increased claimant's award to one of permanent total disability in its first order, allowed the insurer to offset. The Board reasoned that, although the insurer had not previously requested an offset, its delay did not interfere with the orderly system of compensation as the insurer had no reason to ask for an offset after the Referee's order, because the effective date of the award was unknown at that point.

The Board's order on reconsideration in Wilkinson, as well as the court's determination in Wilson, adhere to the principle requiring the parties to raise all issues presenting a justiciable controversy before the Referee at the time of hearing. SAIF's entitlement to an offset, or credit, resulting from permanent partial disability benefits paid under the Determination Order was such an issue in this case. SAIF knew, or should have known, the offset or credit issue was properly before the Referee in the event the Referee made claimant permanently and totally disabled. The issue was not raised before the Referee at the outset of the hearing, before issuance of the Opinion and Order, or, by motion for reconsideration, after issuance of the Opinion and Order. In order to further the policy considerations set forth in Wilson and Wilkinson, we conclude the raise or waive rule is applicable to this case. Mavis v. SAIF, 45 Or App 1059 (1980). The Board should not now decide the issue of SAIF's entitlement to an offset, or credit. SAIF waived the right to raise the issue at the Board review level.

Accordingly, our prior order is withdrawn. On reconsideration, the SAIF Corporation's request for an offset, or credit, is denied. Except for that portion of our November 10, 1987 order which concerned the offset issue, the remainder of our former order is republished and adhered to, effective this date.

RICHARD A. MOORE, Claimant
Charles D. Maier, Claimant's Attorney
Davis & Bostwick, Defense Attorneys

WCB 86-00561
July 5, 1988
Order on Remand

This matter is before the Board on remand from the Court of Appeals. EBI Companies v. Moore, 90 Or App 99 (1988). We have been instructed to "dismiss the proceeding."

In accordance with the court's mandate, the insurer's request for Board review and claimant's request for hearing are dismissed.

IT IS SO ORDERED.

DELORES PRESTON, Claimant
Starr & Vinson, Claimant's Attorneys
Cowling & Heysell, Defense Attorneys

Own Motion 88-0130M
July 5, 1988
Own Motion Order

The insurer has submitted to the Board claimant's claim for an alleged worsening of her September 26, 1979 industrial injury. Claimant's aggravation rights have expired. The insurer opposes reopening of this claim for the payment of temporary total disability compensation during claimant's participation in a pain center program as it contends claimant's condition has not worsened.

Pursuant to ORS 656.278(1)(a), we may exercise our "Own Motion" authority when we find that there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. In such cases, we are authorized to award temporary disability compensation commencing from the time the worker is actually hospitalized or undergoes outpatient surgery. We are persuaded that pain center treatment can qualify the worker for temporary total disability compensation under ORS 656.278. We also find that when the worker enters into a pain center program, she becomes less able to work and, in fact, unavailable for work during the time she is actually in the program. We conclude, therefore, claimant's claim should be reopened with temporary total disability to commence February 3, 1988 and to continue until claimant returns to her regular work at her regular wage or is medically stationary, whichever is earlier. Claimant's attorney is awarded 25% of the additional compensation granted by this order, not to exceed $350 as a reasonable attorney's fee. Reimbursement from the Reopened Claims Reserve is authorized to the extent allowed under ORS 656.625 and OAR 436, Division 45. When appropriate, the claim shall be closed by the insurer pursuant to OAR 438-12-055.

IT IS SO ORDERED.

JAMES M. SWANSON (Deceased), Claimant
Charles J. Merten, Claimant's Attorney
James E. Griffin, Assistant Attorney General

WCB TP-87026
July 5, 1988
Third Party Order of Dismissal

The SAIF Corporation, as paying agency, has petitioned the Board for an order distributing the proceeds of a third party settlement pursuant to ORS 656.593(3). Specifically, SAIF contends that its third party lien attaches to the settlement proceeds prior to their distribution by the probate court to the deceased worker's family, most of whom are not "beneficiaries" under the Workers' Compensation Law. See ORS 656.005(3).

Asserting that the Circuit Court of Umatilla County has recently addressed this very issue, claimant moves for dismissal of these proceedings. We grant claimant's motion.

FINDINGS

In February 1983, the deceased worker died as a result of electrocution on the job. The deceased was survived by his widow, Lyndalue Swanson, (hereafter claimant), his parents, an adult child, and a minor step-daughter. SAIF accepted the claim and paid benefits to claimant, as well as the deceased's

step-daughter until she reached the age of 18 years. See ORS 656.204(2). Claimant, as personal representative for the decedent's estate, commenced a civil action for wrongful death against a third party.

In October 1987, with SAIF's approval, claimant settled the third party action for $125,000. At the time of the settlement, all of the wrongful death beneficiaries contended that SAIF's lien applied only to that portion of the proceeds which might be subsequently distributed to claimant by the probate court. In approving the settlement, SAIF was aware of, but did not agree with, these contentions. Rather, SAIF contended that, after deducting for attorney fees and litigation costs, its lien attached to the settlement proceeds remaining prior to the probate court's ultimate distribution to the deceased worker's family.

Attorney fees for the third party action totalled $41,666.67, while litigation costs equalled $11,615.00. Consequently, the estate's share of the settlement totals $71,718.33. After reducing the settlement's remaining balance by the statutory one-third share under ORS 656.593(3) and 656.593(1)(b), the amount of the settlement which is arguably subject to SAIF's statutory lien equals $47,812.22.

SAIF's lien for its actual costs currently totals $49,730.12. This lien is composed of $591.20 in medical benefits and $49,138.92 in death benefits. Because these costs exceed its maximum distributive statutory share from the remaining balance of the settlement, SAIF does not assert a lien for future expenditures. These future costs would necessarily include SAIF's continuing obligation to provide monthly death benefits to claimant as the surviving spouse until she remarries, if ever. See ORS 656.204(2). The third party settlement would have no effect on SAIF's ongoing obligation to provide these monthly benefits.

On November 25, 1987, SAIF filed a petition with the Board, seeking resolution of this dispute concerning the just and proper distribution of proceeds from the third party settlement. See ORS 656.593(3). Claimant moved to dismiss SAIF's request, noting that a petition to apportion the proceeds from the settlement to the wrongful death benificiaries had been filed with the Circuit Court for Umatilla County, Oregon.

Thereafter, SAIF moved for its dismissal from the Circuit Court proceedings, contesting the court's jurisdiction over it, as well as its lien. The court denied SAIF's motion to dismiss and, on March 3, 1988, decreed that SAIF's lien would only attach to claimant's share of the proceeds.

CONCLUSIONS

Pursuant to ORS 656.578, if a worker receives a compensable injury due to the negligence or wrong of a third person, entitling the worker under ORS 656.154 to seek a remedy against such third person, such worker or, if death results from the injury, the other beneficiaries shall elect whether to recover damages from the third person. If the worker or the beneficiaries of the worker elect to recover damages from the third person, notice of such election shall be given to the paying agency. ORS 656.593(1). The paying agency has a lien against the cause of action, which lien shall be preferred to all claims except the cost of recovering damages from the third party. ORS 656.580(2).

If the worker or beneficiaries settle the third party claim with agency approval, 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); Estate of Troy Vance v. Williams, 84 Or App 616, 619-20 (1987). Any conflict as to what may be a "just and proper distribution" shall be resolved by the Board. ORS 656.593(3).

Here, as previously described, a conflict has arisen because the parties disagree as to what portion of the settlement SAIF's lien applies. Despite the Circuit Court's decree, SAIF asks that we proceed to adjudicate its lien. SAIF reasons that the Court of Appeals will eventually overturn the probate court's decree, thereby concluding that the Board has exclusive jurisdiction to resolve disputes concerning the distribution of proceeds from a third party recovery. In anticipation of the Court of Appeals' forthcoming decision, SAIF submits that it would be expedient for the Board to determine SAIF's share of the third party recovery at this time.

Pursuant to the aforementioned points and authorities, we are empowered to resolve third party disputes such as this. Furthermore, should the Court of Appeals subsequently hold that our jurisdiction is exclusive over such matters, SAIF's argument for, in effect, the issuance of an alternative finding has some appeal. Yet, the indisputable fact remains that SAIF is requesting that we consider the identical issue that has previously been addressed and resolved pursuant to the decree of the Umatilla County Circuit Court. Parenthetically, it would appear that, insofar as the substantive issue is concerned, the probate court has accurately anticipated the Court of Appeals' recent pronouncement on the subject. See Scarino v. SAIF, 91 Or App 350 (June 1, 1988).

Inasmuch as this matter has been directly determined by a court of this state, its decision is conclusive between the parties and we are obligated to honor it. See ORS 43.130(2). Accordingly, SAIF's petition is dismissed.

IT IS SO ORDERED.

MICHAEL WHITTAKER, Claimant
Roberts, et al., Claimant's Attorneys
SAIF Corp, Insurance Carrier

Own Motion 88-0163M
July 5, 1988
Own Motion Order

The Board issued an Own Motion Order on April 25, 1988 whereby claimant's request for own motion relief was denied on the premise that, even though surgery had been done, claimant had removed himself from the work force. Claimant has recently submitted an affidavit which indicates that he is, in fact, owner of Whittaker Automotive and performs work repairing cars on a daily basis. We conclude our earlier order should be reversed.

Pursuant to ORS 656.278, we are authorized to reopen claimant's claim from the date of surgery. Claimant's claim is hereby reopened with temporary total disability compensation to commence October 8, 1987 and to continue until claimant returns to his regular work at his regular wage or is medically stationary, whichever is earlier. Claimant's attorney is awarded 25% of the additional compensation granted by this order, not to exceed $350 as a reasonable attorney's fee. Reimbursement from the Reopened

Claims Reserve is authorized to the extent allowed under ORS 656.625 and OAR 436, Division 45. When appropriate, the claim shall be closed by the insurer pursuant to OAR 438-12-055.

IT IS SO ORDERED.

MELVA J. YEIGH, Claimant
Wilbur C. Smith, Claimant's Attorney
Bottini, et al., Defense Attorneys

WCB 88-03576
July 5, 1988
Order of Dismissal

Claimant has requested review of Referee Fink's order dated May 16, 1988. We have reviewed the request to determine whether we have jurisdiction to consider the matter. We conclude that we lack jurisdiction.

FINDINGS

Claimant's request for review of the Referee's May 16, 1988 order was mailed to the Board by certified mail on June 16, 1988. The request included a certificate of personal service by mail upon the self-insured employer and its claims administrator.

We find that the request for Board review was mailed more than 30 days after the date of the Referee's order.

CONCLUSIONS

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). 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. Argonaut Insurance Co. v. King, 63 Or App 847, 852 (1983).

Here, the 30th day after the Referee's May 16, 1988 order was June 15, 1988. Inasmuch as claimant's request for Board review was mailed by certified mail, it was "filed" on the date of mailing. See OAR 438-05-046(1)(a), (b). The date of mailing was June 16, 1988, 31 days after the date of the Referee's order. Consequently, we lack jurisdiction to review the Referee's order, which has become final by operation of law. See ORS 656.289(3); 656.295(2); Argonaut Insurance v. King, supra.

Claimant asks for relief from the 30-day statutory filing requirement, contending that she received inaccurate advice from her treating chiropractor. We sympathize with claimant's situation. Yet, we are not free to relax a jurisdictional requirement, particularly in view of Argonaut Insurance Co. v. King, supra. See 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.

BUDDY A. FLICKINGER, Claimant
Charles D. Maier, Claimant's Attorney
Davis & Bostwick, Defense Attorneys

WCB 86-18024
July 8, 1988
Order on Reconsideration

The insurer has requested reconsideration of our Order on Review dated June 10, 1988. Claimant requests reconsideration of the Board's June 10, 1988 order that declined to award an assessed fee for his attorney's services on Board review. The request is granted and the order is withdrawn for reconsideration.

The insurer contends that claimant's award of disability should be reduced because claimant's back condition prior to the instant compensable injury had not resolved.

We reject the insurers contention with regard to claimant's disability award. The issue is loss of earning capacity. The preponderance of the lay testimony and medical evidence establishes that claimant is precluded from performing and effectively competing for heavy labor and most medium work due to the instant compensable injury. The insurer has offered nothing in its motion for reconsideration to persuade us otherwise.

We now turn to the attorney fee issue. After review of the statement of services and attorney retainer agreement submitted by claimant's counsel and considering the factors set forth in OAR 438-15-010(6), we approve a reasonable assessed fee of $450.

Accordingly, our June 10, 1988 order is abated and withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our June 10, 1988 order in its entirety. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

JOSEPH R. HYNEMAN, Claimant
Pozzi, et al., Claimant's Attorneys
SAIF Corp, Insurance Carrier

Own Motion 86-0592M
July 14, 1988
Own Motion Determination on Reconsideration

The Board issued an Own Motion Determination on November 13, 1986 whereby claimant's claim was closed. Claimant was, however, granted an additional 30 days to submit evidence regarding his possible entitlement to further permanent partial disability. On December 23, 1986, claimant was granted 60 days more in which to present his evidence. Nothing further was forthcoming, prompting the Board to inquire as to the status of the case in September 1987. Medical reports were submitted by claimant to the Board in February 1988, at which time claimant advised the Board that more medical reports had been requested and would be submitted as soon as possible. On June 8, 1988, claimant advised the Board that his record was complete.

Claimant's claim was closed in November 1986, notwithstanding the fact that claimant wished to produce further evidence to support an increased permanent disability award. All own motion claims currently in a closed status and seeking further disability compensation must now be considered pursuant to the newly enacted own motion law. Pursuant to ORS 656.278(1)(a), we may exercise our "Own Motion" authority when we find that there is

a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. There is no provision in the new own motion law for granting further permanent disability benefits. Orville D. Shipman, 40 Van Natta 537 (June 8, 1988). The request for additional permanent disability compensation is hereby denied.

IT IS SO ORDERED.

MARIA KUNTAR, Claimant
Rolf Olson, Claimant's Attorney
Schwabe, et al., Defense Attorneys

Own Motion 88-0298M
July 14, 1988
Own Motion Order

The insurer has submitted to the Board claimant's claim for an alleged worsening of her August 4, 1981 industrial injury. Claimant's aggravation rights have expired. The insurer authorized the surgery performed on February 18, 1988, but opposes claim reopening for the payment of temporary total disability compensation as it contends claimant has removed herself from the work force.

Pursuant to ORS 656.278(1)(a), we may exercise our "Own Motion" authority when we find that there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. In such cases, we are authorized to award temporary disability compensation commencing from the time the worker is actually hospitalized or undergoes outpatient surgery.

As claimant underwent knee surgery on February 18, 1988, she could be entitled to compensation for temporary total disability compensation pursuant to ORS 656.278. However, the insurer has questioned claimant's entitlement to benefits as it contends she has removed herself from the work force. We find that claimant's claim was last reopened in 1984 for surgery. Claimant became medically stationary on September 9, 1984 and released to work with restrictions. Claimant did return to work, but terminated her employment in October 1984. The claim was closed in November 1984. Claimant was subsequently offered vocational assistance which she refused. The evidentiary record before the Board fails to establish facts sufficient to demonstrate claimant has been regularly employed as a member of the work force since claim closure in November 1984. We have to conclude claimant has removed herself from the work force and is, therefore, not entitled to compensation for temporary total disability while recovering from surgery. Cutright v. Weyerhaeuser Company, 299 Or 290 (1985), and Karr v. SAIF, 79 Or App 250 (1986). The request for own motion relief is hereby denied.

IT IS SO ORDERED.

LEONARD C. THOMPSON, Claimant
Murphy & Lawrence, Claimant's Attorneys
Industrial Indemnity, Insurance Carrier

Own Motion 87-0655M
July 14, 1988
Own Motion Order

Claimant has requested that the Board exercise its own motion authority and reopen his claim for an alleged worsening of his July 10, 1978 industrial injury. Claimant's aggravation rights have expired. The insurer objects to claim reopening for the payment of temporary total disability compensation.

The evidence indicates that claimant underwent surgery on October 20, 1987. The insurer understands that the surgery was paid for by Welfare. The insurer has objected to paying for the surgery based on several reasons, all directly related to ORS 656.245 and not, therefore, under our jurisdiction in ORS 656.278. We will make no finding in this order concerning the insurer's responsibility for the October 1987 surgery. Even if the surgery had been paid for by the insurer, the claimant would not be entitled to compensation for temporary total disability based on the fact that he has not been in the work force for at least the past 3-1/2 years. Cutright v. Weyerhaeuser Company, 299 Or 290 (1985), and Karr v. SAIF, 79 Or App 250 (1986). We conclude the request for own motion relief must be denied on that basis.

IT IS SO ORDERED.

FRANKLIN BROWN, Claimant
Galton, et al., Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB 86-08044
July 18, 1988
Order Denying Request

The insurer's counsel seeks Board authorization of a client-paid fee for services which culminated in the Board's March 2, 1988 Order on Review. The request is denied.

FINDINGS

On March 2, 1988, the Board reversed that portion of a Referee's order that had set aside the insurer's partial denial of claimant's current chiropractic treatment and affirmed that portion of the Referee's order that had increased claimant's unscheduled permanent disability award from 15 percent (48 degrees) to 25 percent (80 degrees). The Board's order did not address the issue of a client-paid fee.

On March 21, 1988, claimant appealed the Board's March 2, 1988 order to the Court of Appeals.

On April 20, 1988, the insurer's counsel sought authorization of a client-paid fee for services rendered on Board review. Included with the request was an executed retainer agreement and statement of services.

CONCLUSIONS

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. See International Paper Co. v. Wright, 80 Or App 444, 447 (1986).

Attorney fee awards are generally included within orders concerning the merits of the case. The Supreme Court does not dispute the efficiency of such a practice. See Greenslitt v. City of Lake Oswego, 305 Or 530, 534-35 & n. 3 (1988). Moreover, it has concluded that if the merits of the case are appealed, the attorney fees issue becomes part of the appeal. Id.

Yet, the determination of an attorney fee does not directly affect a worker's right to, or amount of, compensation

due. Farmers Ins. Group v. SAIF, 301 Or 612, 619 (1986). Thus, the Court has suggested that the attorney fee award need not accompany an order regarding the merits of the case. Greenslitt v. City of Lake Oswego, supra; Farmers Ins. Group v. SAIF, supra. The Court has further indicated that once a Referee's or Board's order on attorney fees becomes final, the appropriate forum for review of attorney fees is the circuit court pursuant to the unique provisions of ORS 656.388(2). Greenslitt v. City of Lake Oswego, supra; Farmers Ins. Group v. SAIF, supra, at page 619.

Here, our March 2, 1988 order did not address the issue of either the insurer's counsel's entitlement to, or the amount of, a client-paid fee. Consequently, based on the aforementioned authorities, we conclude that we have jurisdiction to consider the request for authorization of a client-paid fee.

Although we have jurisdiction to entertain the attorney fee issue, we must turn to the Board's rules to determine whether the request is properly before us. These rules were designed to enable the Referees and the Board to process orders regarding the merits of a case, as well as attorney fee requests, as efficiently as possible.

Pursuant to OAR 438-15-010(1), attorney fees shall be authorized only if an executed attorney retainer agreement has been filed. Furthermore, a client-paid fee shall not be authorized unless the attorney requesting authorization for payment of the fee files a statement of services. OAR 438-15-010(5). A statement of services for proceedings on Board review shall be filed within 15 days after the filing of the last brief to the Board. OAR 438-15-027(1)(d). These rules apply to all cases pending before the Board, effective January 1, 1988. OAR 438-05-010; 438-15-003.

The insurer's counsel has submitted an executed attorney retainer agreement and a statement of services. However, the request for authorization of a client-paid fee has been submitted some 50 days after the issuance of the Board's March 2, 1988 order. We recognize that administrative problems have arisen as parties become accustomed to the Board's rules and, particularly, the application of the rules to all pending cases. Yet, the difficulties occasioned by this adjustment should not prompt us to ignore the very rules which have been implemented.

Inasmuch as the request for a client-paid fee does not comply with the Board's rules concerning the authorization of such a fee and because jurisdiction to consider the merits of the case presently rests with the Court of Appeals, we decline to authorize the insurer's counsel's request. To the extent that our analysis conflicts with the reasoning expressed in Marian S. Dumas, 40 Van Natta 109 (1988), and John L. Rousseau, 40 Van Natta 115 (1988), that reasoning is expressly disavowed.

IT IS SO ORDERED.

PHILLIP CARPENTER, Claimant
Pozzi, et al., Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB 86-03489
July 18, 1988
Order Denying Request

The insurer's counsel seeks Board authorization of a client-paid fee for services rendered on review which culminated in our March 21, 1988 Order on Review. The request is denied.

FINDINGS

On March 21, 1988, the Board affirmed the Referee's order that: (1) increased claimant's unscheduled permanent disability award for a low back injury from 30 percent (96 degrees) to 40 percent (128 degrees); and (2) affirmed an award by Determination Order of 10 percent (15 degrees) scheduled permanent disability for the right leg. The Board's order did not address the issue of a client-paid fee. The March 21, 1988 order has not been appealed, abated, stayed, or republished.

On May 18, 1988, the insurer's counsel sought authorization of a client-paid fee for services rendered on Board review. Included with his request was an executed attorney retainer agreement and a statement of services.

CONCLUSIONS

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. See International Paper Co. v. Wright, 80 Or App 444, 447 (1986).

Attorney fee awards are generally included within orders concerning the merits of the case. The Supreme Court does not dispute the efficiency of such a practice. See Greenslitt v. City of Lake Oswego, 305 Or 530, 534-35 & n. 3 (1988). Moreover, it has concluded that if the merits of the case are appealed, the attorney fees issue becomes part of the appeal. Id.

Yet, the determination of an attorney fee does not directly affect a worker's right to, or amount of, compensation due. Farmers Ins. Group v. SAIF, 301 Or 612, 619 (1986). Thus, the Court has suggested that the attorney fee award need not accompany an order regarding the merits of the case. Greenslitt v. City of Lake Oswego, supra; Farmers Ins. Group v. SAIF, supra. The Court has further indicated that once a Referee's or Board's order on attorney fees becomes final, the appropriate forum for review of attorney fees is the circuit court pursuant to the unique provisions of ORS 656.388(2). Greenslitt v. City of Lake Oswego, supra; Farmers Ins. Group v. SAIF, supra, at page 619.

Here, our March 21, 1988 order did not address the issue of either the insurer's counsel's entitlement to, or the amount of, a client-paid fee. Consequently, based on the aforementioned authorities, we conclude that we have jurisdiction to consider the request for authorization of a client-paid fee.

Although we have jurisdiction to entertain the attorney fee issue, we must turn to the Board's rules to determine whether

the request is properly before us. These rules were designed to enable the Referees and the Board to process orders regarding the merits of a case, as well as attorney fee requests, as efficiently as possible.

Pursuant to OAR 438-15-010(1), attorney fees shall be authorized only if an executed attorney retainer agreement has been filed. Furthermore, a client-paid fee shall not be authorized unless the attorney requesting authorization for payment of the fee files a statement of services. OAR 438-15-010(5). A statement of services for proceedings on Board review shall be filed within 15 days after the filing of the last brief to the Board. OAR 438-15-027(1)(d). These rules apply to all cases pending before the Board, effective January 1, 1988. OAR 438-05-010; 438-15-003.

The insurer's counsel has submitted an executed attorney retainer agreement and a statement of services. However, the request for authorization of a client-paid fee has been submitted approximately two months after the issuance of the Board's March 21, 1988 order. We recognize that administrative problems have arisen as parties become accustomed to the Board's rules and, particularly, the application of the rules to all pending cases. Yet, the difficulties occasioned by this adjustment should not prompt us to ignore the very rules which have been implemented.

Inasmuch as the request for a client-paid fee does not comply with the Board's rules concerning the authorization of such a fee and because our order on the merits of the case has become final by operation of law, we decline to authorize the employer's counsel's request. To the extent that our analysis conflicts with the reasoning expressed in Marian S. Dumas, 40 Van Natta 109 (1988), and John L. Rousseau, 40 Van Natta 115 (1988), that reasoning is expressly disavowed.

IT IS SO ORDERED.

MERLE M. CHRISMAN, Claimant
Robert J. Thorbeck, Claimant's Attorney
Schwabe, et al., Defense Attorneys

WCB 86-10173
July 18, 1988
Order on Review

Reviewed by Board Members Ferris and Crider.

Claimant requests review of Referee Nichols' order that increased his unscheduled permanent disability award for a low back injury from 35 percent (112 degrees), as awarded by a Determination Order, to 40 percent (128 degrees). The sole issue is extent of permanent disability. We affirm.

FINDINGS OF FACT

Claimant, 48 years old on the date of hearing, was employed as a steelworker. He had been with the employer for approximately 20 years when he injured his low back in a lifting incident on August 7, 1984. He filed a claim which was accepted as a disabling injury.

Claimant initially treated with Dr. Crockett, chiropractor. When his condition failed to improve, a CT scan was performed which showed a moderate bulging annulus at the L4-5 level. A subsequent myelogram revealed multiple low grade degenerative events.

In October 1985, claimant began treating with Drs. Whitmire and Lommel, chiropractors. They diagnosed right L5 lateral nuclear protrusion with discogenic spondyloarthrosis, facet syndrome, lumbar spine sprain and strain and lumbar subluxation.

Claimant underwent two independent medical evaluations conducted by the BBV Medical Services. The second such evaluation was conducted in May 1986 by Dr. Stevens, orthopedic surgeon. Dr. Stevens diagnosed degenerative disc disease in the lumbosacral spine with a low back sprain/strain with probable right radiculitis. He reported that claimant should not lift over 20 pounds, should do no repetitive lifting, no repetitive bending or stooping and needed to work in a job where he could sit, stand or walk as necessary. He rated claimant's impairment as mild.

Dr. Lommel was provided with this report and indicated his concurrence.

Claimant was referred for vocational counseling. Claimant reported to his vocational counselor that he wished to return to work with his at-injury employer.

Claimant returned to a light-duty clerical job with the employer in October 1985. He initially worked only part-time. He gradually increased his hours until he was working approximately seven hours per day. He was laid off this job in January 1987 due to a business slow down.

A Determination Order issued on July 17, 1986, awarding claimant 35 percent unscheduled permanent disability.

Claimant is a high school graduate. Prior to working for the employer, he owned and operated two stereo stores. In addition, he worked as a lab analyst for two years and as a prison guard. He has also worked as a quality control inspector for two companies.

A vocational rehabilitation consultant, Mr. McNaught, testified on behalf of claimant.

Claimant suffers constant low back pain which is worse with activity. He has trouble sleeping. He cannot walk farther than about three blocks without experiencing increased pain. Nor can he drive long distances without experiencing increased symptoms. As of the date of hearing, claimant was receiving chiropractic treatments twice per week.

Claimant is limited to light or sedentary activities. His permanent impairment as a result of the August 1984 injury is in the mild range.

CONCLUSIONS OF LAW AND OPINION

On review, the parties do not dispute the underlying facts. Instead, the dispute centers around application of those facts to the relevant legal standards. In that regard, the criteria for rating the extent of claimant's unscheduled permanent disability is the permanent loss of earning capacity due to the compensable injury. ORS 656.214(5). To determine claimant's

permanent loss of earning capacity, we consider his physical impairment as reflected in the medical record, the testimony at 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, 296 Or 505, 510 (1984).

Claimant asserts that the testimony of his vocational rehabilitation consultant establishes that he is entitled to a permanent disability award of at least 50 percent. McNaught testified that whereas claimant previously was qualified for 37 percent of all job titles, now, as a result of his medical limitations, he is limited to 17 percent of all job titles. He calculated this as a 55 percent reduction in available job titles. He also noted that claimant's wage-at-injury was $12.40, and he opined that claimant would now be limited to entry level jobs paying between five and seven dollars per hour.

We have two objections to the approach advocated by claimant. First, the consultant's calculations essentially involve a computation of the general availability of work which the claimant could be expected to obtain and hold. This calculation corresponds to the labor market findings factor contained in the administrative rules. OAR 436-30-460. However, this is only one of several factors used as a guideline for calculating unscheduled disability under the statutes. See OAR 436-30-380. Claimant's approach ignores other relevant factors such as age, education, impairment and emotional and psychological findings.

However, we have an even more fundamental objection to claimant's approach. The approach is excessively mechanical. Just as the administrative rules are guidelines not to be mechanically applied, so too we decline to adopt the mechanical approach advanced by claimant. See Fraijo v. Bay News Co., 59 Or App 260 (1982).

Here, the medical experts are in agreement as to claimant's work-related physical impairment. That impairment is rated in the mild range. Claimant is precluded from his former employment as well as other medium or heavy employments. However, claimant's vocational counselor determined that claimant had many transferable skills. Given claimant's reasonably varied work experience, we agree. We are influenced, in part, by claimant's ability to adequately perform the clerical position with the employer.

After considering claimant's age, impairment, education, work experience and labor market potential, we conclude that the Referee's award of an additional 10 percent permanent disability adequately compensates claimant for his loss of earning capacity.

ORDER

The Referee's order dated May 19, 1987 is affirmed. The Board approves a client-paid fee not to exceed $90.

BILLIE J. CORDERY, Claimant
Dale D. Liberty, Sr., Claimant's Attorney
Roberts, et al., Defense Attorneys

WCB 87-03392 & 87-03393
July 18, 1988
Order on Review

Reviewed by Board Members Johnson and Crider.

Claimant requests review of Referee L. Smith's order that: (1) found that her compensable back injury claim had not been prematurely closed; (2) upheld the insurer's aggravation denial of her compensable back injury; and (3) upheld the insurer's "de facto" aggravation denial of her compensable left shoulder injury.

We reverse in part, modify in part, and affirm in part.

ISSUES

1. Whether claimant's compensable May 1984 back injury claim was prematurely closed.

2. Whether claimant sustained an aggravation of her compensable May 1984 back injury.

3. Whether claimant sustained an aggravation of her compensable January 1984 left shoulder injury.

FINDINGS OF FACT

The Board adopts the Referee's findings and makes the following additional findings.

On June 5, 1986, claimant was examined by the Orthopaedic Consultants. The Consultants, who had previously seen claimant on two occasions, opined that she was medically stationary. In conclusion, the Consultants recommended that claimant avoid lifting in excess of 25 pounds, as well as repetitive bending or lifting.

On July 8, 1986, claimant was examined by her treating physician, Dr. Hickerson. Hickerson noted continued pain in claimant's upper and lower back. The following day, Hickerson reported that his opinion concerning claimant's condition differed from that of the Consultants.

On July 23, 1986, claimant's back injury claim was closed by a Determination Order that awarded temporary total disability through June 5, 1986, and 15 percent unscheduled permanent disability.

Claimant was reexamined by Dr. Hickerson two days after the Determination Order issued. Hickerson noted that claimant's back pain continued.

On November 4, 1986, Dr. Hickerson reported that claimant's condition was worse and that she was unable to work.

The insurer denied an aggravation of claimant's May 1984 back injury by way of a written denial dated February 5, 1987.

Dr. Hickerson did not agree with the Consultants' conclusion that claimant was medically stationary.

Claimant's back condition was not medically stationary at the time of claim closure.

CONCLUSIONS OF LAW

Premature Claim Closure

Claims shall not be closed if a worker's condition has not become medically stationary. ORS 656.268(1). "Medically stationary" means that "no further material improvement would reasonably be expected from medical treatment, or the passage of time." ORS 656.005(17). In deciding whether or not a claim has been prematurely closed, the trier of fact may consider evidence that was not before the Evaluation Section at the time of closure. Scheuning v. J. R. Simplot & Company, 84 Or App 622, 625 (1987). The trier of fact may not, however, consider evidence of a subsequent change in the worker's condition. Alvarez V. GAB Business Services, 72 Or App 694 (1985).

The Referee concluded that claimant's compensable back injury was not prematurely closed. In so doing, he found that Dr. Hickerson did not disagree with the Consultant's opinion that claimant was medically stationary. We disagree.

After the Consultants had examined claimant in June 1986, the insurer sent a letter to Dr. Hickerson inquiring whether he agreed with the findings and recommendations contained in the Consultants' report. The letter requested Hickerson to respond by way of a "check-the-box" response. On July 15, 1986, Hickerson checked the box labeled: "I disagree." That same day, Hickerson reported:

> "I have a differing opinion from the orthopedic [sic] consultants regarding the condition of [claimant]. The low back pain is worse than in 1981 when the ten percent permanent partial impairment was assigned. There is significant upper back pain and left shoulder pain. Even with the lack of objective findings, the pain is definitely a limiting factor in potential employment."
>
> "I agree that lifting no more than 25 pounds and no repetive bending or lifting is acceptable[,] but I doubt that any work in the nurse aid [sic] field will meet those conditions."

Unlike the Referee, the only "agreement" we find between the Consultants and Hickerson is that claimant should limit her bending and lifting activities. We see nothing in Hickerson's opinion that would lead us to conclude that he did not disagree with the Consultants' opinion that claimant was medically stationary. To the contary, Hickerson unequivocally "disagreed" with their findings and recommendations.

Claimant was receiving regular treatment from Dr. Hickerson prior to the closure of her claim on July 23, 1986. Hickerson's chart notes show continued complaints of back pain and authorization for various prescription medications. In October 1987, Hickerson explained that claimant's medications were necessary for the treatment of her "severe back and cervical problem that has been on-going . . . ."

We are persuaded by Hickerson's opinion. He has treated

claimant on a regular basis since 1980. See Weiland v. SAIF, 64 Or App 810, 814 (1983). Unlike Hickerson, the Consultants have examined claimant on three isolated occasions. Hickerson did not believe that claimant was medically stationary on or before July 23, 1986.

Claimant has proven that her claim was prematurely closed by the Determination Order of July 23, 1986.

Aggravation of May 1984 Back Injury

We have found above that claimant's May 1984 back injury claim was prematurely closed. The effect of such a finding is to set aside the July 1986 Determination Order. Therefore, the issue of whether claimant sustained an aggravation of her May 1984 back injury is not ripe for review. Barbara J. Reeves, 39 Van Natta 742 (1987). We do not address that issue.

Aggravation of January 1984 Left Shoulder Injury

The Board affirms and adopts the the Referee's findings and conclusions with respect to whether claimant sustained an aggravation of her January 1984 left shoulder injury.

ORDER

The Referee's order dated December 28, 1987, is reversed in part, modified in part, and affirmed in part. That portion of the Referee's order that affirmed the July 23, 1986 Determination Order is reversed. The Determination Order is set aside as premature and the insurer is directed to pay claimant temporary disability benefits from June 6, 1986, until proper closure of his claim under ORS 656.268. Claimant's attorney is awarded an approved attorney fee equal to 25 percent of claimant's increased temporary disability compensation not to exceed $3,800. Such a fee shall be paid out of, and not in addition to, claimant's increased compensation. That portion of the Referee's order that upheld the insurer's February 5, 1987 aggravation denial is modified. The denial is set aside as a nullity, insofar as claimant's compensable May 1984 back injury claim remains open by virtue of this order. All remaining portions of the Referee's order are affirmed. The Board approves a client-paid fee not to exceed $1,197.50.

DWIGHT E. FILLMORE, Claimant
Max Rae, Claimant's Attorney
Schwabe, et al., Defense Attorneys

WCB 87-13806 & 87-16609
July 18, 1988
Order on Review

Reviewed by Board Members Johnson and Crider.

The self-insured employer requests review of those portions of Referee Seymour's order that: (1) set aside its denial of claimant's chiropractic treatments for his current back condition; and (2) awarded claimant an attorney fee of $2,000. In his brief, claimant contends that the Referee erred in upholding the employer's "de facto" denial of thermographic services and in excluding evidence as to the need for thermographic testing. We affirm in part and modify in part.

Issues

On review, the issues are: reasonableness and necessity of medical services; reimbursement for medical services; remand; and attorney fees.

Findings of Fact

Claimant, 36, was compensably injured on July 31, 1984, while employed as a tree faller. He suffered injuries to his back when he slipped and a log rolled against him.

Claimant received chiropractic care, and conservative treatment from a neurosurgeon. His claim was then closed by a September 19, 1985 Determination Order which awarded him 10 percent unscheduled disability.

On November 18, 1985, claimant's treating chiropractor, Dr. Wilson, requested permission to conduct a thermography test on claimant. On November 19, 1985, Dr. Wilson conducted that test. The employer denied permission for the test on December 11, 1985.

Claimant requested a hearing on the Determination Order which was held on July 10, 1986. The Referee awarded claimant an additional 10 percent disability for a total of 20 percent unscheduled permanent disability. The Opinion is final.

On July 29, 1986, claimant was examined by Dr. Tilden, chiropractor, who recommended that further chiropractic treatment was unnecessary.

On November 21, 1986, the employer issued a denial of chiropractic treatment which claimant was receiving from Dr. Wilson. The instant hearing was requested as a result of this denial.

Claimant was working during the time he was receiving chiropractic treatments but was unable to pay for the treatments himself and went without such treatments for three months after the denial issued. He began paying for and receiving treatments on an as-needed basis thereafter. Without the relief the treatments afforded he would have been completely unable to work.

Dr. Wilson believed the treatments to be palliative. Dr. Tilden believed the treatments were neither curative nor palliative but conceded that they made claimant "feel good."

The hearing which is at issue here was held on August 12, 1987. At the hearing claimant attempted to put on evidence regarding thermography and the need for thermographic services. Such evidence was excluded by the Referee on procedural grounds.

Conclusions of Law and Opinion

Dr. Tilden, an examining physician suggested, and the self-insured employer contends, that chiropractic treatment is not reasonable and necessary because it is "neither curative, enabling his condition to improve, nor palliative, preventing his condition from worsening." Dr. Tilden found no objective findings to substantiate claimant's subjective symptoms; found no objective measurable impairment or loss of function; and attributed any pain the claimant might experience to "psychological aberrations." Dr. Wilson, on the other hand, contended that treatment was necessary because it relieved claimant's pain, which worsened with activity. This in turn enabled claimant to continue his work activity. The Referee found Dr. Wilson's opinion more persuasive, and set aside the employer's denial of chiropractic treatments. We affirm.

The employer appears to argue for a definition of palliative treatment that requires the treatment to prevent claimant's condition from worsening. We decline to adopt this definition. Palliative treatment is treatment which affords relief but not cure. Such treatment is reasonable and necessary, and so compensable, when it reduces claimant's pain and enables him to work. West v. SAIF, 74 Or App 317 (1985); Jose Ybarra, 40 Van Natta 5 (1988).

Claimant was receiving treatment from Dr. Wilson until he received the denial letter from the employer. He went without treatment for three months, but began again when the pain became unbearable. Treatment on an as-needed basis eased his pain and he was able to continue working. We conclude that it was reasonable and necessary, and so affirm the Referee.

The Referee found that claimant was not barred by the doctrine of res judicata from seeking review of the employer's refusal to pay for a thermography test conducted in November 1985. However, he found that, because Dr. Wilson had not complied with the administrative rules, claimant was not entitled to payment for the test. We agree.

Claimant is barred from seeking reimbursement for the test because Dr. Wilson violated OAR 436-10-040(10). That rule states that "liquid crystal thermography is not reimbursable without prior authorization." Dr. Wilson requested permission to conduct the thermography test on November 18, 1985. He conducted the test one day later, on November 19, 1985. He did not give the employer a reasonable period of time to respond. Because he did not comply with the rule, reimbursement is unavailable. See Lavine v. SAIF, 79 Or App 511 (1986).

Because we affirm the Referee's ruling on the issue of reimbursement for the thermography, we necessarily affirm his evidentiary ruling. The request for remand to admit testimony on the need for thermography is denied.

Finally, the Referee awarded claimant an attorney fee of $2,000. The employer seeks reduction of this fee.

In determining a reasonable attorney fee, the Referee and the Board consider the factors set forth in OAR 438-15-010(6). Generally, results obtained in the form of medical services are considered to be rather modest. Clifford D. Howerton, 38 Van Natta 1425 (1986). In this case, the amount in dispute was $1,582. After considering the above-mentioned factors, we conclude that a reasonable fee at hearing concerning the chiropractic treatment denial issue was $1,000.

ORDER

The Referee's order dated September 22, 1987 is affirmed in part and modified in part. The attorney fee awarded claimant's attorney for services at hearing is reduced to $1,000. The order is otherwise affirmed. For services on Board review concerning the chiropractic treatment denial issue, claimant's attorney is awarded an assessed fee of $600, to be paid by the self-insured employer. The Board approves a client-paid fee not to exceed $800.

MANUEL GARCIA-MACIEL, Claimant
Pozzi, et al., Claimant's Attorneys
Raymond Smitke (SAIF), Defense Attorney
Schwabe, et al., Defense Attorneys

WCB 86-07831, 86-07830, 85-02588 & 85-02848
July 18, 1988
Order Denying Request

The self-insured employer's counsel seeks Board authorization of a client-paid fee for services rendered on review which culminated in our February 9, 1988 Order on Review. The request is denied.

FINDINGS

On February 9, 1988, the Board affirmed the Referee's order that: (1) upheld the employer's denials of claimant's aggravation claims for his low back condition; and (2) the SAIF Corporation's denials of claimant's "new injury" claims for the same condition. The Board's order did not address the issue of a client-paid fee. The February 9, 1988 order has not been appealed, abated, stayed, or republished.

On May 18, 1988, the employer's counsel sought authorization of a client-paid fee for services rendered on Board review. Included with his request was an executed attorney retainer agreement and a statement of services.

CONCLUSIONS

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. See International Paper Co. v. Wright, 80 Or App 444, 447 (1986).

Attorney fee awards are generally included within orders concerning the merits of the case. The Supreme Court does not dispute the efficiency of such a practice. See Greenslitt v. City of Lake Oswego, 305 Or 530, 534-35 & n. 3 (1988). Moreover, it has concluded that if the merits of the case are appealed, the attorney fees issue becomes part of the appeal. Id.

Yet, the determination of an attorney fee does not directly affect a worker's right to, or amount of, compensation due. Farmers Ins. Group v. SAIF, 301 Or 612, 619 (1986). Thus, the Court has suggested that the attorney fee award need not accompany an order regarding the merits of the case. Greenslitt v. City of Lake Oswego, supra; Farmers Ins. Group v. SAIF, supra. The Court has further indicated that once a Referee's or Board's order on attorney fees becomes final, the appropriate forum for review of attorney fees is the circuit court pursuant to the unique provisions of ORS 656.388(2). Greenslitt v. City of Lake Oswego, supra; Farmers Ins. Group v. SAIF, supra, at page 619.

Here, our February 9, 1988 order did not address the issue of either the employer's counsel's entitlement to, or the amount of, a client-paid fee. Consequently, based on the aforementioned authorities, we conclude that we have jurisdiction to consider the request for authorization of a client-paid fee.

Although we have jurisdiction to entertain the attorney fee issue, we must turn to the Board's rules to determine whether

the request is properly before us. These rules were designed to enable the Referees and the Board to process orders regarding the merits of a case, as well as attorney fee requests, as efficiently as possible.

Pursuant to OAR 438-15-010(1), attorney fees shall be authorized only if an executed attorney retainer agreement has been filed. Furthermore, a client-paid fee shall not be authorized unless the attorney requesting authorization for payment of the fee files a statement of services. OAR 438-15-010(5). A statement of services for proceedings on Board review shall be filed within 15 days after the filing of the last brief to the Board. OAR 438-15-027(1)(d). These rules apply to all cases pending before the Board, effective January 1, 1988. OAR 438-05-010; 438-15-003.

The employer's counsel has submitted an executed attorney retainer agreement and a statement of services. However, the request for authorization of a client-paid fee has been submitted some three months after the issuance of the Board's February 9, 1988 order. We recognize that administrative problems have arisen as parties become accustomed to the Board's rules and, particularly, the application of the rules to all pending cases. Yet, the difficulties occasioned by this adjustment should not prompt us to ignore those very rules which have been implemented.

Inasmuch as the request for a client-paid fee does not comply with the Board's rules concerning the authorization of such a fee and because our order on the merits of the case has become final by operation of law, we decline to authorize the employer's counsel's request. To the extent that our analysis conflicts with the reasoning expressed in Marian S. Dumas, 40 Van Natta 109 (1988), and John L. Rousseau, 40 Van Natta 115 (1988), that reasoning is expressly disavowed.

IT IS SO ORDERED.

DAVID E. GATES, Claimant
Roberts, et al., Defense Attorneys

WCB 86-14351
July 18, 1988
Order on Review

Reviewed by Board Members Johnson and Crider.

Claimant, pro se, requests review of Referee Foster's order that upheld the insurer's denial of medical services relating to his low back. On review, the issue is compensability of medical services. We affirm.

FINDINGS OF FACT

Claimant compensably injured his low back on November 18, 1974 while employed as a welder. The incident involved a twisting motion which caused immediate pain in claimant's mid-to-low back. He was taken to a hospital emergency room where his injury was diagnosed as an acute low back strain.

He subsequently began treating with Dr. Utterback, orthopedic surgeon. He treated with Dr. Utterback for the following six to seven years while experiencing continuing low back symptoms.

Claimant attempted to return to his employment as a welder several times. These attempts resulted in exacerbations which caused additional time loss. He last worked for the employer in June 1976.

A November 26, 1976 Determination Order awarded claimant 10 percent unscheduled low back disability. That award was increased to 20 percent by Stipulation.

Dr. Utterback subsequently noted that claimant would require conservative therapy on a prolonged basis.

Claimant underwent vocational rehabilitation in 1977 which included training as a salesperson. Upon completion of the training, he worked briefly as a delivery route salesman for a medical supplies company. The driving requirements of this job exacerbated his low back symptoms. However, he left this job for reasons unrelated to his medical condition. He then worked briefly as a tire salesman. The lifting requirements of this employment caused increased low back symptoms.

X-rays taken in May 1978 revealed mild degenerative changes of the lumbosacral spine.

Claimant was hospitalized for three days in March 1979 due to increased symptoms. He was treated with bedrest, traction, medication and physical therapy. Dr. Utterback reported that continuing obesity and lack of a good exercise program were the major cause of claimant's back pain.

In September 1981, claimant was self-employed as a painter and handyman. He injured his back on September 18, 1981 while lifting a paint can. In addition to low back pain, claimant reported hip and leg pain and headaches. Numerous prior reports had expressly noted a lack of radiating pain. Claimant began treating with Dr. Wright, chiropractor.

On October 12, 1981, the insurer issued a denial of benefits on the basis that claimant had suffered a new injury on September 18, 1981, and that claimant's aggravation rights had expired in August 1980. Claimant received this denial one week later. He did not request a hearing on the denial.

Claimant sought no medical treatment during 1982, 1983 and 1984, due at least in part to the fact that he could not afford such treatment. During this period he worked a variety of jobs including selling second-hand merchandise, handyman work, light-duty welding, babysitting and bartending.

Claimant moved to California and, in 1984, enrolled in a community college program. He earned money while in the program by working as a teacher's assistant. As such, he taught students how to operate heavy equipment. Operation of the equipment caused him to experience increased symptoms.

Claimant's wife owned a Christmas tree farm in California from which they earned an income.

On September 16, 1985, after awakening with an acute onset of low back pain, claimant began treating with Dr. Masula, a California chiropractor.

On March 11, 1987, the insurer issued a denial of claimant's "current need for treatment" on the following bases: (1) that it had denied further benefits on October 12, 1981; (2) that claimant's aggravation rights had expired; and (3) that any further treatment was unrelated to his November 18, 1974 injury.

On August 25, 1987, claimant underwent a post-hearing independent medical examination by Dr. Tuscher, osteopath. Claimant reported experiencing low back pain, tingling and weakness in both hands, shoulder pain, numbness in his right leg, and headaches.

CONCLUSIONS OF LAW AND OPINION

We first note our agreement with the Referee's conclusion that the insurer's unchallenged October 12, 1981 denial does not bar claimant, on the basis of res judicata, from raising the issue of the compensability of his current need for medical treatment. The res judicata effect of the denial is limited to medical services rendered on or before the date of the denial. The October 1981 denial has no collateral estoppel effect regarding the causal connection between the conditions currently being treated and the compensable injury. See Leonard A. Chambers, 40 Van Natta 117, 118 (1988).

The Referee nevertheless concluded that claimant had not proven that the condition currently being treated was, in fact, related to his compensable injury. We agree.

The question confronting us is whether claimant's 1974 low back strain is causally related to his current low back, leg, upper back and shoulder pain, and his headaches.

Claimant's California chiropractor, Dr. Masula, supports the existence of a causal connection between claimant's current condition and his 1974 injury. In July 1987, he opined that he would apportion at least half of claimant's residual low back disability to the 1974 injury. He further opined that claimant's degenerative condition and his 1985 California "reaggravation" were equally responsible for the other half of claimant's residual disability.

Dr. Tuscher, on the other hand, felt that the principal cause of claimant's current complaints was his underlying degenerative condition, which he rated as moderate to severe. He further opined that claimant's current condition was not "reasonably attributable" to his 1974 injury.

We find the opinions of both Dr. Masula and Dr. Tuscher lacking persuasiveness for several reasons. First, the opinions of both physicians suffer from the same infirmity -- neither physician examined claimant until more than 10 years after his compensable injury. In addition, both physicians' opinions are mostly conclusory. Furthermore, both physicians acknowledge having reviewed the relevant medical records, but neither physician explains in any detail how those records support his conclusions.

Dr. Masula had the advantage of treating claimant on a repetitive basis. We normally grant greater weight to the opinions of a physician who has treated an injured worker over an extended period of time. See Weiland v. SAIF, 64 Or App 810 (1983). However, this advantage is largely illusory where, as

here, the physician does not commence treatment until more than a decade after the compensable injury.

Dr. Masula's opinions are unpersuasive for another reason. Dr. Masula makes no reference to claimant's September 18, 1981 injury as documented by Dr. Wright's First Medical Report dated September 21, 1981. And yet, it was subsequent to this injury that headaches and radiating pain into the legs first appears in the medical records. Furthermore, Dr. Masula's reports do not indicate an awareness of claimant's multiple vocational activities. Medical opinions which are based on inaccurate information or incomplete histories are entitled to little persuasive weight. Moe v. Ceiling Systems, Inc., 44 Or App 429 (1980).

By comparison, Dr. Tuscher's August 26, 1987 report notes claimant's September 1981 injury, while also displaying a familiarity with claimant's multiple vocational activities. For these reasons, we find his opinions marginally more persuasive than those of Dr. Masula.

However, even if we found Dr. Tuscher's opinions as unpersuasive as those of Dr. Masula, we would nevertheless affirm the Referee's order. This results from the fact that claimant bears the burden of proving by a preponderance of the evidence that his industrial injury materially contributed to his need for medical treatment. Hutcheson v. Weyerhaeuser, 288 Or 51, 56 (1979). Because this case involves a complex medical question, expert medical analysis is required. See Kassahn v. Publishers Paper Co., 76 Or App 105 (1985). The only expert medical evidence supporting claimant's position is that of Dr. Masula. That evidence is not persuasive. Claimant has not sustained his burden of proof.

ORDER

The Referee's order dated January 5, 1988 is affirmed. Counsel for the insurer is awarded a client-paid fee not to exceed $960.

SANTOS GONZALES, Claimant
James L. Francesconi, Claimant's Attorney
Bottini, et al., Defense Attorneys

WCB 86-13314
July 18, 1988
Order on Review

Reviewed by Board Members Johnson and Crider.

The self-insured employer requests review of Referee McCullough's order that set aside its partial denial of claimant's medical services claim for chiropractic treatments related to her current back condition. We affirm.

ISSUES

On review, the issue is compensability of medical services.

FINDINGS OF FACT

Claimant compensably injured her right upper back on September 15, 1983, while employed as a tote checker. She used her left arm to adjust a scale to weigh produce, and her right arm

to write the weight in pencil on a ticket. The injury occurred when she accidentally struck her right upper back on the metal handle of the scale. She immediately sought treatment at the hospital emergency room. A contusion was diagnosed, with range of motion listed as "full," with abduction of the right arm at 90 degrees. Claimant was bandaged and given pain medication. She returned to work the next day. The pain decreased but has never completely resolved. Claimant has not suffered any subsequent injury to this area of her back.

Claimant's job with the employer was seasonal, and she was laid off in October, 1983. She held no interim job, and returned to work as a tote checker for the employer from July to October in 1984 and 1985. She did not seek any further medical treatment for her right upper back.

In January 1986, claimant began working for a second employer, polishing and deburring dental equipment. This job required her to hold her arms out in front of her. In April 1986 she sought treatment from Dr. Stellflug, chiropractor, for increased pain in her right upper back. She received treatment three times per week for six weeks, and then twice a month through the time of hearing.

Claimant was laid off by the second employer in July 1986. She returned to work for the first employer in August 1986, this time sorting vegetables on the conveyor belts. This required her to use rapid movements, holding both arms out in front of her. This assignment also caused her right upper back pain to increase. When she was later returned to her job as tote checker, her symptoms improved somewhat.

In September 1986 claimant quit working for the employer in order to take a year-round job as a retail cashier. In this job, claimant operates a cash register with her right arm and uses her left arm to reach and move purchases. This has not caused an increase in pain.

Dr. Stellflug reported that claimant's symptoms persisted from the time of injury in 1983. He therefore believes that claimant's injury never completely resolved and continues to be a material contributing factor of the condition for which he treated her. He further opined that, because her symptoms decreased when she returned to work as a tote checker, her flare-ups at the second employer and on the conveyor belt were symptomatic increases rather than manifestations of worsening.

In June 1986 claimant was examined by Dr. Peterson, a chiropractor. He diagnosed recurring strain to the right middle trapezius muscle and right rhomboid muscle, and attributed it to her work for the second employer, when she held her arms out in front of her. This, he opined, caused the muscles to strain to hold the scapula in place.

In April 1987 claimant was examined by Dr. Duncan, also a chiropractor. He reported that claimant's 1983 injury had resolved fully, and that current symptoms were from "overuse syndrome" due to recent work activities.

Claimant's 1983 injury is a material contributing factor of her current medical treatment.

CONCLUSIONS OF LAW AND OPINION

The Referee found claimant credible. He also found that claimant had established the compensability of her current medical treatment in connection with her 1983 injury. We affirm.

Claimant's right upper back has been symptomatic continuously since her injury. She has suffered no other injury to that area of her back. Following the hospital treatment claimant received on the day of her injury, she went for a considerable period of time without seeking medical treatment for her right upper back. However, a lengthy gap in treatment does not necessarily mean that the injury has resolved and that currently needed treatment is not compensable. Jordan v. SAIF, 86 Or App 29 (1987).

We agree with the Referee that Dr. Stellflug's opinion of causation is more persuasive than that of Dr. Peterson or Dr. Duncan. Both of them ignore claimant's history of continuing right upper back symptoms since 1983. Dr. Peterson's opinion that holding her arms out in front of her caused her recurrent strain fails to explain why the strain did not develop on the left side as well as the right. Likewise, Dr. Duncan's diagnosis of "overuse syndrome" does not account for an absence of symptoms on the left upper back. Dr. Stellflug, on the other hand, considered claimant's history of continuing symptoms, and their presence only on the right side, in concluding that her condition and need for medical treatment are compensably related to her 1983 injury. In this case, his opinion merits the greater weight of a treating physician. Weiland v. SAIF, 64 Or App 810 (1983).

ORDER

The Referee's order dated July 10, 1987 is affirmed. Claimant's attorney is awarded an assessed fee of $1,000, to be paid by the self-insured employer.

CLAUDE E. HARRIS, Claimant
Angelo Gomez, Claimant's Attorney
Roberts, et al., Defense Attorneys

WCB 87-16670
July 18, 1988
Second Order of Dismissal

Claimant requested reconsideration of our April 8, 1988 Dismissal Order, which dismissed his request for Board review for lack of jurisdiction. Specifically, we concluded that claimant's request was untimely and that notice of his request had not been timely provided to the other parties.

In support of his motion for reconsideration, claimant has submitted affidavits indicating that he timely mailed his request for review to the Board, as well as timely provided notice of his request to the insurer's counsel. In order to allow sufficient time to consider the request, we abated our order and granted the insurer an opportunity to respond to claimant's motion within 14 days. Inasmuch as the time for the insurer's response has elapsed without comment, we proceed with our reconsideration.

On reconsideration, we withdraw our April 8, 1988 order and replace it with the following order.

FINDINGS

The Referee's Order of Dismissal issued January 28, 1988. Claimant's February 29, 1988 request for review of the Referee's order was received by the Board on March 3, 1988. The request was neither mailed by registered nor certified mail. The envelope containing the request carried a postmark date of March 2, 1988 from a Portland, Oregon post office.

The request did not include an acknowledgment of service or a certificate of personal service by mail upon the parties at the hearing. However, claimant mailed a copy of his request for review to the insurer's counsel on February 29, 1988.

We find that the request for review was mailed to the Board more than 30 days after the date of the Referee's order.

CONCLUSIONS

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). 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. Argonaut Insurance Co. v. King, 63 Or App 847, 852 (1983).

If filing of a request for Board review of a Referee's order is accomplished by mailing, it shall be presumed that the request was mailed on the date shown on a receipt for registered or certified mail bearing the stamp of the United States Postal Service showing the date of mailing. OAR 438-05-046(1)(b). If the request is not mailed by registered or certified mail and the request is actually received by the Board after the date for filing, it shall be presumed that the mailing was untimely unless the filing party establishes that the mailing was timely. Id.

Here, the 30th day after the Referee's January 28, 1988 order was February 27, 1988, a Saturday. Thus, the last day to timely submit a request for Board review of the Referee's order and to provide notice of the request to the other parties was Monday, February 29, 1988. See ORS 174.120.

Claimant asserts that a copy of his request for review was timely provided to the insurer's counsel. In support of this assertion, he submits an affidavit stating that he deposited an envelope, which was addressed to the insurer's counsel and contained a copy of his request, in a United States Postal Service mailbox on February 29, 1988. This assertion is not disputed.

Under these circumstances, we conclude that claimant provided timely service of his request for Board review to the other parties. Argonaut Insurance v. King, supra, 63 Or App at 850-51; Nollen v. SAIF, 23 Or App 420, 423 (1975), rev den (1976); Robert C. Jaques, 39 Van Natta 299 (1987) (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(5) to vest jurisdiction in the Board).

Claimant further contends that his request for review was mailed to the Board on February 29, 1988. In support of this contention, he submits an affidavit from his girlfriend, Tina Wisely. Ms. Wisely states that she deposited the envelope, which was addressed to the Board and contained claimant's request for review, in a United States Postal Service mailbox located outside a Beaverton, Oregon post office on February 29, 1988. Yet, the envelope in which claimant's request for review was enclosed carries a March 2, 1988 postmark date from a Portland, Oregon post office.

Inasmuch as claimant's request for Board review of the Referee's January 28, 1988 order was neither mailed by registered nor certified mail and since the request was actually received by the Board on March 3, 1988, after the date for filing, it is presumed to be untimely until claimant establishes that the mailing was timely. See OAR 438-05-046(1)(b). After reviewing this record, including the submitted affidavits, we conclude that claimant has not established that his request for review was timely mailed to the Board. Rather, the preponderance of the evidence establishes that claimant's request for review was mailed to the Board on March 2, 1988, two days after the final day to timely mail a request for review.

Consequently, we lack jurisdiction to review the Referee's order, which has become final by operation of law. See ORS 656.289(3); 656.295(2); Argonaut Insurance v. King, supra.

We are mindful that claimant has requested review without benefit of legal representation. We further realize that an unrepresented party is not expected to be familiar with administrative and procedural requirements of the Workers' Compensation Law. Yet, we are not free to relax a jurisdictional requirement, particularly in view of Argonaut Insurance Co. v. King, supra. See 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.

HARRY N. HUNSLEY, Claimant
Michael B. Dye, Claimant's Attorney
Cowling & Heysell, Defense Attorneys

WCB 85-02203
July 18, 1988
Order Denying Request

The insurer's counsel seeks Board authorization of a client-paid fee for services rendered on review which culminated in our January 29, 1988 Order on Reconsideration. The request is denied.

FINDINGS

On October 12, 1987, we vacated a Referee's order and directed that this case be remanded for consideration of a contested vocational report. We abated this order on November 4, 1987.

On January 29, 1988, we issued an Order on Reconsideration, withdrawing our October 12, 1987 order, denying claimant's request for remand, and affirming the Referee's order. The January 29, 1988 order has not been appealed, abated, stayed, or republished.

None of the aforementioned orders addressed the issue of a client-paid fee.

On June 10, 1988, the insurer's counsel sought authorization of a client-paid fee for services rendered on Board review. No executed attorney retainer agreement or statement of service from the insurer's counsel is present in the record.

CONCLUSIONS

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. See International Paper Co. v. Wright, 80 Or App 444, 447 (1986).

Attorney fee awards are generally included within order concerning the merits of the case. The Supreme Court does not dispute the efficiency of such a practice. See Greenslitt v. City of Lake Oswego, 305 Or 530, 534-35 & n. 3 (1988). Moreover, it has concluded that if the merits of the case are appealed, the attorney fees issue becomes part of the appeal. Id.

Yet, the determination of an attorney fee does not directly affect a worker's right to, or amount of, compensation due. Farmers Ins. Group v. SAIF, 301 Or 612, 619 (1986). Thus, the Court has suggested that the attorney fee award need not accompany an order regarding the merits of the case. Greenslitt v. City of Lake Oswego, supra; Farmers Ins. Group v. SAIF, supra. The Court has further indicated that once a Referee's or Board's order on attorney fees becomes final, the appropriate forum for review of attorney fees is the circuit court pursuant to the unique provisions of ORS 656.388(2). Greenslitt v. City of Lake Oswego, supra; Farmers Ins. Group v. SAIF, supra, at page 619.

Here, none of our previous orders addressed the issue of either the insurer's counsel's entitlement to, or the amount of, a client-paid fee. Consequently, based on the aforementioned authorities, we conclude that we have jurisdiction to consider the request for authorization of a client-paid fee.

Although we have jurisdiction to entertain the attorney fee issue, we must turn to the Board's rules to determine whether the request is properly before us. These rules were designed to enable the Referees and the Board to process orders regarding the merits of a case, as well as attorney fee requests, as efficiently as possible.

Pursuant to OAR 438-15-010(1), attorney fees shall be authorized only if an executed attorney retainer agreement has been filed. Furthermore, a client-paid fee shall not be authorized unless the attorney requesting authorization for payment of the fee files a statement of services. OAR 438-15-010(5). A statement of services for proceedings on Board review shall be filed within 15 days after the filing of the last brief to the Board. OAR 438-15-027(1)(d). These rules apply to all cases pending before the Board, effective January 1, 1988. OAR 438-05-010; 438-15-003.

The present record contains neither an executed attorney

retainer agreement nor a statement of services from the insurer's counsel. Moreover, the request for authorization of a client-paid fee has been submitted some five months after the issuance of the Board's January 29, 1988 Order on Reconsideration. We recognize that administrative problems have arisen as parties become accustomed to the Board's rules and, particularly, the application of the rules to all pending cases. Yet, the difficulties occasioned by this adjustment should not prompt us to ignore the very rules which only recently have been implemented.

Inasmuch as the request for a client-paid fee does not comply with the Board's rules concerning the authorization of such a fee and because our order on the merits of the case has become final by operation of law, we decline to authorize the insurer's counsel's request. To the extent that our analysis conflicts with the reasoning expressed in Marian S. Dumas, 40 Van Natta 109 (1988), and John L. Rousseau, 40 Van Natta 115 (1988), that reasoning is expressly disavowed.

IT IS SO ORDERED.

ELMER JACOBS, Claimant
Glenn D. Ramirez, Claimant's Attorney
Schwabe, et al., Defense Attorneys

WCB 86-07590
July 18, 1988
Order Denying Request

The self-insured employer's counsel seeks Board authorization of a client-paid fee for services rendered on review which culminated in our February 22, 1988 Order on Review. The request is denied.

FINDINGS

On February 22, 1988, the Board affirmed the Referee's order that: (1) upheld the employer's denial of claimant's medical services and aggravation claim for a right shoulder and head condition; and (2) declined to assess penalties and attorney fees for an unreasonable denial. The Board's order did not address the issue of a client-paid fee. The February 22, 1988 order has not been appealed, abated, stayed, or republished.

On April 20, 1988, the employer's counsel sought authorization of a client-paid fee for services rendered on Board review. Included with his request was an executed attorney retainer agreement and a statement of services.

CONCLUSIONS

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. See International Paper Co. v. Wright, 80 Or App 444, 447 (1986).

Attorney fee awards are generally included within orders concerning the merits of the case. The Supreme Court does not dispute the efficiency of such a practice. See Greenslitt v. City of Lake Oswego, 305 Or 530, 534-35 & n. 3 (1988). Moreover, it has concluded that if the merits of the case are appealed, the attorney fees issue becomes part of the appeal. Id.

Yet, the determination of an attorney fee does not directly affect a worker's right to, or amount of, compensation due. Farmers Ins. Group v. SAIF, 301 Or 612, 619 (1986). Thus, the Court has suggested that the attorney fee award need not accompany an order regarding the merits of the case. Greenslitt v. City of Lake Oswego, supra; Farmers Ins. Group v. SAIF, supra. The Court has further indicated that once a Referee's or Board's order on attorney fees becomes final, the appropriate forum for review of attorney fees is the circuit court pursuant to the unique provisions of ORS 656.388(2). Greenslitt v. City of Lake Oswego, supra; Farmers Ins. Group v. SAIF, supra, at page 619.

Here, our February 22, 1988 order did not address the issue of either the employer's counsel's entitlement to, or the amount of, a client-paid fee. Consequently, based on the aforementioned authorities, we conclude that we have jurisdiction to consider the request for authorization of a client-paid fee.

Although we have jurisdiction to entertain the attorney fee issue, we must turn to the Board's rules to determine whether the request is properly before us. These rules were designed to enable the Referees and the Board to process orders regarding the merits of a case, as well as attorney fee requests, as efficiently as possible.

Pursuant to OAR 438-15-010(1), attorney fees shall be authorized only if an executed attorney retainer agreement has been filed. Furthermore, a client-paid fee shall not be authorized unless the attorney requesting authorization for payment of the fee files a statement of services. OAR 438-15-010(5). A statement of services for proceedings on Board review shall be filed within 15 days after the filing of the last brief to the Board. OAR 438-15-027(1)(d). These rules apply to all cases pending before the Board, effective January 1, 1988. OAR 438-05-010; 438-15-003.

The employer's counsel has submitted an executed attorney retainer agreement and a statement of services. However, the request for authorization of a client-paid fee has been submitted approximately two months after the issuance of the Board's February 22, 1988 order. We recognize that administrative problems have arisen as parties become accustomed to the Board's rules and, particularly, the application of the rules to all pending cases. Yet, the difficulties occasioned by this adjustment should not prompt us to ignore the very rules which only recently have been implemented.

Inasmuch as the request for a client-paid fee does not comply with the Board's rules concerning the authorization of such a fee and because our order on the merits of the case has become final by operation of law, we decline to authorize the employer's counsel's request. To the extent that our analysis conflicts with the reasoning expressed in Marian S. Dumas, 40 Van Natta 109 (1988), and John L. Rousseau, 40 Van Natta 115 (1988), that reasoning is expressly disavowed.

IT IS SO ORDERED.

PAUL JEWETT, Claimant
William A. Mansfield, Claimant's Attorney
Kimberley Wallan, Defense Attorney

WCB 86-15653
July 18, 1988
Order on Review

Reviewed by Board Members Ferris and Crider.

The insurer requests review of Referee Mongrain's order that set aside its denial of claimant's medical services claim for further diagnostic studies regarding his compensable low back condition. The issue on review is medical services.

The Board affirms the Referee's order.

FINDINGS OF FACT

We adopt the Referee's "Findings" and make the following additional findings.

In addition to continued low back, buttock and posterior thigh pain, claimant experiences frequent twitching and tingling in the legs, occasional radiating pain in the anterior thighs, posterior calves, heels, ankles and left lateral aspect of the feet, and occasional coldness, numbness and tingling in both feet and all toes. Claimant has demonstrated abnormal examination findings during his symptomatic flare-ups, including tenderness and restriction of motion with palpitation of the lumbar spine at L4 and L5, and pain with Ely's prone heel-to-buttock test, leg raising, foot dorsiflexion and Kemp's and Lasegue's maneuvers.

Dr. Colwell initially attributed claimant's symptoms to chronic lumbar strain/sprain, myofacial pain syndrome, and dyskinesia at the L4-L5 level of the lumbar spine. Other evaluating physicians diagnosed high muscle tension and autonomic reactivity, possibly related to hyperthyroidism, and overuse syndrome.

On October 6, 1986, Dr. Horniman, M.D., completed an independent medical report based on a file review and his prior examination of claimant in February 1984.

Drs. Horniman and Kho both rendered their independent medical opinions without benefit of Dr. Narus' examination findings and recommendations.

Claimant credibly testified regarding his symptomatic history.

CONCLUSIONS AND OPINION

On review, the insurer contends that Dr. Colwell's opinion does not support the Referee's decision that further diagnostic tests are reasonable and necessary. It also argues that the Referee improperly deferred to Dr. Narus as a "treating physician." Finally, it notes that the Referee's decision is inconsistent with the opinions from Drs. Horniman and Kho and the Orthopaedic Consultants. Dr. Horniman opined that claimant had totally recovered from his compensable injury and attributed his current symptoms to an unrelated overuse syndrome. As noted on Page 1 of the Referee's order, Dr. Kho and the Consultants opined that further diagnostic tests were not needed.

After de novo review of the record, we affirm the Referee's opinion as supplemented.

In order to prevail on his medical services claim, claimant must prove that the CT scan and myelogram procedures are reasonable and necessary medical care required for recovery from his compensable injury. ORS 656.245(1); West v. SAIF, 74 Or App 317, 320 (1985); McGarry v. SAIF, 24 Or App 883, 888 (1976). In determining whether a medical service is reasonable and necessary, we defer to the opinion of the treating physician unless there are persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810, 814 (1983); Ward Neihart, 38 Van Natta 1418 (1986); Nancy E. Cudaback, 38 Van Natta 423 (1986).

We disagree with the insurer's contention that treating physician Colwell's opinion does not support further diagnostic testing. Dr. Colwell recommended additional diagnostic studies in his August 1986 and October 1986 reports. The insurer's argument apparently is based on Dr. Colwell's subsequent November 1986 report in which he indicated that claimant's condition had become medically stationary. We note that there is no language in that report clearly indicating that he was changing his recommendation regarding further diagnostic studies. Furthermore, in his prior October 1986 report he stated that "at this juncture, while (claimant) may be medically stationary for the procedures which I have to offer him, I'm not certain he is completely recovered." (Emphasis added). This statement indicates that Dr. Colwell's subsequent medically stationary finding referred only to further improvement from conservative chiropractic care and had no bearing on the need for further diagnostic testing. Moreover, there is no evidence that claimant's condition improved between Dr. Colwell's October and November reports so that further testing would no longer be necessary. To the contrary, the latter report indicates that claimant's condition remained relatively stable during that period. In light of these facts, we conclude that Dr. Colwell did not intend to retract his earlier opinion in support of a CT scan and myelogram.

We turn to the underlying medical services issue. Like the Referee, we rely on the opinions of Drs. Narus and Colwell recommending additional diagnostic studies.

Claimant had the right to be examined by Dr. Colwell in the pursuit of treatment directed toward a resolution of her chronic pain problem. ORS 656.245(3). His recommendation is entitled to special consideration because he has had a much better opportunity to evaluate claimant's condition than the independent medical examiners who rendered contrary opinions. Weiland v. SAIF, 64 Or App 810, 814 (1983); Ward Neihart, 38 Van Natta 1418 (1986); Nancy E. Cudaback, 38 Van Natta 423 (1986). Furthermore, he explained that claimant's MRI studies, examination findings and continuing symptomatic flare-ups suggested the need for further testing.

Unlike Dr. Colwell, Dr. Narus is not claimant's treating physician, notwithstanding the Referee's characterization. See ORS 656.005(13); former OAR 436-10-005(1), (22) and 436-10-060(1), (3). However, he examined claimant on referral from treating physician Colwell, and his opinion is otherwise entitled to significant weight as an expert in diagnosing neurological abnormalities and disc injuries. See Kenneth J. Howell, 39 Van Natta 1064 (1986).

Furthermore, the contrary opinions of the independent medical examiners are not persuasive. These doctors each examined

claimant on only one occasion. See Weiland v. SAIF, supra; Hammons v. Perini, 43 Or App 299 (1979). Moreover, their opinions were not well-reasoned. See Somers v. SAIF, 77 Or App 259 (1986). Specifically, none of these opinions persuasively explain why claimant's MRI findings, low back pain and associated leg and foot symptoms were not sufficient indication of a possible disc problem to justify further diagnostic studies.

Moreover, Drs. Horniman and Kho based their opinons on an incomplete medical record. Id. Their reports made no mention of Dr. Narus' findings and recommendations, and the record does not otherwise indicate that they were aware of those findings and recommendations at the time they completed their reports. Accordingly, we are persuaded that they rendered their opinions without benefit of Dr. Narus's examination report and recommendations.

In light of the above factors, and the fact that there is no medical evidence that the risk involved in the recommended procedures outweighs the potential gain, we conclude that the CT scan and myelogram are reasonable and necessary medical services. Accordingly, we affirm the Referee's order.

Because claimant has prevailed over an insurer-initiated request for Board review, his attorney is statutorily entitled to a reasonable carrier-paid fee for services rendered on review. See ORS 656.382(2); OAR 438-15-005(2). However, the Board cannot authorize a carrier-paid fee for claimant's attorney without a statement of services. See OAR 438-15-005(5) and OAR 439-15-010(5). Because no statement of services has been received to date, a fee shall not be authorized.

ORDER

The Referee's order dated January 3, 1988 is affirmed. We approve a client-paid fee for the insurer's attorney for services on Board review, not to exceed $306.

SHARON E. KELLEY (nee VAN GORDER), Claimant
Roll, et al., Claimant's Attorneys
Bottini & Bottini, Defense Attorneys

WCB 86-01948, 86-13153 & 86-15802
July 18, 1988
Order on Review

Reviewed by Board Members Johnson and Crider.

Claimant requests review of those portions of Referee Fink's March 18, 1987 Opinion and Order which: (1) failed to award unscheduled permanent partial disability for a compensable hernia repair; (2) granted 32 degrees for 10 percent unscheduled permanent partial disability for injury to the low back; (3) affirmed denials of claimant's current psychological condition as related to either the hernia or the low back injury; and (4) dismissed a claim relating to temporary total disability for the low back claim as barred by a prior stipulation. We affirm.

ISSUES

1. Extent of unscheduled permanent partial disability relating to claimant's hernia repair.

2. Extent of unscheduled permanent partial disability for claimant's low back.

3. Compensability of claimant's psychological condition.

4. Rate of temporary disability compensation on claimant's low back claim.

FINDINGS OF FACT

We adopt as findings of fact those findings set forth on pages two and three of the referee's Opinion and Order.

OPINION AND CONCLUSIONS

Extent of Permanent Partial Disability Resulting From Hernia Repair

There is no medical evidence to substantiate an award of permanent partial disability resulting from the hernia surgery. The only evidence of permanent impairment is claimant's subjective complaints. Subjective complaints may be sufficient to establish an award of permanent partial disability. See Garbutt v. SAIF, 297 Or 148, 151 (1984). However, on review of the record, we agree with the Referee that claimant is not a credible witness, and we find her subjective complaints and testimony alone insufficient to establish such an award.

Extent of Permanent Partial Disability Resulting From Low Back Injury

Claimant raised as an issue on review, "Whether Claimant's low back permanent disability award should have been suspended." Claimant is apparently referring to the Determination Order's reduction of benefits from 25 percent to zero because of her failure to lose weight. Claimant mischaracterizes the September 12, 1986 Determination Order as a "suspension" of benefits rather than a reduction under ORS 656.325(4). The Referee found in claimant's favor on the question of whether or not her failure to lose weight was volitional, and concluded that her failure to lose weight was not grounds for reducing the permanent partial disability award. He then proceeded to review the evidence and awarded 32 degrees for 10 percent unscheduled permanent partial disability.

Claimant contends she is entitled to a greater award of unscheduled disability for injury to her low back. As noted by Dr. Parvaresh, the records regarding claimant's low back condition are not very revealing. Considering the dynamics of her longstanding psychological pattern, together with the absence of objective verification of impairment, we do not accept claimant's representations of her current limitations and agree with the Referee that an award of 10 percent unscheduled permanent partial disability fairly and accurately compensates her for the loss of earning capacity resulting from the 1985 low back injury.

Compensability of Psychological Condition

Claimant contends that the hernia and low back injuries are material contributing causes of her current psychological condition.

In order to establish a compensable relationship between the hernia or low back injury and her psychological condition, claimant must show that the injury was a material contributing cause of her psychological disability or need for medical services. See Jeld-Wen, Inc. v. Page, 73 Or App 136 (1985). We conclude that claimant has failed to carry her burden of proof.

Claimant has a long history of psychological difficulties, many dating back to childhood. The record shows that regular and aggressive treatment was begun at least by 1980. Claimant was hospitalized on several occasions for depression, substance abuse, and suicide attempts. In 1983, James L. Miller, MA, MHT, a counselor who worked with claimant for more than a year in the Providence Day Treatment Program, described deficits in claimant's personality structure, her mental capabilities, and her lifestyle and adjustment. Claimant created chaotic and self-defeating situations and then attempted to project the responsibility onto others or the situations, denying any responsibility for herself. Mr. Miller described crisis stories or fabrications which claimant consciously constructed in order to establish a tool for projection.

This behavior was confirmed by Daniel Voiss, M.D., who performed a psychiatric/psychological evaluation on February 6, 1984. After having claimant undergo extensive psychological testing, he felt that, in claimant, "...injury and pain become the vehicle through which care, interest, and concern may be realized." Although claimant had reported a low back injury in 1982, Dr. Voiss doubted the validity of the claim and felt that her whole sense of herself was that she was sick, injured, hurt, abused, and rejected. Like Mr. Miller, Dr. Voiss felt that claimant's descriptions of events to achieve this did not necessarily coincide with the reality of what actually transpired. The alleged low back injury, according to Dr. Voiss, actually arose out of claimant's lifelong psychological disability and provided a temporary adaptive solution to her inner turmoil and confusion. He felt that future accidents, illnesses, and injuries were an absolute certainty.

Dr. Voiss' prediction proved to be true. Claimant thereafter described several injuries and illnesses, many of which are not substantiated by the record. She did undergo a hernia surgery in 1985, and, within one month of returning to work, she reported another low back injury, the subject of this case.

On September 19, 1986, claimant, in a reported crisis situation, first saw Dr. Erkkila. On November 26, 1986, Dr. Erkkila described claimant's current episode of depression as being precipitated by anxiety over termination of workers' compensation benefits on closure of her claim. It is that opinion upon which claimant relies to substantiate her claim that the psychiatric condition is a compensable consequence of the 1985 low back injury.

Guy A. Parvaresh, M.D., performed a psychiatric interview and mental status examination on October 8, 1986. He opined that claimant's current psychological problems were of longstanding duration and were not at all related to her industrial injury of November, 1985.

We are more persuaded by the opinion of Dr. Parvaresh than by that of Dr. Erkkila. Dr. Erkkila, although identified as the treating psychiatrist at hearing, did not see claimant until September 19, 1986. In none of her reports did she indicate that she had reviewed claimant's extensive and revealing medical file. The abbreviated histories presented in her reports apparently came from claimant, whose psychiatric history would invalidate any of her reports. Neither did Dr. Erkkila indicate she had tested or reviewed any psychological testing of claimant.

Dr. Parvaresh, on the other hand, reviewed claimant's entire medical file dating back to 1982, examined claimant, and performed an MMPI. With this background, he formulated his opinion.

We conclude that claimant has not established the compensability of her psychiatric condition as materially caused or worsened by her compensable hernia or low back injuries.

Adjustment of Time Loss on Low Back Claim

The referee concluded that claimant was barred by principles of res judicata from raising the issue relating to time loss on the low back claim. Claimant has presented various arguments in her brief on review contesting that conclusion. We agree with the Referee.

On January 27, 1986, the insurer wrote to claimant explaining the recalculation of time loss benefits to reflect a 7-1/2-hour workday. On March 31, 1986, a stipulated settlement on the low back claim was approved by Referee St. Martin. The agreement provided that the February 17, 1986 request for hearing should be dismissed "with prejudice, as to all issues which were raised or could have been raised."

At the time of the stipulation, the time loss issue was ripe for litigation. It arose out of the same aggregate of operative facts as those involved in the issues specifically addressed in the stipulation. We agree with the Referee, therefore, that claimant is barred from raising the issue. See Carr v. Allied Plating Co., 81 Or App 306 (1986).

On the question of the overpayment on the hernia claim, we agree with the referee.

ORDER

The March 18, 1987 Opinion and Order is affirmed.

JAMES C. KILBURN, Claimant
Kulongoski, et al., Claimant's Attorneys
Daryll E. Klein, Defense Attorneys

WCB 87-07439
July 18, 1988
Order on Review

Reviewed by Board Members Johnson and Crider.

Claimant requests review of Referee Sam Galloway's order that affirmed a Determination Order that declined to award scheduled or unscheduled permanent disability for a head, neck, and low back injury.

ISSUE

Whether claimant is entitled to an award of permanent partial disability.

FINDINGS OF FACT

Claimant, a 35-year-old-used-car-sales manager, slipped and fell on November 4, 1986, injuring his head, neck, and low back.

Claimant received his GED in 1970. He attended insurance school and is licensed in life and health insurance. Previous work history includes ten years in the sale of automobiles. Claimant has held the position of salesman, assistant sales manager, finance manager and sales manager.

Since his injury, claimant has completed a course in real estate and is a licensed real estate broker. He is associated with Hoffman and Associates and has been engaging in the sale of residential real estate, as well as, health and life insurance.

Claimant sought medical attention for his condition from Dr. Olson, internist. Dr. Olson diagnosed acute cervical strain. X-rays were normal. Prescribed treatment included rest, muscle relaxants, and physical therapy. Following six physical therapy sessions, claimant was instructed to continue exercises at home.

Claimant was released and returned to regular work on November 19, 1986. He was terminated December 1, 1986 due to lack of performance in sales.

Dr. Olson conducted a follow up examination on December 1, 1986. Claimant was deemed medically stationary with no permanent impairment.

The claim was closed by Notice of Closure, December 17, 1986. No award for permanent disability was granted. On April 8, 1987 a Determination Order issued, affirming the Notice of Closure in all respects.

On August 28, 1987, Dr. Pasquesi, orthopedist, performed an independent medical examination. X-rays of the lumbar spine were normal. Subjectively, Dr. Pasquesi found claimant to have generalized myofascitis in the lumbosacral area with no measurable impairment.

Claimant experiences low back, right leg and buttock discomfort when walking on hard surfaces for more than one-half hour, which is relieved by sitting, lying down and taking Tylenol. Additionally, he experiences weekly headaches which too are relieved by Tylenol. However, the pain has not interfered with his ability to function. He has not sought medical treatment since December 1, 1986 when he was deemed medically stationary.

We find Claimant's compensable injury has not resulted in permanent impairment.

CONCLUSIONS

The extent of unscheduled permanent partial disability is measured by the permanent loss of earning capacity due to the compensable injury. Barrett v. D & H Drywall, 300 Or 325 (1985), clarified, 300 Or 553 (1986). Earning capacity is defined as the "ability to obtain and hold gainful employment in the broad range of general occupations." Surratt v. Gunderson Bros., 259 Or 65 (1971). It is claimant's burden to prove he has incurred a permanent loss of earning capacity as a result of his November 4, 1986 injury.

In rating the extent of claimant's unscheduled permanent partial disability, consideration is given to his physical impairment as reflected in the medical record and the testimony at hearing. Garbutt v. SAIF, 297 Or 148 (1984). Relevant social and vocational are considered in the totality of the circumstances. See OAR 436-30-380 et. seq. The rules are merely guidelines used

in the evaluation of the extent of permanent partial disability. They are not mechanically applied. Harwell v. Argonaut Insurance Co., 296 Or 505, 510 (1984); Howerton v. SAIF, 70 Or App 99 (1984); Fraijo v. Fred N. Bay News Co., 59 Or App 260 (1982).

A claimant's subjective testimony alone may be sufficient to sustain an award of permanent disability. Garbutt v. SAIF, supra. However, if the testimony is unpersuasive or insufficient, the Board is not bound by it, and may require expert medical opinion to resolve the issue. 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).

Following our de novo review of the medical and lay evidence, we are not persuaded that claimant has suffered permanent impairment as a result of his compensable injury. Such a finding is a condition precedent to an award of permanent disability. In reaching this conclusion, we find the medical evidence, which unamimously indicates claimant has experienced no permanent impairment, more persuasive than claimant's testimony concerning his pain and physical limitations.

Accordingly, we agree with the Referee's conclusion and find claimant is not entitled to an award of permanent disability.

ORDER

The Referee's order dated November 30, 1987 is affirmed. Counsel for the insurer is authorized to charge a client-paid fee of up to $312.

SAMUEL R. LOUDEN, Claimant
Roll, et al., Claimant's Attorneys
Davis & Bostwick, Defense Attorneys

WCB 87-06176
July 18, 1988
Order on Review

Reviewed by Board Members Ferris and Crider.

Claimant requests review of Referee Blevin's order that: (1) upheld the insurer's denial of claimant's aggravation claim for a bilateral carpal tunnel condition; (2) declined to award additional temporary disability; and (3) declined to assess penalties and related attorney fees for an alleged unreasonable failure to timely pay temporary disability benefits.

ISSUES

1. Aggravation of claimant's bilateral carpal tunnel condition.

2. Temporary disability compensation.

3. Penalties and attorney fees for untimely payment of interim compensation.

On review, we affirm.

FINDINGS OF FACT

Claimant, a 37-year-old oyster harvester, developed the gradual onset of bilateral wrist symptoms in 1983. These symptoms

included numbness and an inability to move his wrists. He filed a claim for bilateral carpal tunnel syndrome which was accepted by the insurer. He underwent surgery on the left wrist in December 1983, and he had surgery on the right wrist in March 1984.

The claim was closed by a May 10, 1985 Determination Order which awarded claimant 10 percent scheduled permanent partial disability for loss of use of each wrist. Pursuant to an April 14, 1986 Stipulation, claimant received an additional 10 percent permanent disability for each wrist. This April 14, 1986 Stipulation is the last award or arrangement of compensation.

Claimant began treating with Dr. Neumann, orthopedic surgeon, in August 1985. Dr. Neumann's August 9, 1985 chart notes reveal that claimant continued to experience bilateral wrist symptoms post-surgeries. Claimant reported persistent pain with numbness and tingling especially in the right hand with lesser similar symptoms in the left hand. Dr. Neumann prescribed wrist supports for each wrist.

Claimant was examined by Dr. Cherry, orthopedist, at the Veterans Administration Hospital on October 15, 1985. Dr. Cherry noted severe pain residual as a result of claimant's bilateral carpal tunnel syndrome. He reported that claimant was incapacitated.

Claimant sought no medical treatment from April 1986 until January 1987. During that time, he attempted to work manning water hoses while burning slash. He was unable to continue, however, due to his condition.

Claimant returned to Dr. Neumann in Janaury 1987 for "symptomatic supportive treatment." Dr. Neumann referred claimant for neurological testing. Dr. Troop, neurologist, performed a study which disclosed minor evidence of medial neuropathy bilaterally.

By letter dated March 1, 1987, Dr. Neumann reported that claimant had experienced a gradual worsening of his condition. In reaching this conclusion, he compared his current examination findings with the findings when he last saw claimant on September 6, 1985. He reported a more sensitive Phalen's and Tinel's sign.

Dr. Neumann then referred claimant to Dr. Martens, orthopedic surgeon, for a second opinion. Dr. Martens found claimant medically stationary and reported that there had been no change in the functional impairment of claimant's wrists since his claim was closed. By chart note dated April 2, 1987, Dr. Neumann concurred with Dr. Martens' report.

Dr. Neumann's March 1, 1987 letter to the insurer also noted that claimant was unemployable as a result of the severity of his symptoms. The insurer received this report on March 6, 1987. The insurer commenced payment of temporary disability compensation on March 13, 1987 covering the period from March 1, 1987 through March 14, 1987. By letter dated March 27, 1987, the insurer denied the claim for aggravation. Additional temporary disability compensation was paid through March 28, 1987. (Ex. 23)

During the summer of 1987, claimant attempted to work as a roofer and as a clam diver. He was unable to continue at either of these jobs due to his wrist symptoms.

As of the date of hearing, claimant continued to experience bilateral wrist pain and stiffness which increases with activity.

Based upon our de novo review, we find that claimant's bilateral carpal tunnel condition had not worsened, either temporarily or permanently, as of January 1987.

CONCLUSIONS OF LAW AND OPINION

Aggravation

In order to establish an aggravation claim, claimant must show "worsened conditions resulting from the original injury." ORS 656.273. To prove a worsening of his condition, claimant must establish that he is more disabled, meaning less able to work, than he was at the time of the last award or arrangement of compensation. Smith v. SAIF, 302 Or 396, 399 (1986). Increased symptoms alone are not compensable, unless the worker suffers pain or additional disability that reduces his ability to work, thereby resulting in a loss of earning capacity. Id. at 401.

On review, claimant argues that his own testimony and the opinions of Dr. Neumann establish that his condition has worsened since the last arrangement of compensation on April 14, 1986. The Referee found claimant's evidence unpersuasive. We agree.

Dr. Neumann initially opined in March 1987 that claimant's condition had worsened since he last examined him in September 1985. However, subsequent to his March 1987 report, Dr. Neumann concurred with Dr. Martens' report which indicated that claimant remained medically stationary and that his impairment had not changed since his claim was previously closed. Dr. Neumann's reports are inconsistent and, therefore, lack persuasiveness.

Turning to claimant's testimony, we note that persuasive testimony from a medical expert is not required to establish an aggravation claim. A worker's testimony alone may be sufficient to sustain his burden of proving an aggravation. Garbutt v. SAIF, 297 Or 148, 152 (1984). In this regard, claimant testified that his current condition had worsened since April 1985. He reported increased pain, decreased grip strength and reduced flexibility. We conclude, however, that claimant's testimony is not supported by the medical record.

Dr. Cherry submitted the report which is closest in time to the last arrangement of compensation in April 1986. Dr. Cherry noted that claimant had never been free of pain since surgery. He reported that claimant was not only unable to function at work, but he was also unable to do any type of activity around his house. He opined that claimant's condition had resulted in severe pain residual. Comparing Dr. Cherry's October 1985 report with claimant's testimony, we are not persuaded that, in January 1987, claimant suffered a level of pain beyond that he was experiencing at the time of his last arrangement of compensation.

In addition, Dr. Cherry reported claimant's grip strength as 60 pounds on the right and 30 pounds on the left. By contrast, Dr. Martens' March 25, 1987 report notes grip strength

on the right at 69 pounds and on the left at 73 pounds. We conclude that claimant's grip strength actually improved between late 1985 and early 1987.

Claimant further argues that the fact that Dr. Neumann released him from work for 60 days commencing in February 1987 supports his contention of a worsening of his condition. Claimant relies upon the Supreme Court's opinion in Gwynn v. SAIF, 304 Or 345, (1987) on remand 91 Or App 84 (1988), in support of his position. See also International Paper Co. v. Turner, 304 Or 354 (1987), on remand 91 Or App 91 (1988).

The issue before the Court in Gwynn was whether an award of permanent partial disability precludes an aggravation award for a "flare-up" of symptoms. 91 Or App at 86. Claimant had received an award of 20 percent unscheduled permanent partial disability for his back. He thereafter accepted employment from another employer which he believed would be within his physical limitations. However, approximately eight months later, he was forced to quit work due to a symptomatic exacerbation. He subsequently filed an aggravation claim. ORS 656.273. SAIF denied the claim. The Referee upheld the denial. On review, we affirmed the Referee's order, stating:

> "While a symptomatic worsening alone can represent a compensable claim under the proper facts,...it is generally not sufficient if the claimant has received an award of permanent partial disability that takes into account future symptomatic flare-ups."

We concluded that claimant's 20 percent award did, in fact, contemplate future symptomatic exacerbations. On judicial review, the Court of Appeals affirmed our decision.

On review of the Court of Appeals, the Supreme Court assumed, arguendo, that the prior award was predicated in part on the anticipation that there would be some short periods of time in which claimant's physical condition would worsen or symptoms would flare up, or wax, and then subside. 304 Or at 352. The Court then noted that if claimant's physical condition worsened or the symptoms of his injury produced a greater disability for more than the short time anticipated by the prior award, the law required additional compensation. 304 Or at 353.

The question thus confronting the Court was:

> "how to draw the line between the period of incapacity that will justify payment of compensation and that which constitutes a mere flareup that has been taken into consideration by the fixing of the existing award." Id.

As to this question, the Court concluded:

> "If the worker, as a result of worsening of the worker's condition from the original injury, becomes totally disabled for more than 14 consecutive days..., the worker is

at least entitled to compensation for temporary total disability...." Id. (Emphasis added).

The Court remanded to the Court of Appeals to determine whether "waxing and waning" was anticipated in arriving at the prior award. If so, then the Court was instructed to decide whether claimant was entitled to any additional compensation under the 14-day guideline.

On remand, the Court of Appeals interpreted the Supreme Court's decision as holding "that, as a matter of law, there is always a worsening when, as a result of a flare-up, a worker is totally disabled for 14 days or is hospitalized. 91 Or App at 86 (emphasis added).

Both the opinion of the Supreme Court in Gwynn and that of the Court of Appeals on remand presuppose a flare-up, or waxing, of either claimant's condition or symptoms resulting in a period of time loss. Similarly, in International Paper Co v. Turner, 304 Or at 358, the Court assumes that the period of time loss was caused by a "recurrence of symptoms."

Here, by contrast, the evidence establishes that there has been no "waxing," "flare-up," or "recurrence of symptoms." Instead, claimant continues to experience the same symptoms, albeit symptoms severe enough to keep him off work, that he suffered at the time of the last arrangement of compensation. Nor has claimant been forced off work anew as a result of those symptoms. Rather, he has remained incapacitated from work since at least the date of Dr. Cherry's examination in October 1985. We conclude that claimant was no more disabled in January 1987 than he was at the time of the last arrangement of compensation. Gwynn, supra, is inapposite given the facts of this case.

In sum, although claimant continued to experience significant bilateral wrist symptoms in early 1987, the record does not establish that his compensable condition had worsened since the last arrangement of compensation in April 1986. Claimant's claim for aggravation must fail.

Temporary Disability Benefits, Penalties, Attorney Fees

Pursuant to ORS 656.273(6), the insurer is required to pay the first installment of compensation no later than the 14th day after the employer has notice or knowledge of medically verified inability to work resulting from the worsened condition. Here, there is no evidence when the employer had such knowledge. However, the insurer had such notice on March 6, 1987. The insurer commenced payment of temporary compensation on March 13, 1987. In addition, the insurer paid compensation for the period until the claim was denied on March 27, 1987. We conclude that the insurer timely paid interim compensation. It follows that the claim for penalties and attorney fees must also fail.

ORDER

The Referee's order dated December 30, 1987 is affirmed. A client-paid fee not to exceed $391 is approved.

PHILLIP D. MATHENY, Claimant
Olson Law Firm, Claimant's Attorney
Gatti, et al., Attorneys
Davis & Bostwick, Defense Attorneys
John Motley (SAIF), Defense Attorney

WCB 87-13824, 87-15799 & 87-16038
July 18, 1988
Order on Review

Reviewed by Board Members Ferris and Crider.

Claimant requests review of that portion of Referee Daron's order which upheld Liberty Northwest Insurance Corporation's denial of his aggravation claim for a low back condition. On review, claimant contends that the aggravation claim was compensable. We agree and reverse.

FINDINGS OF FACT

Claimant compensably injured his back during a lifting incident on February 3, 1984, while employed by Liberty Northwest's insured. He experienced severe pain all along his spine. The initial diagnosis was a severe thoracic sprain with muscle spasms and costovertebral facet syndrome with positive rib sign. The diagnosis was later expanded to include an acute lumbar strain. Claimant was taken off work and treated conservatively by Dr. Kelley, a chiropractor.

In July 1984, claimant was released for light work. He worked for several months as an accounting clerk for a video rental store. He became medically stationary on May 21, 1985. The claim was closed by Determination Order on June 12, 1985 with 10 percent unscheduled permanent disability. Claimant continued to treat with Dr. Kelley for pain and discomfort in the low back and legs.

Claimant then began working as a filling station attendant, which required that he stand on concrete for several hours per day. The physical requirements of that job exceeded his vocational limitations. On several occasions, claimant saw Dr. Kelley with severe low back spasms and pain and discomfort radiating into the lower extremities. No longer medically stationary, claimant quit the attendant job in August 1985 and began treating with Dr. Kelley three times per week.

Claimant regained medically stationary status in December 1985. By Opinion and Order on April 8, 1986, Referee Foster increased claimant's unscheduled disability award from 10 percent to 20 percent. The Referee granted the award with the expectation that claimant's low back symptoms would flare up occasionally. The Referee's order was affirmed on Board review.

Beginning in December 1985, claimant worked for approximately a year as a filling station attendant. He continued to suffer some low back pain radiating into the legs. In early 1987, he worked in a mill for two months as a saw operator. That job involved prolonged standing, causing his back symptoms to flare up occasionally; however, he missed no time from work due to those symptoms.

In May 1987, claimant began working as a stake mill worker for the SAIF Corporation's insured. He continued to experience "toothache-like" low back pain with occasional flare-ups and treated with Dr. Kelley about once per week. On July 22, 1987, he sneezed at work and felt a severe "flash" of low back pain. He went to Dr. Kelley's office immediately with "severe midsacral pain;" however,

Kelley was in China at the time. Kelley's staff could not relieve the pain and claimant was unable to stand and walk despite several attempts. By telephone, Dr. Kelley instructed that claimant be transported to the hospital for out-patient care with muscle relaxants and anti-inflammatory medication. After hospital care, claimant underwent rehabilitation and rest at home. Dr. Kelley returned from China and saw claimant on July 31, 1987.

Claimant subsequently filed claims for the July 22 incident with SAIF and Liberty Northwest. SAIF denied compensability of the "new injury" claim, while Liberty Northwest denied the aggravation claim, citing contradictory information on the etiology of the low back condition.

Claimant has not returned to work since July 22, 1987, and, as of August 13, 1987, was still unable to return to gainful employment. At the time of hearing, he continued to suffer back pain and had difficulty sitting or standing for any length of time. He was also treating with Dr. Kelley and Dr. Malloy, a medical physician.

We find that claimant's low back condition had worsened since the April 8, 1986 Opinion and Order and that the 1984 injury was a material contributing cause of that worsening.

CONCLUSIONS AND OPINION

The Referee upheld both denials. In upholding Liberty Northwest's aggravation denial, the Referee found insufficient evidence of a causal relationship between the original 1984 injury and the low back condition which followed the sneezing incident. We disagree with the Referee's decision and, instead, find the aggravation claim compensable.

To establish a compensable aggravation, claimant must prove that: (1) his condition has worsened since his last award of compensation, so that he is more disabled, meaning less able to work; and (2) his compensable injury was a material contributing cause of his worsened condition. ORS 656.273(1); Grable v. Weyerhaeuser Company, 291 Or 387, 400-401 (1981); Smith v. SAIF, 302 Or 396, 399 (1986).

Worsened Condition

Increased symptoms, in and of themselves, do not establish a worsened condition unless they result in a greater loss of earning capacity than that anticipated by the prior award of compensation. Id. at 401. We assume, in the absence of an indication to the contrary, that all relevant evidence concerning anticipated symptomatic flare-ups which was before the Referee was considered in making the prior award. International Paper Co. v. Turner, 91 Or App 91, 93, (1988).

If the prior award contemplated some flare-ups, claimant must show that his current symptoms resulted in greater inability to work than anticipated by the last award. Gwynn v. SAIF, 304 Or 345, 352-53 (1987). Current symptoms producing more than 14 days of total disability or requiring in-patient hospitalization would constitute a flare-up greater than that anticipated by the prior award and would be a worsening as a matter of law. Gwynn v. SAIF, 304 Or 345, 353 (1987), on remand 91 Or App 84, 88, (1988).

Here, the last award of compensation was granted by Referee

Foster on April 8, 1986. At that time, the Referee considered medical evidence from Dr. Kelley that claimant continued to experience pain and muscle spasms along his low back with radiating symptoms in the left great toe. Dr. Kelley further reported that he was unable to stabilize claimant's back condition due to its "current chronicity." Kelley added that claimant had recently experienced an increase in pain with no known etiology. Based on the evidence before him, Referee Foster found that claimant had a "considerable amount of problems," including the loss of ability to do heavy work, and increased claimant's unscheduled award from 10 percent to 20 percent.

Given the medical evidence before Referee Foster, we find that the 20 percent unscheduled award was granted with the expectation that claimant's condition would flare up occasionally. However, after the sneezing incident on July 22, 1987, claimant's low back pain was so severe that he had extreme difficulty walking, even with crutches, and eventually required out-patient hospital care. Claimant was unable to work and, as of August 13, 1987, Dr. Kelley was still unsure when claimant would be able to return to gainful employment. Because claimant was totally disabled for more than 14 days, his low back condition had worsened as a matter of law. See Gwynn v. SAIF, supra.

Causal Relationship

Dr. Kelley opined that the 1984 injury was the "major contributing factor" in claimant's worsened condition. Kelley noted that the nature and location of the current symptoms were the same as those following the original injury. Kelley explained that the sneeze was simply the "final straw" for the spinal disc which had also been involved in the original injury. Given the absence of evidence to the contrary, we find that the compensable injury in 1984 was a material contributing cause of claimant's worsened low back condition. Consequently, we conclude that claimant's aggravation claim was compensable.

ORDER

The Referee's order dated December 23, 1987 is reversed in part and affirmed in part. That portion of the order which upheld Liberty Northwest's aggravation denial is reversed and the claim is remanded to Liberty Northwest for processing according to law. The remainder of the Referee's order is affirmed. Claimant's attorney is awarded an assessed fee of $1,000, to be paid by Liberty Northwest. The Board approves a client-paid fee not to exceed $1,232.50.

DOROTHY L. PACKARD, Claimant
Schouboe, Marvin, et al., Claimant's Attorneys
Scheminske & Lyons, Defense Attorneys

WCB 86-16200
July 18, 1988
Order on Review

Reviewed by Board Members Ferris and Crider.

The insurer requests review of Referee Davis' order that set aside its denial of claimant's occupational disease claim for a right shoulder, arm and hand condition. On review, the insurer challenges the Referee's admission of evidence not timely submitted by claimant prior to hearing.

The issues on review are evidence and compensability.

We affirm the Referee's order.

FINDINGS OF FACT

Claimant had no prior history of right shoulder, arm or hand problems when she began working in the employer's business office in January 1979. She initially did a great deal of handwriting and insurance form filing. Between six and twelve months after she began work, claimant began having pain in her right arm, hand and shoulder which she associated with her handwriting activities at work. Claimant sought treatment for her symptoms on three occasions in the spring of 1980. At that time, she was diagnosed with tendinitis and treated with pain medication. She substituted typing for much of her handwriting and her symptoms resolved.

Sometime around November 1984, claimant began spending half of her workday in the employer's medical records department where a major part of her time was spent in repetitive handwriting activities. She also did some computer data entry and lifted and carried heavy stacks of medical files. Claimant experienced an immediate recurrence of her right arm, hand and shoulder symptoms after she began her medical records assignment. Her symptoms were most significant during her handwriting activities, but she also had discomfort while performing computer data entry.

Claimant substituted typing for some of her handwritten work but was still required to do a significant amount of repetitive handwriting. Her symptoms persisted; and she sought treatment from Dr. Hamlin, M.D, in January 1985. X-rays ordered by Dr. Hamlin were normal, and he treated claimant with pain medication.

Claimant's pain worsened and became fairly constant when she began working full-time in the employer's medical records department in March 1985. Dr. Hamlin referred claimant to Dr. Schmidt, neurosurgeon, in May 1985. By that time, claimant was also experiencing numbness, tingling and weakness in her right hand, symptoms at night, and aching in her left hand when she used it for normally right-handed functions.

Dr. Schmidt's examination findings included a positive Phalen's maneuver with burning and sensory loss in the radial three fingers of both hands. He diagnosed bilateral carpal tunnel syndrome, right much greater than left, and referred claimant to Dr. Podemski, neurologist, for nerve conduction studies. These studies were completed in June 1985 and demonstrated no electrical evidence of carpal tunnel syndrome.

Claimant was evaluated by Dr. Button, hand surgeon, in April 1986. Examination findings included a positive Tinel's sign and positive wrist flexion tests on the right. Dr. Button diagnosed a right carpal tunnel syndrome and performed a surgical release on April 17, 1986. Claimant remained off work for five weeks following surgery and her condition improved. When she returned to work, her symptoms returned during her handwriting activities.

Claimant continued working, and by mid-October 1986 her symptoms had reached the point that she was no longer able to write. She left work at that time and filed a claim for chronic tendinitis. The insurer issued a denial of both carpal tunnel syndrome and tendinitis, and claimant requested a hearing.

Claimant began treating with Dr. Kiest, orthopedist, in June 1987. At that time, she was experiencing right arm and hand pain but no hypesthesia or paresthesia on examination. Dr. Kiest felt that claimant's carpal tunnel syndrome was only partially responsible for her condition and opined that she also suffered from chronic tendinitis. A subsequent report from Dr. Button indicates that he agreed with Dr. Kiest's additional diagnosis of tendinitis.

Claimant's symptoms improved after she quit working for the employer in October 1986. She has not worked since that time. At the time of hearing, she continued to favor her right hand. In particular, she had a loss of strength in that hand and used both hands to operate yard equipment, open jars and turn door knobs.

Claimant's attorney believed that the so-called "seven-day rule" for submission of additional hearing evidence was applicable to this case. Pursuant to that rule, he submitted a follow-up report from Dr. Kiest to the Referee and the insurer on November 18, 1987. At the November 23, 1987 hearing, the insurer objected to the admission of the report because it had been submitted after the normal ten-day deadline. The Referee determined that the confusion generated by changes in the Board's evidence rule was good cause for claimant's failure to submit Dr. Kiest's follow-up report within the normal ten-day deadline. The Referee then admitted the report into evidence after giving the insurer the opportunity to keep the record open in order to solicit a response to the report.

After de novo review of the record, we find that claimant credibly testified regarding the nature of her work activity and her right upper extremity symptoms.

We are also persuaded that claimant's symptoms are attributable to the combined effect of chronic tendinitis and carpal tunnel syndrome.

Finally, we find that claimant's off-work activities did not contribute to her right upper extremity condition.

CONCLUSIONS AND OPINION

Evidence

The insurer argues that the Referee erred in admitting Dr. Kiest's November 1987 report into evidence. We disagree.

The administrative rules governing admission of evidence at hearing are set forth in former OAR 438-07-005(3)(b) and (4). Prior to April 15, 1987, claimants were generally required to submit evidence at least ten days prior to hearing. However, under the so-called "seven-day rule" a party could include evidence not meeting the ten-day deadline so long as it was submitted by the party within seven days of receipt. Moreover, additional evidence not meeting either the ten-day deadline or the "seven-day rule" was admissable at the discretion of the Referee. In exercising this discretion, referees were required to consider factors of surprise and prejudice and determine whether good cause had been shown for the failure to file within the ten-day deadline.

A temporary administrative rule repealing the special "seven-day rule" became effective for a six-month period beginning April 15, 1987. This temporary rule otherwise mirrored the requirements discussed in the previous paragraph, except that Referees were no longer required to consider factors of surprise or prejudice in exercising their discretion to admit evidence not submitted within the ten-day deadline.

The original administrative rule became effective again after the sunsetting of the temporary rule on October 15, 1987. As a result, claimant's attorney believed that the special "seven-day rule" was applicable in this case. However, on November 16, 1987, the prior temporary administrative rule became effective again as a permanent rule. Therefore, the "seven-day rule" was not in effect when claimant's attorney submitted Dr. Kiest's followup report on November 18, 1987, or when the hearing was held on November 23, 1987.

We conclude that the Referee did not abuse his discretion in admitting Dr. Kiest's report. We note that the "seven-day rule" was in effect when claimant's attorney requested the report on November 5, 1987 and received it from Dr. Kiest on November 13, 1987. Furthermore, the Referee made the requisite finding of good cause before admitting the report into evidence. Specifically, he determined that the confusion generated by the change in the Board's evidence rule was good cause for claimant's failure to file the report within the ten-day deadline. Moreover, the report did not present new evidence but merely restated a prior opinion in different language. Finally, the insurer received the report a full seven days prior to hearing, and the Referee offered the insurer's attorney the opportunity to keep the record open to respond to the report. Under these circumstances, we conclude that the Referee did not abuse his discretion in admitting Dr. Kiest's November 1987 report.

Compensability

The insurer contends that the Referee erred in setting aside its denial of claimant's occupational disease claim for her right upper extremity condition. In particular, it argues that the Referee improperly relied on Dr. Kiest's opinion over that of Dr. Button.

After de novo review of the record, we affirm the Referee's order, but for different reasons.

To prevail on her claim, claimant must demonstrate that her work activities, when compared to nonwork activities, were the major contributing cause of the onset or worsening of her carpal tunnel syndrome and tendinitis. See former ORS 656.802(1)(a); Dethlefs v. Hyster Co., 295 Or 298, 310 (1983); Devereaux v. North Pacific Ins. Co., 74 Or App 388 (1985). If claimant's condition preexisted her employment, she must prove that her work activities were the major contributing cause of a worsening of her condition resulting in an increase in pain to the extent that it caused disability or required medical services. See Wheeler v. Boise Cascade Corp., 298 Or 452, 457 (1985); Devereaux v. North Pacific Ins. Co., supra; SAIF v. Gygi, 55 Or App 570 (1982). If claimant's condition did not preexist her employment, she must prove that her work activities were the major contributing cause of the onset of the condition itself. Devereaux, supra; SAIF v. Gygi, supra.

Claimant's right upper extremity condition has been variously diagnosed throughout the course of her medical treatment. We defer to the most recent diagnosis of carpal tunnel syndrome and chronic tendinitis made by Drs. Button and Kiest.

Claimant credibly testified that she had no prior history of right upper extremity symptoms. Furthermore, there is no other evidence, medical or otherwise, indicating that she suffered from carpal tunnel syndrome or tendinitis prior to her work for the employer. Accordingly, we find that claimant's condition did not preexist her employment exposure. As a result, she need only prove that her work activities were the major contributing cause of the onset of her condition. Id.

Although lay testimony is probative in this case, the causation issue is of sufficient medical complexity to require expert medical opinion. See Kassahn v. Publishers Paper Co., 76 Or App 105 (1985). Claimant's current treating physician, Dr. Kiest, opined that claimant "would not have had [her present] difficulty if she had not done continuous writing over an extended period of time." He further opined that claimant's work activities "were a major contributing cause of her present arm distress" and that "both the right hand tendinitis and carpal tunnel syndrome [were] work related and made worse by [claimant's] working conditions . . ." Claimant's treating surgeon, Dr. Button, agreed that claimant's work activities were an aggravating factor. However, he did not feel they were the major contributing cause of the development of that condition. He, instead, opined that claimant's condition was ideopathic in origin.

We conclude that claimant has satisfied her burden of proving that her work was the major contributing cause of the onset of her carpal tunnel syndrome and tendinitis.

In reaching this decision, we rely on the opinion of Dr. Kiest. We are not persuaded by the insurer's argument that his opinion is entitled to less weight than Dr. Button's because Kiest only recently began treating claimant and based his opinion on medical history rather than personal observation. There is nothing in the nature of claimant's treatment that would put either Dr. Button or Dr. Kiest in a better or worse position to render an opinion on the causation issue in this case. See Harris v. Farmer's Co-Op Creamery, 53 Or App 618 (1981); Hammons v. Perini Corporation, 43 Or App 299 (1979).

We, instead, give greater weight to the better-reasoned opinion based on the most complete evidence. See Somers v. SAIF, 77 Or App 259 (1986). Accordingly, we are not persuaded by Dr. Button's opinion that claimant's condition is ideopathic in origin. The only support he gives for that opinion is his statement that "carpal tunnel syndrome and tendinitis are not uncommon with normal aging." He makes no attempt to explain why those conditions were ideopathic in origin in this particular case. In addition, his discussion of claimant's work activities is cursory. Finally, the record does not otherwise indicate that Dr. Button was aware of claimant's repetitive handwriting activities. See Blakely v. SAIF, 89 Or App 653, (1988); Somers v. SAIF, supra.

In contrast, Dr. Kiest's opinion demonstrates that he had an accurate understanding of the nature of claimant's work

activities. Furthermore, his opinion is consistent with the record as a whole, including the absence of alternative off-work causes and claimant's credible testimony regarding the close correlation between her symptoms and work activities. We are aware that Dr. Kiest opined that claimant's work was a major contributing cause rather than the major contributing cause of claimant's condition. However, "magic words" are not a prerequisite where, as in this case, a physician's opinion generally supports a conclusion. See McClendon v. Nabisco Brands, Inc., 77 Or App 412 (1986); Duane B. Driver, 38 Van Natta 498 (1986).

For the reasons discussed above, we defer to Dr. Kiest's opinion and conclude that it is more likely than not that claimant's work activity was the major contributing cause of the onset of her carpal tunnel syndrome and tendinitis. See Int'l Paper Company v. Tollefson, 86 Or App 706 (1987). Accordingly, we affirm the Referee's order.

ORDER

The Referee's opinion dated December 23, 1987 is affirmed. Claimant's attorney is awarded an assessed fee of $1,600 for services on Board review. We approve a client-paid fee for the insurer's attorney for services on Board review, not to exceed $1,552.50.

STEPHEN A. ROGERS, Claimant
W.D. Bates, Jr., Claimant's Attorney
Luvaas, Cobb, et al., Defense Attorneys

WCB 87-10610
July 18, 1988
Order on Review

Reviewed by Board Members Johnson and Crider.

Claimant requests review of Referee Mirassou's order that upheld the insurer's denial of his aggravation claim for a back condition.

The Board affirms the order of the Referee as amended herein below.

ISSUE

Whether claimant sustained a compensable aggravation of his August 1984 injury.

FINDINGS OF FACT

The Board adopts the Referee's findings.

CONCLUSIONS OF LAW

In aggravation cases, a worker must prove: (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, 441 (1986); see Smith v. SAIF, 302 Or 396 (1987); ORS 656.273(1). If a worker's prior award of permanent disability contemplated future symptomatic flare-ups of his condition, then the trier of fact must determine whether the flare-up was greater than that contemplated. Gwynn v. SAIF, 304 Or 345, 353 (1987); see also Gwynn v. SAIF, 91 Or App 84, 88 (1988). In the absence of an indication to the contrary, the trier of fact must assume

that all relevant medical evidence concerning a worker's anticipated permanent disability was considered at the time of the last arrangement of compensation. Id. International Paper Company v. Turner, 91 Or App 91, 93 (1988). If, however, the prior award did not contemplate future symptomatic flare-ups of the worker's condition, then a flare-up that reduces the worker's ability to work establishes a worsening. Gwynn v. SAIF, supra, 91 Or App at 88.

The Referee found that although claimant's condition had worsened, he had not proven that his worsening was causally related to his compensable injury. Therefore, the Referee declined to find an aggravation and upheld the insurer's denial. While we agree with the result reached by the Referee, we do so for different reasons.

Here, claimant compensably injured his back in August 1984. His claim was eventually closed by a Determination Order that awarded 10 percent unscheduled permanent disability. Claimant appealed the Determination Order, but Referee Nichols declined to award additional permanent disability. Referee Nichols' Opinion and Order, which issued on October 15, 1986, was claimant's last arrangement of compensation. See Gettman v. SAIF, 289 Or 609, 614 (1980) (A worker's permanent disability is evaluated at the time of hearing).

In her order, Referee Nichols found, inter alia:

> "In August 1985, Dr. Tilchin stated that he had been seeing the claimant for occasional flare-ups of low back difficulty but felt that his care was basically palliative and that the claimant was medically stationary."
>
> "* * * * *
>
> "[Later, Tilchin] indicate[d] that the claimant would need continuing palliative care on as needed basis."

In light of Referee Nichols' references to Tilchin's reports, we conclude that she considered all the relevant medical evidence concerning the likelihood that claimant would experience future symptomatic flare-ups. We, therefore, turn to the question of whether claimant's alleged aggravation of March 1987 was a flare-up greater than that contemplated by the medical evidence before Referee Nichols. In Gwynn v. SAIF, supra, the Supreme Court provided, inter alia:

> "If the worker, as a result of worsening of the worker's condition from the original injury, becomes totally disabled for more than 14 consecutive days or becomes an inpatient at a hospital for treatment of that condition, the worker is at least entitled to compensation for temporary total disability. If inpatient treatment is required or a flareup exceeds such 14-day period, when the worker's medical condition becomes stationary, the worker's

degree of permanent disability must be fixed in one of the ways prescribed by the Worker's Compensation Law . . . ." 304 Or App at 353.

In the instant case, claimant was disabled from work for five days. See Mathis v. Modoc Lumber Company, 91 Or App 67 (1988) (Worker disabled from work for 13 days did not sustain a worsening greater than that anticipated at the time of his last arrangement of compensation). Accordingly, under the above analysis in Gwynn v. SAIF, we conclude that claimant did not experience a worsening sufficient to reopen his claim for an aggravation and to entitle him to either temporary or permanent disability benefits.

ORDER

The Referee's order is affirmed as amended. The Board approves a client-paid fee not to exceed $610.50.

RICHARD J. SCHREIBER, Claimant
Francis & Martin, Claimant's Attorneys
Moscato & Byerly, Defense Attorneys
Roberts, et al., Defense Attorneys

WCB 86-11559 & 84-06167
July 18, 1988
Order on Review

Reviewed by Board Members Ferris and Crider.

Claimant requests review of that portion of Referee Peterson's order which increased his unscheduled permanent disability award for a low back injury from 10 percent (32 degrees), as awarded by Determination Order, to 20 percent (64 degrees). No briefs were timely filed on review. The sole issue on review is extent of unscheduled disability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following supplementation. We find that claimant is capable of performing light work only. We rate the permanent disability due to the compensable injury as mild to mildly moderate.

CONCLUSIONS AND OPINION

We adopt the Referee's opinion and conclusions of law with the following supplementation. The criterion for rating unscheduled permanent disability is the permanent loss of earning capacity due to the compensable injury. ORS 656.214(5). In determining the loss of earning capacity, we consider medical and lay evidence of physical impairment resulting from the compensable injury and all of the relevant social and vocational factors set forth in former OAR 436-30-380 et seq. We apply these rules as guidelines, not as restrictive mechanical formulas. Harwell v. Argonaut Insurance Co., 296 Or 505, 510 (1984); Fraijo v. Fred N. Bay News Co., 59 Or App 260, 269 (1982).

Claimant's limited education, work experience, adaptability to less strenuous physical labor, and mild to mildly moderate permanent impairment impact his earning capacity. However, that impact is mitigated somewhat by his youthful age. After considering these aforementioned factors, we conclude that a 20 percent unscheduled permanent disability award adequately compensates claimant for his low back injury.

ORDER

The Referee's order dated January 7, 1988 is affirmed. The Board approves a client-paid fee not to exceed $645, to be paid to counsel for Fred S. James & Company. The Board also approves a client-paid fee not to exceed $184, to be paid to counsel for United Pacific Insurance Corporation.

JANE E. STANLEY, Claimant
Welch, Bruun, et al., Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB 86-11196
July 18, 1988
Order Denying Request

The self-insured employer's counsel seeks Board authorization of a client-paid fee for services rendered on review which culminated in our February 22, 1988 Order on Review. The request is denied.

FINDINGS

On February 22, 1988, the Board affirmed the Referee's order that affirmed an award by Determination Order of 25 percent (80 degrees) unscheduled permanent disability for a neck, left shoulder and left arm condition. The Board's order did not address the issue of a client-paid fee. The February 22, 1988 order has not been appealed, abated, stayed, or republished.

On May 18, 1988, the employer's counsel sought authorization of a client-paid fee for services rendered on Board review. Included with his request was an executed attorney retainer agreement and a statement of services.

CONCLUSIONS

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. See International Paper Co. v. Wright, 80 Or App 444, 447 (1986).

Attorney fee awards are generally included within orders concerning the merits of the case. The Supreme Court does not dispute the efficiency of such a practice. See Greenslitt v. City of Lake Oswego, 305 Or 530, 534-35 & n. 3 (1988). Moreover, it has concluded that if the merits of the case are appealed, the attorney fees issue becomes part of the appeal. Id.

Yet, the determination of an attorney fee does not directly affect a worker's right to, or amount of, compensation due. Farmers Ins. Group v. SAIF, 301 Or 612, 619 (1986). Thus, the Court has suggested that the attorney fee award need not accompany an order regarding the merits of the case. Greenslitt v. City of Lake Oswego, supra; Farmers Ins. Group v. SAIF, supra. The Court has further indicated that once a Referee's or Board's order on attorney fees becomes final, the appropriate forum for review of attorney fees is the circuit court pursuant to the unique provisions of ORS 656.388(2). Greenslitt v. City of Lake Oswego, supra; Farmers Ins. Group v. SAIF, supra, at page 619.

Here, our February 22, 1988 order did not address the issue of either the employer's counsel's entitlement to, or the

amount of, a client-paid fee. Consequently, based on the aforementioned authorities, we conclude that we have jurisdiction to consider the request for authorization of a client-paid fee.

Although we have jurisdiction to entertain the attorney fee issue, we must turn to the Board's rules to determine whether the request is properly before us. These rules were designed to enable the Referees and the Board to process orders regarding the merits of a case, as well as attorney fee requests, as efficiently as possible.

Pursuant to OAR 438-15-010(1), attorney fees shall be authorized only if an executed attorney retainer agreement has been filed. Furthermore, a client-paid fee shall not be authorized unless the attorney requesting authorization for payment of the fee files a statement of services. OAR 438-15-010(5). A statement of services for proceedings on Board review shall be filed within 15 days after the filing of the last brief to the Board. OAR 438-15-027(1)(d). These rules apply to all cases pending before the Board, effective January 1, 1988. OAR 438-05-010; 438-15-003.

The employer's counsel has submitted an executed attorney retainer agreement and a statement of services. However, the request for authorization of a client-paid fee has been submitted approximately three months after the issuance of the Board's February 22, 1988 order. We recognize that administrative problems have arisen as parties become accustomed to the Board's rules and, particularly, the application of the rules to all pending cases. Yet, the difficulties occasioned by this adjustment should not prompt us to ignore the very rules which only recently have been implemented.

Inasmuch as the request for a client-paid fee does not comply with the Board's rules concerning the authorization of such a fee and because our order on the merits of the case has become final by operation of law, we decline to authorize the employer's counsel's request. To the extent that our analysis conflicts with the reasoning expressed in Marian S. Dumas, 40 Van Natta 109 (1988), and John L. Rousseau, 40 Van Natta 115 (1988), that reasoning is expressly disavowed.

IT IS SO ORDERED.

WILLIAM H. STRINGFIELD, Claimant
Malagon & Moore, Claimant's Attorneys
H. Thomas Andersen (SAIF), Defense Attorney

WCB 87-01537
July 18, 1988
Order on Review

Reviewed by Board Members Ferris and Crider.

The SAIF Corporation requests review of those portions of Referee Baker's order which: (1) set aside its partial denial of claimant's claim for a psychological condition; (2) found that claimant's neck injury claim had been prematurely closed; and (3) assessed attorney fees against it totaling $3,100. Claimant cross-requests review of that portion of the order which upheld SAIF's partial denial of his claim for a cardiovascular condition, including myocardial infarction.

We reverse that portion of the Referee's order which found that the neck injury claim had been prematurely closed. We affirm the remainder of the order.

ISSUES

1. Compensability of psychological condition
2. Premature claim closure
3. Attorney fees
4. Compensability of cardiovascular condition

FINDINGS OF FACT

Claimant, a temporary construction superintendent, compensably injured his neck on November 3, 1985 when he fell 12 feet from a ladder onto a concrete floor. The diagnosis was a cervicothoracic strain. He received conservative treatment and returned to sedentary work until the job was completed in March 1986.

Claimant was declared medically stationary on August 13, 1986. The claim was closed by Determination Order on October 24, 1986 with awards of temporary total disability from March 16, 1986 through August 13, 1986 and 30 percent unscheduled permanent disability. We find that claimant was medically stationary on the date of closure.

Prior to this compensable injury, claimant had a history of psychological and cardiovascular difficulties. His prior work history was primarily in the lumber yard business. During the 1960's and 1970's, claimant started, operated, and eventually sold two lumber yards. The proceeds from both sales were substantial. Yet, in both instances, claimant lost virtually all of the proceeds in investment failures. By 1983, claimant lost his home through foreclosure, forcing him and his family to reside with friends.

From 1983 through 1984, claimant experienced extreme stress, anxiety and depression, due to business and financial pressures. He continued to suffer emotional stress until early 1985. Claimant also experienced chest pains in early 1983. Coronary angiography in March 1983 revealed mild coronary artery disease with 60 to 70 percent occlusion of the right posterior descending artery and an irregularity (i.e. slight narrowing) of the left anterior descending artery.

Claimant began working for the instant employer in February 1985 and sustained the compensable injury nine months later. Vocational assistance services began in September 1986. As part of his reemployment efforts, claimant attended a building trades convention in Seattle on November 8, 1986. His attendance was sponsored by his vocational assistance provider.

Claimant approached the convention with great anxiety, because he felt that he would be "begging" for a job from ex-competitors and acquaintances who had known him in better times. At breakfast on the first day of the convention, claimant began experiencing heart symptoms which later developed into severe chest pains. He was transported by ambulance to the hospital where the diagnosis was a myocardial infarction. He subsequently underwent open-heart bypass surgery. Prior to the infarction, claimant had seen two acquaintances at breakfast, but had not yet spoken to anyone.

On December 18, 1986, claimant saw Dr. Carter, a psychiatrist, for psychiatric evaluation. Carter diagnosed

"[p]sychological factors affecting physical condition," i.e., adjustment disorder with depression and anxiety and somatization of emotional distress superimposed upon probable spinal cord injury. Carter added that claimant was not medically stationary.

On January 21, 1987, SAIF denied the compensability of the cardiovascular and psychological conditions.

We find that the compensable injury materially contributed to claimant's psychological condition. However, we are unable to find that stress relating either to the compensable injury or subsequent vocational rehabilitation efforts was a material contributing cause of his cardiovascular condition.

CONCLUSIONS AND OPINION

Compensability of Psychological Condition

To establish compensability, claimant must prove by a preponderance of the evidence that the compensable injury materially contributed to his disability or need for treatment. See Hutcheson v. Weyerhaeuser, 288 Or 51, 56 (1979); Milburn v. Weyerhaeuser Company, 88 Or App 375, 378 (1987). The medical evidence was divided on this question.

Dr. Carter, the treating psychiatrist, identified the compensable injury as one of four major factors to have a "significant bearing" and "material role" in the psychological condition, for which treatment is indicated. A contrary opinion was offered by Dr. Klein, a psychiatrist who interviewed claimant once. Klein opined that claimant's psychological condition was not materially caused by the compensable injury and its sequelae. Klein characterized the compensable injury as a "minor stressor" compared to others, such as business reversals, financial problems, appearance in the community, inability to support the family, living with friends, taking gifts, and coronary problems.

We are most persuaded by Dr. Carter's opinion for three reasons. First, we tend to give greater weight to the conclusions of the treating physician, absent persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810, 814 (1983). We see no such reasons here. Second, the Referee found Dr. Klein not credible based on demeanor and the content of her testimony. We defer to the Referee's determination of credibility, when it is based on demeanor. Coastal Farm Supply v. Hultberg, 84 Or App 282, 285 (1987). Third, after reviewing Dr. Klein's reports and testimony, we are not persuaded by the foundation for her conclusions. For example, part of the foundation for Klein's conclusions was her finding that the compensable injury was "remote and minor" and did not prevent claimant from working. We do not agree with that assessment and, instead, found that claimant was able to perform sedentary work after the injury.

Relying on Dr. Carter's expert opinion, we find that the compensable injury materially contributed to claimant's psychological condition and resultant need for treatment. Consequently, we conclude that the psychological condition was compensable.

Premature Claim Closure

To determine whether a claim was prematurely closed, we determine whether claimant's condition was medically stationary on the date of closure, without considering subsequent changes in his condition. Scheuning v. J.R. Simplot & Company, 84 Or App 622, 625, rev den 303 Or 590 (1987). "Medically stationary" means that "no further material improvement would reasonably be expected from medical treatment, or the passage of time." ORS 656.005(17). In determining whether claimant was medically stationary on the date of closure, we may consider evidence that was before the Referee, though it was not available to the Evaluation Section at the time of closure. Scheuning, supra.

Here, it is undisputed that claimant was physically, medically stationary on October 24, 1986, the date of claim closure. The dispute concerns whether he was psychologically, medically stationary on the date of closure.

Claimant's psychological condition was not diagnosed until December 18, 1986, approximately nine weeks after the date of closure. At that time, Dr. Carter found him not medically stationary. However, neither Carter nor any other physician stated that claimant was not medically stationary on the date of closure.

On review, claimant contends that he was suffering the compensable, psychological condition on the date of closure, noting that, on October 27, 1986, Dr. Jacobson, the treating internist, informed claimant's vocational counselor that he "has been depressed for years, but not to the extent of seeking medical assistance." We are not persuaded. That report merely reflects a history of depression which preexisted, and was probably unrelated to, his compensable injury. Moreover, the report fails to prove that claimant was not medically stationary on the date of closure.

As further support for his contention, claimant cites Dr. Carter's March 31, 1987 report that claimant was experiencing "extreme apprehension, peer embarrassment and shame" prior to the Seattle convention, which occurred approximately two weeks after claim closure. However, that report did not suggest that claimant was experiencing a continuation of symptoms dating back to claim closure. Rather, it suggested that he suffered an acute episode of emotional distress precipitated by the prospect of attending the convention and "begging" for a job from ex-competitors and acquaintances. Claimant himself testified that it was "exceedingly tough" and "very, very stressful" for him to attend the convention. At most, that episode of emotional distress merely represented a post-closure change in claimant's condition. We do not consider such changes in our determination. See id.

In sum, there is no evidence that claimant was not psychologically, medically stationary on the date of claim closure. Indeed, there is no persuasive evidence that claimant was suffering from a work-related psychological condition on that date. Consequently, we find that claimant was medically stationary on the date of closure and conclude that the claim was properly closed.

Attorney Fees

The Referee assessed attorney fees against SAIF totalling $3,100, granting claimant's attorney $2,500 for prevailing on the denied claim for the psychological condition, $400 for prevailing on a denied claim for medical services, and $200 as a penalty-related fee for SAIF's unreasonable denial of the medical services claim. We find the attorney fees to be reasonable.

We consider several factors in determining the reasonableness of attorney fees. Prior to January 1, 1988, those factors were limited to those listed in Barbara A. Wheeler, 37 Van Natta 122, 123 (1985). We then adopted those factors with some supplementation in OAR 438-15-010(6), effective January 1, 1988. After reviewing the record in light of the factors in Wheeler and OAR 438-15-010(6), we conclude that the attorney fees assessed against SAIF were reasonable.

Compensability of Cardiovascular Condition

At the outset, we note the absence of contemporaneous medical evidence diagnosing the cardiovascular condition which claimant suffered at the Seattle convention. No medical records from Seattle were offered into evidence. Indeed, the only diagnostic evidence in the record is claimant's own testimony regarding what he was told of his condition by the doctors. Based on that testimony, we find that claimant sustained a myocardial infarction at the Seattle convention, which resulted in disability and the need for treatment.

Claimant apparently advanced two alternative theories in support of the compensability of his cardiovascular problems. First, he contended that the stress he was experiencing as a sequela of his compensable injury and disability materially contributed to his cardiovascular condition, resulting in disability and the need for treatment. See Hutcheson v. Weyerhaeuser, supra; Milburn v. Weyerhaeuser Company, supra.

Second, claimant contended that stress precipitated by his attendance at the convention materially contributed to his cardiovascular condition. This theory is based on the principle that injuries sustained during activities which are a "direct and natural consequence" of the original industrial injury are injuries arising out of and in the course of employment, and are therefore compensable. See Wood v. SAIF, 30 Or App 1103, 1108-09 (1977), rev den 282 Or 189 (1978). The courts have recognized that an injury sustained while engaged in vocational rehabilitation from a compensable injury is a compensable consequence of that injury. Fenton v. SAIF, 87 Or App 78, 81 (1987); Wood v. SAIF, supra, 30 Or App at 1109-10. Here, claimant's attendance at the convention was sponsored by his vocational assistance provider, bringing that activity within the scope of vocational rehabilitation.

Under either theory, the dispositive question is whether stress materially contributed to claimant's cardiovascular problems. Resolution of this complex medical question largely turns on expert medical evidence. Uris v. Compensation Department, 247 Or 420, 426 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985).

In support of compensability, claimant offered opinions from Dr. Carter, a psychiatrist and physician, and Dr. Romm, a consulting cardiologist. Carter opined that stress constituted a "major and material factor" in the precipitation of the myocardial infarction and the need for surgery. Carter indicated that the American Heart Association lists stress as one of the factors in the development of myocardial infarction. Dr. Romm opined that stress was a "significant contributing factor" in the development of the infarction.

A contrary opinion was offered by Dr. Kloster, a cardiologist and professor of medicine at the Oregon Health Sciences University, who testified that stress "almost certainly" did not cause the myocardial infarction. He explained that acute myocardial infarction is caused by a total occlusion (i.e. narrowing) of the artery by a blood clot and that there is no evidence that stress will cause formation of such a clot.

Kloster noted that claimant had preexisting coronary heart disease, i.e., partial occlusion of coronary arteries, and had three of the five major risk factors in the development of heart disease. He listed those factors as an elevated cholesterol level, high blood pressure or hypertension, and a history of cigarette smoking. He noted the absence of conclusive evidence that stress is a risk factor in the development of heart disease.

We find Dr. Kloster's conclusions to be most persuasive for two reasons. First, as a specialist in cardiology, he is more qualified than Dr. Carter to analyze and discuss claimant's cardiovascular problems. Second, his opinion was more thorough and well-reasoned than those of both Drs. Carter and Romm. See Somers v. SAIF, 77 Or App 259, 263 (1986). Consequently, we are unable to find that stress, resulting either from the compensable injury and sequelae or from attendance at the convention, materially contributed to claimant's cardiovascular condition. We conclude, therefore, that the cardiovascular condition was not compensable.

ORDER

The Referee's order dated December 18, 1987 is reversed in part and affirmed in part. That portion of the Referee's order which set aside the Determination Order of October 24, 1986 and granted additional temporary total disability compensation is reversed. The Determination Order is reinstated. The remainder of the order is affirmed. Claimant's attorney is awarded an assessed fee of $400, to be paid by the SAIF Corporation.

LEO R. WIDENMANN, Claimant
Roll, Westmoreland & Lavis, Claimant's Attorneys
Jeff Gerner (SAIF), Defense Attorney
Roberts, et al., Defense Attorneys

WCB 86-10622 & 85-03572
July 18, 1988
Order on Review

Reviewed by Board Members Johnson and Crider.

The SAIF Corporation requests review of Referee Quillinan's order that awarded claimant interim compensation for the period from August 1, 1985, to July 8, 1986. SAIF also asserts that the Referee erred in admitting a document in violation of OAR 438-07-005(3)(a). The issues on review are whether the Referee erred in admitting Exhibit 64A and whether claimant is entitled to interim compensation from August 1, 1985 to July 8, 1986.

FINDINGS OF FACT

In 1970, claimant sustained broken ribs and a broken pelvis in a noncompensable motor vehicle accident. He apparently achieved symptomatic recovery from that injury.

On March 6, 1978, claimant sustained a compensable low back and left hip injury when, while working for Oceanlake Ready Mix Co., an insured of SAIF, he was buried up to his shoulders in dirt. The claim was accepted and processed through closure.

In 1979, claimant filed an aggravation claim which was ordered accepted by a March 23, 1981 Opinion and Order as an aggravation of the underlying preexisting degenerative left hip condition. The order was affirmed on Board review. A Determination Order granted 15 percent unscheduled permanent partial disability for injury to the low back. That award was increased to 55 percent by a July, 1982 Opinion and Order, and was affirmed on Board review.

In September of 1984, claimant obtained employment as a maintenance man for Surftides Beach Resort. On November 27, 1984, he filed a claim for a November 13, 1984 injury to his upper back, which allegedly occurred while he was bailing water from a flooding area. He reported feeling a snap in his neck and shoulder area.

On December 7, 1984, Roman Wolansky, D.C., described pain in the cervical and thoracic regions and diagnosed T-2 subluxation. A December 19, 1984 supplemental medical report identified a November 13, 1984 injury at Surftides Beach Resort and released claimant to modified work as of December 10, 1984, with restrictions against lifting more than 20 pounds or raising arms overhead.

On January 2, 1985, claimant saw John M. Vargo, D.O., who took a history of neck and upper back discomfort and "very subjective low back 'problems.'" Dr. Vargo felt that claimant's upper back complaints were legitimate and diagnosed cervical myositis and degenerative joint disease of the cervical spine.

Reliance Insurance Company, the insurer for Surftides, denied responsibility by letter dated February 28, 1985, alleging that the claim was an aggravation of the 1978 low back injury.

On August 2, 1985, an order denying designation of a paying agent pursuant to ORS 656.307 issued. SAIF Corporation was identified as a party and received that order on August 5, 1985.

On January 15, 1986, the Orthopaedic Consultants performed an independent medical examination at the request of Reliance Insurance Company. They described complaints in the cervical-dorsal spine at the posterior shoulder girdle, which they related to the November, 1984 injury. They specifically stated that the November 13, 1984 incident "in no way flared-up the previous condition in relation to his (claimant's) low back and pelvis, which seems unrelated to the present injury." (Ex 68-7).

On July 8, 1986, SAIF Corporation formally denied responsibility for the cervical, upper back, and shoulder problems.

Richard C. Arbeene, M.D., an orthopedist, saw claimant on

July 16, 1986, at SAIF's request. He found no relationship between claimant's neck, shoulder, and upper back complaints and his 1978 low back injury.

At the commencement of the October 23, 1986 hearing, claimant withdrew all issues relating to SAIF's denial of responsibility for the aggravation. The remaining issue was claimant's entitlement to interim compensation from the date claimant's lawyer allegedly sent SAIF Corporation a demand for benefits (August 1, 1985), to July 8, 1986, the date SAIF formally denied the claim. Over SAIF's objection, the Referee admitted into evidence a document dated August 1, 1985, entitled "NOTICE OF AGGRAVATION AND BENEFIT DEMAND," authored by claimant's attorney and addressed to SAIF Corporation. The Referee found that SAIF received medical verification of claimant's inability to work on August 1, 1985, and that it neither commenced payment of interim compensation benefits nor denied the claim until July 8, 1986. She concluded that claimant was entitled to interim compensation benefits for that period.

CONCLUSIONS AND OPINION

Evidentiary Ruling

At hearing, claimant offered Exhibit 64A, which was an August 1, 1985 form letter to SAIF Corporation entitled "NOTICE OF AGGRAVATION AND BENEFIT DEMAND." It stated that medical verification of aggravation was enclosed, identified five documents, and requested "immediate compensation payment."

The document was admitted over SAIF's objection on the basis that "...it's already part of SAIF Corporation's claims file, and it appear (sic) to me merely to indicate what was enclosed with additional enclosures on the bottom, which are already a part of this record." The Referee used the date of that letter to establish the date of SAIF's obligation to commence payment of interim compensation on the aggravation claim. On review, the insurer renews its objection.

OAR 438-07-005(3)(b), the rule in effect on the date of hearing, provides that a claimant must file with the Hearings Division any evidence upon which he intends to rely not less than 10 days prior to the hearing. In the present case, claimant submitted an exhibit relevant to the issue of his entitlement to interim compensation on the date of hearing. The document had allegedly been prepared by claimant's attorney and in his possession since August 1, 1985, more than one year prior to hearing.

OAR 438-07-005(4) provides that the referee has discretion to admit exhibits filed in violation of the "10-day rule," upon a finding of good cause for the failure to file within the prescribed time limits. The Referee made no specific finding with regard to whether or not good cause had been demonstrated. Her admission of the exhibit without first establishing good cause was improper, and we do not consider it on review. See David W. Martin, 37 Van Natta 1699, 1700 (1985) and Bruce D. Craig, 37 Van Natta 1143, 1145 (1985).

Interim Compensation

ORS 656.273(6) provides that a claim for aggravation shall be processed by the insurer the same as a claim in the first

instance, "...except that the first installment of compensation due ...shall be paid no later than the 14th day after the subject employer has notice or knowledge of medically verified inability to work resulting from the worsened condition." This statutory language has been construed to require medical verification of a worsened condition arising out of the original injury or disease. Silsby v. SAIF, 39 Or App 555 (1979).

The Referee identified Dr. Wolansky's initial report, the 801, and Dr. Vargo's reports, as being in SAIF's possession on August 1, 1985. She stated, "Those reports while showing an inability to work due to a worsening would also raise the question as to whether this claim was related to the earlier 1978 injury. A reasonably prudent carrier could and should have immediately investigated this claim and denied within 14 days, or 60 days at the most. It did not do so." On that basis, the Referee concluded that SAIF was required to commence interim compensation under the statute. We disagree.

First, there is no evidence, either by affidavit, testimony, postmarked envelope, return receipt, or date stamp, that any of the medical documents referred to were mailed to or received by SAIF prior to its denial.

Second, even if the documents were in SAIF's possession, they do not indicate that claimant was unable to work as a result of the 1978 low back injury, even by inference. Rather, each refers to the 1984 injury to the neck and upper back.

This is not a claim in the first instance which requires either denial or commencement of interim compensation within 14 days of receipt of the claim. The requirements that trigger the obligation to pay interim compensation in a claim for aggravation are specific.

The Referee's statement that the carrier should have investigated the claim, while relevant in determining the carrier's reasonableness in timely accepting or denying the claim, is not the standard for determining whether the insurer is obliged to commence interim compensation benefits on an aggravation claim under ORS 656.273(6).

We conclude that claimant has failed to establish that SAIF received medical verification of claimant's inability to work as a result of a worsening of his compensable low back injury, so as to trigger SAIF's responsibility to commence payment of interim compensation benefits.

ORDER

The Referee's order dated November 18, 1986, is reversed and SAIF Corporation's July 8, 1986 denial is reinstated.

GARY P. WOOD, Claimant
Theresa Welch, Claimant's Attorney
Waggoner, Farleigh, et al., Defense Attorneys
John Motley (SAIF), Defense Attorney

WCB 86-14237 & 87-01392
July 18, 1988
Order on Review

Reviewed by Board Members Johnson and Crider.

Claimant requests review of Referee Huff's order that upheld the SAIF Corporation's denials of his back injury on the basis that claimant was not a "subject worker" within the meaning of the Workers' Compensation statutes. On April 7, 1988, claimant filed a motion to remand the case to the Referee for the taking of additional evidence. We deferred ruling on the motion until the time of Board review. No briefs were filed on the merits. On review, we decline to remand the matter to the Referee, and we affirm the Referee's order.

ISSUES

1. Remand for the taking of additional evidence.

2. Whether claimant was a "subject worker" at the time of his industrial injury.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Remand

We may remand to the Referee if we find that the record has been "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(5). To merit remand, it must be shown that material evidence was not obtainable with due diligence before the hearing. Bernard L. Osborn, 37 Van Natta 1054, 1055, aff'd mem 80 Or App 152 (1986).

Claimant requests remand in order to take additional evidence concerning his status as a "subject worker." See ORS 656.027; 656.006(27). Specifically, claimant wishes to introduce evidence purportedly showing that SAIF's insured had elective coverage of claimant. Claimant has made no showing that the proferred evidence was not reasonably obtainable prior to hearing. To the contrary, claimant asserts that he believed that the evidence would be presented by SAIF.

The two denials at issue both contended that claimant was not a "subject worker." In addition, the record establishes that claimant's attorney was aware that the coverage question was at issue. Under the circumstances, we conclude that the record has not been "improperly, incompletely or otherwise insufficiently developed." Claimant's motion for remand is denied.

"Subject Worker"

We affirm and adopt the Referee's Opinion on the merits.

unscheduled disability is the permanent loss of earning capacity due to the compensable injury. ORS 656.214(5). Permanent loss of earning capacity is rated based upon a combination of the worker's physical impairment, work experience, and other social and vocational factors. Id.; OAR 436-30-380 et seq. Claimant relies upon his own testimony and the opinions of Drs. Bolin, Fitchett and Carlstrom to establish permanent impairment resulting from the accepted injury.

Apart from claimant's degenerative disc disease, which is not work-related, the basis for the physicians' recommended restrictions from heavy labor is claimant's reported symptoms. Further, the physicians' attribution of claimant's disability, either totally or in part, to the accepted injury is dependent upon the history given by claimant regarding his low back condition prior to February 20, 1986. The Referee found that claimant's report of his symptoms was not reliable and that the history given to the three physicians regarding his pre-February 20, 1986 condition was inaccurate. We affirm and adopt the Referee's discussion and conclusions regarding these questions as found on Pages 2 and 3 of the order.

When, as here, claimant's case is based almost entirely upon his veracity, and that veracity is discredited, we do not find that the evidence preponderates in favor of a finding of permanent impairment. See Timothy J. Swodeck, 39 Van Natta 341 (1987). Absent compensable permanent impairment resulting in a loss of earning capacity, there is no basis for an award of unscheduled permanent partial disability.

ORDER

The Referee's order dated May 26, 1987 is affirmed.

DALE R. BENNETT, Claimant
Emmons, et al., Claimant's Attorneys
Acker, et al., Defense Attorneys

WCB 87-09835
July 20, 1988
Order on Review

Reviewed by Board Members Johnson and Crider.

Claimant requests review of Referee Blevins' order that: (1) awarded additional temporary total disability; and (2) affirmed a Determination Order that declined to award scheduled permanent disability for her arms and awarded 20 percent (64 degrees) unscheduled permanent disability for a back injury. On review, claimant raises the issues of extent of scheduled and unscheduled permanent disability. In its brief, the insurer argues that claimant was not entitled to the additional temporary disability.

FINDINGS OF FACT

Claimant, 28 at hearing, worked as a fish filleter. She suffered a compensable cervical back strain on September 12, 1986. She sought treatment from Dr. Schmidt, osteopath, on September 15, 1986. He diagnosed cervical and dorsal (thoracic) back strain. Claimant was treated conservatively with rest, muscle relaxants, and physical therapy. She also dieted at Dr. Schmidt's suggestion, losing 47 pounds.

Claimant was examined on December 10, 1986 by Dr. Martens, orthopedist. He found claimant medically stationary as of that date, and rated her minimally impaired.

On January 13, 1987, Dr. Schmidt completed a form report to the insurer noting that claimant was medically stationary.

A Determination Order issued on February 18, 1987 which found claimant medically stationary as of January 13, 1987 and awarded 20 percent (64 degrees) unscheduled permanent disability for her back condition. A second Determination Order issued on March 21, 1987 affirming the first order.

On April 13, 1987, Dr. Schmidt reported claimant medically stationary in a letter to the insurer.

On July 25 and 26, 1987, claimant returned to her employer in a modified job as a shrimp picker. The work aggravated her back strain, and Dr. Schmidt took her off work. She has since been released to light work, with restrictions to lifting no more than 30 pounds, no lifting above the shoulder, and no repetitive pushing and pulling. She has not returned to work.

Claimant finished the ninth grade, and later obtained her GED. Her work history consists of unskilled work in the medium category.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant was not medically stationary on January 13, 1987, the date on which the Determination Order found her medically stationary. Instead, he found claimant medically stationary on April 13, 1987, the date on which Dr. Schmidt reported by letter that she was stationary.

To set aside a Determination Order as premature, claimant has the burden of proving her compensable condition was not medically stationary at the time of claim closure. Brad T. Gribble, 37 Van Natta 92 (1985). Medically stationary means that "no further material improvement would reasonably be expected from medical treatment or the passage of time." ORS 656.005(17). We may consider evidence on that issue that was not available to the Evaluation Section, so long as it addresses claimant's condition at time of closure. Scheuning v. J.R. Simplot & Co, 84 Or App 622 (1987). Dr. Martens reported claimant had become medically stationary on December 10, 1986. Her treating physician reported the same on January 13, 1987. His conclusion was briefly noted, without explanation, on a form submitted to the insurer. In a letter to the insurer dated April 13, 1987, Dr. Schmidt said claimant was medically stationary, but did not specify on what date she had become so. On May 11, 1987, he again reported on a form that claimant became stationary on approximately April 15, 1987. Again this statement is not explained.

We conclude that claimant was medically stationary on January 13, 1987. Although Dr. Schmidt later said claimant was stationary as of a later date, those opinions are not persuasive. Neither report clearly states that claimant was not stationary on January 13, 1987. Assuming they should be read to say that, there is no explanation for Dr. Schmidt's change of opinion. There is no evidence of what, if any, medical treatment claimant received after January 13, 1987 until a subsequent aggravation in July 1987. We conclude that claimant was medically stationary on January 13, 1987. We therefore reinstate the Determination Order on that issue.

Claimant contends that she is entitled to scheduled permanent disability for pain in her arms, particularly her right arm. The October 3, 1986 report from Dr. Schmidt includes the comment that claimant's right arm was "tired and achy." Dr. Martens' report contains claimant's complaints of pain radiating down her right inner arm to the elbow. She reported that the pain increased with pushing, pulling, lifting, and work above shoulder level. Her range of motion was normal. Dr. Martens found claimant did not have any functional overlay. Claimant testified that she suffers the same symptoms, now sometimes extending down her right arm to her fingers.

A physician's report is not necessary regarding extent of disability. A claimant may be a competent witness as to her pain and resulting disability. Garbutt v. SAIF, 297 Or 148 (1984); Uris v. Compensation Dept., 247 Or 420 (1967). In this case, the Referee did not find claimant's testimony persuasive. The record does not contain sufficient indices of right arm disability to persuade us that the Referee erred. After reviewing the medical and lay evidence, we are not persuaded that claimant's compensable injury has resulted in a permanent loss of use or function of her right arm. Consequently, we affirm that portion of the Referee's order that declined to award scheduled permanent disability.

Claimant's job at injury is rated as medium work. After claimant became medically stationary, Dr. Schmidt released her to work lifting no more than 30 pounds, never working above shoulder level, with no repetitive pushing and pulling. Claimant agreed with her doctor, but felt she could lift no more than 20 pounds. Dr. Martens reported her permanent back impairment as minimal, but agreed with the limitations set by Dr. Schmidt. All of these reports describe a worker capable of doing light work. We find that claimant's permanent impairment is in the minimal range.

In rating the extent of claimant's unscheduled permanent disability, we consider the medical and lay evidence of physical impairment from the compensable injury, and all the relevant social and vocational factors set forth in OAR 436-36-380 et seq. We apply these rules as guidelines, not mechanical formulas. Harwell v. Argonaut Insurance, 296 Or 505 (1985); Fraijo v. Fred S. Bay News Co., 50 Or App 260 (1982). Following our de novo review of the evidence, including claimant's testimony, and due consideration of the aforementioned guidelines, we conclude that the 20 percent award granted by the Determination Order does not adequately compensate claimant for her disability. In terms of permanent loss of wage earning capacity, she is now limited to light work. She has medically imposed restrictions on activities of lifting, repetitive push-pull movements and working with her arms above her shoulder level. We therefore modify the Referee on this issue. Claimant is allowed an award of compensation of 30 percent unscheduled permanent disability.

ORDER

The Referee's order dated October 20, 1987 is modified and affirmed. Claimant is awarded 10 percent (32 degrees) unscheduled permanent disability in addition to the 20 percent awarded by Determination Order, for a total of 30 percent (96 degrees) unscheduled permanent partial disability. Claimant's

attorney is awarded an attorney fee equal to 25 percent of claimant's increased compensation, not to exceed $3,800. The Referee's order is otherwise affirmed. The Board approves a client-paid fee not to exceed $595.

VERNON D. CULP, JR., Claimant
Coons & Cole, Claimant's Attorneys
Cummins, et al., Defense Attorneys

WCB 87-13958
July 20, 1988
Interim Order of Remand

The self-insured employer has requested Board review of Referee Huffman's March 1, 1988 order that set aside its denial of claimant's occupational disease claim for bilateral carpal tunnel syndrome. Contending that the record has been improperly transcribed, the employer has asked that the transcript either be corrected or this matter remanded to the Referee. We grant the request to remand.

FINDINGS

The alleged inaccuracy concerns the testimony of an expert witness, Dr. Nathan. Specifically, the transcript reflects that the witness answered "I believe so" to the question as to whether it was medically probable that certain previously described hand activities would in any way affect the obviously preexisting median nerve pathology present in claimant's case.

Enclosing Dr. Nathan's affidavit stating that to the best of his recollection he testified "I don't believe so" to the aforementioned question, the employer requests that we either correct the transcript or remand this case to the Hearings Division for further development. In response, claimant's counsel recalls that Dr. Nathan did answer as reported in the transcript. However, since he concedes that Dr. Nathan probably intended to answer in the negative, claimant is not opposed to the Board treating the answer as "I don't believe so."

CONCLUSIONS

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. See ORS 656.295(5). Considering the aforementioned circumstances, we are not prepared to "treat" Dr. Nathan's answer as something other than the transcript reports. Instead, we conclude that this case should be remanded for further development concerning this issue.

Accordingly, this matter is remanded to Referee Gruber, the Presiding Referee for the Board's Eugene office. Referee Gruber is instructed to take further evidence designed to clarify Dr. Nathan's testimony concerning the aforementioned question. This evidence may take the form of either testimony at hearing or by means of deposition or interrogatory.

We retain jurisdiction over this matter. After admitting this evidence into the record, Referee Gruber shall provide an interim order on remand, discussing the effect, if any, the additional evidence has had upon the prior order. Once the Board receives the record and the Referee's interim order on remand, a supplemental briefing schedule will be implemented. Thereafter, the Board will proceed with its review.

IT IS SO ORDERED.

CAROL A. FISHER, Claimant
Pozzi, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys
James Griffin, Assistant Attorney General

WCB 87-15218 & 87-12543
July 20, 1988
Order Withdrawing Abatement Order

On June 17, 1988, we abated our May 18, 1988 Order on Review to consider the SAIF Corporation's request for reconsideration. It has come to our attention that, on June 16, 1988, SAIF filed its petition for judicial review of our May 18, 1988 order.

Jurisdiction to consider this matter vested with the Court of Appeals upon the filing of SAIF's appeal. Inasmuch as SAIF had perfected its appeal prior to the issuance of our abatement order, our June 17, 1988 order is a nullity.

We have previously held that it is possible to withdraw an order of abatement after the filing of a petition for judicial review. Dan W. Hedrick, 38 Van Natta 208, 209 (1986). However, we exercise this authority rarely. Ronald D. Chaffee, 39 Van Natta 1135 (1987).

Under these circumstances, we decline to withdraw our May 18, 1988 Order on Review. 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.

DERYLE E. FOSTER, Claimant
Philip H. Garrow, Claimant's Attorney
Schwabe, et al., Defense Attorneys
Richard Barber (SAIF), Defense Attorney

WCB 86-10776 & 86-10775
July 20, 1988
Order on Review

Reviewed by Board Members Ferris and Crider.

EBI Companies requests review of those portions of Referee Seifert's order that: (1) set aside its denial of claimant's aggravation claim for a back condition; and (2) upheld the SAIF Corporation's denial of claimant's "new injury" claim for the same condition. Although claimant has not formally cross-requested review, he argues that the Referee erred in not assessing penalties and attorney fees against SAIF for alleged improper claims processing. SAIF has motioned the Board to strike claimant's brief for arguing issues not raised by a formal cross-request for review.

The Board reverses on the issue of responsibility, but, otherwise, affirms the Referee's order.

ISSUES

1. Whether SAIF's motion to strike claimant's brief should be granted.

2. Whether claimant suffered a compensable occupational disease as a result of his work activities at SAIF's insured.

3. Whether claimant's recurrent disk herniation and need for surgery are the responsibility of EBI or SAIF.

4. Whether SAIF should be assessed penalties or attorney fees.

FINDINGS OF FACT

The Board adopts the Referees findings and makes the following additional findings.

Claimant sustained a compensable disk herniation at L5-S1 in January 1984, while working as a truck driver for EBI's insured. In March 1984, he underwent a lumbar laminectomy and diskectomy performed by Dr. Newby, a surgeon. A few months later, he resumed full-time employment as a truck driver for EBI's insured. In February 1985, he began to experience a return of pain in his right hip and thigh. He was reexamined by Newby in May 1985. Newby suspected a recurrent disk herniation, but myelogram and CT scan results showed no abnormalities. Claimant continued working for EBI's insured until November 1985.

Shortly thereafter, he began working for SAIF's insured, a trucking company. Although he worked fewer hours at SAIF's insured, his back pain increased. In May 1986, he quit work due to his back pain. The following month, repeat myelogram and CT scan tests revealed a recurrent disk herniation at L5-S1. After reviewing the diagnostic test results and reexamining claimant, Dr. Newby recommended further low back surgery.

EBI requested Board review of that portion of the Referee's order that set aside its denial of claimant's aggravation claim. No cross-requests for review were filed. In his "Response Brief," claimant argues that SAIF should be assessed penalties and attorney fees.

CONCLUSIONS OF LAW

Motion To Strike

SAIF's motion to strike claimant's response brief is denied. The Board has juridiction to consider issues not raised by a formal cross-request for review. Miller v. SAIF, 78 Or App 158, 161 (1986); Kenneth Privatsky, 38 Van Natta 1015 (1986).

Compensability

In cases involving issues of both compensability and responsibility, the threshold issue is compensability. If the claim is compensable, then the trier of fact proceeds to determine the issue of responsibility. See Runft v. SAIF, 303 Or 493, 498-99 (1987); Joseph L. Woodward, 39 Van Natta 1163, 1164 (1987).

Here, although SAIF clearly placed the compensability of claimant's "new injury" claim in issue, the Referee analyzed the claim as solely an issue of responsibility. On Board review, SAIF continues to place compensability in issue. Consequently, claimant must prove the compensability of his "new injury" claim before we address the issue of responsibility.

To establish a compensable occupational disease claim, a worker must prove by a preponderance of the evidence that his work activities, when compared to non-work activities, were the major contributing cause of either the onset or worsening of his condition. Dethlefs v. Hyster Co., 295 Or 298 (1983); Weller v. Union Carbide, 288 Or 27, 35 (1979); see former 656.802(1)(a). If the worker's condition preexisted his employment, he must prove that

his work activities caused a worsening of his underlying condition. Devereaux v. North Pacific Insurance Co., 74 Or App 388, 391 (1985).

In the instant case, claimant suffered a herniated disk at L5-S1 prior to his employment at SAIF's insured. He, therefore, must prove a worsening of his underlying condition.

In May 1985, claimant suffered increased low back pain, but diagnostic tests showed no evidence of a disk herniation. One year later, after working at SAIF's insured for approximately six months, repeat diagnostic tests revealed a recurrent disk herniation at L5-S1. The record contains no evidence of nonwork activities that could explain claimant's recurrent disk herniation. See James v. SAIF, 290 Or 343, 350-51 (1981) (non-work activities substantially different from at-work activities will not defeat a claim for occupational disease). Moreover, claimant testified that his back pain worsened after his employment at SAIF's insured. When he finally quit work in May 1986, his pain had "peaked."

The medical evidence in this case consists of reports from the Orthopaedic Consultants and Dr. Newby. In July 1986, the Consultants opined, inter alia:

> "His current problem extends from the January 31, 1984 injury."
>
> "The long truck driving hours undoubtedly contributed to the recurrence of his symptoms." (Emphasis added).

A few months later, Newby reported, inter alia:

> "Presently[,] it is my opinion that [claimant's] need to undergo repeat surgery arises from his occupation as a truck driver. I believe that the primary need arises from his most recent job, although his pre-existing job did in fact set him up for the problems that he now has." (Emphasis added).
>
> "* * * * *
>
> "It would be my opinion that [claimant's] most recent occupation as a truck driver did contribute to his current need to undergo surgery. It was also the primary cause for him to seek out further medical treatment." (Emphasis added).

We are persuaded by Dr. Newby that claimant's work activities at SAIF's insured were the major contributing cause of a worsening of his underlying back condition. See McClendon v. Nabisco Brands Inc., 77 Or App 412, 417 (1986) (lack of precise legal terminology by a medical expert does not bar compensability). Newby began treating claimant in February 1984 and observed him both before and after May 1986. Weiland v. SAIF, 64 Or App 810, 814 (1983); see Kienow Food Stores v. Lyster, 79 Or App 416, 421 (1986). Thus, we conclude that Newby was in the best position to render an opinion concerning whether claimant's work activities at SAIF's insured resulted in a worsening of his underlying condition.

Claimant has proven the compensability of his claim.

Responsibility

In successive injury cases, Oregon courts apply the "last injurious exposure rule" adopted from 4 A. Larson, The Law of Workmen's Compensation §§ 95.20 to 95.23 (1988). The rule provides that responsibility shifts to the later insurer unless the evidence shows that the last injury did not "contribute independently" to the causation of his disability (i.e., to a worsening of the underlying condition). Champion International v. Castilleja, 91 Or App 556, 560-61 (1988); Hensel Phelps Const. v. Mirich, 81 Or App 293-94 (1986).

We concluded above that claimant suffered a worsening of his underlying back condition as a result of his truck driving activities at SAIF's insured. Accordingly, we conclude that he has sustained a "new injury," which independently contributed to the causation of his recurrent disk herniation and need for surgery. See Home Ins. Co. v. EBI Companies, 76 Or App 112, 118-19, (1985) (a worker's new disk herniation, even in the absence of a specific traumatic event, held to be a "new injury.").

Penalties and Attorney Fees

An insurer or self-insured employer may be assessed penalties and attorney fees for unreasonably delaying or refusing to pay compensation, or unreasonably delaying acceptance or denial of a claim. ORS 656.262(10).

Claimant contends that SAIF unreasonably refused to pay interim compensation from May 15, 1986. At the beginning of the hearing, however, claimant acknowledged on the record that the contested period of interim compensation ran from July 26, 1986. Under such circumstances, we decline to consider whether SAIF unreasonably refused to pay interim compensation from May 15, 1986. See Cynthia J. Clark, 39 Van Natta 130 (1987). However, we wish to make clear that we have reviewed and affirm the Referee's finding that SAIF did not unreasonably refuse to pay interim compensation from July 26, 1986.

In addition, claimant contends that SAIF's denial of compensability was unreasonable. Although claimant raised this issue at the hearing, the Referee did not address it in his order. We, therefore, proceed to do so.

Claimant sustained a compensable low back injury in January 1984, which resulted in a disc herniation and surgical intervention. In May 1986, he was unable to continue working for SAIF's insured due to low back pain. Shortly thereafter, a recurrent disk herniation was diagnosed. When SAIF denied the compensability of claimant's claim in August 1986, the focus of the medical evidence was whether claimant's recurrent disk herniation had been caused by his former or recent work activities. See Price v. SAIF, 73 Or App 123, 126, n. 3 (1985). There was no discusssion, however, of any causal contribution from non-work activities.

Under such circumstances, we conclude that SAIF's denial of compensability was unreasonable. See Industrial Indemnity v. Weaver, 83 Or App 73 (1986). However, because there are no "amounts then due" we assess only an attorney fee and not a penalty. See Mischel v. Portland General Electric, 89 Or App 140, 142 (1987); Spivey v. SAIF, 79 Or App 568 (1986); ORS 656.262(10).

ORDER

The Referee's order dated October 3, 1986, is reversed in part and affirmed in part. That portion of the Referee's order that set aside EBI Companies denial and ordered it to pay claimant's attorney an assessed fee of $1,000, is reversed. SAIF is directed to accept claimant's occupational disease claim, to pay claimant's attorney an assessed fee of $1,000, and to process the claim according to law. In addition, for its unreasonable denial of compensability, SAIF shall pay claimant's attorney a reasonable attorney fee of $400. All remaining portions of the Referee's order are affirmed. Claimant's attorney is awarded an assessed fee of $500 for his services on Board review, to be paid by the SAIF Corporation. The Board approves EBI Companies' request for a client-paid fee of $2,620.

PAMELA M. GILMORE, Claimant
Roll, et al., Claimant's Attorneys
Davis & Bostwick, Defense Attorneys

WCB 86-07019
July 20, 1988
Order on Reconsideration

The insurer has requested reconsideration of the Board's Order on Review dated January 7, 1988, which affirmed the order of the Referee. On January 29, 1988, the Board's order was withdrawn and claimant was granted an opportunity to respond. Having received claimant's response, the Board has reconsidered the matter.

On reconsideration, we affirm and adopt the Referee's order with the following amendments.

ISSUE

The compensability of certain dental surgery bills.

FINDINGS OF FACT

Claimant, 25 at hearing, sustained a compensable nondisabling head injury in November 1984. Shortly after returning to work, she experienced symptoms of fuzzy vision, headaches, and nosebleeds. At least twice, she had to leave work due to headaches. Her claim was closed by a Notice of Closure in June 1985. A few months later, her condition was diagnosed as temporamandibular joint displacement ("TMJ"). In December 1985, she underwent TMJ repair surgery. Since the surgery, her symptoms have largely resolved.

Claimant has a history of preexisting dental and cervical problems. In the early 1980's she had approximately 17 surgeries for a cleft lip and palate. In 1982, she sustained an automobile "whiplash-type" injury. Lastly, in 1983, she had a bridge inserted into her gum.

Following claimant's December 1985 TMJ surgery, she submitted her surgical billings to the insurer. The insurer declined to pay the bills by way of a "de facto" denial.

Four medical experts have rendered opinions concerning the causal relationship between claimant's November 1984 injury and her TMJ condition or surgery. Dr. Walker, treating dentist, opined that claimant's preexisting problems could have initially caused her TMJ condition, but usually "an incident . . . breaks

the camel's back." According to Walker, the "last incident" was the compensable November 1984 injury. Dr. Garey, treating oral surgeon, felt that the November 1984 injury greatly aggravated claimant's TMJ symptoms. Dr. Anderson, dentist, initially reported that there was a "100% [sic] correlation between the traumatic [November 1984] event and the need for [TMJ] surgery . . . ." Later, one week prior to the hearing, Anderson opined that claimant's 1982 automobile accident was the original cause of her TMJ condition. Finally, Dr. Morrison, dentist, testified that the November 1984 injury "probabl[y]" did not cause claimant's TMJ condition. Morrison added, however, that headaches were one indicia of a TMJ condition.

CONCLUSIONS OF LAW

A worker is entitled to reasonable and necessary medical services for the disabling results of a compensable injury, even if preexisting problems contribute to her disability. Van Blokland v. Oregon Health Sciences University, 87 Or App 694, 698 (1987); see James v. Kemper Insurance Co., 81 Or App 80, 84 (1986); ORS 656.245(1). The compensable injury need not be the sole or principal cause of a worker's need for medical services, but only a material contributing cause. Van Blokland v. Oregon Health Sciences University, supra, 87 Or App at 698.

Here, the Referee concluded that claimant's testimony combined with the opinions of her treating doctors, i.e., Drs. Walker and Garey, established the compensability of her TMJ condition and surgery. However, in so doing, the Referee inconsistently found that "the most reasoned and the most knowledgeable opinion[]" was that of Dr. Morrison. Although we agree with the Referee's conclusion concerning compensability, we disagree with his finding concerning Morrison's opinion.

Drs. Walker and Garey opined that claimant's TMJ condition was either caused or greatly aggravated by her November 1984 injury. See Harris v. Albertson's Inc., 65 Or App 254, 257 (1983). Although Dr. Anderson initially opined that claimant's TMJ condition was causally related to her November 1984 injury, he unpersuasively changed his opinion one week prior to the hearing. Dr. Morrison never examined claimant. His opinion was based solely upon a review of some medical documents. Moreover, Morrison admitted that headaches were one indicia of a TMJ condition. Here, claimant credibly testified that she began to experience significant headache problems shortly after her November 1984 injury.

Under such circumstances, we are more persuaded by the well-reasoned opinions of claimant's treating physicians, Walker and Garey. See Somers v. SAIF, 77 Or App 259, 263 (1986); Weiland v. SAIF, 64 Or App 810, 814 (1983). Claimant has proven by a preponderance of the evidence that her TMJ condition and surgery are compensable.

Claimant's attorney is entitled to a reasonable assessed fee for his services on Board review. ORS 656.382(2); OAR 438-15-005(2). However, we cannot authorize an assessed fee unless claimant's attorney files a statement of services. OAR 438-15-010(5). Because no statement of services has been received to date, an assessed fee shall not be authorized.

The insurer must seek Board approval of a reasonable

client-paid attorney fee for its attorney's services on Board review. ORS 656.388(1); OAR 438-15-005(5). However, we cannot authorize a client-paid fee unless the insurer's counsel files a statement of services. OAR 438-15-010(5). Because no statment of services has been received to date, a client-paid fee shall not be authorized.

On reconsideration, the Board adheres to and republishes its former order as amended, effective this date.

IT IS SO ORDERED.

DAVID A. HERRERA, Claimant
Garrett, Seidemann, et al., Defense Attorneys

WCB 87-13055
July 20, 1988
Order on Review

Reviewed by Board Members Ferris and Crider.

Claimant, pro se, requests review of Referee Seymour's order that upheld the insurer's denial of his back injury claim. Some of the materials claimant submits on review are not otherwise in the hearing record. We treat the presentation of these materials as a request for remand. See Judy A. Britton, 37 Van Natta 1262 (1985).

On review, the issues are remand and compensability.

We deny the request for remand and affirm the Referee's order.

FINDINGS OF FACT

Claimant has been employed as a laborer in the employer's citrus processing plant for approximately ten years. Sometime prior to July 7, 1987, he received a disciplinary warning from the employer.

On July 7, 1987, claimant experienced low back pain while moving a television in his home. This injury was witnessed by his former brother-in-law, Robert Romero.

The following day, claimant complained of back pain to his work supervisor after engaging in heavy, work-related lifting activities. In a conversation with Mr. Romero that evening, claimant stated that he was going to file a worker's compensation claim for his low back injury in retaliation for the employer's disciplinary warning.

On July 13, 1987, claimant sought treatment from Dr. Weeber, his family physician.

On July 14, 1987, claimant filed a back injury claim with his employer.

On April 13, 1987, the employer denied claimant's injury claim, and claimant requested a hearing.

After de novo review of the record, we find that Mr. Romero credibly testified about the nature of claimant's low back injury and worker's compensation claim. Accordingly, we are persuaded that claimant's version of the alleged work injury is not credible.

CONCLUSIONS AND OPINION

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). To merit remand for consideration of additional evidence 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, 170 (1985).

After de novo review, we are not persuaded that the record has been improperly, incompletely or otherwise insufficiently developed. Furthermore, we find that the additional evidence presented in claimant's brief was obtainable with due diligence. Accordingly, we conclude that remand is not warranted.

Compensability

The Referee first concluded that the compensability of claimant's injury claim turned on his credibility. The Referee then found that claimant was not credible and upheld the insurer's denial.

We agree with the Referee's conclusion that the outcome of this claim turns on claimant's credibility. In this regard, we note that Dr. Anderson's opinion relating claimant's back condition to his work assumes the accuracy of the history given by claimant.

On July 15, 1987, claimant sought treatment for pain in his left upper and lower back, neck and right leg from Dr. Anderson, chiropractor. At that time, claimant attributed his back pain to work activities on July 8 and 9, 1987. He did not mention that he experienced pain after moving a television at his home on July 7, 1987. Dr. Anderson diagnosed lumbosacral strain. Based on the history given to him by claimant, Dr. Anderson related claimant's condition to the alleged job injury.

We also agree with the Referee's finding that claimant was not credible. We note that claimant acknowledged at hearing that he was angry with the employer in July 1987 because of his recent disciplinary warning. Furthermore, Mr. Romero testified that claimant injured his back moving a television set at his home and subsequently told Mr. Romero that he was going to file a fraudulent worker's compensation claim in retaliation for the employer's disciplinary warning. The record suggests no reason why the brother-in-law would not be telling the truth in regard to claimant's injury. In particular, we note that claimant and his wife were divorced many months before the former brother-in-law came to stay with claimant.

Moreover, surveillance films introduced by the insurer indicate that claimant has not been truthful regarding his symptoms and physical limitations. These films, which were taken on August 13 and 14, 1987, showed claimant bending and standing for significant periods of time while he washed and crawled in and out of automobiles. These activities conflict with claimant's statements under oath to an unemployment referee concerning claimant's condition during the period August 13 through 17, 1987. Specifically, claimant stated that his back hurt so bad

that he could not stand up long enough to wash dishes, and that it hurt the most when he bent forward. Although the extent of claimant's injury is not the crucial issue here, the fact that he did not testify truthfully on this matter reflects adversely on his overall credibility.

In light of the above factors, we are persuaded that Mr. Romero credibly testified about the nature of claimant's injury and that claimant had a bias against his employer. Accordingly, we find that claimant's version of the alleged work injury is not credible, and we affirm the Referee's opinion upholding the insurer's denial.

ORDER

The Referee's opinion dated January 11, 1988, is affirmed. The insurer's attorney is awarded a client-paid fee, not to exceed $980, for services at hearing and on Board review.

COURTLAND RHOADES, Claimant
Leeroy O. Ehlers, Claimant's Attorney
Cummins, Cummins, et al., Defense Attorneys

WCB 87-05558
July 20, 1988
Order on Review

Reviewed by Board Members Ferris and Crider.

Claimant requests review of Referee Wasley's order that upheld the insurer's denial of compensability for his chest condition.

ISSUE

Compensability of claimant's chest condition.

FINDINGS OF FACT

Claimant, 20 years old at the time of hearing, worked on the potato trim line, trimming bad spots off potatoes. In February 1987 he was assigned to remove 36-pound boxes from a pallet to a glue line. The next day, while at his potato trimming job, he felt a sharp pain in his left chest area.

Claimant moved boxes for part of one day and then returned to his potato trimming job. Claimant did not experience an onset of pain while he moved the boxes.

That evening claimant went to a hospital emergency room where he was tested for a myocardial infarction. The tests were negative. Claimant remained in the hospital for two and one half days. He returned to work for two days and thereafter felt pain in his chest area.

The proper diagnosis of claimant's condition is uncertain on the record as developed.

Claimant remained off work for approximately one week. Claimant returned to work. He ultimately stopped working due to the chest pain he experienced when he worked. He is presently unemployed.

Claimant's prior work experience was as a sheet rock carrier. Claimant did not experience any pain in his chest area while employed carrying sheet rock.

OPINION AND CONCLUSIONS

Claimant has the burden of proving the compensability of his claim. Gerald Hannah, 39 Van Natta 109 (1987). Claimant bears the burden of demonstrating the need for medical services resulting from a work-related injury. North Clackamas School District v. White, 84 Or App 560 (1987). 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, if a worker's testimony is 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, the only medical expert to render an opinion on causation was Dr. Johnson. An examination of his April 17, 1987 letter shows an opinion that is conclusory in nature and based on an erroneous history of claimant's work duties. Dr. Johnson stated that the type of work claimant did "significantly contributed" to his chest pain. The doctor's letter indicates that he believed claimant's work consisted of moving boxes. The doctor was not aware that claimant moved boxes for only a few hours one day and that he experienced the sharp chest pain while performing his usual job of trimming potatoes. Therefore, Dr. Johnson's opinion is not persuasive. Moe v. Ceiling Systems, Inc., 44 Or App 429 (1980).

We conclude that the causation of claimant's chest pain is a complex medical question requiring expert medical analysis. The only opinion claimant offered was that of Dr. Johnson's. His opinion is flawed because it is based on an incorrect history of claimant's job duties and is of a conclusory nature. Therefore, claimant has failed to carry his burden of proof.

ORDER

The Referee's order dated December 11, 1987 is affirmed. The Board approves a client-paid fee not to exceed $771.50.

WILLIAM G. STORY, Claimant
Malagon & Moore, Claimant's Attorneys
Foss, Whitty, et al., Defense Attorneys

WCB 86-13092
July 20, 1988
Order on Review

Reviewed by Board Members Johnson and Ferris.

The self-insured employer requests review of Referee Mongrain's order that set aside its denial of compensability for claimant's elbow ulnar nerve compression neuropathy. We affirm.

ISSUES

The issues on review are whether claimant's elbow ulnar nerve compression neuropathy is compensable and whether surgery is reasonable and necessary for Guyon's entrapment.

FINDINGS OF FACT

Claimant, 33 years old, was employed by the employer on the survey crew from 1972 until 1986. During his tenure he performed all of the jobs on the crew. He started as an axeman, primarily cutting brush for approximately six months. Next he worked as a chainman for about one month. Then he worked as compassman for four or five years. For three of the last five years, he performed work as instrument man and chief member of a two-man crew for three out of the past five years. In each position he was required to use a machete or hatchet-like cutting tool to cut down brush, vines and small trees. As an instrument man his cutting duties had decreased as compared to his axeman duties.

Claimant filed a claim for a hand condition in April 1986. He sought treatment from Dr. Bert, orthopedist. Dr. Bert noted that claimant began experiencing hand problems three years earlier which had progressively worsened. Dr. Bert found claimant's hand condition to be a combination of DeQuervain's syndrome and Guyon entrapment. He treated claimant with medication. One month later, claimant continued to have numbness in his right hand small finger. Dr. Bert treated claimant's hand with an injection. He improved following the injection, but continued to experience tendonitis in both hands.

On August 4, 1986, Dr. Nathan, orthopedic hand surgeon, examined claimant and found that claimant had bilateral elbow nerve compression. He recommended surgery.

On August 22, 1986, employer accepted claimant's Guyon entrapment condition, but denied his DeQuervain syndrome. At hearing the employer accepted responsibility for claimant's DeQuervain syndrome.

On September 10, 1986, Dr. Bert reported that claimant continued to have numbness and tingling in his ring and small finger and a recurrent DeQuervain's syndrome. He recommended decompression surgery of the Guyon's canal.

On September 26, 1986, employer denied responsibility for claimant's bilateral elbow ulnar compression neuropathy, focal slowing of the right median nerve at the wrist, and irritation, radial aspect, right wrist in the first dorsal compartment as not being related to his work. At hearing, the parties agreed that the irritation of claimant's right wrist was related to the accepted DeQuervain's syndrome and the denial of the median nerve condition at the wrist was premature, as claimant had not filed a claim.

On January 7, 1987, Dr. Nathan reported that no medical or surgical treatment was indicated for claimant's ulnar nerve at the canal of Guyon at the wrist. He did indicate that claimant's nerve conduction studies showed a slowing of the left ulnar nerve at the elbow and that his history was consistent with ulnar nerve abnormalities at the elbow. Dr. Bert felt that surgery was indicated.

Based on the evidence in the record, we find that claimant's work activities were the major contributing cause of his bilateral ulnar nerve entrapment.

CONCLUSIONS OF LAW

The Referee concluded that claimant's condition was compensable. He found that the major contributing cause of claimant's ulnar nerve compression at his elbows was a result of his work activity. The Referee found Dr. Bert's opinion to be persuasive. We agree.

To establish an occupational disease, claimant must prove that his work activities were the major contributing cause of either the onset or worsening of his nerve entrapment condition. ORS 656.802(1)(a); Dethlefs v Hyster Co., 295 Or 298, 310 (1983); Blakely v SAIF, 89 Or App 653, 656 (1988). "Major contributing cause" means a cause or combination of causes which contributed more to the onset or worsening than all other causes combined. See McGarrah v SAIF, 296 Or 145, 166 (1983); Dethlefs v Hyster Co., supra, 295 Or at 309-310; Clark v Erdman Meat Packing, 88 Or App 1, 5 (1987).

Dr. Bert addressed the issue of major contributing cause in his December 16, 1986 report. He found that claimant's work activities were the major contributing factor of his ulnar entrapments and DeQuervain syndrome. He reasoned that cutting brush with a machete required arm movements of acceleration and deceleration. Such movements could cause irritation of the ulnar nerve, resulting in inflammation and compression. Dr. Bert recommended surgery first at the elbows and then at the wrist if no pathology was found.

Dr. Nathan, on the other hand, did not find claimant's work activity to be the major contributing cause of his ulnar entrapment condition. He testified that the side-to-side motion of a machete does not affect the ulnar nerve. Further, he stated that the movement of the hand, wrist and arm required by claimant's work would not cause the elbow problem and that the work activities were not of sufficient impact, frequency or intensity to cause nerve injury. Dr. Nathan opined that the cause of claimant's condition was idiopathic. He believed that wrist surgery was not necessary or recommended because test results indicated no lesions in the canal of Guyon. However, he did concur with Dr. Bert that elbow surgery was indicated.

Both Dr. Bert and Dr. Nathan are hightly qualified orthopedic surgeons. Both also relied on the same medical history in reaching their conclusions. Where the record contains conflicting medical opinions, we weigh each to determine its persuasiveness. Somers v SAIF, 77 Or App 259 (1986). Further, absent persuasive reasons to do otherwise, we generally give greater weight to the opinion of claimant's treating physician. Weiland v SAIF, 64 Or App 810 (1983).

We find Dr. Bert's opinion most persuasive. As treating physician, he had the best opportunity to evaluate claimant's progress and needs over the course of his treatment. Moreover, we conclude that he was in a better position than Dr. Nathan to

determine whether surgery was warranted. Dr. Nathan examined claimant only once. We conclude that claimant's work activity was the major contributing cause of his ulnar nerve entrapment condition and is therefore compensable.

Employer accepted claimant's Guyon entrapment on August 22, 1986. Claimant is entitled to medical services "for such period as the nature of the injury or the process of the recovery requires." ORS 656.245(1). Claimant's medical expenses are compensable so long as they are reasonably and necessarily incurred in the treatment of his injury. West v SAIF, 74 Or App 317 (1985); McGarry v SAIF, 24 Or App 883 (1976). Claimant bears the burden of proving that the treatment is reasonable and necessary. James v Kemper Ins. Co., 81 Or App 80 (1986).

Dr. Bert, claimant's treating orthopedic surgeon, has repeatedly recommended surgery for the treatment of his condition. Both Dr. Bert and Dr. Nathan agree that surgery at the elbow is indicated. Dr. Bert indicated that he would proceed conservatively, only operating on the wrists if there was no evidence of lesion at the elbows. We do not see this as inconsistent with Dr. Nathan's opinion.

We conclude that claimant's need for surgery is reasonable and necessary.

ORDER

The Referee's order dated November 12, 1987 is affirmed. For services on board review, claimant's attorney is awarded an assessed fee of $700, to be paid by the insurer. A client-paid fee is approved, not to exceed $140.

DEAN W. TILLER, Claimant
Coons & Cole, Claimant's Attorneys
Brian L. Pocock, Defense Attorney

WCB 83-00926
July 20, 1988
Order of Dismissal

Claimant has requested review of Referee Smith's February 26, 1988 order and Referee Gruber's May 4, 1988 order. We have reviewed the request to determine whether we have jurisdiction to consider the matter. We conclude that we lack jurisdiction.

FINDINGS

On February 26, 1988, Referee Smith issued an order that: (1) affirmed two Determination Orders which had awarded claimant a total of 15 percent (48 degrees) unscheduled permanent disability for a back injury; and (2) upheld the self-insured employer's denial of claimant's medical services claim for his current chiropractic treatment. This order was neither abated, withdrawn, stayed, republished, modified, nor appealed within 30 days of its issuance.

On May 4, 1988, Referee Gruber issued an "Order Approving Statement of Services." Noting that claimant's attorney had submitted a Statement of Services, the Referee approved a "client-paid" fee, not to exceed $500.

On May 27, 1988, the Board received claimant's request for review. The request did not specify which order claimant

wanted reviewed. The request did not include an acknowledgment of service or a certificate of personal service by mail upon any of the parties who appeared at the hearing and their attorneys. See OAR 438-05-046(2)(b); 438-11-005(3). Neither the employer nor its representatives have received notice of claimant's request for review within 30 days of either order.

CONCLUSIONS

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 February 26, 1988 order addressed claimant's entitlement to further compensation. The order was neither abated, withdrawn, stayed, modified, nor republished. Under these circumstances, we conclude that we lack jurisdiction to review the issues relating to claimant's compensation as addressed by the Referee's February 26, 1988 order, which has become final by operation of law. See ORS 656.289(3); International Paper Co. v. Wright, supra; Farmers Ins. Group v. SAIF, supra.

The May 4, 1988 order addressed attorney fee issues only. Claimant has filed his request for review within 30 days of the issuance of the Referee's May 4, 1988 "Order Approving Statement of Services." We note parenthetically that claimant's attorney is not entitled to a "client-paid fee," since such fees are to be paid by an insurer or self-insured employer to its attorney. See OAR 438-15-005(5). Furthermore, because claimant's compensation was not increased by the Referee and claimant did not prevail against the employer's denial, there is no basis for an award of attorney fees to his attorney. See ORS 656.386(1), (2).

In any event, neither the employer nor its representatives have been timely provided with, or received actual knowledge of, the request within the statutory 30-day period. Consequently, we also lack jurisdiction to review the May 4, 1988 order. See ORS 656.289(3); 656.295(2); Argonaut Insurance Co. v. King, supra.

We are mindful that claimant has requested review without benefit of legal representation. We further realize that an unrepresented party is not expected to be familiar with administrative and procedural requirements of the Workers' Compensation Law. Yet, we are not free to relax a jurisdictional requirement, particularly in view of Argonaut Insurance Co. v. King, supra. See Alfred F. Puglisi, 39 Van Natta 310 (1987); Julio P. Lopez, 38 Van Natta 862 (1986).

Accordingly, the request for Board review is dismissed.

The employer's counsel seeks authorization of a client-paid fee to be paid by the employer. Yet, the record does not contain an executed attorney retainer agreement. Under such circumstances, we cannot grant the employer's counsel's request. See OAR 438-15-010(1).

IT IS SO ORDERED.

DAVID L. WALL, Claimant
Hayner, et al., Claimant's Attorneys
Acker, et al., Defense Attorneys

WCB 87-16946
July 20, 1988
Order on Review

Reviewed by Board Members Ferris and Crider.

The self-insured employer requests review of that portion of Referee Mongrain's order which affirmed the medically stationary date established in the Determination Order. On review, the sole issue is the medically stationary date. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following supplementation. We find that claimant became medically stationary on September 30, 1987.

CONCLUSIONS AND OPINION

"Medically stationary" means that "no further material improvement would reasonably be expected from medical treatment, or the passage of time." ORS 656.005(17). As the proponent of a medically stationary date earlier than that established in the Determination Order, the employer bears the burden of proving that claimant became medically stationary before September 30, 1987. See Harris v. SAIF, 292 Or 683, 690 (1982); Norton v. SAIF, 86 Or App 447, 452 (1987). The employer has failed to sustain that burden here.

On review, the employer contends that claimant became medically stationary on May 18, 1987, relying on Dr. Freudenberg's August 27, 1987 report that claimant "has been medically stationary as of his May 18, 1987, visit." However, Freudenberg's chart note of May 18, 1987 bears no indication that further improvement in claimant's condition was not expected. On the contrary, in that note Freudenberg reported "SATISFACTORY PROGRESS" after a period of physical therapy and recommended further therapy at home, evidencing an expectation of further progress or improvement in claimant's condition. Furthermore, Freudenberg completed a Form 828 on July 6, 1987, on which he marked an "X" in the "NO" box in response to the question of whether claimant was medically stationary at that date.

Dr. Freudenberg later conducted a closing examination on September 30, 1987 and declared claimant medically stationary "at this point." The employer suggests that Freudenberg was merely reporting claimant's continuing stationary status, a status which had begun on May 18, 1987. However, that suggestion is not consistent with a later statement in the report that claimant's claim "may be closed on the basis of this report." Moreover, it ignores the aforementioned Form 828 which declared claimant not medically stationary as of July 6. Accordingly, after our de novo review, we conclude that the employer has not sustained its burden of proving that claimant became medically stationary before September 30, 1987.

Claimant's counsel is statutorily entitled to a reasonable, carrier-paid attorney fee for services rendered on Board review. ORS 656.382(2). Such a fee is defined as an "assessed fee." OAR 438-15-005(2). However, we cannot authorize

an assessed fee unless claimant's counsel files a statement of services. OAR 438-15-010(5). Because no statement of services has been received to date, an assessed fee shall not be authorized.

ORDER

The Referee's order dated January 11, 1988, as supplemented on January 27, 1988, is affirmed.

DAVID S. ZIMMERMAN, Claimant
Burt, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 86-15055
July 20, 1988
Order on Review

Reviewed by Board Members Johnson and Crider.

Claimant requests review of Referee Wilson's order that upheld the insurer's denial of his accidental injury claim relating to his left knee.

ISSUE

Whether claimant's left knee injury arose out of and in the course of his employment.

FINDINGS OF FACT

Claimant injured his left knee in October 1986 when he jumped approximately five feet from one of the employer's loading docks to the ground as he was leaving work to go home after the completion of his shift. A doorway near the dock opened to a flight of stairs which led from the dock area to the ground. The employer had never instructed claimant not to jump from the dock and claimant had done so on several occasions in the presence of supervisory personnel without reprimand. An employee manual issued by the employer and read by claimant prior to the date of the injury prohibited "unsafe acts" on the employer's premises. The manual, however, did not expressly designate jumping from a loading dock as an "unsafe act." Claimant sought medical treatment the day after the injury and filed his claim several days later. The insurer denied the claim on the ground that the injury did not arise out of and in the course of claimant's employment.

OPINION AND CONCLUSIONS

ORS 656.005(7)(a) defines "compensable injury" as "an accidental injury . . . arising out of and in the course of employment requiring medical services or resulting in disability or death." The Referee employed two lines of reasoning in concluding that claimant's injury did not "aris[e] out of and in the course of employment."

First, the Referee analyzed claimant's act of jumping off the dock under the rules announced in Lane v. Gleaves Volkswagen, 39 Or App 5, amplified, 40 Or App 139 (1979) and Clark v. U.S. Plywood, 288 Or 255 (1980). In Lane, the claimant was injured while leaving the employer's premises after a special training meeting when he fell while attempting to climb a seven foot chain link fence. 39 Or App at 7. The court held that the claimant's injuries did not arise out of and in the course of his employment because it was unreasonable for him to attempt to climb the fence before investigating safe alternative routes. Id. at

7-8; 40 Or App at 142. In Clark, a worker heated his lunch on a piece of dangerous machinery and was killed when he went to retrieve it and another worker who was unaware of his presence activated the machine. 288 Or at 257-59. The court ruled that the compensability of injuries sustained while engaging in personal comfort activities on the employer's premises should be determined by a test which asks: Was the conduct expressly or impliedly allowed by the employer? Id. at 266.

The Referee concluded that claimant's act of jumping off the loading dock was unreasonable given the safe alternative route provided by the stairway. He also concluded that jumping off the dock was not authorized by the employer given the employer's prohibition of "unsafe acts." He then applied the rules of Lane and Clark and held that claimant's injury did not arise out of and in the course of his employment.

The Referee's second line of reasoning was an analysis of claimant's act of jumping off the loading dock under the factors set forth in Jordan v. Western Electric, 1 Or App 441 (1970). Those factors are: (1) whether the activity was for the benefit of the employer; (2) whether the activity was contemplated by the employer and employee either at the time of hiring or later; (3) whether the activity was an ordinary risk of, and incidental to, the employment; (4) whether the employee was paid for the activity; (5) whether the activity was on the employer's premises; (6) whether the activity was directed by or acquiesced in by the employer; and (7) whether the employee was on a personal mission of his own. 1 Or App at 443-44. The Referee concluded that claimant's act of jumping off the dock satisfied only factor (5) and held that this factor alone did not render claimant's injury compensable.

We first address the Referee's application of the Jordan factors. Claimant was injured on the employer's premises while in the process of going home from work. One step in this process was claimant's step off the loading dock to the ground below. The Referee isolated this step from the process of going home from work. He then applied the Jordan factors to this act without considering its role in the larger process. This led him to conclude that the act of jumping off the dock served no purpose with respect to claimant's employment.

We conclude that the proper focus for a Jordan analysis in this case was the process of going home from work rather than the isolated act of jumping off the dock. The step off the dock had the same purpose as all the steps which preceded it and those which followed it. That purpose was to take claimant from his work station, off the employer's premises and to his home. Given this continuity of purpose, the step off the dock was just as causally related to claimant's employment as any other step in the process of leaving the employer's premises. The step off the dock, of course, involved dangers not associated with a step on level ground or a step from one stair to another. These dangers raise an issue regarding the method by which claimant chose to leave the employer's premises. That issue, however, is not addressed by the Jordan factors and thus will require additional analysis.

Application of the Jordan factors to claimant's on-premises injury while going home from work leads to the conclusion that the injury arose out of and in the course of his

employment. The activity of leaving the employer's premises after the completion of the workday was of benefit to the employer; it was certainly contemplated by the employer and claimant at the time of hiring; it was an ordinary risk of, and incidental to, the employment; it was on the employer's premises; it was directed or acquiesced in by the employer; and it was not a purely personal mission. The only factor which was not satisfied was that claimant was not paid for the activity. That factor, however, is not determinative. The Board and the courts have long held that injuries sustained on the employer's premises during going and coming activities are compensable even though the claimant was technically off work at the time. See, e.g., Montgomery v. SIAC, 224 Or 380, 388 (1960); Montgomery Ward & Co. v. Malinen, 71 Or App 457, 459 (1984); Jan D. Walker, 38 Van Natta 160 (1986). Claimant's injury was compensable, therefore, under Jordan.

As an alternative to his Jordan analysis, the Referee concluded that claimant's act of jumping from the loading dock was unreasonable and was not authorized by the employer. He then held under the rules of the Lane and Clark decisions that the resulting injury was not compensable. We conclude that the rule of Lane is no longer viable and that the rule of Clark does not apply to this case.

In Lane, the Court of Appeals ruled that injuries resulting from a worker's "unreasonable" actions did not arise out of and in the course of the worker's employment. In so ruling, the court relied upon its own decision in the Clark case. Clark v. U.S. Plywood, 38 Or App 381 (1979). In that case, the court held that the claimant's action of warming his lunch on a dangerous piece of machinery was "so unreasonable as to compel a conclusion that it could not have been in the course of employment." 38 Or App at 385. After the Court of Appeals rendered its Lane decision, the Supreme Court issued its opinion in Clark. In that opinion, the Supreme Court rejected the reasonableness approach adopted by the Court of Appeals because it injected an element of fault into the workers' compensation system and thus was "at variance with the purpose of the Workers' Compensation Law -- to provide compensation for injuries arising out of and in the course of employment, irrespective of worker fault." 288 Or at 265. Instead, as previously noted, the court proposed its "express or implied authorization test" for on-premises personal comfort activities. See 288 Or at 266-67. The court did not cite or discuss the Court of Appeals' Lane decision.

In light of the Supreme Court's Clark decision, we conclude that the Referee erred in considering the reasonableness of claimant's action of jumping off the loading dock in determining whether claimant's injury arose out of and in the course of his employment. The Referee gleaned the reasonableness standard from the Court of Appeals' Lane decision. That standard was rejected by the Supreme Court in Clark. Although Lane was not expressly mentioned in Clark, we must conclude that it was overruled sub silentio by the Supreme Court. Claimant's injury is compensable, therefore, regardless of whether the act of jumping from the loading dock can be characterized as "unreasonable."

This leaves the question of whether the Clark express or implied authorization test should be applied to going and coming activities as well as personal comfort activities. When Clark was decided in 1980, the only statutory limitation on the

compensability of injuries "arising out of and in the course of employment" was for injuries sustained as a result of the "deliberate intention of the worker." ORS 656.156(1). In Clark, the court created a second limitation, at least for personal comfort activities, with its express or implied authorization test. Some statements in the court's opinion suggest that the test was also intended to apply to other activities not directly involved with a worker's appointed task, including going and coming activities. See 288 Or at 260-61. Since Clark, however, the Legislature has enacted two other limitations for injuries arising out of and in the course of employment which cause us to question whether the Clark limitation should be extended beyond personal comfort activities.

In 1981, the Legislature enacted a limitation for injuries sustained by "any active participant in assaults or combats which are not connected to the job assignment and which amount to a deviation from customary duties." Or Laws 1981, ch 535, § 30 (codified at former ORS 656.006(8)(a), now ORS 656.005(7)(a)(A)). In 1987, the Legislature enacted another limitation for injuries sustained by a worker who engages in "any recreational or social activities solely for the worker's personal pleasure." Or Laws 1987, ch 713, § 3 (codified at ORS 656.005(7)(a)(B)). These enactments reflect a legislative intent to define and limit the phrase "arising out of and in the course of employment" through statutory amendments. The Clark test, however, which the court applied to personal comfort activities, has not been legislatively expanded to apply to on-site activities ancillary to job performance such as going and coming activities. We conclude, therefore, that Clark should be limited to personal comfort activities until the Legislature extends it to other cases. A general limitation to the definition of a compensable injury for "unauthorized incidental activities" has no basis in ORS chapter 656, would be contrary to the intent of the Legislature and thus is beyond our power to create. See ORS 656.726(1) & (4); Oregon Fire/Police Retirement Committee, 62 Or App 777, 779 (1983)("An administrative agency may not, by its rules, amend, alter, enlarge or limit the terms of a legislative enactment."), rev den 296 Or 464 (1984).

There is no evidence in the record that claimant's injury was sustained during an "assault or combat" or that it was sustained through the "deliberate intention of the worker." Those statutory limitations, therefore, do not apply. The limitation for social and recreational activities did not become effective until after claimant's injury and thus is inapplicable. See Or Laws 1987, ch 713, § 8. As for the rule of Clark v. U.S. Plywood, supra, we conclude that it is inapplicable because the present case involves going and coming activities rather than personal comfort activities. Regardless of whether claimant's injury was sustained as a result of activity that was expressly or impliedly authorized by the employer, therefore, the injury arose out of and in the course of claimant's employment and thus is compensable.

Claimant's counsel has requested Board authorization of an assessed fee of $500. Apparently this is the total fee requested for services both at hearing and on Board review. Counsel for the insurer has requested authorization for a client-paid fee of $100. After reviewing the factors set forth in OAR 438-15-010(6), we conclude that the fees requested are reasonable.

ORDER

The Referee's order dated February 20, 1987 is reversed. The insurer's denial dated October 28, 1986 is set aside and the claim is remanded to the insurer for processing according to law. Claimant's attorney is awarded $300 for services at the hearing and $200 for services on Board review, to be paid by the insurer. Counsel for the insurer is authorized to bill a client-paid fee of up to $100 in connection with Board review.

DALE L. TICHENOR, Claimant
Olson Law Firm, Claimant's Attorney
Foss, Whitty, et al., Defense Attorneys
Marcus Ward, Defense Attorney
Charles Lisle (SAIF), Defense Attorney
Schwabe, et al., Defense Attorney

WCB 87-14700, 87-1498, 87-14699 & 87-17319
July 21, 1988
Order on Review

Reviewed by Board Members Crider and Johnson.

The SAIF Corporation requests review of Referee Brown's order which found it responsible for treatment related to claimant's current low back condition. The issue on review is responsibility. We affirm.

FINDINGS OF FACT

The Board adopts the findings of fact set forth on pages 1 through 3 of the Referee's Opinion and Order.

CONCLUSIONS AND OPINION

The Board affirms and adopts the Referees conclusions and opinion with the following additional comments.

SAIF argues on review that work activities at claimant's most recent employment contributed independently to his current disabling condition. It states, "[T]here is substantial evidence indicating that claimant's work activities at Columbia Plywood contributed to the cause of, aggravated, and exacerbated claimant's underlying condition." It points to no evidence, however, except to contend that, contrary to claimant's testimony at deposition and at hearing, "The preponderance of the medical evidence indicates that claimant's low back condition did not become symptomatic until after he started working for Columbia Plywood."

Even if we were to find that claimant had no symptoms between 1983 and 1987, based on medical reports which relied on histories of the claimant who is not credible, a temporal connection between symptoms and work activity is not sufficient to establish a causal connection in light of the medical evidence which anticipated a worsening of the 1981 condition in the absence of intervening trauma. See Edwards v. SAIF, 30 Or App 21 (1977), and Bradshaw v. SAIF, 69 Or App 589 (1984).

On de novo review, we agree with the Referee that SAIF's insured, Maywood Industries, remains the responsible insurer for claimant's current back condition.

ORDER

The Referee's Opinion and Order dated February 8, 1988, is affirmed and adopted as supplemented. A client-paid fee not to exceed $1,892, to be paid by Liberty Northwest Insurance Corporation, is approved. A client-paid fee not to exceed $187.50, to be paid by the SAIF Corporation to the firm of Foss, Whitty, et al., is approved.

DALE L. TICHENOR, Claimant
Olson Law Firm, Claimant's Attorney
SAIF Corp, Insurance Carrier

Own Motion 86-0183M
July 21, 1988
Own Motion Order

The SAIF Corporation has submitted to the Board claimant's claim for an alleged worsening of his June 26, 1981 industrial injury. Claimant's aggravation rights have expired. SAIF opposes the request, contending that it is not responsible for claimant's current condition.

On September 4, 1987, claimant was admitted to the hospital and underwent surgery for an extruded L4 disc on the left.

On June 2, 1988, we issued an "Order Postponing Action on Own Motion Request," pending the outcome of the responsibility issue which was then before the Board in WCB Case Nos. 87-14698, 87-14699, 87-14700 and 87-17319. By order entered this date, we affirmed the Referee's assignment of responsibility to the 1981 injury.

SAIF also requests that if own motion relief is granted, it be allowed to apply interim compensation benefits paid in claim number D728298E to benefits awarded in this own motion claim, for the reason that the two claims were investigated jointly and the claim under which the benefits have been paid is for the same medical treatment and disability.

We note that the two claims involved are both insured by SAIF but involve different employers. In Cascade Steel Rolling Mills v. Madril, 62 Or App 598, rev den 295 Or 541 (1983), the Court of Appeals declined to allow an offset of an overpayment made by a different insurer on a prior claim. The rule in effect at that time specifically allowed offsets of overpayments made earlier on the same claim. OAR 436-54-320. The current administrative rule does not address the issue, see OAR 436-60-170, and we conclude, in the absence of specific authority, that an offset of benefits paid on one claim involving one employer against amounts due on another claim involving a different employer, is not authorized.

The request for own motion relief is hereby allowed. The claim is reopened and SAIF shall pay temporary total disability benefits from September 4, 1987 until he returns to his regular work at his regular wage or is medically stationary, whichever is earlier. See OAR 438-12-052(2). Reimbursement from the Reopened Claims Reserve is authorized to the extent allowed under ORS 656.625 and OAR 436, Division 45. When appropriate, the claim shall be closed by SAIF pursuant to OAR 438-12-055. SAIF's request for authorization to apply benefits paid under claim number D728298E, to those due under this claim number is denied.

IT IS SO ORDERED.

PAUL M. MARSTON, Claimant
Kirkpatrick & Zeitz, Claimant's Attorneys
Roberts, et al., Defense Attorneys
Lester Huntsinger (SAIF), Defense Attorney
Carl M. Davis, Assistant Attorney General

WCB 86-02370 & 86-07148
July 22, 1988
Order on Review

Reviewed by Board en banc.

Claimant requests review of that portion of Referee Shebley's order that upheld Farmers Insurance Company's denial of his industrial injury claim relating to his right shoulder. The issue is compensability.

The Board affirms the order of the Referee.

ORDER

The Referee's order dated December 15, 1986 is affirmed. A client-paid fee, not to exceed $160, is approved.

Board Member Crider, dissenting:

The majority has affirmed the Referee's order upholding a denial of compensability under the "aggressor defense" although the claimant did not initiate any physical contact with his coworker who, nonetheless, shoved claimant thereby causing claimant's injury. I dissent because I believe the construction of ORS 656.005(7)(a)(A) implicit in this decision is inconsistent with the purposes of the Workers' Compensation Law and wrong.

The Referee found that claimant and coworker, who had taken a break from their outdoor work to put on warmer clothing, began arguing when the coworker was unable to produce claimant's gloves. Claimant "came nose-to-nose with Kraft and shouted obscenities. Kraft, the coworker, responded by grabbing claimant in both arms and throwing him to the ground. Claimant's shoulder struck a tree stump or other immovable object and separated his acromioclavicular joint. Claimant never struck a blow..." Indeed, the Referee did not find that claimant initiated any physical contact of any kind with the coworker. Under these circumstances, I believe claimant's injury was compensable.

Although the Referee's opinion implies that claimant's conduct was threatening because he was "six inches taller and 30 pounds heavier than" his assailant, shouting of obscenities (even by a large person) does not constitute an assault in the common law or the criminal code. It should not be treated as an assault for purposes of ORS 656.005(7)(a)(A).

ORS 656.005(7)(a)(A) excludes from the general definition of compensable injury, "Injury to any active participant in assaults or combats which are not connected to the job assignment and which amount to a deviation from customary duties from customary duties." The statute must be interpreted consistent with its plain meaning and with the purpose of the Workers' Compensation Law. The Workers' Compensation Law is to be liberally construed in favor of the injured worker. Reynaga v. Northwest Farm Bureau, 300 Or 255 (1985). Thus, this exclusion must be read narrowly in order that its application not interfere with the general purpose of the law -- that is, to provide benefits to injured workers without regard to fault. ORS 656.012(2)(a).

A combat, in ordinary usage, is a fight -- a two-way affair. An assault, however, has been interpreted by the Court of Appeals to involve a lesser event. Kessen v. Boise Cascade, 71 Or app 545 (1984). Nevertheless, a person is not guilty of an assault and therefore to be denied benefits for an injury inflicted by another if he has simply initiated an unpleasant encounter. To prove assault, under Oregon common law, one had to prove wrongful conduct causing serious physical injury. State v. Rainwater, 26 Or app 593 (1976). Under the 1977 Criminal Code, even assault in the fourth degree requires, at a minimum, intentional, knowing or reckless causation of physical injury. ORS 163.160.

The statutory aggressor exclusion should be read in light of the common law and statutory meaning of the word assault. Thus, the aggressor defense would exclude from compensability only injuries to workers whose aggressive conduct results in physical injury to another (the equivalent of criminal assault) or who are active participants in two-way brawls. Such construction of the law is also consistent with the majority rule in the states. Common law aggressor defenses are generally applied to deny compensation to employees who have initiated an altercation with the willful intent to injure another person -- not to employees who have aggressed by words alone. 1 Larson, Workmen's Compensation, Section 15(c) and (d). Verbal combats are part and parcel of life in the workplace. In the absence of clear legislative direction that we deny compensation to workers whose words are met with physical violence, I would not do so.

This is not inconsistent with Kessen v. Boise Cascade, supra. The Kessen court stated that, "Although [claimant] was the recipient of the only blow struck, he was the one who, because of his anger, vocal tirade and threatening gestures, actually initiated the fight." However, Kessen threatened his coworker not by talk but by grabbing the coworker's injured arm. In other words, although Kessen did not strike his coworker, he did take aggressive physical action.

The Referee nonetheless relied on the quoted sentence from Kessen to conclude that claimant had engaged in an assault. The result is not compelled by Kessen. Claimant did not escalate the argument from a verbal to a physical episode. I would reverse and order the claim accepted.

ELLENA D. NEWKIRK, Claimant
Malagon & Moore, Claimant's Attorneys
Schwabe, et al., Defense Attorney

WCB 87-02381
July 26, 1988
Order on Review

Reviewed by Board Members Ferris and Johnson.

The self-insured employer requests review of that portion of Referee McCullough's order which set aside its denial of responsibility for medical services for claimant's current back condition. The issue on review is compensability of medical treatment under ORS 656.245. We affirm.

FINDINGS OF FACT

Claimant sustained a compensable low back injury in October, 1978, while pulling lumber on the planer chain for the employer, Weyerhaeuser. Dr. Hockey performed a lumbar laminectomy on October 20, 1978, after a myelogram showed a herniated nucleus

pulposis on the left at L-5, S-1. Claimant's postoperative course was uneventful and her left leg pain was relieved. She continued to complain of left hamstring tightness for which exercises were prescribed. On March 29, 1979, Dr. Hockey released her to return to light duty.

On July 5, 1979, Dr. Hockey reported that claimant fell off of a horse and landed on her back. He felt that claimant sustained a small strain, but that it didn't affect her former disc problem.

On July 23, 1979, claimant returned to Dr. Hockey after returning to work and pulling chain for two days. She complained of tenderness in the right sacroiliac area and a sharp pain in the right buttock. She had no pain at the site of the prior laminectomy. Dr. Hockey felt that the pain possibly represented a herniated disc developing on the opposite side of the previous problem, but that it was more likely a lumbosacral strain.

On December 28, 1979, claimant complained of bilateral lumbar pain to Dr. Stainsby, a neurologist. Dr. Stainsby requested claimant's medical records. On July 18, 1980, he felt that she was medically stationary resulting from her low back injury and that she had minimal disability. He released her to regular work.

A September 15, 1980 Determination Order and subsequent stipulation granted a total of 20 percent unscheduled permanent partial disability.

Vocational services were terminated on September 18, 1980 because claimant had quit work without medical authorization. She had returned to work, but quit after two hours when she suffered spasms and felt she could not do the work.

Claimant's bilateral symptoms persisted, but she did not seek further medical treatment because Drs. Hockey and Stainsby had told her she needed to learn to live with the pain. She thereafter worked short periods as a meat wrapper, an attendant for a handicapped person, a dishwasher, a cook, a waitress, and a live-in babysitter.

On October 28, 1986, she sought chiropractic treatment from Dr. McCarthy, chiropractor. He provided no diagnosis and felt that he had insufficient medical history to render an opinion as to the cause of claimant's complaints.

In January 1987, claimant saw Dr. Kuller, an orthopedic surgeon, and complained of constant aching and numbness in the low back and right leg.

On February 5, 1987, the employer denied responsibility for current medical treatment on the ground that it was not related to her compensable 1978 claim.

A CAT scan showed multiple abnormalities and Dr. Kuller referred claimant to Dr. Hockey for possible repeat surgery. Dr. Hockey felt that claimant had a possible right L5 herniated nucleus pulposus and recommended a myelogram.

Claimant was dissatisfied with Dr. Hockey, and she changed physicians to Dr. Rockey, another orthopedic surgeon.

Dr. Rockey diagnosed chronic degenerative lower lumbar disc disease and felt that any relationship to her 1978 industrial injury was obscure.

Claimant's attorney referred her to Dr. Smith, a neurosurgeon. Dr. Smith presented a detailed history, with the exception that he did not mention the 1979 fall from a horse. He reviewed the 1978 x-rays which he interpreted to show a congenital lesion on the right at L5-S1, and the 1987 CT scan which clearly demonstrated the lesion on the right. Based on these findings, he opined that claimant has a complex back problem with a congenital defect upon which has been superimposed a traumatic injury and a probable unstable lumbosacral articulation. He concluded that the 1978 injury was the major contributing factor leading to the 1978 surgery on the left and the subsequent intractable back and leg pain.

Claimant is a credible witness.

CONCLUSIONS AND OPINION

Claimant is entitled to ongoing medical treatment "for conditions resulting from the injury for such a period as the nature of the injury or the process of recovery requires * * *." ORS 656.245(1). Claimant bears the burden of proving that the medical services are for conditions resulting from the industrial injury. McGarry v. SAIF, 24 Or App 883, 888 (1976).

There is disagreement among the experts in this case. Drs. Hockey and Rockey find no connection between claimant's 1978 injury and her current complaints; Drs. Kuller and Smith believe that the two are related. The relative weight to be given to their opinions is determined by the accuracy of the histories upon which they base their opinions. Drs. Hockey and Rockey were under the misconception that claimant did not experience right-sided symptoms until recently and that claimant did not experience symptoms during the six-year hiatus during which she sought no treatment. Drs. Kuller and Smith based their opinions on a history of intractable right-sided pain since the 1978 injury.

The claimant testified that she experienced right-sided pain since shortly after the 1978 injury, that she did not originally focus on it because the left side was so much worse, and that she did not seek medical treatment between 1980 and 1986 because she had been told by Drs. Hockey and Smith that she would just have to learn to live with the pain.

The Referee found the claimant credible. We defer to his finding. See Kenneth L. Frisby, 37 Van Natta 280 (1985).

As did the Referee, we find Dr. Smith's opinion to be based on the most accurate and complete history. Unlike the other experts, he noted the presence of a right-sided defect on x-rays taken in 1978. Assuming he was unaware of the fall from the horse in 1979, we do not see that omission as significant. Dr. Hockey, who examined claimant after the fall, felt that it was a small strain and did not affect her prior injury.

We agree with the Referee that the opinion of Dr. Smith is the most persuasive and that claimant has established that her current medical treatment is a compensable result of the 1978 industrial injury.

ORDER

The Referee's order dated October 8, 1987 is affirmed. For services on Board review, claimant's attorney is awarded $500, to be paid by the self-insured employer.

ELLENA D. NEWKIRK, Claimant
Malagon & Moore, Claimant's Attorneys
Schwabe, et al., Defense Attorneys

Own Motion 87-0098M
July 26, 1988
Own Motion Order

Claimant initially submitted her claim to the Board for an alleged worsening of her October 10, 1978 industrial injury. Claimant's aggravation rights have expired. The self-insured employer issued a denial of medical services under ORS 656.245 which claimant appealed to the Hearings Division (WCB Case No. 87-02381). The Board postponed action on the own motion request until resolution of the pending hearing. We have, this date, issued an Order on Review in WCB Case No. 87-02381 whereby we affirmed the Referee's order which reversed the employer's denial and found it responsible for claimant's treatment, including surgery. The issue currently before us is claimant's entitlement to claim reopening for the payment of temporary total disability compensation pursuant to ORS 656.278.

Although these own motion proceedings commenced prior to January 1, 1988, we have previously ruled that consideration of claimant's entitlement to temporary total disability compensation must be done under the current own motion law. Andy Webb, 40 Van Natta 586 (June 22, 1988). Pursuant to ORS 656.278(1)(a), we may exercise our "Own Motion" authority when we find that there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. In such cases, we are authorized to award temporary disability compensation commencing from the time the worker is actually hospitalized or undergoes outpatient surgery.

The evidence indicates that claimant's condition did worsen requiring surgery on October 30, 1987. Pursuant to the current law she could be entitled to compensation for temporary total disability from the date of her hospitalization. The employer argues that claimant has not worked since 1983 and, therefore, has not incurred any time loss. We find the case of Chapel of Memories v. Davis, 91 Or App 232 (May 18, 1988) to be instructive. In that case, as in this one, the claimant had not performed gainful employment for a significant period of time. However, there, the claimant testified that he had not withdrawn from the work force and would accept suitable employment. The claimant was found credible and, based on that credible testimony, was allowed temporary total disability benefits. The claimant in this case has also indicated that she looked for work after 1983. The Referee specifically found her credible. We conclude claimant is entitled to compensation for temporary total disability from the date she was hospitalized for the low back surgery in October 1987.

Accordingly, claimant's claim is reopened with temporary total disability compensation to commence October 30, 1987 and to continue until claimant returns to her regular work at her regular wage or is medically stationary, whichever is earlier. Claimant's attorney is awarded 25 percent of the additional compensation

granted by this order, not to exceed $600 as a reasonable attorney's fee. Reimbursement from the Reopened Claims Reserve is authorized to the extent allowed under ORS 656.625 and OAR 436, Division 45. When appropriate, the claim shall be closed by the employer pursuant to OAR 438-12-055.

IT IS SO ORDERED.

ROGER J. ACKERMAN, Claimant
Leo R. Probst & Assoc., Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB 84-07497
July 27, 1988
Order on Review

Reviewed by Board Members Ferris and Crider.

The insurer requests review of Referee Peterson's order that granted claimant permanent total disability for his June 29, 1976 back injury. On review, the insurer contends that claimant has not established an entitlement to permanent total disability, though he is entitled to a substantial award of unscheduled permanent partial disability. We reverse.

ISSUES

1. Whether claimant is permanently and totally disabled.

2. If he is not permanently and totally disabled, the extent of his permanent partial disability, unscheduled and scheduled.

FINDINGS OF FACT

Claimant injured his back on June 29, 1976 as a result of his employment as a line truck driver. He subsequently received conservative medical treatment for his injury and remained off work for the next several years.

In September 1980 claimant had a laminectomy and discectomy at the L4-5 level. His claim was closed by a Determination Order issued on October 7, 1981. He was awarded 40 percent unscheduled permanent partial disability for the low back. He continued to experience low back and lower extremity symptoms. Another surgical procedure was performed in January 1983: a laminectomy at the L3-S1 levels and a fusion at the L4-S1 levels.

Vocational rehabilitation efforts were initiated in June 1983. Claimant became medically stationary in April 1984 and his claim was closed again by a May 15, 1984 Determination Order. He was awarded an additional 10 percent unscheduled permanent partial disability.

A vocational rehabilitation training plan was proposed in September 1984. The plan provided for 12 months of training as a public safety dispatcher. Such work was classified as sedentary and claimant's treating surgeon, Dr. Ray Grewe, approved the plan. This plan proved unsuccessful in early October 1984 when the trainer decided not to participate. A second plan was proposed in June 1985, again involving training as a public safety dispatcher. The training program involved nine months of training under the supervision and guidance of Ross Brisco, the security manager at Portland Adventist Hospital. The purpose of the training program was to provide claimant with the skills and

knowledge necessary to apply for entry level employment as a public safety dispatcher. The training program also contemplated claimant obtaining his GED certificate.

Claimant obtained his GED in October 1985. He successfully completed the vocational training program in March 1986. However, because of budget limitations the hospital was unable to offer him a permanent job. Further job search efforts were thereafter made, but as of the date of hearing claimant had not obtained employment.

Claimant's claim was closed again by a May 22, 1986 Determination Order. He was awarded additional temporary disability compensation in connection with his vocational rehabilitation program. No additional unscheduled permanent disability was awarded, but he was awarded 5 percent scheduled permanent partial disability for the left leg.

Claimant was 58 years old at the time of hearing. He has an eighth grade education and, as noted earlier, obtained his GED in 1985. His past work experience has been almost entirely as a line truck driver. He worked almost 30 years in this capacity. Prior to such work, he was employed for about a year in a tool factory.

Prior to his 1985-86 training program, claimant had no transferable marketable job skills with which to locate employment, other than as a truck driver, without some type of retraining.

Claimant had no disability prior to his 1976 work injury. He has chronic back and left leg pain resulting from his 1976 injury and because of said residuals he is unable to return to work as a truck driver and is limited to sedentary work activity. Considering his residual physical problems related to his back injury, he is capable of performing such sedentary work activity on a full-time basis.

Claimant has bowel problems that affect his functional capacity from time to time. He also has Dupytren's contracture, which sometimes limits his use of his right hand. His bowel and right hand problems arose subsequent to his 1976 injury and are not causally related to said injury. Claimant also has a heart condition which is unrelated to his injury and was not disabling prior to his injury.

Claimant's vocational training in 1985-86 has given him skills to be employable in the area of his training.

OPINION AND CONCLUSIONS

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 any work at a gainful and suitable occupation. See former ORS 656.206(1)(a). A worker may establish permanent total disability by showing that he is totally incapacitated, from a physical/medical standpoint alone, from regularly performing gainful and suitable employment. Failing this, a worker may still establish permanent total disability status by showing that he is unable to regularly perform gainful and suitable employment based upon a combination of his

less-than-total physical/medical impairment and such nonmedical factors as age, education, adaptability to nonphysical labor, mental capacity, and emotional conditions. See Wilson v. Weyerhauser, 30 Or 403, 409 (1977).

Unscheduled permanent partial disability is based upon loss of earning capacity. Earning capacity is the ability to obtain and hold gainful employment in the broad field of general occupations. Evaluation of loss of earning capacity considers the claimant's permanent impairment/limitations resulting from the injury along with such factors as age, education, training, and work experience. See Ford v. SAIF , 7 Or App 549 (1972). Scheduled permanent partial disability is based upon loss of use of the injured member due to the injury. See former ORS 656.214(1).

Claimant's entitlement to permanent total disability will be discussed first. We first address the factor of permanent impairment. We are persuaded that claimant has suffered a very substantial degree of physical impairment as a result of his 1976 back injury and subsequent surgeries. However, we do not give full credence to claimant's assertions in his testimony regarding the extent of his impairment because the record contains evidence of his tendency to exaggerate. In this regard, we note the comments of Dr. Colistro, a psychologist who evaluated claimant in early 1984. He opined that there was an element of hyperbole/exaggeration in claimant's complaints. We further note claimant's testimony which indicated exaggeration with respect to the hours he worked and the days he missed during his training program in 1985. Accordingly, we feel that the most reliable basis for assessing the extent of claimant's injury related-permanent impairment is the medical evidence.

Claimant's impairment has been assessed by Dr. Grewe, the neurosurgeon who performed his laminectomy and discectomy in 1983, and by Dr. Waldram, the orthopedic surgeon who performed the fusion operation in 1983. Dr. Waldram has opined that claimant is limited to no lifting over 25 pounds and no repetitive bending. He has also advised that claimant needs to move around during a portion of the day. Dr. Grewe has characterized claimant's residual physical capacity regarding his back as being in the light-sedentary range. In terms specific restrictions Dr. Grewe has opined that claimant should do no lifting/carrying over 10 pounds, no bending or crawling, only occasional squatting or climbing, and his standing/walking should be limited to two hours in an eight-hour workday. These restrictions put claimant closer to the sedentary, rather than light, work level. See OAR 436-65-605(2)(c) and (d).

Dr. Waldram's assessment of claimant's permanent impairment is not quite as restrictive as Dr. Grewe's. We find Dr. Grewe's assessment more persuasive because the record indicates that he has followed claimant's post-surgical condition on a more frequent basis than Dr. Waldram and is therefore likely to be in a better position to accurately assess the nature and extent of claimant's residual limitations. Although he has sometimes used the term light, as opposed to sedentary, in characterizing claimant's impairment, we find that Dr. Grewe's assessment of impairment in terms of specific restrictions puts claimant at the sedentary work level. We further find from Dr. Grewe's reports as a whole that claimant is capable of performing sedentary work on a full-time basis, considering his back

injury-related problems alone. We note that Dr. Grewe advised in 1984 that claimant ought to be limited to part-time hours initially upon returning to work, but he also indicated that he felt that claimant could move to full-time hours within a short period of time. Dr. Grewe has more recently opined that claimant can do sedentary work on a full-time basis.

The evidence establishes that claimant has physical problems apart from his compensable back condition that add to his overall impairment. One such problem involves his right hand. This has been described as Dupuytren's contracture. To the extent that claimant has any disability regarding the right hand, such disability has arisen since his 1976 compensable injury and the medical evidence does not establish any causal connection between claimant's right hand problem and the 1976 injury.

Claimant also has bowel problems. He has advised his vocational rehabilitation counselor that because of his bowel problems he is unable to work on a full-time basis; that is, an eight-hour work shift. Claimant's disabling bowel problems have arisen since his 1976 injury and the medical evidence does not establish a causal connection between said problems and the injury. In this regard, Dr. Grewe reported in April 1986 that he did not know whether claimant's gastrointestinal problems were related to his back pain and irritation, his medication, his eating habits, or something else. He referred claimant to a gastroenterologist for a consultation. However, the record contains no report from a gastroenterologist or any other medical opinion that causally relates claimant's bowel problems to his 1976 back injury and/or its sequelae.

Finally, we note that the record contains references to some problems claimant has experienced regarding his heart. To the extent that such problems are disabling at all, and the record is not clear on this point, such disability has arisen since claimant's 1976 injury and is not compensably related to the injury.

Because claimant's problems regarding his right hand, heart, and bowels have arisen subsequent to his 1976 injury and because the evidence does not establish a compensable relationship between said problems and the injury, the disabling effects of these conditions cannot be considered in evaluating his entitlement to permanent total disability. See Emmons v SAIF, 34 Or App 603 (1978).

Considering our findings regarding claimant's permanent injury-related impairment and the nonmedical factors pertinent to the evaluation of permanent disability, including his lack of transferable skills prior to his 1985-86 training program, we are persuaded, as was the Referee, that prior to his training program claimant was unemployable. The question is whether, considering claimant's injury-related impairment along with the pertinent nonmedical factors, claimant's training in 1985-86 made him capable of regularly performing work at a gainful and suitable occupation. The record contains conflicting opinions from vocational rehabilitation experts on this question.

Susie Yeiter, claimant's vocational rehabilitation counselor since October 1985, has indicated in her reports and

testimony that claimant's training as a security dispatcher has made him employable. Although job search efforts have not yet resulted in claimant becoming employed, she has opined that she feels claimant can work. Ray Rees, a vocational rehabilitation counselor who testified at the hearing on claimant's behalf, has opined that claimant is not able to perform gainful work even on a part-time basis.

We find Ms. Yeiter's opinion more persuasive than Mr. Rees. We find nothing in the record that persuades us that Ms. Yeiter has any reason to fabricate or exaggerate her opinions regarding claimant's employability. Her substantial involvement in claimant's rehabilitation activity has given her a better familiarity with claimant's case than Mr. Rees. Her view that claimant is employable, even though he has not yet become employed, is supported by evidence in the record. For example, the record shows that claimant would have been hired at Portland Adventist Hospital but for budget limitations. Further, an employment opportunity in the area of claimant's training developed with a security system. Ms. Yeiter obtained a job description and gave it to claimant's doctor, who approved it. However, claimant was not interviewed for the position because he advised the employer that he could not work an eight-hour day. As noted earlier, claimant has told his vocational rehabilitation counselor that the reason he cannot work a full day is because of his bowel problems, which we have found to be noncompensable.

We do not find Mr. Rees' opinion as persuasive as Ms. Yeiter's for several reasons. First, as indicated earlier, Ms. Yeiter is in a superior position to Mr. Rees in terms of her familiarity with claimant's case. Further, there are significant flaws in Mr. Rees' opinion. Although he initially testified that his opinion regarding claimant's lack of employability was based upon claimant's overall conditions, including his right hand and bowel problems he subsequently advised that he felt that claimant was unemployable due to his back problems alone. In this regard, Mr. Rees did not think claimant's back condition would allow him to satisfactorily perform gainful activities on a part-time basis over a sustained period of time. Such an opinion resembles an assessment of claimant's physical impairment, which is within the expertise of claimant's treating physician, not Mr. Rees. In any event, Mr. Rees' opinion is inconsistent with the assessment of Dr. Grewe who, as noted earlier, has opined that claimant is capable of performing sedentary work activity on a full-time basis.

Mr. Rees' opinion in this case is also flawed because it is based in material part on factual information the accuracy and reliability of which is not established by the evidentiary record. Mr. Rees testified that based upon a telephone conversation he had with Terry Shupe, a coworker with claimant during his training program at Portland Adventist Hospital, and based upon his review of a written statement from Ross Brisco, claimant's supervisor/trainer at Portland Adventist Hospital, he had concluded that claimant was unable to satisfactorily perform the duties involved in his training program. He further indicated that he relied upon this information from Mr. Shupe and Mr. Brisco in forming his opinion as to whether or not claimant was permanently and totally disabled. Mr. Rees also indicated that he had a telephone conversation with Dr. Grewe which also formed a part of the basis for his opinion. He said Dr. Grewe indicated to him that claimant could only work at a sedentary job on a part-time basis.

The information that Mr. Rees received from Mr. Shupe, Mr. Brisco, and Dr. Grewe was not admitted at hearing for its probative value. Rather, it was admitted simply to show what information was used by Mr. Rees in forming his opinion. In fact, it is not clear that the "information" from Mr. Shupe was admitted on any basis.

We agree that the above referenced information from Mr. Shupe, Mr. Brisco, and Dr. Grewe is not entitled to be given any probative value in this matter. Said information was not presented in verbatim form. Rather, it was merely presented in the form of Mr. Rees' recollection of what Mr. Shupe and Dr. Grewe had told him. Mr. Brisco's "statement" was not quoted, but was simply paraphrased by Mr. Rees in his testimony. This lessens one's confidence in the accuracy of the information. In addition, the sources of said information were not subjected to and tested by cross-examination. This further lessens the reliability of the information. Finally, Mr. Rees' understanding of Dr. Grewe's assessment of claimant's impairment and his understanding of Mr. Brisco's assessment of claimant's training performance is not consistent with other evidence in the record. As noted earlier, Dr. Grewe has indicated in his reports that claimant is capable of sedentary work activity on a full-time basis. As for Mr. Brisco, the record contains numerous indications of his positive view of claimant's training performance and employment capability. He advised claimant's vocational rehabilitation counselor in late 1985 that claimant was "the best there is." In early 1986 he advised the counselor that claimant was excelling in his performance and was very dependable. He further advised that he hoped to secure employment for claimant at the hospital. He subsequently wrote a very positive letter of recommendation for claimant in which he stated that he would have hired claimant if there had been a position available in the budget.

Mr. Rees was free to choose to rely upon the above-referenced information in forming his opinion regarding claimant's disability. However, because we find, for the foregoing reasons, that said information is not entitled to any probative value, we discount the persuasiveness of Mr. Rees' opinion because of such reliance. Based upon the foregoing factual findings and reasoning, and the applicable law, we conclude that claimant has failed to establish by a preponderance of the evidence that he is permanently and totally disabled as a result of his 1976 back injury.

Although we are persuaded that claimant is employable, it is clear that his employment options in the general labor market are quite limited. Considering our findings regarding his injury-related impairment and the nonmedical factors pertinent to the evaluation of loss of earning capacity, we conclude that claimant has suffered a loss of earning capacity as a result of his 1976 injury that warrants an award of 90 percent unscheduled permanent partial disability. We further conclude that the evidence does not establish claimant's entitlement to an award of scheduled left leg permanent partial disability in excess of what he has already been awarded.

ORDER

The Referee's order is reversed. In lieu of the

permanent total disability award granted by the Referee and in addition to the 50 percent (160 degrees) unscheduled permanent partial disability claimant has previously been awarded by the Determination Orders, claimant is hereby awarded an additional 40 percent (128 degrees) unscheduled permanent disability, giving him a total award to date of 90 percent (288 degrees) unscheduled permanent partial disability for his June 29, 1976 back injury. Claimant's prior award of 5 percent scheduled permanent partial disability for the left leg is affirmed. The insurer shall not offset against the unscheduled permanent partial disability award granted herein the payments it made on the permanent total disability award pending its appeal of the Referee's order. The insurer is entitled to take a credit, against the unscheduled permanent partial disability award granted herein, for its 1986 temporary disability overpayment of $3,356.08 to the extent that it has not already offset said overpayment against the permanent disability compensation awarded claimant by the Referee's order.

In lieu of the attorney fee awarded by the Referee's order, claimant's attorney is awarded a fee of 25 percent of the increase in permanent disability compensation due claimant as a result of this order, to be paid from said compensation and not to exceed $2,000. Said attorney fee is allowed only to the extent that it has not already been paid from the permanent total disability benefits resulting from the Referee's order.

A client-paid fee is approved, not to exceed $1,188.

SHIRLEY M. BROWN, Claimant
Kirkpatrick & Zeitz, Claimant's Attorneys
Dennis Martin (SAIF), Defense Attorney

WCB 85-12591
July 27, 1988
Order on Review

Reviewed by Board Members Johnson and Crider.

The SAIF Corporation requests review of that portion of Referee Tuhy's order that granted claimant permanent total disability, whereas a Determination Order had awarded 25 percent (80 degrees) unscheduled permanent disability for a back injury. The issue is extent of unscheduled permanent disability, including permanent total disability. We affirm.

ISSUES

1. Whether claimant is permanently totally disabled.

2. If not, the extent of claimant's unscheduled permanent partial disability.

3. Whether claimant's counsel is entitled to an attorney fee award on Board review.

FINDINGS OF FACT

Claimant, 51 years old at the time of hearing, was employed as a part-time bartender. She worked approximately 30 hours per week. She injured her back in February 1984 while lifting an empty beer keg. Her symptoms included pain in her back and a sensation of heat down the back of her right leg.

On April 5, 1984, claimant underwent a CT scan which disclosed a large herniated disc at L5-S1, as well as degenerative

changes. SAIF accepted her claim on April 17, 1984. In June 1984, she underwent a laminectomy at L5-S1 and decompression of the L4-5 nerve root.

Claimant improved briefly following surgery, but her condition then began to gradually worsen. In addition to back pain, she developed pain radiating down her right leg to her right heel. She also developed headaches and right foot drop.

A Determination Order issued on September 19, 1985 awarding claimant 25 percent unscheduled permanent partial disability.

Claimant's primary treating physician since the injury has been Dr. Leveque, osteopath. He has treated claimant with ultrasound and pain shots. In April 1986, Dr. Leveque reported that claimant was limited to occasionally lifting and carrying up to five pounds. He further reported that claimant could sit for maybe one-half hour, stand up to two hours and walk up to two hours.

Claimant was twice referred to vocational assistance. Both referrals were terminated because, in the opinion of the service provider, the limitations imposed by Dr. Leveque and by claimant herself precluded a return to suitable employment.

In addition to her job at the time of injury, claimant spent two years working as a teacher's aide with mentally retarded students. She is no longer physically capable of performing this work. She has a high school education.

Claimant cannot lift her arms above her shoulders without experiencing pain. She cannot walk with her right heel on the ground without experiencing headaches. She cannot sit in one place without experiencing low back and buttock pain. She sleeps three to five hours each night. She has severely restricted her household activities. Her impairment as a result of the 1984 injury is in the moderately severe range.

Claimant is a credible and reliable witness.

Claimant is physically incapable of regular, gainful employment.

CONCLUSIONS AND OPINION

Permanent Total Disability

We adopt the Referee's "Opinion" on the permanent total disability issue with the following supplementation.

SAIF's primary argument on review is that claimant is capable of part-time light to sedentary work. See Georgia-Pacific Corp. v. Perry, 92 Or App 56 (July 6, 1988). In support of its position, SAIF notes that claimant was examined by the Orthopaedic Consultants in August 1985 and that they reported that claimant was capable of performing work in the light to sedentary categories. However, this report was authored 15 months prior to the hearing. Claimant's credible testimony, along with the opinions of Dr. Leveque, establish that claimant's condition progressively worsened prior to hearing.

Moreover, the Orthopaedic Consultants reexamined claimant in September 1986. They noted at that time that claimant reported feeling better prior to surgery than she did following surgery. They further stated:

> "If this patient is considered to remain stationary, in the opinion of these examiners, she ultimately will be awarded a permanent total disability. For this reason, it is our joint opinion that in order to recover any degree of usefulness in this individual it would be of definite benefit to have her enrolled at the Northwest Pain Center..."

While this report is not without ambiguity, we conclude that the most reasonable interpretation is that the Consultants felt claimant was then permanently totally disabled and, in the absence of improvement, would remain so. The credible lay and medical evidence establishes that claimant's condition has not improved.

Attorney Fee Award

We next address the question whether claimant's attorney is entitled to an award of a reasonable attorney fee on Board review. The case appears before us on a carrier-initiated request for review. Pursuant to our decision on the merits, claimant has successfully defended against reduction of her compensation. Under these circumstances, an attorney fee award is appropriate, if at all, pursuant to ORS 656.382(2). See Shoulders v. SAIF, 300 Or 606, 616 (1986). 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."

Here, claimant failed to timely file her brief on review. Nevertheless, she has prevailed over an insurer-initiated request for review. We have previously held that ORS 656.382(2) mandates an insurer-paid attorney fee under such circumstances. See e.g. Myron W. Rencehausen, 39 Van Natta 56 (1987). We take this opportunity to reexamine our interpretation of the statutory language. A review of prior caselaw is instructive in this regard.

It was at one time our position that claimant's counsel was not entitled to an attorney fee award where the only legal services performed on review consisted of an untimely filed respondent's brief. Richard N. Couturier, 36 Van Natta 59 (1984).

We impliedly overruled our decision in Couturier in Betty J. McMullen, 38 Van Natta 117 (1986). In McMullen, neither the insurer nor claimant filed a brief on review. We concluded that ORS 656.382(2) nevertheless required an award of an attorney fee. We noted that the insurer's request for review "necessitated further services which otherwise would not have been required." Id. at 118.

We again addressed this question in Dan W. Hedrick, 38 Van Natta 208 (1986), aff'd mem 83 Or App 275 (1987). In Hedrick, no briefs were filed, but claimant presented motions and other documents in response to the employer's request for review. Citing our order in McMullen, we concluded that ORS 656.382(2) mandated an insurer-paid attorney fee in such situations.

Our McMullen and Hedrick line of cases culminated in our decision in Myron W. Rencehausen, 39 Van Natta 56 (1987). In Rencehausen, the employer filed an appellant's brief but claimant did not timely respond. Claimant nevertheless prevailed on review. We again concluded that ORS 656.382(2) required an insurer/employer-paid attorney fee. We cited the Supreme Court decision in Shoulders v. SAIF, 300 Or 606 (1986), in support of our position.

The primary issue in Shoulders was whether ORS 656.382(2) or ORS 656.386(1) was applicable to a case where review was sought by the insurer from an order awarding compensation. The Court concluded that ORS 656.382(2), rather than ORS 656.386(1), was the applicable statute. There was no suggestion in Shoulders that claimant had failed to timely file a brief. Therefore, on further consideration, we conclude that Shoulders v. SAIF, supra, does not support the proposition for which it was advanced in Rencehausen.

Considering the question anew, we now find that ORS 656.382(2) provides for an attorney fee award where three requirments are met. First, the request or cross-request for review must be initiated by the employer or insurer. Second, we must find "that the compensation awarded to a claimant should not be disallowed or reduced." Third, claimant's attorney must have actually performed services on review. Finally, the statute requires an insurer-paid attorney fee for "legal representation by an attorney for the claimant at and prior to hearing, review on appeal or cross-appeal."

We conclude that this final test has not been adequately considered in our prior decisions on this question. We interpret this third test as requiring more than the mere submission of an untimely brief. An untimely submitted brief is not subject to our review and, therefore, is of no assistance to us in the review process. See OAR 438-11-015 & 438-11-020. We conclude that an untimely brief does not qualify as "legal representation...for the claimant...[upon] review on appeal" as that phrase is used in the statute. Therefore, the filing of an untimely brief does not create entitlement to an insurer-paid attorney fee. It follows that failure to file any brief, even an untimely brief, similarly does not create entitlement to an insurer-paid attorney fee. We disavow our prior decisions to the extent they reach a contrary conclusion.

We acknowledge that claimant's counsel might provide

some "legal representation" short of briefing which would support an attorney fee award on review. See Dan W. Hedrick, supra (claimant's attorney presented motions and other documents in response to the employer's request for review). Where such efforts are documented in the record, we will continue to award a reasonable attorney fee. No such efforts are documented in the record here. We, therefore, conclude that claimant's counsel is not entitled to award of an insurer-paid attorney fee on review.

ORDER

The Referee's order dated April 13, 1987 is affirmed.

CATHEY M. DAVIDSON, Claimant
Daryll E. Klein, Claimant's Attorney
Schwabe, et al., Defense Attorneys
Thomas Sheridan (SAIF), Defense Attorney
Ann Kelley, Assistant Attorney General

WCB 86-17404 & 86-08865
July 27, 1988
Amended Order on Review

Reviewed by Board Members Crider and Ferris.

SAFECO Insurance Company's counsel seeks Board authorization of a client-paid fee for services rendered on review which culminated in our June 28, 1988 Order on Review.

After review of the statement of services and attorney retainer agreement submitted by SAFECO's counsel, and considering the factors set forth in OAR 438-15-010(6), we approve a client-paid fee not to exceed $2,825.50. In doing so, we note that all attorney fees are subject to Board approval. OAR 438-15-001. However, costs incurred by an attorney in pursuing a matter on behalf of a party are not included in fees paid to any attorney. OAR 438-15-005(7). Therefore, Board approval for reimbursement of costs incurred by the attorney is not required. See OAR 438-15-005(4), (5), (7); OAR 438-15-010(5); Janelle I. Neal, 40 Van Natta 359 (1988).

Accordingly, our June 28, 1988 order is abated and withdrawn. As amended herein, we adhere to and republish our June 28, 1988 order in its entirety. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

TRACI D. FEICKERT, Claimant
Dennis O'Malley, Claimant's Attorney
Roberts, et al., Defense Attorneys

WCB 86-11496
July 27, 1988
Order on Review

Reviewed by Board Members Crider and Johnson.

The insurer requests review of that portion of Referee Neal's order that set aside its denial of claimant's occupational disease claim for mental stress. We affirm.

ISSUE

On review, the issue is the compensability of claimant's mental disorder.

FINDINGS OF FACT

We adopt the findings of fact made on Pages 1 through 3 of the Referee's order, excluding the final partial paragraph, and make the following findings of fact.

Claimant treated with Dr. Tinker a clinical psychologist, beginning on April 28, 1986. She gave him a history which included incidents of on-the-job stress from criticism, regular evening discussions about her performance, and reprimands in front of patients. She told the doctor of off-the-job stressors including parents who are recovered alcoholics, drug experimentation and a suicide gesture in high school, and a serious automobile accident. Dr. Tinker found that claimant was vulnerable to development of psychophysiological disorders, and diagnosed major single episode depression. He found no preexisting mental disorder.

Dr. Tinker referred claimant to Dr. Harrison, a psychiatrist, for evaluation and anti-depressant treatment. Dr. Harrison was given the same history as was given to Dr. Tinker, and he reviewed claimant's medical records from Kaiser. He agreed with Dr. Tinker's diagnosis. He knew of no non-work factors which he considered significant contributors to her current mental condition.

On July 11, 1986, claimant was examined by Dr. Parvaresh. He diagnosed adjustment reaction, and a mixed personality disorder with passive dependency and avoidance predominant. Claimant's history to him included only on-the-job stressors, but Dr. Parvaresh also reviewed claimant's medical records. He doubted the veracity of claimant's history, but reported that, assuming harassment at work and no outside stressors, her preexisting mental disorder was made more symptomatic by her job.

The insurer denied claimant's mental stress claim on August 5, 1986.

Dr. Parvaresh attended the hearing, and was later deposed. He did not change his original diagnosis.

CONCLUSIONS OF LAW AND OPINION

To establish the compensability of her mental stress claim, claimant must prove that real events or conditions of her work, when viewed objectively, were capable of producing stress, and that the work conditions were the major contributing cause of her mental disorder. McGarrah v. SAIF, 296 Or 145 (1983). The stressful conditions must be objectively real. However, the medical effect on claimant is measured by her actual reaction, rather than the reaction of an "average" worker. Id.

The Referee found, based on her observation of the witnesses' demeanor at hearing, that the office manager downplayed the nature and frequency of the criticism, and that claimant exaggerated it. Because this is a case in which the record cannot convey the tone of the relationship, we defer to the Referee's conclusion on that issue.

We find that there were events at claimant's work which

were both real and capable of producing stress. Claimant was frequently corrected, and her shortcomings pointed out. Claimant correctly perceived that the office manager and the employer were critical of her performance. Claimant was called at home on her days off and told about things not correctly done. On one instance, the employer called claimant and chastized her for the condition of the office. This call led claimant and her grandmother to spend several hours stripping the floors in the office. The purpose of these criticisms was intended to help claimant learn to perform her job better. However, the pattern of criticism was sufficient to cause stress, and to cause someone with claimant's preexisting condition or vulnerability to develop disabling symptoms.

The insurer contends that claimant's non-work stressors contributed to or caused her condition. Of the stressors identified by the insurer, claimant's abortions, drug use, suicide gesture and family stress were past events which had concluded before claimant began working for the employer. Her alleged financial problems and difficulties with her boyfriend were speculative only. There were stressful events involving mistreatment of a cat, an auto accident, moving from her parents' home, and being home alone at night. However, we find that these incidents, when weighed against the regular pattern of criticism at work, were very different in degree and did not contribute significantly to her mental disorder.

We further find that claimant's treating psychologist and her attending psychiatrist were aware of the current, on-going stressors in her life, both off-work and at work. Dr. Parvaresh, on the other hand, based his opinions about contribution on inferences he drew from claimant's medical file and from a series of hypothetical facts presented to him in deposition. We find Dr. Tinker and Dr. Harrison's first-hand familiarity with claimant's history more persuasive, and conclude that claimant's work-related stressors were the major contributing cause of her mental disorder.

ORDER

The Referee's order dated June 5, 1987 is affirmed. Claimant's attorney is awarded an assessed fee of $1,500 for services on Board review, to be paid by the insurer.

DAVID F. GENISE, Claimant
Garry L. Kahn, Claimant's Attorney
Larry Dawson, Defense Attorney

WCB 86-01658
July 27, 1988
Order on Review

Reviewed by Board Members Ferris and Crider.

Claimant requests review of that portion of Referee Podnar's order which upheld the insurer's denial of claimant's heart attack claim. We affirm.

ISSUE

Whether claimant's cardiac condition is compensable.

FINDINGS OF FACT

On December 13, 1985, claimant, a 53-year-old truck

driver, experienced a sudden onset of chest pain and left arm numbness while driving his truck. Earlier that day, claimant and a coworker loaded the truck with approximately fifty 700 pound oil barrels and numerous five gallon cans of grease. Each oil barrel was pushed onto a handtruck and wheeled up a ramp into the truck. The grease cans were individually placed on pallets and loaded with a forklift. It was a warm day and the activity was very strenuous.

Claimant's risk factors for coronary artery disease were very strong. He was a prior smoker, 5'5" in height and weighed approximately 206 pounds, 40 pounds more than his recommended weight. He had a strong family history for heart disease. In 1979, he was diagnosed with congestive heart failure, arteriosclerotic heart disease and hypertensive cardiovascular disease. Thereafter, he experienced chest pain frequently when driving his truck, when tired, or following some stress or activity. His chest pains and left arm numbness continued through 1984. He also had intermittent chronic fatigue and exertional dyspnea with mild activity. He carried nitroglycerine with him at all times and utilized it regularly.

Although electrocardiograms taken three days after the December 13, 1985 episode of chest pain revealed no evidence of a myocardial infarction, the chest pain may very well have been an acute myocardial infarction.

On January 10, 1986, Dr. Leveque, osteopath, opined that claimant had suffered work-related "effort angina" due to the December 13, 1985 activities.

On March 5, 1986, Dr. Intile, internist, opined that claimant's angina was either work-related or had been aggravated by the physical and emotional distress of his job.

On April 17, 1986, Dr. Hamilton, cardiologist, diagnosed underlying atherosclerotic heart disease with a subsequent episode of severe angina or possible myocardial infarction, unrelated to work exposure.

The major underlying contributing factors to the development of claimant's atherosclerotic heart disease were his hypertension, family history, probable hypercholesteremia and prior smoking. His work activities did not worsen this underlying disease process. The episode of chest pain and left arm numbness on December 13, 1985 was caused by severe angina or possible myocardial infarction which represented the symptoms of the atherosclerotic heart disease. The work activities, including the loading of barrels, were not a material contributing cause of claimant's symptomology.

Claimant's increased symptoms have since precluded his return to work.

Based on the inaccurate histories provided to the examining and consulting physicians, claimant was not a reliable witness.

CONCLUSIONS OF LAW

The Referee concluded that claimant failed to prove that his cardiac problems were either materially caused or worsened by his work exposure. We agree.

To establish compensability of an occupational disease claim for a preexisting condition, claimant must prove that work conditions caused a worsening of his underlying condition producing disability or the need for medical services. Weller v. Union Carbide, 288 Or 27, 35 (1979). He must also establish that his work conditions were the major contributing cause of the worsening of his preexisting condition. Dethlefs v. Hyster Co., 295 Or 298, 310 (1983); SAIF v. Gygi, 55 Or App 570, 574, rev den 292 Or 825 (1982). A mere recurrence or exacerbation of symptoms is insufficient to establish a compensable condition. Wheeler v. Boise Cascade, 298 Or 452, 457-8 (1985).

To establish a compensable industrial injury, claimant has the burden of proving that a work event or series of events within a discrete time period was a material contributing cause of his disability or need for medical services. See Harris v. Albertson's, Inc., 65 Or App 254, 256-7 (1983); Valtinson v. SAIF, 56 Or App 184, 187-8 (1982). "Material contributing cause" means a substantial cause, but not necessarily the sole cause or even the most significant cause. See Van Blokland v. Oregon Health Sciences University, 87 Or App 694, 698 (1987); Lobato v. SAIF, 75 Or App 488, 492 (1985). Compensability must be proven by a preponderance of the evidence. Hutcheson v. Weyerhaeuser Co., 25 Or App 851, 856 (1976). 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); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985).

Following our de novo review of the medical and lay evidence, we are not persuaded that the December 13, 1985 lifting activities either materially contributed to claimant's need for medical treatment or worsened his underlying atherosclerotic heart disease. Consequently, the evidence fails to establish the claim's compensability under either an injury or an occupational disease theory.

Considering claimant's prior chest pain and left arm numbness, his continuing symptoms and his medical history of atherosclerotic heart disease, we have determined that the resolution of this complex causation issue can best be achieved through an appraisal of the medical opinions. Although the lay testimony is by no means rejected, the medical opinions are given significant probative value.

All of the medical opinions regarding causation are based on an inaccurate history of the December 13, 1985 incident. Therefore, our reliance upon these opinions is tempered with caution.

Claimant has a long history of congestive heart failure, arteriosclerotic heart disease and hypertensive cardiovascular disease, dating back to 1979. Since that time, he has frequently complained of chest pain and left arm numbness while driving his truck.

On January 10, 1986, Dr. Leveque, osteopath, opined that claimant had suffered work-related "effort angina" due to the December 13, 1985 activities.

On March 5, 1986, Dr. Intile, internist, was given a history by claimant of driving 19 hours the night before December 13, 1985, followed by loading 110 barrels of oil into his truck. In fact, claimant had not driven 19 hours the night before December 13, 1985. Rather, he hadn't driven at all. Also, with the help of a coworker, claimant lifted 50 barrels of oil, not 110 by himself. Based on that incorrect history, Dr. Intile opined that claimant's angina was either work-related or had been aggravated by the physical and emotional distress of his job.

On April 17, 1986, Dr. Hamilton, cardiologist, was given a history by claimant of no unusual activity occurring on December 13, 1985 prior to his chest pain. Dr. Hamilton diagnosed underlying atherosclerotic heart disease with a subsequent episode of severe angina or possible myocardial infarction. In Dr. Hamilton's opinion, the major underlying factors to the development of the atherosclerotic heart disease were claimant's hypertension, family history, probable hypercholesteremia and prior smoking. The chest pains were considered to be merely symptoms of the disease. Finally, Dr. Hamilton concluded that claimant's chest pain had no relationship whatsoever to his job, but was a coincidental occurrence.

We consider Dr. Hamilton's opinion to be the best reasoned medical opinion. His statements were based on a complete analysis of claimant's family history and preexisting heart conditions. While Dr. Hamilton was unaware of the barrel loading by claimant, he further opined that physical activity would not accelerate claimant's underlying atherosclerotic condition.

The statements of Drs. Leveque and Intile, on the other hand, are conclusory and not based on a thorough analysis of claimant's preexisting conditions. Also, Dr. Intile's opinion is based on an exaggerated history of physical and emotional stress.

Although we view the medical opinions with caution, we find Dr. Hamilton's opinion to be the most persuasive. Therefore, we hold that claimant's work activities were neither a material contributing cause of his heart condition nor did they worsen his heart condition. Claimant has failed to carry his burden of proof.

ORDER

The Referee's order dated July 31, 1987 is affirmed. A client-paid fee, not to exceed $1,220, is approved.

BENJAMIN C. MEEK, Claimant
Emmons, et al., Claimant's Attorneys
Jeff Gerner (SAIF), Defense Attorney

WCB 86-10751
July 27, 1988
Order on Review

Reviewed by Board Members Johnson and Crider.

Claimant requests review of that portion of Referee Michael Johnson's order that granted him 10 percent (32 degrees) unscheduled permanent partial disability for his low back and hip condition, in addition to the 15 percent (48 degrees) awarded by Determination Order. We affirm.

ISSUE

The issue on review is the extent of claimant's unscheduled permanent disability.

FINDINGS OF FACT

We adopt the findings of fact of the Referee, and make the following additional findings.

After claimant's compensable injury, he was diagnosed as suffering from a left iliac artery occlusion, which caused left leg pain. The condition was surgically corrected by Dr. Mukherjee. The surgery was essentially successful, resolving claimant's leg pain. He had some residual left buttock pain, which Dr. Mukherjee expected to slowly dissipate. The vascular condition was not work-related, and did not affect claimant's low back or left hip conditions.

Claimant has fully cooperated in his vocational assistance and has seriously attempted to find employment within his capabilities. As of the time of hearing, he had not found work.

CONCLUSIONS OF LAW AND OPINION

The test for measuring extent of unscheduled permanent disability is "loss of earning capacity." Surratt v. Gunderson Bros., 3 Or App 288, mod. 259 Or 65 (1971). In rating loss of earning capacity, we consider the medical and lay evidence of claimant's physical impairment, and all the relevant social and vocational factors set forth in OAR 436-30-380 et seq.

There is no medical dispute as to the level of claimant's impairment. Dr. Mukherjee's last report indicates that claimant suffers some residual impairment from his noncompensable vascular condition. However, this impairment is distinct from the impairment related to his compensable low back and hip condition. We have reviewed the evidence de novo, considering only claimant's compensable impairment, as well as the aforementioned social and vocational factors. We conclude that claimant is adequately compensated by the total award of 25 percent unscheduled permanent disability.

ORDER

The Referee's order dated June 10, 1987, is affirmed.

ALBERT W. OSBORNE, Claimant
Vick & Gutzler, Claimant's Attorneys
Davis & Bostwick, Defense Attorneys

WCB 86-12420
July 27, 1988
Order on Review

Reviewed by Board Members Ferris and Crider.

The insurer requests review of Referee Thye's order that: (1) set aside its denial of claimant's medical services claim for his current low back condition; and (2) awarded an attorney fee of $1,500. We affirm the order of the Referee.

ISSUES

The issues are medical services and attorney fees.

FINDINGS OF FACT

On April 21, 1983, claimant, 59 years old at hearing, suffered a compensable acute back strain with right radiculitis.

Claimant has a history of on-the-job back injuries dating back to 1972. He injured his back in December 1982 and was receiving chiropractic treatments from his treating doctor, Dr. Close, at the time he sustained his April 1983 injury.

Claimant continued treating with Dr. Close after his April 1983 injury. The Orthopaedic Counsultants examined claimant in July and diagnosed a resolved lumbar strain. On November 8, 1983, Dr. Close indicated that claimant would require two to four treatments per month to prevent a worsening of his condition. In December 1983, the Consultants agreed that claimant should not lift 35 pounds more than four times a day and that extra rest breaks were necessary.

A February 1984 Determination Order awarded 25 percent (80 degrees) unscheduled permanent partial disability for his low back injury. In 1984, claimant retired.

Claimant and the insurer requested a hearing concerning the Determination Order. On May 16, 1985, a prior Referee awarded an additional 15 percent permanent disability for a total of 40 percent (128 degrees) unscheduled permanent disability as a result of claimant's compensable injury.

In 1985 Dr. Bussanich, chiropractor, diagnosed chronic lumbosacral sprain and strain, and a degenerating L5 disc. In April 1986, claimant moved his residence. In May 1986, Dr. Johnson became claimant's treating chiropractor. Claimant's complaints at that time consisted of sharp low back pain and numbness in the right leg. Dr. Johnson treated conservatively.

Dr. Johnson referred claimant to Dr. Goe, neurophysiolgist. He diagnosed a chronic lumbosacral strain and sprain. Claimant was then referred to Dr. Baum, orthopedic osteopath, who diagnosed a herniated disc at L3-L4. Dr. Baum recommended surgery.

On October 14, 1986, the insurer issued a denial for claimant's current medical treatment. In November 1986, the Orthopaedic Consultants noted disc changes of a mild degree and attributed the degenerative changes in claimant's spine to the aging process.

Claimant's April 21, 1983 compensable injury was a material contibuting cause of claimant's current condition for which claimant sought medical treatment.

CONCLUSIONS OF LAW AND OPINION

The Referee reasoned that claimant's degenerative back condition was found compensable by the prior Referee's order and compensability could not be relitigated. The Referee relied on the Court of Appeal's decision in North Clackamas School Dist. v. White, 85 Or App 560 (1987). Here, the doctrine of res judicata is inapplicable.

In a decision issued subsequent to the Referee's order, the Supreme Court addressed the doctrine of res judicata in workers' compensation cases. See North Clackamas School Dist. v. White, 305 Or 48, 52 (1988). The Court adopted the phraseology found in the Restatement (Second) of Judgments which refers to the

preclusive effect on an issue as "issue preclusion." See Restatement (Second) of Judgments, Introduction at 1-5 (1980). Here, the Referee applied both the "claim preclusion" and "issue preclusion" principle to bar adjudication of the compensability of claimant's back condition. We specifically reject the res judicata analysis applied by the Referee. Neither this issue nor claim was before the prior Referee at the time of the hearing concerning the extent of claimant's permanent disability.

The Referee further reasoned that ORS 656.245(1) directs employers to furnish medical services for conditions resulting from the injury for such period of time as the nature of the injury or the process of recovery requires. Therefore, on the merits, the Referee alternatively concluded that claimant's current medical treatment for his back condition was compensable.

The employer contends claimant's treatment between May 2, 1986 and the October 1986 denial was due to his noncompensable underlying degenerative back condition. It further maintains that claimant experienced increased back problems due to an off-the-job injury incurred while moving. We disagree.

The issue is whether claimant's compensable injury is a material contributing cause to his current need for medical services. Hutcheson v Weyerhaeuser, 288 Or 51 (1979); Summit v. Weyerhaeuser Company, 25 Or App 851, 857 (1976). Although there is evidence that indicates the aging process is a contributor, we nonetheless conclude that claimant's compensable injury remains a material contributing factor.

Initially, Dr. Close, chiropractor, treated claimant for his April 1983 injury. Dr. Mertens, neurologist, examined claimant and found a minimal L5-S1 narrowing. In July 1983, the Orthopaedic Consultants examined claimant and diagnosed a resolved recurrent lumbar strain. Dr. Close reported that claimant worsened in November 1983 and in December the Orthopaedic Consultants agreed that he should not lift over 35 pounds four times a day.

In February 1985, Dr. Bussanich, chiropractor, found chronic lumbosacral sprain and strain and a degenerating L5 disc. In May 1986, claimant sought treatment for sharp low back pain and numbness in his right leg that had gradually worsened after moving his household to a new location. Dr. Johnson, claimant's treating chiropractor, opined that claimant's symptoms were related to his April 1983 industrial injury.

Dr. Johnson referred claimant to Dr. Goe, neurophysiologist. In June 1986, Dr. Goe reported that claimant suffered a lumbosacral strain or sprain, myofacial pain syndrome of the right hip and leg, and L5-S1 radiculopathy. He opined that claimant's condition was a result of the April 1983 injury.

Further examination by the Orthopaedic Consultants resulted in an opinion that claimant's condition was substantially the same as it had been in July 1983.

Claimant's treating chiropractors agree that claimant's condition is a result of his April 1983 industrial injury. The opinions of treating physicians are accorded great weight absent persuasive reasons to the contrary. Weiland v. SAIF, 64 Or App 810 (1983). Finding no persuasive reason to do otherwise, we

conclude that the treating physicians' opinions were more persuasive than that of the Orthopaedic Consultants.

After reviewing the record and considering the factors as set forth in OAR 438-15-010(6), we conclude that the Referee's attorney fee award was reasonable.

ORDER

The Referee's order dated June 11, 1987 is affirmed. For services on Board review concerning the medical services issue, claimant's attorney is awarded a reasonable attoney fee of $1,000, to be paid by the insurer.

OLEN D. RAGSDALE, Claimant
Gary J. Susak, Claimant's Attorney
Cummins, Cummins, et al., Defense Attorneys
Schwabe, et al., Defense Attorneys

WCB 86-11324 & 86-10262
July 27, 1988
Order on Review

Reviewed by Board Members Crider and Ferris.

Pacific Employers' Insurance Company requests review of Referee Wasley's order that: (1) set aside its denials of claimant's "new injury" claim for a back condition; and (2) upheld Adjustco, Inc.'s denials of claimant's aggravation claim for the same condition. Claimant did not file a brief on review. We affirm.

ISSUES

1. Compensability of claimant's low back condition on and after June 5, 1986.

2. If claimant's condition is compensable, then responsibility for that condition as between successive insurers of the same employer.

FINDINGS OF FACT

Claimant, 56 years old as of the date of hearing, has been employed by Garrett Freightlines, Inc., and its predecessor in interest, since 1965. He has had some managerial responsibilities, but he has been primarily involved with driving truck and delivering freight. The weight of this freight can vary from under a pound to over a ton.

On November 3, 1982, while the employer was insured by Transport Insurance with Adjustco as the processing agent, claimant was attempting to get into a trailer when he fell backwards and landed on his back. He filed an industrial injury claim which was accepted by Adjustco. Thereafter, claimant had intermittent pain in his low back for which he had chiropractic treatments over the next few years administered by Dr. Rarey. He suffered no time loss. Prior to this 1982 injury, claimant had not experienced problems with his back other than an occasional mild backache.

On June 5, 1986, while Pacific Employers' was on the risk, claimant was descending from his tractor in Pendleton, Oregon when he stepped on either a rock or into a hole and twisted his back. Claimant immediately reported the incident to his supervisor. He continued working the remainder of the day, but he had difficulty doing so because of back pain. That evening

claimant drove from Pendleton to Baker for treatment by Dr. Rarey. Claimant returned to work in Pendleton the following morning.

Thereafter, claimant took a two-week vacation. He telephoned his supervisor on the morning he was scheduled to return to work and informed him that, due to back pain, he would not be able to work. He was off work for an additional four weeks. He then returned to his regular employment until January 1987, when he quit altogether pursuant to advice from his treating physician, Dr. German, orthopedic surgeon.

On July 2, 1986, Pacific Employers' denied responsibility for claimant's low back condition on the ground that claimant had suffered no "new injury" but instead had experienced an aggravation of his 1982 injury. On July 30, 1986, Adjustco denied responsibility on the ground that claimant had suffered a "new injury" on June 5, 1986. Pursuant to an order dated August 22, 1986, Adjustco was designated as the paying agent for this claim.

Adjustco subsequently issued a second denial on January 15, 1987 on the ground that claimant's ongoing problems were related to a preexisting degenerative arthritic condition and not to his November 1982 injury. Pacific Employers' issued a second denial on February 18, 1987, on the ground that claimant's 1986 condition was neither an aggravation nor a "new injury." On April 6, 1987, the order designating Adjustco as the paying agent was terminated because Adjustco had raised the issue of compensability.

Based upon the record and the content of his testimony, claimant was a credible and reliable witness. The insurers' witnesses were also credible, but they were not reliable as to the date of various conversations.

During his two-week vacation in June 1986, claimant obtained the services of a plumber and a carpenter to remodel his bathroom. Claimant did not actively participate in this work. Nor did he cut or haul firewood during this time. Instead, during a prior vacation in May 1986, claimant cut several cords of firewood.

Claimant has a degenerative osteoarthritic condition in his lumbar spine which preexisted his November 1982 injury. Subsequent to the June 1986 incident, his low back pain became constant and more severe. Claimant also began to experience new symptoms involving a tingling sensation down both legs with a "dead" spot in his right leg.

Based upon our de novo review of the evidence, we find that claimant's work activities worsened his underlying degenerative condition, and that the June 5, 1986 incident independently contributed to a worsening of this condition.

CONCLUSIONS OF LAW AND OPINION

In compensability/responsibility cases, the threshold issue is compensability. Joseph L. Woodward, 39 Van Natta 1163, 1164 (1987). If the claim is compensable, then the trier of fact must address the issue of responsibility. See Runft v. SAIF, 303 Or 493, 498-99 (1987). The insurers argue that the medical

evidence establishes that claimant's degenerative condition in 1987 was unrelated to his work activities. The insurers also argue that claimant has failed to disprove the occurrence of a nonwork injury during his June 1986 vacation allegedly incurred while either remodeling his home or hauling firewood.

Turning to the medical issue first, claimant bears the burden of proving that a condition giving rise to a need for medical treatment or disability is materially related to a compensable claim. Grable v. Weyerhaeuser Company, 291 Or 397 (1981). We consider this to be a complex medical question largely dependent on expert medical opinion. Kassahn v. Publishers Paper Co. 76 Or App 105, 109 (1985).

By letter dated October 26, 1987, Dr. German unambiguously stated that both the 1982 injury and the 1986 injury aggravated claimant's underlying condition of degenerative arthritis. Earlier, Dr. German had "suspected" that the June 5, 1986 incident "aggravated the facet joint that is under pressure because of a degenerative disc disease and degenerative condition within the facet joints." Earlier still, Dr. German stated:

> "This patient has had a progressive deteriorating process of degenerative disc disease. Now, without any question, the nature of his work which has required him to do prolonged sitting over long periods of time in a bouncing truck and also requiring him to do a lot of heavy lifting associated with this has aggravated this condition...."

Adjustco argues that we should reject the opinions of Dr. German as "underwhelming." We decline to do so. Dr. German began treating claimant in November 1984 and continued to treat claimant up to the date of hearing. Thus, he has had the opportunity to observe the progression of claimant's condition over several years. This is precisely the kind of reason we give greater weight to the conclusions of a treating physician. Weiland v. SAIF, 64 Or App 810, 814 (1983).

Opposing Dr. German's opinions are those of Dr. Howell and the Orthopaedic Consultants. Both Dr. Howell and the Orthopaedic Consultants examined claimant only once. In addition, Dr. Howell was uncertain whether or not there was a new injury and, in fact, diagnosed a strain by history. Furthermore, the Orthopaedic Consultants' opinion that claimant's underlying condition was not affected by his work activities took the form merely of signifying its agreement with a letter to that effect. Conclusory medical opinions are of limited persuasiveness. Moe v. Ceiling Systems, 44 Or App 429 (1980).

Adjustco also argues that it has proved that claimant's complaints arose not as the result of the June 5, 1986 work incident, but instead as the result of activities he performed over the course of his subsequent vacation. However, claimant's credible testimony, and that of his witnesses, convinces us that claimant did not cut and haul wood during his vacation, nor did he personally engage in any strenuous remodeling activities.

We conclude that claimant has sustained his burden of proving the compensability of his low back condition on and after June 5, 1986.

We now turn to the responsibility issue. The Referee determined that claimant sustained a compensable injury on June 5, 1986, which materially contributed to a worsening of claimant's underlying condition. Consequently, he assigned responsibility for claimant's condition to the insurer on the risk at the time of the second injury -- Pacific Employers'. We agree with the Referee's conclusion, although we disagree with a portion of his analysis.

The Referee cited the Kearns "rebuttable presumption" which holds that the carrier on the risk at the time of the most recent injury has the burden of proving that some other accepted injury last contributed independently to the condition which gives rise to the claim for compensation. Industrial Indemnity Co. v. Kearns, 70 Or App 583 (1984). However, the Kearns "rebuttable presumption" applies to cases involving multiple accepted claims. In successive injury cases such as the present case, where only the original claim has been accepted, Kearns does not apply. Rather, the correct standard is set forth in Hensel Phelps Construction v. Mirich, 80 Or App 290 (1986). See Stephen Vinzant, 39 Van Natta 1487 (1987).

In Hensel Phelps v. Mirich, supra, the court held that the last insurer is responsible for a worker's disability and medical treatment if an injury or the work activities at the time it is on the risk independently contributed, even slightly, to a worsening of the worker's underlying condition. On the other hand, the first insurer remains responsible if the second injury takes the form of a recurrence of the first and the second incident did not contribute to the causation of the disabling condition. Boise Cascade Corp. v. Starbuck, 296 Or 238, 244 (1984).

We are persuaded that the June 5, 1986 injury independently contributed to a worsening of claimant's condition. We are influenced by several factors. First, we are persuaded that Dr. German's reports, properly interpreted, support our finding of an independent contribution. Dr. German reported on January 21, 1987:

> "The more recent symptoms of June 5th getting out of the truck is an aggravation of the underlying condition and that in itself is not the specific cause for his current symptoms but it has also resulted in increasing of his symptoms sufficient enough that it makes it difficult even for him to continue on with his work as a truck driver."

Pacific Employers' notes the reference in Dr. German's report to an "aggravation" as support for its contention that claimant has suffered a legal "aggravation" rather than a "new injury." It is apparent, however, from the context within which Dr. German uses the term "aggravation" that he is referring to an aggravation in the medical sense rather than the legal sense. In fact, Dr. German expressly states that claimant has experienced an aggravation "of the underlying condition."

Further, claimant credibly testified that his pain following the earlier 1982 incident was not constant, whereas his

pain after the June 5, 1986 incident was constant. Furthermore, the pain claimant experienced after the June 5, 1986 accident was "sharper" than that before the accident. In addition, claimant missed no time from work until after the June 5, 1986 incident. Claimant also began to experience new symptoms in his right leg subsequent to the June 5, 1986 injury. Considered together, these factors support a finding of an independent contribution.

We conclude that the June 5, 1986 work incident independently contributed to a worsening of claimant's underlying condition. We find that Pacific Employers', the insurer on the risk at the time of this worsening, is the responsible insurer.

ORDER

The Referee's order dated December 14, 1987 is affirmed. A client-paid fee not to exceed $1,006.50, payable to counsel for Pacific Employers', is approved. A client-paid fee not to exceed $1575, payable to counsel for Adjustco, is also approved.

RALPH H. GARRELTS, Claimant
Roberts, et al., Attorneys

WCB 87-17585
July 29, 1988
Order of Remand

Reviewed by Board Members Johnson and Crider.

Claimant seeks Board review of Referee Huffman's order which dismissed the matter with prejudice for the reason that claimant had withdrawn his request for hearing.

On January 13, 1988, a notice of hearing was mailed to the parties, identifying February 10, 1988 as the date of hearing. Claimant was represented by counsel.

Both parties requested a postponement of the matter, but the requests were denied.

No hearing was held in this case. On February 11, 1988, an Order of Dismissal issued on the basis that the request for hearing had been withdrawn. Claimant thereafter terminated the services of his attorney and has proceeded on this matter unrepresented since the date scheduled for hearing.

Within 30 days of the Referee's order, claimant requested review of the Order of Dismissal. The insurer moved to dismiss the request for review on the grounds that the content of the request was not sufficient to meet the requirements of a Request for Review and that all parties had not been served.

In our June 2, 1988 Order Denying Motion to Dismiss, we found that, on February 22, 1988, claimant filed a request for review of that order and that all parties were properly served. We adhere to those findings.

In its renewed motion to dismiss, the insurer cites Anna M. Ryan, 39 Van Natta 774 (1987), for the proposition that the Referee's order is not an appealable order. In Ryan, we stated,

"Board review of a Referee's order is only appropriate following the conclusion of a hearing." In that case, we concluded that a settlement order dismissing the case was not appealable and we dismissed the request for review.

ORS 656.289 (1) and (3), which provide for Board review of Referees' orders, does not require completion of a hearing before the issuance of an order disposing of the case. Any order which requires no further action to dispose of a case is a final order and is appealable. See Price v. SAIF, 296 Or 311, 315 (1984). We specifically overrule our decision in Ryan, supra, to the extent that it held to the contrary.

The Order of Dismissal issued by the Referee in the present case was a final order. Accordingly, the order was an appealable order and we have jurisdiction to consider the matter.

Claimant contends, contrary to the Referee's statement in the Order of Dismissal, that he did not withdraw his claim. No hearing was held and there is nothing in the record to explain the Referee's statement that claimant had withdrawn his request for hearing. Although issuance of an order of dismissal prior to the conclusion of a hearing may be valid under the statute, that order must be supported by the record.

The official record contains a request for hearing, a specification of issues, an acknowledgement of the request for hearing, the insurer's response to the request for hearing, the notice of hearing, the requests for postponement, the denial of the requests, and the order of dismissal. There is nothing in the record before the Board to indicate the basis for the Referee's statement that claimant had withdrawn his request for hearing. Consequently, we conclude that the order should be set aside.

We interpret claimant's request for Board review to be a request to vacate the Referee's Order of Dismissal and to remand to the Hearings Division for a hearing on the merits of the claim. Claimant has submitted several exhibits on review, all of which appear to address the merits of his claim. We do not consider the documents on review, but interpret claimant's request to be one for remand. ORS 656.295(5).

On review of the record before us, we conclude that the case has been incompletely or otherwise insufficiently developed. See ORS 656.295(5). Accordingly, the order shall be vacated and set aside and the case shall be remanded to the Hearings Division for a hearing on the merits of the claim.

ORDER

The February 11, 1988 Order of Dismissal is vacated. This matter is remanded to the Hearings Division for a hearing on the merits of claimant's request for hearing. A client-paid fee, not to exceed $1,076, is approved.

GERALDINE Y. KENDALL, Claimant
Olson Law Firm, Claimant's Attorney
Schwabe, et al., Defense Attorneys
Nelson, et al., Defense Attorneys

WCB 86-16940 & 86-12256
July 29, 1988
Order on Review

Reviewed by Board Members Johnson and Crider.

United Employers Insurance (United) requests review of that portion of Referee McCullough's order which found it responsible for claimant's current low back condition. Claimant cross-requests review of that portion of the order which failed to award an insurer-paid fee for services performed on the responsibility issue.

ISSUES

1. Whether Liberty Northwest Insurance Corporation (Liberty) was prohibited from issuing a "backup" denial of responsibility for claimant's low back condition.

2. Whether claimant's current condition is the result of an aggravation of his September 1976 low back injury or of a "new injury" sustained on May 31, 1986.

3. Whether claimant is entitled to an attorney fee for efforts involved in litigating the responsibilty issue.

FINDINGS OF FACT

The Board adopts as fact all statements in the first five paragraphs of the Referee's "Findings and Opinion" section, with the following additional findings. Liberty formally accepted claimant's May 31, 1986 low back injury claim on June 20, 1986, within 60 days after the employer received notice or knowledge of the claim. After further investigation, Liberty denied the claim on July 31, 1986, 61 days after the employer received notice or knowledge of the claim.

CONCLUSIONS AND OPINION

"Backup" Denial

The general rule with regard to post-acceptance denials is that, once an insurer has officially accepted a claim under ORS 656.262(2), it 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. Bauman v. SAIF, 295 Or 788 (1983). The Referee, citing D. Maintenance Company v. Mischke, 84 Or App 218 (1987), held that the rule in Bauman does not apply in responsibility cases and that Liberty was not prohibited from denying the previously accepted claim more than 60 days after the employer received notice of the claim.

Subsequent to the issuance of the Referee's order, the Supreme Court, in Ebbtide Enterprises v. Tucker, 303 Or 459 (1987), held that the rule in Bauman, supra, applies to backup denials of responsibility as well as compensability.

We conclude that Liberty could not deny the claim after the 60 days had elapsed. Because it did so, the denial must be set aside, and responsibility for claimant's low back beginning May 31, 1986, shifts to Liberty.

Because we resolve the responsibility issue under Bauman, supra, we do not reach the merits of the claim.

Attorney Fees

Claimant requests an attorney fee for efforts expended in litigating the claim. No order under ORS 656.307 issued. Claimant's right to compensation was, therefore, at risk. Hunt v. Garrett Freightliners, 92 Or App 40 (1988) and Petshow v. Farm Bureau, 76 Or App 563 (1985), which address claimant's right to attorney fees in cases in which responsibility is the only issue, do not apply. Claimant is entitled to an insurer-paid fee under ORS 656.386(1). Such a fee is defined as an "assessed fee." OAR 438-15-005(2). However, we cannot authorize an assessed fee unless claimant's counsel files a statement of services. See OAR 438-15-010(5). Because no statement of services has been received to date, an assessed fee shall not be authorized.

ORDER

The Referee's order dated May 29, 1987, is reversed in part and affirmed in part. United Employers Insurance's October 15, 1986 denial is reinstated and upheld. Liberty Northwest Insurance Corporation's July 31, 1986 denial is set aside. The claim is remanded to Liberty for processing in accordance with workers' compensation law. Pursuant to ORS 656.307(1)(d), Liberty shall reimburse United Employers for amounts expended on this claim. In all other respects, the Referee's order is affirmed.

CARL ALATALO, Claimant
Malagon & Moore, Claimant's Attorneys
Karen Wiggins, Defense Attorney

WCB 86-16504
August 3, 1988
Order on Review

Reviewed by Board Members Johnson and Crider.

Claimant requests review of Referee Mongrain's order that upheld the self-insured employer's denial of his back injury claim.

ISSUE

The issue on review is compensability.

FINDINGS OF FACT

Claimant is a 30-year-old green chain puller. In this position, he pulls and stacks sliced green lumber from a conveyor belt. Claimant began working for the employer in late August 1986. Hired as a temporary employee, he was initially assigned to the day shift, where he pulled lumber from the left side of the green chain conveyor. On October 27, 1986, he was placed on permanent status and transferred to the swing shift. On the swing shift, he was required to pull lumber from the right side of the green chain.

Claimant alleges he hurt his back during his shift on October 27, 1986. He was able to work the entire shift, although he felt as if he pulled a back muscle. His wife picked him up from work that evening. He told her he had hurt his back. Claimant did not tell his supervisor or anyone else he had hurt his back.

The next day he returned to work and completed his shift. His back was sore. Again he did not mention his back problem to his employer or co-workers.

On October 29, 1986, claimant telephoned his employer and informed Jean Schriner, production clerk, that he would not be working his shift due to his back condition. When asked if he had hurt his back at work, claimant responded that he did not know. The next day, he also reported his absence.

Claimant sought medical treatment from Dr. Damond, chiropractor, on October 31, 1986. Dr. Damond diagnosed acute sacrospinalis strain with possible mild L5-S1 disc protrusion. Claimant's date of injury was recorded as October 27, 1986. Claimant was released from work.

After his treatment, claimant returned to the plant and presented his work release statement to Joe Stewart, plant supervisor. Claimant met with Mr. Stewart and Mr. Schirmer, the day shift foreman. During their meeting, they discussed claimant's injury and whether it had occurred on the job, as well as his lack of health insurance due to his status as a new permanent employee. A note was presented to claimant for his signature, summarizing their discussion and confirming that claimant was filing a claim because he did not have health insurance. Claimant refused to sign.

On October 31, 1986, claimant filled out an employer accident form. He did not fill out or sign a Form "801". Rather, the "801" was signed by the employer on his behalf, November 3, 1986.

On November 3, 1986, claimant's wife presented another work release statement from Dr. Damond, releasing claimant indefinitely until his back condition improved.

Claimant's claim was denied November 10, 1986, based on the employer's contention that his injury was not work related.

On December 8, 1986, Dr. Womack, Medical Director, Physical Medicine and Rehabilitation, Douglas Community Hospital, examined claimant and diagnosed probable lumbosacral strain. He recommended further x-rays to rule out a herniated nucleus pulposus.

On January 13, 1987, Dr. Golden, surgeon, examined claimant and found a possible lumbar disk herniation. A CT scan indicated a herniated L4-5 disc and a moderated lateral recess stenosis at L5-S1.

Claimant underwent surgery on February 24, 1987. Dr. Golden performed a lumbar laminectomy of L4-5 and a decompression of the L5 root.

We find claimant credible.

CONCLUSIONS OF LAW

The Referee concluded that claimant's claim was not compensable, holding that claimant had not met his burden of proof. The decision was based on the evidence being in equipoise, and the history provided to claimant's medical providers, which the Referee concluded had been faulty. We disagree.

We find that claimant's claim is 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).

To establish compensability, claimant must prove that the alleged back incident at work was a material contributing cause to his need for medical treatment. Summit v. Weyerhaeuser Co., 25 Or App 851, 856 (1976). It is claimant's burden to prove by a preponderance of the evidence that the alleged accident occurred as described. Hutcheson v. Weyerhaeuser, 288 Or 51 (1979). Although claimant's testimony is probative in that regard, Garbutt v. SAIF, 297 Or 148 (1984), we find his condition 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).

Because claimant's alleged injury was unwitnessed, his credibility is of considerable importance. The Referee made no specific credibility finding, although he noted that claimant's demeanor at times appeared confused. The Referee also noted that claimant did not immediately inform his employer of his injury, concealed information regarding his DUI conviction from his employer, and has a history of violence and drug abuse.

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. Costal Farm Supply v. Hultberg, 84 Or App 282 (1987); Davies v. Hanel Lumber Co., 67 Or App 35, 38 (1984).

The employer argues most strenuously that claimant is not credible. The employer cites Steven J. Marshall, 39 Van Natta 16 (1987), as controlling. In Marshall, the Board found that claimant had not met his burden of proof in his unwitnessed compensability claim.

We do not believe Marshall to be dispositive. In Marshall, the claimant did not seek medical treatment until three weeks after his initial complaints of pain. Further, the treating physican in Marshall did not initially articulate his date of injury, but only reported that the claimant complained of a gradual onset of back pain, resulting from pushing and pulling on the job. Without medical evidence supporting his claim, claimant's credibility was key. The Board differed with the Referee and found that the insurer raised several inferences which demonstrated that claimant had several reasons for submitting a claim. These reasons included being sought by the county authorities with regard to civil and criminal matters, on or about the date his claim was filed, as well as receiving several warnings from the employer regarding absences and tardiness so that additional tardiness could have resulted in his termination.

The employer argues that claimant filed a workers' compensation claim for reasons other than a work injury. It first contends that he filed a claim because he did not have medical insurance. In support of its contention, the employer offered the testimony of several witnesses to refute claimant's claim that he was hurt on the job.

Mr. Stewart, plant supervisor, testified that claimant repeatedly told him that the claim was filed only because of a lack of medical insurance. Mr. Stewart testified that he asked claimant to sign a statement to that effect, but he refused. The statement presented to claimant can no longer be found; however, notes made summarizing claimant's contacts with the employer were introduced as evidence to support its position.

Mr. Stewart also testified that he made the decision to deny claimant's claim. Therefore, he was familiar with the requisite forms required in claims processing. Yet, claimant did not sign the "801". It was signed by the employer on claimant's behalf, November 3, 1986. The employer statement on the "801" mirrored Mr. Stewart's notes. No evidence was offered to explain why claimant was not asked to fill out the "801" during his meeting with Mr. Stewart on October 31, 1986. Mr. Stewart's notes indicate that claimant's wife returned to the plant with the "accident paperwork" and a work release statement from Dr. Damond.

Mr. Shirmer, day shift foreman, also testified on behalf of the employer. Mr. Shirmer had been present during the October 31, 1986 meeting with claimant. He too stated that claimant had been requested to sign a statement but was unable to remember its contents. He agreed with Mr. Stewart that claimant stated he was filing a claim because he did not have medical insurance. We do not agree with the employer's contention that claimant's lack of medical insurance influenced his decision to file a workers' compensation claim.

Further, the employer argues that claimant's history of alcohol and drug abuse, as well as assault convictions, raise persuasive inferences that claimant was motivated to file a claim for reasons other than an injury. We are unpersuaded by these arguments.

We find claimant to be credible. Claimant first experienced back pain near the end of his first day on swing shift. Claimant's wife testified that he told her he had hurt his back at work that evening. She also testified that he had no previous back problems. Claimant's sister, Suzanna Jones, testified that he borrowed her heating pad for his back which he had hurt at work. She too stated that claimant had not previously complained about his back. The Referee found claimant's wife and sister to be credible.

Claimant was able to work the next day even though he continued to experience pain, believing that he had only pulled a muscle as a result of pulling from the right instead of the left on the green chain. On October 29 and 30, 1986, he informed his employer of his back condition and inability to work.

On October 31, 1986, he sought treatment from Dr. Damond. Claimant told Dr. Damond that he hurt his back on October 27, 1986, that the pain was gradual, and he believed it stemmed from his change in pulling sides on the green chain.

Dr. Damond's first medical report, Form 827, dated November 3, 1986, stated an on-the-job injury date of October 27, 1986. His report indicated that claimant exhibited physical findings of disc protrusion, due to an exertional strain from pulling on the green chain.

On December 11, 1986, Dr. Womak examined claimant and assessed claimant's lumbosacral strain of October 27, 1986 to be referable to his change in activity from one side of the veneer chain to the other. Claimant's history to Dr. Womak was consistent with that given to Dr. Damond.

On January 13, 1987, claimant was examined by Dr. Golden. The history reported was consistent with claimant's other medical providers.

On February 27, 1987, Dr. Damond opined that it was probable that claimant's work was the major contributing cause of his low back condition. He based his opinion on the fact that claimant had no prior symptoms and due to his change in pulling on the green chain from the opposite side. Additionally, claimant's other treating physicians related his injury to the change in position on the green chain beginning October 27, 1986. We find that there is sufficient medical evidence to support claimant's claim that his work on the green chain was a material cause of his back condition. See McClendon v. Nabisco Brands, Inc., 77 Or App 412 (1986).

We find that the evidence preponderates in favor of compensability. Our reading of the substance of the testimony satisfies us that claimant answered questions presented to him truthfully. We also are satisfied that claimant's witnesses testified credibly, even though they were concerned with claimant's welfare. Further, we find that the medical evidence establishes the etiology of claimant's low back condition to have occurred on the job. Claimant has established compensability by the preponderance of the evidence.

Claimant's counsel is statutorily entitled to a reasonable, employer-paid attorney fee for services rendered at hearing and on Board review. See ORS 656.386(1). Such a fee is defined as an "assessed fee." However, we cannot authorize an assessed fee unless claimant's counsel files a statement of services. See OAR 438-15-010(5). Because no statement of services has been received to date, an assessed fee shall not be authorized.

ORDER

The Referee's order dated November 10, 1986 is reversed. The self-insured employer's denial dated November 10, 1986 is set aside and the claim is remanded to the self-insured employer for processing according to law.

CARL R. BRADLEY, Claimant
Francesconi & Associates, Claimant's Attorneys
Schwabe, et al., Defense Attorneys
Roberts, et al., Defense Attorneys

WCB 86-17149 & 86-14461
August 3, 1988
Order Denying Reconsideration

Reviewed by Board Members Crider and Ferris.

Claimant seeks reconsideration of our Order on Review dated May 3, 1988. The request was filed with the Board on July 6, 1988.

An order of the Board is final by operation of law unless one of the parties appeals the order to the Court of

Appeals within 30 days after the Board mails the order to the parties. ORS 656.295(8). In the present case, claimant filed his request for reconsideration 64 days after the Board mailed its order. The order, therefore, has become final by operation of law and the Board is without jurisdiction to withdraw it and consider claimant's request. Accordingly, the request for reconsideration is denied.

IT IS SO ORDERED.

VICKIE L. COX, Claimant
Allan Coons, Claimant's Attorney
David C. Force, Attorney
Schwabe, et al., Defense Attorneys

WCB 85-13911
August 3, 1988
Order on Review

Reviewed by Board Members Ferris and Crider.

Claimant requests review of those portions of Referee Brown's order that: (1) upheld the insurer's denial of claimant's medical services claim for an incisional neuroma; and (2) authorized the insurer to recover an overpayment of interim compensation.

We affirm and adopt the Referee's opinion and order with the following additions and modification.

ISSUES

(1) Compensability of medical services associated with an incisional neuroma.

(2) Offset of overpaid interim compensation.

FINDINGS OF FACT

Claimant had noncompensable gynecological surgery on September 4, 1984. She did well after the surgery, but developed a left-sided incisional neuroma, a nerve fiber and fibrous tissue mass which is painful when subject to pressure. On October 29, 1984, a physical examination was performed by doctors acting on behalf of the insurer in connection with a compensable injury sustained on January 20, 1984. Claimant later developed a worsening of her neuroma and received treatments. Compensability was denied by the insurer on November 1, 1985. The worsening of claimant's preexisting neuroma was not caused by the physical examination conducted by doctors for the insurer.

Claimant was paid temporary total disability while she continued to work between November 5, 1986 and March 4, 1987.

Claimant is not a credible witness.

OPINION AND CONCLUSIONS

Medical Services

ORS 656.245(1) provides in pertinent part: "For every compensable injury, the insurer or the self-insured employer shall cause to be provided medical services for conditions resulting from the injury." The adverse effects of medical examinations or treatment associated with a compensable injury are themselves compensable. See Terry L. Link, 40 Van Natta 17, 19 (1988); cf. William v. Gates McDonald & Co., 300 Or 278 (1985).

The Referee found the claimant not credible based on discrepancies in her testimony and the contemporaneous record and her demeanor at the hearing. We generally defer to the Referee's finding on credibility due to the Referee's observation of the witness. We also evaluate the witness when credibility is based on the substance of the witness's testimony in view of the entire record. See Coastal Farm Supply v. Hultberg, 84 Or App 282 (1987). We agree with the Referee that claimant is not credible. There are too many discrepancies in her testimony when compared with other portions of the record.

The Referee did not rely on the opinion of Dr. Kaufman, claimant's treating physician, regarding the incisional neuroma. The Referee concluded that the doctor's opinion was based solely on what claimant told him concerning whether there was any intervening trauma other than that of the doctors examining her. In light of claimant's lack of credibility, we agree that without sufficient independent corroboration of claimant's history of the injury we are unable to find that her neuroma was worsened by the examination by doctors for the insurer.

Offset

Paragraph (4) of the Referee's order provided that, "[t]he carrier may recover its overpayment . . . [of temporary benefits between certain dates]" (emphasis supplied). Claimant contends that this allows the insurer to affirmatively seek collection in a context other than an offset from compensation due to claimant.

We find from the context of the Referee's discussion of overpayment that by "recovery" he meant "offset". Only an offset from future permanent disability benefits on this claim is appropriate in any event. We clarify the Referee's order accordingly.

ORDER

The Referee's order dated June 29, 1987 is affirmed as clarified.

RICHARD W. CROW, Claimant
MacPherson & Associates, Claimant's Attorneys
Acker, et al., Defense Attorneys

WCB 86-17307
August 3, 1988
Order on Review

Reviewed by Board Members Johnson and Ferris.

Claimant requests review of Referee Michael Johnson's order that upheld the insurer's denial of compensability of claimant's bronchial condition. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

Claimant, 54 at hearing, was temporarily employed as a truck driver in August 1986. His duties consisted of hauling truck loads of wet ash from a holding pond to a dump. The wet ash "slurry" leaked out of the truck onto the roadway and dried. The vehicles driving repeatedly up and down the road then kicked up the dry ash into a fine dust. Claimant's assigned truck was not new, and had holes in the floor around the pedals and transmission. The dust filtered up through these holes, filling the cab.

After a week, claimant developed a dry, hacking cough. In the following week his symptoms also included shortness of breath and pain in his lungs.

Claimant's temporary job ended on Friday, August 22, 1986. On the following Monday he was not feeling better, so sought treatment from Dr. Cookson, family physician. Dr. Cookson diagnosed mild to moderate lung disease preexisting the exacerbation for which the claim is made, acute bronchitis and bronchiospasms. He treated claimant with bronciodialators and antibiotics. After a month of treatment, claimant's symptoms abated.

Claimant was formerly a full-time school teacher. Half of his assignment was teaching woodshop. Claimant also smoked a pack of cigarettes a day for 30 years, a habit he quit about 1983. Claimant had no prior history of lung disease symptoms.

CONCLUSIONS OF LAW AND OPINION

Mere exacerbation of symptoms of a disease is not compensable. Exacerbation of the underlying condition, even temporarily, is. Wheeler v. Boise Cascade, 298 Or 452 (1985); Hutcheson v. Weyerhaeuser, 288 Or 51 (1979). Claimant's treating physician reported:

> ". . .Mr. Crow had some element of lung disease before beginning his work for [employer]. This predisposing factor was exacerbated by the type of work that he performed. Now that he is working in an environment which is relatively free of dust, his symptoms have abated and he is back to his baseline levels of mild to moderate lung disease. Based upon this, it is my opinion that had he not been exposed to dust during this particular job, his symptoms would not have exacerbated and he would not have been ill.
>
> "My recommendation to Mr. Crow at this time is to avoid work-related activities that would expose him to increased levels of dust, as he will be predisposed to developing exacerbations of his lung disease as a result of continued exposure."

The Referee focused on the doctor's use of the word "symptoms," and found the condition noncompensable under Weller v. Union Carbide, 288 Or 27 (1979) and Wheeler, supra.

The doctor also says that claimant's "predisposing factor [lung disease] was exacerbated." There are no other medical reports. Claimant bears the burden of proving by a preponderance of the evidence that his work was the major contributing cause of the worsening of his underlying condition. Hutcheson, supra. When the evidence presented reflects two explanations for claimant's condition that are equally plausible, and one is noncompensable, claimant has failed to sustain the burden of proof. Van Horn v. Jerry Jerzel, Inc., 66 Or App 457 (1984); Gormley v. SAIF, 52 Or App 1005 (1981).

We find that claimant's claim was properly denied.

ORDER

The Referee's order dated August 11, 1987 is affirmed.

RICHARD A. DALY, Claimant
Kenneth D. Peterson, Claimant's Attorney
Richard Barber (SAIF), Defense Attorney

WCB 86-12374
August 3, 1988
Order on Review

Reviewed by Board Members Johnson and Crider

Claimant requests review of that portion of Referee Neal's order that affirmed a Determination Order that declined to award unscheduled permanent partial disability for a low back injury. Should claimant receive an award of permanent disability, the SAIF Corporation reiterates its request at hearing for authorization to offset previously overpaid temporary disability benefits. The sole issue is extent of permanent disability. We affirm.

FINDINGS OF FACT

Claimant, 44 years old at the time of hearing with a ninth grade education and work experience as a mill worker, janitor and welder's helper, worked for six years in the employer's mill before he compensably injured his low back on October 20, 1985 while straightening logs for the cut-off saw. The injury was diagnosed as a low back strain. Claimant had previously injured his back in 1981 requiring a few days in the hospital. The prior injury resolved without residuals.

Claimant spent three days in the hospital in traction for his new injury. He was referred by the hospital physician to Dr. Stephens, orthopedic surgeon. Dr. Stephens examined claimant twice. The second examination was in January 1986. Claimant was to return to Dr. Stephens in two months.

Claimant did not return to Dr. Stephens. Instead, he transferred his care to Dr. Whalen, chiropractor. Dr. Whalen began treating claimant two to three times per week.

SAIF sent claimant to the Orthopaedic Consultants to be examined in early May 1986. A Work Tolerance Screening was subsequently undertaken in the Consultants' office. Thereafter, SAIF had claimant examined by the Independent Chiropractic Consultants.

While under Dr. Whalen's care, claimant began to complain of upper back and neck complaints.

In August 1986, a Determination Order issued which did not award claimant any permanent partial disability.

Claimant has not returned to work since the injury. He has searched for work in the janitorial area. Claimant experiences low back pain and neck pain with extended walking and sitting. He experiences a tingling sensation in his right leg with extended standing. These symptoms do not rise to the level that they disable him from performing work.

We find, based upon our de novo review of the evidence,

that claimant has experienced no permanent impairment as a result of his 1985 injury.

CONCLUSIONS OF LAW AND OPINION

It is claimant's burden to prove that he has incurred a permanent loss of earning capacity as a result of the October 1985 injury. ORS 656.214(5); Hutcheson v. Weyerhaeuser Co., 288 Or 51, 56 (1979). A finding of permanent impairment is a condition precedent to an award of permanent disability. See former OAR 436-30-380.

In June 1986, Dr. Whalen opined that claimant had permanent impairment. Four months later, in October 1986, Dr. Whalen reported that all neurological deficit had cleared and that claimant's general range of motion was within normal limits with the exception of L4 in right lateral flexion. In November 1986, Dr. Whalen indicated that he had advised claimant to pursue vocational counseling and rehabilitation "so that [claimant] may again resume a productive livelihood." Dr. Whalen's recommendation of vocational rehabilitation suggests some continuing level of impairment. However, given that Dr. Whalen previously reports normal neurological findings and near normal range of motion findings, it is not clear on what basis Dr. Whalen finds this continuing impairment. Presumably, Dr. Whalen's conclusion is based upon claimant's subjective complaints.

Dr. Whalen's opinion is opposed by the opinions of Dr. Stephens, the Orthopaedic Consultants, and the Independent Chiropractic Consultants. Dr. Stephens opined in January 1986 that claimant would be able to return to regular work after a one-month period of light-duty work. While a worker's return to regular work does not preclude a finding of permanent impairment (see Jacobs v. Louisiana-Pacific, 59 Or App 1, 3 (1982)), nevertheless, we find that Dr. Stephens' January 1986 report is evidence of lack of permanent impairment.

Similarly, the Orthopaedic Consultants opined in May 1986 that claimant could return to his regular work following a short period of modified work. This opinion was supported by the vocational evaluator who administered claimant's work tolerance screening. Furthermore, the Consultants concluded that claimant's loss of function due to the injury was zero.

Claimant was examined by the Independent Chiropractic Consultants in July 1986. They, too, opined that claimant could return to his regular employment. They recommended a graduated return to work over 30 to 45 days. They found no evidence of impairment.

We conclude that the medical evidence preponderates on the side of a finding of no permanent impairment. 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, we are not persuaded by claimant's testimony that he has suffered permanent impairment as a result of his injury. While claimant experiences periodic low back pain, his testimony does not establish that the pain reaches a level whereby it disables him from obtaining and holding gainful employment in the broad field of general occupations. ORS 656.214; 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 April 22, 1987 is affirmed.

CAROL DAVIS, Claimant
Vick & Gutzler, Claimant's Attorneys
Dennis Martin (SAIF), Defense Attorney
Garrett, et al., Defense Attorneys

WCB 85-00169 & 86-10997
August 3, 1988
Order on Reconsideration

The SAIF Corporation requested reconsideration of that portion of the Board's Order on Review dated January 27, 1988, which reversed the Referee and set aside SAIF's aggravation denial for claimant's current right shoulder condition. In addition, Northwest Farm Bureau has requested reconsideration of that portion of our order, which directed it to pay claimant's attorney an insurer-paid attorney fee for services at hearing and on Board review. On March 2, 1988, the Board's order was abated and the parties were granted an opportunity to respond to both of the requests for reconsideration. Having received the parties' responses, the Board has reconsidered both matters.

The Board continues to find that SAIF remains responsible for claimant's current right shoulder condition, regardless of the particular diagnosis.

Turning to the matter of attorney fees, in our former order we found that SAIF had solely denied responsibility, and not compensability and responsibility as had Northwest Farm. Thus, our former order directed Northwest Farm to pay claimant's attorney's fee. See Karen J. Bates, 39 Van Natta 42 (1987). Upon reconsideration, however, we note that SAIF's denial did not expressly concede the issue of compensability. More importantly, at the hearing the Referee stated, inter alia:

> "In regards to these two Denials, we're talking only of the right shoulder condition, as I understand it. Neither of the two organizations admits responsibility, as I understand it -- or admits compensability, so compensability is at issue in regards to each outfit, right? (pause) Okay." (Emphasis added).

Inasmuch as SAIF acquiesced to the Referee's framing of the issue as involving both compensability and responsibility, we find that Bates, supra, is not applicable to the instant case. Therefore, that portion of our former order that directed Northwest Farm Bureau to pay claimant's attorney fee is withdrawn, effective this date. Instead, SAIF is directed to pay claimant's attorney assessed fees of $1,200 for services at hearing and $500 for services on Board review. A client-paid fee not to exceed $1,552.50 is approved.

IT IS SO ORDERED.

DELBERT E. ELLIOTT, Claimant
Vick & Gutzler, Claimant's Attorneys
Carrol Smith (SAIF), Defense Attorney

WCB 86-09385
August 3, 1988
Order on Review

Reviewed by Board Members Johnson and Crider.

The SAIF Corporation requests review of Referee St. Martin's order which granted claimant permanent total disability. We affirm.

ISSUE

Whether claimant is permanently and totally disabled.

FINDINGS OF FACT

On January 30, 1985, claimant, a truck driver for 30 years, sustained a compensable cervical spine injury. He was diagnosed with: (1) cervical dorsal sprain; (2) moderate cervical osteoarthritis at the C5-6 level; and (3) paracapulitis of the left shoulder. As a result of this injury, claimant was unable to return to work as a long distance truck driver. Claimant's wage at the time of injury was $11.65 per hour.

Claimant's prior injuries included a broken leg, an ulcer condition requiring partial removal of the stomach, an ankle injury and frost bite of the fingers.

Claimant has a seventh grade education. Vocational testing revealed his vocabulary grade level to be 2.1 and his comprehension grade level to be 3.9. These scores suggested a poor reading ability. His arithmetic ability placed him in the bottom seventh percentile, suggesting borderline arithmetic computational skills. Claimant's exceptionally low scores on spatial, motor coordination, and finger dexterity eliminated him from most occupational areas. Overall, his general learning ability was judged to be low average. His ability to learn new skills was thought to be an extreme challenge unless on-the-job training was provided.

Dr. Winslow treated claimant conservatively. On February 22, 1986, he released claimant to sedentary work.

On March 3, 1986, claimant initiated vocational rehabilitation efforts. His counselor reported that it was "questionable" whether claimant possessed transferable skills and sought a return to his employment at injury. Claimant's employer at injury, however, refused to offer modified employment due to the size of his operation.

On May 18, 1986, claimant secured another truck driving position without the aid of his vocational rehabilitation counselor. That position did not involve loading and unloading of cargo. By July 1986, however, claimant voluntarily terminated his employment due to increasing cervical pain, headaches and left arm numbness.

On June 9, 1986, a Determination Order awarded claimant 35 percent unscheduled permanent disability.

On July 16, 1986, Dr. Winslow opined that claimant's physical limitations included: (1) occasional lifting up to 50 pounds; (2) no pushing or pulling; (3) no climbing, crawling or reaching above shoulder; and (3) occasional bending, squatting and twisting. Dr. Winslow released claimant to part-time modified work.

In October 1985 claimant began to exhibit signs of depression. This reaction was attributable to a sudden physical disability following 41 years of gainful employment.

On February 12, 1987, Dr. Hazel's examination of claimant revealed very limited cervical motion. Claimant manifested no more than 35 percent normal cervical flexion, 50 percent normal extension, and no more than 35 percent normal rotation right and left. Claimant exhibited pronounced moderately severe degenerative cervical intervertebral disc disease without radiculitis or radiculopathy. Claimant was not thought to be a good candidate for surgery. It was evident to Dr. Hazel that claimant was physically incapacitated. He was also unquestionably depressed.

Despite the physical incapacitation, Dr. Hazel opined that claimant was clearly employable, although not at an arduous task. He felt that long distance truck driving required too many hours, too much vibration, and inadequate resting facilities; it was therefore not a viable employment alternative. On the other hand, Dr. Hazel believed that claimant was clearly employable driving light vehicles. Accordingly, he regarded claimant's award of 35 percent permanent disability to be both generous and sufficient.

Contrary to Dr. Hazel's opinion, claimant possessed no transferable skills. As a result, he was unable to go out and compete on the open labor market for wages. Without those skills, claimant was limited to unskilled jobs that would allow a sit/stand option. Unfortunately, his lack of academic skills limited his ability to perform entry level unskilled clerical jobs, such as security work or dispatching. Also, his poor eye-hand coordination, spatial aptitude, and manual dexterity greatly restricted his ability to do any entry level jobs involving use of the hands and fingers, such as assembly work. Claimant was incapable of engaging in light vehicle delivery due to the heavy nature of that work; the minimum lifting requirement was 70 pounds. Likewise, claimant could not qualify as a school bus driver due to the requirement that he be able to move a 100 pound body 100 feet in 30 seconds. Medical laboratory courier-type jobs were also inappropriate for claimant due to the constant driving and fast-paced physical activity.

If a return to some kind of modified work at the employer at injury was not possible, then claimant needed retraining to enhance his skills in order to become employable.

Claimant could possibly be a parking lot attendant, a gate tender, a security guard, or work in a service station. However, these options were not explored by claimant's vocational counselor by either discussing them with claimant or presenting a physical capacities evaluation to claimant's doctor to determine if he would approve such a job.

Other than the light-duty truck driving job which terminated in July 1986 due to increasing pain, no offers of employment were made to claimant. Neither was he ever involved in any vocational training efforts.

At the time of hearing, claimant, a credible witness, was taking Clinoril and a muscle relaxer regularly. He had difficulty sleeping due to pain and was forced to lie on the sofa two times a day. If he moved too much or did too much walking, a burning sensation spread from his upper back into his neck and produced

headaches. If he sat too long, his neck hurt. Bending and lifting caused considerable pain. He could not do any of the old jobs that he held in the past.

Claimant could not read the newspaper because there were too many words that he did not know. His wife did all the bookkeeping and taxes because he did not understand them. Claimant was functionally illiterate.

CONCLUSIONS OF LAW

The Referee concluded that claimant was unable to sell his services regularly in the labor market and would not be able to do so without retraining. Therefore, claimant was awarded permanent total disability benefits commencing as of the date of the hearing.

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

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

In interpreting this provision, the Court of Appeals has noted that a worker may be able to perform "some work" and nonetheless succeed in proving permanent total disability. Clark v. Boise Cascade Co., 72 Or App 397, 399 (1986). Moreover, a worker need not be a "basket case." Wilson v. Weyerhauser, 30 Or App 403 (1977). If a worker is incapable of performing gainful and suitable work in a competetitive labor market, he is permanently and totally disabled. Harris v. SAIF, 292 Or 683, 695 (1982). We have held, however, that the ability of a worker regularly to perform suitable and gainful work on a part-time basis may preclude an award of permanent total disability. Pournelle v. SAIF, 70 Or 56 (1984); Darla Falcon, 38 Van Natta 204 (1986).

Claimant may still establish permanent total disability even though he is not totally incapacitated from a medical standpoint. Under the "odd lot" doctrine, a worker's physical disability as well as nonmedical factors such as age, education, adaptability, emotional conditions, and the state of the labor market can establish permanent total disability. Lee v. Freightliner Corporation, 77 Or App 238 (1986); Fred S. Sheppard, 39 Van Natta 418, 420 (1987); Charlotte Haug, 39 Van Natta 768 (1987); Max S. Swanberg, 39 Van Natta 823 (1987).

ORS 656.208(3) states that:

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

See Welch v. Banister Pipeline, 70 Or App 699 (1984), rev den 298 Or 470 (1985); Doc A Perkins, 31 Van Natta 181 (1981).

A claimant's medical condition, combined with nonmedical factors, may support the conclusion that greater efforts to secure employment would be futile. SAIF v. Simpson, 88 Or App 638 (1987). However, a worker's refusal to cooperate with vocational rehabilitation efforts may be grounds for denial of permanent total disability. Taylor v. SAIF, 67 Or App 193 (1984).

Permanent total disability cannot be denied based on a speculative future change in a worker's employment status; disability must be rated as it exists at the time of hearing. Gettman v. SAIF, 289 Or 609 (1980). Furthermore, any preexisting disability should be considered. Arndt v. National Appliance, 74 Or App 20 (1984).

If claimant proves entitlement to permanent total disability, benefits are awarded from the earliest date claimant was able to prove that all elements necessary to his claim existed. Adams v. Edwards Heavy Equipment, Inc., 90 Or App 365 (1988).

In the present case, claimant's moderately severe degenerative cervical disc disease was not completely incapacitating, although it did preclude his return to truck driving. Therefore, claimant's claim for permanent total disability could not be based solely on his medical disability. If his claim is to succeed, he needs to prove that the nonmedical factors place him within the "odd lot" category. These factors include age, intelligence, education, work experience, transferable skills and adaptability. Lee v. Freightliner Corp., supra, at 242. The record indicates that claimant carried his burden of proof and, based on the "odd lot" doctrine, is permanently and totally disabled.

At the time of hearing, claimant was 57 years of age. Prior to his January 30, 1985 injury, he was a long-haul truck driver for 30 years with the same employer. He had a seventh grade education but was, in fact, functionally illiterate.

On March 26, 1986, claimant was discharged from the Callahan Center following extensive vocational and physical evaluation. Claimant's counselor opined that, due to a number of factors, the most appropriate vocational area to pursue was truck driving. Those factors included: (1) claimant's prior experience and strong interest in staying in that occupation; and (2) claimant's poor performance in vocational testing. He demonstrated a 3.9 grade level reading ability, borderline (7th percentile) arithmetic computational skills, and an overall low average general learning ability. Claimant did not qualify for any of the 66 possible Occupational Aptitude Patterns, even after the standard error of measurement was added. Based on the above test results, claimant's counselor believed that learning a new skill would be a real challenge unless it was learned on the job.

The Callahan Center's assessment of claimant's physical capacities included: (1) no lifting greater than 35 pounds; and (2) no repetitive use of the left arm overhead. It was felt that claimant could engage in long-haul truck driving without loading and unloading.

On May 18, 1986, claimant secured a long-haul truck driving job which did not involve loading or unloading. By July 1986,

however, he was forced to discontinue employment due to increasing neck pain, headaches and left arm numbness.

On July 16, 1986, Dr. Winslow, claimant's treating physician, assessed claimant's physical limitations as: (1) occasional lifting up to 50 pounds; (2) no climbing, crawling or reaching above shoulder level; and (3) no pushing or pulling. He released claimant for modified part-time work.

On September 12, 1986, Robert Gaffney, claimant's vocational rehabilitation counselor reported that claimant had become more willing to consider vocational opportunities in light of his failure to return to truck driving. However, on October 9, 1986, claimant's vocational rehabilitation was terminated because: (1) 120 days had passed since the issuance of his Determination Order, and (2) no employment had been found. It was not until January 8, 1987 that claimant's vocational rehabilitation was re-authorized. At the time of hearing, claimant had received neither job offers nor training of any kind.

Mr. Gaffney testified at hearing. He was of the opinion that claimant could be a parking lot attendant, a gate tender, a security guard, or work in a service station. Wages for those jobs ranged between minimum wage and $5.00 per hour. As a general rule, he testified that 75 to 80 percent of claimant's wage at injury was his usual goal. Claimant's wage at injury was $11.65 per hour. He also perceived claimant as having greater vocational ability than the Callahan test results had revealed. He admitted, however, that he had no follow-up testing to support this perception.

Byron McNaught, a vocational rehabilitation counselor with extensive experience, also testified at hearing concerning claimant's employability and trainability. He persuasively opined that, due to a number of reasons, claimant's ability to go out and compete on the open labor market for wages was practically nil. Mr. McNaught believed that claimant's physical limitations themselves would not keep him from being employable. It was a combination of physical disability, education, and restricted skill level which pushed claimant into unemployability.

Physically, claimant was limited to sedentary work and would have to change positions during his shift. Intellectually, vocational testing had revealed that he was functionally illiterate. His work history was limited to truck driving. Based on the above factors, Mr. McNaught believed that claimant had no transferable skills. He felt that if job modification with the employer at injury was not possible, then claimant needed some type of training. We agree with Mr. McNaught's analysis of claimant's vocational situation.

Although it is possible that claimant could be retrained in another field, we cannot consider such speculative future change in claimant's employment status. Gettman v. SAIF, supra.

During the course of claimant's vocational rehabilitation efforts, he cooperated with his counselor in every way and was motivated to return to work. In May 1986 claimant found a truck driving position on his own which did not require loading and unloading. Soon, however, he discovered that he could not even perform the driving duties of a trucker. Prior to this experience, it is understandable that claimant, a long-haul truck driver for 30 years with the same employer, would be resistant to a vocational

change. Following claimant's realization that there was no other choice, he became open to his counselor's alternate vocational suggestions and made suggestions of his own.

Although the medical evidence alone does not show that claimant was totally disabled, we are persuaded, as was the Referee, that claimant falls within the "odd lot" category, due to his age, physical limitations, below average intelligence, lack of education, limited work experience, lack of transferable skills and lack of adaptability. Since claimant also made reasonable efforts to find work, he is entitled to an award of permanent total disability.

Claimant's counsel is statutorily entitled to a reasonable, carrier-paid fee for services rendered on Board review. See ORS 656.382(2). Such a fee is defined as an "assessed fee." OAR 438-15-005(2). However, we cannot authorize an assessed fee unless claimant's counsel files a statement of services. See OAR 438-15-010(5). Because no statement of services has been received to date, an assessed fee shall not be authorized.

ORDER

The Referee's order dated April 24, 1987 is affirmed.

JACQUELINE J. ERSLAND, Claimant
Roll, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys
Gail Gage (SAIF), Defense Attorney

WCB 87-01320 & 86-01266
August 3, 1988
Order on Review

Reviewed by Board Members Ferris and Crider.

Claimant requests review of those portions of Referee Menashe's order which: (1) upheld the SAIF Corporation's denial of the compensability of claimant's low back condition and the aggravation of her compensable upper back/neck condition; (2) affirmed a Determination Order awarding claimant 10 percent (32 degrees) unscheduled permanent disability for her compensable upper back/neck condition; and (3) upheld CNA Insurance Companies' denial of compensability and responsibility for claimant's low back condition and responsibility for claimant's upper back/neck condition. We affirm.

ISSUES INVOLVING SAIF

1. Whether claimant's low back condition is compensable.

2. Whether claimant suffered an aggravation of her December 14, 1984 upper back/neck injury.

3. The extent of claimant's permanent disability attributable to her compensable upper back/neck condition.

ISSUE INVOLVING CNA INSURANCE COMPANIES

1. Whether claimant's low back condition is compensable.

FINDINGS OF FACT

Claimant, 31 years old, suffered a compensable injury on December 14, 1984, while working for SAIF's insured as a nurse assistant. She had upper back and neck complaints and underwent

conservative treatment. On March 13, 1985, SAIF accepted the claim as a disabling injury for cervical and thoracic strain. Her claim was last closed by a January 17, 1986 Determination Order which awarded 10 unscheduled percent permanent disability.

Claimant studied through the 10th grade and obtained her GED in approximately 1975. Her work history consisted primarily of nursing aide and security guard work.

On April 16, 1986, claimant began to work as a security officer for CNA's insured. She worked until July 22, 1986.

On August 1, 1986, Dr. Erickson, her treating doctor, reported claimant was suffering from increased upper back and neck pain and low back pain.

On October 7, 1986, SAIF denied claimant's aggravation claim saying that no causal relationship between her upper back and neck injury and the low back condition had been established. Further, SAIF contended that any falls which claimant had experienced were not related to her upper back/neck condition.

On December 10, 1986, CNA denied compensability and responsibility for claimant's low back condition and responsibility for her upper back/neck condition. CNA reasoned that none of her symptoms arose out of or in the course of employment as a security officer.

Claimant began to experience falling incidents subsequent to her compensable upper back/neck condition. These incidents, however, were not related to that condition. Neither were they caused by her activities as a security officer.

In August 1986, Dr. Erickson reported that claimant was suffering from low back pain due to another falling incident and was not medically stationary. Dr. Erickson recommended that claimant discontinue work and be retrained in an occupation which would not stress her back.

We conclude that while claimant was employed as a security guard, no falling incident occurred to produce low back pain or increase upper back and neck pain.

On September 15, 1986, Dr. Snodgrass, neurologist, was unable to see any objective indication of a worsening of claimant's back condition. He believed that claimant's complaints were more strongly suggestive of functional overlay and suggested psychiatric or psychologic consultation. Dr. Snodgrass rated claimant's impairment as none to minimal based on claimant's subjective complaints.

Dr. Erickson, on the other hand, diagnosed myofascitis of claimant's cervical and thoracic spine. She believed, however, that all of claimant's symptoms were subjective in nature and no objective change had occurred in her back condition.

Claimant exhibited no objective physical impairment. All of her complaints were subjective in nature. Unrelated psychological factors have contributed heavily to the severity and chronicity of claimant's symptoms, which have not changed since the last arrangement of compensation. Claimant has sustained very minimal permanent impairment due to her compensable upper back/neck

condition. This impairment would not preclude her from returning to her former work.

We agree with the Referee that claimant was not a credible witness. Therefore, we do not rely on her testimony.

CONCLUSIONS OF LAW

The Referee disregarded claimant's testimony concerning continuing back pain, based on the near unanimous medical evidence which indicated no objective findings. Moreover, many of claimant's statements concerning nonmedical matters were convincingly refuted by contrary documentation or testimony. Finding claimant's testimony to lack credibility, the Referee primarily relied upon the medical evidence to render his decision.

The Referee found that the expert medical evidence established that: (1) claimant's falling incidents were unrelated to her compensable upper back/neck condition; (2) claimant had not sustained an aggravation of her upper back/neck condition; (3) claimant did not suffer a "new injury" to either her upper or lower back while employed as a security officer; and (4) the 10 percent unscheduled permanent disability award was sufficient compensation.

Low Back Condition

To establish compensability of claimant's low back condition, she must show that the exertion connected with her employment was a material contributing cause to her injury. Thurston v. Mitchell Bros. Contractors, 58 Or App 568 (1982); Summit v. Weyerhaeuser Co., 25 Or App 851 (1976). A material cause is more than just a minimal or de minimus cause. Bloomfield v. National Union Ins. Co., 72 Or App 126 (1985); Pattucci v. Boise Cascade Corp., 8 Or App 503 (1972). Claimant is required to prove compensability of her claim by a preponderance of the evidence. Hutcheson v. Weyerhaeuser Co., 288 Or 51 (1979); Ford v. SAIF, 71 Or App 825 (1985).

Claimant contended that her low back condition was caused by the constant falls that she experienced as a result of upper back pain. The record, however, does not support any relationship between the upper back pain and claimant's falls. Furthermore, the record does not support the existence of a low back condition at all.

In November 1986, Dr. Duff opined that there was no reason to attribute claimant's falling episodes to any of her work activities. He felt that the falls, described by claimant as emanating from the upper back pain, did not have any physiopathologic basis. Although Dr. Erickson, treating chiropractor, felt that the persistent falls had caused claimant's low back condition, he could not link the falls to the compensable upper back condition. We are not persuaded that claimant's current low back condition is materially related to her compensable upper back/neck condition. Therefore, that portion of SAIF's denial which denied a causal relationship between claimant's falling episodes and her compensable upper back/neck condition was proper and is affirmed.

We turn our attention to claimant's low back injury claim with CNA. The Referee was not convinced that claimant fell while working as a security officer for CNA's insured. She filled out daily guard reports and, although there was a space to note an accident, she did not indicate on any of those forms that she had

fallen. Furthermore, her supervisor denied that claimant called and reported the accident. In addition to finding the supervisor's testimony credible, the Referee found that claimant's testimony was not credible.

In exercising de novo review, we generally defer to the Referee's determination of credibility when it is based on the Referee's opportunity to observe the witness. Humphrey v. SAIF, 58 Or App 360 (1982). We agree with the Referee that claimant was not credible, based both on her demeanor and the substance of her testimony at hearing. See Coastal Farm Supply v. Hultberg, 84 Or App 282 (1987).

Finally, there was no objective evidence to establish that claimant had a low back condition. In February 1985, Dr. Pasquesi was unable to arrive at an objective diagnosis. He suspected psychological problems or anxiety tension. In April 1985, the Orthopaedic Consultants were also unable to arrive at a diagnosis. They suspected functional overlay. In October 1985, Dr. Wicher, psychologist, stated that claimant was the sort of individual who tended to focus on somatic concerns as a means of attempting to resolve underlying life and emotional difficulties. She strongly recommended that any further medical treatment be provided on the basis of objective physical findings rather than on the patient's subjective complaints. In September 1986, Dr. Snodgrass reported that claimant's complaints and findings were more strongly suggestive of functional overlay. He suggested psychiatric consultation. Only Dr. Erickson felt that claimant had sustained a lumbosacral strain. Even he conceded there was a strong emotional component to her complaints, exhibited through the overly dramatic presentation of her symptoms.

After conducting our review of the medical and lay evidence, we conclude that claimant has failed to establish that her low back condition was materially related to any work incident or activity occurring during her employment for CNA's insured. Therefore, that portion of CNA's denial which denied compensability and responsibility for claimant's low back condition was also proper and is affirmed.

In conclusion, we agree with the Referee that: (1) claimant's falling episodes were not related to her compensable upper back condition with SAIF; (2) claimant did not fall while working as a security guard for CNA's insured; and (3) claimant did not, in fact, have a compensable low back condition, attributable to her employment with either employer.

SAIF Aggravation Claim

In order to establish a compensable aggravation, claimant has the burden of showing that her upper back and neck conditions worsened since January 17, 1986, the date of the last award of compensation (award of 10 percent permanent disability), and that the worsening was materially caused by her 1984 injury. See ORS 656.273(1). "A worsened condition is a changed condition which makes the claimant more disabled, meaning less able to work, either temporarily or permanently, than at the last arrangement of compensation." DeMarco v. Johnson Acoustical, 88 Or App 439, 441-2 (1987), citing Smith v. SAIF, 302 Or 396, 399 (1986).

On August 1, 1986, Dr. Erickson recommended claimant discontinue work due to noncompensable low back pain. Although

claimant lost time from work due to low back pain, a symptomatic worsening which causes temporary disability will amount to a compensable aggravation only if due to an industrial injury.

The only evidence of a worsening of claimant's compensable upper back and neck conditions is claimant's own reporting of increased symptoms. Because of the questionable credibility and reliability of such evidence, we conclude that, in the absence of medical findings supporting a worsening, this evidence is insufficient to sustain claimant's burden. Accordingly, we agree with the Referee that there has been no showing of an aggravation.

Extent of Disability

In rating the extent of claimant's unscheduled permanent disability, we consider her loss of earning capacity and physical impairment attributable to the compensable injury, 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. Harwell v. Argonaut Insurance Co., 296 Or 505, 510 (1984); Fraijo v. Fred N. Bay News Co., 59 Or App 260 (1982).

Following our review of the medical and lay evidence, and considering claimant's physical impairment, age, education and work experience, we conclude that an award of 10 percent unscheduled permanent disability appropriately compensates claimant for her compensable injury.

ORDER

The Referee's order dated May 26, 1987 is affirmed.

SANDRA M. FRIBERG, Claimant
Steven C. Yates, Claimant's Attorney
Moscato & Byerly, Defense Attorneys

WCB 85-13618
August 3, 1988
Order on Review

Reviewed by Board Members Ferris and Crider.

Claimant requests review of Referee St. Martin's order that upheld the self-insured employer's partial denial of claimant's chiropractic treatments as unrelated to her compensable right arm and shoulder injury. The issue is medical services. We affirm.

FINDINGS OF FACT

Claimant worked in the employer's warehouse where her duties included pulling orders from shelves. She was performing this duty on July 28, 1983, when, in the process of pulling an order, her right hand slipped. This resulted in her striking the palm of her hand against a metal shelf. Claimant subsequently sought medical treatment at a hospital emergency room where her injury was diagnosed as a contusion of the right hand.

On August 1, 1983, claimant was examined by her family physician, Dr. Rasor. At the time, claimant reported right hand, right elbow and right shoulder pain. Dr. Rasor diagnosed right shoulder bursitis, right tennis elbow and contusion of the right hand. Claimant filed a claim for a right hand and arm injury which was accepted by the employer.

Claimant received physical therapy and right shoulder

injections. Claimant meanwhile performed light-duty work for the employer. Her right hand and arm complaints improved. However, she continued to experience marked right shoulder complaints.

In January 1984, claimant was examined by Dr. Hoppert, orthopedic surgeon. Claimant complained of right shoulder and neck pain. Dr. Hoppert diagnosed right acromioclavicular joint synovitis. On March 1, 1984, Dr. Hoppert performed right distal clavicle resection. Several months later, claimant returned to work for the employer as an auditor which involved less repetitive movement.

An August 2, 1984 Determination Order awarded claimant temporary disability from July 30, 1983 through June 29, 1984. Claimant was also awarded 20 percent permanent unscheduled disability resulting from injury to her right shoulder.

As of May 1985, claimant was experiencing right arm pain and numbness. However, her neck had full range of motion and was pain free.

On July 31, 1985, claimant left work as a result of right arm and neck pain. She subsequently filed a claim for a right shoulder and neck injury. At the time, Liberty Northwest Insurance Corporation had come on the risk. Liberty Northwest denied the claim on the ground that her current medical problems were an exacerbation of her 1983 injury and not a new injury. Claimant apparently did not appeal this denial.

On August 5, 1985, claimant began treating with Dr. Buttler, chiropractor. He noted complaints of pain in claimant's cervical region, her right shoulder, her thoracic area and her lumbosacral area. He diagnosed cervical sprain and myalgia with associated radicular symptoms into her right arm along with thoracic and lumbosacral sprain and myalgia and concurrent right shoulder sprain and strain complicated by failed surgery. Initially, Dr. Buttler treated claimant every day. This was subsequently reduced to approximately two treatments per week.

On October 10, 1985, the employer issued its denial of claimant's current cervical, thoracic and lumbosacral treatments as unrelated to her compensable 1983 injury. As of the date of hearing, the outstanding balance of Dr. Buttler's bills was approximately $6,800.

Claimant had experienced neck, shoulder and low back complaints prior to her 1983 injury. In June 1978, claimant reported to the hospital emergency room with low back and neck pain. Discogenic back syndrome and probable cervical intervertebral disc disease without frank radiculopathy were diagnosed.

In Janaury 1980, claimant experienced a low back twisting injury which resulted in three weeks of bed rest. Claimant continued to experience symptoms into 1981.

In April 1982, claimant filed a claim for an injury resulting from an incident where a box slipped and struck her in the shoulder. The condition was diagnosed as bursitis of the right shoulder and the claim was accepted. Claimant was off work for one week.

Dr. Buttler's treatments are directed toward claimant's entire spine. The treatments do not provide any benefit to claimant's right shoulder. In addition, claimant's current neck, thoracic, and lumbosacral complaints are not caused, in whole or in part, by her compensable 1983 injury.

CONCLUSIONS OF LAW AND OPINION

To establish entitlement to compensation for medical services under ORS 656.245(1), a claimant must prove the reasonableness and necessity of medical services and a causal relation between the medical services and a compensable injury or disease. Jordan v. SAIF, 86 Or App 29, 32 (1987); West v. SAIF, 74 Or App 317, 320 (1985). This is a two-pronged test. The employer's denial was directed solely to the causal relation component of the test. Claimant has failed to prove a causal relationship between the injury and the conditions being treated. Therefore, the services are not compensable.

Claimant relies upon her own testimony and that of Dr. Buttler to establish the requisite causal relationship. To this effect, claimant opined that overuse of her left arm subsequent to the right shoulder injury caused her to develop the multiple complaints for which Dr. Buttler was treating her. We conclude, however, that the causal relationship between claimant's current symptoms and her compensable injury is a complex medical question largely dependent on expert medical opinion. Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985). This is particularly true given the complicating factor of claimant's pre-1983 shoulder and back symptoms.

Turning to the medical opinions, Dr. Buttler opined that claimant's spinal complaints were causally related to her 1983 injury. In a December 4, 1985 letter to the employer, he states:

> "The problem...was not simply in her hand but was throughout her entire right shoulder, arm and hand complex and, of course, then radiating to her spine and her thoracic and cervical regions."

In cases where expert observation is important, we generally defer to the opinion of the treating physician because of that doctor's opportunity to see and treat the patient over an extended period of time. See Harris v. Farmer's Co-op Creamery, 53 Or App 618, 625 (1981). Here, we find several reasons to conclude that Dr. Buttler's opinion is not entitled to such deference.

We first note that at the time claimant initially treated with Dr. Buttler, she reported symptoms throughout her back and neck. Consequently, Dr. Buttler did not have the advantage of observing the development of these additional symptoms. Therefore, the deference to be given his opinion as the treating physician is diminished. See HarrisV. Farmer's Co-Op Creamery, Supra. . In addition, Dr. Buttler's opinion is largely conclusory. He states that claimant's symptom complex radiated to her spine and her thoracic and cervical regions, but he does not explain how or why this occurred. Further, there is no evidence in the record that claimant informed Dr. Buttler of her prior right shoulder and low back injuries. An expert medical opinion which is based on incomplete information is entitled to little weight. See Hammons v. Perini Corp., 43 Or App 299, 302 (1979).

Dr. Rasor opined that by guarding her right shoulder claimant developed a resistent trapezius spasm on the right and cervical and dorsal spine dysfunction. As claimant's family physician, Dr. Rasor had some knowledge of claimant's pre-1983 symptoms. He was, for example, aware of claimant's April 1982 shoulder injury. On the other hand, he was never claimant's treating physician for her spinal or shoulder conditions. Furthermore, he offered no explanation for claimant's low back symptoms. We conclude that Dr. Rasor provides only limited support for claimant's contention regarding the causation of her present condition.

The Orthopaedic Consultants examined claimant in November 1985. They concluded that there was no relationship between the treatment for claimant's present cervical, thoracic, and lumbar sprain and her 1983 injury. Dr. Hoppert indicated his agreement with the Consultants' report. Dr. Wilson, a neurologist who was on the Orthopaedic Consultants' panel, testified by deposition that it was not medically probable that the symptoms from a hand contusion would progress beyond the shoulder. Dr. Duncan, chiropractor, reviewed the medical exhibits and opined that claimant's own theory that overuse of her left extremity resulted in her spinal complaints was unlikely. Without reviewing claimant's x-rays, Dr. Duncan opined that claimant might have degenerative joint disease in the thoracic and cervical spine.

The employer's medical evidence is somewhat conclusory and, therefore, not particularly persuasive. However, as previously explained, claimant's evidence is unpersuasive, especially considering the absence of any discussion in the record of the relationship between claimant's pre-1983 symptoms and her current complaints. The only evidence with even marginal persuasive value in claimant's favor is that of Dr. Rasor. Yet, his opinion is opposed by those of the Orthopaedic Consultants, Dr. Hoppert, and Dr. Duncan. We conclude that the medical evidence, even viewing it in a way most favorable to claimant, is at most in equipose. We, therefore, conclude that claimant has failed to sustain her burden of proving that the conditions being treated by Dr. Buttler are causally related to the compensable 1983 injury.

ORDER

The Referee's order dated Janaury 15, 1988 is affirmed.

JOHN B. GUERRERO, Claimant
Richard Condon, Claimant's Attorney
Roberts, et al., Defense Attorneys

WCB 87-13424
August 3, 1988
Order on Review

Reviewed by Board Members en banc.

The self-insured employer requests review of Referee Danner's order that set aside its denial of claimant's claim for a low back condition. Claimant submits no brief on Board review.

The issue is compensability of claimant's condition as an injury or an occupational disease.

We reverse.

FINDINGS OF FACT

Claimant had no history of back problems when he began working for the employer in 1980. For the first three years of his employment, he was engaged in heavy lifting and carrying activity. During this period, he experienced no back problems.

In August 1983, claimant began operating a forklift and a turret truck. Approximately six to twelve months later, he began to experience waxing and waning pain in the left side of his lower back and numbness down into the buttock and groin area. He continued to experience gradually worsening symptomatic flare-ups over the next nine months.

Claimant suspected that his symptoms were related to his equipment operating activities. In an average day, he worked a four-hour shift on each piece of equipment. In operating the forklift, he repeatedly craned his neck out of the left side of the cab to observe the materials being moved at the front of the lift. For ever four-hour shift he craned his neck in this

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correspond to periods when he has spent more time operating the turret truck, as opposed to operating the forklift or performing clerical duties. In particular, he experiences a marked increase in pain when he presses down on the turret truck brake pedal.

Claimant's off-work activities include hunting and fishing. He also hikes once a month, water skis about five times a year and mows his own yard with a push mower. He is able to participate in these activities without any significant increase in his symptoms.

Claimant filed a claim for his current condition on May 1987, and the employer initially processed the claim as an injury. In July 1987, the employer issued a denial of the claim on the basis that "work was not the primary cause or the major contributing factor in causing (the) condition." Claimant filed a hearing request on the issue of compensability under an injury theory. At hearing, claimant did not state whether he was relying on an injury or occupational disease theory. However, the questions asked by his attorney on direct and cross examination indicate that claimant was arguing compensability under either theory.

After de novo review of the record, we find that claimant was a credible and reliable witness.

We also find that claimant had no preexisting low back condition.

CONCLUSIONS AND OPINION

The Referee found that claimant had met his burden of proof as to compensability but did not identify whether he did so on an injury or occupational disease theory. On review, the employer argues that claimant's condition should be treated as an occupational disease. It further contends that claimant has not satisfied his burden of proving a compensable occupational disease.

We must first determine whether claimant's condition is properly characterized as an occupational disease or an industrial injury. An occupational disease is distinguished from an injury both by the fact that the former cannot honestly be said to be unexpected, and the fact that an occupational disease is gradual rather than "sudden in onset." James v. SAIF, 290 Or 343, 348 (1981); Clark v. Erdman Meat Packing, 88 Or App 1 (1987); O'Neal v. Sisters of Providence, 22 Or App 9, 16 (1975).

In determining whether claimant's condition was "unexpected", we consider the likelihood that the condition would result from the kind, rate and duration of activity or exposure related to operating a forklift and a turret truck. If claimant's left lower back and hip condition was not an inherent hazard of his equipment operating activities, or otherwise expected from such activity or exposure, an industrial injury, rather than an occupational disease, is indicated. See O'Neal v. Sisters of Providence, supra at 17.

In determining whether claimant's condition was "sudden in onset", we consider whether the condition occurred as a result of a "discrete period" of work activity or exposure. Valtinson v. SAIF, 56 Or App 184, 188 (1982). If the condition resulted from a

sufficiently discrete period of work activity, an industrial injury, rather than an occupational disease, is indicated. Professor Larson states that most jurisdictions recognize a period of several days to be sufficiently discrete to satisfy the requirement. 1B A. Larson, The Law of Workmen's Compensation §39.20 (1987). The Court of Appeals has held that the activity of driving a vehicle for several hours during a single workday satisfied this requirement. Valtinson v. SAIF, supra. The court has also applied injury rules where the initial onset of symptoms "coincided precisely" with severe jolting caused by a malfunctioning front-end loader operated by a claimant, regardless of the fact that the symptoms gradually worsened over a period of several weeks. Donald Drake Co. v. Lundmark, 63 Or App 261 (1983). See also Hall v. Home Insurance Co., 59 Or App 526, 528-29 (1982) (injury rules applied to gradually deteriorating low back condition which suddenly worsened after two full days of work activity).

Here, claimant's condition cannot be viewed as wholly unexpected in view of the constant twisting and braking maneuvers he performed on a daily basis. Furthermore, his condition is not associated with any specific incident, and the onset of his symptoms did not "coincide precisely" with the commencement of his equipment operating activities. Instead, his symptoms initially developed after several months of equipment operation, returned a second time after several weeks of the same activity and then gradually worsened over a four-month period to the point that he sought medical treatment. Moreover, Dr. Hawkins attributed claimant's symptoms as an "accumulative microtrauma to the low back" and opined that the condition is properly characterized as an occupational disease. In light of these factors, we conclude that claimant's condition is properly characterized as an occupational disease.

To prevail on his occupational disease claim, claimant must demonstrate that his work activities, when compared to nonwork activities, were the major contributing cause of the onset or worsening of his low back condition. See former ORS 656.802(1)(a); Dethlefs v. Hyster Co., 295 Or 298, 310 (1983); Devereaux v. North Pacific Ins. Co., 74 Or App 388 (1985). If claimant's condition preexisted his employment, he must prove that his work activities were the major contributing cause of a worsening of his condition resulting in an increase in pain to the extent that it caused disability or required medical services. See Wheeler v. Boise Cascade Corp., 298 Or 452, 457 (1985); Devereaux v. North Pacific Ins. Co., supra; SAIF v. Gygi, 55 Or App 570 (1982). If claimant's condition did not preexist his employment, he must prove that his work activities were the major contributing cause of the onset of the condition itself. Devereaux v. North Pacific Ins. Co., supra; SAIF v. Gygi, supra.

Here, Dr. Hawkins opined that claimant had no significant back condition prior to 1984, and his opinion is supported by the record. Claimant had no prior history of back problems, and physical and radiographic evaluation revealed no evidence of any preexisting low back condition. As a result, we are persuaded that claimant had no preexisting back condition.

Accordingly, claimant must demonstrate that his work activity was the major contributing cause of the "onset" of his low back condition. Id. After de novo review of the record, we conclude that claimant has not carried his burden of proof on the causation issue.

In reaching this decision, we are not disputing the Referee's finding that claimant was a credible witness. We also recognize that claimant's lay testimony is probative. Nevertheless, the causation issue in this case is of sufficient medical complexity to require expert medical opinion. See Uris v. Compensation Department, 247 Or 420, 424-26 (1965); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985). The only medical report in the record is Dr. Hawkins' opinion that claimant's work activity was not the major contributing cause of his chronic condition. Absent a persuasive medical opinion supporting claimant's position, a temporal relationship between claimant's symptoms and work activities is not sufficient to satisfy his burden of proof. See Allie v. SAIF, 79 Or App 284, 287 (1986).

ORDER

The Referee's order dated January 7, 1988 is reversed. The self-insured employer's denial is reinstated and upheld. We approve a client-paid fee for the self-insured employer's attorney for services on Board review, not to exceed $1,440.

Board Member Crider, dissenting:

I agree with the majority's characterization of claimant's condition as an occupational disease and the finding that claimant's back condition did not preexist his employment. However, I conclude that claimant has demonstrated a compensable occupational disease. Therefore, I dissent.

Claimant has persuasively demonstrated a consistent, long-term relationship between his symptoms and his equipment operating activities for the self-insured employer. His treating physician, Dr. Hawkins, although unwilling to state that these work activities were the major contributing cause of claimant's back condition, acknowledged that claimant's work activities contributed to his current condition. There being no evidence that claimant engaged in other activities that produced the symptoms supporting the diagnosis, claimant has carried his burden of proof on the question of compensability.

We are generally hesitant to infer causation from chronological sequence. See Allie v. SAIF, 79 Or App 284, 288 (1986). However, in certain circumstances a temporal relationship is sufficient to demonstrate causation. For example, a temporal relationship has been found sufficient where a very close connection existed between the injury and the condition and claimant had eliminated all alternative causes. See Bradshaw v. SAIF, 69 Or App 587, 589 (1984).

The facts in this case are similar to those in Bradshaw. Claimant has demonstrated not a single, and possibly coincidental, instance in which a medical condition followed work activities, but rather a continuing pattern of waxing and waning back difficulty related to the nature of his work activities. His back problems first arose while he was assigned to equipment operation. His symptoms totally resolved when he transferred to the shipping department and began again within a few weeks of his return to his equipment operating functions. His symptomatic flare-ups and periodic treatments continued to occur during periods when he spent more time at work operating the turret truck.

Furthermore, although both the treating physician and

counsel inquired into claimant's nonemployment activities, there is no evidence that any such activities contributed in any way to the causation of the condition. Dr. Hawkins did not identify any alternative cause for claimant's symptoms. His written reports make no mention of off-work activities. His discussion of alternative causes at hearing was limited to a brief comment that claimant's water skiing and similar off-work activities "might" have "predisposed him" to a low back condition or put a mild strain on his low back. He subsequently acknowledged that this was pure speculation and that claimant had never related his symptoms to any of those activities. Tr. 59. With the exception of this unfounded speculation at hearing, the record contains no evidence that any cause outside of claimant's employment contributed in any way to his condition. To the contrary, claimant credibly testified that he was able to water ski and participate in other off-work activities without any increase in symptoms.

I am aware that no medical expert has opined that claimant's work activities were the major contributing cause of his back condition. However, claimant's condition is a simple chronic low back strain. Furthermore, as there is no evidence that claimant's off-work activity in any way contributed to his condition, there is no need for an expert opinion to assist us in evaluating the relative contribution of work and nonwork activities. Given these facts, I conclude that the issue of medical causation in this case is not so complex that expert medical opinion is a prerequisite to a finding of compensability. See Uris v. Compensation Department, 247 Or 420, 424-26 (1965) (expert medical opinion not required to prove compensability of a simple chronic low back strain).

Moreover, findings made by Dr. Hawkins, claimant's treating physician, support the conclusion that his work activities were the major contributing cause of his back problems. Dr. Hawkins identified the nature of the injury in his First Medical Report as "accumulative microtrauma to low back". Ex. 3. He stated in a later report that "the increase in symptomatology noted by the patient during his work in the equipment department leads me to conclude there had been a material worsening of his condition..." Ex. 8. Finally, Dr. Hawkins observed that claimant's work "exacerbated his low back condition" and was "the probable cause of his discomfort." Ex. 8. See also Tr. 60-61. These comments, read in light of the physician's further observation that claimant suffered no preexisting back disorder, support the conclusion that work activities were the major contributing cause of his back problems.

The majority errs in relying on Dr. Hawkins' ultimate conclusion that "while work did serve to exacerbate his low back condition, it was not the primary cause nor the major contributing factor in producing the symptomatology experienced by the patient." Ex. 4. That opinion is unexplained and without evidentiary foundation. As discussed above, Dr. Hawkins did not identify any alternative cause for claimant's symptoms, and his ultimate conclusion is in conflict with the import of his other comments. *

In summary, the close relationship between claimant's symptoms and his equipment operating activities, the lack of persuasive contrary medical opinion, Dr. Hawkins' opinion that

work activities contributed to claimant's condition, and the absence of any identifiable alternative cause lead me to conclude that it is more likely than not that claimant's work activity was the major contributing cause of his current low back condition. Accordingly, I would affirm the Referee's order.

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*I reluctantly hypothesize that Dr. Hawkins' inability to render consistent opinions may be related to the fact that, in addition to treating injured workers, Hawkins maintains an on-going consulting relationship with the employer conducted under the business name "LesComp, Inc." Tr. 47. In any event, I do not find his opinion persuasive.

The Beneficiaries of
DANIEL HUWA (Deceased), Claimant
Pozzi, Wilson, et al., Claimant's Attorneys
Bullard, et al., Defense Attorneys

WCB 84-07911
August 3, 1988
Order on Review

Reviewed by Board Members Ferris and Crider.

The insurer requests review of Referee Shebley's order that set aside its denial of the decedent's claim for a heart attack. The issue is compensability. We reverse.

FINDINGS OF FACT

Claimant was employed as a foreman in a truck and tractor repair shop. On or about Monday, December 19, 1983, he began to experience pain in his left shoulder and arm. The pain became acute that evening while watching television. He went outside in the hope that the pain would improve. It did eventually subside.

The following day, Tuesday, claimant reported to work as usual. He appeared pale and ill, but he experienced no acute pain as he had the evening before. Claimant thought that he had a pinched nerve or a shoulder sprain.

He reported to work on Wednesday, once again looking pale and quite ill. He began working outside, but several fellow employes, concerned for his health, convinced him to return indoors. Sometime around midday, he was using a sledgehammer to repair a truck or tractor axle when he experienced another incident of acute chest, shoulder and arm symptoms.

Claimant spent the remainder of the day doing lighter work. Just before going home that evening, he suffered yet another incident of acute pain. He allowed his son-in-law, whom he worked with and commuted with daily, to drive him to his home.

On arriving home, he had a cup of coffee with his son-in-law. He then lay down for three-to-four hours. This was unusual as he rarely napped or went to bed on getting home from work.

Later that evening, claimant had his son drive him to the emergency room at the hospital. Dr. Crislip, the admitting cardiologist at the hospital, diagnosed "arteriosclerotic heart disease with coronary insufficiency." At the time of his admission, he was reported to be pain-free. However, at about 1:00 a.m., he suffered a heart attack. The heart attack was a Q-wave infarction caused by an arterial blood clot.

He was eventually discharged from the hospital, although he had experienced substantial heart damage. He subsequently filed an injury claim relating to the heart attack. He died approximately nine months later of heart failure resulting from ventricular fibrillation. Claimant's heart attack in December caused his heart failure the following September.

Based upon our de novo review of the record, we find that claimant's work activities led to increased angina but did not cause, or combine with other factors to cause, claimant's heart attack in December 1983.

CONCLUSIONS OF LAW AND OPINION

As a preliminary matter, we note that we are persuaded claimant's work activities produced increased angina symptoms which eventually led claimant to seek medical treatment. Had the issue of claimant's December 21, 1983 medical services been before us, we would conclude that at least a portion of those services were compensably related to claimant's work activities. However, the parties have defined the issue to be whether the physical stress of claimant's work activities, specifically the sledgehammer activity on Wednesday, December 21, 1983, was a material contributing cause of the heart attack. We confine the remainder of our discussion to this issue.

Three physicians expressed opinions on this question. The first is claimant's treating physician, Dr. Crislip, cardiologist. Dr. Crislip initially agreed with a letter from the insurer's attorney which stated that the work activities were not a material contributing cause of claimant's heart attack. Dr. Crislip indicated his agreement with this statement by signing a blank on the letter. Dr. Crislip subsequently retreated from this opinion, stating that to give an opinion whether claimant's heart attack was caused by his work activity would be "mere speculation."

Testifying for claimant at the hearing was Dr. Rogers, cardiologist. Dr. Rogers testified, based upon his review of the medical records, that the sledgehammer incident aggravated claimant's underlying unstable angina and caused some injury to his heart muscle. He stated that an EKG taken at the time of claimant's admission to the hospital indicated some injury to the heart muscle. Dr. Rogers based his opinion upon his conclusion that claimant was a "sicker" man after the sledgehammer incident than he had been before it. This conclusion, in turn, was based upon the severity of claimant's reported symptoms at the moment of the incident as well as claimant's conduct following the incident. In this regard, he specifically noted that claimant allowed his son-in-law to drive him home, and that he went to sleep almost immediately upon arriving home.

The insurer's expert at hearing was Dr. Toren, cardiologist. Dr. Toren testified, based upon his review of the medical record, that physical exertion played no role in claimant's subsequent heart attack. He characterized claimant's heart attack as a "Q-wave" infarction. This characterization is accepted by the parties. He explained that a "Q-wave" infarction involves the formation of a blood clot in an artery feeding the heart. Once again, the parties agree on the basic mechanics behind a "Q-wave" infarction. However, it was Dr. Toren's

opinion, based upon what he termed the consensus medical opinion, that physical exertion plays no role in "Q-wave" infarctions.

When pressed upon cross-examination to name any article to this effect, Dr. Toren stated that the articles were too numerous to cite to any particular one. He offered to provide names of articles after the conclusion of the hearing. Such material was neither requested nor provided.

The Referee found Dr. Rogers to be more persuasive. He did so without explanation. On de novo review, we disagree.

Both Dr. Rogers and Dr. Toren are highly qualified cardiologists. Both also relied upon the same medical history in order to reach their conclusions. Where the record contains conflicting medical opinions, we weigh each to determine its persuasiveness. Somers v. SAIF, 77 Or App 259 (1986); Stanley C. Stanchfield, 38 Van Natta 146 (1986). We find that Dr. Toren's opinion is better supported by the record and more persuasively reasoned. He not only stated his opinion that physical exertion played no role in claimant's "Q-wave" infarction, but he also provided a convincing explanation. We rely upon his persuasive explanation rather than his reference to a consensus medical opinion on this question.

Commencing on at least the previous Monday, claimant was experiencing a condition variously termed by the parties as unstable angina or pre-infarction angina. The parties agree that claimant had experienced a crack in the plaque lining the arterial wall and that a blood clot had begun to form almost immediately thereafter.

Dr. Rogers' opinion was dependent upon his conclusion that claimant was a "sicker" man following the sledgehammer incident. We first note that claimant had already experienced at least one incident of acute symptoms prior to Wednesday, December 21. Certainly claimant's condition deteriorated following the incident to the point where he suffered his heart attack. However, we are not persuaded that this deterioration resulted in material part from the sledgehammer incident rather than a natural growth of the blood clot leading to a reduction in the arterial flow until, as Dr. Rogers stated, only a "trickle" remained by Wednesday afternoon.

Dr. Rogers' opinion that claimant's condition materially worsened due to the sledgehammer incident was also influenced by claimant's conduct following the incident. In this regard, we note that claimant had an additional acute incident just before leaving to return home. It is, therefore, not surprising that he allowed his son-in-law to drive him home. Nor is it surprising that after experiencing three days of unstable angina, including at least three incidents of acute symptoms, claimant would lay down to rest following work. We find that Dr. Rogers' opinion is weakened as a result of our conclusions. Further, as explained below, we are persuaded by Dr. Toren's testimony that even though claimant did become a "sicker" man following the incident, this did not materially contribute to his subsequent infarction.

Dr. Rogers testified that 35 percent of patients with unstable angina such as claimant's go on to have heart attacks. The Referee interpreted Dr. Rogers' statement as meaning that claimant had a better than even chance of escaping his heart attack had he not worked that day. Insofar as the Referee may

have interpreted this statement as establishing, on a more probably than not basis, that claimant's work activities contributed to his subsequent heart attack, we disagree. Dr. Rogers' precise statement was "I think that, had he stayed home on the 21st and not gone to work, I think there's probably a 35 percent chance a 'Q wave' infarction would have ensued anyway." Dr. Rogers' statement must be interpreted in its context. He subsequently testified that a patient experiencing severe angina, like that experienced by claimant, has a one-in-three chance of suffering a "Q-wave" infarction. The dispositive factor apparent in the doctor's opinion is the severity of the symptoms, not the undertaking of physical exertion except insofar as that exertion affects the severity of the symptoms.

Even if we interpret Dr. Rogers' statement as suggested by the Referee, we nevertheless find his testimony less persuasive than that of Dr. Toren.

Dr. Rogers testified that claimant's hospital admission EKG showed evidence of existing damage to the heart which he attributed to the sledgehammer incident. Dr. Toren, on the other hand, said that the EKG showed no evidence of existing damage. Dr. Toren supported his position by reference to Dr. Crislip's admission diagnosis which made no reference to existing damage, instead stating "arteriosclerotic heart disease with coronary insufficiency." He also testified that Dr. Crislip did not treat claimant on admission as he would have done if he felt that muscle damage had occurred.

Dr. Toren acknowledged that extreme and prolonged exertion could cause muscle damage in a patient suffering from unstable angina. He also stated that a patient who has experienced muscle damage during a period of unstable angina is statistically more likely to experience a "Q-wave" infarction. He testified persuasively, however, that the presence of heart muscle damage would have no material causative relationship with regard to a subsequent "Q-wave" infarction. As explained by Dr. Toren, a "Q-wave" infarction results from a blood clot in the artery, not from any preexisting condition of the heart itself.

Dr. Rogers stated that most cardiologists would have hospitalized claimant even before the sledgehammer incident, and that sound medical advice would have cautioned him against any physical exertion of the kind he performed on December 21. Dr. Toren agreed. However, Dr. Toren explained that physical exertion is discouraged in heart patients because of the fear of heart failure resulting from electrical disturbances such as the one which eventually took claimant's life.

Dr. Rogers testified that physical exertion "probably does eventually" have an effect on the progression of the blood clot. We are not persuaded, however, that claimant's sledgehammer activity had any material effect on the progression of the clot resulting in his "Q-wave" infarction. First, we note that Dr. Roger's statement is couched in very indefinite terms. The statement also presumes that exertion caused muscle damage which then affected the flow of blood through the artery. And yet, Dr. Rogers stated that claimant's work activities may have caused "little individual fibers to die" but that this would not be capable of measurement. Furthermore, Dr. Toren refutes Dr. Rogers' opinion.

Claimant has the burden of proving the compensability of his claim. Carter v. Crown Zellerbach Corp., 52 Or App 215, rev den 291 Or 368 (1981). We conclude that claimant has failed to prove that his work activities on December 21, 1983 were a material contributing cause of his subsequent heart attack. We, therefore, reverse the order of the Referee.

ORDER

The Referee's order dated March 25, 1987 is reversed. The insurer's denial dated July 10, 1984 is reinstated and upheld. A client-paid fee not to exceed $350 is approved.

PAUL H. KRAUCHE, Claimant
Darrell L. Cornelius, Claimant's Attorney
Moscato & Byerly, Defense Attorneys

WCB 86-05512
August 3, 1988
Order on Review

Reviewed by Board Members Johnson and Crider.

The self-insured employer requests review of Referee Mulder's order that found claimant permanently and totally disabled. We affirm.

Issue

Extent of claimant's unscheduled and scheduled disability, including permanent total disability.

Findings of Fact

Claimant, 56 at hearing, suffered multiple compensable crush injuries to his right foot and leg on December 21, 1983. As a result, he had four surgeries, including skin grafts. His residuals included loss of tissue, loss of joint movement which caused him to walk with an antalgic gait, posttraumatic arthritis and leg deformities. He developed problems in his low back as a result of his abnormal gait.

Claimant has had many doctors. His current treating orthopedic surgeon, Dr. Gripekoven, found claimant medically stationary on December 24, 1985, with "very significant residual impairment." He limited claimant's return to work to very sedentary work, part time, with the ability to sit and stand at will.

Claimant developed psychological problems as a result of his compensable injury. His organic pain and physical limitations caused depression. Both his attending psychiatrist, Dr. Colbach, and Dr. Klein evaluated claimant as making a poor adjustment to his disability, and as having permanent psychological disability. Dr. Colbach rated claimant's depression as severe; Dr. Klein rated it as moderate. This depression is not voluntary. Claimant also is enraged at his situation and at the employer.

Claimant was examined by the Orthopaedic Consultants on January 6, 1986. They rated claimant's low back disability related to the injury as mild, and his right leg disability as moderately severe. They agreed that claimant could not work as a stationary engineer, and was restricted to sedentary, part-time work where he could change positions. They noted possible problems with his emotional status.

Dr. Gripekoven generally agreed with the Orthopaedic Consultants, but felt claimant's injury-related back disability was at least moderate. He also felt that claimant's psychological impairment was significant, and would probably preclude his return to work.

Dr. Colbach reported that he agreed with the Orthopaedic Consultants and Dr. Klein, but believed that it would be difficult to find any kind of work which claimant could tolerate.

An April 16, 1986 Determination Order awarded claimant 35 percent unscheduled permanent partial disability for his back condition and 45 percent scheduled permanent partial disability for loss of use or function of his right leg.

Claimant returned to work for the employer in late 1986, at a desk job, for two hours per day. The job was specially created for claimant. He did some fleet record keeping and parts purchasing. His work kept him busy about one hour out of each day. He earned $8.50 per hour, with no fringe benefits.

Neither Dr. Gripekoven nor Dr. Colbach could say whether claimant could work more than two hours per day. His physical pain and psychological problems present more obstacles to his return to work than do his purely physical limitations.

Claimant has a GED and and associate's degree in general studies. He was a military aircraft electrician for twenty years. He then worked as a stationary engineer for fifteen years, including seven with the employer at injury. At the time of injury, claimant earned $11.65 per hour, plus pension and medical benefits. The employer considered claimant a very good, motivated and conscientious employee.

Dr. Colbach described claimant as an independent, "Type A" person who had a strong work ethic. He has tested in the 99th percentile for nonverbal comprehension, and the 87th percentile for mathematic abilities. He has many transferable skills. Dr. Colbach was not surprised to learn that claimant was not kept busy at work, and that he did not seek more work to do, because claimant perceived the work to be a make-work job.

Claimant is 5 feet 6 inches tall and weighs 230 pounds. His doctors have generally advised that he lose weight, but have not put him on a diet or weight loss program.

Conclusions of Law and Opinion

Claimant must prove by a preponderance of the evidence that he is permanently totally disabled. Harris v. SAIF, 292 Or 683 (1982). "Permanent total disability" means the loss 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 occuaption. ORS 656.206(1)(a). The Referee found that claimant had met his burden of proof. We agree.

Claimant walks with a cane, and moves slowly. Walking causes great pain in his injured ankle and leg. He can no longer do the physical climbing, bending, and working required of a stationary engineer. His back condition necessitates that he change position frequently. Even so, he has a lot of discomfort which, in turn, fuels his depression and rage.

The fact that claimant was going to work for two hours each day does not change our conclusion. The determination of permanent total disability status turns not on claimant's money-earning capacity, but on whether he is employable on a regular basis in a hypothetically normal labor market. Wiley v. SAIF, 77 Or App 486 (1986). In this case, claimant's employer at injury has created a job for him. It is not a "make work" job, in that the tasks he performs are ones that someone in the company must do. However, the job is specially tailored for claimant alone. He is paid well above the normal rate, is not supervised, and is allowed to keep his own hours. The employer would keep him on the payroll under these conditions for as long as claimant alone desired. He has his job because of the sympathy of the employer. See, Harris v. SAIF, 292 Or 683 (1982).

The employer contends that claimant has not shown motivation to work. Claimant may lack motivation, as seen by others. However, a large component of his disability is his psychological condition and his inability to adjust to his condition. His psychiatrist testified that his depression is involuntary. The Referee found claimant's testimony regarding his great difficulty in working credible. We concur that claimant's motivation is not a bar to an award of permanent total disability.

The employer also contends that claimant has failed to mitigate the extent of his disability by unreasonably failing to follow medical advice that he lose weight. An award of permanent total disability is inappropriate when an employer proves failure to mitigate disability in this way. Lee v. Freightliner Corp., 77 Or App 238 (1986); Nelson v. EBI Companies, 296 Or 246 (1984).

Claimant is overweight, and his doctors have generally advised him that losing weight would lessen his physical disability. However, there is no indication that he has ever been given a weight loss program which he failed to follow for reasons within his control. Lee, supra.; Christenson v. Argonaut Ins. Co., 72 Or App 110 (1985). Under these circumstances, his weight does not preclude a finding that he is permanently, totally disabled.

ORDER

The Referee's order dated March 23, 1987 is affirmed. Claimant's attorney is awarded an assessed fee of $945, to be paid by the self-insured employer. The Board approves a client-paid fee not to exceed $108.

KEVIN MARSH, Claimant
Quintin B. Estell, Claimant's Attorney
Kevin L. Mannix, Defense Attorney

WCB 86-17490
August 3, 1988
Order on Review

Reviewed by Board Members Ferris and Crider.

Claimant requests review of that portion of Referee Seymour's order that allowed the insurer an offset of overpaid temporary benefits against additional permanent disability awarded in the Referee's order. In its respondent's brief, the insurer contends that the Referee erred in determining the date that claimant's compensable low back condition became medically stationary and in increasing claimant's unscheduled permanent disability from 15

percent (48 degrees) as awarded by a Determination Order, to 30 percent (96 degrees).

We affirm the Referee's order.

ISSUES

(1) Extent of unscheduled permanent partial disability

(2) Entitlement to temporary total disability.

(3) Offset for overpayment of temporary disability

FINDINGS OF FACT

The Board adopts the Referee's findings of fact as set forth in the "Findings and Opinion" section of his order with the following supplementation.

Claimant was not able to return to the work force and had continuing need for medical treatment until April 22, 1986. This is also the date when claimant's treating physician first declared him medically stationary.

Claimant is medically limited to light bending, twisting, turning and pulling, lifting of no more than 20 pounds and must be allowed to change positions from sitting, standing and walking every hour or two.

OPINION AND CONCLUSIONS

The Board adopts the remainder of the Referee's conclusions as set forth in the "Findings and Opinion" section of his order with the following supplementation.

Claimant's compensable condition became medically stationary on April 22, 1986; therefore he was not entitled to temporary disability benefits after that date. Claimant received temporary disability payments after that date. The insurer should be allowed to offset this overpayment even if the insurer was dilatory in seeking claim closure. A claimant is not left without a remedy if there is an unreasonable refusal or delay in closing a claim. A penalty and attorney fee can be assessed for unreasonable processing. See ORS 656.262 (10), Lester v. Weyerhaeuser, 70 Or App 307 (1984). However, this was not raised as an issue in this proceeding and, therefore, is waived. See Mavis v. SAIF, 45 Or App 1059 (1980): Brian J. Shaw, 39 Van Natta 438 (1987).

The Board affirms the Referee's award of an additional 15 percent (48 degrees) unscheduled permanent partial disability for claimant's low back problems making a total award of 30 percent (96 degrees). Claimant's earning capacity is permanently impacted by his medical impairment that limits him to light activities and his work experiences which limits his adaptability to less strenuous activities. See ORS 656.214(5)

ORDER

The Referee's order dated June 29, 1987 is affirmed.

NORMA J. NELSON, Claimant
Pozzi, Wilson, et al., Claimant's Attorneys
Thomas H. Johnson (SAIF), Defense Attorney

WCB 86-12412
August 3, 1988
Order on Review

Reviewed by Board Members Johnson and Crider.

The SAIF Corporation requests review of Referee Shebley's order which found the decedent's death to be materially caused by a compensable fall and awarded survivor's benefits to the decedent's widow. The issue on review is compensability. We reverse.

FINDINGS OF FACT

Decedent was a 60-year-old electrician who, on June 5, 1986, sustained a compensable fall while working on the roof of a one-story residence. The ladder upon which he was standing broke, and he hung from the eaves until he fell, landing on his buttocks. He sustained a laceration to the scalp in the occipital area, a fractured left radius, and complained of dizziness and double vision which quickly resolved.

During the following five days, decedent rested at home. On June 10, 1986, when his wife returned at approximately 2:30 p.m. from running errands, decedent complained of the sudden development of severe abdominal pain. He was taken by ambulance to the hospital and was again attended by Dr. Thomas, the emergency room physician. The decedent's blood pressure was low and there was a palpable mass in the abdomen. He was taken to the operating room where Dr. Eustermann, a general surgeon, prepared for immediate surgery. The decedent went into cardiac arrest, and a thoracotomy for open chest massage was performed. Resuscitation efforts were unsuccessful and the decedent expired. The abdomen was not opened and no autopsy was performed. Dr. Eustermann made no definitive diagnosis of the intra-abdominal crisis. Cause of death was listed as hemorrhagic shock due to dissecting abdominal aneurysm. The diagnosis was based on the abdominal symptoms, and other possible causes were not excluded.

By letter dated September 3, 1986, SAIF issued a partial denial on the basis that the worker's death was not materially caused by the compensable injury.

SAIF obtained the opinions of Dr. Girod, an internist, and Dr. Porter, Professor of Surgery, Division of Vascular Surgery at Oregon Health Sciences University. Based on their review of the records, neither felt that the decedent's death was related to his fall five days earlier. Dr. Eustermann felt that it was "more likely, "rather than just "possible," that the fall was a material contributing cause of the decedent's death.

CONCLUSIONS AND OPINION

In order to establish an entitlement to death benefits, the decedent's widow (claimant) must show that the compensable fall from the roof was, to the degree of reasonable medical probability, a material contributing cause of the decedent's death. Lenox v. SAIF, 54 Or App 551 (1981). Causation in this case involves a complicated medical question. Therefore, we rely on the expert medical evidence in determining whether or not claimant has met her burden of proof. Uris v. Compensation Department, 247 Or 420 (1967).

Three physicians have offered opinions regarding whether or not claimant's fall on June 5, 1986, contributed to his death five days later. There are several reasons why, unlike the Referee, we are not persuaded by the opinion of Dr. Eustermann. First, Dr. Eustermann is a general surgeon, and there was no showing that he is an expert in vascular accidents. Second, although he attended the decedent during his final moments, Dr. Eustermann did not open the abdomen to determine the process or cause of claimant's condition. Thus, he was in no better position to determine what happened and what was the cause than another expert who was provided an accurate history. Third, Dr. Eustermann made no definitive diagnosis, nor was an autopsy performed to determine what actually occurred. Dr. Eustermann based his opinion on what he described as a "supposition" of what had occurred with the decedent. Fourth, Dr. Eustermann offered no explanation for the delay between the fall and the sudden onset of abdominal symptoms five days later. Neither did he explain why claimant had no abdominal symptoms when he presented to the emergency room on the day of the fall.

Dr. Girod is an internist. He identified the risk factors present in decedent, including hypertension, cigarette use, elevated cholesterol level, a positive family history of heart disease, a previous myocardial infarction, his male gender, and advancing age. He further stated that aortic aneurysms almost always occur spontaneously, without trauma, as a result of athrosclerotic heart disease. He further opined that, if the aneurism was related to trauma, it would be expected to occur within minutes or hours of the fall, not five days later.

Dr. Porter, a vascular surgeon, reviewed the medical file and stated that it was clear to him that claimant died of a massive intra-abdominal aortic aneurysm. He agreed with Dr. Girod that there was probably no relationship between trauma and the subsequent rupture of the aneurysm.

We disagree with the Referee that Dr. Porter's opinion was flawed because his assumption that decedent experienced a "short fall off of a ladder" was incorrect. A comparison of the fall and injuries sustained by decedent with the severe trauma and resulting massive internal organ injuries described by Dr. Porter as necessary to cause a rupture of the abdominal aorta places Dr. Porter's opinion regarding the severity of claimant's fall into perspective. In addition, the Referee's assumption that Dr. Porter did not know that there was a large abdominal mass, is incorrect. Dr. Porter, having expertise in this area, was identifying possible causes of claimant's problem. Finally, the Referee's attribution of greater weight to the opinion of Dr. Eustermann because he had a first-hand look at what was actually going on disregards Dr. Eustermann's own statement that he did not open the abdomen to determine what had occurred in that area.

Standing alone, Dr. Eustermann's opinion, which deals with "supposition" and "more likely," does not rise to the level of reasonable medical probability required to meet claimant's burden of proof. When the well-reasoned opinions of the experts, Porter and Girod, are considered, the causal connection becomes even more remote. We conclude claimant has not met her burden of proof.

ORDER

The Referee's order dated May 26, 1987, is reversed. The SAIF Corporation's September 3, 1986 denial is reinstated and affirmed.

JAMES R. NEWTON, Claimant
Quintin B. Estell, Claimant's Attorney
Meyers & Terrall, Defense Attorneys

WCB 86-09390
August 3, 1988
Order on Review

Reviewed by Board Members Ferris and Crider.

The self-insured employer requests review of that portion of Referee Peterson's order that set aside its partial denial of claimant's medical treatment for his cervical and right shoulder condition. Claimant cross-requests review of that portion of the Referee's order that affirmed a Determination Order granting claimant no permanent disability. We reverse in part and affirm in part.

ISSUES

1. Whether medical treatment for claimant's compensable neck and right shoulder injury was reasonable and necessary.

2. Whether claimant is entitled to an award of permanent disability.

FINDINGS OF FACT

Claimant is a 36 year old mill worker whose right leg fell through a floor, thereby causing injury to his neck and right knee on July 29, 1985. Dr. Taylor, chiropractor, diagnosed cervical and lumbosacral sprain/strain and began conservative treatment.

On October 15, 1985, Dr. Taylor referred claimant to "The Growth Place" for counseling for depression.

On May 21, 1986, the employer denied current medical treatment "on the ground that treatment was not reasonable or necessary at this time." Dr. Taylor continued to provide treatment.

On July 3, 1986, a Determination Order awarded temporary disability from August 23, 1985 through April 14, 1986, but awarded no permanent disability.

On August 6, 1986, the employer denied responsibility for claimant's counseling at "The Growth Place."

Claimant is a high school graduate and has previously worked as a truck driver, auto mechanic, car salesman, and laborer. He has had no prior back problems, except for a neck injury in 1980. He has had a very stormy marriage with many marital and emotional problems that preexisted this industrial injury.

Claimant is not a credible witness. He has no permanent impairment related to his 1985 industrial injury. Further, claimant's chiropractic treatment after May 21, 1986 was neither reasonable nor necessary treatment regarding his compensable injury.

CONCLUSIONS OF LAW

Extent of permanent disability

The Referee concluded that claimant failed to carry his burden of proof in establishing any permanent disability as a result of the compensable injury. According to the Referee, claimant's failure of proof was due to both his lack of credibility or objective physical findings. We agree.

In rating the extent of claimant's unscheduled permanent disability, we consider his loss of earning capacity and physical impairment attributable to the compensable injury, 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. Harwell v. Argonaut Insurance Co., 296 Or 505, 510 (1984); Fraijo v. Fred N. Bay News Co., 59 Or App 260 (1982). Claimant has the burden of proving his contentions by a preponderance of the evidence. Hutcheson v. Weyerhaeuser, 288 Or 51 (1979).

Claimant testified that he has occasional low back pain and constant neck and shoulder pain which increases with activities. He said he could not return to any of his former occupations. Dr. Taylor has opined that claimant has some permanent impairment as a result of his July 1985 injury, but he has not elaborated on this vague, general assessment. Dr. Bolin, a chiropractor who saw claimant in April 1986, has opined that claimant has some minimal permanent impairment.

Matched against the above evidence is a great deal of contrary evidence. Several examiners who have seen claimant since his injury have questioned his reliabity and have found no objective evidence of impairment. Dr. Howell, an osteopathic physician who saw claimant in September 1985, found no objective abnormalities to support claimant's subjective complaints of pain in his neck and back. He also suggested that claimant might not be a reliable historian. Dr. Colbach, a psychiatrist who saw claimant in April 1986, reported that claimant was extremely uncooperative and he opined that claimant might be malingering. The Orthopaedic Consultants saw claimant in April 1986 and reported no objective abnormalities to substantiate claimant's subjective complaints. They opined that claimant had no disability as a result of his July 1985 injury. Dr. Gatterman, a chiropractor who saw claimant in May 1986, reported no objective findings and felt that claimant had no permanent impairment. She also suggested that claimant might not be a reliable historian. Dr. Peterson, a chiropractor who saw claimant in March 1987, opined that claimant had no permanent impairment.

Surveillance films taken of claimant's activities in November 1986 and February 1987 undermine the reliability of his subjective assertions of pain and limitations. As noted earlier, claimant testified that he had low back and neck and shulder pain which increased with activities; he also said that he would not be able to return to any of his former occupations. He further testified that he occasionally worked on his own car but limited such activity to changing spark plugs and oil. He added that he had not done any pushing or pulling activities since his injury,

with the exception of his lawn mower. The surveillance films present a very different picture of claimant's physical capabilities. The films show no obvious disability. Claimant was seen working under the hood of his truck, on the truck door, and under the dashboard on numerous occasions. The films also revealed that claimant was able to push and pull his truck out of his driveway on numerous occasions to get it started. On two occasions he pushed his truck back up the hill after it failed to start. Dr. Taylor viewed the surveillance films and although he did not fully retract his opinion regarding claimant's permanent impairment, he did acknowledge that claimant has a tendency to overstate things.

Considering the reports of Drs. Howell, Colbach, and Getterman and the surveillance films, we find that claimant is not reliable regarding his subjective assertions of pain and limitations. Further, considering the opinions of Drs. Howell, Gatterman, Peterson and the Orthopaedic Consultants, and the unreliability of claimant's subjective complaints/limitations, we find that claimant has no permanent impairment as a result of his 1985 work injury. Absent permanent impairment there is no basis for a finding of loss of earning capacity and a resultant award of unscheduled permanent partial disability.

Medical services

The Referee concluded that the preponderance of the evidence established that claimant was in need of some further chiropractic treatment after he became medically stationary. We disagree that the treatment addressed by the May 21, 1986 denial was reasonable or necessary.

To establish entitlement to compensation for medical services under ORS 656.245(1), claimant must prove the reasonableness and necessity of the medical services and a causal relation between the medical services and the compensable injury. Jordan v. SAIF, 86 Or App 29, 32 (1987); West v. SAIF, 74 Or App 317, 320 (1985). To prove the reasonableness and necessity of rendered medical services, claimant must show that at the time the services were rendered they were likely to be of significant curative, palliative, preventive or restorative benefit. Id. at 320-21; Michael D. Barlow, 38 Van Natta 196, 197-8 (1986). To prove a causal relation between the medical services and a compensable injury or disease, claimant must show that the compensable injury was a material contributing cause of the need for the services. Van Blokland v. Oregon Health Sciences University, 87 Or App 694, 697-98 (1987); Jordan v. SAIF, supra, 86 Or App at 32. Material contributing cause means a substantial cause, but not necessarily the sole cause or even the most significant cause. Van Blokland v. OHSU, supra. 87 Or App at 698.

We have already concluded that claimant's subjective complaints are not a reliable guide for the rating of permanent disability. Therefore, we also conclude that claimant's subjective complaints are not a reliable basis for establishing the reasonableness and necessity of his continuing medical treatment. Instead, we rely upon the objective medical evidence in determining whether claimant's medical treatment was likely to be of significant curative, palliative, preventive or restorative benefit. We conclude that it was not.

The Orthopaedic Consultants, Dr. Gatterman and

Dr. Howell reported no objective findings to substantiate claimant's subjective complaints. Dr. Gatterman believed that chiropractic treatment was not necessary. Dr. Howell had previously expressed the same view.

Dr. Bolin recommended further chiropractic treatment, but he did not indicate whether such treatment should continue for a prolonged period or only for a short duration.

While Dr. Taylor believed that claimant's condition would have deteriorated without chiropractic treatment, we do not find his opinion persuasive. Dr. Taylor admitted to a rather substantial financial stake in the outcome of claimant's hearing. He also admitted to a bias against workers' compensation carriers. Finally, his medical opinions were in large part based upon claimant's reliability as a historian.

Dr. Peterson believed that claimant's subjective complaints outweighed any objective findings and there was no evidence of permanent disability. He opined that claimant's cervical and upper thoracic spine could possibly benefit from some occasional chiropractic care. We attach little weight to an opinion expressed only in possibilities.

Considering claimant's unreliability regarding his subjective complaints, the lack of objective findings reported by several examiners, and the weakness of the opinions of Drs. Taylor, Bolin, and Peterson, we conclude that claimant has failed to establish the reasonableness and necessity of any further chiropractic treatment subsequent to the May 21, 1986 denial.

ORDER

The Referee's order dated May 12, 1987 is reversed in part and affirmed in part. The self-insured employer's denial dated May 21, 1986 is reinstated and upheld. The Referee's award of an attorney fee to claimant for prevailing against the denial is reversed. The remainder of the Referee's order is affirmed. The Board approves a client-paid fee not to exceed $240.

SCOTT E. PARKER, Claimant
Max Rae, Claimant's Attorney
Bottini, et al., Defense Attorneys
Cummins, et al., Defense Attorneys

WCB 87-12751 & 87-13571
August 3, 1988
Order on Review

Reviewed by Board Members Ferris and Crider.

Claimant requests review of Referee Hettle's order that: (1) upheld the self-insured employer's aggravation and medical services denial relating to his neck and shoulder condition; and (2) upheld Liberty Northwest Insurance Corporation's "new injury" denial for the same condition. We affirm.

ISSUES

1. Compensability of claimant's current neck and shoulder condition.

2. Responsibility for the condition.

3. The self-insured employer's medical services denial.

FINDINGS OF FACT

On July 22, 1982, claimant was working for Norpac Foods Inc., a self-insured employer, when he struck the left side of his neck on a beam while cleaning. Dr. Barnes, family practitioner, diagnosed neck contusion and released claimant from work.

Claimant began treatment with Dr. Degner, M.D. On August 11, 1982, Dr. Degner released claimant to regular work without restrictions. Claimant subsequently experienced a brief flare-up of symptoms. However, on August 24, 1982, Dr. Degner reported that claimant was medically stationary as of August 20, 1982 and could return to work without restrictions.

A September 27, 1982 Determination Order awarded no permanent disability.

In October 1982, claimant again treated with Dr. Barnes for neck stiffness and pain. Dr. Barnes took claimant off work from September 21, 1982 until October 14, 1982. On October 28, 1982, the Orthopaedic Consultants examined claimant and diagnosed cervical contusion and strain involving the left proximal trapezius area.

In January 1983, claimant began treating with Dr. Klass, physician and surgeon, for neck complaints which had commenced one week earlier. Dr. Klass noted that claimant's complaints began without a new incident of trauma. He wrote Norpac requesting that claimant's claim be reopened. The claim was not reopened for time loss, but Norpac continued to pay medical benefits.

In 1983, claimant began seasonal work for a nursery. Claimant's work activities included preparing plants for shipment, moving trays of plants weighing around 30 pounds and cleaning up greenhouses. The number of days and hours claimant worked depended on the needs of the employer. Claimant worked at the nursery from 1983 until 1986. Due to the seasonal nature of claimant's work, he cut firewood when not working for the nursery.

Dr. Klass' chart notes reveal that claimant treated for an eye problem related to his wood cutting activities in July 1984. Claimant also treated with Dr. Klass for an ankle injury in August 1985. The chart notes concerning these conditions contain no mention of neck problems.

In December 1986, claimant went to work for Liberty Northwest's insured, grading veneer. This work required that claimant repetitively grasp veneer sheets weighing approximately one pound and toss them from a moving chain into a cart. In June 1987, claimant began treating with Dr. Klass for neck and shoulder pain. Dr. Klass released claimant from his regular work. Claimant underwent physical therapy in June and July 1987. However, on July 21, 1987, Dr. Klass noted little change in claimant's condition and referred him to Dr. Pollard, orthopedist.

On July 28, 1987, Dr. Pollard reported that claimant had subjective complaints of neck pain without objective findings. Subsequently, Dr. Klass released claimant for regular work on August 10, 1987.

On August 10, 1987, Liberty Northwest denied claimant's "new injury" claim on the basis of compensability and responsibility. Subsequently, claimant filed an aggravation claim with Norpac. On August 24, 1987, Norpac denied the aggravation claim on compensability and responsibility grounds. Claimant timely appealed both denials. Because compensability was an issue, the Workers' Compensation Department declined claimant's request for a designated paying agent pursuant to ORS 656.307.

Based upon our de novo review of the record, we find that claimant experienced intermittent neck symptoms between 1982 and 1987 of unknown etiology. We further find that claimant's current condition is not causally related to either his 1982 injury or his employment activities with Liberty Northwest's insured.

CONCLUSIONS OF LAW AND OPINION

In compensability/responsibility cases, the threshold issue is compensability. Joseph L. Woodward, 39 Van Natta 1163, 1164 (1987). If the claim is compensable, then the trier of fact must address the issue of responsibility. See Runft v. SAIF, 303 Or 493, 498-99 (1987). Further, claimant carries the burden of proving that a condition giving rise to a need for medical treatment or disability is materially related to a compensable claim. Grable v. Weyerhaeuser Company, 291 Or 397 (1981); Milburn v. Weyerhaeuser Company, 88 Or App 375 (1987).

Compensability of the Aggravation Claim

In order to prove an aggravation claim, claimant must establish that his neck and shoulder condition is related to his original injury and has worsened since the last award of compensation. ORS 656.273.

Drs. Degner and Barnes treated claimant following his original compensable injury. On November 12, 1987, Dr. Degner reported that claimant should have fully recovered from the 1982 injury within 6 to 12 months. Therefore, he did not feel that claimant's current neck problems were related to the 1982 injury. We acknowledge that Dr. Degner last examined claimant in August 1982, more than five years prior to the date of his report. This fact goes to the weight to be assigned to his opinion but is not cause to reject his testimony in toto.

Similarly, Dr. Barnes last examined claimant in 1982. However, he also had the opportunity to observe claimant's testimony at hearing. Dr. Barnes initially testified that claimant's ongoing complaints were related, at least in part, to his 1982 injury. However, Dr. Barnes had not yet reviewed the reports of Dr. Pollard and Dr. Klass. After reviewing these reports, Dr. Barnes concluded that claimant's condition was probably not related to his 1982 injury. Dr. Barnes further opined that Drs. Klass and Pollard were in a better position than he in order to evaluate causation of claimant's ongoing symptoms.

Neither Dr. Klass nor Dr. Pollard found a relationship between the 1982 injury and claimant's neck and shoulder condition in 1987. Dr. Klass, who first treated claimant in January 1983, was uncertain as to any causal relationship between claimant's 1982 injury and his reported January 1983 symptoms. It follows

that a causal relationship between claimant's 1982 injury and his symptoms five years later, in 1987, is even more attenuated. In conclusion, we agree with the Referee that the medical evidence does not support a causal relationship between claimant's current condition and his 1982 injury.

Claimant testified to continuing symptoms ever since the 1982 injury. This history is suggestive of a causal relationship between the injury and claimant's current condition. However, during this period, claimant spent two to three years working in a nursery and cutting firewood. The record lacks any expert medical evidence as to the effect this intervening labor may have had on claimant's condition. Given this history of intervening physical labor, we consider the medical causation of claimant's ongoing neck symptoms to be a complex medical question. While claimant's testimony is probative, we find resolution of this question to be largely dependent on expert medical opinion. Kassahn v. Publishers Paper Co., 76 Or App 105 (1985).

The medical evidence uniformally suggests that claimant's 1982 injury was minimal and should have resolved within a relatively brief period of time. Only Dr. Barnes opines that claimant's ongoing symptoms in 1987 are related to his 1982 injury. Dr. Barnes subsequently changes his opinion. From claimant's standpoint, the best that can be said of Dr. Barnes testimony is that it is equivocal regarding the causal relationship question. Consequently, claimant has failed to prove that his current condition is related to his 1982 industrial injury.

Compensability of the "New Injury" Claim

Claimant's contention of a "new injury" while working for Liberty Northwest's insured similarly lacks persuasive medical or lay support. Dr. Barnes testified that claimant's employment for Liberty Northwest's insured was the least likely cause of his condition. The most likely cause in Dr. Barnes' opinion was either an idiopathic cause or an incident of some sort which claimant had forgotten.

Dr. Pollard noted an absence of objective findings and was suspicious of secondary gain. Dr. Klass reported that he was uncertain whether claimant's neck symptoms were related to his employment with Liberty Northwest's insured. He opined that claimant's condition "may have been completely unrelated to any employment." Consistent with the medical evidence, claimant did not believe that his employment in 1987 had made his condition worse. We conclude that claimant has failed to prove that his employment with Liberty Northwest's insured was causally related to his ongoing symptoms.

Denial of Medical Services

For the same reasons stated above, we conclude that the 1982 injury is not a material cause of claimant's current condition. Norpac's medical services denial is upheld. See Jordan v. SAIF, 86 Or App 29 (1987).

Responsibility

We affirm and adopt the Referee's conclusion and opinion with regard to the responsibility issue.

ORDER

The Referee's order dated January 11, 1988 is affirmed. A client-paid fee not to exceed $1,341 is approved, payable to counsel for Liberty Northwest Insurance Corporation. A client-paid fee not to exceed $600 is approved, payable to counsel for the self-insured employer.

ANA M. PINEDA, Claimant
Kenneth D. Peterson, Claimant's Attorney
Schwabe, et al., Defense Attorneys

WCB 86-12896
August 3, 1988
Order on Review

Reviewed by Board Members Ferris and Crider.

The self-insured employer requests review of that portion of Referee Fink's order which set aside its denial of claimant's aggravation and medical services claim for her current low back, left leg and left foot conditions. Claimant cross-requests review of those portions of the order which: (1) declined to assess a penalty and attorney fee for the employer's alleged failure to accept or deny her "new injury" claim for the aforementioned conditions in a timely manner; and (2) affirmed the Determination Order that awarded no permanent disability. We affirm.

ISSUES

1. Extent of permanent disability for a low back condition.
2. Aggravation of low back, left leg and left foot conditions.
3. Penalty and attorney fee for late denial.

FINDINGS OF FACT

Claimant is a utility worker whose duties include pushing and arranging totes (large cardboard boxes), often with her feet. On January 29, 1986, she compensably injured her low back and left leg and foot. The diagnosis was a lumbosacral strain, though she also suffered left leg and foot pain. She became medically stationary on March 4, 1986. Her claim was closed by Determination Order on March 18, 1986 with no permanent disability award. She began treating with Dr. Feinberg, a chiropractor, and was released for regular work in June 1986. Later that month, claimant changed her care to Dr. Peterson, a chiropractor. She experienced no low back or leg pain for several weeks prior to August 1986. We are unable to find that claimant sustained any permanent physical impairment from this injury.

Claimant returned to work and, in early August 1986, experienced a sudden onset of increasing pain in her low back and left leg and foot while pushing a tote with her left foot. Claimant treated with Dr. Feinberg and, on August 11, 1986, Feinberg completed a Form 827 (First Medical Report), designating August 5 as the date of injury. The doctor diagnosed a sprain-type injury to the low back and released her for regular work, noting that claimant was "injured similarly early this year at work." Later in August, Feinberg restricted claimant to light work. Claimant did not complete a Form 801 for the August episode.

On September 3, 1986, the employer issued a "partial

denial" based on medical information that claimant's current complaints were not related to her January 29 injury. It suggested that claimant submit bills for her medical treatment to her private health insurer. Thereafter, claimant requested a hearing, listing as potential issues, the compensability of an industrial injury, medical services, and a penalty and attorney fee for an improper denial. On November 13, 1986, the employer filed a response, denying claimant's contentions.

On November 19, 1986, claimant filed a Supplemental Request For Hearing, raising the issue of the employer's failure to accept or deny the "new injury" claim which was reported on the Form 827. On December 1, 1986, the employer filed a supplemental response, denying that its conduct was unreasonable. On December 9, 1986, the employer's counsel advised claimant's attorney that the "new injury" claim was denied as well.

At the time of hearing, claimant continued to have low back and left foot pain, though it had diminished to some degree since August 1986. Although she continued to perform regular work duties for the employer, her job was modified to allow for the use of a hook in moving totes. We find that claimant has sustained a permanent loss of earning capacity since the March 18, 1986 Determination Order. We further find that the January 1986 injury materially contributed to that loss of earning capacity.

CONCLUSIONS AND OPINION

The Referee affirmed the March 18, 1986 Determination Order that awarded no permanent disability for the January 29, 1986 injury. The Referee also set aside the employer's denial and remanded the claim to the employer for acceptance as an aggravation; however, he declined to assess a penalty and attorney fee.

Extent of Disability

Claimant has the burden of proving that she has incurred a permanent loss of earning capacity as a result of the January 29, 1986 injury. ORS 656.214(5); Hutcheson v. Weyerhaeuser Co., 288 Or 51, 56 (1979). A finding of permanent physical impairment is a condition precedent to an award of permanent disability. See former OAR 436-30-380.

Dr. Feinberg, the treating physician, reported on March 3, 1986, that claimant continued to experience low back discomfort and concluded that she had sustained a mild impairment "on a symptomatic basis only." However, Feinberg provided no objective findings of permanent impairment. Indeed, Feinberg later reported on August 15, 1986 that claimant had experienced no low back or leg pain for several weeks prior to August 1986. Moreover, claimant's testimony tended to prove the absence of permanent impairment. She testified that she had not missed any time from work since March 1986. She continued to perform her regular work duties which required lifting, twisting, bending and walking. Therefore, we are unable to find that claimant sustained any permanent impairment as a result of the January 1986 injury. Consequently, we agree with the Referee that the March 18, 1986 Determination Order should be affirmed.

Aggravation

To establish a compensable aggravation, claimant must

prove that: (1) her condition has worsened since her last award of compensation, so that she is more disabled, meaning less able to work; and (2) her compensable injury was a material contributing cause of her worsened condition. ORS 656.273(1); Grable v. Weyerhaeuser Company, 291 Or 387, 400-401 (1981); Smith v. SAIF, 302 Or 396, 399 (1986). Increased symptoms, in and of themselves, do not establish a worsened condition unless they result in a greater loss of earning capacity than that anticipated by the prior award of compensation. Id. at 401.

Here, the March 18, 1986 Determination Order awarded no permanent disability; therefore, any loss of earning capacity would establish a worsened condition. Dr. Feinberg, the treating physician, reported that claimant experienced a sudden onset of increasing pain and discomfort in her low back and left leg and foot after the August 1986 incident. Claimant testified that she continued to experience pain in her low back and left foot at the time of hearing. Her job with the employer was modified to allow for the use of a hook in moving totes. Given claimant's persistent symptoms and resulting work modification, we conclude that she has sustained a permanent loss of earning capacity sufficient to prove a worsened condition.

The medical evidence is divided on the question of causation. Dr. Feinberg related claimant's current symptoms to the original injury in January 1986, noting that the two injuries were similar and that claimant had not experienced similar symptoms prior to the original injury. Even before the August 1986 incident, Feinberg warned the employer that claimant's condition from the original injury was regularly aggravated when moving totes with her feet, explaining that the injured low back was "the foundation against which forces are delivered when the foot is used to push." Feinberg warned that further aggravations would lead to a very unstable back and perhaps permanent disability.

Contrary opinions were offered by Drs. Weeks and Gehling. Dr. Weeks, an orthopedist, last examined claimant in April 1986 and based his opinion on unspecified documents. Therefore, we are not persuaded by his opinion. Dr. Gehling, a neurosurgeon, opined in August 1986 that claimant's obesity, rather than the original injury, was the sole cause of her low back symptoms. However, Gehling later retreated from that opinion during his post-hearing deposition, acknowledging the "probability" that claimant's motion in pushing the tote with her foot contributed in precipitating her low back symptoms. Given the irreconcilable inconsistency between Gehling's conclusions, we are most persuaded by the more well-reasoned conclusions of Dr. Feinberg. See Somers v. SAIF, 77 Or App 259, 263 (1986). We find that the original injury materially contributed to claimant's worsened condition and conclude that her aggravation claim is compensable.

Penalty and Attorney Fee

Claimant contends that she is entitled to a penalty and attorney fee for the employer's alleged failure to accept or deny her "new injury" claim in a timely manner. We disagree.

Under ORS 656.262(6), a self-insured employer must furnish written notice of acceptance or denial of a claim within 60 days after the employer has notice or knowledge of the claim. After our review of the Form 827, we find that it did not provide

adequate notice of a "new injury" claim. Rather, the claim could have reasonably been interpreted as one for medical services or aggravation stemming from claimant's January 1986 compensable injury. Consequently, we do not consider the employer's failure to deny claimant's "new injury" claim prior to her supplemental hearing request concerning the "de facto" denial of the claim to have been unreasonable. Accordingly, claimant is not entitled to a penalty and attorney fee under ORS 656.262(10).

ORDER

The Referee's order dated June 19, 1987 is affirmed. Claimant's attorney is awarded an assessed fee of $800, to be paid by the self-insured employer. The Board approves a client-paid fee not to exceed $1,334.

The Beneficiaries of
ROBERT F. SCHARDT (Deceased), Claimant — WCB 85-04324
Pozzi, Wilson, et al., Claimant's Attorneys — August 3, 1988
Schwabe, et al., Defense Attorneys — Order on Review

Reviewed by Board Members Johnson and Crider.

The insurer requests review of Referee Shebley's order that set aside its denial of claimant's heart attack and death claim and awarded an extraordinary attorney fee. We affirm.

ISSUES

The issues on review are compensability and attorney fees.

FINDINGS OF FACT

Claimant, age 53, suffered a heart attack while at work on January 23, 1985. He died several days later without ever regaining consciousness.

Claimant was employed as a salesman. He had worked for the employer for less than one month. He worked more than eight hours per day, during the evenings at home, and on the weekends. He was reported to have enjoyed his position and had been quite successful during his short tenure.

Approximately one week before his heart attack, claimant had been verbally chastised by a supervisor. He was worried about his continued employment.

Claimant had injured his back in a motor vehicle accident in June of 1983. He continued to experience pain from his back injury.

For a few days prior to January 23, 1985, claimant complained to his wife that he had back pain. During the early morning hours of January 23, 1985, he experienced back, chest, and arm pain. In the morning he felt very nauseous. His wife noted that he looked pale and sweaty, as if he was suffering from the flu. She suggested that he stay home from work. He insisted on working. His co-worker's also reported that he looked ill.

Claimant spent the morning making telephone calls. He went out to buy lunch, brought it back to the office, ate it at his desk and continued to work.

In the early afternoon, claimant left the office to make sales calls. He parked his car and made three potential sales visits. He carried two briefcases, combined weight of approximately 25 pounds. His last call required him to climb up a rather steep hill and flight of stairs.

An employee observed him climbing the stairs and greeted him. She did not note that he was sweating or was short of breath. The receptionist spoke to him and then left to announce his arrival to the manager. She also noted nothing unusual about him.

Claimant collapsed within three minutes after his arrival. Cardiopulmonary resuscitation was started and thereafter continued during his transportation to the emergency room. Claimant was hospitalized until he died on February 1, 1985.

At the hospital, claimant was treated by Dr. Kliks, a cardiologist. Claimant was resuscitated after nine or ten cardioversive shocks. He had no cortical activity and responded only with brain stem responses. Lab results indicated that his blood gases were extremely hypoxic, CPK enzymes were elevated at 335, and the MB fraction was up to 38, normal in the 3-4 range. His EKG on admission was abnormal, indicative of an acute myocardial infarction.

Claimant was placed in intensive care for several days. He developed pneumonia which was successfully treated. However, he did not regain consciousness. Aggressive treatment was discontinued when it was felt he had no reasonable chance for brain recovery.

Claimant had no previous cardiac history. He smoked for 20, but had quit five years earlier.

The temperature on January 23, 1985, was approximately 38 degrees.

We find that claimant's work activity on January 28, 1985, precipitated his cardiac arrest.

CONCLUSIONS OF LAW

The Referee found claimant's cardiac arrest and subsequent death compensable. He found the opinions of Dr. Kliks and Dr. Rogers to be persuasive. Further, he did not find Dr. Shepherd's opinion very convincing. The Referee relied on the fact that all three cardiologists agreed that claimant was in the midst of a myocardial infarction when he made his last sales call. He found that the hill and stair climbing, as well as carrying two brief cases, placed an undue strain on claimant's heart and subjected him to a high risk of additional damage, which ultimately resulted in his cardiac arrest and death. We agree.

Claimant's widow bears the burden of proving by a preponderance of the evidence that claimant sustained a compensable injury. Summit v Weyerhaeuser Co., 25 Or App 851 (1976). In order to prove compensability of his cardiac arrest, claimant's widow must prove that it was both legally and medically caused by the exertion at work. Coday v Willamette Tug & Barge, 250 Or 39 (1968); Carter v Crown Zellerbach Corp., 52 Or App 215 rev den 291 Or 368 (1981). Legal causation is established by a

showing that claimant was engaged in his usual job exertion at the time of his cardiac arrest. Thurston v Mitchell Brothers Contractors, 58 Or App 568 (1982); Carter, supra, 52 Or at 219. Medical causation is established by expert medical evidence that the exertion experienced during employment was a material contributing factor to the cardiac arrest within the realm of medical probability. Bales v SAIF, 294 Or 224 on remand 61 Or App 613 (1983); Batdorf v SAIF, 54 Or App 496 (1981).

Here, legal causation has been clearly established. Claimant was selling his goods in the normal and usual way in the performance of his job when he suffered a cardiac arrest and died. Both parties agree that the only issue is medical causation.

Three doctors testified with regard to claimant's condition. Dr. Kliks and Dr. Shepherd testified by deposition. Dr. Rogers testified at hearing. All three physicians are board certified in cardiology, and practice at the same hospital.

Each of the doctors agrees that claimant was in the middle of a myocardial infarction when he arrived at work on the morning of January 23, 1985. Additionally, they all agree that he was suffering from angina rather than back pain in the days preceding his myocardial infarction.

Dr. Kliks and Dr. Rogers opined that claimant's activity immediately preceding his collapse, (eating, walking up the hill and stairs, carrying the briefcases, the excitement of making a potential sale for his new company, the cold weather), combined with his myocardial infarction, could reasonably be expected to have precipitated his cardiac arrest.

Dr. Kliks explained that physical activity, such as that engaged in by claimant immediately before he collapsed, would tend to increase his heart rate and blood pressure, which would then produce a greater risk of arrhythmia, an extension of the infarction, or a rupture of a coronary artery. Dr. Kliks opined that claimant's work activities accelerated his cardiac arrest.

Dr. Rogers testified that claimant probably collapsed from ventricular fibrillation, the most acute form of arrythmia and a total dysfunction of the heart muscle, caused by the myocardial infarction. He also believed that claimant experienced an additional infarction just before he collapsed. Further, Dr. Rogers opined that climbing the hill and ascending the stairs represented a substantial amount of work for a person in claimant's condition, and that he considered claimant's emotional stress from making the sales call to have contributed to his condition. The stress caused an increased outpouring of adrenalin, increased heart rate and stimulation of the injured heart muscle, and a probable increase in the number of ectopic ventricular beats that culminated in ventricular fibrillation. He stated that if he had seen claimant that morning he would have hospitalized him immediately. Bed rest would have been ordered to prevent dysrhythmias, to reduce the work of the heart in order to allow it to heal, to forestall a rupture of the heart, and to protect the patient from stress. If such action had been instituted, Dr. Rogers believed that claimant would have had a "two-out-of-three" chance of not experiencing cardiac arrest.

It was Dr. Shepherd's opinion that there was no correlation between physical or emotional stress and ventricular fibrillation. Further, he opined that the stair climbing had

nothing to do with claimant's ultimate condition. However, on cross-examination he admitted that it would have been unwise to administer a treadmill test to a man in claimant's condition prior to his collapse. And, he agreed that claimant's physical activities immediately preceding his cardiac arrest increased his heart rate, oxygen consumption, and blood pressure. Dr. Shepherd ultimately opined that claimant's work activities immediately prior to his collapse were not of sufficient intensity and duration to have caused the cardiac arrest and death because he showed no signs of exertion before he collapsed, thus indicating he had engaged in ordinary activity.

After conducting our de novo review of the lay and medical evidence, we find the opinions of Drs. Kliks and Rogers to be more persuasive. Accordingly, we conclude that claimant's wife has proved by a preponderance of the evidence that the exertion of claimant's job activity was a material contributing cause of his cardiac arrest and death. Hutcheson v Weyerhaeuser, 288 Or 51 (1979); Batdorf v SAIF, 54 Or App 496 (1981). Finally, we affirm and adopt that portion of the Referee's order concerning the award of an extraordinary attorney fee for claimant's attorney's services at the Hearings level. Claimant's counsel is statutorily entitled to a reasonable, carrier-paid attorney fee for services rendered on Board review. See ORS 656.382(2). Such a fee is defined as an "assessed fee." OAR 438-15-005(2). However, we cannot authorize an assessed fee unless claimant's counsel files a statement of services. See OAR 438-15-010(5). Because no statement of services has been received to date, an assessed fee shall not be authorized.

ORDER

The Referee's order dated June 9, 1987 is affirmed. The Board approves a client-paid fee not to exceed $3,390.

RALPH W. SCHEMMEL, Claimant
Bruce W. Williams, Claimant's Attorney
Roberts, et al., Defense Attorneys

WCB TP-88006
August 3, 1988
Third Party Partial Distribution Or

Claimant has petitioned the Board for resolution of a dispute concerning the just and proper distribution of the proceeds from a third party settlement. See ORS 656.593(3). Specifically, the dispute involves the distribution of claimant's attorney's fee payable from a "structured settlement."

FINDINGS

In March 1985, while operating a forklift amid two delivery trucks, claimant sustained a compensable injury. The injury resulted in the amputation of his left leg, as well as a permanently disabling back condition.

Claimant engaged legal counsel to explore the possibility of bringing suit against the trucking companies. He and his attorney entered into a contingent fee agreement, providing that the attorney would receive 33-1/3 percent of the recovery if the action was settled. The agreement further provided that if claimant prevailed, he "would be liable for [his attorney's] fees at termination of litigation which would come out of the settlement or award."

Thereafter, claimant instituted a third party action against the owners of the two trucks, Midwestern Distribution, Inc. and Silver Eagle Company. The action proceeded to trial. On the third day of the trial, claimant and Midwestern resolved their dispute pursuant to a structured settlement.

Under the settlement, claimant received a lump sum payment of $400,000. In addition, Midwestern purchased a lifetime annuity for $150,595. The annuity was designed to pay claimant $1,440 a month through his life expectancy of 17.9 years, with a ten-year guarantee of $572,800. The present value of the total settlement was appraised at $759,942. The paying agency approved the settlement and subsequently endorsed the $400,000 cash settlement draft.

Litigation costs on the Midwestern lawsuit amounted to $7,988.89. At the time of claimant's petition to the Board, the paying agency's lien for its actual claim costs totalled $105,021.25. Since that time, the paying agency has incurred an additional $4,848.52 in claim costs. Inasmuch as the claim presently remains in open status, further costs will continue.

The parties proceeded to distribute the $400,000 lump sum payment. After deducting claimant's one-third attorney's fee, litigation costs, and his one-third statutory share, a balance of $172,451.85 remained. The paying agency has received $105,021.25 of those funds, leaving a remaining balance of $67,430.60.

Claimant also obtained a judgment against Silver Eagle totalling $172,506.61. After deducting claimant's one-third attorney's fee, litigation expenses and his one-third share pursuant to ORS 656.593(1)(b), the remaining balance of the judgment equals $76,470.49.

The paying agency submits that it is reasonably foreseeable that claimant will be granted an award of permanent total disability. The agency further offers the figure of $5,000 as a reserve for reasonably to be expected future medical expenditures for the claim during the remaining years of claimant's life. Finally, the paying agency asserts a lien for future claim costs in the amount of $180,436.92. The record, as presently developed, fails to provide persuasive support for any of these contentions.

The remaining balances of the two third party recoveries are deposited in claimant's attorney's trust account. The balances total approximately $144,447.88.

CONTENTIONS

Claimant contends that his attorney is entitled to an additional sum of $50,198.33 from the proceeds of the settlement, which equals one-third of the $150,595 cost of the annuity. Furthermore, claimant submits that his attorney's fee should be paid from the residual funds remaining from the $400,000 cash settlement with Midwestern.

The paying agency disagrees with claimant's proposed distribution. Because the attorney fee is contingent, the agency asserts that it should be distributed as claimant receives his recovery. i.e., as the annuity is paid. At the very most, the agency argues that the fee should be limited to the present value of the ten-year guaranteed portion of the annuity.

The agency further submits that its lien will be compromised if claimant's attorney receives one-third of the "up front value" of the annuity. Rather than recovering its share of the settlement proceeds from the monthly annuity, the paying agency proposes that it be authorized to credit those annuity payments against its ongoing obligation to provide temporary and, eventually permanent, disability compensation until such time as its third party lien is satisfied.

CONCLUSIONS

Pursuant to ORS 656.578, if a worker receives a compensable injury due to the negligence or wrong of a third person, entitling the worker under ORS 656.154 to seek a remedy against such third person, such worker or, if death results from the injury, the other beneficiaries shall elect whether to recover damages from the third person. If the worker or the beneficiaries of the worker elect to recover damages from the third person, notice of such election shall be given to the paying agency. ORS 656.593(1). The proceeds of any damages recovered from a third person by the worker or beneficiaries shall be subject to a lien of the paying agency for its share of the proceeds. ORS 656.593(1).

If the worker or beneficiaries settle the third party claim with agency approval, 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); Estate of Troy Vance v. Williams, 84 Or App 616, 619-20 (1987). Any conflict as to what may be a "just and proper distribution" shall be resolved by the Board. ORS 656.593(3).

The statutory scheme for the allocation of damages is precise. Robert B. Williams, 38 Van Natta 119, 123 (1986), aff'd. Estate of Troy Vance v. Williams, supra. ORS 656.593(1) provides in exact detail how, and in what order, the proceeds of any damages shall be distributed. Pursuant to ORS 656.593(1)(a), costs and attorney fees incurred shall be initially disbursed. Then, the worker shall receive at least 33-1/3 percent of the balance of the recovery. ORS 656.593(1)(b). However, the amount that the agency is "authorized to accept" from a third party settlement is less precise than the amount of its lien from damages recovered from a third party 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." Estate of Troy Vance v. Williams, supra. 84 Or App at page 620.

Here, the "proceeds" of the third party settlement encompass not only immediate cash payments, but also the purchase of an annuity. That these annuity payments are payable over a period of years does not alter the fundamental principle that they are "proceeds" from a third party recovery. As such, they are to be distributed in accordance with the schedule set forth in ORS 656.593(1) and (2). See ORS 656.593(3). Pursuant to that schedule, incurred litigation costs and attorney fees shall initially be paid, followed by the worker's statutory one-third share of the remaining balance. See ORS 656.593(1)(a), (b). The paying agency's lien applies only after the aforementioned shares have been disbursed. See ORS 656.593(3); 656.593(1)(c).

The paying agency submits that the portion of claimant's attorney fee which is attributable to the annuity should be gradually recovered as claimant receives his monthly installments. In so doing, it concedes that this situation presents a case of first impression.

We agree that no case precedent presently exists concerning this issue. However, as detailed above, we consider the statutory distribution scheme to be both clear and precise. That is, the aforementioned schedule concerns the distribution of the "total proceeds" of any damages recovered from a third person. See ORS 656.593(1). Inasmuch as the annuity installments represent amounts recovered from a third person, we conclude that the cost of purchasing the annuity should likewise be included as "total proceeds" of the settlement. As such, these "total proceeds" shall be apportioned in accordance with the statutory distribution scheme. See ORS 656.593(3); 656.593(1), (2).

The paying agency argues that its lien is being further compromised because that portion of claimant's attorney fee attributable to the annuity is being paid "up front" from the $400,000 lump sum payment, thereby reducing the remaining balance of the proceeds to which its lien will apply. We find this argument unpersuasive for several reasons. To begin, as explained above, the distribution scheme applies to the "total proceeds" of the recovery and clearly specifies the order of participation. Secondly, we note that the paying agency approved of the settlement. Thus, if it objected to any provision, it had an opportunity to do so. Finally, the alternative of apportioning each annuity installment between claimant and his attorney would appear to be an extremely cumbersome and unwieldy process. Furthermore, such an apportionment would be contrary to the terms of the settlement.

Consequently, we conclude that the "total proceeds" of the settlement equal the $400,000 lump sum payment and the $150,595 cost of the annuity. These proceeds should have been computed and distributed as follows:

Settlement (Cash + Cost of Annuity)	$550,595.00
Claimant's Attorney Fee (1/3)	183,651.66
Subtotal	$366,943.34
Litigation Costs	7,988.89
1st Remaining Balance	$358,954.45
Claimant's Share (1/3)	119,651.48
2nd Remaining Balance	$239,302.97
Paying Agency's Actual Costs	$109,869.77
Final Remaining Balance	$129,433.20

As previously discussed, we realize that only $400,000 in cash was available from the settlement. Therefore, the amount of funds was insufficient to fully apportion the proceeds as detailed above. However, we consider a detailed description of the appropriate distribution scheme essential in following our analysis.

Had the $400,000 been appropriately distributed, claimant's attorney would have received $183,651.66 in fees and $7,988.89 in litigation expenses. Claimant would then have received $119,651.48 for his statutory one-third share. When these amounts are deducted from $400,000, a balance of $88,707.97 remains. Because the paying agency's lien for its actual claim

costs exceed that remaining balance, the entire balance would have been distributed to the paying agency.

In actuality, the funds from the $400,000 lump sum payment have been apportioned as follows: (1) claimant's attorney - $133,333.33; (2) litigation costs - $7,988.89; (3) claimant - $86,225.93; and (4) paying agency - $105,021.25. The remaining cash balance from the $400,000 payment is $67,430.60.

Therefore, claimant and his attorney have been underpaid in the amount of $33,425.55 and $50,318.33, respectively. On the other hand, the paying agency has received $16,313.28 more than its share of the $400,000 lump sum payment. The underpaid attorney fee can be recovered from the $67,430.60 remaining balance of the cash settlement. In addition, the remaining $17,430.60 can be distributed to claimant to offset the $33,425.55 due him. However, these funds will be insufficient to fully reimburse claimant for his statutory share of the third party settlement.

After reviewing this matter, we find that a mechanism exists to rectify these miscalculations. That mechanism is the $76,470.49 remaining balance from claimant's third party judgment against Silver Eagle.

Inasmuch as claimant's third party recoveries emanate from the same compensable injury, we consider it appropriate to use a portion of the remaining balance of proceeds from the Silver Eagle judgment to satisfy the $15,994.95 deficit in claimant's share of proceeds from the Midwestern settlement. We find this action justifiable since this deficit was created by the overpayment of cash settlement proceeds to the paying agency. Moreover, in view of the apparent severity of claimant's condition, it is conceivable that, when his disability is finally determined, the remaining balance of the Silver Eagle judgment will be submitted to the paying agency as partial reimbursement for its claim costs. Since the agency has received a larger share of the lump sum proceeds from claimant's third party settlement than it was rightfully entitled, it follows that this payment, whether characterized as an overpayment or premature payment, can be offset against its share of claimant's third party judgment.

Consequently, we conclude that claimant shall receive a portion of the remaining balance of the Silver Eagle judgment in an amount that will satisfy the outstanding balance of his one-third statutory share from the third party settlement. i.e., $15,994.95. The remaining balance of the third party judgment (approximately $60,475.54) shall be subject to the paying agency's lien for its actual and future claim costs. See ORS 656.593(1)(c).

As mentioned above, the agency received approximately $16,313.28 more than its rightful share of the immediate cash proceeds from the third party settlement. Yet, there is no contention that its lien for actual claim costs is not justified. Therefore, we conclude that the agency was entitled to reimbursement for these costs, although we would have preferred that the source of this reimbursement had been the remaining balance from the third party judgment rather than the third party settlement.

Accordingly, we belatedly approve of the $105,021.25

distribution of funds to the paying agency in partial reimbursement for its actual claim costs. Since the time of this distribution, the agency has incurred additional claim costs totalling $4,848.52. Under these circumstances, we further conclude that the paying agency is entitled to reimbursement for these costs from the remaining balance of the third party judgment.

The paying agency also seeks reimbursement for its future claim costs. Yet, because the claim has not been closed, it is unclear what degree of permanent disability claimant has sustained as a result of his compensable injury. Inasmuch as there has not been a final order determining the extent of claimant's disability arising out of his compensable injury, we shall defer ruling on the question of the paying agency's entitlement to a lien for its future claim costs. See John T. Elicker, 40 Van Natta 68 (1988); Robert B. Williams, 37 Van Natta 711 (1985); George Bedsaul, 35 Van Natta 695 (1983).

In reaching these conclusions, we are mindful that the existing cash funds are insufficient to fully reimburse the paying agency for its statutory share of the "total proceeds" from the third party settlement. Furthermore, we acknowledge that we have not addressed the agency's proposal to offset its future temporary and permanent disability obligations against claimant's monthly annuity payments until its third party lien is satisfied.

As to these points, we wish to clarify that today's decision is expressly limited to a resolution of the dispute concerning the "just and proper" distribution of the $400,000 lump sum payment and partial distribution of the remaining balance of the proceeds of the third pary judgment. We will not address the issues of the paying agency's entitlement to, as well as the amount of, a share of claimant's annuity payments unless a dispute is presented to us when his condition has become medically stationary and his disability finally determined. Since the claim presently remains in open status and the degree of claimant's disability is presently uncertain, we consider the paying agency's offset request to be premature.

Accordingly, claimant's attorney is directed to distribute the total proceeds of the third party settlement in accordance with ORS 656.593(1)(a), and (b). This distribution shall be based on a value of $550,595. Therefore, claimant's attorney is entitled to an attorney fee of $183,651.66 and $7,988.89 for reimbursement of litigation costs. Since claimant's attorney has not received the total amount of this fee, he is directed to distribute additional funds from the proceeds in an amount sufficient to reach the aforementioned total. i.e., $50,318.33.

Claimant's share of the total proceeds from the third party settlement is $119,651.48. Since claimant has not received the total amount of his share, his attorney is directed to distribute to claimant the remaining funds from the third party settlement with Midwestern ($17,430.60) and additional funds from the third party judgment against Silver Eagle ($15,994.95). These amounts should be sufficient to reach the aforementioned total. However, if more or less funds are necessary, claimant's attorney is directed to take appropriate action to reach the required total.

Claimant's attorney is also directed to distribute $4,848.52 to the paying agency as further partial reimbursement for its actual claim costs. Portions of the remaining balance of

the proceeds from the third party judgment (approximately $60,475.54) shall continue to be distributed to the paying agency insofar as it justifies its actual claim costs. Upon final resolution of the permanent disability issue, the parties shall notify the Board of their respective positions regarding distribution of any remaining balance. At that time, the parties shall present further comment regarding the paying agency's proposal for authorization to offset its continuing obligations for temporary and permanent disability compensation against claimant's future annuity payments under the third party settlement until such time as its third party lien is satisfied.

IT IS SO ORDERED.

GEORGE G. SHAFER, Claimant
Peter O. Hansen, Claimant's Attorney
Carrol J. Smith (SAIF), Defense Attorney

WCB 86-03258
August 3, 1988
Order on Review

Reviewed by Board Members Ferris and Crider.

Claimant requests review of Referee Galton's order which: (1) declined to grant him permanent total disability; and (2) increased his scheduled permanent disability award for the loss of use or function of the left leg from 15 percent (22.5 degrees), as awarded by Determination Order, to 25 percent (37.5 degrees). On review, claimant contends that he is entitled to permanent total disability. The sole issue is permanent total disability.

We affirm and adopt the Referee's order with the following supplemental findings of fact. Claimant has a tenth grade education. His prior work experience included electric motor repair, roofing, shore crew work, bartending, and employment as a union business agent. Prior to the injury, claimant had worked 11 years as a senior mechanic for the employer.

Claimant became medically stationary on June 11, 1986 with mildly moderate loss of left knee function. He has permanent limitations on lifting, standing, sitting, kneeling and bending. However, he is capable of returning to at least sedentary work.

Claimant began receiving vocational assistance in January 1986. His vocational counselors had persistent difficulty in securing a solid commitment from claimant to participate in vocational services. This difficulty was due primarily to claimant's recurring thoughts about retirement and his wish that reemployment not interfere with his receipt of social security benefits. We find that claimant has not made reasonable efforts to obtain employment. We further find that such efforts would not have been futile.

ORDER

The Referee's order dated July 10, 1987 is affirmed.

LINDA D. SIMPSON, Claimant
Alice M. Bartelt, Defense Attorney

WCB 86-11495
August 3, 1988
Order on Review

Reviewed by Board Members Ferris and Crider.

Claimant requests review of those portions of Referee Menashe's order which: (1) found that claimant's back injury claim was not prematurely closed; (2) awarded 10 percent (32 degrees) unscheduled permanent disability for a back injury, whereas a Determination Order had awarded no permanent disability; (3) upheld the insurer's denial of claimant's right knee condition; and (4) upheld the insurer's denial of claimant's chiropractic treatments in excess of the Director's guidelines. Some of the materials claimant has submitted on review were not otherwise in the hearing record. We treat the presentation of these materials as a request for remand. See Ramona Steckmann, 40 Van Natta 90 (1988).

The Board affirms and adopts the Referee's order with the following supplemental comments with regard to claimant's request for remand.

The materials submitted by claimant were medical documents which either could have been submitted prior to hearing or were generated subsequent to claimant's hearing and pertained to certain medical conditions which were not timely raised as issues.

We infer from claimant's brief and submitted materials that she wished to raise the issues of compensability of her post polio syndrome, candidiasis and Epstein Bar Virus conditions subsequent to hearing. These issues, however, were not raised at hearing. When an issue is not properly raised before a Referee at hearing, and the record is closed, that issue will not subsequently be considered. Randy D. Johnson, 39 Van Natta 463 (1987). Therefore, we refuse to consider them at this late date.

We also refuse to remand this case to the Referee. 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 for consideration of additional evidence it must be clearly shown that material evidence was not obtainable with due diligence at the time of hearing. Kienow's Food Stores v. Lyster, 79 Or App 416 (1986); Delfina P. Lopez, 37 Van Natta 164, 170 (1985).

After de novo review, we are not persuaded that the record has been improperly, incompletely or otherwise insufficiently developed. We find that the additional evidence presented in claimant's brief pertaining to issues raised at hearing was obtainable with due diligence. The other additional evidence presented by claimant is not relevant to the issues raised at hearing. Accordingly, we conclude that remand is not warranted.

ORDER

The Referee's order dated June 16, 1987 is affirmed.

GLEN A. STROSKY, Claimant
Yturri, Rose, et al., Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB 84-12935
August 3, 1988
Order on Review

Reviewed by Board Members Ferris and Crider.

Claimant requests review of Referee Shebley's order that: (1) affirmed the Determination Order awarding claimant 35 percent (112 degrees) unscheduled permanent disability for his low back condition; and (2) upheld the self-insured employer's partial denial of claimant's current right knee condition. We affirm in part and reverse in part.

Issues

(1) Compensability of claimant's current right knee condition; and

(2) extent of unscheduled disability.

Findings of Fact

Claimant, 59 at hearing, has worked for the self-insured employer for 30 years as a truck driver. He has a ninth grade education, and has no GED or any additional formal education or training.

On February 10, 1984, claimant slipped and fell while alighting from his truck cab. He landed on his back, right wrist, and right knee, and felt immediate pain in those areas and his groin. He sought medical treatment that day, and was taken off work. He filed a claim form describing the injury or disease as "back, right rist (sic), R knee pain." The employer accepted the claim by checking the box on the form.

Claimant received immediate and ongoing treatment for his low back. Although his right knee remained painful, he sought no treatment for it. On July 13, 1984, he experienced a dramatic increase in right knee pain when he put his foot up onto the back of a flatbed trailer, hyperflexing the knee. The incident was trivial and would not ordinarily have caused pain. He was seen two days later for knee complaints by Dr. Dahlin, his treating physician for his back condition.

In September 1984, Dr. Dahlin performed an arthroscopy of claimant's knee, and diagnosed fraying of the meniscus and degenerative joint disease secondary to osteoarthritis. Claimant's degenerative condition was related to his compensable February 1984 injury. He had difficulty bending over and lifting, which caused flare-ups of his pain.

Claimant was enrolled in the Callahan Center. Dr. Schwan, osteopath and claimant's case manager at the Center, reported that claimant's right knee condition was the result of his February 1984 injury, or of an occupational disease related to his work activities. He could not return to his work at injury, and was given work limitations.

The claim was closed by Determination Order on March 8, 1985, with an award of 35 percent unscheduled permanent disability for his low back.

On July 15, 1985, Dr. Dahlin rated claimant's impairment as 10 percent of the whole person, not distingushing between claimant's back and knee conditions, and released him for light duty. The employer did not have light duty to which claimant could return.

On July 31, 1985, claimant was evaluated by Dr. Bills because of complaints of pain over the medial aspect of the knee. Dr. Bills diagnosed degenerative joint disease.

Claimant had two prior injuries to his right knee, and suffers from degenerative joint disease in his left knee.

On November 1, 1984, the employer denied the compensability of claimant's right knee condition.

In September 1985, claimant sought treatment with Dr. Edwards, a California chiropractor who had treated him for a prior back ailment. After two weeks of intensive therapy claimant was substantially improved. When he returned to Oregon, he was seen by Dr. Dahlin. He had full range of motion in the low back and no pain. His knee bothered him slightly, and Dr. Dahlin released him to regular work without restrictions.

Claimant passed his Interstate Commerce Commission standard physical examination on November 7, 1985, and was released for work as a truck driver. He resumed his work on November 8, 1985, and has been employed on a full-time basis since that date.

Claimant's avocational interests include small engine work and woodworking, for which he possesses significant skill.

Conclusions of Law and Opinion

Compensability of knee condition

Once an employer officially accepts a claim for compensation, it may not later deny the compensability of the underlying claim, absent fraud, misrepresentation or other illegal activity. Georgia Pacific Corp. v. Piwowar, 305 Or 494 (1988); Johnson v. Spectra Physics, 303 Or 49, 55 (1987); Bauman v. SAIF, 295 Or 788 (1983). In Piwowar, the Court noted that an employer must compensate a claimant for the specific condition in its notice of acceptance, regardless of the cause of that condition. Id. at 501. The Court further stated that once an employer accepts compensability of a symptom, it must continue to compensate a claimant for that symptomatic condition, even when subsequent medical evidence demonstrates that the condition is attributable to a noncompensable cause or disease. Id. Accordingly, the Court held that an employer accepting a claim for a "sore back" could not subsequently deny compensability of an otherwise noncompensable ankylosing spondylitis condition diagnosed after the employer issued its acceptance. Id. at 501-502.

Here, claimant's injury claim form included a claim for "back, right rist [sic], right knee pain," and that "driver. . . slipped and injured. . . right knee." There was no formal letter of acceptance of the claim. The only notation of acceptance is on the form itself. Therefore, we conclude that the employer has accepted the claim as stated on the form, including a claim for "right knee pain" of whatever source.

Extent of disability: low back

To prevail on the issue of unscheduled permanent disability, claimant must prove by a preponderance of the evidence that, as a result of his industrial injury, he has sustained a permanent loss of earning capacity. "Earning capacity" is defined as claimant's "ability to obtain and hold gainful employment in the broad field of general occupations," and considers the degree of physical impairment as well as "age, education, training, skills and work experience." ORS 656.214(5).

In rating the extent of claimant's unscheduled permanent disability, we consider the medical and credible lay evidence of his physical impairment from the compensable injury, and all the relevant social and vocational factors set forth in OAR 436-36-380 et seq. Some of these factors hinder claimant. However, he has many skills which would transfer to other employment should that become necessary. And while his back continues to give him some difficulty, the chiropractic treatment he received afforded him great relief. His treating physician subsequently found claimant's range of motion restored and his pain reduced, and released him to regular work. He has performed that work successfully since. Consequently, after due consideration of the aforementioned guidelines, we conclude that 35 percent unscheduled permanent disability adequately compensates claimant for his low back condition.

ORDER

The Referee's order dated July 16, 1987 is affirmed in part and reversed in part. The self-insured employer's denial of claimant's right knee condition is set aside, and the claim remanded for acceptance and processing in accordance with the law. Claimant's attorney is awarded an assessed fee of $2,000, to be paid by the self-insured employer.The Board approves a client-paid fee not to exceed $2,352.

ROBERT L. SWEENEY, Claimant
Bottini, et al., Claimant's Attorneys
Cliff, Snarskis, et al., Defense Attorneys

WCB 86-08438
August 3, 1988
Order on Review

Reviewed by Board Members Johnson and Ferris.

Claimant requests review of that portion of Referee Knapp's order that awarded claimant 10 percent (32 degrees) unscheduled permanent partial disability for his low back condition, in addition to the Determination Order award of 15 percent (48 degrees), for a total award of 25 percent (80 degrees) unscheduled permanent partial disability. We affirm.

ISSUE

On review, the issue is extent of claimant's unscheduled disability.

FINDINGS OF FACT

We adopt as our own the findings of fact made by the Referee in Paragraphs 3 through 9 of his Opinion and Order. We also make the following additional findings of fact.

Claimant returned to regular work for the employer at injury without any of the equipment modifications which had been considered. He moved more cautiously and slowly in performing his job. Bending and twisting increased his symptoms, which included leg pain and numbness in his right foot. Long drives caused him increased discomfort in his back and leg, and he occasionally talked about quitting because of the pain. He did in fact give the employer two weeks notice in mid-October 1986. However, before he quit the employer was forced to lay him off because of an inability to insure drivers with negative driving records. The employer considered claimant a good driver, even after his injury.

After claimant was laid off, he took a part-time job driving a truck hauling rock, and driving a front-end loader. The job ended in December 1986.

Claimant went elk hunting and camping once during the 1986-7 season. He drove a 3/4 ton pickup to the hunting site. He shot an elk, which was carried out by others.

Claimant has mild impairment due to his compensable injury.

CONCLUSIONS OF LAW AND OPINION

We affirm and adopt the Referee's conclusions of law and opinion regarding the extent of claimant's unscheduled permanent partial disability.

ORDER

The Referee's order dated March 19, 1987 is affirmed.

LINDA M. THORNBURG, Claimant
Francesconi, et al., Claimant's Attorneys
Judy Johnson (SAIF), Defense Attorney

WCB 86-11552
August 3, 1988
Order on Review

Reviewed by Board Members Ferris and Crider.

Claimant requests review of Referee Podnar's order which upheld the SAIF Corporation's denial of chiropractic treatments in excess of two per month. We affirm.

ISSUE

Whether claimant has proven that chiropractic treatment in excess of two times per month is reasonable and necessary as a result of her compensable upper back and neck injury.

FINDINGS OF FACT

Claimant has a history of back problems. She was first treated by a chiropractic physician in 1978. Claimant began treating with Dr. Berardi, chiropractor, in March 1983, because she was experiencing back stiffness. Subsequently, in May 1983, claimant sustained a compensable upper back injury while lifting files. In January 1984, claimant was involved in an automobile accident which caused her to bounce off the passenger seat and strike the windshield of the car.

On July 10, 1984, claimant compensably injured her neck

and upper back. Dr. Berardi, claimant's treating chiropractor for purposes of this claim, diagnosed an upper back and neck strain. Claimant lost no time from work due to her injury.

Claimant suffered no permanent impairment from her compensable injury.

On November 21, 1985, claimant's claim was closed with no award of temporary or permanent disability. In August 1986, SAIF denied chiropractic treatments in excess of two per month.

Claimant is able to function with two chiropractic treatments per month.

CONCLUSIONS OF LAW AND OPINION

Claimant contends that chiropractic treatment in excess of two per month is reasonable and necessary to maintain her current level of functioning.

OAR 436-10-040(2)(a) provides the guideline of two treatments per month. The number of treatments may be limited to those shown to be reasonable and necessary to relieve pain and enable claimant to work. West v. SAIF, 74 Or App 317, 321 (1985). Claimant bears the burden of proving treatments are reasonable and necessary. McGarry v. SAIF, 24 Or App 883, (1976).

There are five opinions regarding the reasonableness and necessity of claimant's current chiropractic treatment. Dr. Langston, orthopedist, and the Orthopeadic Consultants examined claimant and opined that her chiropractic treatments were palliative rather than curative. Dr. Fechtel, chiropractor, examined claimant's medical records and found no objective evidence to support treatment in excess of two treatments per month.

In December 1985 Dr. Berardi reported that claimant was suffering an exacerbation of her condition and would require treatment 3-5 times a week for several weeks. In February 1986 he indicated that claimant was progressing, but required 2 treatments per week for 1 month followed by 1 visit per week for 1 month. In April 1986 Dr. Berardi reported another exacerbation that would require treatments twice a week for 6 weeks.

In June 1986, the Western Medical Consultants examined claimant and found that her recurring episodes of discomfort were not directly related to her prior injury. In August 1986 SAIF denied chiropractic treatments in excess of 2 per month.

We conclude that the level of chiropractic treatment claimant is receiving is not reasonable or necessary. ORS 656.245(1). This is a case where the treating doctor's opinion, as such, is of lesser importance than the other expert evidence presented. See Allie v. SAIF, 79 Or App 284 (1986); Hammons v. Perini, 43 Or App 299 (1979). All the medical experts, except for Dr. Berardi, favor palliative care on a reduced scale.

Although Dr. Berardi's longitudinal experience with claimant is a factor, the analysis offered by the other physicians is supported by objective medical evidence and more persuasive. Consequently, we affirm the order of the Referee.

ORDER

The Referee's order dated April 16, 1987 is affirmed.

YVONNE WALBURN, Claimant
Bischoff & Strooband, Claimant's Attorneys
Cowling & Heysell, Defense Attorneys

WCB 86-17065
August 3, 1988
Order on Review

Reviewed by Board Members Ferris and Crider.

Claimant requests review of Referee Mongrain's order that upheld the insurer's denial of claimant's aggravation and "new injury" claims for her back condition. We affirm.

ISSUE

Compensability of claimant's back condition.

FINDINGS OF FACT

In March 1986, claimant suffered a compensable injury when she fell while working as a chain puller. The next day, she was examined by Dr. Herscher, osteopath. He noted tenderness in the tailbone area and diagnosed a tailbone contusion. He prescribed light duty for a few days. Five days later, he reported that claimant's bruises had resolved and that she could return to full duty.

Claimant returned to work and received no further medical treatment for problems relating to her March 1986 compensable injury. She worked at her chain pulling job until June 1986, when she change to another job with the same employer. Between March and October 1986, claimant did not mention any problems concerning her left hip and leg to her supervisor.

On October 10, 1986, while off work, claimant fell off a cooler on which she had been sitting while riding in a van. She fell approximately three to four feet and landed on her thighs.

Claimant went to her foreman's office and told him that she had fallen off an ice chest and felt left hip and leg pain.

On October 17, 1986, claimant saw Dr. Kopa, osteopath, for her complaints. He diagnosed a herniated disc. In November, Dr. Campagna, neurologist, diagnosed a herniated disc.

Claimant failed to prove that her work contributed to her herniated disc condition.

CONCLUSIONS OF LAW AND OPINION

We adopt the opinion of the Referee.

ORDER

The Referee's order dated May 1, 1987 is affirmed. A client-paid fee not to exceed $463 is approved.

DAVID F. WEICH, Claimant
Peter O. Hansen, Claimant's Attorney
Acker, Underwood, et al., Defense Attorneys
Schwenn, Bradley, et al., Defense Attorneys
Barbara Brainerd (SAIF), Defense Attorney

WCB 86-05419, 86-04681 & 86-04682
August 3, 1988
Order on Review

Reviewed by Board Members Johnson and Ferris.

Claimant requests review of those portions of Referee Podnar's order that: (1) upheld the SAIF Corporation's medical services/aggravation denial of a left knee condition; (2) upheld SAIF's occupational disease denials for a bilateral knee condition; and (3) upheld SAIF's denial of an alleged psychiatric condition.

The Board affirms and adopts the order of the Referee as supplemented.

ISSUE

Whether claimant's compensable August 1982 right knee injury materially contributed to a left knee condition and need for medical treatment.

FINDINGS OF FACT

The Board adopts the Referee's findings and makes the following additional findings.

There are three employers in this case, all of whom were insured by SAIF. In August 1982, claimant sustained a compensable right knee injury while employed at Kach Machine Works. He later worked for two additional employers. Against Kach, he filed a claim asserting that his compensable August 1982 right knee injury had materially contributed to a left knee condition. Against the two later employers, he filed occupational disease claims contending that his work activities were the major contributing cause of a bilateral knee condition.

Claimant, 62 years of age at hearing, suffers from obesity and minimal osteoarthritis in his knees and feet. Other than osteoarthritic changes, there are no bony or soft tissue abnormalities in either of his knees. His minimal osteoarthritis is compatible with a person of his age and weight.

As a result of the compensable August 1982 right knee injury, claimant began to walk with an altered gait. His altered gait did not materially contribute to the onset or worsening of his minimal left knee osteoarthtitis.

CONCLUSIONS OF LAW

The Referee did not address the question of whether claimant's compensable August 1982 injury materially contributed to his left knee condition and need for medical treatment. We, therefore, proceed to do so.

Because we are not sure whether claimant presents a medical services or aggravation theory to support his claim for compensability, we address both theories.

A worker is entitled to medical services for the disabling results of a compensable injury, even if preexisting problems contribute to his disability. Van Blokland v. Oregon Health Sciences University, 87 Or App 694, 698 (1987); see ORS 656.245(1).

To establish a compensable aggravation claim, a worker must prove a causal relationship between the worsened condition and the compensable injury. Stepp v. SAIF, 78 Or App 438, 441 (1986); see Smith v. SAIF, 302 Or 396 (1987); ORS 656.273(1).

The medical evidence in this case is divided. In October 1983, Dr. Wilson, claimant's orthopedic surgeon, stated:

> "In my opinion, no permanent impairment resulted from [claimant's] work injury of August 25, 1982, and that his current problems are the result of an arthritic process that has anteceded that work injury."

Nearly two years later, in response to a hypothetical question from claimant's attorney, Wilson opined, inter alia:

> "[B]ecause of favoring the right knee and changes in gait, that would tend to increase or accelerate degenerative changes already underlying and present in the left knee. Although it is not a major contributing factor, it certainly would be [a] contributing factor."

In February 1986, claimant was examined by Dr. Gambee, an orthopedic surgeon. Gambee recorded claimant's complaints of left knee pain resulting from an altered gait. After doing so, Gambee opined inter alia:

> "KNEES BILATERALLY: [X-rays] [f]ailed to reveal significant bony or soft tissue abnormalities except for the osteoarthritic change one would associate with a man of this age and body build."
>
> "IMPRESSION: This man has osteoarthritis of his knees and feet. I think that his problems in his feet are causally unrelated to any industrial accident, and in my estimation are almost entirely related to his rather dramatic exogenous obestity and his age. He has apparently had an arthroscopic menisectomy and I think with a reasonable end result."

We are persuaded by Dr. Gambee's opinion. Despite Dr. Wilson's later change of opinion, he initially opined that there was no causal relationship between the August 1982 injury and claimant's left knee osteoarthritis. His subsequent change of opinion was conclusory. Moe v. Ceiling Systems, 44 Or App 429, 433 (1980). On the other hand, Gambee thoroughly examined claimant and reported that there was no abnormality in the left knee except for osteoarthritis, which, in Gambee's view, was due to claimant's age and obesity.

Accordingly, the evidence does not preponderate in favor of compensability.

ORDER

The Referee's order dated January 18, 1987, is affirmed as supplemented.

MELVIN WHITTLE, Claimant
Burt, Swanson, et al., Claimant's Attorneys
Jeff Gerner (SAIF), Defense Attorney

WCB 86-15480
August 3, 1988
Order on Review

Reviewed by En Banc.

Claimant requests review of Referee McCullough's order that found he was paid the correct rate of temporary disability compensation. The issue is temporary disability.

The Board affirms and adopts the order of the Referee.

ORDER

The Referee's order dated April 17, 1987 is affirmed.

BOARD MEMBER CRIDER, CONCURRING:

I concur in the Board's order solely because I am bound by the Court of Appeals holding in Reed v. SAIF, 63 Or App 1 (1983). Although Reed dealt with calculation of permanent total disability benefits, I see no rational grounds for distinguishing this case involving temporary total disability benefits.

The order affirmed by the Board provides, consistent with Reed, that although claimant was employed at the time of injury on an on-call basis for three different moving companies his temporary total disability benefits shall be calculated based solely on the hours he worked for Cummings, the employer for which he was performing work when he was injured. Claimant's injury performing work for Cummings, however, rendered him temporarily disabled from performing not only his work for Cummings but also for his other two employers.

This result is totally at odds with the purpose of the Workers' Compensation system--that is, "To provide, regardless of fault, sure, prompt and complete medical treatment for injured workers and fair, adequate and reasonable income benefits to injured workers and their dependents." ORS 656.012. It is also at odds with the notion that temporary total disability payments are designed to take the place of wages lost owing to an on-the-job injury. See e.g., Cutright v. Weyerhaeuser, 299 Or 290 (1985). And, the comments of the Reed majority notwithstanding, it is at odds with the principle that the employer should protect the employee against the risk incurred in his employ; for the risk incurred by the employee is that he will suffer an injury that will not only destroy his ability to work for the employer-at-injury but also his ability to work for other employers.

The Reed court conceded that the statute did not clearly require the result it reached. ORS 656.210 simply says that, during the period of temporary disability, claimant shall receive "compensation equal to 66-2/3 percent of wages". It further provides

that "For the purpose of this section, the weekly wage of workers shall be ascertained by multiplying the daily wage the worker was receiving at the time of injury" by the number of days the worker was regularly employed. It further provides that for those not regularly employed, the director shall establish a method for calculating weekly wage. Nothing in that section or in the definition of wage in ORS 656.005(26), relied on so heavily in Reed, even contemplates the concurrent employment problem. The statute simply explains how to calculate weekly wage for a single employment. It remains to the Board and the courts to apply the law to the concurrent employment case in light of the purpose of the Workers' Compensation Law.

Where, as here, an employee was concurrently employed by multiple employers and therefore concurrently earning wages from multiple sources, claimant will only receive "fair, adequate and reasonable income benefits" which will truly serve as a substitute for lost wages if we construe ORS 656.210 to require payment of disability benefits based on the total of separate calculations of his weekly wage from each employer.

Were we to follow this rationale in this case, we would conclude that claimant is entitled to benefits based on his average weekly earnings at Cummings plus his average weekly earnings at Bekins plus his average weekly wages at Bertsch subject to the maximum prescribed by ORS 656.210(1). That, I believe, would be the correct result.

DALE R. BENNETT, Claimant
Emmons, et al., Claimant's Attorneys
Acker, et al., Defense Attorneys

WCB 87-09834
August 4, 1988
Order on Reconsideration

The insurer has requested reconsideration of the Board's Order on Review dated July 20, 1988. The request is granted and our prior order is withdrawn.

The insurer requests that we reconsider our rating of the extent of claimant's unscheduled permanent partial disability. We found claimant minimally impaired, and rated her disability at 30 percent. This was a partial error.

Claimant's treating physician has limited her to light work with restrictions. She may lift no more than 30 pounds, do no lifting above the shoulder, and do no repetitive pushing and pulling. An examining physician, Dr. Martens, agreed with the limitations, but rated claimant's impairment as minimal. We found, based upon the opinions of both doctors and of claimant herself, that the restrictions were appropriate, and that claimant was limited to light work. Implicit in that finding must be a rejection of Dr. Martens' impairment rating. The restrictions themselves describe a worker with mild impairment.

We also found that claimant's pain impaired her. Pain is to be included in the rating of impairment. Harwell v. Argonaut Ins., 296 Or 505 (1984).

Finally, the legislature has instructed us to consider so-called "social and vocational factors" in rating disability. ORS 656.214(5). "Disability" is, indeed, a combination of impairment and these other factors, and may well be higher than impairment alone. We consider these factors as guidelines. Harwell, supra. In our review, we found that claimant has a ninth grade education and a GED, and that her entire work history

consisted of unskilled work which does not give her transferrable skills. Based upon our findings, we rated claimant's overall unscheduled disability at 30 percent. On reconsideration, we adhere to that disability rating. Therefore, except for our amendment herein to find claimant mildly impaired, we adhere to and republish our former order, effective this date.

IT IS SO ORDERED.

LEONARD A. CHAMBERS, Claimant
Doblie & Associates, Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 87-03511
August 4, 1988
Order on Review (Remanding)

Reviewed by Board Members Ferris and Crider.

The insurer requested reconsideration of our Order on Review (Remanding) dated March 24, 1988. We abated our order on April 19, 1988. We have received and considered a response from claimant. In light of the parties' arguments and the recent decisions in White v. North Clackamas School District, 305 Or 48, clarified, 305 Or 468 (1988) and Armstrong v. Asten-Hill Co., 90 Or App 200 (1988), we amend our Order on Review (Remanding) as follows.

Claimant requests review of Referee Daughtry's order that dismissed his request for hearing on the ground that the request was not timely filed. We reverse in part.

ISSUES

1. Whether claimant's supplemental hearing request vested jurisdiction in the Hearings Division.

2. Whether res judicata bars claimant's claim for medical services rendered after the insurer's June 12, 1986 denial.

FINDINGS OF FACT

Claimant injured his neck in June 1974 when he slipped and bumped his head on a door casing. He was treated conservatively for a few weeks and then discontinued treatment. Claimant's claim was accepted by the insurer, but has never been closed, apparently because of a clerical error. Claimant experienced periodic bouts of neck pain and in 1976 began treating about once every two weeks with Dr. Peltzer, a chiropractor. In 1981, he transferred his care to another chiropractor, Dr. Holman.

On June 12, 1986, the insurer issued a denial which stated in pertinent part:

> "This will advise you that we are denying responsibility for your chiropractic treatment as the preponderance of medical evidence indicates that this is neither reasonable and necessary nor related to your original compensable condition."

Claimant was represented by an attorney at the time the denial was issued, but the insurer was unaware of that fact and did not send the attorney a copy of the denial. Claimant's attorney first became aware of the denial in March 1987 when claimant inquired whether the attorney had filed a request for hearing on the denial.

Claimant's contact with his attorney was prompted by the insurer's refusal to pay medical bills it received from claimant in late January 1987.

The attorney immediately filed a request for hearing on the June 1986 denial. In April 1987, the insurer moved to dismiss the hearing request on timeliness grounds. A few days later, claimant's attorney filed a supplemental hearing request on what he characterized as the insurer's "de facto" denial of medical services in January 1987.

The Referee found that claimant had not filed his original request for hearing within 180 days and granted the insurer's motion to dismiss. The Referee's order does not mention or expressly dispose of the supplemental hearing request filed in April 1987. We find, however, that he intended his order to dispose of both the original and supplemental hearing requests.

CONCLUSIONS OF LAW

Jurisdiction

Claimant concedes that the dismissal of his original request for hearing was proper. He argues, however, that the supplemental hearing request was timely and vested jurisdiction in the Hearings Division.

Claimant submitted medical bills to the insurer in late January 1987 for payment. The insurer did not issue a formal denial of the bills, but refused to pay them. More than 60 days after the insurer received the bills, claimant requested a hearing on a "de facto" denial theory. Assuming that the supplemental hearing request, standing alone, satisfied the jurisdictional requirements of ORS 656.283, the request vested jurisdiction in the Hearings Division. See Syphers v. K-W Logging, Inc., 51 Or App 769, 771, rev den 291 Or 151 (1981).

ORS 656.283(3) provides that "[a] request for hearing may be made by any writing, signed by or on behalf of the party [requesting the hearing] and including the address of the party, requesting a hearing, stating that a hearing is desired, and mailed to the Board." Claimant's supplemental hearing request was in writing, was signed on his behalf by his attorney, stated that a hearing was desired on the insurer's "de facto" denial of medical services and was mailed to the Board. The only requirement of ORS 656.283(3) that the supplemental hearing request did not directly satisfy was that the request include the address of the party requesting the hearing. The request did include the address of claimant's attorney and a claim number, both of which provided the insurer with information from which it could easily identify claimant and obtain his address. The question of whether the Hearings Division has jurisdiction to consider claimant's supplemental hearing request, therefore, depends upon whether strict compliance with the address requirement of ORS 656.283(3) is necessary.

In Burkholder v. SAIF, 11 Or App 334, 340-41 (1972), the court ruled that the address requirement was not jurisdictional and thus that strict compliance with that requirement was not required. We reach the same conclusion under the analysis proposed in Thomas E. Harlow, 38 Van Natta 1406, 1411 (1986). We conclude, therefore, that the supplemental hearing request was sufficient to vest jurisdiction in the Hearings Division independent of the original hearing request.

Res Judicata

Although we could remand the case to the Hearings Division without commenting on the res judicata issue, we address the issue because it is certain to arise on remand. The doctrine of res judicata precludes litigation of claims and issues previously adjudicated. North Clackamas School District v. White, 305 Or 48, 50, modified, 305 Or 468 (1988). "Claim preclusion" is the name given to the preclusive effect of a prior adjudication on a claim and "issue preclusion" to the preclusive effect of a prior adjudication on an issue. Id.

The rule of claim preclusion is that if a claim is litigated to final judgment, the judgment precludes a subsequent action between the same parties on the same cause of action or any part thereof. Restatement (Second) of Judgments §§ 17-19, 24 (1982); see also 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). A cause of action is an aggregate of operative facts which compose a single occasion for judicial relief. Carr v. Allied Plating Co., supra, 81 Or App at 310.

Each bill for rendered medical services allegedly associated with an accepted claim is a separate cause of action. See Billy J. Eubanks, 35 Van Natta 131, 135 (1983). The scope of a cause of action relating to a denial of an ongoing course of medical treatment, therefore, is limited to those treatments rendered on or before the date of the denial. See Patricia M. Dees, 35 Van Natta 120, 124 (1983).

The insurer's June 1986 denial was not a "back-up" denial of the compensability of claimant's original claim. It was a denial of an ongoing course of medical treatment allegedly associated with an accepted claim. Under the rules set forth above, the scope of the cause of action associated with the denial was limited to those treatments rendered on or before the date of the denial. Treatments rendered after the date of the denial, therefore, represent separate causes of action which are not barred by the rule of claim preclusion.

The rule of issue preclusion is that if an issue of fact is actually litigated and determined by a valid and final judgment and the determination is essential to the judgment, the determination is conclusive in a subsequent action between the parties, whether on the same or a different cause of action. See North Clackamas School District v. White, supra, 305 Or at 53; Restatement (Second) of Judgments § 27 (1982).

Although the insurer's denial raised the issue of the causal relation between the accepted claim and the condition being treated, that issue was never actually litigated. The only issue of fact which was actually litigated and has been determined with respect to the insurer's June 1986 denial is that claimant's original request for hearing was not filed within 180 days of the denial. The rule of issue preclusion, therefore, does not bar litigation of the causal relation between the accepted claim and claimant's ongoing course of treatment.

To summarize our conclusions on the res judicata issue, the rule of claim preclusion bars claimant from litigating the compensability of medical treatments rendered on or before June 12, 1986. Neither the rule of claim preclusion nor the rule of issue preclusion, however, bars claimant from litigating the compensability of medical treatments rendered after that date.

ORDER

The Referee's order dated May 13, 1987 is reversed in part. That portion of the order that dismissed claimant's supplemental request for hearing is reversed and the case is remanded to the Hearings Division for further proceedings consistent with this order. The remainder of the Referee's order is affirmed.

WILLIAM R. GWYNN, Claimant
Olson Law Firm, Claimant's Attorney
Jeff Gerner (SAIF), Defense Attorney

WCB 84-11354
August 4, 1988
Order on Remand

This matter is before the Board on remand from the Court of Appeals. Gwynn v. SAIF, 91 Or App 84 (1988). The court has concluded that claimant suffered a flare-up of symptoms resulting in "total disability for more than 14 days and, thus, necessarily in greater disability than the [December 1983 stipulated 20 percent permanent disability] award contemplated." Consequently, the court held that claimant's flare-up of symptoms constituted a worsening as a matter of law under the guidelines established by the Supreme Court in Gwynn v. SAIF, 304 Or 345 (1987).

Consistent with the court's decision, the SAIF Corporation's October 11, 1983 denial of claimant's aggravation claim is set aside and the claim is remanded to SAIF for processing according to law.

IT IS SO ORDERED.

HARRY N. HUNSLEY, Claimant
Michael B. Dye, Claimant's Attorney
Cowling & Heysell, Defense Attorneys

WCB 85-02203
August 4, 1988
Order Approving Request

The insurer's counsel moves for reconsideration of our July 18, 1988 order that declined a request for Board authorization of a client-paid fee for services rendered on review which culminated in our January 29, 1988 Order on Reconsideration. The motion is granted and our July 18, 1988 order withdrawn. On reconsideration, based on the findings and reasoning expressed below, the request is granted.

FINDINGS

On October 12, 1987, we vacated a Referee's order and directed that this case be remanded for consideration of a contested vocational report. We abated this order on November 4, 1987.

On January 29, 1988, we issued an Order on Reconsideration, withdrawing our October 12, 1987 order, denying claimant's request for remand, and affirming the Referee's order. The January 29, 1988 order has not been appealed, abated, stayed, or republished.

None of the aforementioned orders addressed the issue of a client-paid fee.

On February 16, 1988, the administrator for the Board notified all practitioners with cases currently pending review that executed retainer agreements and statement of services would be required in all cases that involved the approval of an assessed, client-paid or extraordinary fee. The practitioners were further advised that where the last brief in a case presently pending review

had been filed more than 15 days from the date of the administrator's February 16, 1988 letter, the statement of services was due within 15 days of the date of the letter.

On February 24, 1988, the insurer's counsel sought authorization of a client-paid fee, forwarding an executed retainer agreement and statement of service to the Board. This submission did not reach the Board's file.

On June 10, 1988, the insurer's counsel again sought authorization of a client-paid fee. No executed retainer agreement or statement of services was included with the request. Inasmuch as the record lacked these required materials, we declined the insurer's counsel's request on July 18, 1988.

In response to our order, the insurer's counsel has submitted copies of the required materials along with his affidavit asserting that he mailed these documents to the Board on February 24, 1988.

We find that the insurer's counsel filed a request for authorization of a client-paid fee, including an executed attorney retainer agreement and a statement of service, within 15 days of the administrator's February 16, 1988 letter.

CONCLUSIONS

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. See International Paper Co. v. Wright, 80 Or App 444, 447 (1986).

Attorney fee awards are generally included within orders concerning the merits of the case. The Supreme Court does not dispute the efficiency of such a practice. See Greenslitt v. City of Lake Oswego, 305 Or 530, 534-35 & n. 3 (1988). Moreover, it has concluded that if the merits of the case are appealed, the attorney fees issue becomes part of the appeal. Id.

Yet, the determination of an attorney fee does not directly affect a worker's right to, or amount of, compensation due. Farmers Ins. Group v. SAIF, 301 Or 612, 619 (1986). Thus, the Court has suggested that the attorney fee award need not accompany an order regarding the merits of the case. Greenslitt v. City of Lake Oswego, supra; Farmers Ins. Group v. SAIF, supra. The Court has further indicated that once a Referee's or Board's order on attorney fees becomes final, the appropriate forum for review of attorney fees is the circuit court pursuant to the unique provisions of ORS 656.388(2). Greenslitt v. City of Lake Oswego, supra; Farmers Ins. Group v. SAIF, supra, at page 619.

Here, none of our previous orders on the merits addressed the issue of either the insurer's counsel's entitlement to, or the amount of, a client-paid fee. Consequently, based on the aforementioned authorities, we conclude that we have jurisdiction to consider the request for authorization of a client-paid fee.

Although we have jurisdiction to entertain the attorney fee issue, we must turn to the Board's rules to determine whether the request is properly before us. These rules were designed to enable the Referees and the Board to process orders regarding the merits of a case, as well as attorney fee requests, as efficiently as possible.

Pursuant to OAR 438-15-010(1), attorney fees shall be authorized only if an executed attorney retainer agreement has been filed. Furthermore, a client-paid fee shall not be authorized unless the attorney requesting authorization for payment of the fee files a statement of services. OAR 438-15-010(5). A statement of services for proceedings on Board review shall be filed within 15 days after the filing of the last brief to the Board. OAR 438-15-027(1)(d). These rules apply to all cases pending before the Board, effective January 1, 1988. OAR 438-05-010; 438-15-003.

As previously mentioned, on February 16, 1988, the administrator for the Board notified all practitioners with cases currently pending review that the Board would be applying its rules concerning the authorization of assessed, client-paid, and extraordinary attorney fees to all cases pending Board review. Practitioners were advised that, under OAR 438-15-010(1) and 438-15-027(1)(d), an executed retainer agreement and statement of services were due within 15 days after the filing of the last brief in a case. For those cases where the last brief had been filed more than 15 days from the date of the administrator's February 16, 1988 letter, the administrator further stated that the statement of services would be due within 15 days of the date of the letter.

On February 24, 1988, in compliance with the administrator's directive, the insurer's counsel forwarded an executed retainer agreement and statement of service to the Board. Unfortunately, this submission did not reach the Board's file. Therefore, on June 10, 1988, when the insurer's counsel repeated his request for authorization, we were forced to deny it. Since our refusal, the insurer's counsel has resubmitted copies of these documents, along with his affidavit stating that he previously mailed these materials to the Board on February 24, 1988.

After reviewing the insurer's counsel's affidavit and accompanying submission, we are persuaded that the request for authorization of a client-paid fee, including an executed retainer agreement and statement of services, was forwarded to the Board on February 24, 1988. These materials were initially submitted while the Board still had jurisdiction to abate, amend, or reconsider its January 29, 1988 Order on Reconsideration.

Under such circumstances, the Board makes every effort to promptly process such requests. Regrettably, because neither the request nor the required documents were received within the statutory 30-day period, jurisdiction to further consider the merits of the case elapsed without further Board action. In addition, on June 10, 1988, when the insurer's counsel reiterated his request without indicating that the necessary attorney retainer agreement and statement of service had been submitted on February 24, 1988, we denied the request for authorization as untimely.

However, as discussed above, we are persuaded that the insurer's counsel timely complied with the administrator's notification concerning the application of the Board's rules concerning the authorization of attorney fees. Inasmuch as we have jurisdiction to consider the request for authorization of a client-paid fee and since the request was timely submitted, we shall address the issue.

In reaching this decision we wish to distinguish this case

from Jane E. Stanley, 40 Van Natta 831 (July 18, 1988). In Stanley, the employer's counsel submitted a request for authorization of a client-paid fee, including an executed retainer agreement and statement of services, approximately three months after the issuance of our February 22, 1988 unappealed Order on Review. As in the present case, our prior order in Stanley had neither addressed the issue of the employer's counsel's entitlement to, nor the amount of, a client-paid fee. Consequently, we concluded that we had jurisdiction to consider the request. However, because the request was submitted untimely and since our order on the merits had become final by operation of law, we declined to authorize the request.

Here, unlike the counsel in Stanley, we have found that the insurer's counsel timely submitted the requisite documentation in support of a request for authorization of a client-paid fee. Therefore, we conclude that the request is properly before us. As we stated in Stanley, to the extent that our analysis conflicts with the reasoning expressed in Marian S. Dumas, 40 Van Natta 109 (1988), and John L. Rousseau, 40 Van Natta 115 (1988), that reasoning is expressly disavowed.

After reviewing the statement of services and the attorney retainer agreement submitted by the insurer's counsel and considering the factors set forth in OAR 438-15-010(6), we approve a client-paid fee not to exceed $238.

IT IS SO ORDERED.

RONALD J. WARREN, Claimant
Pozzi, et al., Claimant's Attorneys
David Jorling, Defense Attorney

WCB 85-15275
August 4, 1988
Order on Review

Reviewed by Board Members Crider and Ferris.

Claimant requests review of Referee Neal's order which upheld the self-insured employer's denial of claimant's heart attack claim. In his brief, claimant asks that this matter be remanded to the Referee for the taking of additional evidence. We affirm and adopt with the following comment.

ISSUES

1. Whether claimant sustained a compensable heart attack.

2. Whether the record requires a remand to the Referee for further taking of evidence.

FINDINGS OF FACT

We adopt the Referee's findings with the following supplementation.

Claimant was readmitted to Kaiser Hospital on July 21, 1985, after he experienced an additional onset of pain while helping his wife carry groceries into the house.

Claimant's work activities did not materially contribute to or accelerate his myocardial infarction.

CONCLUSIONS OF LAW

Claimant argues that the record is incomplete without inclusion of medical articles cited by Dr. Toren during his testimony at hearing. We disagree.

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 for consideration of additional evidence it must be clearly shown that material evidence was not obtainable with due diligence at the time of hearing. Kienow's Food Stores v. Lyster, 70 Or App 416 (1986); Delfina P. Lopez, 37 Van Natta 164, 170 (1985).

After de novo review, we are not persuaded that the record has been improperly, incompletely or otherwise insufficiently developed. Furthermore, we find that the evidence presented in claimant's brief was obtainable with due diligence. At hearing, claimant was given the opportunity to cross-examine Dr. Toren regarding the medical articles which formed the basis of the doctor's opinion, but claimant declined to do so. Accordingly, we conclude that remand is not warranted.

ORDER

The Referee's order dated February 27, 1987 is affirmed.

VIRGIL A. CHAPPELLE, Claimant
Malagon & Moore, Claimant's Attorneys
Cummins, et al., Defense Attorneys

WCB 86-18098
August 5, 1988
Order of Dismissal

The insurer requests review of that portion of Referee Foster's order that awarded claimant's attorney a $1,750 insurer-paid fee for finally prevailing at hearing against the insurer's denial of claimant's back injury claim. On review, the insurer contends that the fee is excessive. In his brief, claimant argues that the Circuit Court has exclusive jurisdiction over the attorney fee issue in this case.

On review, the issues are jurisdiction and attorney fees.

We dismiss the insurer's request for review.

FINDINGS OF FACT

Claimant requested a hearing concerning the insurer's denial of his back injury claim. The Referee set aside the denial and awarded claimant's attorney a $1,750 attorney fee. The insurer initially requested Board review on all issues decided adversely to it. However, the only issue it raised in its brief on review was the amount of the attorney fee awarded at hearing. We interpret the insurer's brief as a withdrawal of its initial request for Board review on all issues except the amount of attorney fees.

CONCLUSIONS AND OPINION

When a claimant has finally prevailed on the issue of compensability, disputes concerning the amount of attorney

fees awarded pursuant to ORS 656.386(1) must be settled by the appropriate circuit court as provided in ORS 656.388(2). Greenslitt v. City of Lake Oswego, 305 Or 530, 533-34 (1988) (dicta); Farmers Insurance Group v. SAIF, 301 Or 612, 619 (1986) (dictum); Granby v. Weyerhaeuser Company, 91 Or App 711 (1988).

In accordance with the aforementioned authority, we recently dismissed a request for Board review of an attorney fee awarded under ORS 656.386(1), where the compensability issue was finally decided at hearing. See Arbra Williams, 40 Van Natta 506, 507 (May 25, 1988). The facts in the present case are similar to those in Williams. Claimant prevailed finally at hearing against the insurer's denial of his back injury claim, and the insurer is challenging the amount of the attorney fee awarded by the Referee under ORS 656.386(1). As in Williams, the Board lacks jurisdiction to entertain the attorney fee issue in this case. See Greenslitt, supra; Granby, supra.

Accordingly, we dismiss the insurer's request for review. We approve a client-paid fee for services on Board review, not to exceed $177.50.

IT IS SO ORDERED.

BETTY J. EYLER, Claimant
Garry L. Kahn, Claimant's Attorney
Meyers & Terrall, Defense Attorneys

WCB 86-18034
August 5, 1988
Order Denying Request

The self-insured employer's counsel seeks Board authorization of a client-paid fee for services rendered on review which culminated in our April 25, 1988 Order of Dismissal. The request is denied.

FINDINGS

Claimant timely requested Board review of the Referee's October 2, 1987 order. On January 6, 1988, claimant filed her appellant's brief. The employer did not file a respondent's brief.

On March 30, 1988, the Board received claimant's withdrawal of her request for review. On April 25, 1988, the Board issued its Order of Dismissal. The Board's order did not address the issue of a client-paid fee. The April 25, 1988 order has not been appealed, abated, stayed, or republished.

On May 9, 1988, the Board received the employer's counsel request for authorization of a client-paid fee for services rendered on Board review. Included with this request was an executed attorney retainer agreement and a statement of services.

CONCLUSIONS

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. See International Paper Co. v. Wright, 80 Or App 444, 447 (1986).

Attorney fee awards are generally included within orders concerning the merits of the case. The Supreme Court does not dispute the efficiency of such a practice. See Greenslitt v. City of Lake Oswego, 305 Or 530, 534-35 & n. 3 (1988). Moreover, it has concluded that if the merits of the case are appealed, the attorney fees issue becomes part of the appeal. Id.

Yet, the determination of an attorney fee does not directly affect a worker's right to, or amount of, compensation due. Farmers Ins. Group v. SAIF, 301 Or 612, 619 (1986). Thus, the Court has suggested that the attorney fee award need not accompany an order regarding the merits of the case. Greenslitt v. City of Lake Oswego, supra; Farmers Ins. Group v. SAIF, supra. The Court has further indicated that once a Referee's or Board's order on attorney fees becomes final, the appropriate forum for review of attorney fees is the circuit court pursuant to the unique provisions of ORS 656.388(2). Greenslitt v. City of Lake Oswego, supra; Farmers Ins. Group v. SAIF, supra, at page 619.

Here, our April 25, 1988 dismissal order did not address the issue of either the employer's counsel's entitlement to, or the amount of, a client-paid fee. Consequently, based on the aforementioned authorities, we conclude that we have jurisdiction to consider the request for authorization of a client-paid fee.

Although we have jurisdiction to entertain the attorney fee issue, we must turn to the Board's rules to determine whether the request is properly before us. These rules were designed to enable the Referees and the Board to process orders regarding the merits of a case, as well as attorney fee requests, as efficiently as possible.

Pursuant to OAR 438-15-010(1), attorney fees shall be authorized only if an executed attorney retainer agreement has been filed. Furthermore, a client-paid fee shall not be authorized unless the attorney requesting authorization for payment of the fee files a statement of services. OAR 438-15-010(5). A statement of services for proceedings on Board review shall be filed within 15 days after the filing of the last brief to the Board. OAR 438-15-027(1)(d). These rules apply to all cases pending before the Board, effective January 1, 1988. OAR 438-05-010; 438-15-003.

As previously noted, on May 9, 1988, the Board received the employer's counsel's request for authorization of client-paid fee, which included an executed attorney retainer agreement and a statement of services. This submission was received while the Board still had jurisdiction to abate, amend, or reconsider its April 25, 1988 dismissal order. Under such circumstances, the Board makes every effort to promptly process these requests. Unfortunately, in this particular instance, the 30-day period to further consider the merits of the case elapsed without Board action. Thus, the merits of the April 25, 1988 order have become final by operation of law.

Furthermore, the request for authorization of a client-paid fee has been submitted approximately four months after the filing of the last brief to the Board. Such a submission is untimely under the Board rules, which apply to all cases pending before the Board on January 1, 1988. See OAR 438-05-010; 438-15-003; 438-15-027(1)(d). We recognize that administrative

problems have arisen as parties become accustomed to the Board's rules and, particularly, the application of the rules to all pending cases. Yet, the difficulties occasioned by this adjustment should not prompt us to ignore the very rules which only recently have been implemented.

Inasmuch as the request for a client-paid fee does not comply with the Board's rules concerning the authorization of such a fee and because our order on the merits of the case has become final by operation of law, we decline to authorize the employer's counsel's request. To the extent that our analysis conflicts with the reasoning expressed in Marian S. Dumas, 40 Van Natta 109 (1988), and John L. Rousseau, 40 Van Natta 115 (1988), that reasoning is expressly disavowed.

In reaching this conclusion, we wish to stress that we are neither questioning the employer's counsel's entitlement to, nor the amount of, a requested client-paid fee. We are only stating that, for reasons discussed above, we are unable to approve the request.

IT IS SO ORDERED.

GENE L. LANCASTER, Claimant
Pozzi, et al., Claimant's Attorneys
Mark Bronstein (SAIF), Defense Attorney

WCB 86-07633
August 5, 1988
Order on Review

Reviewed by Board Members Johnson and Crider.

Claimant requests review of Referee Thye's order that: (1) declined to grant permanent total disability; (2) awarded 55 percent (176 degrees) unscheduled permanent disability award for a low back injury, in addition to a Determination Order that had awarded no permanent disability beyond the 25 percent (80 degrees) previously awarded by another Determination Order; and (3) declined to award additional scheduled permanent disability for a right knee condition. We conclude that claimant is permanently and totally disabled. Consequently, we reverse the Referee's order.

Issues

(1) Whether claimant is permanently, totally disabled; or

(2) In the alternative, extent of claimant's scheduled and unscheduled disability.

Findings of Fact

We adopt the Referee's findings of fact labelled "Evidence" as our own, and make the following additional findings of fact.

At the conclusion of claimant's two year training program in insurance adjusting, he actively sought work as an adjuster by sending out resumes to companies in Oregon and Texas. Claimant's vocational counselor personally contacted insurance companies and auto body shops in Oregon in an attempt to locate openings and establish claimant's qualification. Claimant also applied for work with the Washington State Fish and Game Department, at the counselor's suggestion. The employer at injury did not have any modified work for claimant.

Conclusions of Law and Opinion

Claimant must prove by a preponderance of the evidence that he is permanently totally disabled. Harris v. SAIF, 292 Or 683 (1982). Permanent total disability means that claimant is permanently incapacitated from regularly performing work at a gainful and suitable occupation, which is an occupation that he has the ability and training or experience to perform, or which he is able to perform after rehabilitation. ORS 656.206(1). There are two types of permanent total disability: (1) that arising entirely from physical or mental incapacity; and (2) that arising from less than total physical incapacity plus non-medical conditions, which together result in permanent total disability. Welch v. Bannister Pipeline, 70 Or App 699 (1984); Wilson v. Weyerhaeuser, 30 Or App 403 (1977). If claimant relies on the second type, a compensable injury must be a material contributing factor in claimant's disability. Destael v. Nicoli Co., 80 Or App 596 (1986).

Claimant must also demonstrate that he is willing to re-enter the workforce, and that he has made reasonable efforts to do so. Failure to look for work is considered reasonable in cases in which such attempts would obviously be futile. ORS 656.206(3); Butcher v. SAIF, 45 Or App 313 (1980).

Claimant's physical complaints in this case are extensive. His chronic low back strain, low back nerve damage resulting in foot drop, right knee pain and instability, bowel condition and depression all arise from his compensable accident.

Social and vocational factors also increase his disability. He was 55 at hearing. He has a high school diploma, as well as a 52 hour course and a two year associate degree in insurance adjusting, the latter two provided through vocational rehabilitation. He has not been bonded as an insurance adjuster because of his criminal record, and SAIF has refused to reinstitute services to enable him to obtain bonding through the Federal Bonding Program for ex-offenders. Following his latest surgery, he is physically able to work only in a special environment. He has no transferrable skills.

We disagree with the Referee and find that claimant has demonstrated that he is motivated to return to work and that his efforts to work have been reasonable under the circumstances. After receiving his degree, and prior to his surgery for foot drop, he cooperated with his vocational counselor in seeking work, but did not find employment. Following surgery, he was evaluated by Mr. Lageman, vocational counselor, for two days. Mr. Lageman testified at hearing that because claimant was no longer able to perform the job of insurance adjuster, and because the degree gave claimant no transferrable skills, there was no work which claimant was qualified or able to perform without further vocational assistance. In Mr. Lageman's opinion, it would take a vocational counselor familiar with the programs available to encourage employers to hire disabled workers to sell any potential employer on the idea of hiring claimant. SAIF has refused that assistance, most recently on the basis that claimant's multiple physical problems make him unable to participate in any return to work programs.

We find Mr. Lageman's testimony persuasive. It was

based on two days of evaluation, testing and observation of claimant only a few weeks before the hearing. His conclusion is supported by that of the Ex-Offender Placement Specialist, and by the admission of the insurer. In contrast, the vocational counselor who believed claimant capable of employment was working with claimant prior to his latest physical deterioration.

Claimant is not totally physically disabled. He has been released for sedentary to light work by his doctors. However, his physical condition requires that he work only in an office or other facility with nearby restrooms and even floors. He must also be able to sit, stand, and walk at will. His stamina has been reduced such that he must be able to work only part-time. And he must locate such a position although he has no notable transferrable skills or the benefit of vocational placement services. We conclude that, under these circumstances, claimant is permanently totally disabled.

Permanent total disability is effective from the first date that it is proved to have existed. Morris v. Denny's, 53 Or App 863 (1981). Here, the May 23, 1986 Determination Order found claimant to be medically stationary as of April 18, 1986. In June 1986 direct employment assistance efforts were initiated. However, these efforts proved to be short-lived and fruitless.

Following our de novo review of the medical and lay evidence, we are persuaded that all social and vocational factors relevant to claimant's permanent total disability existed at the time his condition was considered to be medically stationary. See Morris v. Denny's, supra; Adams v. Edwards Heavy Equipment, Inc., 90 Or App 365 (1988). Consequently, we conclude that claimant's permanent total disability benefits should begin as of April 18, 1986.

ORDER

The Referee's order dated March 20, 1987 is reversed. Claimant is granted permanent total disability, in lieu of all earlier awards of unscheduled permanent partial disability, effective April 18, 1986. Claimant's attorney is awarded an approved fee of 25 percent of the increased compensation created by this order. However, claimant's attorney's fees for services at the hearing level and on Board review shall not exceed $6,000. The SAIF Corporation is authorized to offset against the permanent total disability award the permanent partial disability benefits awarded by the Referee's order.

The Beneficiaries of
THOMAS McBROOM (Deceased), Claimant
Pozzi, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys
Joseph D. Davis, Attorney

WCB TP-87029
August 5, 1988
Order Denying Request

The paying agency's counsel seeks Board authorization of a client-paid fee for services which culminated in the Board's May 25, 1988 Third Party Distribution Order. The request is denied.

FINDINGS

On December 1, 1987, claimant petitioned the Board to resolve a dispute concerning the proper distribution of the proceeds from a third party judgment. See ORS 656.593. On December 30, 1987, the paying agency's response was filed with the Board. On

January 28, 1988, claimant filed a reply brief, which was the last brief filed in this case.

On May 25, 1988, we issued a Third Party Distribution Order, directing that claimant receive a share of the proceeds from a third party judgment. On June 24, 1988, we declined to grant the paying agency's request to abate and reconsider our May 25, 1988 Third Party Distribution Order. Also on June 24, 1988, the paying agency appealed our May 25, 1988 order to the Court of Appeals.

On July 14, 1988, the paying agency's counsel sought authorization of a client-paid fee for services rendered before the Board. Included with the request was an executed retainer agreement and statement of services.

CONCLUSIONS

We first must determine whether a request for authorization of a client-paid fee in a third party case is necessary. To do so, we turn to the relevant statutory and regulatory law.

Pursuant to ORS 656.388(1), no claim or payment for legal services by an attorney representing the worker or by an attorney, other than a salaried staff attorney, representing the insurer or self-insured employer, or for any other services rendered before a Referee or the Board, in respect to any claim or award for compensation to or on account of any person, shall be valid unless approved by the Referee or the Board. In accordance with this statute, the Board has promulgated rules relating to the allowance or award of attorney fees in contested cases under the Workers' Compensation Law. See OAR 438-15-001 et seq. These rules became effective January 1, 1988 and apply to all cases pending before the Hearings Division and the Board. OAR 438-05-010; 438-15-003.

OAR 438-15-015 provides that no charge for legal services for representation of claimants, insurers or self-insured employers in connection with any claim under ORS Chapter 656 is valid unless the charge has been authorized in accordance with ORS 656.307, 656.382 to 656.390 or 656.593 or these rules. ORS 656.593 describes the applicable procedures to follow when a worker elects to bring a third party action. However, the statute contains no procedure concerning the authorization of a client-paid fee to the attorney for the paying agency.

Thus, to receive authorization for a client-paid fee in a third party case, the requesting attorney must turn to the Board's rules. Under the Board's rules, an executed attorney retainer agreement and a statement of services must be filed. OAR 438-15-010(1), (5).

The Board's rules do discuss attorney fees in third party cases. See OAR 438-15-095. In effect, the rule serves as the "advisory schedule of fees established by the board" as described in ORS 656.593(1)(a). The requirement of a statement of services is specifically exempted from attorney fees authorized under OAR 438-15-095. Yet, because the aforementioned rule only addresses attorney fees to plaintiffs in third party cases, we find that the exemption from filing a statement of services does not apply to an attorney for a paying agency seeking authorization of a client-paid fee.

Accordingly, we conclude that authorization is required before an attorney for a paying agency can charge for legal services rendered in a third party case. See OAR 438-15-015. To receive authorization for a client-paid fee in third party cases, the requesting attorney must file an executed retainer agreement and a statement of services. See OAR 438-15-010(1), (5). The agreement and statement will be considered in conjunction with the Board's review of the third party dispute and authorization to charge the client-paid fee will be included with the Board's order.

We next turn to the question of whether we have jurisdiction to consider the attorney fee request. 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. See International Paper Co. v. Wright, 80 Or App 444, 447 (1986).

Attorney fee awards are generally included within orders concerning the merits of the case. The Supreme Court does not dispute the efficiency of such a practice. See Greenslitt v. City of Lake Oswego, 305 Or 530, 534-35 & n. 3 (1988). Moreover, it has concluded that if the merits of the case are appealed, the attorney fees issue becomes part of the appeal. Id.

Yet, the determination of an attorney fee does not directly affect a worker's right to, or amount of, compensation due. Farmers Ins. Group v. SAIF, 301 Or 612, 619 (1986). Thus, the Court has suggested that the attorney fee award need not accompany an order regarding the merits of the case. Greenslitt v. City of Lake Oswego, supra; Farmers Ins. Group v. SAIF, supra. The Court has further indicated that once a Referee's or Board's order on attorney fees becomes final, the appropriate forum for review of attorney fees is the circuit court pursuant to the unique provisions of ORS 656.388(2). Greenslitt v. City of Lake Oswego, supra; Farmers Ins. Group v. SAIF, supra, at page 619.

Here, our May 25, 1988 order did not address the issue of either the paying agency's counsel's entitlement to, or the amount of, a client-paid fee. Consequently, based on the aforementioned authorities, we conclude that we have jurisdiction to consider the request for authorization of a client-paid fee.

Although we have jurisdiction to entertain the attorney fee issue, we turn to the Board's rules to determine whether the request for authorization of a client-paid fee is properly before us. We conclude that the current request is untimely.

The Board's rules concerning the filing of statements of services do not expressly discuss third party proceedings. See OAR 438-15-027. However, the rules do establish the time for the filing of statements for other Board proceedings. For example, statements of services for proceedings before the Board in own motion matters shall be filed within 30 days after mailing of the Board's order. OAR 438-15-027(1)(c). In addition, statements of services for proceedings on Board review of a Referee's order are due within 15 days after the filing of the last brief to the Board. OAR 438-15-027(1)(d).

Here, the paying agency's counsel has requested

authorization of a client-paid fee, enclosing an executed attorney retainer agreement and a statement of services. Yet, the request has been submitted nearly 6 months after the filing of the last brief, some 50 days after the issuance of the Board's May 25, 1988 order and approximately 20 days after the Board's order was appealed to the Court of Appeals. In keeping with the Board's filing requirements for statements of services in other proceedings, we conclude that the request for authorization of a client-paid fee in this third party case is untimely.

We recognize that administrative problems have arisen as parties become accustomed to the Board's rules and, particularly, the application of the rules to all pending cases. However, the difficulties occasioned by this adjustment should not prompt us to ignore the very rules which have been implemented. See Franklin Brown, 40 Van Natta 786 (July 18, 1988).

Inasmuch as the request for a client-paid fee is untimely and because jurisdiction to consider the merits of the case presently rests with the Court of Appeals, we decline to authorize the paying agency's counsel's request. To the extent that our analysis conflicts with the reasoning expressed in Marian S. Dumas, 40 Van Natta 109 (1988), and John L. Rousseau, 40 Van Natta 115 (1988), that reasoning is expressly disavowed.

In reaching this conclusion, we wish to stress that we are neither questioning the paying agency's counsel's entitlement to, nor the amount of, a requested client-paid fee. We are only stating that, for the reasons discussed above, we are unable to approve the request.

IT IS SO ORDERED.

BEVERLY NEWKIRK, Claimant
Black, et al., Claimant's Attorneys
Giesy, Greer, et al., Defense Attorneys
Moscato, et al., Defense Attorneys

WCB 85-11733
August 5, 1988
Order on Remand

This matter is before the Board on remand from the Court of Appeals. Newkirk v. Curry Good Samaritan Center, 90 Or App 208 (1988). The court concluded that claimant's temporary total disability should be based on her weekly earnings for the five full weeks of her employment, before the week she stopped working. Consequently, the court held that claimant's temporary total disability benefits should be calculated on a weekly average of 33.65 hours, rather than the 32.6 weekly average used by the self-insured employer.

Consistent with the court's opinion, claimant is awarded the difference between temporary total disability benefits based on a weekly average of 33.65 hours and the temporary total disability benefits calculated on a weekly average of 32.6 hours which she has previously received. Claimant's attorney is awarded 25 percent of the increased compensation resulting from this order, to be paid from, rather than in addition to, claimant's compensation.

IT IS SO ORDERED.

MARK S. GEIMER, Claimant
Bloom, Marandas & Sly, Claimant's Attorneys
Kevin L. Mannix, Defense Attorney

WCB 86-09965
August 11, 1988
Order on Review

Reviewed by Board Members Ferris and Crider.

The insurer requests review of those portions of Referee Galton's order which: (1) awarded claimant additional temporary disability; (2) assessed penalties and attorney fees for an alleged unreasonable unilateral termination of time loss benefits; and (3) increased claimant's scheduled permanent disability award for loss of use or function of his left foot (ankle) from 55 percent (74.25 degrees), as awarded by Determination Order, to 75 percent (101.25 degrees). Claimant cross-requests review of that portion of the Referee's order which found claimant's claim was not prematurely closed. We affirm.

ISSUES

1. Whether claimant's claim was prematurely closed by Determination Order dated September 3, 1986.

2. Whether claimant was entitled to temporary disability benefits beyond July 1, 1986.

3. Whether the insurer's unilateral termination of claimant's time loss benefits was unreasonable.

4. Whether claimant was entitled to 75 percent scheduled disability for loss of use or function of his left ankle.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW

We adopt the Referee's conclusions of law as our own with the following comments.

Premature claim closure

The Referee found that the evidence overwhelmingly established that claimant did not become medically stationary until August 15, 1986. We agree and adopt the Referee's reasoning.

Claimant's back complaints were not known by the insurer until Dr. Walker's October 3, 1986 report. Post-closure reports are proper medical evidence on the issue of claimant's medically stationary date, even though not available to the Evaluation Division at the time of closure, provided they address claimant's condition at the time of closure. Schuening v. J.R. Simplot & Co., 84 Or App 622, rev den 303 Or 590 (1987).

Dr. Walker did not examine claimant until September 30, 1986, several weeks after issuance of the September 3, 1986 Determination Order. Neither Dr. Walker's First Medical Report of October 3, 1986 nor his letter of April 13, 1987 address claimant's condition as of September 3, 1986. Rather, they simply state that as of those reports, claimant's back

condition was not medically stationary. Furthermoore, we are unable to determine from these reports whether claimant's condition was not medically stationary at the time of closure or whether he suffered an aggravation thereafter. Assuming, arguendo, that claimant suffered from a back disorder related to the compensable injury, the evidence is insufficient to establish that he suffered such a condition at the time of closure and that he was not stationary at that time. Austin v. Consolidated Freightways, 74 Or App 680 (1984). Therefore, the Referee correctly concluded that the claim was not prematurely closed.

Unilateral time loss termination

The Referee found that Dr. Kiest, claimant's treating physician, gave claimant a tentative release to attempt a trial return to regular work. He held that this "trial basis" at regular work did not warrant the termination of temporary disability benefits. We agree and adopt the Referee's reasoning with the following supplement.

ORS 656.268(2)(c) provides in part:

> "If the attending physician has not approved the worker's return to the worker's regular employment, the insurer or self-insured employer must continue to make temporary total disability payments until termination of such payments is authorized following examination of the medical reports submitted to the Department of Insurance and Finance under this section."

We have previously held that a trial release does not terminate an insurer's duty to pay time loss. Wayne A. Volk, 36 Van Natta 1083, 1084 (1984). In Volk, two physicians released claimant to return to regular work. SAIF subsequently discontinued payment of temporary benefits. We found that the releases were on a trial basis. We held that SAIF had a duty to continue paying time loss until a Determination Order issued, until claimant actually returned to full time regular work or until he obtained a full release. We also held that penalties were not warranted as SAIF had not acted unreasonably. The Court of Appeals reversed on the penalty issue only. Volk v. SAIF, 73 Or App 643 (1985).

We conclude that a worker's release to return to work on a "trial basis" does not extinguish his entitlement to temporary disability benefits. Instead, the amount of benefits is subject to reduction for wages actually earned. See Donald W. Courtier, 39 Van Natta 705, 708 (1987).

On July 1, 1986, Dr. Kiest opined that claimant was not medically stationary, but he gave claimant a tentative release to his regular work on a trial basis to see if he could actually perform the job. Subsequent reports from Dr. Kiest did not alter this "trial basis" strategy.

On August 15, 1986, Dr. Kiest found claimant medically stationary.

The record unequivocally reflects Dr. Kiest's plan to return claimant to his regular work on a trial basis due to the doctor's doubts concerning claimant's vocational rehabilitation

potential. Therefore, the insurer improperly terminated claimant's temporary disability benefits. Benefits should have been paid until the issuance of the September 3, 1986 Determination Order subject to a reduction of wages actually earned.

ORDER

The Referee's order dated June 17, 1987 is affirmed. Claimant's attorney is awarded an assessed fee of $300 for services rendered on Board review, to be paid by the insurer. A client-paid fee not to exceed $300 is approved.

DOUGLAS J. HAGNER, Claimant
Wittrock & O'Brien, Claimant's Attorneys
Acker, et al., Defense Attorneys

WCB 87-03784
August 11, 1988
Order on Review

Reviewed by Board Members Ferris and Crider.

Claimant requests review of Referee Thye's order which: (1) upheld the insurer's denial of his occupational disease claim for bilateral carpal tunnel syndrome; and (2) declined to assess a penalty and attorney fee for the alleged unreasonable denial. On review, claimant contends that this case should be remanded to the Referee for the taking of further medical evidence. We affirm.

ISSUES

1. Remand for taking of additional evidence.
2. Compensability of claimant's occupational disease claim for bilateral carpal tunnel syndrome.
3. Penalty and attorney fee on the ground that the insurer's denial was unreasonable.

FINDINGS OF FACT

Claimant began working for the employer as a tow truck operator in mid-November 1986. During the first three or four weeks of his employment, claimant hauled cars only. Sometime during this period, he complained to his supervisor of numbness in his hands and indicated that they had been numb for a while.

Thereafter, he hauled mostly trucks and an occasional trailer. When towing trailers he was required to use a wheel assembly, called a "fifth wheel." The assembly could be operated automatically with no lifting required, but if operated manually, it could be operated without lifting more than 20 pounds. Manual operation of the assembly required insertion and removal of pins necessary to hold the assembly in place. Claimant used the "fifth wheel" approximately once per week.

On January 12, 1987, claimant saw Dr. Cohen for numbness and shooting pains in both arms. Claimant told Cohen that he had been experiencing symptoms in both arms during the previous two-and-a-half months. Cohen took him off work and referred him for a neurological evaluation by Dr. Podemski. The diagnosis was bilateral carpal tunnel syndrome.

Dr. Cohen opined that the bilateral condition was work related, based on claimant's history that he had to use the "fifth wheel" three or four times daily and that he developed the symptoms after using that assembly.

The insurer denied the compensability of the condition on January 23, 1987. We are unable to find that work activities were a significant cause of claimant's bilateral carpal tunnel syndrome.

We find that both parties had an adequate opportunity to present evidence on the substantive issues in this case.

CONCLUSIONS AND OPINION

Remand

We may remand to the Referee for further evidence taking if we determine that this case has been "improperly, incompletely or otherwise insufficiently developed or heard by the referee." ORS 656.295(5). To merit remand, claimant must establish that the evidence relevant to the issues raised in the request to remand was unobtainable with due diligence before the hearing. See Bernard L. Osborn, 37 Van Natta 1054, 1055 (1985), aff'd mem 80 Or App 152 (1986). Here, the medical evidence sought by claimant was readily obtainable prior to hearing. Indeed, both parties had an adequate opportunity to present evidence on the substantive issues in this case. We conclude that this record has not been "improperly, incompletely or otherwise insufficiently developed." Remand is not warranted.

Compensability

To establish a compensable occupational disease claim, claimant has the burden of proving that his work activities were the major contributing cause of either the onset or the worsening of his bilateral carpal tunnel syndrome. See former ORS 656.802(1)(a); Dethlefs v. Hyster Co., 295 Or 298, 310 (1983); Blakely v. SAIF, 89 Or App 653, 656 (1988).

We adopt the "OPINION" portion of the Referee's order, and conclude that claimant has not proven that work activities were the major contributing cause of either the onset or worsening of his bilateral carpal tunnel syndrome. Because there was no reliable evidence to support compensability, we further conclude that the insurer's denial was reasonable and that a penalty and attorney fee are not warranted.

ORDER

The Referee's order dated June 12, 1987 is affirmed.

DENNIS KNIGHT, Claimant
SAIF Corp, Insurance Carrier

Own Motion 88-0425M
August 11, 1988
Own Motion Order

SAIF Corporation has submitted to the Board claimant's claim for an alleged worsening of his March 26, 1979 industrial injury. Claimant's aggravation rights have expired. SAIF opposes reopening of this claim for the payment of temporary total disability compensation as claimant's treatment plan does not qualify under ORS 656.278 and claimant has removed himself from the work force.

Pursuant to ORS 656.278(1)(a), we may exercise our "Own Motion" authority to award temporary disability benefits only when

we find that there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. In such cases, we are authorized to award temporary disability compensation commencing from the time the worker is actually hospitalized or undergoes outpatient surgery. Claimant plans to attend a three-week pain center program on a outpatient basis. We conclude this does not satisfy the criteria in ORS 656.278 and OAR 438-12-052(2). Therefore, the request for own motion relief must be denied.

IT IS SO ORDERED.

DOUGLAS MEULER, Claimant
Emmons, Kyle, et al., Claimant's Attorneys
John Motley (SAIF), Defense Attorney

WCB 88-00373
August 11, 1988
Order of Dismissal

Claimant has requested review of Referee Hettle's May 20, 1988 order. We have reviewed the request to determine whether we have jurisdiction to consider the matter. We conclude that we lack jurisdiction.

FINDINGS

On May 20, 1988, the Referee issued his order that: (1) upheld the SAIF Corporation's denial of claimant's aggravation claim for his current bilateral hand and wrist condition; and (2) upheld SAIF's denial of claimant's current brachial plexus and/or thoracic outlet syndrome. Copies of the order were mailed to all parties to the hearing on May 20, 1988. However, the envelope containing the copy mailed to claimant was "returned to sender" by the U.S. Postal Service as undeliverable. On May 26, 1988, a copy of the order was remailed to claimant. Claimant received this copy.

On June 24, 1988, the Board received claimant's request for review. The request did not include an acknowledgment of service or a certificate of personal service by mail upon any of the parties who appeared at the hearing and their attorneys. See OAR 438-05-046(2)(b); 438-11-005(3).

The request for Board review was filed within 30 days after the date on which a copy of the order was mailed to all the parties to the hearing. However, neither the employer nor its representatives have received notice of claimant's request for review within 30 days of the date on which a copy of the order was mailed to all the parties.

CONCLUSIONS

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). 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. Argonaut Insurance Co. v. King, 63 Or App 847, 852 (1983).

A Referee's order shall be mailed to all parties in interest. ORS 656.289(2). If a Referee's order is not mailed to all parties, the order is not final and is not subject to Board review.

ORS 656.289(2), (3); Armstrong v. SAIF, 65 Or App 809 (1983), after remand 67 Or App 498 (1984); Robert E. Lundeen, 38 Van Natta 1388 (1986).

Here, copies of the Referee's May 20, 1988 order were mailed to all the parties to the hearing the day the order issued. Yet, the envelope addressed to claimant, which contained a copy of the order, was "returned to sender" as undeliverable. This misdelivery was corrected on May 26, 1988, when a copy of the order was properly mailed to claimant. Thus, the Referee's order was neither final nor subject to Board review until May 26, 1988. See ORS 656.289(2); Armstrong v. SAIF, supra; Robert E. Lundeen, supra.

The 30th day after May 26, 1988 was June 25, 1988, a Saturday. Therefore, the last day to timely submit a request for Board review of the Referee's order was Monday June 27, 1988. See ORS 174.120. Inasmuch as claimant's request was received on June 24, 1988, it was timely. See ORS 656.289(2), (3).

However, neither the employer nor its representatives were timely provided with, or received actual knowledge of, the request within the statutory 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); 656.295(2); Argonaut Insurance v. King, supra.

We are mindful that claimant has requested review without benefit of legal representation. We further realize that an unrepresented party is not expected to be familiar with administrative and procedural requirements of the Workers' Compensation Law. Yet, we are not free to relax a jurisdictional requirement, particularly in view of Argonaut Insurance Co. v. King, supra. See Alfred F. Puglisi, 39 Van Natta 310 (1987); Julio P. Lopez, 38 Van Natta 862 (1986).

Accordingly, the request for Board review is dismissed.

COLLETTE J. NORTON, Claimant
Pozzi, Wilson, et al., Claimant's Attorneys
Kevin L. Mannix, Defense Attorney

WCB 86-11887
August 11, 1988
Order on Review

Reviewed by Board Members Ferris and Crider.

The insurer requests review of Referee T. Lavere Johnson's order that increased claimant's unscheduled permanent disability for her neck and back injury from 15 percent (48 degrees), as awarded by a previous Determination Order, to 35 percent (112 degrees). In addition, the insurer has asked that this case be remanded to the referee for inclusion of a post-hearing report. We affirm the order of the Referee.

ISSUES

1. Remand;

2. Extent of claimant's unscheduled permanent disability.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

We adopt the Referee's conclusions of law as supplemented.

The insurer submitted a motion requesting remand for consideration of a doctor's report received one month after the hearing. In the report, claimant stated she helped with farm chores.

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. ORS 656.295(5). To merit remand, it must be established that the evidence is relevant to the issues raised in the remand request and was unobtainable with due diligence before the hearing. See Bernard L. Osborne, 37 Van Natta 1054, 1055 (1985), aff'd mem 80 Or App 152 (1986). Moreover, we must find that the record is incomplete without it.

After conducting our review of this matter, we are persuaded that the present record, without inclusion of the proffered 1987 Oregon Health Sciences report, is sufficiently developed. Claimant testified on cross-examination regarding the work activities she performed during the day and in the evening on the farm. Specifically, she testified that she helps with weeding and feeding the cows. As the record contains evidence of claimant performing work relating to the farm, the requested evidence is cumulative. Therefore, we do not consider remand to be an appropriate action. Accordingly, the request is denied.

Turning to the merits, we affirm the order of the Referee.

Claimant's counsel is statutorily entitled to a reasonable, carrier-paid attorney fee for services rendered on Board review. See ORS 656.382(2). Such a fee is defined as an "assessed fee." OAR 438-15-005(2). However, we cannot authorize an assessed fee unless claimant's counsel files a statement of services. See OAR 438-15-010(5). Because no statement of services has been received to date, an assessed fee shall not be authorized.

ORDER

The Referee's order dated May 19, 1987 is affirmed.

EARL E. PFAENDLER, Claimant
Myrick, Coulter, et al., Claimant's Attorneys
Cowling & Heysell, Defense Attorneys

WCB 86-03949
August 11, 1988
Order on Review

Reviewed by Board Members Ferris and Crider.

The self-insured employer requests review of Referee Leahy's order which set aside its denial of claimant's dermititis condition. The sole issue is compensability. We affirm.

FINDINGS OF FACT

Claimant worked as a millwright and shop foreman for the employer. In June 1982 he developed a small patch of eczema on his right foot which, over the course of a year, gradually spread to both legs, the lower trunk and both arms. In January 1983 he began treating with with Dr. Naversen, a

dermatologist. Dr. Naversen referred him for hospitalization at the Oregon Health Sciences University (OHSU). Upon discharge from OHSU in August 1983, claimant was diagnosed as having nummular dermititis and venous varicosities.

On October 7, 1983, claimant filed a claim for "allergic reaction" to chemicals at work, listing his symptoms as "severe weeping sores, involving legs, arms, nose, throat, eyes, and lower back." In addition, Dr. Naversen submitted a Form 827 (First Medical Report), reporting the diagnosis of nummular dermititis with secondary infection, aggravated by varicose veins. Dr. Naversen also wrote that patch testing was positive for formaldehydes, which are present at claimant's work site.

On October 17, 1983, the claim was accepted for a disabling occupational disease on the same claim form that claimant had submitted. The employer's claims administrator subsequently processed the claim for more than two years.

Claimant retired from work on September 30, 1985. He continued to have nummular eczema all over his body. Due to the lack of work exposure, Dr. Naversen opined that the condition was not work related, but rather, was related to vascular insufficiency in the lower legs.

On February 25, 1986, the employer issued a denial letter, stating that the accepted "industrial dermititis" had cleared up and that it was now denying responsibility for the current "non-industrial eczema." We find that the employer was attempting to deny the same skin condition which it had already accepted in 1983.

CONCLUSIONS AND OPINION

The dispositive issue on Board review is whether the employer's denial is barred by ORS 656.262(6), as construed in Bauman v. SAIF, 295 Or 788 (1983). We conclude that the denial is barred.

ORS 656.262(6) requires acceptance or denial of a claim within 60 days after the employer has notice or knowledge of the claim. Once the claim is "specifically" or "officially" accepted under ORS 656.262(6), the employer may not, after the 60 days have elapsed, deny the compensability of that claim unless there is a showing of fraud, misrepresentation or other illegal activity. Johnson v. Spectra Physics, 303 Or 49, 55 (1987); Bauman v. SAIF, supra, 295 Or at 793-94.

Here, the employer attempts to distinguish between claimant's "industrial dermititis" condition and his "non-industrial eczema" condition. However, the record is devoid of any evidence in support of that distinction. Indeed, claimant credibly testified that his symptoms have remained the same since his retirement. In addition, the diagnosis of claimant's skin condition -- nummular dermititis -- has essentially remained the same. The employer specifically and officially accepted that condition on the same claim form submitted by claimant, and subsequently paid benefits for more than two years. The employer attempted to deny the condition only after Dr. Naversen concluded that the condition was not work related. There is no showing of fraud, misrepresentation

or other illegal activity. The denial was not proper. See Georgia-Pacific v. Piwowar, 305 Or 494, 501 (1988); Bauman v. SAIF, supra.

ORDER

The Referee's order dated June 22, 1987 is affirmed. Claimant's attorney is awarded an assessed fee of $600 to be paid by the self-insured employer. The Board approves a client-paid fee not to exceed $877.

RONALD A. SHAMBERGER, Claimant
Callahan, Hittle, et al., Claimant's Attorneys
Gary Wallmark (SAIF), Defense Attorney

WCB 86-02880
August 11, 1988
Order on Review

Reviewed by Board Members Ferris and Crider.

Claimant requests review of that portion of Referee Seymour's order that rejected his request for penalties and attorney fees for the SAIF Corporation's alleged unreasonable conduct in processing his claim for massage services. The issue is penalties and attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

Claimant sustained a compensable injury to his back, elbow and shoulder. His treating physician was Dr. Wilson, chiropractor. Dr. Wilson referred claimant for massage therapy. In January 1985, claimant began receiving massage treatments at the Family Massage Center. Claimant initially paid for these treatments himself.

On October 8, 1985, SAIF received a bill from the Family Massage Center for seven treatments. This bill represented a claim for medical services. Three weeks later, SAIF sent a letter to Dr. Wilson stating that in order to pay for massage therapy, SAIF would need both a copy of the doctor's prescription for the therapy and a treatment plan. SAIF also stated that the therapy must be administered under the direct supervision of a doctor.

Dr. Wilson responded with a letter to SAIF enclosing a copy of a note prescribing one treatment a month for claimant. Dr. Wilson noted that the treatments were benefiting claimant, and he stated that he doubted any physician was actually physically present to directly supervise physical therapy.

Receipt of this letter triggered a second letter from SAIF, this one to the Family Massage Center. The letter returned the Center's billing and stated that additional information was needed. A copy of a portion of former OAR 436-69-201 [now OAR 436-10-040] was included with the letter. The Center made no response.

On February 25, 1986, claimant filed a request for hearing indicating the issues as "Refusal of medial [sic] care and treatment...", along with penalties and attorney fees.

On June 9, 1986, SAIF received a second set of billings from the Center. SAIF responded by letter to the Center stating that the therapy was not provided under the direct supervision of the physician and, therefore, was not reimbursable.

CONCLUSIONS AND OPINION

The Referee agreed with SAIF that the treatments were not compensable. See Verna Herb, 37 Van Natta 1247 (1985). Claimant does not challenge this ruling. The Referee also concluded that, since no compensation had been delayed, no penalties could be imposed. See ORS 656.262(10). The Referee further concluded that no attorney fees were payable by SAIF. The Referee reasoned that SAIF was not required to issue a denial because there was no request for medical services. He explained that a billing for massage therapy without a statement from the attending physician stating that it was done under the physician's direct supervision cannot be considered a billing for a "medical service."

We conclude that the submission of the bill was a claim for "medical services." See OAR 436-10-005(17). However, as the Referee properly found, it was a claim for noncompensable medical services. Nevertheless, it was a claim requiring processing by SAIF. The issues therefore are whether SAIF's delay in accepting or denying the claim was reasonable, see ORS 656.262(10), and whether penalties and attorney fees are appropriate.

SAIF first learned of the claim upon its October 8, 1985 receipt of the billing from the Center. SAIF timely responded by sending a letter to Dr. Wilson, the attending physician, requesting more information. This entitled SAIF to delay its acceptance or denial of the claim for a reasonable time. See Kevin Bethel, 36 Van Natta 1060 (1984).

Dr. Wilson's response letter did not fully respond to the minimum requirements for compensability established in Verna Herb, supra. After receiving Dr. Wilson's letter, SAIF sent a letter to the Center requesting additional information. Rather than specifying precisely what additional information was needed, SAIF simply copied a portion of the administrative rules and mailed it to the Center along with a cover letter. The Referee referred to this copied material as not having "anything to do with the matter at hand."

The Center never responded. SAIF never followed up its request for additional information. Moreover, claimant did not receive a copy of any of this correspondence, although we have required notification to the claimant when payment for services is denied. See Billy J. Eubanks, 35 Van Natta 131 (1983).

We conclude that SAIF unreasonably delayed processing the bill. Our conclusion is based upon the inadequate nature of SAIF's request for additional information from the Family Massage Center. The copy of the rule provided to the Center was incomplete. Moreover, we noted in Verna Herb, supra, that the rule in question is not directly applicable to massage therapy. Verna Herb, 37 Van Natta at 1248. We consider it unreasonable for SAIF to have expected such a request to generate the response necessary in order to reach an appropriate decision to accept or deny the claim.

Having concluded that SAIF's request for additional information was inadequate, we need not decide whether SAIF was obligated to follow up its request within a reasonable period of time. See Kevin Bethel, supra.

No penalties are due, however, because a penalty can only be assessed against "amounts then due." ORS 656.262(10). Here, there were no "amounts then due" because the massage therapy was found to be noncompensable. John D. Ellis, 39 Van Natta 319 (1987).

Unlike a penalty, however, an attorney fee can be awarded even though there are no "amounts then due." Mischel v. Portland General Electric Co., 89 Or App 140, 143 (1987); Spivey v. SAIF, 79 Or App 568, 572 (1986). We therefore award a reasonable attorney fee to claimant's counsel.

ORDER

The Referee's order dated March 4, 1987 is affirmed in part and reversed in part. Claimant's attorney is awarded an assessed fee of $400 to be paid by the SAIF Corporation. The remainder of the Referee's order is affirmed.

JOANN SPIVEY, Claimant
Vick & Gutzler, Claimant's Attorneys
Rick Dawson (SAIF), Defense Attorney

WCB 86-10532
August 11, 1988
Order on Review

Reviewed by Board Members Johnson and Crider.

Claimant requested review of that portion of Referee Thye's order which allowed the SAIF Corporation to offset temporary disability benefits paid subsequent to March 28, 1986, the date her condition was found to be medically stationary. SAIF cross-requests review of that portion of the order which directed it to pay for diagnostic procedures related to urinary problems. The issues on review are the date claimant became medically stationary and compensability of diagnostic services.

ISSUES

1. Whether claimant is entitled to temporary total disability benefits subsequent to the date she became medically stationary with respect to her compensable injury.

2. Whether diagnostic procedures for symptoms of a condition ultimately found not related to the industrial injury are compensable.

FINDINGS OF FACT

Claimant sustained compensable cervical, dorsal, and lumbosacral sprains on September 21, 1984, when she slipped and fell while working for an auto supply company, SAIF's insured. She originally treated conservatively with Dr. Becker, orthopedist, and, on June 28, 1985, she changed treating physicians to Dr. Moore, a chiropractor.

On February 13, 1986, Dr. Stranburg, a urologist, saw claimant in consultation. He reported a history of intermittent urinary spotting and incontinence, beginning shortly after the industrial injury and becoming worse during the preceding four months. Dr. Stranburg recommended an IVP, a cystomatrogram, and a cystoscopic examination.

Claimant became medically stationary with respect to her compensable injury on March 28, 1986.

On October 15, 1986, SAIF denied responsibility for claimant's hematuria and urinary incontinence and the associated diagnostic procedures. Claimant's urinary problems were ultimately found not compensable. She does not dispute that finding. The Referee, nevertheless, ordered SAIF Corporation to pay for the diagnostic procedures.

CONCLUSIONS AND OPINION

We affirm and adopt the opinion of the Referee, with the following additional comments.

Temporary Total Disability

The Referee found that claimant's compensable condition had become medically stationary on March 28, 1986. Claimant does not dispute that finding. She contends, however, that she is entitled to temporary total disability for the period after she became medically stationary until the date of Dr. Stolzberg's examination because it was not yet determined whether or not the urinary problems were compensable and the condition had not yet been denied. We disagree.

Claimant is substantively entitled to temporary total disability benefits until the date her compensable condition becomes medically stationary. That she is procedurally entitled to such benefits until the Determination Order issues does not affect her substantive entitlement and a possible offset for the insurer. Although the claim was not closed by Determination Order until October 24, 1986, claimant was medically stationary on March 28, and is entitled to temporary disability benefits through that date.

Compensability of Diagnostic Tests

SAIF concedes that tests performed to determine the cause of a condition, even though the condition is ultimately found to be noncompensable, may be compensable. In this case, Dr. Stranburg recommended certain tests to diagnose a condition which had manifested symptoms since shortly after claimant's compensable injury. In order to determine causation, a condition must first be diagnosed. We do not see a distinction between the diagnostic tests which preceded the examination performed to determine the cause of the condition and the examination to determine the cause. We conclude that the tests recommended by Dr. Stranburg are compensable.

ORDER

The Referee's order dated May 23, 1987, is affirmed. The SAIF Corporation shall pay to claimant's attorney an assessed fee of $500 for services performed on Board review.

VELMA C. WILCH, Claimant
Charles D. Maier, Claimant's Attorney
Ann Kelley (SAIF), Defense Attorney

WCB 86-09754
August 11, 1988
Order on Review

Reviewed by Board Members Ferris and Crider.

The SAIF Corporation requests review of those portions of Referee Baker's order that: (1) directed it to pay medical service billings that were not timely denied; and (2) assessed a penalty and attorney fee for untimely denial of those billings. In her brief, claimant contends that the Referee erroneously upheld SAIF's denial of current chiropractic treatment relating to her low back condition. We reverse those portions of the Referee's order that required SAIF to pay medical service billings that were not timely denied and that assessed a penalty based upon the amount of those untimely denied billings.

ISSUES

1. Compensability of claimant's chiropractic treatments.

2. If noncompensable, whether SAIF is nevertheless required to pay untimely denied medical service billings.

3. Penalties and attorney fees for untimely denial.

FINDINGS OF FACT

Claimant, 70 years old as of the date of hearing, suffered a compensable back injury in 1970 while employed by SAIF's insured. She experienced additional injuries to her back in 1971, 1972 and 1980. She received chiropractic treatments following each of these injuries. Claimant retired in 1978. Subsequent to 1980, claimant sought only occasional chiropractic treatment.

In 1986, claimant was accompanying her husband to a chiropractic appointment when the chiropractor, Dr. Utter, noticed that claimant walked in a guarded manner. Dr. Utter opined that claimant would benefit from chiropractic treatment. Claimant replied that she could not afford treatment. Dr. Utter asked how claimant originally injured her back. Claimant told him of the 1970 work injury. Dr. Utter suggested that the 1970 claim could be "reopened" so that SAIF paid for the treatments.

Claimant began receiving treatments from Dr. Utter on April 2, 1986. SAIF received billings for chiropractic treatments on April 21, 1986 and April 28, 1986. SAIF issued its denial of these billings on July 7, 1986.

Claimant suffers from arthritis and lumbar disc degeneration. These conditions were neither caused nor worsened by the compensable 1970 injury.

CONCLUSIONS AND OPINION

Compensability

Claimant's chiropractic treatments are compensable if the injury of 1970 continues to be a material contributing cause

of her low back condition requiring treatment. ORS 656.245; see Jordan v. SAIF, 86 Or App 29, 32 (1987).

Dr. Utter opines that claimant's current condition is causally related to her compensable 1970 injury. He theorizes that claimant's 1970 injury resulted in vertebral misalignments and spinal degeneration. He further theorizes that claimant's treatments in the past were not sufficient to totally resolve her condition and that this incomplete recovery resulted in progressive spinal degeneration.

Opposing Dr. Utter's opinion are the opinions of BBV Medical Service, Inc. and Dr. Bolin, chiropractor. A panel of physicians from BBV opined that claimant's current symptoms resulted from progressive arthritis over a number of years. They felt that the 1970 incident was merely a temporary exacerbation of this arthritic condition. Dr. Bolin also related claimant's current symptoms to her underlying arthritic condition. He opined that there was no causal relationship between claimant's current condition and the 1970 injury.

While Dr. Utter is claimant's treating physician, he did not commence treating claimant until sixteen years following the compensable injury. Consequently, his opinion as to the causal relationship between that injury and claimant's current condition is entitled to no special deference. See Harris v. Farmer's Co-op Creamery, 53 Or App 618, 625 (1981). Furthermore, Dr. Utter's opinion is unpersuasive. He first opines that traumatic spinal injuries generally result in degenerative conditions. He then opines that claimant's 1970 injury was traumatic because it resulted in a degenerative condition. This argument is essentially circular. It assumes the very fact that claimant need prove in order to prevail.

It is the opinion of the BBV panel and Dr. Bolin that claimant's 1970 injury did not cause or contribute to a worsening of her degenerative condition. These opinions are largely conclusory, just as Dr. Utter's opinion is conclusory once it is shorn of its circular argument. We are left with no persuasive medical evidence in either direction. Considering the fact that claimant is asserting a claim for medical services relating to a sixteen-year-old injury, we conclude that expert medical opinion is required to prove claimant's case. Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985). Absent persuasive medical evidence in support of her position, claimant has failed to sustain her burden of proof. See Milburn v. Weyerhaeuser, 88 Or App 375, 378 (1987).

Payment of untimely denied bills

The Referee concluded that the medical evidence did not causally connect the condition treated in April 1986 to the 1970 work incident. As explained above, we agree.

The Referee nevertheless ordered SAIF to pay the billings in question. The Referee reasoned that medical service claims must be paid or denied within 60 days after billing. ORS 656.262(6); Gloria J. King, 39 Van Natta 779 (1987). He noted that SAIF had received the two billings more than 60 days before the July 7, 1986 denial. He concluded that SAIF must, therefore, pay those billings.

Former OAR 436-69-801(4) required an insurer to pay medical bills not denied within 60 days. However, in Kemp v. Workers' Compensation Department, 65 Or App 659 (1983), rev den 296 Or 638, dec mod 67 Or App 270, rev den 297 Or 227 (1984), the Court of Appeals held that the rule exceeded the Department's authority and, therefore, was invalid. We find no other authority supporting the Referee's conclusion. We, therefore, reverse on this issue.

Penalties and attorney fees

The Referee also assessed a penalty against SAIF based upon the total of the untimely denied bills. The Board has previously held that where medical services are found to be noncompensable, there are no "amounts then due" and, consequently, there can be no penalty. ORS 656.262(10); John D. Ellis, 39 Van Natta 319 (1987). We reverse the Referee's assessment of a penalty.

An attorney fee may be assessed under ORS 656.382(1), however, even though no compensation was due. Mischel v. Portland General Electric Co., 89 Or App 140, 143 (1987). We, therefore, affirm the Referee's award of an attorney fee. In addition, having considered the relevant factors to be considered in determining the amount of the fee, we conclude that the $400 fee awarded by the Referee was appropriate. See Barbara Wheeler, 37 Van Natta 122 (1985).

ORDER

The Referee's order dated May 14, 1987 is affirmed in part and reversed in part. We reverse those portions of the order that required the SAIF Corporation to pay untimely denied medical service billings and that assessed a penalty for failure to timely process the medical service billings. The remainder of the Referee's order is affirmed.

WILLIAM E. WOOD, Claimant
Bennett, Hartman, et al., Claimant's Attorneys
Cummins, et al., Defense Attorneys

WCB 86-16273 & 87-04717
August 11, 1988
Interim Order Denying Motion to Dismiss

Claimant has moved the Board for an order withdrawing his request for review of a Referee's order insofar as it pertains to the Referee's decision in WCB Case No. 87-04717. The motion is denied.

FINDINGS OF FACT

On April 2, 1987, the Board referred claimant's request for Own Motion relief in WCB Case No. 87-0192M to the Hearings Division for consolidation with pending hearing requests in WCB Case Nos. 86-16273 and 87-04717. The Referee was instructed to provide a recommendation concerning claimant's request for Own Motion relief.

These consolidated matters were heard by Referee Galton and resulted in the following decisions. In WCB Case No. 86-16273, Referee Galton upheld the self-insured employer's denial of claimant's "new injury" claim for his current low back

condition. In addition, the Referee assessed penalties and attorney fees for unreasonable claims processing. In WCB Case No. 87-04717, Referee Galton set aside the employer's partial denial of continuing medical services for claimant's low back condition and awarded a reasonable employer-paid attorney fee. Although the Referee's decisions in these cases were separately discussed, they were encompassed within one final, appealable order. The Referee's Own Motion Recommendation in WCB Case No. 87-0192M was separately stated in an independent document.

Claimant timely requested Board review of the Referee's order. He expressly stated that "[r]eview is not requested in WCB No. 87-04717 or in those portions of WCB No. 86-16273 in which the Referee found in claimant's favor." (Emphasis in original). Inasmuch as the Referee's order carried both WCB Case Numbers, each case number was noted in the Board's acknowledgment of the request for review. Contending that he expressly did not request review in WCB Case No. 87-04717, claimant moves for dismissal of this case from the Board's review.

CONCLUSIONS OF LAW

Pursuant to ORS 656.289(3), 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 a review by the Board under ORS 656.295. The request for review by the Board of an order of a Referee need only state that the party requests a review of the order. ORS 656.295(1). The Board may affirm, reverse, modify or supplement the order of the Referee and make such disposition of the case as it determines to be appropriate. ORS 656.295(6).

The statutes expressly refer to the Board's review of the Referee's order, rather than particular case numbers. Furthermore, the courts have held that the Board's review is de novo and that it may reverse or modify the order of the Referee, or make such disposition of the case as it determines to be appropriate. Destael v. Nicolai Co., 80 Or App 596 (1986); Miller v. SAIF, 78 Or App 158 (1986); Russell v. A & D Terminals, 50 Or App 27, 31 (1981); Neely v. SAIF, 43 Or App 319, 323, rev den 288 Or 493 (1979).

Finally, the Board has repeatedly stated that it has the authority to consider a respondent's contentions notwithstanding its failure to cross-request review. Kenneth Privatsky, 38 Van Natta 1015 (1986); Jimmie Parkerson, 35 Van Natta 1247, 1249-50 (1983). Of course, under such circumstances, a respondent is at the mercy of the appellant who may choose to withdraw the request for Board review, thereby terminating the Board's jurisdiction. Id. at 1250.

In support of his motion to dismiss, claimant cites Eder v. Pilcher Construction, 89 Or App 425 (1988). In Eder, the appealing party withdrew its request for Board review of the Referee's order after the responding party, without filing a timely cross-request, questioned the validity of the Referee's order. The court agreed that the Board could reach issues raised by a responding party on de novo review without a formal cross-petition. However, the court held that the Board lost jurisdiction to exercise its review powers when the appealing party withdrew its request for review and the responding party had not timely filed a cross-request.

We do not consider the Eder decision to be contrary to the rationale expressed above. As with the aforementioned points and authorities, the Eder court discusses the Board's jurisdiction to review a Referee's order, not particular case numbers.

Case numbers are assigned purely for the administrative convenience of the agency. Neither the statutes nor the rules assign any significance to case numbers. On the contrary, the Board's rules require the Referee to consolidate for hearing cases which, although assigned different case numbers, ought to be heard together "for full determination of the issues." OAR 438-06-065. Similarly, the rules require joinder of parties prior to hearing where "joinder is necessary to determine an issue of responsibility." OAR 438-06-065. When this is done, it is the Board's practice to assign a new case number for each party joined by this procedure even though, in order to achieve a just and consistent result and to comply with the decision in Runft v. SAIF, 303 Or 493 (1987), a single hearing will be conducted and a single order will issue.

Where no party, in its request for review of the order, challenges the consolidation or joinder and the Board does not find the consolidation or joinder to have been improper, no parties may, by the terms of its request for review, limit the Board's jurisdiction to that portion of the order directed to a particular case number.

Here, the Referee heard and considered these matters on a consolidated basis. Although his conclusions and opinions in each case were separately stated, his decisions in WCB Case Nos. 86-16273 and 87-04717 were contained in one final order. Inasmuch as claimant has requested review of that order, the Board retains jurisdiction to consider all matters contained therein.

The parties are certainly encouraged to focus their arguments on specific issues present in an appealed Referee's order. However, the parties cannot attempt to limit the scope of the Board's de novo review by requesting review of only select case numbers which are included with other case numbers in the same Referee's order.

Accordingly, the motion to dismiss is denied. This matter shall now be docketed for Board review.

IT IS SO ORDERED.

LORETTA AMSTAD, Claimant
Peter O. Hansen, Claimant's Attorney
Mark P. Bronstein (SAIF), Defense Attorney

WCB 86-02367
August 12, 1988
Order on Review

Reviewed by Board Members Ferris and Crider.

Claimant requests review of those portions of Referee Mulder's order that: (1) declined to grant permanent total disability; and (2) increased claimant's unscheduled permanent disability award for a back injury from 40 percent (128 degrees), as awarded by a Determination Order, to 65 percent (208 degrees). We affirm.

ISSUES

1. Whether claimant is permanently and totally disabled.

2. If claimant is not permanently and totally disabled, whether claimant is entitled to an increased award of permanent partial disability.

FINDINGS OF FACT

On November 15, 1984, claimant, a 53 year old roofer, sustained a compensable low back injury when she slipped while hooking a kettle of tar to a truck. Dr. Bald, claimant's treating orthopedic surgeon, diagnosed a lumbosacral strain with evidence of right-sided sacral iliitis and trochanteric bursitis. Initially, claimant's lumbosacral strain was complicated by mild functional overlay.

Claimant has a fifth-grade education and has difficulty reading and writing. Her work history consists of: (1) hand launderer; (2) nurse's aide for six months; (3) bus driver for six seasons; (4) farm laborer; (5) nursery worker for nine years; and (6) roofer for four years.

On November 13, 1985, Dr. Bald reported that claimant's condition was medically stationary and that she continued to have a moderate level of impairment based primarily on pain. Physical restrictions included: (1) no lifting greater than 20 pounds; (2) no carrying greater than 30 pounds; (3) no sitting for more than 2 hours at one time; (4) no standing for more than six hours at one time; (5) no bending, squatting or crawling; and (6) only occasional twisting. He recommended that she not return to roofing.

On January 14, 1986, a Determination Order awarded claimant 40 percent (128 degrees) unscheduled permanent disability for her low back condition.

By April 21, 1986, claimant's area of pain had increased to include the upper dorsal spine and cervical region. Dr. Bald felt that the level of stress related to claimant's injury and her inability to come to grips with the consequences of her injury could be significantly contributing to the level of her physical dysfunction.

During July 1986 claimant attended the Northwest Pain Center (NWPC). The examining doctors diagnosed claimant as somatically preoccupied with a tendency to somatize stress and tension as well as a tendency to overreact to physical problems. It was their opinion that claimant saw herself as more limited than she actually was and lacked motivation for change. Although their prognosis for claimant's successful vocational rehabilitation and return to work was very guarded, she was thought to be capable of returning to full-time light-duty work.

Vocational rehabilitation testing indicated that, due to claimant's lack of educational skills, a formal training program was not possible. Based upon claimant's poor performance at the NWPC, her vocational counselor questioned claimant's motivation to return to work; claimant appeared to be focused on permanent total disability status. Goals in claimant's Return-to-Work plan included house sitter, food demonstrator, photocopy machine operator, and store buyer (plant nursery and plant maintenance).

On October 28, 1986, the Oregon City Orthopedic Clinic

found claimant to be "amazingly fit" for a 53-year-old woman who had not done any serious work for two years. They determined claimant's condition was "perception of low back pain" but reluctantly diagnosed it as a chronic lumbar strain syndrome. They believed that claimant had significant functional overlay which was compromising her physical capacity.

On November 7, 1986, Dr. Bald concurred with the Oregon City Orthopedic Clinic's October 28, 1986 report.

The level of claimant's pain complaints is not a true indication of her physical limitations. She has exaggerated her back symptoms and lacks motivation to return to work. Claimant is capable of performing light or sedentary work.

CONCLUSIONS OF LAW

The Referee declined to grant claimant permanent total disability benefits since she: (1) lacked significant physical impairment; (2) was capable of performing sedentary or light work; and (3) lacked motivation to return to work. Instead, the Referee increased claimant's 40 percent (128 degrees) permanent disability, as awarded by Determination Order, to 65 percent (208 degrees) permanent disability. We agree.

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

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

Permanent total disability can be established by proving total incapacity from a medical standpoint alone, or where incapacity is not total, by proving permanent total disability based upon the worker's less-than-total impairment combined with such nonmedical factors as age, education, adaptability, emotional conditions, and the state of the labor market. Wilson v. Weyerhaeuser, 30 Or App 403, 409 (1977).

Considering the reports from the NWPC and the Oregon City Orthopedic Clinic, as well as Dr. Bald's November 7, 1986 concurrence with the latter, we find that claimant's assertions of pain and limitations are exaggerated. Therefore, we rely on the medical evidence in assessing her permanent injury-related impairment. Considering Dr. Bald's recommended restrictions and the report by the Northwest Pain Center physicians, we are persuaded that claimant is not totally incapacitated from a medical standpoint but is physically capable of performing light or sedentary work on a full-time basis.

Claimant has the burden of proving that she is unemployable at even light or sedentary jobs, given the non-medical factors present in her case. In this regard, she has

offered the testimony of Byron McNaught, vocational counselor. He opined at hearing that claimant is not currently employable. Based on internal inconsistencies, however, we are not persuaded by his testimony. His opinion was based in part upon claimant's perceived sitting and standing limitations. As noted above, we find that claimant's assertions regarding her limitations are exaggerated. Also, although Mr. McNaught initially believed that it was futile for claimant to look for work, he later indicated that it would not be futile for claimant to attempt a job as a mailroom clerk. He further believed that claimant was employable at certain sedentary or light positions on at least a part-time basis. As noted earlier, we are persuaded by the medical evidence that claimant can do such work on a full-time basis. Even if claimant were limited to only part-time work, however, this does not necessarily warrant an entitlement to permanent total disability. See Georgia-Pacific Corporation v. Perry, 92 Or App 56 (July 6, 1988); Pournelle v. SAIF, 70 Or App 56 (1984).

Although we acknowledge that claimant's compensable lumbosacral strain has resulted in a substantial loss of earning capacity, we conclude that she has not met her burden of proving that she is permanently and totally disabled.

In rating the extent of claimant's unscheduled permanent partial disability, we consider her loss of earning capacity and physical impairment attributable to the compensable injury, 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. Harwell v. Argonaut Insurance Co., 296 Or 505, 510 (1984); Fraijo v. Fred N. Bay News Co., 59 Or App 260 (1982).

Following our review of the medical and lay evidence, and considering claimant's physical impairment, advanced age, limited education and work experience, decreased adaptability to lighter occupations, average mental capacity, and emotional and psychological condition, we conclude that an award of 65 percent unscheduled permanent disability appropriately compensates claimant for her compensable injury.

ORDER

The Referee's order dated March 16, 1987, as reissued on May 1, 1987, is affirmed.

MARY E. BRANSON, Claimant
Vick & Gutzler, Claimant's Attorneys
Bottini & Bottini, Defense Attorneys

WCB 87-01194
August 12, 1988
Order on Review

Reviewed by Board Members Ferris and Crider.

Claimant requests review of Referee Menashe's order that upheld the insurer's denial of her low back, left hip and left leg condition. On review, claimant contends that her claim is compensable whether analyzed as an injury or an occupational disease. We affirm.

FINDINGS OF FACT

Claimant, 63 years old as of the date of hearing, worked since 1979 as a cutter and sealer for a company that makes window

coverings. She had a history of low back complaints dating to 1972. In 1983, claimant was off work for approximately two months after waking up one morning with right hip, leg and back pain. She received chiropractic treatment for this condition.

In October 1986, she began working exclusively with a manual cutting machine that required her to twist her body repetitively in order to activate the cutting mechanism. She was required to activate this mechanism up to 1,000 times each workday. Claimant worked overtime during this period. She had worked with this machine in the past, but never on a continuous basis. She worked on this machine for approximately two to three weeks, until November 4, 1986, at which time she left work due to left hip, leg and low back pain. The onset of claimant's pain preceding November 4, 1986, was gradual.

The following day, November 5, 1986, claimant commenced treatment with Dr. Milam, chiropractor. Dr. Milam took claimant off work as of that date and undertook conservative treatment in the form of physiotherapy, chiropractic manipulation and exercise. Claimant had not returned to work as of the date of hearing.

Claimant has degenerative disc disease, degenerative spondylarthrosis, generalized osteoporosis and compound senile scolioses. These conditions preexisted her work exposure in question. Claimant's work activities neither caused nor accelerated the progression of these conditions.

CONCLUSIONS OF LAW AND OPINION

Claimant contends that she has a compensable claim whether characterized as an injury or an occupational disease. ORS 656.005(8)(a) and former 656.802(1). The Referee concluded that claimant had failed to prove either a compensable injury or occupational disease. Consequently, before addressing the merits of the compensability issue, we must determine whether claimant's claim is one for an industrial injury or an occupational disease.

In O'Neal v. Sisters of Providence, 22 Or App 9 (1975), the court adopted a two-pronged test for distinguishing between industrial injuries and occupational diseases:

> "'What set[s] occupational diseases apart from industrial injuries [is] both the fact that they can[not] honestly be said to be unexpected, since they [are] recognized as an inherent hazard of continued exposure to conditions of the particular employment, and the fact that they [are] sudden in onset.'" Id. at 16 (alterations in original) (quoting 1A A. Larson, The Law of Workmen's Compensation s. 41.31 (1973).

Thus, an occupational disease is distinguishable from an injury in that a disease does not arise unexpected and is gradual rather than sudden in onset. James v. SAIF, 290 Or 343, 348 (1981).

We first consider whether claimant's back problems were "unexpected." This requires that we determine whether claimant's low back, hip and leg condition in November 1986 represents an "inherent hazard of continued exposure" to her conditions of

employment. In turn, we understand this test to require an examination of the kind, rate and duration of activity or exposure alleged to be the cause of the condition. If the condition claimed was not unlikely to follow such activity or exposure, an occupational disease is suggested. If the condition claimed was not expected from such activity or exposure, an industrial injury is indicated.

The conditions of claimant's employment were such that she was required to activate the cutting mechanism up to 1,000 times each workday. In order to do so, she was required to twist, or flex, her torso each time she activated the switch. We conclude that claimant's low back, hip and leg condition was not unlikely to follow from the repetitive stress placed on her as a result of activity of this kind, rate and duration.

We next consider whether claimant's complaints are better characterized as "gradual" or "sudden" in onset. We note that the identifiable event distinguishing an injury from an occupational disease need not be an instantaneous happening. Valtinson v. SAIF, 56 Or App 184, 188 (1982). Instead, it is sufficient if the onset of problems occurs during a short, discrete period of time. Donald Drake Co. v. Lundmark, 63 Or App 261, 266 (1983).

Claimant cites Drake, supra, for the proposition that a six-week onset of symptoms satisfies the "discreet period of time" requirement for establishing an industrial injury claim. In Drake, the worker testified that the onset of his neck and back pain began at the same time that he began having transmission problems with the front-end loader that he operated. From that point on, claimant's pain progressively worsened over a six-week period. The court found that the worker's back trouble "coincided precisely" with the traumatic jolting of the faulty loader. Id. at 266. The court noted that claimant was able to point to an identifiable event that caused his disability. Id. The court concluded that claimant's pain was not "gradual in onset." Id.

Here, there is conflicting evidence regarding the onset of claimant's symptoms. In a report dated December 12, 1986, Dr. Milam recounts a three-week onset of symptoms characterized by a substantial worsening in the final week. At one point in her testimony, claimant suggested that she did not notice symptoms until November 4, 1986. She subsequently agreed, however, that she had noticed symptoms the week prior to November 4, 1986. Considering claimant's inconsistent testimony on this question, we find that the history reported by Dr. Milam, which was closest in time to the events at issue, is likely the most accurate recounting of those events. We conclude that claimant's symptoms came on gradually over a several week period until, on November 4, 1986, she was no longer able to work. We further determine that claimant's symptoms were not "sudden in onset." See AMFAC, Inc. v. Ingram, 72 Or App 168, 170 (1985) (conditions arising after two weeks of repetitive activity treated as occupational disease).

Having determined that claimant's back, hip and leg problems in November 1986 were not wholly unexpected, nor was the onset of those problems sudden, we conclude that the claim is properly classified as one for an occupational disease.

Claimant suffers from multiple underlying degenerative

conditions. Pursuant to an occupational disease analysis, claimant must prove by a preponderance of the evidence that her work activity was the major contributing cause of a worsening of her underlying diseases. Weller v. Union Carbide, 288 Or 27, 35 (1979); Amfac, Inc. v. Ingram, supra, 72 Or App at 171-72. "Worsening" in the occupational disease context means pathological exacerbation of the underlying condition. See Wheeler v. Boise Cascade Corp., 298 Or 452, 457 (1985); Weller, supra, 288 Or at 31-35.

The question whether claimant experienced a pathological exacerbation of her preexisting degenerative conditions is a complex medical question requiring expert medical anaysis. See Uris v. Compensation Department, 247 Or 420, 424-26 (1965); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985). Moreover, as the question before us requires expert medical analysis rather than expert observation, claimant's treating physician is entitled to no special deference. See Hammons v. Perini Corp., 43 Or App 299, 301 (1979).

Three medical experts offer opinions as to whether claimant's employment activities resulted in a pathological exacerbation of her underlying condition. Dr. Milam concluded that claimant's work activities caused a worsening of her underlying degenerative condition. Opposing his opinion are the opinions of two independent medical examiners -- Dr. Thompson, orthopedic surgeon, and Dr. Duncan, chiropractor. They opined that claimant's work activities did not cause a worsening of her underlying condition.

Claimant argues that the reports of Drs. Thompson and Duncan are inaccurate and, therefore, are entitled to little weight. The insurer argues that Dr. Milam's opinion is based upon an inaccurate history and, therefore, is not persuasive.

All three opinions are largely conclusory. In addition, none of the medical experts had the advantage of treating claimant prior to November 1986. However, we conclude that Dr. Milam's opinion is based on a fundamental inaccuracy. He was under the impression that, for the eight years prior to November 1986, claimant operated a machine similar to the one she was using in November 1986, requiring repetitive twisting motions of her torso. Claimant testified, however, that she used such a machine only occasionally, and then for only a portion of any workday. The remainder of the time claimant operated a machine with a foot-activated switch.

In addition, Dr. Milam was not aware that claimant had missed two months of work in 1983 due to low back, right hip and leg pain. In fact, he reported that claimant denied any similar injuries. We conclude that Dr. Milam's opinion is based upon an inaccurate history of both claimant's work conditions and her prior medical history. Therefore, we find his opinion unpersuasive. Miller v. Granite Construction Co., 28 Or App 473, 476 (1977).

We conclude that claimant has not sustained her burden of proving a worsening of her underlying condition.

ORDER

The Referee's order dated July 14, 1987 is affirmed.

DENNIS J. DESMARAIS, Claimant
Doblie & Associates, Claimant's Attorneys
Randolph Harris (SAIF), Defense Attorney

WCB 87-05998
August 12, 1988
Order on Review

Reviewed by Board Members Crider and Johnson.

The SAIF Corporation requests review of that portion of Referee Bethlahmy's order that: (1) assessed a penalty and attorney fee for its allegedly unreasonable delay and refusal to pay certain medical billings. Claimant cross-requests review of that portion of the Referee's order that declined to consider the compensability of his "medical service claims."

The Board affirms and adopts the order of the Referee as modified.

ISSUE

Whether the Referee erred in not deciding the compensability of claimant's then current medical services.

FINDINGS OF FACT

The Board adopts the findings of the Referee and makes the following additional findings.

Claimant, a construction worker, compensably injured his low back in January 1985. He was initially seen by Dr. Utterback, a physician, who diagnosed a lumbar strain and released him from work for two weeks. After returning to work, his low back pain worsened and Utterback apparently released him from work for three additional weeks. In April 1985, he began to treat with Dr. King, a chiropractor. King referred him to a radiologist for a CT scan, which revealed a mild disc bulge at L5-S1.

Thereafter, claimant apparently sustained an industrial injury to his right foot and ankle. In early 1986, he underwent right ankle surgery.

Dr. King reexamined claimant in April 1986 and found that his low back condition was very dependent on the condition of his right foot and ankle. King felt that claimant was neither medically stationary nor ready to return to regular work. In August 1986, King referred claimant to Dr. Sears, a chiropractor, for a supervised rehabilitation program. Under Sears' supervision, claimant began a rehabilitation program of swim and whirpool therapy, weight training, and calisthenics. After a few months of rehabilitation, his low back condition began to improve.

A repeat CT scan performed in October 1986, revealed a central bulging disc at L5-S1 without nerve root impingement.

Dr. King reexamined claimant in December 1986 and, as before, found that he was still neither medically stationary nor ready to return to regular work.

In approximately March 1987, claimant stopped treating with Dr. Sears, because he became aware that SAIF was not paying his medical bills. A few months later, he experienced an off-the-job sharp pain in his low back and was taken to a hospital. In June 1987, he returned to Dr. Sears for a resumption of supervised rehabilitation.

The following month, claimant was examined by the Orthopaedic Consultants. The Consultants recommended an at-home exercise program, but discontinuation of the rehabilitation program supervised by Dr. Sears.

In September 1987, Dr. King reported, by way of a "check-the-box" reply, that claimant should continue with Sears' treatment "for another month." That same month, Dr. Sears stated that he disagreed with the Consultants' recommendation. According to Sears, claimant's low back condition was improving as a result of supervised rehabilitation.

Claimant's back pain was reduced as a result of Dr. Sears' treatment. Sears' supervised rehabilitation program provided reasonable and necessary medical treatment for claimant's compensable low back condition.

SAIF issued three "de facto" denials of claimant's medical treatment under the care of Dr. Sears. The three denials pertained to bills submitted by Sears in December 1986, March 1987, and September 1987.

CONCLUSIONS OF LAW

A party may request a hearing on any question concerning a claim. ORS 656.283(1). A physician's bill submitted to an insurer constitutes a claim. See former ORS 656.005(7) & 656.005(9); Billy J. Eubanks, 35 Van Natta 131, 132 (1983). After notice or knowledge of a claim, an insurer must issue a timely acceptance or denial. ORS 656.262(6). If an insurer fails to do so, the claim is deemed to be "de facto" denied. Barr v. EBI Companies, 88 Or App 132, 134 (1987). A worker may request a hearing on a "de facto" denial." Id.; see ORS 656.262(8).

For every compensable injury, an insurer shall provide medical services for the disabling results of a compensable injury for such period as the nature of the injury or process of recovery requires. ORS 656.245(1). To be compensable, the medical treatment must be reasonable and necessary. James v. Kemper Ins. Co., 81 Or App 80, 84 (1986).

The Referee did not address the issue of whether claimant's medical services were compensable. We conclude that the Referee erred in not addressing that issue.

First, Dr. Sears submitted a chiropractic billing to SAIF on December 23, 1986. The billing shows that it was received by SAIF on December 29, 1986. Inasmuch as SAIF failed to either accept or deny the billing within the 60-day time period, i.e., by February 27, 1987, it is deemed to have "de facto" denied the billing. Claimant timely appealed from the "de facto" denial by requesting a hearing and specifically raising the issue of: "Medical Services ORS 656.245." Second, documentary evidence shows that SAIF delayed payment beyond the 60-day period on a second billing, which was submitted by Dr. Sears in March 1987. Third, at the beginning of the hearing, the following colloquy took place between claimant's attorney and the Referee:

> "REFEREE: [Claimant's attorney], please state the issues and relief requested."

"[CLAIMANT'S ATTORNEY: The issue, and the only issue, is the failure to pay medical expenses, penalties and attorney fees."

Last, testimony at the hearing revealed that SAIF had refused payment on a third billing from Sears' office, which was more than 60 days overdue.

Accordingly, the compensability of the denied medical services was an issue properly before the Referee. Inasmuch as we find that the record below was sufficiently developed to review that issue, we proceed to do so. See ORS 656.295(5).

Claimant initially treated with Dr. King. After nearly a year of conservative treatment, his low back pain had not resolved. Consequently, King recommended a program of rehabilitation therapy under the supervision of Dr. Sears. In December 1986, King reexamined claimant and stated his condition was "progressing" as a result of Sears' treatment. Moreover, King felt that claimant was neither medically stationary nor ready to return to regular work. After claimant's hospitalization in May 1987, King recommended that he return to Sears for further treatment. In July 1987, Sears reported, inter alia:

"[Claimant] restarted his physical reconditioning program on 6/12/87. He stated that since he had been restricted from this program by SAIF in March[,] he has noted a considerable increase of symptoms, loss of flexibility, and strength. He also states he finds it much harder to perform even simple activities without increased low back and leg pain; activities such as standing or sitting for more than ten minutes."

"He was restarted with swim therapy, inversion therapy, and cold plunge therapy. Over the last month, he has been able to increase from 15 total strokes to 37 total strokes in the 20 yard pool. He often attends with pain . . . and leaves therapy with greatly reduced pain."

A few days later, the Orthopaedic Consultants examined claimant. Although the Consultants recommended an at-home exercise program, they felt that claimant's chiropractic and medical treatments should be discontinued as not "necessary."

In September 1987, Dr. King reported that claimant should continue his rehabilitation for another month. Moreover, Dr. Sears opined that the most useful form of rehabilitation included swim therapy and weight training, which was not available to claimant at home.

We are persuaded by the opinion of Drs. King and Sears. Taylor v. SAIF, 75 Or App 583, 585 (1985); Kenneth D. Kirkwood, 37 Van Natta 43, 217 (1985). King and Sears were in a superior position to evaluate claimant's need for further rehabilitation. See Jordan v. SAIF, 86 Or App 29, 33 (1987).

Accordingly, we conclude that Dr. Sears' medical treatment was reasonable, necessary, and causally related to claimant's compensable January 1985 low back injury.

ORDER

The Referee's order dated December 10, 1987, is affirmed as modified. SAIF's three "de facto" denials are set aside and it is directed to make payment on the unpaid medical billings associated with those denials. Claimant's attorney is awarded a reasonable assessed fee of $1,500 for his services at the hearing and on Board review, to be paid by the SAIF Corporation. All remaining portions of the Referee's order are affirmed.

CARLA J. HUTMACHER, Claimant
Olson Law Firm, Claimant's Attorney
Roberts, et al., Defense Attorneys

WCB 86-05955
August 12, 1988
Order on Review

Reviewed by Board Members Ferris and Crider.

Claimant requests review of Referee Borchers' order that awarded 25 percent (48 degrees) scheduled permanent partial disability for loss of use or function of her right arm, in lieu of a Determination Order awarding 5 percent (9.6 degrees).

The issue on review is extent of scheduled permanent partial disability.

We affirm the order of the Referee.

FINDINGS OF FACT

We adopt the findings of fact set forth in the "Facts" section of the Referee's order, subject to the following corrections and additions.

In the second paragraph of the "Facts" section, the Referee states that claimant's injury occurred on February 28, 1985. We, instead, find that the injury occurred on January 7, 1985.

In the last paragraph of the "Facts" section, the Referee finds that claimant is not able to do various specified activities "because of pain and inability." This language suggests that claimant's disability is due to both mechanical impairment and disabling pain, whereas the record is devoid of any evidence of permanent mechanical impairment. Accordingly, we amend the above finding to read that claimant's limitations are "because of disabling pain."

Finally, we find that claimant has sustained permanent, mildly moderate impairment as a result of her disabling right elbow pain.

CONCLUSIONS AND OPINION

We affirm the Referee's order with the following comment.

The "Opinion" section of the order discusses a purported inconsistency between two reports from claimant's treating physician, Dr. Poulson. Specifically, he opined in March 1986

that claimant's claim could be closed at any time and that there "is no impairment but there is disability based on pain." He subsequently opined in November 1987 that "[b]ecause of [claimant's] lack of background and training to do other things, [her right elbow] condition has seriously disabled her from doing productive work . . ."

We do not agree that the two reports are inconsistent. Our interpretation of the March 1986 report is that Dr. Poulson felt that claimant was impaired as a result of disabling pain but had no loss of range of motion or other mechanical impairment. Our interpretation of the later November 1987 report is that Poulson felt that claimant's lack of transferable skills for work not involving repetitive use of the elbow presented serious barriers to reemployment. We do not believe that he was of the opinion that claimant's mechanical impairment or disabling pain, in and of themselves, were seriously disabling. Accordingly, we find that the two opinions are consistent and that the Referee's effort to reconcile the reports was unnecessary.

Finally, we conclude that the Referee's 25 percent scheduled permanent disability award adequately compensates claimant for her right arm impairment. The criterion for rating scheduled disability is the permanent loss of use or function of the body part due to the compensable condition. ORS 656.214(2). In determining scheduled disability, we consider disabling pain as well as mechanical impairment. See Boyce v. Sambo's Restaurants, 44 Or App 305 (1980).

As discussed above, claimant's limitations are due to disabling pain. The administrative guidelines applicable to this case suggest an award of 5 percent to 15 percent for disabling pain. See former OAR 436-30-220(3). However, the record supports a somewhat greater award. Dr. Poulson opined that claimant had a significant degree of disabling pain with repetitive use of her right arm, and he restricted her from lifting over 10 pounds and repetitive pushing, pulling or grasping. Moreover, claimant credibly testified that she is less able to write and do yard work, that she is no longer able to do needle work or drive over an hour, and that she now uses her left arm to perform many housekeeping chores which she formerly performed with her right arm.

In light of these factors, we find that claimant has sustained a mildly moderate permanent impairment in her right arm. Accordingly, we affirm the Referee's award of 25 percent permanent disability for loss of use or function of the right arm.

ORDER

The Referee's order dated January 5, 1988 is affirmed. The Board approves a client-paid fee, not to exceed $932.

NEIL J. POWERS, Claimant
Black, et al., Claimant's Attorneys
Ronald Pomeroy (SAIF), Defense Attorney
Cowling & Heysell, Defense Attorneys

WCB 87-04526 & 87-03217
August 12, 1988
Order on Review

Reviewed by Board Members Ferris and Crider.

Liberty Northwest Insurance Corporation (Liberty) requests review of those portions of Referee Neal's order that: (1) set aside its denial of claimant's aggravation claim for a back condition; and (2) upheld the SAIF Corporation's denial of claimant's "new injury" claim for the same condition. SAIF requests review of that portion of the Referee's order that awarded claimant an attorney fee for his services at hearing. We affirm.

ISSUE

1. Whether claimant sustained an aggravation or "new injury" of his compensable back condition.

2. If SAIF is found to be responsible for claimant's back condition, whether claimant's attorney is entitled to a fee for his services at hearing.

FINDINGS OF FACT

Claimant, 34 at the time of hearing, has worked most of his life at physical labor jobs. Claimant worked for Liberty's insured about two years as a lumber sticker feeder. Over a period of nine months, he slowly developed low back, left shoulder and hip pain while feeding a joint machine. He left work on April 1, 1985.

Claimant treated with Dr. Albrecht, chiropractor, and subsequently with Dr. Potter, orthopedic surgeon. Dr. Potter diagnosed back pain with lumbar-5 nerve root irritation, probably secondary to repetitive vocational injury. X-rays showed a reverse spondylolisthesis at L5-S1. Dr. Potter treated claimant with physical therapy and traction.

On April 3, 1985, claimant filed an injury claim, which was denied.

On April 16, 1985, Dr. Potter released claimant for work with no restrictions. Claimant returned to modified duty. Dr. Potter noted that claimant had resolving minimal low back pain. He felt claimant should continue in modified work for a month. When claimant saw Dr. Potter in May 1985, claimant felt that he could not continue to work because of severe back pain which had come on during the last week or week and a half. Dr. Potter diagnosed recurrent low back strain. Dr. Potter wanted to keep claimant working at his normal duties with only about half time feeding the machine. However, this continued to cause claimant problems; therefore, Dr. Dunn, neurologist, returned claimant to therapy and traction. By the end of May 1985, claimant had improved. During that time, however, claimant had been forced to quit his job since repeated requests that he be taken off certain aggravating activities went unheeded by his employer.

Dr. Potter continued to treat claimant after he left

employment with Liberty's insured. He saw claimant on June 20, 1985 and July 9, 1985. He injected claimant's back. On July 9, 1985, Dr. Potter diagnosed resolving low back pain, secondary to the industrial injury. He found claimant stationary and felt claimant had returned to preinjury status. Claimant treated from July 1985 to October 1985 with Dr. Albrecht; Dr. Potter was not aware of claimant's continued treatment. Claimant continued to have low back symptoms, even though he no longer had treatment after October 1985.

On December 30, 1985, a hearing was held concerning the denial of claimant's occupational disease claim. By a January 28, 1986 order, a prior Referee found claimant's claim compensable. Thereafter, the claim was closed by a March 6, 1986 Determination Order that granted him periods of temporary total and temporary partial disability compensation from April 1, 1985 through April 16, 1985.

In December 1985, claimant obtained about two weeks of temporary work grinding metal with SAIF's insured. He then worked off and on in the welding shop repairing heavy equipment for two months for a total of 80 hours. After January 1986, he did not work until he obtained a full-time position with SAIF's insured on June 23, 1986, with the exception of a few hours he worked moving pipe and hauling hay. Claimant, who continued to have low back pain, experienced increased symptoms with his temporary work.

After June 1986 claimant's work at SAIF's insured required that he lift up to 30 pounds. He stood at an adjustable bench and applied a grinder to metal doors and other parts of a wood stove. He developed increasing left arm, shoulder and low back pain. He was only able to work an average of three days of a regular five-day week due to low back pain. In August 1986, he returned for treatment with Dr. Albrecht. He continued to work until November 15, 1986, when he was replaced because he asked for too much time off work as a result of back pain. After he left work, his symptoms improved to the level at which they had been since July 1985.

In December 1986, claimant saw Dr. Dunn, neurologist, on referral from his attorney. X-rays showed an essentially normal lumbar spine with mild degenerative changes. Dr. Dunn diagnosed a myofascial syndrome, left scapular and chronic lumbosacral muscular strain. He treated claimant with physical therapy.

On December 30, 1986, Dr. Dunn saw claimant in a follow-up examination. Dr. Dunn also saw claimant on three occasions in January and February 1987. Claimant improved with physical therapy and relaxation training.

On February 17, 1987, Liberty denied claimant's aggravation claim on the ground that claimant sustained a new injury in 1986. On March 20, 1987, claimant filed a new injury claim. Liberty requested an ORS 656.307 Order.

In March 1987, Dr. Dunn saw claimant. On April 1, 1987, he found claimant medically stationary and released him to return to employment with a 35 pound lifting restriction and restriction in repetitive use of his arms.

On April 28, 1987, an ORS 656.307 Order was issued which named SAIF as the paying agent.

Claimant's employment with SAIF's insured, which involved polishing brass, did not significantly contribute to the low back symptoms that he experienced from December 1986 to March 1987. Claimant's back problems associated with the brass polishing activities represented a minor exacerbation. The activities at SAIF's insured did not independently contribute to a worsening of claimant's underlying back condition.

CONCLUSIONS OF LAW

The Referee set aside Liberty's denial of claimant aggravation claim based upon the persuasiveness of claimant's testimony and Dr. Dunn's opinion regarding causation. We agree.

The main issue involves responsibility for claimant's back condition after August 1986. In this case, where there was no specific injury at either the first or second employer, but the first employer was found responsible for claimant's initial occupational disease claim, the first employer remains responsible if the subsequent exposure merely reactivates symptoms but does not independently contribute to claimant's condition or disability, or, in other words, does not worsen the underlying condition. Industrial Indemnity Co. v. Weaver, 81 Or App 493, 497 (1986). We agree with the Referee that Liberty's insured, the first employer, remains responsible for claimant's condition.

On April 14, 1987, Dr. Dunn opined that claimant's brass polishing activities did not significantly contribute to the symptoms for which he had seen claimant from December 1986 through March 1987. Dr. Dunn believed that those activities only caused a very temporary and minor exacerbation, but he did not feel that they represented an independent contributing factor.

On April 23, 1987, Dr. Potter reported that since there had been no activity in claimant's file from July 1985 until he saw a chiropractor in September 1986 and claimant had a year and a half of no pain in his back, he felt that claimant had recovered from his 1985 injury and had sustained a new injury in 1986.

Also on April 23, 1987, Dr. Dunn opined that claimant's work at SAIF's insured, the second employer, which included polishing copper, represented a minor aggravation, evidenced by the change in claimant's symptomatology.

On April 24, 1987, Dr. Albrecht reported that claimant had sustained multiple work-related injuries which ultimately resulted in his leaving employment in November 1986.

Dr. Dunn's opinion that claimant's work activities at the second employer caused a temporary minor exacerbation of symptoms, but were not an independent contributing factor, was the most persuasive medical evidence. His analysis of causation was based upon a correct history of claimant's continuing symptomology following the 1985 injury.

Dr. Potter, on the other hand, who had not treated claimant for over a year, was unaware that claimant continued to seek treatment from Dr. Albrecht for back problems. Dr. Potter was also unaware that claimant continued to have symptoms even after he stopped seeing Dr. Albrecht. Therefore, Dr. Potter's opinion that by 1986 claimant had recovered from his 1985 work-related back problems was based upon an erroneous history and is not persuasive.

Dr. Dunn's opinion is more in accord with the facts. According to claimant's credible testimony, he was never pain free following his 1985 injury at Liberty's insured. The temporary jobs in which he engaged prior to his work at SAIF's insured caused an increase in back symptoms. From October 1985 until August 1986 he did not receive medical treatment because he hoped his problems would go away with rest. Also, he had some financial difficulties. The back problems that he had at SAIF's insured were the same problems that he had while working at Liberty's insured, only not as painful.

We conclude that claimant's work at SAIF's insured did not worsen his underlying back condition. Therefore, Liberty remains responsible for that same condition.

Since we find Liberty responsible and it did not raise claimant's entitlement to an attorney fee for services at hearing, we will not address SAIF's argument on Board review that, should it be found responsible, claimant's attorney was not entitled to a fee for his services at hearing.

ORS 656.382(2) states that if an insurer initiates a request for review and the Board finds that the compensation awarded to claimant should not be disallowed or reduced, that insurer shall be required to pay to the claimant or claimant's attorney a reasonable attorney fee. However, a reasonable attorney fee will be allowed under these circumstances only where: (1) the review was requested by the insurer; (2) claimant's compensation was not disallowed or reduced; and (3) claimant's attorney actually performed services on review. Shirley M. Brown, 40 Van Natta 879 (July 27, 1988). In the present case, the insurer requested review. Claimant's stake in the outcome of our determination of responsibility amounted to $86.72 per week for temporary disability benefits. That award was neither disallowed nor reduced. Claimant's counsel, however, did not file a brief with the Board or otherwise perform services on review. Therefore, no fee is awarded.

ORDER

The Referee's order dated May 28, 1987 is affirmed. The Board approves a client-paid fee, payable by Liberty Northwest Insurance Corporation to its counsel, not to exceed $490.

KENYON D. RUSSELL, Claimant
Doblie & Associates, Claimant's Attorneys
Meyers & Terrall, Defense Attorneys

WCB 87-02111
August 12, 1988
Order on Review

Reviewed by Board Members Johnson and Crider.

The self-insured employer requests review of Referee Foster's order that set aside its denial of claimant's low back injury claim. We affirm.

ISSUE

The issue is compensability.

FINDINGS OF FACT

Claimant, 23 years old at the time of hearing, was employed by the employer as a green chain puller, which required pulling and

Claimant seeks remand to establish that he had surgery on August 21, 1987 for his low back condition and to offer new evidence obtained as a result of surgery. The medical reports which claimant would offer on remand include post-operative reports suggesting that claimant did not suffer from a herniated disc.

CONCLUSIONS OF LAW AND OPINION

Pursuant to ORS 656.295(5), we may remand to the Referee for taking of additional evidence when we determine that a case has been improperly, incompletely or otherwise insufficiently developed. The Court of Appeals has held that, when surgery done before an order becomes final sheds light on the issue of causation of claimant's condition, claimant should have an opportunity to explore fully the medical opinions following surgery. Parmer v. Plaid Pantry #54, 76 Or App 405, 409 (1985).

Claimant has undergone low back surgery which has apparently improved his condition, and which has also identified the physical source of his pain, an unknown at the time of hearing. Under Parmer, claimant is entitled to explore whether it is causally related to his compensable injury.

ORDER

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

ALVIN L. WOODRUFF, Claimant
Coons & Cole, Claimant's Attorneys
Lindsay, et al., Defense Attorneys

WCB 85-09473
August 12, 1988
Order on Review

Reviewed by Board Members Johnson and Crider.

Claimant requests review of that portion of Referee Galton's order that affirmed a Determination Order which awarded claimant 15 percent (48 degrees) unscheduled permanent disability for a low back condition. Claimant failed to timely file his appellant's brief. The self-insured employer declined to submit a respondent's brief. The sole issue is extent of unscheduled permanent disability. We affirm.

FINDINGS OF FACT

Claimant originally injured his back in 1973 in a compensable work incident. A lumbar laminectomy was performed in November 1973. He subsequently received an award of permanent partial disability in an amount not specified in the record.

In July 1983, claimant compensably injured his left knee while performing maintenance work on a rock crusher. He subsequently developed back pain secondary to an abnormal gait resulting from the knee injury.

His treating physician for both his knee and his back has been Dr. Hoppert, orthopedic surgeon. Dr. Hoppert first noted back pain in a December 1984 chart note. He prescribed conservative treatment in the form of medication, exercise and at-home traction.

Claimant was 49 years old at the time of hearing. He acquired a high school graduate equivalency degree and a two-year associates degree in industrial drafting. He has electronics and

welding experience. He underwent vocational training where he learned civil engineering and computerized drafting skills. At the time of hearing, he was working in a temporary job as a draftsman at a wage of $18 per hour. At the time of his injury, he was earning approximately $15 per hour.

Claimant's low back pain involves a constant dull ache in his lower back which radiates into the buttocks. The pain is increased with activity and prolonged sitting. Claimant takes aspirin for the pain. He uses a TENS unit occasionally for both his back and knee pain and also occasionally uses a back brace.

Claimant's low back impairment as a result of his compensable 1983 injury is in the mild range.

CONCLUSIONS AND OPINION

The criterion for rating unscheduled permanent disability is the permanent loss of earning capacity due to the compensable injury or condition. ORS 656.214(5). In determining the loss of earning capacity, we consider medical and lay evidence of physical impairment resulting from the compensable injury and all of the relevant social and vocational factors set forth in former OAR 436-30-380 et seq. We apply these rules as guidelines, not as restrictive mechanical formulas. Harwell v. Argonaut Insurance Co., 296 Or 505, 510 (1984); Fraijo v. Fred N. Bay News Co., 59 Or App 260, 269 (1982).

Dr. Hoppert reported in June 1985 that claimant's low back impairment was in the mild range. Nine months later, he stated that the impairment was mild to moderate. He further stated that claimant had experienced an increase in his symptoms from his preexisting low back condition but that his current impairment was primarily a result of his preexisting problems. We conclude that claimant's low back impairment due to his compensable injury is in the mild range. See ORS 656.214(5).

Dr. Hoppert has also limited claimant to light work. It is not clear, however, how much of this limitation results from claimant's knee disability and how much results from his low back pain. Our sense from reading Dr. Hoppert's reports is that at least a significant portion of this limitation is a consequence of his knee condition. Claimant has received an award of scheduled permanent disability for his knee. That award is not before us on review.

Claimant's age of 49 years is a negative factor in rating his loss of earning capacity. In addition, a sizable portion of his prior work experience has been in occupations from which he is now precluded. However, he has undergone successful vocational training so that he is now capable of performing drafting work which is within his physical capabilities and which presently produces a wage in excess of his preinjury wage. After considering these aforementioned factors, we conclude that the 15 percent permanent disability awarded by Determination Order adequately compensates claimant for his loss of earning capacity.

ORDER

The Referee's order dated June 3, 1987 is affirmed.

DICK A. COLE, Claimant
Malagon & Moore, Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB TP-88012
August 17, 1988
Third Party Partial Distribution Order

Claimant has petitioned the Board for resolution of a dispute concerning the just and proper distribution of the proceeds from a proposed third party settlement. See ORS 656.587; 656.593(3). Specifically, the dispute involves the distribution of the proceeds from a "structured settlement."

FINDINGS

In March 1986, while performing his employment duties as a trucker, claimant was injured when a forklift driver for another employer caused a load of pipe products to fall onto him. As a result of the incident, claimant sustained injuries to, among other areas, his head, left hip, knees, low back, groin, and left thumb. The claim was accepted and currently remains in open status, while claimant participates in an authorized training program.

Claimant engaged legal counsel to explore the possibility of bringing suit against the third party. Thereafter, an action for negligence was initiated. Claimant and the third party have agreed to settle the pending lawsuit pursuant to the following terms. An initial lump sum payment of $200,000. Three payments of $35,000, payable on the 5th, 10th, and 15th year anniversary of the settlement. Finally, $750 per month for the remainder of claimant's life. To finance these monthly and five-year installments, the third party will purchase an annuity for approximately $136,000. Thus, the total cost of the settlement equals roughly $336,000.

The paying agency does not oppose the "gross dollar amount of the proposed settlement." Its lien for actual claim costs currently total $92,701.50. This amount is comprised of temporary disability benefits, medical expenses, and vocational service benefits. Inasmuch as the claim presently remains in open status, further costs will continue.

The proposed settlement is reasonable. The paying agency is entitled to recover its current lien for actual claim costs from the proceeds of the settlement. However, any request to receive reimbursement for future expenses is premature.

CONTENTIONS

Claimant contends that his attorney is entitled to a one-third share of the present value of the settlement. i.e., $112,000. Furthermore, claimant submits that his attorney's fee should be paid from the initial $200,000 lump sum payment.

The paying agency does not object to the "gross dollar amount of the proposed settlement." However, it disagrees with claimant's proposed distribution. Since claimant's statutory one-third share of the remaining balance of the proceeds would also be paid from the initial lump sum payment, the agency submits that its lien for actual claim costs would be significantly compromised. That is, it would be relegated to recovering its lien "in bits and pieces over claimant's lifetime monthly payments and later lump sum payments." The agency argues that such a method of distribution would not be "just and proper."

As possible solutions to this predicament, the agency suggests several options: (1) prorating claimant's attorney's fee and the paying agency's lien so that the effect of the structured settlement is equalized; (2) reducing claimant's share of the initial lump sum payment to the extent necessary to reimburse the agency for its current actual claim costs; and (3) reducing claimant's attorney's one-third fee.

CONCLUSIONS

Pursuant to ORS 656.587, the Board is authorized to resolve disputes concerning the approval of any compromise of a third party action. In exercising this authority, we employ our independent judgment to determine whether the compromise is reasonable. Natasha D. Lenhart, 38 Van Natta 1496 (1986).

Generally, we will approve settlements negotiated between a claimant/plaintiff and a third party defendant, unless the settlement appears to be grossly unreasonable. Kathryn I. Looney, 39 Van Natta 1140 (1987), Steven B. Lubitz, 39 Van Natta 809 (1987), Virginia Merrill, 35 Van Natta 251 (1983), Rose Hestkind, 35 Van Natta 250 (1983).

After reviewing this record and applying the aforementioned standards, we find the proposed settlement to be reasonable. Consequently, we approve the settlement offer of approximately $360,000.

In reaching our conclusion, we note that the paying agency does not contest the "gross dollar amount" of the settlement. As further support for our decision, we rely on the reasoning expressed in the "distribution of proceeds" portion of this order.

Having resolved the "approval" issue, we turn to the "distribution of proceeds" question.

Pursuant to ORS 656.578, if a worker receives a compensable injury due to the negligence or wrong of a third person, entitling the worker under ORS 656.154 to seek a remedy against such third person, such worker or, if death results from the injury, the other beneficiaries shall elect whether to recover damages from the third person. The proceeds of any damages recovered from a third person by the worker or beneficiaries shall be subject to a lien of the paying agency for its share of the proceeds. ORS 656.593(1).

If the worker or beneficiaries settle the third party claim with agency approval, 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); Estate of Troy Vance v. Williams, 84 Or App 616, 619-20 (1987). Any conflict as to what may be a "just and proper distribution" shall be resolved by the Board. ORS 656.593(3).

The statutory scheme for the allocation of damages is precise. Robert B. Williams, 38 Van Natta 119, 123 (1986), aff'd. Estate of Troy Vance v. Williams, supra. ORS 656.593(1) provides in exact detail how, and in what order, the proceeds of any damages shall be distributed. Pursuant to ORS 656.593(1)(a), costs and attorney fees incurred shall be initially disbursed.

Then, the worker shall receive at least 33-1/3 percent of the balance of the recovery. ORS 656.593(1)(b). However, the amount that the agency is "authorized to accept" from a third party settlement is less precise than the amount of its lien from damages recovered from a third party 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." Estate of Troy Vance v. Williams, supra. 84 Or App at page 620.

The aforementioned statutes do not discuss the distribution of proceeds from a third party "structured" settlement. However, we recently addressed this question in Ralph W. Schemmel, 40 Van Natta 951 (August 3, 1988). In Schemmel, we found that the "proceeds" of a third party settlement encompass not only immediate cash payments, but also the purchase of an annuity. We reasoned that the fact that these annuity payments are payable over a period of years did not alter the fundamental principle that they are "proceeds" from a third party recovery. As "proceeds," we concluded that they are to be distributed in accordance with the schedule set forth in ORS 656.593(1). See ORS 656.593(3).

Here, as in Schemmel, we hold that the "total proceeds" of the structured settlement are comprised of the initial lump sum payment plus the cost of the annuity. We further conclude that these proceeds should be distributed in accordance with the aforementioned statutory schedule. Pursuant to that schedule, incurred litigation costs and attorney fees shall initially be paid, followed by the worker's statutory one-third share of the remaining balance. See ORS 656.593(1)(a), (b). The paying agency's lien applies only after the aforementioned shares have been disbursed. See ORS 656.593(3); 656.593(1)(c).

The paying agency's proposal to prorate its and claimant's attorney's share of the initial lump sum payment has some appeal. We recognize the agency's objective to "fully equalize" the impact of the settlement among the parties. Yet, as stated in Schemmel, we consider the statutory distribution scheme to be both clear and precise. That is, the aforementioned schedule concerns the distribution of the "total proceeds" of any damages recovered from a third person. See ORS 656.593(1). Inasmuch as the installments represent amounts recovered from a third person, we conclude that the cost of purchasing the annuity to fund those installments should likewise be included as "total proceeds" of the settlement. As such, these "total proceeds" shall be apportioned in accordance with the statutory distribution scheme. See ORS 656.593(3); 656.593(1), (2).

We acknowledge that the distribution of the "total proceeds" of the structured settlement to claimant and his attorney from the initial $200,000 lump sum payment will leave a minimal remaining balance to which the paying agency's lien for actual claim costs can immediately apply. However, as we explained in Schemmel, the distribution scheme applies to the "total proceeds" of the recovery and clearly specifies the order of participation. Thus, the paying agency will share in the recovery only after claimant's and his attorney's portions have been distributed.

The amount of the paying agency's current lien for its

actual claim costs is not in dispute. This is $92,701.50. Consequently, we find that the agency is entitled to reimbursement for these funds from the "total proceeds" of the settlement. This reimbursement shall initially come from the balance of the $200,000 lump sum payment remaining after claimant's attorney and claimant have received their shares. Inasmuch as the $750 monthly and $35,000 five-year installments also represent the "total proceeds" from the structured settlement, reimbursement for the remaining portion of the agency's lien for its actual claim costs shall be realized from these payments.

Because the claim has not been closed, it is unclear what degree of permanent disability claimant has sustained as a result of his compensable injury. Since there has not been a final order determining the extent of claimant's disability arising out of his compensable injury, we shall defer ruling on the question of the paying agency's entitlement to a lien for its future claim costs. See John T. Elicker, 40 Van Natta 68 (1988); Robert B. Williams, 37 Van Natta 711 (1985); George Bedsaul, 35 Van Natta 695 (1983).

As a final matter, we note that claimant's attorney's fee from the proposed settlement does not exceed 33 1/3 percent of the gross third party recovery. Inasmuch as the fee does not exceed the advisory schedule of fee established by the Board, it is considered reasonable and is authorized. See ORS 656.593(1)(a); OAR 438-15-095.

Accordingly, claimant's attorney is directed to distribute the "total proceeds" of the third party settlement in accordance with ORS 656.593(1)(a), (b), and (c). The "total proceeds" shall be comprised of the $200,000 initial lump sum payment plus the purchase price of the annuity necessary to guarantee claimant $750 a month for life and $35,000 lump sum payments on the 5th, 10th, and 15th year anniversary of the settlement. i.e., a total of approximately $360,000.

Following disbursement to claimant and his attorney, the paying agency shall receive the remainder of the remaining balance of the proceeds from the $200,000 initial lump sum payment. The paying agency shall also receive claimant's $750 monthly payments and $35,000 5-year installments to the extent necessary to receive full reimbursement for its $92,701.50 current lien for actual claim costs.

Should a dispute continue to exist upon final resolution of the permanent disability issue, the parties shall notify the Board of their respective positions regarding the paying agency's entitlement to additional portions of the settlement proceeds.

IT IS SO ORDERED.

DEBORAH K. HARMON, Claimant
Welch, Bruun & Green, Claimant's Attorneys
Raymond T. Smitke (SAIF), Defense Attorney

WCB 85-11803
August 17, 1988
Order on Review

Reviewed by Board Members Ferris and Crider.

The SAIF Corporation requests review of that portion of Referee Mulder's order that set aside its denial of claimant's aggravation claim for her low back condition. We affirm.

ISSUE

On review, the issue is aggravation of claimant's low back condition.

FINDINGS OF FACT

Claimant suffered a compensable low back injury on June 26, 1984. Her condition was diagnosed as cervicodorsal strain and chronic low back strain. Her claim was closed by Determination Order on September 10, 1985 with an award of 25 percent (80 degrees) unscheduled permanent disability.

On September 17, 1985, Dr. Baum, osteopath, diagnosed a herniated nucleus pulposis at L5-S1, with S1 nerve root compression. The claim was reopened. Thereafter, claimant had a laminectomy and discectomy on October 7, 1985.

Claimant's treating osteopath, Dr. Heatherington, released claimant to sedentary-light work on May 12, 1986.

On July 17, 1986, claimant began working part time at a nursing home, doing bookkeeping and general office work.

The claim was again closed by Determination Order on September 24, 1986, with an award of temporary total disability, but no additional unscheduled permanent disability.

Claimant's low back discomfort began to worsen. Dr. Heatherington prescribed a home traction unit. By late October 1986, claimant had increased pain in her low back, upper back, neck and right extremity. Because of her increased back pain, her employer terminated her employment.

On December 10, 1986, consulting physician Dr. Aversano reported that claimant's pain had been worsening for the past six months. He ordered an "MRI" which, on January 20, 1987, revealed central bulging of the L5-S1 disc.

On January 25, 1987, claimant and her roommate were involved in an altercation during which the roommate struck claimant several times. Claimant and her roommate continued this physically abusive behavior for several months, during which time claimant had a restraining order issued against the roommate. Their fights involved primarily blows to the face and chest.

On March 4, 1987, Dr. Aversano hospitalized claimant. She was released on March 10, 1987, with a final diagnosis of lumbar radiculopathy, somatic dysfunction and bipolar disorder with depression.

On March 31, 1987, Dr. Heatherington saw claimant, and noted continuing complaints of severe pain in the low back and right leg. He reported that her condition did not allow her to return to work at that time.

Since February 10, 1987, claimant's condition has been worse than it was at the time of the September 1986 claim closure.

A denial letter was issued on April 23, 1987, on the basis that claimant's condition had not worsened since the claim had been closed on September 24, 1986.

Claimant's condition has worsened since the last claim closure. The worsening is causally related to her compensable injury.

CONCLUSIONS OF LAW AND OPINION

To reopen a claim because of an aggravation, claimant must prove: (1) a worsening of her condition that renders her 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. ORS 656.273(1); Smith v. SAIF, 302 Or 396 (1986); Stepp v. SAIF, 78 Or 438 (1986). Increased symptoms alone are not compensable, unless the worker suffers pain or additional disability that reduces her ability to work, thereby resulting in a loss of earning capacity. Smith, supra at 401.

Claimant was working part time in a sedentary position at the time her claim was closed for the second time. She began experiencing increased pain in October 1986. On January 20, 1987, the source of some of that pain was identified when a recurrent bulging disc was diagnosed. The disc was diagnosed as reherniated in March 1987. That month, claimant's treating physician reported that her condition prevented claimant from returning to gainful employment at that time.

We recognize that claimant has a complex history of personal, medical and psychological problems, some of them unrelated to her compensable injury. However, she has established a worsening of her compensable condition prior to the eruption of abusive interpersonal relationships. Her pain increased gradually, and matched temporally the changing diagnosis from bulging to reherniated disc. The troublesome disc was the same one which had herniated as a result of the compensable injury. These facts support a causal link between that worsening and the compensable injury.

ORDER

The Referee's order dated June 26, 1987, as amended July 6, 1987, is affirmed. Claimant's attorney is awarded an assessed fee of $1,000, to be paid by the SAIF Corporation.

RONALD HAUCK, Claimant
Roll & Westmoreland, Claimant's Attorneys
Garrett, et al., Defense Attorneys

WCB 86-13154
August 17, 1988
Order on Review

Reviewed by Board Members Ferris and Crider.

The insurer requests review of that portion of Referee Shebley's order which awarded claimant 50 percent (160 degrees) unscheduled permanent disabilty for a middle and low back injury, whereas a Determination Order had declined to award permanent disability. Claimant cross-requests review of those portions of the order which: (1) upheld the insurer's denial of his aggravation claim for his back condition; and (2) declined to award interim compensation. Claimant also contends that his unscheduled disability award should be increased. We affirm.

ISSUE

1. Extent of unscheduled permanent disability for a middle and low back injury.

2. Aggravation of low back condition.

3. Claimant's entitlement to interim compensation.

FINDINGS OF FACT

We adopt the findings of fact contained in the third through seventh paragraphs of the Referee's order with the following supplementation. The diagnosis of the compensable injury was a thoracolumbar strain. Claimant became medically stationary on May 6, 1986. Claimant's back condition or symptoms have not materially worsened since claim closure on September 11, 1986. Neither the employer nor its insurer received notice or knowledge of claimant's medically verified inability to work due to any worsening of his back condition. As a result of the compensable back injury, claimant has sustained a mild permanent impairment and is capable of performing light work only.

CONCLUSIONS AND OPINION

We adopt the opinion and conclusions of law contained in the eighth through tenth paragraphs of the Referee's order, with the following supplementation.

To establish a compensable aggravation, claimant must prove, inter alia, that his condition has worsened since the last award of compensation, so that he is more disabled, meaning less able to work. ORS 656.273(1); Smith v. SAIF, 302 Or 397, 399 (1986). Increased symptoms may be sufficient to establish a worsened condition if they result in a greater loss of earning capacity than that anticipated by the prior award of compensation. Id. at 401. Here, there was no medical evidence to establish a worsening of condition or symptoms. Indeed, the medical evidence established just the opposite. Dr. Oksenholt, the treating physician since September of 1986, wrote in his final report on April 2, 1987 that he was unaware of any acute material worsening of claimant's compensable back injury. Claimant has not established a compensable aggravation.

ORDER

The Referee's order dated May 27, 1987 is affirmed. Claimant's attorney is awarded an assessed fee of $300, to be paid by the insurer.

FORREST A. LAFFIN, Claimant
Pozzi, et al., Claimant's Attorneys
Davis & Bostwick, Defense Attorneys
Norman Kelley, Assistant Attorney General

WCB 84-07454 & 82-01857
August 17, 1988
Order on Review

Reviewed by Board Members Ferris and Crider.

Claimant requests review of those portions of Referee Lipton's order that: (1) upheld the Director's denial of authorization for a program of vocational rehabilitation obtained out-of-state; (2) declined to award additional temporary disability benefits; and (3) increased claimant's unscheduled permanent disability for a back injury from 35 percent (112 degrees), as

awarded by previous Determination Orders, to 50 percent (160 degrees). Claimant contends that he is entitled to the aforementioned program, additional temporary disability benefits during the program, and an increased award of unscheduled permanent disability. In its respondent's brief, the insurer contests the increased disability award, and the Referee's refusal to allow the insurer to offset temporary disability payments against the permanent disability award. We affirm in part and reverse in part.

ISSUES

(1) Claimant's entitlement to vocational assistance benefits outside the state of Oregon;

(2) entitlement to temporary total disability benefits during enrollment in a vocational rehabilitation program;

(3) extent of unscheduled permanent disability; and

(4) the insurer's entitlement to offset alleged overpayments of temporary disability against permanent disability.

FINDINGS OF FACT

We adopt the Referee's findings of fact as our own, and make the following additional findings.

Claimant enrolled in a vocational training program in Iowa in September 1983. He completed that program in May 1985.

The insurer paid claimant temporary disability benefits from September 1983 until August 1984, when the Board vacated the July 1983 order which "authorized" the vocational assistance. The insurer sought reimbursement of the benefits from the Workers' Compensation Department's Rehabilitation Reserve, which was denied. The insurer appealed that denial to the Court of Appeals on the basis that the first Referee's order required it to make temporary total disability payments. The insurer simultaneously requested review by the Board, contending in the alternative that it is entitled to offset temporary total disability against permanent partial disability.

In the argument raised before the Court of Appeals, the court held that the insurer was not entitled to reimbursement. See Argonaut Ins. Co. v. Workers' Compensation Dept., 89 Or App 591 (1988). The court found that the Director's rules allow reimbursement from the Department's Rehabilitation Reserve only when the particular program is authorized by the Department. Claimant had not sought prior authorization of his vocational program. Because these terms were not complied with, the court concluded that the Referee did not have jurisdiction to order the Field Services Division to provide vocational services, and that the insurer therefore had no obligation to pay temporary total disability nor was it entitled to receive reimbursement.

CONCLUSIONS OF LAW AND OPINION

Vocational Assistance

Claimant requests review of the Director's decision that he was not eligible for vocational services because he was

unavailable for those services within the State of Oregon. Claimant contends that his claim is governed by the administrative rules in effect at the time of his injury, and not by those in effect at the time of his request for services. We disagree.

ORS 656.202(2) says that "payments of benefits" are to continue in accordance with the law in effect at the time of injury, unless otherwise provided by law. ORS 656.005(9) defines "compensation" as "all benefits . . . provided for a compensable injury to a subject worker." In 1983, when claimant was declared ineligible for vocational assistance, such assistance may have been a "benefit" controlled by the law in effect at the time of injury, unless otherwise provided. We find that the law did provide otherwise.

Before 1985, the Workers' Compensation statutes themselves created no entitlement to vocational assistance. Rather, the statutes authorized the Director to create a rehabilitation program by rule, and to pay for the program and reimburse insurers from the Rehabilitation Reserve. Former ORS 656.616. The entitlement language existed entirely within these rules.

In 1983, the Director promulgated new vocational rehabilitation rules. They included the rule that claimants were entitled to services only under the revised rules, unless the vocational services program had already been authorized under the old rules. The new rule provided that a claimant was eligible for services only if he or she was available to receive them in Oregon. Former OAR 436-61-004. Claimant requested services after the 1983 rules took effect. He was not available to accept services in Oregon. Therefore, the Director's determination that he was ineligible under them was proper.

Temporary Total Disability

Claimant contends that he is entitled to temporary disability benefits while enrolled in vocational rehabilitation outside the state of Oregon. We are bound by the holding of the Court of Appeals that the Iowa vocational rehabilitation program had not been preauthorized by the Director. Argonaut Ins. Co. v. Workers' Compensation Dept., supra. Because it was not, claimant is now barred from obtaining payment for vocational services, including temporary disability payments.

Extent of Disability

We affirm and adopt the opinion of the Referee on this issue.

Offset

The insurer requests authorization to offset amounts paid to claimant as temporary time loss while he was enrolled in a vocational assistance program in Iowa against future benefits. We reverse the Referee's order, and authorize the offset.

The Referee decided that the insurer was not entitled to an offset, because the program under which the payments were made was not authorized. Thus, he reasoned, the insurer was not legally compelled to make the payments. Rather, he termed the payments "gratuitous" and not recoverable under ORS 656.018(4).

We do not understand the insurer to have made the payments in question as a gift to claimant. They were made in the belief that they were required by law. Payments of compensation are due while the claimant is enrolled and actively engaged in authorized training. ORS 656.268(1). However, they were not required here. Instead, the payments were made erroneously, under the misapprehension that the program was authorized.

The circumstance under which these payments were made is more aptly described as a mistake. The payments themselves are comparable to payments of interim or temporary compensation, which must be paid promptly, but overpayments of which may be offset once it is determined that claimant's entitlement has ended. Because we find the payments which the insurer made in this case comparable, we authorize the requested offset.

ORDER

The Referee's order dated February 12, 1987, as amended February 27, 1987, is affirmed and modified. The insurer is authorized to offset the temporary disability benefits paid to claimant while he was enrolled in an out-of-state vocational rehabilitation program against future permanent disability benefits due as a result of the compensable injury. The Referee's order is otherwise affirmed.

WILLIAM C. MILLER, Claimant
Charles D. Maier, Claimant's Attorney
Ronald E. Rhodes, Defense Attorney

WCB 86-01313
August 17, 1988
Order on Review

Reviewed by Board Members Ferris and Crider.

Claimant requests review of that portion of Referee Michael Johnson's order that declined to award him additional, recomputed temporary total disability compensation. If the Board finds that claimant is entitled to additional benefits, it must also review that part of the order that authorized the insurer to offset an alleged overpayment of temporary disability benefits. On review, the issues are the rate of temporary total disability and offset.

The Board affirms the order of the Referee.

FINDINGS OF FACT

Claimant sustained a compensable injury on January 4, 1985 while delivering fuel on a "per load" basis. The injury was accepted as disabling, and the insurer began paying temporary disability based on an average weekly wage of $430 for the 26-week period preceding claimant's injury. (Ex. 1 and 2A). Claimant disagreed with the amount of temporary disability paid by the insurer, and requested a hearing. The insurer subsequently discovered that the employer's pay records documented an even lower average weekly wage of $328.84. (Ex. 16, 21-23, 25). Based on this information, the insurer concluded that claimant had received more temporary disability than he was entitled to, and it cross-requested authorization to offset the alleged overpayment against future awards of permanent partial disability.

We find that claimant was not a credible or reliable

witness. We further find that the employer's pay records are consistent with its monthly statements of earnings and deductions, as well as claimant's W-2 Form and personal income tax return. We are persuaded that claimant did not receive cash payments in addition to the amounts reflected in the employee's pay records. We are further persuaded that those records present the most accurate account of claimant's work activity. Finally, we find that claimant earned an average weekly wage of $328.84 for the 26-week period preceding his injury.

CONCLUSIONS OF LAW AND OPINION

Pursuant to former OAR 436-60-020(7)(b), claimant's temporary disability benefits are based on his average weekly earnings for the 26-week period preceding his injury. The Referee relied on the employer's pay records and found that claimant received an average weekly wage of $328.84 for the relevant 26-week period.

On review, claimant contends that the employer's pay records understate his earnings. In support of his position, claimant relies on his own personal log book which indicates that he delivered an average of 6 loads per week and received an average weekly wage of $391 for the period July 1, 1984 through September 29, 1984. (Ex. 19). In addition, claimant testified that he delivered an average of 9 loads per week and received additional cash payments not included in the employer's records or his own personal income tax return. (Tr. 16-25).

We are not persuaded by claimant's argument. The employer's records are consistent with its monthly statements of earnings and deductions and claimant's W-2 form. Even more significant, the employer's pay records are consistent with claimant's own personal income tax return. Furthermore, claimant's log book is inconsistent with his testimony that he delivered an average of 9 loads per week. Finally, claimant presents no documentation to support his assertion that he received additional cash payments not reflected in the employer's records or his own tax return.

In light of these facts, we agree with the Referee's finding that claimant did not receive payments in addition to those reflected in the employer's records. In addition, we are persuaded that the employer's pay records present an accurate account of claimant's wage history. Based on those records, we agree with the Referee's finding that claimant earned an average weekly wage of $328.84 for the 26-week period preceding his injury.

We, therefore, affirm the Referee's conclusion that claimant is not entitled to additional temporary disability compensation. As we are declining claimant's request for additional temporary disability, it is not necessary for us to address the Referee's ruling on the offset issue.

ORDER

The Referee's order dated May 29, 1987 is affirmed.

WESLEY L. MILLS, Claimant
Haugh & Foote, Claimant's Attorneys

WCB TP-88008
August 17, 1988
Interim Third Party Partial Distribution Order

Claimant has petitioned the Board to resolve a dispute concerning the amount of the balance of the proceeds from a third party judgment which may be retained by the paying agency. See ORS 656.593(1), (c), (d).

FINDINGS

In November 1986 claimant sustained a compensable neck and lower back injury when the automobile he was operating was struck from behind by another motor vehicle. His condition has been diagnosed as chronic cervical and lumbosacral strain. Treatment has been conservative.

In January 1987 claimant returned to work. His condition was found to be medically stationary, effective August 25, 1987. Dr. Eubanks, his treating physician, opined that claimant had suffered "15% partial disability." The last medical bill received by the paying agency was dated February 5, 1988.

On March 18, 1988, the paying agency closed the claim by means of a Notice of Closure. Claimant has advised the paying agency that he does not intend to contest the administrative closure of his claim. To date, neither a Determination Order nor a hearing request has been sought.

Claimant initiated a cause of action against the driver of the other vehicle. Following a trial, he obtained a judgment against the third party. The judgment, including damages and litigation costs, totalled $35,329.30. After deducting claimant's attorney's fee, litigation costs, and his one-third statutory share, a balance of $6,000 remains.

The paying agency has expended $1,644.45 in temporary disability benefits and $2,880.66 in medical bills. The agency projects $5,800 in future expenses. Other than the physician's conclusory prediction of 15 percent "partial disability," no evidence in support of these expenses has been submitted.

We find that the paying agency is entitled to recover its actual claim costs. However, we find that the request to receive reimbursement for future expenses is premature.

CONCLUSIONS

When the worker elects to recover damages from the third party, the proceeds of any recovery shall be distributed as set forth in ORS 656.593(1). The statutory scheme for the allocation of damages is precise. Robert B. Williams, 38 Van Natta 119, 123 (1986), aff'd. Estate of Troy Vance v. Williams, 84 Or App 616 (1987).

Costs and attorney fees incurred shall be initially disbursed. ORS 656.593(1)(a). Then, the worker shall receive at least 33-1/3 percent of the balance of the recovery. ORS 656.593(1)(b). The paying agency shall be paid and retain the balance of the recovery 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. ORS 656.593(1)(c). Any remaining balance shall be paid to the worker. ORS 656.593(1)(d

Here, the parties are in agreement that the funds subject to the paying agency's lien claim total $6,000. Furthermore, there is no contention concerning the agency's claim for its actual costs incurred to date. Therefore, we conclude that $4,101.11 of the aforementioned sum shall be promptly disbursed to the paying agency in reimbursement for its actual claim costs.

The remaining balance of the proceeds from the third party judgment shall be held in trust pending a final determination of the extent of claimant's permanent disability, if any. Claimant submits that he has no intention of contesting the closure of his claim. Despite this assurance, the closure has not become final by operation of law. See ORS 656.268(3),(4). Consequently, because there has not been a final order determining the extent of claimant's disability arising out of his compensable injury, we deem it appropriate to defer ruling on the question of the paying agency's entitlement to a lien for anticipated future expenditures. See John T. Elicker, 40 Van Natta 68 (1988); Robert B. Williams, 37 Van Natta 711 (1985).

Accordingly, from the remaining balance of proceeds from the third party recovery, claimant's attorney is directed to distribute to the paying agency, as reimbursement for its actual claim costs incurred to date, the sum of $4,101.11. The remaining balance of the proceeds shall be held by claimant's attorney in trust pending a final determination concerning the extent of claimant's permanent disability. Upon final resolution of disability issue and assuming a dispute continues to exist, the parties shall notify the Board of their respective positions. Thereafter, the Board will order distribution of the remaining balance.

IT IS SO ORDERED.

RAYMOND D. MOLONEY, Claimant
Haugh & Foote, Claimant's Attorneys
Ruth Cinniger (SAIF), Defense Attorney

WCB 86-06170
August 17, 1988
Order on Review

Reviewed by Board Members Ferris and Crider.

Claimant requests review of Referee Mulder's order that upheld the SAIF Corporation's "back up" denial of his shoulder condition. We affirm.

ISSUE

"Back up" denial.

FINDINGS OF FACT

Claimant sought treatment at a hospital emergency room at 4:35 p.m. on May 12, 1985. He reported slipping and falling at work the previous day. However, he did not report a slip and fall incident to anyone on May 11, 1985. On May 28, 1985, SAIF received medical reports concerning claimant's right shoulder and upper back pain which was attributed to a fall onto concrete. A claims representative for SAIF apparently signed a claim form accepting the

claim on May 29, 1985. Thereafter, claimant signed the form which described the injury as resulting from a slip on loose gravel in the loading area of the employer's shop.

No one witnessed claimant's alleged accident.

After work on May 11, 1985, claimant was involved in a fight and was thrown against a car. He had broken his shoulder several years before this incident. Claimant did not inform his doctors or his employer of this fight or that he had previously suffered a broken shoulder.

Claimant told a co-worker that he had injured his shoulder during the fight. He further advised the co-worker that he intended to report the shoulder injury as work-related.

Claimant saw two orthopedists, Dr. Pasquesi and Dr. McKillop. Both doctors diagnosed a separated shoulder and a mild permanent disability. An October 14, 1985 Determination Order awarded temporary disability and 10 percent (32 degrees) unscheduled permanent disability. A second Determination Order issued in December 1985, affirmed the prior award.

On January 14, 1987, SAIF issued a denial of benefits based upon information which indicated that claimant had been injured in the May 1985 fight.

SAIF accepted the claim without knowledge of claimant's May 1985 fight which took place on the same day as his alleged compensable accident. Furthermore, at the time of its acceptance of his claim, SAIF was unaware that claimant had a broken shoulder several years prior to this incident.

CONCLUSIONS OF LAW AND OPINION

The Referee reasoned that the case turned on claimant's credibility. A co-worker testified that claimant stated he had been injured in a fight and was going to report the injury as a work injury in order to have SAIF pay his medical expenses. Furthermore, the Referee noted that claimant had changed his version of how the injury occurred before the hearing and during his testimony at the hearing. Accordingly, the Referee concluded that the claimant was not credible. We agree.

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 and, approximately five months later, SAIF issued a denial of compensability.

Claimant asserts that the denial was impermissible under Bauman, supra. SAIF responds that the "back-up" denial was procedurally proper because claimant misrepresented the cause of his shoulder condition. A review of the case law reveals that the Bauman exception has been invoked when an employer has shown that it was induced to accept the claimant's claim by his 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., 73 Or App 790 (1985); and Skinner v. SAIF, 66 Or App 467 (1984).

Here, claimant presented different versions of how he received his injury. A co-worker testified that claimant said he was in a fight and intended to say his resultant injury was job related. Claimant testified that he had hurt his shoulder when he slipped on some debris located on the dock. However, he admitted that he did not tell his employer that he had been in a fight the evening of his alleged accident.

We conclude that the record contains sufficient evidence to indicate that claimant made misrepresentations by omission and that these misrepresentations were a material factor in causing SAIF to accept his claim. Accordingly, the "back-up" denial was procedurally proper.

Despite our conclusion that the "back-up" denial was procedurally proper, claimant has the opportunity of proving by a preponderance of the evidence that his claim was nonetheless compensable. Parker v. D.R. Johnson Lumber Co., 70 Or App 683, 687 (1984). The only evidence of the alleged accident and injury, however, was provided by claimant's testimony, which we find not credible. We, therefore, uphold SAIF's "back-up" denial on the merits.

ORDER

The Referee's order dated July 29, 1987 is affirmed.

PHYLLIS J. MORETZ, Claimant
Pozzi, Wilson, et al., Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB 86-13206 & 86-10214
September 16, 1988
Order on Review

Reviewed by Board Members Ferris and Crider.

Claimant requests review of those portions of Referee Tenenbaum's order which: (1) upheld the self-insured employer's denial of her occupational disease claim for a bilateral foot condition; and (2) increased her unscheduled permanent disability award for a dysphonic condition from 25 percent (80 degrees), as awarded by a Determination Order, to 65 percent (208 degrees).

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

ISSUES

1. Compensability of bilateral foot condition.

2. Extent of unscheduled permanent disability for a dysphonic condition.

FINDINGS OF FACT

Claimant's foot conditions were diagnosed as left foot and ankle pain and right foot tendonitis. We are unable to determine the etiology of either condition. We do not find that work activities were a major contributing cause of either condition. In addition, claimant has flatfeet and an accessory navicular in the left foot, conditions which preexisted her employment as a mail clerk for the employer. We do not find that her work activities contributed to a pathological worsening of those preexisting conditions.

Claimant also suffers from a compensable conversion reaction, which has resulted in symptoms of dysphonia, fatigue, and pain in the middle back, right shoulder, neck, jaw, roof of the mouth, back of the tongue and throat. In addition, she has secondary depression symptoms of slower productivity, reduced capacity for problem solving, inability to think clearly, and fear of being around other people. We find that the degree of permanent impairment resulting from these symptoms does not exceed moderate.

Claimant is 50 years of age and has a high school education. Her prior work history consists primarily of jobs requiring verbal communication, such as a telephone operator and receptionist. She has worked several years as a courier, mail room clerk, and a typist in the employer's accounting department.

CONCLUSIONS OF LAW AND OPINION

With regard to the extent of disability issue, claimant has sustained a permanent loss of earning capacity due to her permanent impairment, age and limited work experience. However, we do not conclude that she is entitled to more than 65 percent unscheduled permanent disability for the dysphonic condition and attendant disabling symptoms.

ORDER

The Referee's order dated March 6, 1987 is affirmed. The Board approves a client-paid fee, not to exceed $719.50.

CAROL PACKARD, Claimant
Carney, et al., Claimant's Attorneys
Lester Huntsinger (SAIF), Defense Attorneys

WCB 87-12755
August 17, 1988
Order of Dismissal

The SAIF Corporation requested Board review of Referee Podnar's order that denied, as untimely, its request for authorization to recover permanent partial disability benefits previously paid to claimant during the period she was subsequently found to be entitled to an award of permanent total disability. SAIF has now withdrawn its request for review.

Accordingly, the request for Board review is dismissed and the order of the Referee is final by operation of law.

Claimant requests an insurer-paid attorney fee for prevailing against SAIF's appeal. The request is 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); Matthew W. Johnson, 40 Van Natta 393 (1988).

IT IS SO ORDERED.

SHIRLEY R. WAGGONER, Claimant
Leeroy O. Ehlers, Claimant's Attorney
Alan Ludwick (SAIF), Defense Attorney

WCB 86-01811
August 17, 1988
Order on Review

Reviewed by Board Members Ferris and Crider.

Claimant requests review of Referee St. Martin's order which upheld the SAIF Corporation's partial denial of her claim for treatment for neck and right shoulder pain. We affirm.

ISSUE

Compensability of treatment for neck and right shoulder pain.

FINDINGS OF FACT

Claimant compensably injured her right foot on May 31, 1984 when she slipped and fell on her right foot in a seated position. The diagnosis was a right foot sprain. The claim was closed by Determination Order on January 16, 1985 with a 5 percent (6.75 degree) scheduled permanent disability award.

In approximately 1981, claimant apparently injured her neck or right shoulder in a non-compensable accident. As a result of that accident, she had neck and arm pain and missed two or three days of work. She also missed approximately ten days in late January and early February of 1984 due to neck and right shoulder pain.

During the seven months following the compensable ankle injury, claimant never complained of symptoms involving her neck, right shoulder or back. Claimant began treating with Dr. Kuzma in June of 1984 and with Dr. Fleck in August of 1984. Both doctors are family practitioners. On January 11, 1985, claimant complained to Dr. Fleck for the first time of soreness in the back of her neck and head. She also told Fleck that she had been experiencing intermittent right shoulder pain during the previous year. She later told Fleck that these symptoms related to the four-year-old non-compensable accident and that they might have been aggravated by the compensable injury. Fleck referred her for physical therapy. She quit work in late January of 1985 due to increasing pain in the neck and right shoulder. The following month, claimant complained to Dr. Kuzma for the first time of headaches, right arm pain, and chest pain radiating into the back. She told Kuzma that these symptoms had been bothering her since the compensable ankle injury. A neurological evaluation by Dr. Eisler revealed minimal arthritis in the neck but no evidence of nerve impingement.

On January 6, 1986, SAIF denied the compensability of treatment for claimant's neck and shoulder pain. We find that the compensable injury in May of 1984 was not a material contributing cause of the neck and shoulder pain.

CONCLUSIONS AND OPINION

To establish the compensability of medical treatment for a condition, claimant must sustain her burden of proving that the compensable injury was a material contributing cause of that

condition. ORS 656.245(1); Jordan v. SAIF, 86 Or App 29, 32 (1987). The "material contributing cause" need not be the sole, or even the principal, cause. See Aquillon v. CNA Insurance, 60 Or App 231, 236 (1982), rev den 294 Or 460 (1983).

Here, claimant's condition is neck and right shoulder pain. Given her prior history of neck and shoulder problems, the causation of claimant's condition presents a complex medical question. Hence, although her testimony is probative, resolution of this case turns largely on the medical evidence. Uris v. Compensation Department, 247 Or 420, 426 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985).

The medical evidence was generated by Dr. Fleck, the treating physician since August of 1984. Fleck initially opined that claimant had preexisting chronic neck and right shoulder pain which was aggravated by the compensable accident in May of 1984. However, Fleck later retreated from that opinion and concluded, instead, that it was "equally possible" that the pain was caused by either the non-compensable accident in 1981 or the compensable accident in May of 1984. We conclude that the medical evidence in this case does not establish with reasonable certainty that claimant's chronic pain condition is causally connected to the May 1984 injury. See Gormley v. SAIF, 52 Or App 1055, 1059-60 (1981).

Claimant testified that the neck and right shoulder symptoms worsened after the compensable injury. However, we are not persuaded by that testimony, because claimant performed her regular job for more than seven months before complaining of any symptoms. Claimant has not sustained her burden of proof.

ORDER

The Referee's order dated May 27, 1987 is affirmed.

DALLAS H. GREENSLITT, Claimant
Peter O. Hansen, Claimant's Attorney
Mark Bronstein (SAIF), Defense Attorney
Meyers & Terrall, Defense Attorneys

WCB 86-13426 & 86-11726
August 18, 1988
Order on Review

Reviewed by Board Members Crider and Ferris.

West Coast Grocery Distributors (West Coast), a self-insured employer, requests and the SAIF Corporation, on behalf of the Lundborg Company (Lundborg), cross-requests review of those portions of Referee Peterson's order which set aside their denials of claimant's injury claim and found that West Coast and SAIF should jointly bear responsibility for the claim. West Coast also contends that the Referee erred in declining to admit an advertising brochure prepared by Lundborg. We affirm.

ISSUES

1. Responsibility for claimant's neck, left shoulder and back injury.

2. Admissibility of advertising brochure into evidence.

FACTS

Claimant injured his neck, left shoulder and back on July 14, 1986 when a case of tomato juice fell on him while he was working concurrently as a warehouseman for West Coast and an undercover investigator for Lundborg. The injury occurred as he was filling an order for West Coast. The diagnosis was cervicothoracic strain/sprain, lumbosacral strain/sprain, and left shoulder contusion. Claimant filed claims with both employers. Each claim was denied on the basis that claimant was not a subject employe. Both employers denied responsibility, though West Coast also denied compensability and refused to agree to the designation of a paying agent under ORS 656.307.

West Coast, a distributor of grocery products, suspected that some of its employes were involved in illicit drug activities on the business premises. Consequently, West Coast contacted and met with the owner/director of Lundborg, a security and investigative services firm, to discuss hiring an undercover investigator. On March 31, 1986, West Coast and Lundborg entered into a written agreement with the following terms: (1) Lundborg would furnish an undercover agent to perform investigative services on West Coast premises; (2) West Coast would pay the agent directly for his work as a warehouseman; (3) West Coast would pay Lundborg $400 weekly, from which the agent would be paid for investigative services; (4) West Coast would reimburse Lundborg for amounts advanced to the agent for unusual expenses, such as drug buys; (5) Lundborg would report the agent's findings to West Coast on a weekly basis; and (6) the agent would be employed in the aforementioned capacity for a minimum period of four months, subject to meeting minimum work requirements for the warehouseman position. The parties anticipated that the agent would observe employe activity while working as a warehouseman and that he would initiate contacts with employes when he was not working. There was no agreement or discussion as to which employer was to provide workers' compensation insurance coverage for the agent.

Claimant, who had been working for Lundborg as a part-time security officer, was selected by Lundborg for the undercover assignment. Lundborg agreed to pay claimant $100 weekly for undercover investigative services. When a position with West Coast opened, claimant began his assignment as a full-time warehouseman at regular wages. His wages were paid from the same funds used to pay the other employes. By agreement between the two employers, claimant completed a tender of resignation prior to his assignment, which could be used by West Coast to terminate his assignment at any time and for any reason. Claimant did not undergo the usual pre-employment screening process; he did not complete an application, have any interview, or submit to a physical examination. He submitted a W-4 tax form and later joined the union as required by the union's contract with West Coast. West Coast ultimately reimbursed him for his union membership dues.

As part of his undercover investigation, claimant observed employe activities while performing his warehouse functions and established contacts with employes during breaks, lunch hours and off-work hours. Only the top management of West Coast knew of claimant's undercover role. Claimant was under the

complete supervision and control of West Coast with regard to his warehouse functions. He was treated the same as any other West Coast employe and was subject to the usual disciplinary actions for failure to perform his warehouse duties adequately.

Claimant was under the complete supervision and control of Lundborg with regard to his investigative functions. He contacted Lundborg three to five times weekly and submitted written reports prepared after work. He never contacted Lundborg during hours when he was working as a warehouseman.

After claimant sustained the injury in question, West Coast used his pre-signed tender of resignation to terminate his undercover assignment. Claimant performed no further investigative services for Lundborg.

At hearing, the Referee refused to admit an advertising brochure produced by Lundborg, which was submitted by West Coast. We find that the brochure would have been cumulative of other evidence already in the record.

We find that: (1) claimant was under contract of hire with West Coast and Lundborg; (2) claimant was under the control of West Coast with regard to his warehouse functions and under the control of Lundborg with regard to his investigative functions; (3) the functions on behalf of each employer were separate and distinct; and (4) claimant's employment activity at the time of injury was not separable.

CONCLUSIONS AND OPINION

We adopt the Referee's conclusions of law and opinion with the following supplementation. The Referee concluded that these facts constituted "dual employment" and that, because claimant was performing two jobs simultaneously for the joint benefit of both employers, both employers should jointly bear responsibility. We agree.

Responsibility

In order to establish a case of "dual employment," three elements are necessary: (1) a worker must be under contract with two employers; (2) the worker must be under the separate control of each employer; and (3) the worker must perform distinct and separate services for each employer. Mission Insurance Co. v. Miller, 73 Or App 159, 163 (1985)(citing 1C Larson, Workmen's Compensation Law, 48.40 (1982)). All three elements are satisfied here.

A contract of hire between claimant and each employer may be either express or implied. See Oremus v. Or. Pub. Co./Leibrand, 11 Or App 444, 446-47 (1972), rev den (1973); 1C Larson, Workmen's Compensation Law, § 48 (1986). It is undisputed that claimant was under contract with Lundborg. Rather, the issue is whether a contract of hire existed between claimant and West Coast. West Coast placed claimant in a regular job at regular wages drawn from the same funds used to pay other West Coast employes. For his part, claimant performed his regular duties under the direction and supervision of West Coast and knowingly accepted wages from West Coast. For these reasons, we find that claimant was under an implied contract of hire with West Coast.

We are also persuaded that claimant was under the separate control of each employer. It is undisputed that Lundborg

had complete control of claimant's investigative functions. West Coast directed and supervised claimant's warehouse functions, and retained the power to terminate his assignment at any time and for any reason. In addition, claimant was expected to meet minimum work requirements and was subject to the usual disciplinary actions for failure to perform adequately. We find that West Coast had complete control of claimant's warehouse functions. We further find that claimant's warehouse functions were separate and distinct from his investigative functions.

In a case of "dual employment," the employers may be liable for workers' compensation separately or jointly, depending on the severability of claimant's activity at the time of injury. Mission Insurance Co. v. Miller, supra; Larson, Workmen's Compensation Law, § 48.50 (1986). Here, the dispositive question is whether the warehouse activity that claimant was performing at the time of injury was severable from his investigative activity. If so, West Coast is solely responsible for the injury; otherwise, West Coast and Lundborg are jointly responsible. We find that claimant's activity at the time of injury was not severable because, as part of his investigative functions, he was expected to make observations while performing warehouse functions. For the most part, these functions were performed simultaneously. Accordingly, we conclude that West Coast and Lundborg should jointly bear responsibility.

Admissibility of Evidence

Finally, we do not disturb the Referee's evidentiary ruling. We find that the advertising brochure was cumulative of other evidence already in the record. The Referee did not abuse his discretion in declining to admit it. OAR 438-07-005(4).

Claimant's counsel is statutorily entitled to a reasonable, insurer-paid attorney fee for services rendered on Board review. Such a fee is defined as an "assessed fee." See OAR 438-15-005(2). However, we cannot authorize an assessed fee unless claimant's attorney files a statement of services. See OAR 438-15-010(5). Because no statement of services has been received to date, an assessed fee shall not be authorized. See OAR 438-15-010(5).

ORDER

The Referee's order dated January 23, 1987, as amended on February 18, 1987, is affirmed. The Board approves a client-paid fee not to exceed $178.50.

ROBERT D. BILLICK, Claimant
Malagon & Moore, Claimant's Attorneys
Meyers & Terrall, Defense Attorneys

WCB 88-00743
August 19, 1988
Order Denying Motion to Dismiss

The self-insured employer has requested Board review of Referee Mills' June 17, 1988 order, as reconsidered July 15, 1988. Claimant has moved for an order dismissing the employer's request on the ground that it was untimely filed. The motion is denied.

FINDINGS

On June 17, 1988, the Referee issued an order, setting

aside the employer's denial of claimant's aggravation claim. In addition, the employer was assessed penalties and accompanying attorney fees for failing to timely process the claim. The order indicated that the interim compensation benefits, upon which the penalty was based, would terminate on January 11, 1988, the date of the employer's denial. However, the order did not state when those benefits should have commenced.

Shortly thereafter, the employer moved for reconsideration and claimant submitted a response to the motion. On July 15, 1988, the Referee issued an Order on Reconsideration. This order expressly modified the June 17, 1988 order by providing that the penalty for unreasonable claims processing should be based on the interim compensation payable from December 4, 1987 through January 11, 1988.

Save for the aforementioned modification, the July 15, 1988 Order on Reconsideration stated that the June 17, 1988 order "remain[ed] intact." Finally, the July 15, 1988 order provided that the parties' rights of appeal "shall run from the date of this Order on Reconsideration." As with the June 17, 1988 order, the July 15, 1988 order contained a statement explaining the parties' rights of appeal under ORS 656.289 and 656.295.

On July 18, 1988, the employer mailed its request for review of both of the Referee's orders to the Board. The request was mailed by certified mail. A certificate of service, submitted with the request, indicated that copies of the request had been mailed to all parties to the proceeding.

We find that the July 15, 1988 Order on Reconsideration modified the June 17, 1988 order. We further find that the request for review of both orders was timely mailed to the Board and to the parties.

CONCLUSIONS

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). 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. Argonaut Insurance Co. v. King, 63 Or App 847, 852 (1983).

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 June 17, 1988 order was neither abated, stayed, nor withdrawn. However, the prior order was expressly modified by the Referee's July 15, 1988 Order on Reconsideration. Inasmuch as the employer requested Board review within 30 days of the July 15, 1988 Order on Reconsideration, we conclude that we have jurisdiction. See Connie R. Walker, 40 Van Natta 84 (1988).

Assuming arguendo that the July 15, 1988 Order on Reconsideration did not modify the June 17, 1988 order, we would continue to retain jurisdiction over this matter. We reach this conclusion because the employer's request for review was timely submitted for both orders.

Here, the thirtieth day after the Referee's June 17, 1988 order was July 17, 1988, a Sunday. Thus, the last day to timely file a request for Board review was Monday, July 18, 1988. See ORS 174.120. Inasmuch as the employer's request for Board review of the Referee's orders was mailed by certified mail on July 18, 1988, it is timely for both of the Referee's orders. See OAR 438-05-046(1)(b).

Accordingly, the motion to dismiss is denied. Upon receipt of the hearing transcript, the Board will provide the parties with copies and implement a briefing schedule.

IT IS SO ORDERED.

JOE LAWSON, Claimant
Peter O. Hansen, Claimant's Attorney
Judy Johnson (SAIF), Defense Attorney

WCB 83-11960
August 19, 1988
Order on Review

Reviewed by Board Members Crider and Ferris.

Claimant requests review of those portions of Referee Peterson's order that upheld the SAIF Corporation's denials of: (1) claimant's current psychological condition; and (2) claimant's ulcer condition. We affirm.

ISSUES

1. Whether SAIF's "back up" denial of claimant's accepted psychological condition was proper.

2. If SAIF's "back up" denial was proper, whether claimant's psychological condition was compensable.

3. Whether penalties and attorney fees should be assessed for SAIF's alleged improper preclosure partial denial.

4. Whether claimant's ulcer condition was compensable.

FINDINGS OF FACT

At the outset of this complex and unusual case, we would like to emphasize our agreement with the Referee that, based on a record which spans more than 15 years, claimant was consistently untruthful and unreliable. During this period, he was seen by three sets of approximately 30 doctors who, until recently, were unaware of the existence of the others. The first group of doctors dealt with claimant's drug addiction. The second set dealt with his workers' compensation claim. The third group of doctors dealt with claimant's alleged narcolepsy condition.

On April 19, 1979, Claimant, 44, was working as a drywall finisher when he fell through a hole in the floorboards of a house and injured his low back.

Claimant treated conservatively with Dr. Cherry who released him for work with the following restrictions: (1) no lifting greater than 50 pounds; (2) no carrying greater than 30 pounds; (3) incidental walking and kneeling; and (4) unrestricted sitting.

On September 8, 1980, a Determination Order awarded claimant 10 percent unscheduled permanent disability for his low back condition.

In October 1980 claimant began vocational rehabilitation efforts. Vocational testing indicated that claimant had significant personality problems with a strong focus on physical complaints and possible secondary gain.

On November 17, 1980, a stipulation raised claimant's unscheduled permanent disability award for his low back condition to 20 percent.

On March 5, 1981, Dr. Brown reported that claimant exhibited the classic features of narcolepsy with the accompanying symptoms of cataplexy and somnambulism and prescribed amphetamines. This prescription was refilled on a regular basis until 1986. At that time, Dr. Brown suspected that claimant never had narcolepsy and refused further medication. We specifically find that claimant fabricated symptoms of narcolepsy in order to obtain amphetamines.

On March 13, 1981, SAIF authorized an on-the-job auto body repair training program for claimant. On May 1, 1981, however, claimant terminated the training program and returned to drywall work. On June 10, 1981, claimant's claim was again closed by Determination Order with no change in his permanent disability. On January 4, 1982, SAIF authorized a second training program, now in industrial clutch repair. On August 10, 1982, the training program was terminated due to claimant's psychological and emotional problems. This process of closure and reopening of claimant's vocational assistance continued until January 25, 1986 when for the last time claimant's case was closed due to his unwillingness to fully participate in vocational evaluation.

On August 20, 1982, Dr. Quan, psychiatrist, diagnosed: (1) work-related depression; and (2) organic brain dysfunction based on a history of multiple head traumas. The evidence, however, is unclear whether claimant had a history of head traumas.

On September 20, 1982, SAIF agreed by stipulation to voluntarily reopen claimant's claim and provide medical care and treatment for his psychological condition arising out of the 1979 compensable injury.

Subsequent to 1982, claimant's psychological condition continued to deteriorate. He exhibited increased paranoia, confusion, depression and memory loss.

On November 23, 1983, Dr. Binder, clinical neuropsychologist, tested claimant's intellectual functioning. Claimant exhibited a marked deficit in concept formation, abstract thinking, and mental tracking. Although his memory for verbal material was only mildly impaired and his verbal intellectual abilities were average, his reading skills were severely deficient.

In March 1984 Claimant began treating with Dr. Christensen, clinical psychologist. He reported that claimant showed many signs

of brain damage and diagnosed: (1) amnestic syndrome; (2) organic personality syndrome; and (3) recurrent major depression.

In May 1984 Dr. Christensen became aware of claimant's drug addiction for the first time.

On June 19, 1984, SAIF denied responsibility for claimant's upper gastrointestinal bleeding ulcer since it was not the result of, or causally related to, his compensable back injury.

On February 14, 1986, SAIF denied claimant's claim for a psychological condition since investigation revealed that it was long standing and not affected or worsened by claimant's industrial injury. The denial further explained that SAIF's earlier acceptance of claimant's psychological condition was based upon his misrepresentation of the psychological history.

Claimant was a drug addict from a very early age. His drugs of choice were amphetamines, cocaine, and opiates, often codeine and heroin. He successfully withheld this information from all medical providers involved in the treatment of his back injury and depression until he accidentally shot himself in the foot and was hospitalized in 1984.

In 1971, claimant voluntarily entered the Comprehensive Options for Drug Abuse (CODA) methadone program in order to combat his heroin addiction. He remained on the methadone program from 1971 through 1985. While on the program, his "dirty" urine tests indicated continued use of amphetamines and opiates.

Amphetamines and cocaine are stimulants which increase brain activity. They impair desire, drive, and motivation. They cause tremendous mood swings with profound depression. (Tr. 126-2; 92-17). Other symptoms of amphetamine abuse include anxiety, nervousness and agitation. People who use amphetamines also don't eat or sleep for long periods of time and often develop gastritis, esophagitis and bleeding ulcers. (Tr. 98-1). Drug abuse, especially involving amphetamines and cocaine, may cause organic brain disease.

Organic brain syndrome is a combination of symptoms which represents the behavioral results of brain trauma. Trauma may be induced through genetic predispositions, infections, blows to the head or drug abuse. Organic brain damage due to drug abuse becomes progressively worse over time. (Tr. 90-11).

Claimant's depression and unemployability reflected two aspects of his chronic drug abuse: (1) the symptoms of polydrug use and withdrawal; and (2) cognitive impairment caused by the slow progression of polydrug-induced organic brain dysfunction. In fact, the CODA records indicate that claimant complained of depression as early as 1976.

Neither claimant's organic brain dysfunction nor his resulting depression were worsened by his compensable low back injury. Furthermore, claimant's ulcer condition was not causally related to his injury.

CONCLUSIONS OF LAW

Psychological condition

The Referee upheld SAIF's "back up" denial by asserting

that: (1) SAIF had shown material fraud or misrepresentation by claimant; and (2) claimant's psychological condition was not worsened by the 1979 compensable injury. We agree.

SAIF's "back up" denial was not an attempt to terminate future responsibility of claimant's psychological condition before the extent of his disability could be determined, but rather an attempt to revoke its original acceptance of claimant's claim for psychological benefits ab initio. Therefore, SAIF's denial did not constitute an improper preclosure denial forbidden by the court in Roller v. Weyerhaeuser Co, 67 Or App 583, 586 (1984). See Safstrom v. Riedel International, Inc., 65 Or App 728 (1983). Accordingly, we also refuse to assess a penalty or attorney fee against SAIF.

Once an employer officially accepts a claim for compensation, it may not later deny the compensability of the underlying claim, absent fraud, misrepresentation or other illegal activity. Bauman v. SAIF, 295 Or 788, 794 (1983). In order for nondisclosed information to be deemed sufficiently material to come within the Bauman exception, the insurer must establish the colorable materiality of the undisclosed fact and how its acceptance decision could reasonably have been affected by the insurer's knowledge of the fact. Ebbtide Enterprises v. Tucker, 303 Or 459, 463-4 (1987). A "back up" denial is permissible where acceptance of a claim is based on incomplete medical evidence due to claimant's failure to disclose prior medical information. Timothy J. Swodeck, 39 Van Natta 341, 343 (1987).

If misrepresentation is shown to be sufficiently material to come within the Bauman exception, claimant may still prevail over the denial if he can establish by a preponderance of the evidence that, although he had a preexisting condition, the injury which he sustained at work materially worsened his condition. Skinner v. SAIF, 66 Or App 467, 470 (1984), citing Larson v. Brooks-Scanlon, 54 Or App 861 (1981), rev den 292 Or 581 (1982).

To establish compensability of a psychiatric condition following an industrial injury claimant must prove by a preponderance of the evidence that the work-related injury was a material cause of the psychiatric condition, or, if claimant's mental condition predated the injury, that the injury worsened that preexisting condition. Jeld-Wen, Inc. v. Page, 73 Or App 136, 139 (1985). See Partridge v. SAIF, 57 Or App 163, 167, rev den 293 Or 394 (1982). The Court of Appeals in Grace v. SAIF, 76 Or App 511, 517 (1985) broadened the Jeld-Wen language to include underlying psychological conditions whose symptoms were precipitated by a compensable injury. (Emphasis added).

The record is replete with claimant's denials of drug use and the manipulation of doctors treating his various medical problems. Claimant consistently denied alcohol and drug use to medical providers. In order to obtain amphetamines, he fabricated nonexistent neurological disorders. In all probability, he also fabricated a history of multiple head traumas. Throughout the course of claimant's injury claim, he systematically concealed the truth and made false statements regarding his drug abuse and symptomatology, both physical and emotional. When SAIF finally became aware of claimant's drug abuse in 1984, claimant continued to obstruct its efforts to uncover the truth by refusing to authorize release of the CODA records for more than a year. SAIF's acceptance of claimant's psychological claim was based upon false and incomplete medical information regarding claimant's history of drug abuse. The

colorable materiality of these undisclosed facts could reasonably have affected SAIF's acceptance decision. Such deception, fraud, and misrepresentation satisfies the Bauman exception. Therefore, SAIF's "back up" denial was proper and it became claimant's burden to prove the compensability of his claim.

In May 1984 Dr. Christensen became aware of claimant's chronic drug addiction for the first time. He did not believe, however, that claimant's addiction played any role in his cognitive dysfunction. (Ex. 145).

On April 8, 1985, the Orthopaedic Consultants found that from a purely physical point of view claimant could return to drywall application. They also believed, however, that due to claimant's possible organic brain syndrome, which was related to multiple head injuries and/or drug abuse, his chances of being gainfully employed were not good. (Ex. 159).

On April 9, 1985, Dr. Quan opined that claimant's depression arose from his impaired mental function, loss of memory, and threat of future security. Dr. Quan thought that claimant's back injury, despite being mild, was an important event in his life which had brought about a high level of self-concern. (Ex. 160).

On January 13, 1986, Dr. Goranson, psychiatrist, conducted a file review at SAIF's request. He believed that claimant was not suffering from major depression. A more appropriate diagnosis was organic affective syndrome. Dr. Goranson concluded that claimant's low back injury in no way worsened his preexisting psychological condition and, therefore, the current psychological treatment was not related to claimant's industrial injury. (Ex. 177).

On February 14, 1986, Dr. Turco concurred with Dr. Goranson's January 13, 1986 report. He diagnosed chronic brain syndrome associated with multiple head trauma and drug abuse in an individual with a mixed personality disorder. He did not believe that claimant's long standing psychological problems were worsened by his industrial injury.

On March 11, 1986, Dr. Christensen reiterated his belief that claimant's depression was due to the effect of his industrial injury which prevented him from returning to the one occupation (drywall work) that allowed him to maintain a sense of dignity in spite of his cognitive deficits. Dr. Christensen opined that claimant's cognitive limitations, which left him riddled with self-doubt, confusion, forgetfulness, a lack of judgment and initiative and poor impulse control, were attributable to a history of multiple head injuries. He believed that claimant was permanently and totally disabled due to the combined effects of his industrial back injury, brain impairment and emotional problems. (Ex. 184).

On April 26, 1986, Dr. Binder diagnosed organic affective syndrome, atypical dementia, borderline personality disorder, and mixed substance abuse. He felt that claimant's unemployability was due to a worsening of his cerebral dysfunction, attributable solely to polydrug abuse and multiple head injuries. He also believed that it was highly likely that claimant never had narcolepsy and reported a false history of narcoleptic symptoms in an attempt to obtain amphetamines.

Dr. Larsen, psychiatrist, treated claimant at CODA throughout 14 years on the methadone program. He opined that

claimant was a chronic amphetamine abuser whose behavior over the years presented the classic case of organic-based, amphetamine-induced, intermittent psychosis. He believed that, absent the 1979 low back injury, claimant would still be unemployable today. Dr. Larsen also thought that claimant's addiction to opiates, methadone and amphetamines precluded him from working in any effective capacity due to extreme mood swings and impaired attention span. (Tr. 96-13). This belief was supported by the fact that, prior to 1979, the physical and mental demands of claimant's drug habit precluded steady employment. Dr. Larson indicated that, although claimant's inability to work in 1982 did contribute to his depression, that depression and immobilization was due to his amphetamine use, not his back injury. He concluded that claimant's psychological deterioration in 1982 had no relationship whatsoever with his 1979 compensable back injury. (Tr. 125-10).

On November 12, 1986, Dr. Ekanger, consulting psychologist, performed a file review at claimant's request. He believed that all of the consulting physicians had hit on a part of the truth: (1) claimant's head injuries and drug abuse caused brain damage; (2) claimant had a preexisting personality disorder; and (3) claimant's industrial injury was a material contributing factor to his need for psychiatric treatment. He further opined that increased stress, loss of wage earning ability, and loss of self-esteem as an independent and successful worker contributed to his psychiatric problems, including depression. In turn, the depression aggravated his potential for drug abuse.

We generally accord greater weight to the opinion of the treating physician, absent persuasive reasons to the contrary. Weiland v. SAIF, 64 Or App 810 (1983). When there is a dispute between medical experts, more weight is given to those medical opinions which are both well-reasoned and based on complete information. Somers v. SAIF, 77 Or App 259 (1986). Also, where expert analysis, rather than expert external observation, is more important in determining causation, we do not give special credit to the treating physician. Hammons v. Perini Corp., 43 Or App 299 (1979).

Dr. Christensen, claimant's treating psychiatrist, believed that claimant's depression was work-related and rarely addressed claimant's drug abuse throughout the course of his treatment. On the other hand, Drs. Goranson, Turco, and Larsen expressed their view that Dr. Christensen demonstrated little knowledge of claimant's drug use and its effect on claimant. We agree that Dr. Christensen had little understanding or concern for the psychiatric effect of claimant's longstanding drug abuse. Therefore, we do not find his opinion persuasive.

Drs. Goranson and Turco's diagnoses of personality disorder and organic brain disorder are supported by Dr. Binder's neuropsychological tests which revealed diffuse cerebral dysfunction, personality disorder and other cognitive difficulties attributable to claimant's polydrug use.

Dr. Larsen is an expert on drug abuse who treated claimant over a period of 14 years under the CODA program. From 1978 until 1985, Dr. Larsen was not even aware that claimant had sustained a compensable injury. We agree with his persuasive opinion that, absent the 1979 industrial injury, claimant would still be unemployable due to continuing cognitive deterioration caused by polydrug abuse.

We agree with the opinions of Drs. Binder and Larsen that the worsening of claimant's psychological condition was caused by the progressive deterioration of his mental function due to polydrug use. Claimant's depression was a symptom of both drug withdrawal and increasing cognitive impairment due to polydrug trauma. Claimant's psychological symptoms, including depression, were not precipitated by his industrial injury. Therefore, claimant failed to prove the compensability of his psychological condition. Jeld-Wen, Inc. v. Page, supra.

Ulcer condition

The Referee concluded that claimant's ulcer condition was not compensable since the medical evidence indicated it was only possible that the ulcer condition was related to his 1979 industrial injury. We agree.

Claimant had the burden of proving his contention by a preponderance of the evidence. Hutcheson v. Weyerhaeuser, 288 Or 51 (1979). A preponderance of the evidence does not mean a mere possibility of causal connection. Lenox v. SAIF, 54 Or App 551, 554 (1981); Gormley v. SAIF, 52 Or App 1055, 1060 (1981).

Drs. Veillet and Budden, claimant's treating vascular surgeons, both agreed that his ulcer condition was only possibly, and not probably, related to the 1979 industrial injury. We therefore agree with the Referee that claimant did not prove that his ulcer condition was work-related.

ORDER

The Referee's order dated December 15, 1986 as reconsidered February 20, 1987, is affirmed.

KENNETH OWENS, Claimant
Velure & Yates, Claimant's Attorneys
Cowling & Heysell, Defense Attorneys

WCB TP-87016
August 19, 1988
Third Party Distribution Order

Claimant has petitioned the Board to resolve a dispute concerning the proper distribution of the proceeds from a third party judgment. See ORS 656.593. Specifically, claimant contends that the paying agency's lien should not apply to the general damages awarded in the judgment. We disagree.

FINDINGS

Claimant suffered a compensable inguinal hernia. This condition has necessitated five surgeries. The current dispute concerns the fourth surgery, a right orchectomy.

Claimant initiated a malpractice action against his surgeon, contending that the removal of his testicle was unnecessary, did not improve his condition, and caused him psychological problems. Claimant sought $30,000 in special damages, which represented three months of lost earnings and medical expenses for the "unnecessary" fourth surgery and a subsequent fifth surgery. At trial, claimant alleged that the fifth surgery should have been performed rather than the "unnecessary" orchectomy.

The jury returned a verdict for claimant. He was awarded $100,000 in general damages and $12,000 in special damages.

We find that claimant received a compensable injury due to the negligence of a third person. We further find that the damages resulting from claimant's third party action are attributable to the negligence of that third person.

Finally, we consider the present record sufficient to sustain judicial review.

CONTENTIONS

Claimant contends that the paying agency's lien is limited to the $12,000 in special damages and not the $100,000 in general damages. He submits that the general damages were awarded primarily for pain and suffering attributable to the loss of the testicle, "which disability is not cognisable [sic] under the Workers' Compensation Act." We disagree.

CONCLUSIONS

In order to address third party disputes, a record sufficient to sustain judicial review under ORS 656.298 is required. See Blackman v. SAIF, 60 Or App 446, 448 (1982). Here, other than correspondence from the parties' respective counsels, the present record consists of claimant's petition and an affidavit from his trial attorney. Although the facts of this matter have been presented in a rather conclusory manner, they are not disputed. Moreover, the issue is a legal one. Consequently, we conclude that the current record is sufficient to judicial review.

We turn to the merits of the dispute.

If a worker receives a compensable injury due to the negligence or wrong of a third person not in the same employ, the worker shall elect whether to recover damages from such third person. ORS 656.578. The proceeds of any damages recovered from a third person by the worker shall be subject to a lien of the paying agency for its share of the proceeds. ORS 656.593(1).

When the worker elects to recover damages from the third party, the proceeds of any recovery shall be distributed as set forth in ORS 656.593(1). The statutory scheme for the allocation of damages is precise. Robert B. Williams, 38 Van Natta 119, 123 (1986), aff'd. Estate of Troy Vance v. Williams, 84 Or App 616 (1987).

Costs and attorney fees incurred shall be initially disbursed. ORS 656.593(1)(a). Then, the worker shall receive at least 33-1/3 percent of the balance of the recovery. ORS 656.593(1)(b). The paying agency shall be paid and retain the balance of the recovery 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. ORS 656.593(1)(c). Any remaining balance shall be paid to the worker. ORS 656.593(1)(d).

Here, claimant elected to seek recovery against the negligent third party. Upon exercising that election, the provisions of ORS 656.593 became applicable. Thus, the proceeds of any damages recovered from the third party became subject to

the paying agency's lien for its share of the proceeds. See ORS 656.593(1). The statute is both clear and unambiguous. It expressly provides that the proceeds of any damages resulting from a third party recovery are subject to the paying agency's lien. Furthermore, the statute contains no provision which would otherwise limit the applicability of the lien to special or any other form of damages.

In accordance with the aforementioned statutory authority, we hold that the paying agency's lien applies to the proceeds of any damages recovered from the third party. Therefore, regardless of the composition of the judgment, we conclude that since claimant's recovery of damages arose out of the negligent conduct of the third party, the proceeds of that recovery are properly subject to the paying agency's lien.

Accordingly, claimant's attorney is directed to distribute the proceeds of the third party judgment, comprised of the $12,000 in special damages and the $100,000 in general damages, in accordance with the provisions of ORS 656.593(1).

IT IS SO ORDERED.

DONALD L. ROBY, Claimant
Malagon & Moore, Claimant's Attorneys
Brian L. Pocock, Defense Attorney

WCB 85-13293
August 19, 1988
Order on Review

Reviewed by Board Members Johnson and Crider.

The self-insured employer requests review of that portion of Referee Peterson's order which set aside its partial denial of claimant's medical services claim for pain center treatment for his neck condition. We affirm.

ISSUE

Reasonableness and necessity of pain center treatment for a neck injury.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following supplementation. As a result of his compensable neck injury, claimant suffered from chronic cervicodorsal pain syndrome, which typically begins focally and spreads to surrounding musculature. The syndrome is reversible with proper rehabilitation, consisting of pain center treatment, education and exercise. We find that pain center treatment is reasonable and necessary for the effects of claimant's neck injury.

CONCLUSIONS OF LAW AND OPINION

For his compensable injury, claimant is entitled to medical services "for such period as the nature of the injury or the process of the recovery requires." ORS 656.245(1). Medical expenses are compensable provided that they are reasonably and necessarily incurred in the treatment of the compensable injury. West v. SAIF, 74 Or App 317, 320 (1985); McGarry v. SAIF, 24 Or App 883, 888 (1976). Claimant bears the burden of proving that the treatment is reasonable and necessary. James v. Kemper Ins. Co., 81 Or App 80, 81 (1986).

Dr. Bernstein, claimant's treating neurologist, implicitly found pain treatment to be reasonable and necessary when he referred claimant to the pain center in early 1986. The referral was made only after several months of drug therapy yielded no substantial improvement. We tend to give greater weight to the opinion of the treating physician, absent persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810, 814 (1983). Here, Dr. Bernstein's opinion was further bolstered by that of Dr. Holmes, who explained that claimant's diagnosed pain syndrome was reversible with rehabilitation at the pain center. After claimant's discharge from the center, both doctors agreed that his function and symptoms had improved substantially.

We find the aforementioned opinions more persuasive than that of the panel at the Northwest Pain Center. They recommended against pain center treatment based in part on what they perceived to be elements of secondary gain. After our de novo review of the record, we find inadequate support for that perception. Inasmuch as we consider their opinion speculative, it is discounted accordingly. After weighing the evidence, we conclude that claimant has sustained his burden of proving the pain center treatment to be reasonable and necessary to the process of recovery from his compensable injury.

ORDER

The Referee's order dated May 18, 1987 is affirmed. Claimant's attorney is awarded an assessed fee of $600, to be paid by the self-insured employer.

RODNEY W. SMEDSRUD, Claimant
Kenneth D. Peterson, Claimant's Attorney
Davis & Bostwick, Defense Attorneys

WCB 85-15699
August 19, 1988
Order on Review

Reviewed by Board Members Ferris and Crider.

Claimant requests review of those portions of Referee Leahy's order which: (1) approved the insurer's use of claimant's current wage to calculate temporary disability benefits; (2) declined to assess penalties and related attorney fees for an alleged unreasonable failure to pay temporary disability; and (3) affirmed a Determination Order which had awarded 15 percent (48 degrees) unscheduled permanent disability.

ISSUES

1. Whether the insurer correctly calculated claimant's temporary disability benefits: Specifically, whether the wage base for calculating temporary disability for a sole proprietor is wages at the time of injury or the assumed wage set by the insurer when the policy issues.

2. Whether claimant was entitled to penalties and related attorney fees for the insurer's alleged unreasonable failure to pay temporary disability.

3. Whether claimant is entitled to increased permanent disability.

FINDINGS OF FACT

Claimant, 35, completed high school and subsequently learned aircraft mechanics at a vocational institute. During 1970 and 1971, he also enrolled in various electrical courses. From 1969 to 1980 claimant worked as an electrician. His wages ranged from $8 to $12 per hour. Since 1980, claimant was a self-employed licensed electrical contractor. He charged customers $25 per hour. In July 1984 he hired three to four employees and obtained workers' compensation coverage for himself as well as his employees through the insurer. Claimant's premium was paid on the basis of an assumed wage of $5200 per quarter, or $1733.33 per month.

On October 24, 1984, claimant fell from a ladder and injured his back. His injury claim was accepted by the insurer.

The injury has been variously diagnosed. On November 25, 1985, Dr. Smith opined that claimant had a chronic strain of the muscles and ligaments of the lumbar spine centered at the L4-5 disc on the left. On June 18, 1986, Dr. Hanson, radiologist, diagnosed: (1) slight to mild narrowing of the central canal at L3-4 and L4-5; (2) a mild to moderate central bulge of the annulus at L4-5; and (3) a mild central bulge of the annulus at L5-S1.

The insurer initially paid temporary total disability based upon the claimant's assumed wage of $1733.33 per month.

On January 3, 1985, Dr. Rasmussen released claimant to modified work. Claimant returned to conducting his electrician business but refrained from any physical labor. His back injury prevented him from pulling feeders, kneeling to install wall plugs and bending conduit. Instead, claimant hired other employees at $13 per hour to perform such work. Claimant continued conducting his business in this fashion until at least the time of hearing.

Claimant was advised by the insurer that his March 12, 1985 check was based on the full temporary disability rate, but where appropriate, only temporary partial disability would be paid in the future.

By letter of March 25, 1985, the insurer requested that claimant provide hours worked and rate of pay or, "if this is unavailable or inapplicable" his gross earnings in order that they might "compute [his] wages." It was not clear whether the insurer sought pre-injury or post-injury earnings records. On April 16, 1985, the insurer received information from claimant listing the hours he billed customers and the rate at which he billed them during the latter part of the previous month. He submitted similar information from time to time thereafter.

The insurer paid claimant temporary disability based upon the "assumed monthly wage" from the date of injury until June 4, 1985. The insurer then unilaterally terminated temporary disability payments altogether between June 4, 1985 and September 12, 1985. Following the termination of payments, the insurer requested tax and earning records for the six month period preceding the date of injury. Some information was provided; however, it did not satisfy the insurer.

Beginning September 12, 1985, the insurer resumed paying temporary partial disability benefits of $50 per week. The insurer advised claimant it was reducing his benefits to $50 per week until he provided it with "gross payroll and the number of hours worked" or "if you are unable to supply us with copies of your payroll information..., your bookkeeping documentation".

The insurer continued to pay at the rate of $50 per week until the claim was closed.

On December 19, 1985, a Determination Order awarded claimant 15 percent (48 degrees) unscheduled permanent disability. It also established dates of temporary disability covering the entire period from the date of injury through November 25, 1985 and authorized a deduction of overpaid temporary disability.

Based on its calculation of temporary disability benefits paid to claimant from October 24, 1984 through June 4, 1985, the insurer believed that claimant had been overpaid the amount of $8,008.29. Therefore, it deducted claimant's permanent disability award of $4800, leaving an alleged outstanding overpayment of $3,208.29.

Claimant is no longer able to engage in the physical labor of an electrician. Attempts to install wall plugs or bend conduit result in muscle spasms and incidents of falling.

CONCLUSIONS OF LAW

Temporary disability calculation

The Referee concluded that since claimant had offered no legal authority prohibiting the insurer from using current wages in its calculation of temporary disability, claimant had failed to meet his burden of proof. We disagree. Claimant established that the insurer erroneously calculated his base wage and therefore his temporary total disability rate.

ORS 656.128 specifically and unambiguously explains the insurer's responsibility in those situations where sole proprietors elect to be covered by workers' compensation insurance. It states that:

> "[a]ny person who is a sole proprietor. . . may make written application to an insurer to become entitled as a subject worker to compensation benefits. Thereupon, the insurer may accept such application and fix a classification and an assumed monthly wage at which such person shall be carried on the payroll as a worker for purposes of computations under this chapter." (Emphasis added).

Former OAR 436-54-212(4)(m), currently OAR 436-60-020(7)(m), states that the insurer shall use the sole proprietor's assumed wage on which his premium was based when calculating payment of temporary total disability payments.

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Claimant was a sole proprietor who made written

application to the insurer to become entitled as a subject worker to compensation benefits. Thereupon, the insurer accepted claimant's application and fixed an "assumed monthly wage" of $1733.33. This became the wage at which claimant was carried on the payroll as a worker for the purpose of computing temporary disability in case of occupational injury or disease. Claimant's premiums were based upon this "assumed monthly wage."

One of the purposes of an assumed monthly wage in cases involving sole proprietors is to avoid substantial injustice regarding the payment of temporary disability benefits. Normally, a sole proprietor's income is not based upon a fixed wage but rather the unpredictable fluctuations of profits and losses. ORS 656.210, which pertains to the calculation of temporary disability benefits, was not designed to fairly assess such fluctuations and is not applicable in cases involving sole proprietors. Therefore, we find that ORS 656.128 is controlling and claimant's temporary disability benefits should not be based upon current wages but instead upon the "assumed weekly wage" which was agreed to by the parties.

The insurer contends that, contrary to this analysis, it is not required to pay temporary total disability benefits unless it has been provided "corroborative evidence" of claimant's earnings. The insurer relies on ORS 656.128(3) which states that no claim shall be allowed or paid under this section, except upon corroborative evidence in addition to the evidence of the claimant. This provision is irrelevant to the issues before us. It pertains to the initial acceptance or denial of a claim, not to the calculation and payment of temporary disability in a previously accepted claim. Since claimant's wage base is established by the insurer at the time it accepts an application for coverage, there is no need for evidence of earnings at the time of injury for purposes of calculating his temporary total disability rate.

Penalties and attorney fees

ORS 656.128 and former OAR 436-54-212(4)(m) required the insurer to use claimant's "assumed monthly wage" when performing computations under Chapter 656. ORS 656.210 and 656.212 require computations of temporary disability benefits and are within and under Chapter 656. Therefore, the "assumed monthly wage" was the proper wage from which to compute temporary disability. The language of ORS 656.128, and particularly former OAR 436-54-212(4)(m), is clear and unambiguous. No further investigation was necessary by the insurer in order to calculate claimant's temporary disability benefits.

The insurer's continuous attempt to obtain pre-injury wage information from claimant was irrelevant to the calculation of claimant's temporary disability benefits. The insurer's unilateral termination of temporary disability benefits and its reduction of benefits to the statutory minimum for failure to provide pre-injury wage data was improper.

ORS 656.262(10) states that:

> "[i]f the insurer or self-insured employer unreasonably delays or unreasonably refuses to pay compensation. . . the insurer or

self-insured employer shall be liable for an additional amount up to 25 percent of the amount then due plus any attorney fees which may be assessed under ORS 656.382."

We conclude that the insurer can not use the statutory language of ORS 656.210 to legitimize its unreasonable conduct since ORS 656.128 clearly required it to calculate claimant's temporary disability based upon the "assumed monthly wage." Therefore, we assess the maximum penalty of 25 percent of compensation owed.

Permanent disability

Based upon claimant's age, education, work experience, adaptability to less strenuous physical labor, mental capacity, emotional and psychological findings, post injury status and disabling pain, the Referee affirmed the Determination Order award of 15 percent unscheduled permanent disability. We agree.

In rating the extent of claimant's unscheduled permanent disability, we consider his loss of earning capacity and physical impairment attributable to the compensable injury, 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. Harwell v. Argonaut Insurance Co., 296 Or 505, 510 (1984); Fraijo v. Fred N. Bay News Co., 59 Or App 260 (1982).

On April 1, 1985, Dr. Smith, orthopedic surgeon, hospitalized claimant for four days and diagnosed chronic cervical and lumbar strain with a possible herniated L4-5 disc on the left. On April 15, 1985, he assessed claimant's physical capacities as follows: (1) no lifting or carrying greater than 25 pounds; (2) no sitting, standing or walking for longer than an hour at a time; and (3) occasional bending, squatting, crawling, climbing and reaching above the shoulders.

On November 6, 1985, claimant also saw Dr. Carpenter, orthopedic surgeon, who referred him to Dr. Isaacs, neurologist. While Dr. Isaacs found claimant's symptoms difficult to explain on a neuropathic basis, Dr. Carpenter diagnosed back sprain. Dr. Carpenter also believed psychological testing indicated that claimant somatized emotional distress. Even so, he considered claimant's chronic low back pain to be of a soft tissue nature and recommended: (1) no lifting in excess of 40 pounds; (2) no rapid or repetitive flexion or extension of the low back; and (3) no crawling.

We rely more heavily upon Dr. Carpenter's assessment of claimant's physical capacities because Dr. Smith's opinion was formed at a time when claimant was still experiencing significant low back discomfort due to an acute exacerbation of his low back condition. On the other hand, Dr. Carpenter's assessment was established at a time when claimant's condition was medically stationary and not subject to earlier, more extreme exacerbations.

Claimant credibly testified that he attempted to perform the physical labor required of an electrician and was unable to do so. Attempts to bend conduit or install wall plugs, which required twisting, bending and pulling, caused him to experience

muscle spasms and episodes of falling. Consequently, claimant assumed a supervisory role because the strength and repetitive bending and twisting required of an electrician were beyond his physical capabilities.

Following our review of the medical and lay evidence, and considering claimant's physical impairment, age, education and work experience, decreased adaptability to lighter occupations and emotional and psychological conditions, we conclude that an award of 15 percent unscheduled permanent disability appropriately compensates claimant for his compensable injury.

ORDER

The Referee's order dated August 8, 1986 is reversed in part and affirmed in part. The insurer is ordered to calculate claimant's temporary disability rate according to the "assumed monthly wage" of $1,733.33 and pay claimant temporary disability benefits based upon that rate for the time periods designated by the December 19, 1985 Determination Order. Additionally, the insurer is ordered to pay claimant his award of 15 percent unscheduled permanent disability which was errroneously offset to recoup the insurer's alleged overpayment. The insurer is also assessed a penalty of 25 percent of temporary disability owed to claimant and claimant's counsel is awarded an attorney fee of $500. The remainder of the Referee's order is affirmed. Claimant's attorney is awarded 25 percent of the increased compensation created by this order. However, the total attorney fees awarded by the Referee and Board orders shall not exceed $3,800.

MADELYN C. STRADFORD, Claimant
Jeffrey Foxx, Claimant's Attorney
Alice Bartelt, Defense Attorney

WCB 86-15179
August 19, 1988
Order on Review

Reviewed by Board Members Ferris and Crider.

Claimant requests review of Referee Brown's order that upheld the insurer's denial of her occupational disease claim for bilateral carpal tunnel syndrome. The issue on review is compensability.

The Board reverses the order of the Referee.

FINDINGS OF FACT

Claimant, 31 years of age at the time of hearing, complained of carpal tunnel syndrome symptoms during her employment as a process worker. She began working for this employer in 1984. Prior to working for this employer, claimant worked on a dairy farm where she sustained a neck injury which resulted in neck, shoulder, arm and hand pain. She was treated conservatively for those complaints.

In February 1985, claimant was transferred to the assembly room where her duties were comprised of fine and repetitive hand movements for a full eight-hour shift. She began to experience hand cramping and numbness. Claimant mentioned her problems to her supervisor, the company nurse and co-workers. Claimant was pregnant at this time.

Initially, claimant treated her hand symptoms with

Dr. Said, chiropractor. Claimant reported to him that she had experienced bilateral wrist and hand numbness, cramps and spasms during her work at the dairy. Dr. Said diagnosed carpal tunnel syndrome.

Dr. Said referred claimant to Dr. Dickerman, neurologist. Dr. Dickerman performed nerve conduction studies which demonstrated severe bilateral carpal tunnel syndrome.

In December 1985 claimant was referred to Dr. Maurer, orthopedic surgeon. He diagnosed carpal tunnel syndrome and recommended monitoring claimant to see if her symptoms would abate following the conclusion of her pregnancy.

Claimant's child was born in November, 1985; and her hand symptoms were somewhat relieved.

Dr. Worland, hand specialist, examined claimant. Her symptoms were still severe five months after termination of her pregnancy. Dr. Worland recommended surgical decompression.

Dr. Worland performed decompression surgery on both wrists.

Pregnancy induced carpal tunnel syndrome terminates at the end of pregnancy.

Claimant has shown a worsening of her underlying disease, resulting in pain to the extent that it produced disability and required medical services. Her carpal tunnel syndrome was not pregnancy induced. The worsening was connected to work activities.

CONCLUSIONS OF LAW AND OPINION

Claimant contends that the insurer's denial of her occupational disease claim for bilateral carpal tunnel syndrome should be set aside. She argues that her case involves the aggravation of a preexisting condition.

The Referee reasoned that the physician's opinions were based on the history given by claimant. Although the Referee found claimant credible, he opined that she gave varied versions of her medical history to different doctors. Therefore, he concluded that the doctors' opinions were not persuasive and that claimant's carpal tunnel syndrome was not compensable. We disagree.

Initially, claimant began treating her hand symptoms with Dr. Said, chiropractor. Dr. Said indicated that claimant reported she experienced bilateral wrist and hand numbness, cramps and spasms when she worked at the dairy. He diagnosed carpal tunnel syndrome and noted that claimant's pregnancy exacerbated her symptoms.

Following the birth of claimant's child in November 1985, her hand symptoms were somewhat relieved.

Thereafter, Dr. Said referred claimant to Dr. Dickerman, neurologist. Dr. Dickerman performed nerve conduction studies which demonstrated severe bilateral carpal tunnel syndrome.

In December 1985, claimant was referred to Dr. Maurer, orthopedic surgeon. He viewed claimant's carpal tunnel syndrome as a classic pregnancy-induced case and recommended monitoring claimant to see if her symptoms would abate. Dr. Maurer's notes indicate that claimant had experienced carpal tunnel symptoms before her pregnancy, when she worked on the dairy farm.

In March 1986 Dr. Said opined that claimant's carpal tunnel syndrome was exacerbated by her pregnancy.

Dr. Worland examined claimant. He recommended immediate surgical decompression since claimant's symptoms were still severe five months after delivery of her child. Dr. Worland stated that pregnancy-induced carpal tunnel syndrome terminates at the end of pregnancy.

Claimant received a second opinion from Dr. Matthews, orthopedist. He indicated the work described by claimant could produce carpal tunnel syndrome and opined that surgery was needed.

Dr. Said opined that the nerve conduction studies indicated that the effect of her pregnancy on her condition was minimal and that the major cause of her carpal tunnel syndrome was her work. Dr. Worland indicated claimant's work was the major cause of carpal tunnel syndrome and that her pregnancy further exacerbated it. There are no contrary medical opinions.

Claimant has shown a worsening of her underlying disease resulting in pain to the extent it produced disability and required medical services. Weller v. Union Carbide, 288 Or 21, 602 P2d 259 (1979). The worsening was connected to work activities. According to the medical opinions, claimant's at-work activities were the major contributing cause of her condition; her condition is compensable. SAIF v Gygi, 55 Or App 570, 574 rev den 292 Or 825 (1982).

ORDER

The Referee's order dated May 11, 1987 is reversed. The insurer's denial is set aside and the claim is remanded to the insurer for processing according to law. Claimant's attorney is awarded an assessed fee of $2,750.

BRIAN D. TAYLOR, Claimant
Roberts, et al., Defense Attorneys

WCB 86-08653
August 19, 1988
Order on Review

Reviewed by Board Members Crider and Ferris.

Claimant, pro se, requests review of Referee St. Martin's order that upheld the self-insured employer's denial of his occupational disease claim for a low back and neck condition. In his brief on review, claimant raises the issue of the employer's alleged untimely denial of his claim. We affirm.

ISSUES

1. Compensability of claimant's low back and neck condition.

2. Timeliness of the employer's denial.

FINDINGS OF FACT

Claimant has a history of intermittent low back symptoms dating to the mid-1970s. He worked as a volunteer firefighter in 1974 and 1976 during which time he occasionally developed back pain associated with lifting activities. He worked as an orderly and then as a registered nurse from 1976 onward. He began working for the employer in November 1982. His schedule involved seven 10-hour days on, then seven days off. In the fall of 1985 he also began working as a fill-in nurse through a temporary agency. He worked 8 to 16 hours every two weeks through the temporary agency. In late 1985, he also became an acting and modeling student which resulted in occasional employment in those areas.

In February 1986, claimant attended a fair where Dr. Shipp, chiropractor, had a booth. Dr. Shipp performed a brief on-the-spot examination. Later in February, claimant began receiving chiropractic treatments from Dr. Shipp for low back and neck complaints.

Claimant also increased his recreational activities in February. Prior to February, claimant went bicycling approximately once a month. He increased this in February. He started jogging once or twice a week in February. He also started to play tennis three to four times a week. In addition, he continued to lift weights on a sporadic basis as he had done prior to February 1986.

Claimant experienced an exacerbation of symptoms in June 1986. Dr. Shipp imposed a 25-pound lifting restriction. Claimant missed 12 days of work as a result of this restriction.

Claimant's work shift overlapped other work shifts by six out of every ten hours so that he frequently had help performing the lifting activities of his employment. Claimant also spent a considerable portion of his workday performing sedentary activities such as monitoring patients' vital signs.

Claimant experiences intermittent low back and neck pain of unknown etiology. His work activities, compared to his off-work activities, were not the major contributing cause of his chronic low back and neck condition or its worsening.

Claimant filed his claim with the employer on February 24, 1986. A denial letter was sent to claimant on May 15, 1986, more than 60 days following notice of the claim.

CONCLUSIONS AND OPINION

Compensability

To establish a compensable occupational disease, claimant must first establish that he suffers a disease requiring medical services. Brown v. SAIF, 79 Or App 205 (1986). If so, he must prove that his work activities were the major contributing cause of either the onset or worsening of his disease. Dethlefs v. Hyster Co., 295 Or 298, 310 (1983); Weller v. Union Carbide Corp., 288 Or 27, 31-5 (1979); see former ORS 656.802(1)(a). This requires a comparison of claimant's at-work conditions with his non-employment exposures. McGarrah v. SAIF, 296 Or 145, 166 (1983).

Claimant argues that his work activities for the

employer were the major contributing cause of his low back and neck condition. He relies upon the opinions of chiropractors Shipp, Bussanich and Christensen to establish both the condition and its compensability.

Dr. Shipp diagnosed claimant as suffering from low back sprain strain, cervical thoracic segmental dysfunction, lumbar segmental dysfunction, segmental dysfunction -- lower extremities, spinal esthesopathy, degeneration of lumbosacral intervertebral disc, enthesopathy of the knee, and cervicalgia. Dr. Shipp opined that claimant's work activities with the employer were the major contributing cause of a worsening of his condition.

Dr. Shipp referred claimant to Dr. Bussanich for a consulting opinion in Janaury 1987. Dr. Bussanich was more equivocal in his opinion than Dr. Shipp. He noted that claimant's examination findings were "admittedly minimal." He further stated that it was "difficult to ascertain" whether claimant's neck and low-back discomfort was job related or was caused by his off-work activities. He concluded, however, that claimant's problems were "caused by his employment for the most part."

Dr. Shipp also referred claimant to Dr. Christensen for a consulting examination. Dr. Christensen in his report referred to a February 1986 injury. He opined that claimant's complaints, test results and treatment response were consistent with the type of accident reported.

We find claimant's medical evidence to be unpersuasive. While Dr. Shipp diagnosed a host of physical ailments, his opinions are opposed by a panel of the Orthopaedic Consultants, as well as the Independent Chiropractic Consultants. The Orthopaedic Consultants reported normal cervical and lumbar radiological test results. In addition, Dr. Berman from the Chiropractic Consultants testified persuasively as to the absence of any objective evidence of spinal pathology which could account for claimant's low back and neck symptoms. Furthermore, Dr. Bussanich's report of admittedly minimal findings is scant support for claimant's position. We conclude that claimant has failed to prove that he suffers from a disease requiring treatment.

However, even assuming that claimant has proven the existence of a disease requiring treatment, his evidence nevertheless falls short of proving that his work exposure was the major contributing cause of that condition or its worsening. See Weller v. Union Carbide Corp., supra. We find Dr. Shipp's opinion on this question unpersuasive for two reasons. First, his reports do not reflect a complete understanding of the nature of claimant's work activities. More specifically, he assumes a greater level of physical exertion than is reflected in the record. Secondly, Dr. Shipp indicates no awareness of claimant's extensive recreational activities during the period in question. We, consequently, devalue his opinion as based upon an inaccurate and incomplete history.

The opinions of Drs. Bussanich and Christensen are subject to similar infirmities. Dr. Bussanich conceded that it was difficult to ascertain the cause of claimant's complaints. He ultimately concluded that claimant's complaints were caused, for the most part, by claimant's work activities. However, his conclusion assumes that claimant worked 40 to 70 hours per week without noting claimant's week-on and week-off schedule. Nor is

there any indication that Dr. Bussanich was aware of claimant's extensive recreational activities.

Similarly, Dr. Christensen refers to a February 1986 incident which is not otherwise documented in the record. The only February event documented in the record is claimant's attendance at a fair where he first was examined by Dr. Shipp and where he received a certificate from Dr. Shipp for a free consultation.

We conclude that claimant has failed to sustain his burden of proving that his work activities were the major contributing cause of his low back condition or its worsening.

Timeliness

The employer failed to issue its denial within the statutorily required 60 days. ORS 656.262(6). If the employer's failure to timely respond was unreasonable, claimant is generally entitled to a penalty and attorney fee award. ORS 656.262(10). However, the record indicates that claimant missed no work as a result of his back and neck condition between the time he filed his claim with the employer and the date the employer denied the claim. Interim compensation is not required if the worker does not demonstrate that he left work. Bono v. SAIF, 298 Or 405, 410 (1984). Therefore, there were no "amounts then due" upon which to base the award of a penalty. ORS 656.262(10); EBI Companies v. Thomas, 66 Or App 160 (1984). Accordingly, assuming that the timeliness issue could be considered, no penalty would be assessable.

Unlike a penalty, an attorney fee can be awarded even though there are no "amounts then due." Mischel v. Portland General Electric, 89 Or App 140, 142 (1987). Claimant, who was represented by legal counsel at hearing, did not raise the timeliness issue at hearing. Consequently, the record on this issue was not developed at hearing. Under these circumstances, we conclude that it would not be in the interests of substantial justice to further address the timeliness issue. See Cynthia J. Clark, 39 Van Natta 130 (1987).

ORDER

The Referee's order dated April 13, 1987 is affirmed. A client-paid fee, to be paid by the self-insured employer to its counsel, not to exceed $150, is approved.

SUSAN A. BAGWELL, Claimant
Jolles, Sokol, et al., Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

Own Motion 87-0424M
August 22, 1988
Own Motion Order on Reconsideration

Claimant has requested reconsideration of our March 16, 1988 Own Motion Order which concluded that we lacked authority to reopen her December 9, 1978 injury claim for the payment of temporary total disability benefits. Relying on ORS 656.278(1)(a) and OAR 438-12-052(2), which became effective January 1, 1988, we reasoned that we may exercise our own motion authority when we find that there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. Since claimant had neither urdergone surgery nor been hospitalized for treatment concerning her compensable back condition, we concluded that we

were without authority to reopen the claim for payment of temporary total disability benefits.

Claimant asserts that her request should be processed under the law in effect in July 1987, when her request for Own Motion relief was submitted and we referred her petition to the Hearings Division for consolidation with a pending hearing regarding the issue of responsibility for her current condition. Alternatively, she contends that her entry into a hospital to undergo a CT scan constitutes "hospitalization" under the aforementioned statute. We disagree with both arguments.

Although claimant's request for claim reopening was submitted and pending in 1987, the claim was not reopened prior to January 1, 1988. Therefore, processing of the request is subject to the current version of ORS 656.278(1)(a). See OAR 438-12-018.

In accordance with the aforementioned statute, the Board may authorize the payment of temporary disability compensation where there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. Here, claimant entered the hospital to undergo a CT scan. Such a procedure is diagnostic. It is neither surgical nor does it represent treatment requiring hospitalization.

Accordingly, the request for reconsideration is granted and our prior order withdrawn. On reconsideration, as supplemented herein, we adhere to our previous conclusion that we lack authority to award temporary disability compensation. ORS 656.278(1)(a); OAR 438-12-052(2). Consequently, the request for relief is denied.

IT IS SO ORDERED.

DALE R. HEINECKE, Claimant
Malagon & Moore, Claimant's Attorneys
Nelson, et al., Defense Attorneys
Schwabe, et al., Defense Attorneys
E. Jay Perry, Attorney

WCB 85-04756
August 22, 1988
Order on Review

Reviewed by Board Members en banc.

Claimant requests review of those portions of Referee McCullough's order that: (1) reduced his temporary total disability benefits to temporary partial disability benefits beginning August 1985; and (2) upheld Liberty Northwest Insurance Corporation's partial denial of his right wrist condition. Liberty Northwest cross-requests review of that portion of the order that set aside its partial denial of claimant's insomnia, anxiety, and depression conditions. The issues are temporary disability and compensability.

The Board reverses that portion of the Referee's order that reduced claimant's temporary disability benefits. All remaining portions of the Referee's order are affirmed and adopted.

FINDINGS OF FACT

Claimant formed his own timber contracting corporation in 1982. He served as president of the corporation and also worked as a tree faller. The corporation paid him the amount of profit from each tree falling contract. In 1984, he began working

for Liberty Northwest's insured as a tree faller and his corporation ceased performing any further contracts. While falling a tree in November 1984, he compensably injured his head and neck. Liberty Northwest began paying temporary total disability benefits.

In January 1985, his corporation began performing another tree falling contract. Claimant worked three to four days for the corporation and was paid $1,600 in wages. Thereafter, he did no further falling work. He received no earnings, profits, or income from the corporation. In August 1985, claimant resumed working for the corporation and performed the following duties: (1) bidding and contract negotiating; (2) hiring employes; (3) supervising employes; and (4) "scaling" logs.

Due to the corporation's poor performance, claimant's wife, a bookkeeper for the corporation, earned only $1300 in 1985. She and claimant loaned the corporation approximately $4,500 that year. In August 1985, the corporation landed several timber contracts. As a result, in 1986, the corporation was able to pay its expenses and meet its payroll obligations. Claimant's wife's earnings increased to $3,800 a month. Her earnings were, in part, wage recovery for her lack of earnings in 1985.

CONCLUSIONS OF LAW

The Referee found that inasmuch as claimant resumed working for the corporation on August 13, 1985, his temporary total disability status should have been modified to temporary partial disability beginning that date. Based on claimant's wife's 1986 earnings, the Referee determined that the corporation had the capacity to pay claimant a wage beginning in 1986. Accordingly, the Referee "deemed" claimant to have received one-half of the wife's earnings beginning in 1986. The Referee, therefore, ordered claimant's temporary total disability benefits reduced to temporary partial disability from January 1, 1986 to the date of the hearing, May 1, 1986. We disagree.

ORS 656.212 provides:

> "When the disability is or becomes partial only and is temporary in character, the worker shall receive for a period not exceeding two years that proportion of the payments provided for temporary total disability which the loss of earning power at any kind of work bears to the earning power existing at the time of the occurrence of the injury." (Emphasis added).

Claimant argues that he did not receive any actual earnings after August 1985, and, therefore, the Referee erred in reducing his temporary total disability benefits to temporary partial disability. Liberty Northwest, on the other hand, argues that the statute allows for such a reduction when a worker has post-injury "earning power," even though he has not received any actual earnings.

In Fink v. Metropolitan Public Defender, 77 Or App 79, rev den, 296 Or 829 (1984), the worker sustained a compensable injury and returned to only part time work. She argued that

former OAR 436-54-225 (now OAR 436-60-030), which outlined the method of determining a worker's temporary partial disability benefits, was in conflict with ORS 656.212, because the rule defined "loss of earning power" in terms of actual earnings and failed to consider a worker's reduction in hours worked. The court did not agree, and stated, inter alia:

> "We construe ORS 656.212 to provide that compensation for temporary partial disability of a worker who is recovering from a compensable injury but is nonetheless capable of earning wages and is employed is to be proportionate to the decrease in the worker's actual earnings."
>
> "The formula established by former OAR 436-54-225 for computing loss of earning power comports with our construction of ORS 656.212. The rule provided for an adjustment of the compensation to be paid for the difference between the wages the worker actually received and the compensation the worker would have received for temporary total disability . . . ." (Emphasis added).
>
> 77 Or App at 82-3.

Here, claimant received no actual earnings after August 13, 1985. Although he performed duties for the corporation, he did not receive any actual earnings. Moreover, his wife's earnings were her earnings. On this record, we are unwilling to speculate that claimant was sheltering his income by diverting it to his wife. To the contrary, we find that in 1985 the corporation performed poorly and was unable to pay claimant's wife her regular salary. With an upturn in its business towards the end of 1985, the corporation was able to meet its payroll obligations beginning in 1986. Claimant's wife's earnings in 1986, were, in part, wage recovery for her lack of earnings in 1985.

Accordingly, we find that inasmuch as claimant received no actual earnings beyond August 13, 1985, his temporary total disability status and benefits should have continued beyond that date.

Claimant's counsel seeks Board authorization of an assessed fee for services rendered on review. After reviewing the statement of services and attorney retainer agreement submitted by claimant's counsel and considering the factors set forth in OAR 438-15-010(6), we find that a reasonable fee for prevailing against the insurer's cross-request for review is $500.

Lastly, the insurer's counsel is statutorily entitled to a reasonable attorney fee for services rendered on Board review. See ORS 656.388(1). Such a fee is defined as a "client-paid fee." OAR 438-15-005(5). The insurer's counsel has submitted a statement of services and has requested Board authorization for a client-paid fee. However, we cannot authorize a client-paid fee unless the insurer's counsel files an executed attorney retainer agreement. OAR 438-15-010(1). Because no retainer agreement has been received to date, a client-paid fee shall not be authorized.

ORDER

The Referee's order is reversed in part and affirmed in part. Claimant's temporary total disability status and benefits are reinstated for the period from August 13, 1985, to May 1, 1986. Claimant's attorney is awarded an approved fee of 25 percent of the increased temporary total disability compensation, not to exceed $3,800. All remaining portions of the Referee's order are affirmed. Claimant's attorney is awarded a reasonable assessed fee of $500 for prevailing against the insurer's cross-request for Board review.

Board Member Ferris, dissenting:

I would affirm that portion of the Referee's order which the majority reverses. The Referee's conclusion that claimant earned wages in 1986 and diverted those wages to his wife is strongly supported by the record. From August 1985 to the time of the hearing claimant performed valuable services for the corporation. He negotiated contracts; he supervised tree falling operations; he scaled felled trees. The value of these services was approximately $200 a day. (See Tr. 80-81). Claimant's wife worked as a secretary and bookkeeper for the corporation and was paid a total of $1,300 for all of 1985. Beginning in 1986, she suddenly began "earning" $1,900 every two weeks. Claimant received nothing for his services because he was paid only out of corporate profits and after deduction of expenses (including his wife's wages) from the gross income of the corporation, it just broke even. The Referee refused to countenance this ruse and allocated half of claimant's wife's "earnings" to claimant. We should do at least as much.

The majority refuses to "speculate" that claimant was sheltering his income by diverting it to his wife. Instead, it speculates that "[c]laimant's wife's earnings in 1986 were, in part, wage recovery for her lack of earnings in 1985." Claimant's wife gave no indication in her testimony what hours she worked in 1985 or what her salary was supposed to be. Exhibits in the record indicate that the corporation had no active contracts between February 15, 1985 and August 2, 1985 and thus that it was idle for half the year. (See Ex. 3A-6, 39A). Given these facts, it is impossible to conclude from the testimony of claimant's wife how much she was shorted in 1985, if anything.

I would affirm and adopt all of the Referee's well-reasoned order.

STELLA L. MELCHOR, Claimant
Goldberg & Mechanic, Claimant's Attorneys
Davis & Bostwick, Defense Attorneys

WCB 86-07742
August 22, 1988
Order on Review

Reviewed by Board Members Ferris and Crider.

The insurer requests review of that portion of Referee Knapp's order that found claimant permanently and totally disabled. Claimant cross-requests review of those portions of the order that established claimant's permanent total status on February 17, 1987 and failed to award a penalty and attorney fee for the insurer's failure to provide vocational material required by OAR 438-07-015.

We conclude that claimant was permanently and totally

disabled as of May 15, 1986 and modify the Referee's order accordingly. We otherwise affirm the Referee's order.

ISSUES

(1) Extent of disability for claimant's right arm injury, including permanent total disability.

(2) Date of claimant's permanent total disability status.

(3) Penalty and attorney fee for alleged failure to disclose vocational material.

FINDINGS OF FACT

Claimant's right arm was amputated below the elbow, following an April 6, 1981 compensable injury. The Referee's findings of fact in paragraphs 3 through 10 cover her injury, her unsuccessful attempts at using a prosthesis, her unsuccessful attempts to return to work, the development of emotional problems and the establishment of a related compensable claim, the progress of her arm claim, the unsuccessful vocational activities and course of medical treatments. These paragraphs are adopted with the following additions.

Claimant has no functional capacity in the amputated right arm and has total right shoulder adhesive capsulitis ("frozen shoulder"). She has intermittent right arm pain, an occasional phantom feeling concerning the amputated arm and a constant throbbing ache in the right shoulder. Although she was provided with a new prosthesis in 1984, she did not have the strength to manipulate or lift it. She quit using it about three years ago. The function of her left arm is limited because of the chronic adhesive capsulitis of her left shoulder. Her left upper arm is extremely painful most of the time and the pain increases with use. She has trouble lifting even light objects.

Claimant also has post-traumatic stress disorder resulting from the trauma of her injury. This resulted in defensive mechanisms including apparent lack of effort, motivation and negative attitude towards reemployment. She has almost nightly nightmares, anxiety and depression. She cannot stand to be around machinery or even the noise of home appliances. Her psychiatric disability prevents her from being retrained, from raising her educational level and from working around machinery.

Claimant is 46 and did not finish the eighth grade. She worked as a housekeeper, a cook's helper and a punch press operator before working for the employer at the time of her injury. For the employer, a gun scope manufacturer, she worked as a machine operator. She is not able to read or write.

Because of claimant's physical condition, her psychological condition, her work history and functional level claimant was not able to find employment on her own. Attempts through vocational counselors to locate employment for claimant that had no machine noise, required primarily one-hand operation and did not require reading, writing or counting were not successful. It is more probable than not that claimant is incapable of gainful and suitable employment.

During the period in which vocational counseling was provided by Ms. Nelson to claimant, Ms. Nelson was required to and did provide monthly reports to the insurer including reports dated October 16, 1986, January 21, 1987, February 20, 1987, March 13, 1987 and May 5, 1987. The record does not establish that claimant or her attorney asked for disclosure nor does it disclose what she received or did not receive.

CONCLUSIONS AND OPINION

Extent of Disability

The Referee found that claimant's psychological and physical impairments did not exclude all work in the broad field of industrial occupations. He thought that there may be some form of work that claimant could perform but did not identify any particular employment. He then considered nonmedical factors along with her medical impairment and concluded that it was futile for claimant to seek regular and gainful employment and found her permanently and totally disabled.

The insurer agrees with the Referee that claimant is not physically or psychiatrically permanently and totally disabled. It argues that claimant's token efforts to look for work at the suggestion of her attorney was merely a sham effort to meet the requirements of ORS 656.206(3). It argues that the seek work requirement of the statute is excused only if claimant is totally incapacitated from work.

Claimant argues that the evidence establishes that she is medically permanently and totally disabled.

In paragraphs one and two of his opinion, the Referee states the applicable law for establishing permanent total disability status under total medical disability and under "odd lot" considerations. We adopt these paragraphs and add the following.

A finding of futility is reserved for the extreme situation such as when a claimant is physically totally disabled or is not capable of retraining. Georgia-Pacific Corp. v. Perry, 92 Or App 56, 58 (1988).

Based on the findings made we conclude that whether permanent and total disability is based on medical disability alone or a combination of medical and other nonmedical factors, it was futile for claimant to look for work because she could not work and could not be retrained to work. She is permanently and totally disabled.

Date of Permanent Total Disability Status

The Referee found claimant was permanently and totally disabled on February 17, 1987. He did not discuss why he chose that date. However, it is the date of the psychiatric opinion by Access Consulting Systems that claimant's situation was permanent and in all medical probability was unlikely to respond to any intervention.

The effective date of a retroactive permanent total disability award is the earliest date that the disability is

proved to exist and is based on all relevant medical, social and vocational factors. Morris v. Denny's Restaurant, 53 Or App 863, 867 (1981).

Claimant's physical condition, her frozen right shoulder and limitations of motion of her left shoulder were documented on August 25, 1985 by the Orthopaedic Consultants. The continuation of these conditions was verified by Northwest Pain Center Associates on February 25, 1986. On May 30, 1984, Dr. Shepard, a psychiatrist, had concluded that claimant was not benefiting from further psychiatric treatment and could not be rehabilitated to the degree necessary for her to compete in the marketplace. This opinion was supported by Dr Voiss, a consulting psychiatrist, in February 17, 1987. Vocational assistance was ongoing since 1983 and was unsuccessful through May 5, 1987. Attempts at tutoring by her daughter and at Quest Vocational School had failed by mid-1985. Based on the totality of the evidence, we conclude that claimant was permanently and totally disabled as of the May 15, 1986 Determination Order.

Penalty and Attorney Fee

The Referee made no disposition of the claim for penalty and attorney fee for failure to provide vocational exhibits as required by OAR 438-07-015. Claimant seeks a "stringent" penalty and attorney fee because of the importance of vocational records to a resolution of a permanent total disability case. Plaintiff cites two pages of cross-examination as establishing the failure to provide vocational exhibits.

The only evidence that claimant properly asked for and did not receive these exhibits is the statement of claimant's counsel during the cross-examination of Ms. Nelson, a vocational witness for the insurer, that counsel did not receive the exhibits. These matters must be proved by competent evidence. There was a failure of proof. Consequently, no penalty or attorney fee is appropriate.

ORDER

The Referee's order dated July 14, 1987 is affirmed as modified. Claimant's attorney is awarded a fee of $ 2,000 for services on Board review, to be paid by the insurer.

STEVEN E. PUTTIE, Claimant
Peter O. Hansen, Claimant's Attorney
Chelsea E. Mohnike (SAIF), Defense Attorney

WCB 86-07484
August 24, 1988
Order on Review

Reviewed by Board Members Crider and Johnson.

The SAIF Corporation requests review of Referee Fink's order that granted permanent total disability, whereas a Determination Order had awarded claimant 25 percent (80 degrees) unscheduled permanent disability for his back condition. We reverse and modify.

ISSUE

1. Whether claimant is entitled to permanent total disability benefits.

2. If claimant is not permanently and totally disabled,

whether claimant is entitled to an award of permanent partial disability in excess of that granted by Determination Order.

FINDINGS OF FACT

Claimant, 36 years of age, served in the military and received an honorable discharge in about 1971. He completed his GED and two years of college while at the Oregon Correctional Institute from July 1975 through April 1979 on a kidnapping and rape charge. Claimant's work history consists of heavy employment, such as service station work, wood cutting, drywall installing and welding. Claimant has a talent for artistic welding.

On May 18, 1980, claimant compensably injured his low back while lifting a casting mold. On May 20, 1980, Dr. Torres examined claimant and prescribed physical therapy and pain medication. On June 17, 1980, claimant was released by the doctor for light work. On July 1, 1980, claimant stopped working due to increasing pain. On September 6, 1980, Dr. Torres released claimant to work with no restrictions. Subsequently, claimant worked for only five days before he was terminated for falsifying information on his job application.

On November 24, 1980, a Determination Order awarded claimant various periods of temporary disability but no permanent disability. During 1981 claimant worked for a brass polisher for one month before he quit; he was also fired from a subsequent employer after only a few weeks on the job. Claimant did not work during 1982 and instead collected unemployment compensation. On July 27, 1982, a second Determination order awarded additional temporary disability. On September 17, 1982, due to the receipt of additional information, a third Determination Order was issued which affirmed the prior award in all respects. On November 18, 1982, a prior Referee awarded claimant 10 percent unscheduled permanent disability.

On July 22, 1983, Dr. Poulson performed a lumbar laminectomy bilaterally with partial excision of the L4-5 disc and repaired a spinal fluid leak.

On December 27, 1983, SAIF reopened claimant's claim. On March 29, 1984, Dr. Poulson closed claimant's case due to repeated missed appointments. An April 20, 1984, a Determination Order granted claimant no additional permanent disability.

On July 13, 1984, the Vocational Rehabilitation Division of the Department of Human Resources initiated a Direct Employment Program (DEP). On December 14, 1984, claimant's DEP program was closed due to interference from ongoing criminal charges.

On July 9, 1985, Dr. Franks performed surgery on claimant's back for a spinal stenosis condition. He also performed a bilateral discectomy and medial foraminotomy at the L4-5 and L5-S1 levels. On August 20, 1985, SAIF rescinded its April 5, 1985 denial of the spinal stenosis condition by stipulation.

On January 15, 1986, Vocational Rehabilitation Associates, Inc. received claimant's case and attempted to initiate a return to work program. By June 16, 1986, however, claimant's vocational services were terminated due to his lack of cooperation.

On November 4, 1986, a fifth Determination Order increased claimant's unscheduled permanent disability to a total of 25 percent.

On December 19, 1986, a conference with a Vocational Consultant employed by the Rehabilitation Review Division of the Workers' Compensation Department led to a referral to Cooley & Associates for vocational evaluation. Continued vocational assistance was contingent upon claimant's agreement to fully participate and cooperate. By the time of hearing, vocational goals had not yet been identified for claimant.

As a result of claimant's compensable injury, his physical impairment is in the moderate range. Although he is not able to return the occupation of welding, he has minimal transferable skills and is capable of light work.

Claimant was not cooperative in his vocational rehabilitation efforts.

CONCLUSIONS OF LAW

Based upon claimant's moderate physical impairment and minimal transferable skills, the Referee found that claimant was permanently and totally disabled. We disagree.

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

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

Permanent total disability can be established by proving total incapacity from a medical standpoint alone, or where incapacity is not total, by proving permanent total disability based upon the worker's less-than-total impairment combined with such nonmedical factors as age, education, adaptability, emotional condition, and the state of the labor market. Wilson v. Weyerhaeuser, 30 Or App 403, 409 (1977). Also, a worker must 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). A worker's refusal to cooperate with vocational rehabilitation efforts may be grounds for denial of permanent total disability. Taylor v. SAIF, 67 Or App 193 (1984).

Claimant has not shown that he is permanently and totally disabled from a medical standpoint alone. On March 6, 1987, Dr. Franks outlined claimant's physical limitations: (1) no lifting or carrying greater than 25 pounds; (2) no sitting or walking longer than 6 hours and no standing longer than 4 hours during an 8-hour day; (3) no crawling; and (4) only occasional bending, squatting and climbing. Dr. Franks rated claimant's physical impairment as 50 percent. The Orthopaedic Consultants' assessment of claimant's limitations was not unlike Dr. Frank's assessment. They believed that claimant could work in a sedentary to medium capacity and rated his physical impairment in the moderate range.

Since the medical evidence alone does not support permanent total disability, claimant must prove that the aforementioned nonmedical factors combined with his back condition effectively foreclosed him from gainful employment. Claimant has not shown that these factors, combined with his physical condition, make him permanently and totally disabled.

Claimant is relatively young at age 36. He possesses a GED as well as two years of college in welding and general studies. General Aptitude Test Battery scores indicated that his mental capacity is in the average to above average range. Although he was previously employed primarily in heavy labor jobs, he continues to be employable in the sedentary to light labor jobs. Although claimant's vocational counselor from Cooley & Associates believed that claimant had minimal transferable skills, there was no evidence that he was not currently employable in the general labor market. The vocational counselor did not believe that claimant possessed adequate transferable skills to enable him to seek employment with wages comparable to those wages he was earning at the time of injury. However, the purpose of permanent total disability is to maintain claimant, not restore him to preinjury wage status, when he is totally precluded by his injury from supporting himself. Ellen Lankford, 37 Van Natta 1146, 1149 (1985), citing Walter R. LaChappelle, 36 Van Natta 1565, 1566 (1984). Also, the vocational counselor dismissed apartment manager positions, notwithstanding claimant's previous experience in that field, because she did not believe that it would provide claimant with full-time employment. We have held, however, that the ability of a worker regularly to perform suitable and gainful work on a part-time basis may preclude an award of permanent total disability. Pournelle v. SAIF, 70 Or App 56 (1984); Darla Falcon, 38 Van Natta 204 (1986); Georgia Pacific v. Perry 92 Or App 56 (July 6, 1988).

Accordingly, after our de novo review of the lay and medical evidence, we conclude that claimant is not permanently and totally disabled from regularly performing gainful and suitable employment.

Assuming arguendo that claimant is unemployable without training, we further find that claimant's lack of cooperation with vocational rehabilitation efforts precludes a finding of permanent total disability.

A claimant's need for retraining at the time of hearing does not result in entitlement to permanent total disability benefits where claimant unreasonably refused to undertake or complete an offered course of vocational rehabilitation. Taylor v. SAIF, 67 Or App 193, 195 (1984).

In the present case, claimant consistently frustrated the efforts of three different vocational assistance providers. On December 13, 1984, claimant's DEP was closed due to extreme interference from his pending criminal trial. On January 15, 1986, a second vocational rehabilitation provider received claimant's case. Claimant, however, was difficult to contact and failed to respond to three separate certified letters, one noncertified letter and one phone call. In fact, contact with claimant was not established until February 27, 1986 when the counselor visited claimant's home. By May 1986 claimant again had failed to maintain contact. Therefore, on June 16, 1986, claimant's file was closed for the second time due to lack of

cooperation. On December 19, 1986, claimant's vocational rehabilitation assistance was reinstated contingent upon claimant's agreement to fully participate and cooperate. Immediately thereafter, he failed to respond to two letters and did not contact the provider until claim closure was threatened. On February 20, 1987, claimant's file was temporarily closed due to his incarceration for a probation violation. It was not until March 18, 1987, five days prior to hearing, that claimant participated in vocational testing. The process was held up once again, however, due to claimant's failure to provide his counselor with requested financial information, failure to schedule a requested doctor's appointment, and failure to complete a physical abilities assessment.

Claimant's consistent lack of cooperation with his three vocational rehabilitation providers prevented the formulation of a successful return to work plan. Assuming arguendo that claimant was not employable without retraining, we conclude that he had obvious potential for vocational rehabilitation but failed to cooperate with the multiple opportunities given to him. Taylor v. SAIF, supra. Therefore, claimant has not shown that he is permanently and totally disabled.

Permanent partial disability

Unscheduled

In rating the extent of claimant's unscheduled permanent partial disability, we consider his loss of earning capacity and physical impairment attributable to the compensable injury, and all of the relevant social and vocational factors set forth in OAR 436-30-380, which we have previously discussed when considering claimant's entitlement to permanent total disability. We apply these rules as guidelines, not as restrictive mechanical formulas. Harwell v. Argonaut Insurance Co., 296 Or 505, 510 (1984); Fraijo v. Fred N. Bay News Co., 59 Or App 260 (1982).

Following our review of the medical and lay evidence, and considering claimant's moderate physical impairment, relatively young age, education and work experience, adaptability to lighter occupations, average mental capacity, and emotional and psychological conditions, we conclude that an award of 50 percent unscheduled permanent disability appropriately compensates him for his compensable back injury.

Scheduled

When permanent partial disability results from an injury, the criteria for the rating of disability shall be the permanent loss of use or function of the injured member due to the industrial injury. ORS 656.214(2). A separate and additional award should be made for loss of function of a scheduled body part regardless of whether the scheduled impairment is traceable to an injury to an unscheduled portion of the body. Victoria W. Fox, 37 Van Natta 10, 11 (1985), citing Walker v. Compensation Dept., 248 Or 195 (1967). Lay testimony, without medical input, may establish permanent disability. Garbutt v. SAIF, 297 Or 148 (1984).

Although we find that claimant's low back pain does radiate into both legs, we are not persuaded by either the medical

or lay evidence that such radicular pain has resulted in any loss of use or function of claimant's legs. Therefore, we decline to award scheduled permanent disability.

ORDER

The Referee's order dated May 6, 1987 is reversed and modified. The Referee's award of permanent total disability is reversed. In lieu of the Referee's award and in addition to the permanent disability awarded by the Determination Order, claimant is awarded 25 percent (80 degrees) unscheduled permanent disability, giving him a total award to date of 50 percent (160 degrees) unscheduled permanent partial disability for his compensable back injury.

JOSE F. SALAS, Claimant
Burt, et al., Claimant's Attorneys
Gary Wallmark (SAIF), Defense Attorney

WCB 86-13613
August 24, 1988
Order on Review

Reviewed by Board Members Johnson and Crider.

The SAIF Corporation requests review of Referee Danner's order which set aside its denial of claimant's claim for coccygodynia and coccygeal surgery. We affirm in part and reverse in part.

ISSUES

1. Compensability of coccygodynia.

2. Reasonableness and necessity of coccygeal surgery.

FINDINGS OF FACT

Claimant sustained a compensable injury on February 11, 1986 when he fell on his back while descending a flight of stairs. He struck his back against the stairs and felt immediate pain along the low back, including the coccyx (tailbone).

Claimant initially saw Dr. Rissberger with complaints of low back pain. Rissberger diagnosed a low back contusion and referred claimant to Dr. Blake, an orthopedist. Claimant saw Blake on several occasions through October of 1986, with complaints of low back pain and occasional radiating symptoms in the legs. Claimant also saw Dr. Martens, an orthopedist, for an independent medical examination in June 1986. Based on complaints of low back and left leg symptoms, Martens diagnosed lumbosacral strain and contusion. Dr. Blake concurred.

During these aforementioned examinations, claimant did not report symptoms relating to the coccyx, though his coccyx remained painful. Claimant's claim was accepted for a disabling low back injury. The claim was closed by Determination Order on September 19, 1986 with an award of temporary total disability only.

By November of 1986, claimant's coccyx pain was his most significant symptom. He changed care to Dr. Benz, an orthopedist, and, on November 3, 1986, reported coccyx pain for the first time. Tomograms of the coccyx revealed no fracture or abnormality. Benz diagnosed coccygodynia (coccyx pain) and treated with injections in the coccyx to relieve the pain temporarily. Benz later recommended surgery to remove the painful portion of the coccyx.

On January 28, 1987, SAIF issued a partial denial of the compensability of the coccygodynia. SAIF also denied the proposed coccygeal surgery, stating that it was not necessary to claimant's recovery.

We find that the compensable injury was a material cause of the coccygodynia. We further find that coccygeal surgery would not be beneficial where, as here, the pain is not localized to the coccyx region, but rather, is present along the low back. We do not find that coccygeal surgery is reasonable and necessary treatment for the effects of the compensable injury.

CONCLUSIONS AND OPINION

The Referee set aside SAIF's denial of compensability, finding that the coccygodynia is related to the compensable injury. The Referee did not address the denial of surgery. We agree with the Referee's decision concerning compensability of the condition, but uphold the denial of surgery.

Compensability

To establish compensability, claimant must prove by a preponderance of the evidence that the compensable injury materially contributed to his disability or need for treatment. See Hutcheson v. Weyerhaeuser, 288 Or 51, 56 (1979); Milburn v. Weyerhaeuser Company, 88 Or App 375, 378 (1987). Stated differently, claimant must prove that the compensable injury was a material cause of the coccygodynia.

The medical evidence on causation is divided. Drs. Blake and Benz, the treating orthopedists, related the coccygodynia to the compensable injury, notwithstanding claimant's delay in reporting the pain. Dr. Benz supported his opinion with findings that the injury fit the symptomatology precisely and that claimant sustained no other injury during the interim. Benz also offered an explanation for claimant's delay in reporting the coccygodynia, suggesting that the low back pain may have "overshadowed" coccyx symptoms. Both Dr. Blake and, to a greater extent, Dr. Benz relied on claimant's history of the injury and the resulting symptomatology. The Referee found claimant's testimony regarding those matters to be credible, and we adopt that finding on review.

A contrary opinion was offered by Dr. Norton, an orthopedist and SAIF's Medical Administrator. Norton reviewed the medical records and opined that the coccygodynia was not related to the injury. Norton based his opinion on the absence of earlier complaints of coccyx symptoms, explaining that coccygodynia appears immediately after traumatic injury to the coccyx.

Where the medical evidence is divided, we tend to give greater weight to the treating physicians' conclusions, absent persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810, 814 (1983). No such reasons appear here. Unlike Drs. Blake and Benz, Norton has never examined claimant. Furthermore, a research article admitted into evidence indicates that post-traumatic coccygodynia may emerge up to one year after a local injury. Therefore, inasmuch as Norton's opinion is based on claimant's delay in reporting coccygodynia, we discount the persuasiveness of

his opinion accordingly. Consequently, we are persuaded by the treating physician's conclusions and find that the compensable injury was a material contributing cause of the coccygodynia. The coccygodynia is compensable.

Reasonableness and Necessity of Surgery

For his compensable injury, claimant is entitled to medical services "for such period as the nature of the injury or the process of recovery requires." ORS 656.245(1). Medical services are compensable provided they are reasonably and necessarily incurred in the treatment of the compensable injury. West v. SAIF, 74 Or App 317, 320 (1985); McGarry v. SAIF, 24 Or App 883, 888 (1976). Claimant bears the burden of proving that the treatment is reasonable and necessary. James v. Kemper Ins. Co., 81 Or App 80, 81 (1986).

The medical evidence is divided on the question of whether coccygeal surgery would be beneficial to claimant. Dr. Benz recommended surgical excision of the distal coccyx based on his finding that claimant has coccygeal pathology. However, that finding is disputed by other medical experts. Dr. Blake noted that the pain was not localized to the coccyx but was present along the low back, and he concluded that the objective findings were insufficient to support the need for surgery. Drs. Norton and Martens essentially concurred with Blake. Dr. Norton explained that a primary lesion of the coccyx would not produce the multitude of symptoms experienced by claimant.

In efforts to establish the presence of coccygeal pathology, Dr. Benz arranged for tomograms and bone scans of the coccyx. These tests revealed no fractures or abnormalities. Given the lack of objective evidence of primary coccygeal pathology, we are unable to find that the proposed surgery would be beneficial. We do not find that the surgery is reasonable and necessary to claimant's recovery from this injury. The surgery is not compensable.

ORDER

The Referee's order dated December 31, 1987 is reversed in part and affirmed in part. That portion of the SAIF Corporation's denial which denied coccygeal surgery is reinstated and upheld. The remainder of the Referee's order is affirmed.

GLORIA A. BEMBRY, Claimant
Peter O. Hansen, Claimant's Attorney
Schwabe, et al., Defense Attorneys

WCB 84-10824
August 25, 1988
Order on Review

Reviewed by Board Members Crider and Johnson.

Claimant requests review of those portions of Referee St. Martin's order that: (1) declined to set aside a Determination Order as premature; (2) upheld the self-insured employer's denial of chiropractic and acupuncture treatments; (3) upheld the employer's denial of carpal tunnel surgery and claim reopening; (4) declined to award permanent total disability; and (5) declined to assess penalties and attorney fees for allegedly unreasonable claims processing. The issues are premature claim

closure, medical services, aggravation, permanent total disability, and penalties and attorney fees.

We reverse on the issues of medical services and aggravation. We affirm the remainder of the Referee's order.

FINDINGS OF FACT

Claimant, 42 at the time of hearing, compensably injured her back in September 1981. Her condition was eventually diagnosed as a chronic spinal strain. In December 1982, her claim was closed by a Determination Order that awarded no permanent disability. Thereafter, she developed a psychological condition that was denied by the employer. Claimant requested a hearing, however, and in a prior Referee's order the Determination Order and denial were set aside.

In October 1983, claimant was seen by Dr. Long, electrodiagnostic specialist, with complaints of bilateral wrist pain. Long diagnosed bilateral carpal tunnel syndrome. Based on Long's diagnosis, Dr. Tannabe, neurosurgeon, requested authorization for carpal tunnel release surgery. Thereafter, the employer denied compensability of claimant's bilateral carpal tunnel condition. This denial was set aside by another prior Referee.

In May 1984, claimant began to treat with Dr. Kay, physician. Kay treated with acupuncture and referred claimant to Dr. Clark, chiropractor, for spinal manipulation. In November 1984, the employer formally denied further acupuncture and chiropractic treatments.

In December 1984, a Determination Order issued, awarding claimant 25 percent unscheduled permanent disability resulting primarily from injury to her low back.

Due to continuing pain in her wrists and forearms, claimant was reexamined by Dr. Long in June 1985. After performing nerve conduction studies, Long referred claimant to Dr. McCraw, surgeon. Later that month, McCraw performed right carpal tunnel release surgery. The next month, McCraw completed a First Medical Report form indicating that claimant was experiencing increased pain and numbness in both hands. McCraw estimated that claimant would require four months of further treatment. After receiving McCraw's report, the employer denied payment of the right carpal tunnel release surgery. Thereafter, McCraw and Long opined that claimant's current bilateral carpal tunnel syndrome was work related.

CONCLUSIONS AND OPINION

The Referee found that claimant was not entitled to further chiropractic and acupuncture treatments. We modify.

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). To be compensable, treatment must be reasonable and necessary. Wetzel v. Goodwin Brothers, 50 Or App 101 (1981).

Here, claimant testified that the acupuncture and

chiropractic treatment improved her condition and increased her mobility. Likewise, Drs. Kay and Clark felt that claimant's condition had improved as a result of their treatments. In August 1984, Dr. Christensen opined that claimant was "experiencing considerable abatement of her pain with * * * treatment of acupuncture and manipulations." In November 1984, Dr. Blosser, orthopedist, reported that claimant "require[s] further treatment * * *."

On the other hand, several medical experts felt that continued acupuncture and chiropractic treatment was not necessary. In March 1984, Dr. Button, hand surgeon, opined that no further treatment was necessary. Button, however, observed claimant on only one occasion and his opinion related solely to treatment of her upper extremities and hands. In October 1984, Dr. Wilson, neurologist, examined claimant and recommended against further treatment. Like Button, however, Wilson observed claimant on only one occasion. In January 1985, Dr. Kuge, physician, stated that he concurred with Wilson. However, Kuge's opinion consists entirely of a "check the box" response with no explanation.

Accordingly, we are persuaded by the well-reasoned opinions of Drs. Clark, Kay, Christensen, and Blosser. See Somers v. SAIF, 77 Or App 259, 263 (1986). After our de novo review of medical and lay evidence, including claimant's testimony of increased mobility, we find that her current acupuncture and chiropractic treatment is reasonable, necessary, and materially related to her compensable September 1981 back injury.

We now examine whether claimant sustained an aggravation in June 1985, when she underwent right carpal tunnel release surgery. To prove a claim for aggravation, claimant must show: (1) a worsening of her condition that renders her 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. Smith v. SAIF, 302 Or 396 (1986); Stepp v. SAIF, 78 Or App 438 (1986); ORS 656.273(1). Increased symptoms alone are not compensable, unless claimant suffered pain or additional disability that reduced her ability to work thereby resulting in a loss of earning capacity. Smith, 302 Or at 401.

Here, the last arrangement of compensation was the December 1984 Determination Order, which did not award permanent disability for claimant's bilateral carpal tunnel condition. In June 1985, Dr. Long performed nerve conduction studies and compared the results to his earlier studies, stating:

> "[Claimant's] symptoms appear to have progressed over the 15 months and there is some suggestion that median conduction defects have increased a little between October 1983 and June 1985.
>
> "I believe [claimant] is a candidate for definitive treatment of her median lesions."

Thereafter, Dr. McCraw reported increased pain and numbness in both of claimant's hands. As a result, McCraw performed right

carpal tunnel release surgery. After the surgery, Long and McCraw each opined that claimant's condition and need for treatment was related to either her work activities or her accepted bilateral carpal tunnel condition. Accordingly, we find that claimant became more disabled in June 1985 as a result of her compensable bilateral carpal tunnel condition.

Claimant's counsel is entitled to a reasonable, carrier-paid attorney fee for prevailing against the "acupuncture and chiropractic" and "aggravation" denials. See ORS 656.386(1). Such a fee is defined as an assessed fee. OAR 438-15-005(2). This fee cannot be awarded unless claimant's counsel files a statement of services. OAR 438-15-010(5). Inasmuch as no statement of services has been received, an assessed fee shall not be awarded.

The employer's counsel seeks Board authorization of a client-paid fee for services rendered on review. Although a statement of services has been submitted, no executed attorney retainer agreement is present in the record. Because no such agreement has been filed, a client-paid fee shall not be authorized. See OAR 438-15-010(1).

ORDER

The Referee's order dated January 29, 1987 is reversed in part and affirmed in part. That portion of the Referee's order that upheld the self-insured employer's denial of claimant's current acupuncture and chiropractic treatments is reversed. The employer's denial is set aside and the medical services claims are remanded for processing pursuant to law. That portion of the Referee's order that upheld the employer's denial of claimant's aggravation claim is reversed. The employer shall process the claim pursuant to law. All remaining portions of the Referee's order are affirmed.

HAROLD C. KIMSEY (Deceased), Claimant
Malagon & Moore, Claimant's Attorneys
Brian L. Pocock, Defense Attorney

WCB 86-06815
August 26, 1988
Order Denying Motion to Compel Disclosure

On March 21, 1988, before our August 3, 1988 Order on Review issued, the self-insured employer moved the Board to require claimant's attorney to disclose "copies of each of the pieces of correspondence referred to" in the statement of services counsel had submitted in support of his request for an extraordinary, employer-paid fee. The motion also referred to claimant's disclosure obligation under our rules and demanded an order requiring disclosure of "copies of all communications to and from Dr. Morton". The statement of services claimant's attorney had submitted included considerable detail concerning claimant's attorney's activities on the case. It included references to conversations with and a report from a Dr. Morton.

Thereafter, the employer renewed its request that the Board require claimant to disclose medical reports referred to in the statement of services. Our Order on Review sustained the employer's position on the merits but did not address the motion. The employer now renews his request for a disclosure order. The employer does not, however, seek reconsideration of our Order on Review.

The employer's motion reads as follows:

> "Thank you for issuing the Order on Review. However, you have not responded to our previous motions to disclose medical reports. Would you please require claimant to disclose those reports. If claimant were to appeal this matter to the Court of Appeals, we might well wish to rely upon those documents."

It is clear that the employer does not seek reconsideration of our Order on Review and remand. Rather, the employer simply wishes us to direct claimant's counsel to produce documents which, apparently, he thinks might interest the Court of Appeals in the event that claimant appeals our Order on Review.

We decline to grant the employer's motion. Assuming that claimant's counsel did not disclose reports of Dr. Morton and that such reports are relevant to the issues litigated at hearing--a charge that is implicit in the request for a disclosure order but never explicitly made, the employer does not seek reconsideration of our order. Therefore, no additional reports will have any bearing on disposition of the case by this agency. Any disclosure order we might enter at this time would not be ancillary to our authority to adjudicate this case and, therefore, would not be appropriate.

Assuming, arguendo, that the employer's motion should be treated as a request for reconsideration and remand for the taking of additional evidence, we would deny it. The employer prevailed both at hearing and on Board review. Therefore, if there is any further evidence that is detrimental to claimant's case, as the employer implies, that evidence would not affect our disposition of this case. We would decline to remand for an order to compel disclosure where, as here, the requesting party has already prevailed on Board review.

The motion is denied. The issuance of this order shall have no effect upon our August 3, 1988 Order on Review. The parties' rights of appeal shall continue to run from the date of our August 3, 1988 order.

IT IS SO ORDERED.

Board Member Ferris, dissenting:

I dissent. On March 21, 1988, the self-insured employer's attorney, after reviewing claimant's attorney's Statement of Services, wrote the Board and stated:

> "5. We are particularly concerned with reference to Dr. Morton in the Statement of Services. Apparently there is even a report from this Dr. Morton. Claimant's attorneys had an obligation to provide us with full disclosure. We would ask the Board to immediately order claimant's attorneys to provide us copies of all communications to and from Dr. Morton."

On May 2, 1988, the employer's attorney wrote the Board as follows:

> "In correspondence of 03-21-88 we asked you to require claimant to disclose medical reports referred to in the Statement of Services. Would you please issue an Order to that effect immediately."

On July 13, 1988, employer's attorney again wrote the Board requesting production of the medical reports. On August 3, 1988, the Board issued its Order on Review. On August 8, 1988, employer's attorney wrote:

> "Thank you for issuing the Order on Review. However, you have not responded to our previous motions to disclose medical reports. Would you please require claimant to disclose those reports. If claimant were to appeal this matter to the Court of Appeals, we might well wish to rely upon those documents."

Even though the employer does not specifically say, "I request reconsideration," such a letter is normally interpreted by the Board as a request for reconsideration, and I so interpret it.

All letters indicated copies were directed to claimant's attorneys. Through error, no acknowledgment was ever made by the Board of the letters received from the employer's attorney.

The Board rules require that:

> "Upon written demand by the insurer(s), the claimant shall within fifteen (15) days of the mailing of said demand, furnish to the insurer(s), without cost, copies of all medical and vocational reports and other documents pertaining to the claim which the insurer(s) would not reasonably be expected to receive through claims processing . . ." See OAR 438-07-015(3).

Claimant's failure to respond to the request of the employer's attorney would appear to be a flagrant violation of the Board's rules. Furthermore, if the Board's order is appealed, it is entirely possible that the requested documents will never be considered. See United Foam Corp. v. Whiddon, 92 Or App 492 (August 10, 1988). I believe the Board's order should have been abated and remanded to the Referee for an order requiring claimant's attorneys to produce the documents requested.

EVELYN McLAIN, Claimant
Garry L. Kahn, Claimant's Attorney
Rankin, VavRosky, et al., Attorneys
Randolph Harris (SAIF), Defense Attorney

WCB 88-00521
August 26, 1988
Second Order of Dismissal

On August 11, 1988, in accordance with the SAIF Corporation's withdrawal of its request for Board review, we issued our Order of Dismissal. Submitting a statement of services and attorney retainer agreement, claimant seeks an insurer-paid attorney fee for prevailing against SAIF's appeal of the Referee's order.

The request is 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); Matthew W. Johnson, 40 Van Natta 393 (1988).

Accordingly, our August 11, 1988 order is withdrawn. As supplemented herein, we adhere to and republish our prior order, effective this date.

IT IS SO ORDERED.

RONALD L. WARNER, Claimant
Malagon & Moore, Claimant's Attorneys
Meyers & Terrall, Defense Attorneys
Kate Donnelly (SAIF), Defense Attorney

WCB 86-15041 & 86-10648
August 26, 1988
Order on Review

Reviewed by Board Members Ferris and Crider.

The SAIF Corporation requests review of that portion of Referee Nichols' order requiring it to pay claimant's attorney an attorney fee in connection with a denial of medical services set aside by the Referee. Claimant submits a statement of the services rendered by his attorney on Board review and requests that the Board assess a fee against SAIF for those services as well.

ISSUES

1. The jurisdiction of the Board to decide the attorney fee issues raised by SAIF.

2. The entitlement of claimant's attorney to a carrier-paid attorney fee under ORS 656.386(1).

3. Whether the fee should be paid by SAIF or by the self-insured employer, Westbrook Wood Products.

4. Attorney fee on Board review.

FINDINGS OF FACT

Claimant compensably injured his neck and low back in September 1976 while working for SAIF's insured. The claim was accepted by SAIF and was closed by Determination Order dated June 18, 1979. Claimant's aggravation rights on the claim expired on June 18, 1984.

Claimant began working for Westbrook Wood Products (Westbrook), a self-insured employer, on or about March 1, 1986. About three weeks later, he experienced a marked increase in low back pain. He filed a claim with SAIF which was denied on July 25, 1986. (Ex. 77-1). The primary basis of SAIF's denial was responsibility, but the denial also reserved "questions of compensability." Claimant then filed a claim with Westbrook which was denied on both compensability and responsibility grounds. No order pursuant to former ORS 656.307 was sought by SAIF or Westbrook and none was issued.

At the beginning of the hearing, the Referee stated that the parties had just completed a discussion off the record and that the issues were responsibility between SAIF and Westbrook and

compensability as raised in Westbrook's denial. The parties agreed to this statement of the issues. A short time later, claimant's attorney stated that claimant took the position that Westbrook was responsible. In her order, the Referee concluded that claimant had experienced an aggravation of his September 1976 industrial injury and assigned responsibility to SAIF. She set aside what she characterized as SAIF's "denial of .245 medical care" and awarded claimant's attorney a fee of $1,200, payable by SAIF.

SAIF requested Board review. The request was nonspecific, but the only issues argued in the briefs submitted by SAIF are whether claimant's attorney is entitled to a carrier-paid fee and, if so, which carrier should be required to pay it.

CONCLUSIONS OF LAW

Jurisdiction

After the parties filed their briefs in this case, the Supreme Court rendered its decision in Greenslitt v. City of Lake Oswego, 305 Or 530 (1988). In Greenslitt, the Court held that the Board had jurisdiction to entertain a carrier's request for review of the amount of an attorney fee awarded by a Referee under ORS 656.386(1) because the carrier had also challenged the merits of the Referee's decision. 305 Or at 536. The Court also indicated that had the carrier not challenged the Referee's decision on the merits, the Board would not have had jurisdiction to review the fee. Id. at 534.

In the present case, the Referee set aside what she characterized as a denial of medical services and assessed a carrier-paid fee. The Referee cited no authority for her action, but the only authority for a carrier-paid fee in such circumstances would be ORS 656.386(1). See Cavins v. SAIF, 272 Or 162, 164-65 (1975). SAIF did not appeal the Referee's decision to set aside its denial. The issues it raises on Board review relate solely to the attorney fee awarded by the Referee. The question arises, therefore, whether Greenslitt mandates dismissal of SAIF's request for review. Although this issue was not raised by the parties, the Board has a duty on its own motion to determine whether it has jurisdiction of the subject matter of a controversy brought before it and to refuse to proceed further if it does not. See In re Oregon Mass Transportation Financing Authority, 284 Or 241, 248 (1978); 2 Am Jur 2d, Administrative Law § 332 (1962).

The first difference we note between Greenslitt and the present case is the fact that the carrier in Greenslitt requested review of the merits of the Referee's decision and the carrier in the present case did not. Technically, this makes everything the Court said in Greenslitt concerning the present situation dicta. We take this into consideration in our application of Greenslitt, but otherwise consider the Court's decision binding in this case.

The only other difference between the present case and Greenslitt is the difference in the attorney fee issues raised by the carriers. In Greenslitt, the issue was the amount of the fee. 305 Or at 532. In the present case, the issues are entitlement to a fee and which carrier should be required to pay the fee. Our jurisdiction in the present case depends upon whether this difference is a legally significant one.

The basic provision which defines the category of attorney

fee disputes for which review must be sought in circuit court is ORS 656.386(1). The pertinent portion of that subsection provides: "In the event a dispute arises as to the amount [of an attorney fee] allowed by the referee . . . [under ORS 656.386(1)], that amount shall be settled as provided for in ORS 656.388(2)." (Emphasis added). Similarly, ORS 656.388(2) prescribes the circuit court procedure for those cases in which an attorney and the Referee, Board or court "cannot agree upon the amount of the fee." (Emphasis added).

The language employed by these provisions strongly suggests that the circuit court proceeding is required only when the amount of an attorney fee awarded under ORS 656.386(1) is appealed and that other issues, such as those raised by SAIF in the present case, are to be reviewed by the Board. Such an interpretation makes sense from a policy standpoint in that it distributes cases between the Board and the circuit courts based upon their relative spheres of authority and expertise. It allots to the Board the substantive task of defining and construing the elements of ORS 656.386(1) and assigns to the circuit courts the nonsubstantive task of resolving disputes relating to the value of legal services. We adopt this interpretation and, in light of Greenslitt, conclude that the circuit court procedure is required only when the sole issue raised on appeal is the amount of an attorney fee awarded under ORS 656.386(1). We have jurisdiction, therefore, in this case.

Entitlement to a Carrier-paid Fee Under ORS 656.386(1)

A claimant's attorney is entitled to a carrier-paid attorney fee under ORS 656.386(1) if the claimant prevails finally in a hearing before a Referee in a "rejected case." A rejected case is a case in which the claimant's entitlement to receive compensation is at issue. Short v. SAIF, 305 Or 541, 545-46 (1988); see Ohlig v. FMC Marine & Rail Equipment, 291 Or 586, 593-95 (1981); see also Shoulders v. SAIF, 300 Or 606, 613-15 (1986).

Westbrook expressly denied the compensability of claimant's condition. The primary basis of SAIF's denial was responsibility, but the denial also reserved questions of compensability. No order pursuant to former ORS 656.307 was sought by SAIF or Westbrook and none was issued. Indeed, under the law in effect at the time of the carriers' denials, no such order could have been issued. See former OAR 436-60-180(3). Under these circumstances, claimant's entitlement to receive compensation remained unresolved through the hearing and claimant's attorney was entitled to a carrier-paid attorney fee under ORS 656.386(1).

Whether SAIF or Westbrook Should Pay the Fee

In Karen J. Bates, 39 Van Natta 42 (1987), the Board ruled that a carrier ultimately determined not responsible for a claimant's condition may nonetheless be required to pay the claimant's attorney a fee under ORS 656.386(1) if the carrier denies the claim on a basis which threatens the claimant's entitlement to receive compensation and the responsible carrier denies the claim only on responsibility grounds. See also Ronald J. Broussard, 38 Van Natta 59, 61, aff'd mem., 82 Or App 550 (1986). SAIF argues that if claimant's attorney is entitled to a carrier-paid fee at all in this case, Bates mandates that it be paid by Westbrook. We disagree.

In Bates, the carrier ultimately determined to be responsible denied the claimant's claim only on responsibility grounds

and sought issuance of an order pursuant to ORS 656.307. 39 Van Natta at 42. The carrier ultimately determined not to be responsible denied the claim on a basis which threatened the claimant's entitlement to receive compensation and thereby prevented the .307 order from issuing. Id. The Board assessed an attorney fee against the nonresponsible carrier because had it acceded to the other carrier's request, a .307 order would have issued and the claimant's attorney would not have been entitled to an attorney fee under the law at that time. Id. at 43; see Petshow v. Farm Bureau Insurance Co., 76 Or App 563, 569-71 (1985), rev den 300 Or 722 (1986); Stanley C. Phipps, 39 Van Natta 13, 16 (1986), rev'd in part, 85 Or App 436 (1987).

The basic policy underlying Bates is to encourage carriers to seek or accede to the issuance of a .307 order (with the attendant continuation of compensation payments to injured workers) if they do not seriously contest the claimant's entitlement to receive compensation. In the present case, even if SAIF had requested the issuance of a .307 order and Westbrook had acceded to it, no such order could have issued because of the own motion status of the SAIF claim. See former OAR 436-60-180(3). Applying the rule of Bates under these circumstances would not further the policies which engendered the decision. We conclude, therefore, that the Referee correctly ordered SAIF to pay the fee. Due to the own motion status of the disability aspects of claimant's claim, the Referee correctly characterized SAIF's denial as a denial of medical services.

For the sake of completeness, we add one further comment. The fact that claimant's attorney took the erroneous position at the beginning of the hearing that Westbrook was the responsible carrier does not preclude the assessment of a fee against SAIF. The efforts of claimant's attorney in requesting a hearing on SAIF's denial and in preparing and presenting claimant's case contributed to the Referee's decision to set aside SAIF's denial of medical services. A fee under ORS 656.386(1) to compensate these efforts was appropriate.

Attorney Fees on Board Review

Claimant's attorney has submitted a statement of services rendered on Board review and requests that a fee be assessed against SAIF, presumably under ORS 656.382(2). That subsection, however, does not authorize a carrier-paid fee when attorney fees is the sole issue raised by the carrier on Board review. See Dotson v. Bohemia, Inc., 80 Or App 233, 236, rev den 302 Or 35 (1986). No fee, therefore, shall be assessed for the services of claimant's attorney on Board review.

ORDER

The Referee's order dated March 18, 1987 is affirmed. Counsel for Westbrook Wood Products, the self-insured employer, is authorized to charge a client-paid fee of up to $184 for services on Board review.

PHYLLIS BALDWIN, Claimant
Sellers & Jacobs, Claimant's Attorneys
Roy Miller (SAIF), Defense Attorney

WCB 87-08150
August 30, 1988
Order on Review

Reviewed by Board Members Johnson and Crider.

Claimant requests review of Referee Galloway's order that: (1) upheld the SAIF Corporation's denial of her occupational disease claim for bilateral carpal tunnel syndrome; and (2) declined to award penalties and attorney fees for SAIF's alleged unreasonable processing of her claim.

The Board affirms, as amended, on the issue of compensability, but reverses on the issue of penalties and attorney fees.

ISSUES

1. Whether claimant's bilateral carpal tunnel syndrome is compensable.

2. Whether claimant is entitled to an award of penalties and attorney fees for SAIF's alleged unreasonable claims processing.

FINDINGS

The Board adopts the Referee's findings and makes the following additional findings.

Claimant began working as a welder for SAIF's insured, a railroad car manufacturer, on July 1, 1986. She worked ten-hour days, four times a week. Her job required the use of a trigger-operated welding gun. She initially operated the welding gun with only her right hand. After working at SAIF's insured for only a few days, she noticed the onset of right hand pain. Consequently, she switched hands and began operating the welding gun with only her left hand. Shortly thereafter, her left hand became painful. As a result of her bilateral hand pain, she began taking aspirin and operating the welding gun with both hands.

Approximately two weeks after the onset of her right hand pain, claimant informed her foreman of her condition. The foreman apparently scheduled her for a medical examination with Dr. Welborn, SAIF's insured's company physician. On July 30, 1986, claimant reported to Welborn's office as instructed, but Welborn was not available. Consequently, she informed Welborn's nurse of her condition. That same day, she obtained an "801" claim form from SAIF's insured. She completed the form, but did not sign it, alleging bilateral carpal tunnel syndrome. SAIF's insured apparently retained possession of the form, but did not process it until December 1986.

On August 14, 1986, claimant returned to Dr. Welborn's office. After examining claimant, Welborn recommended that she see Dr. Perrin, a hand surgeon. Claimant informed Welborn that she desired to consult her personal physician, Dr. Bell, M.D., rather than Perrin. Welborn scheduled her for an examination by Perrin on August 19, 1986.

Claimant did not attend the scheduled examination with Dr. Perrin. Rather, on the day in which that examination was to occur, she voluntarily terminated her employment with SAIF's insured. Shortly thereafter, she returned to work as a welder for a new employer. Her new job provided a push-button welder, which did not irritate or cause pain in her hands. After beginning her new job, her bilateral hand pain gradually decreased.

In September 1986, claimant was examined by Dr. Bell. Nerve conduction studies performed at Bell's request, revealed bilateral carpal tunnel syndrome. Bell referred her to Dr. Kennedy, M.D., for treatment of her carpal tunnel syndrome.

Claimant returned to SAIF's insured on December 24, 1986, to ascertain the status of her industrial claim for bilateral carpal tunnel syndrome. Dr. Welborn's nurse informed her that her claim had not been processed because she had not seen Dr. Perrin as scheduled.

On January 2, 1987, SAIF received claimant's claim form. It denied her claim on March 24, 1987.

Claimant had bilateral carpal tunnel disease prior to her employment with SAIF's insured. Due to her work activities, her underlying disease became symptomatic, resulting in bilateral carpal tunnel syndrome. Her work activities did not result in a worsening of her underlying bilateral carpal tunnel disease.

SAIF's insured had notice or knowledge of claimant's occupational disease claim and/or her bilateral hand pain by at least July 30, 1986.

CONCLUSIONS OF LAW

Compensability

To establish a compensable occupational disease, a worker must prove that her work exposure was the major contributing cause of her condition. Dethlefs v. Hyster Co., 295 Or 298, 310 (1983). Medical evidence may prove that a worker's condition preexisted her employment, even when she was asymptomatic and did not seek medical attention prior to her work exposure. AMFAC, Inc. v. Ingram, 72 Or App 168, 170 (1985). If a worker's condition preexisted her employment, she must prove that her work exposure was the major contributing cause of a worsening of her condition. AMFAC, Inc., 72 Or App at 171, n. 2.

Here, Drs. Button and Bell concurred that claimant suffered from underlying carpal tunnel disease prior to her employment with SAIF's insured. Accordingly, Button reported, inter alia:

> "I would suspect that this individual [claimant] probably had preexisting [sic] symptomatology prior to being employed by Gunderson [the employer] and that work activity exacerbated her symptomatology[,] but[,] I do not believe caused the fundamental change in the underlying condition . . . ."

Similarly, Bell reported, inter alia:

> "[M]y feeling is that this particular patient probably does have a narrow carpal tunnel ligament with which she was able to function fine with until she got into a line of work that really aggravated that. It is more rapid than one usually sees that occur, but I suspect that she was in a borderline position and the work that she did did bring out the underlying carpal tunnel syndrome."

> "She [claimant] may well have had an underlying tendency to develop it [carpal tunnel syndrome] that was asymptomatic until she started really using her wrists while at Gunderson's [the employer]."

Inasmuch as the medical evidence is uncontradicted that claimant suffered from carpal tunnel disease prior to her employment at SAIF's insured, she must prove a worsening of her condition to establish compensability. AMFAC, Inc., supra, 72 Or App at 171. However, Button opined that there was no such worsening and Bell stated that claimant experienced only increased symptoms as a result of her work exposure at SAIF's insured.

Under such circumstances, we agree with the Referee that claimant has not proven a worsening of her underlying carpal tunnel disease. On this record, she has proven only increased symptoms. Her claim is, therefore, not compensable.

Penalties and Attorney Fees

A claim may be either expressed or implied. Accordingly, former ORS 656.005(7) (new ORS 656.005(6)) defines a "claim" as:

> "a written request for compensation from a subject worker or someone on the worker's behalf, or any compensable injury of which a subject employer has notice or knowledge."

An occupational disease is considered an "injury" for purposes of the above definition. Brown v. SAIF, 79 Or App 205, 208 n.2, rev den 301 Or 666 (1986); see ORS 656.804; former ORS 656.807(5) (new ORS 656.807(3)). Late filing of a claim is excused if the employer had "knowledge" of the worker's injury. ORS 656.265(4)(a). To prove "knowledge" on the part of the employer, "a claimant need not establish that the employer knew of his claim, but only that the employer knew of the injury, even if the employer had good reason to believe that no claim would be filed." Hayes-Godt v. Scott Wetzel Services, 71 Or App 175 (1985). After notice or knowledge of a claim, a self-insured employer or insurer has 60 days in which to either accept or deny the claim, or risk the imposition of penalties and attorney fees. ORS 656.262(6) & (10).

In finding that penalties and attorney fees for SAIF's late denial were not warranted, the Referee found that claimant had a "burden" to follow-up on the status of her claim after she reported her injury on July 30, 1986. Inasmuch as claimant did not do so until December 24, 1986, the Referee reasoned that SAIF's untimely denial was "justified." We disagree.

Here, claimant informed her foreman of her bilateral hand pain after working at SAIF's insured for approximately three weeks. Shortly thereafter, on July 30, 1986, she reported to the medical department at SAIF's insured, as instructed. While there, she informed the company nurse of her condition. That same day, she completed, but did not sign, an "801" claim form and apparently left it in the possession of SAIF's insured. By its own admission, SAIF's insured knew of the injury by July 30, 1986.

Under such circumstances, we conclude that SAIF's insured had notice or knowledge of claimant's "injury" by at least July 30, 1986. Therefore, its insurer, SAIF, had until 60 days thereafter to accept or deny the claim, or risk the imposition of penalties and attorney fees. ORS 656.262(6) & (10). SAIF, however, denied the claim well beyond the 60 day period. Its only excuse is that claimant failed to sign the "801" form and that she did not see Dr. Perrin as scheduled. We are not persuaded by SAIF's argument.

First, whether or not claimant signed the "801" form is not dispositive. What is dispositive, is that SAIF's insured first knew of claimant's injury by at least July 30, 1986. See ORS 656.005(7). Second, with respect to claimant's appointment with Dr. Perrin, she informed Dr. Welborn that she did not wish to see Perrin. Despite her wishes, Welborn scheduled her for an examination with Perrin. However, a worker is required to attend only Independent Medical Examinations, which must be either requested or authorized by an employer's insurer. Former OAR 438-10-030(9) (new OAR 436-10-100(1)(d); ORS 656.325(1). On this record, there is no evidence that SAIF either requested or authorized the examination with Perrin. Claimant was, therefore, under no obligation to attend the examination.

We are persuaded that SAIF acted unreasonably in failing to timely deny claimant's claim. However, on this record, we can find no amounts then due in which to assess a penalty upon. See ORS 656.262(10). Unlike a penalty, an attorney fee may be assessed for an employer's late denial whether or not there were any amounts then due. Mischel v. Portland General Electric, 89 Or App 140, 142-43, (1988). We cannot authorize an assessed fee, however, unless claimant's counsel files a statement of services. OAR 438-15-010(5). Because no statement of services has been received to date, an assessed fee shall not be authorized.

ORDER

The Referee's order dated December 16, 1987, is affirmed in part, as amended, and reversed in part. That portion of the Referee's order that declined to find SAIF's late denial unreasonable is reversed. All other portions of the Referee's order are affirmed as amended.

JOHN SCRIVNER, Claimant
Pozzi, et al., Claimant's Attorneys
Cooney, Moscato & Crew, Defense Attorneys

WCB 87-12102
August 30, 1988
Order Denying Request

The self-insured employer's counsel seeks authorization of a client-paid fee for services rendered before the Board which culminated in our May 24, 1988 Order of Dismissal. The request is denied.

FINDINGS

On May 5, 1988, the employer moved for dismissal of claimant's request for Board review of a Referee's order on the grounds that it was untimely. On May 24, 1988, we dismissed claimant's request for review. Our order did not address the issue of a client-paid fee. The May 24, 1988 order has not been appealed, abated, stayed, or republished.

On August 9, 1988, the employer's counsel sought authorization of a client-paid fee. Included with the request was an attorney referral letter in this particular case and a statement of service.

CONCLUSIONS

We recently addressed a similar request for authorization in Jane E. Stanley, 40 Van Natta 831 (July 18, 1988). In Stanley, the request was submitted approximately three months after the issuance of our final, unappealed order. Since our prior order had neither addressed the issue of the employer's counsel's entitlement to, or the amount of, a client-paid fee, we concluded that we had jurisdiction to consider the request for authorization. However, because the request was untimely under the Board's rules concerning the authorization of a fee and since our order on the merits had become final by operation of law, we declined to authorize the employer's counsel's request.

The Board's rules concerning the filing of statements of services do not expressly discuss situations where the services are provided prior to the filing of briefs on Board review. However, the rules do establish the time for the filing of statements for other Board proceedings. For example, statements of services for proceedings before the Board in own motion matters shall be filed within 30 days after mailing of the Board's order. OAR 438-15-027(1)(c). In addition, statements of services for proceedings on Board review of a Referee's order are due within 15 days after the filing of the last brief to the Board. OAR 438-15-027(1)(d).

Here, the employer's counsel's request has been submitted four months after the motion for dismissal and some three and one-half months after the issuance of our May 24, 1988 Order of Dismissal. In keeping with the Board's filing requirements for statement of services in other proceedings, we conclude that the request for authorization of a client-paid fee under these circumstances is untimely.

As stated in Stanley, we recognize that administrative problems have arisen as parties become accustomed to the Board's rules. Yet, we continue to believe that the difficulties occasioned by this adjustment should not prompt us to ignore the very rules which have been implemented. See also Betty J. Eyler, 40 Van Natta 977 (August 5, 1988).

Inasmuch as the request for a client-paid fee is untimely and because our order on the merits of the case has become final by operation of law, we decline to authorize the employer's counsel's request. In so doing, we wish to stress that we are neither questioning the employer's counsel's entitlement to, nor the amount of, a requested client-paid fee. We are only stating that, for the reasons discussed herein, we are unable to approve the request.

IT IS SO ORDERED.

VELMA C. WILCH, Claimant
Charles D. Maier, Claimant's Attorney
Ann Kelley (SAIF), Defense Attorney

WCB 86-09754
August 30, 1988
Order on Reconsideration

The SAIF Corporation has requested reconsideration of the Board's Order on Review dated August 11, 1988. The request is granted and our prior order is withdrawn.

SAIF requests that we reconsider our decision to affirm the amount of the Referee's attorney fee award. The issue at hearing involved payment of medical services. The Referee concluded that the medical services in question were not compensable. The Referee nevertheless ordered SAIF to pay the medical bills which were not timely denied. In addition, the Referee assessed a penalty and attorney fee for untimely denial of those billings.

On review, the Board affirmed the Referee's order on the compensability issue. However, we reversed the Referee's order insofar as it ordered SAIF to pay the untimely denied bills and assessed a penalty based upon the total of the untimely denied bills. See John D. Ellis, 39 Van Natta 319 (1987). Finally, we affirmed the amount of the attorney fee awarded by the Referee.

SAIF contends that the attorney fee award should be reduced. SAIF argues that, whereas claimant obtained beneficial results at hearing, on review claimant will receive nothing. Because the results have changed, SAIF asserts that the attorney fee award should also change. See Barbara Wheeler, 37 Van Natta 122 (1985).

We do not agree. The award of an attorney fee in this case is premised not upon any beneficial results secured for claimant in the form of additional dollars, but upon service to establish SAIF's unreasonable delay in accepting or denying the medical bills in question. ORS 656.262(10); 656.382(1).

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

IT IS SO ORDERED.

GLENN L. WOODRASKA, Claimant
C. Rodney Kirkpatrick, Claimant's Attorneys
Kevin L. Mannix, Defense Attorney

WCB 86-16658
August 30, 1988
Order Denying Motion to Dismiss

The insurer has moved the Board for an order dismissing claimant's request for review on the ground that it did not receive timely notice of the request. The motion is denied.

FINDINGS

Claimant's request for review of the Referee's April 21, 1988 order was received by the Board on May 9, 1988. The request did not include an acknowledgment of service or certificate of personal service by mail upon the parties at the hearing.

On May 20, 1988, the Board mailed a computer-generated letter to claimant, the employer, and its attorney acknowledging the request. The employer received this letter, but it was not date-stamped. The employer's business was open for a half-day on

Saturday May 21, 1988. However, its District Safety Supervisor, the individual responsible for workers' compensation claims, was not in the office that day.

The supervisor estimates that he received actual notice of the Board's acknowledgment letter "on May 23, 1988 or sometime thereafter." Counsel for the employer/insurer received the Board's letter on May 23, 1988. The insurer received actual notice of the request for review on May 31, 1988, when it was advised by its counsel.

The request for Board review was filed within 30 days of the Referee's order. Furthermore, the employer received actual notice of the request within 30 days of the Referee's order.

CONCLUSIONS

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). ORS 656.005(19). 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. Argonaut Insurance Co. v. King, 63 Or App 847, 852 (1983).

"Party" means a claimant for compensation, the employer of the injured worker at the time of injury and the insurer, if any, of such employer. Attorneys are not included within the statutory definition of "party." Robert Casperson, 38 Van Natta 420, 421 (1986).

Here, the 30th day after the Referee's April 21, 1988 order was May 21, 1988, a Saturday. Thus, the last day to timely file a request for Board review was Monday, May 23, 1988. See ORS 174.120. Inasmuch as claimant's request was filed on May 9, 1988, it was timely. See ORS 656.289(3).

However, the record fails to establish that copies of the request for review were mailed to all parties to the proceeding before the Referee. See ORS 656.295(2). Thus, in order for the Board to retain jurisdiction, the parties must have received actual notice of the request within the 30-day statutory period. See Zurich Ins. Co. v. Diversified Risk Management, 300 Or 47, 51 (1985); Argonaut Insurance Co. v. King, supra.

The record is unclear concerning when the employer received actual notice of claimant's request for review. The employer states that it received actual notice of the existence of the request on Monday "May 23, 1988 or sometime thereafter," when its safety supervisor read the Board's May 20, 1988 acknowledgment letter. Unfortunately, the date of this notice cannot be conclusively determined because the Board's letter was not date-stamped by the employer. Yet, because the employer was open for business on Saturday May 21, 1988, it is entirely possible that it received the Board's acknowledgment letter that day, which is within 30 days of the Referee's April 21, 1988 order, or, at least, Monday May 23, 1988, which is the final day of the statutory period.

As the moving party, the employer has the burden of proof. See Tim J. McAuliffe, 37 Van Natta 76 (1985). After conducting our review of this record, we conclude that the employer has failed to establish that it did not receive a copy of the Board's acknowledgment letter on or before May 23, 1988. Consequently, we find that it is more probable than not that the employer received actual notice of claimant's request for review within the statutory 30-day period.

No contention has been made that the insurer has been prejudiced by not directly receiving a copy of claimant's request for review or the Board's acknowledgment. Absent such a finding, we hold that the employer's timely actual notice of the request for review is adequate compliance with ORS 656.295(2) to vest jurisdiction in the Board. See ORS 656.295(2); Argonaut Insurance Co. v. King, supra, pages 850-51; Nollen v. SAIF, 23 Or App 420, 423 (1975), rev den (1976).

Accordingly, the motion to dismiss is denied. Once a transcript is obtained and copies are distributed to the parties, a briefing schedule will be implemented. Thereafter, this case will be docketed for Board review.

IT IS SO ORDERED.

JOHN B. ZABELL, Claimant
Dennis O'Malley, Claimant's Attorney
David Jorling, Defense Attorney

WCB 86-01425
August 30, 1988
Order of Remand

Claimant requested Board review of Referee McGeorge's order which dismissed his hearing request without prejudice. The parties have submitted for our approval a "Stipulated Order," which is designed to reinstate the hearing request and remand this case to the Hearings Division to be placed in deferred status, in lieu of the Referee's order. On review, the issues are remand and jurisdiction.

We reverse the Referee's order and direct that the hearing request be reinstated; however, we decline to approve the "Stipulated Order."

FINDINGS OF FACT

Claimant compensably injured his back on October 1, 1985 while employed by the self-insured employer. The claim was closed by Determination Order on January 6, 1986 with awards of temporary total disability and 20 percent unscheduled permanent disability. On January 30, 1986, claimant timely filed a hearing request raising issues of temporary partial disability, temporary total disability, scheduled permanent partial disability and unscheduled permanent partial disability. A hearing was set for October 17, 1986.

The hearing was later postponed and the case placed in inactive status while claimant participated in an authorized training program (ATP) from February 1986 through June 1987. Shortly before that training period ended, a request for authorization of further training services was submitted to the Rehabilitation Review Division (RRD). That request was denied in September 1987. Notwithstanding the denial, the employer apparently funded further training services and continued to pay temporary total disability. -1093-

The case was taken from inactive status and set for hearing on November 23, 1987. Prior to hearing, both parties informed the Referee that the claim had been reopened due to claimant's participation in an ATP. On that basis, the employer's counsel moved for postponement of the hearing. On November 9, 1987, the Referee initially denied the motion and dismissed the case without prejudice, but later vacated the dismissal order.

The case was again set for hearing on February 10, 1988. However, prior to hearing, the employer's counsel informed the Referee that claimant would be enrolled in an ATP through at least April 1988, and requested that the case be placed in inactive status until that time. The Referee then entered the January 22, 1988 order now before us on review, dismissing claimant's hearing request "without prejudice preserving to him all issues raised therein."

Under the terms of the "Stipulated Order," the parties agree that: (1) the Referee's dismissal order shall be set aside and the matter remanded to the Hearings Division to be placed in inactive status pending claim closure; (2) the employer waives any claim of offset or overpayment based upon temporary disability compensation paid on or before the date of the stipulation or any such compensation to be paid pursuant to future participation in training programs; and (3) when claimant's claim is closed by Determination Order after completion of the ATP, all issues arising from the prior Determination Order of January 6, 1986 shall be fully preserved for hearing, provided that he timely requests a hearing on that post-ATP Determination Order.

CONCLUSIONS OF LAW AND OPINION

At the outset, we decline to approve the "Stipulated Order" submitted by the parties, because it stipulates that the Referee committed reversible error and that we should process cases differently than we do. Although the parties have a right to stipulate to a resolution of their dispute, e.g., amount of disability award, they have no right to stipulate to such matters as Board jurisdiction or other questions of law and no right to alter Board procedure by agreement.

We now review the Referee's dismissal order. We recently held that, as a matter of Board policy, a request for hearing on a Determination Order should not be dismissed when the issue of permanent partial disability cannot be litigated because the claimant was no longer medically stationary. Robert L. Murphy, 40 Van Natta 442 (1988). In that case, claimant requested a hearing on a Determination Order, but prior to the hearing, his claim was reopened for surgery. After the one-year limitations period for filing a request for hearing on the Determination Order had expired, claimant sought to have his case taken off the docket while preserving his right to litigate issues arising from the prior Determination Order. However, the Referee dismissed his hearing request without prejudice, and claimant requested Board review. We reversed the Referee's order and reinstated the hearing request. We reasoned that, if the dismissal order were upheld, claimant would be unable to contest the Determination Order's award of temporary total disability compensation. Moreover, although claimant could have litigated the issue of permanent partial disability after issuance of a new Determination Order, he would have had the burden of proving that he had become

more disabled since the first Determination Order because the first Determination Order would have been final and the law of the case. See Stepp v. SAIF, 78 Or App 438, 441-42 (1986).

Like the claimant in Murphy, this claimant sought to have his case taken off the docket while preserving his right to litigate issues arising from the prior Determination Order. The crucial distinction is that, whereas the claim in Murphy was reopened for aggravation, this claim was reopened for an ATP. After completion of the ATP, claimant is entitled to a new determination of the extent of his permanent partial disability without regard to a prior award of compensation. Former ORS 656.268(5); Watkins v. Fred Meyer, 79 Or App 521, 524-25 (1986). Accordingly, claimant may seek a greater or lesser permanent partial disability award in the post-ATP Determination Order than that awarded in the prior Order without showing a change in his condition. Hanna v. SAIF, 65 Or App 649, 652 (1983). For that reason, when the sole issue for litigation is extent of permanent partial disability but litigation cannot proceed due to reopening of the claim for ATP, dismissal of claimant's hearing request would not harm his interests.

There is some suggestion that permanent partial disability is the sole issue for litigation here; however, we are not so persuaded. Claimant's request for hearing raised issues of temporary disability, in addition to permanent disability. Therefore, if we dismiss under these circumstances, claimant would be unable to contest the temporary disability compensation awarded by Determination Order on January 6, 1986, because the statutory one-year limitations period for filing a request for hearing on the Determination Order has passed. See former ORS 656.319(4). Given the potential harm to claimant's interests, we reverse the Referee's order of dismissal and reinstate claimant's hearing request. If the claim is no longer open, the case may be scheduled for hearing. If the claim remains open, the hearing may be deferred under the Board rules.

ORDER

The Referee's dismissal order dated January 22, 1988 is reversed. Claimant's hearing request dated January 30, 1986 is reinstated. This case is remanded to the Hearings Division for further action consistent with this order.

LINDA L. CARROLL, Claimant
Peter O. Hansen, Claimant's Attorney
Mark Bronstein (SAIF), Defense Attorney

WCB 87-17793
September 2, 1988
Order on Review

Reviewed by Board Members Johnson and Crider.

Claimant, pro se, requests review of that portion of Referee Fink's order that increased claimant's unscheduled permanent disability award for a back injury from 15 percent (48 degrees), as awarded by a Determination Order, to 25 percent (80 degrees). Enclosed with her appellate briefs, claimant has submitted several notes and reports from her physical therapist and treating psychologist, some of which are dated post-hearing. Such a submission is treated as a motion for remand to the Referee for the taking of additional evidence. Judy A. Britton, 37 Van Natta 1262 (1985). We deny the motion for remand and affirm the Referee's order.

ISSUE

Remand for the taking of additional evidence.

Extent of permanent disability.

FINDINGS OF FACT

On January 13, 1986, while working as a janitor, claimant incurred a compensable injury when she fell on a stairway sliding down three steps. Dr. Langston, orthopedist, diagnosed a contusion of the left buttock. Claimant received conservative treatment.

On October 20, 1986, the Orthopaedic Consultants conducted an independent medical examination. The tests revealed no objective evidence for her complaints.

Claimant has a history of emotional and psychological problems. Pursuant to a March 1987 stipulation, the SAIF Corporation agreed to accept her claim for an adjustment disorder insofar as it resulted from her compensable injury.

A November 17, 1987 Determination Order awarded claimant 15 percent (48 degrees) unscheduled disability as well as temporary total disability for the period of January 13, 1986, through October 12, 1987.

Claimant was 46 years old at the time of hearing. She obtained her GED and has completed several hours of college credit. In addition, she is a licensed cosmetologist.

Claimant has transferable skills in the areas of institutional janitorial practices and basic security procedures. Her vocational file was closed due to her repeated failure to cooperate and provide requested information necessary to vocational assistance.

After hearing and observing claimant, the Referee questioned her credibility as a witness. We defer to this finding and rely on the medical evidence concerning the extent of permanent impairment resulting from the compensable injury.

There are no objective medical findings to support claimant's subjective complaints of pain. However, we find that she has sustained permanent impairment as a result of her compensable adjustment reaction. We find her permanent impairment resulting from the compensable injury and its residuals to be in the mild range.

Claimant has submitted several notes and letters from her physical therapist and treating psychologist. Some of these materials concern the course of her treatment prior to the date of hearing. Others pertain to her psychological condition and vocational capabilities subsequent to the hearing. These materials, which are otherwise not in the record, are either cumulative or not germane to the issue of the extent of claimant's permanent disability as of the date of hearing.

We find that the record has not been improperly, incompletely or otherwise insufficiently developed.

CONCLUSIONS OF LAW AND OPINION

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 established that the evidence relevant to the issues raised in the request was unobtainable with due diligence before the hearing. Bernard L. Osborn, 37 Van Natta 1054, 1055 (1985), aff'd mem. 80 Or App 152 (1986).

Here, we are not persuaded that the record has been either improperly, incompletely or otherwise insufficiently developed. We consider the submitted materials either cumulative or irrelevant to the question at hand, which is the extent of claimant's permanent disability as of the date of hearing. Accordingly, we deny the motion for remand and proceed to the merits of the case.

The Referee awarded 25 percent (80 degrees) unscheduled permanent disability. We agree with the award for the following reasons.

Medical evidence is not statutorily required to establish the extent of permanent disability. Garbutt v. SAIF, 297 Or 148 (1984). Yet, if we find a worker's testimony insufficient to resolve a complicated medical issue, we may require expert medical opinion to resolve the issue presented. Kassahn v. Publishers Paper Co., 76 Or App 105 (1985).

After conducting our de novo review of the medical and lay evidence, the preponderance of the evidence establishes that the compensable injury and its residuals have resulted in a permanent loss of earning capacity. See ORS 656.214(5). In reaching this conclusion, we find the opinion of Dr. Worthington, clinical psychologist, to be persuasive. Dr. Worthington, who treated claimant at the behest of her attending physician, concluded that she was suffering from an adjustment disorder with depression and psychological factors affecting her physical condition. It was Dr. Worthington's opinion that, although claimant was predisposed to a psychological reaction by virtue of a premorbid personality, the major cause of her adjustment disorder was the compensable injury.

The Referee concluded that claimant had established the extent of her permanent disability by "clear and convincing evidence." This statement apparently is in response to the current version of ORS 656.283(7), which provides that:

> "[N]othing in this section shall be construed to prevent or limit the right of a worker, insurer or self-insured employer to present evidence at hearing and to establish by clear and convincing evidence that the degree of permanent disability suffered by the claimant is more or less than the entitlement indicated by the standards adopted by the director under ORS 656.726."

Thus, the "clear and convincing evidence" test does not apply to cases to which we do not apply the disability standards adopted by the Director under ORS 656.726. These standards were

adopted July 1, 1988 and are applicable to all claims closed on or after that date. See OAR 436-35-003. Moreover, the disability rating standards adopted by the Director apply to hearings conducted on and after July 1, 1988 and only to claims closed and evaluated by the Evaluation Section, insurers, and self-insured employers on and after July 1, 1988, where a claimant last became medically stationary on and after January 1, 1988. See OAR 438-10-005, (Effective July 1, 1988, WCB Admin. Order 2-1988).

Inasmuch as these standards were neither adopted nor effective at the time of hearing, the "clear and convincing evidence" burden of proof did not apply in any way. Consequently, the evidence concerning the extent of permanent disability resulting from the compensable injury must be established by a preponderance. Hutcheson v. Weyerhaeuser, 288 Or 51 (1979). Considering that burden of proof, we proceed to rate the extent of claimant's permanent disability.

In rating the extent of claimant's permanent disability, we consider her psychological impairment 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. Harwell v. Argonaut Insurance Co., 296 Or 505, 510 (1984); Fraijo v. Fred N. Bay News Co., 59 Or App 260 (1982). After considering the aforementioned guidelines, we agree with the Referee that a 25 percent unscheduled permanent disability adequately compensated claimant for her compensable back injury.

ORDER

The Referee's order dated February 8, 1988 is affirmed.

VINCENT M. CELLERINI, Claimant
Burt, et al., Claimant's Attorneys
Kevin L. Mannix, Defense Attorney

WCB 87-14640
September 2, 1988
Order on Review

Reviewed by Board Members Johnson and Crider.

Claimant requests review of Referee McMurdo's order which: (1) found that his low back and right ankle injury claim was not prematurely closed; and (2) affirmed a Determination Order that awarded 10 percent (13.5 degrees) scheduled permanent disability for the loss of use or function of the right foot (ankle) and 10 percent (32 degrees) unscheduled permanent disability for a low back injury.

We modify that portion of the Referee's order which affirmed the Determination Order award of 10 percent unscheduled disability, and affirm the remainder of the order.

ISSUES

1. Premature claim closure

2. Extent of scheduled disability

3. Extent of unscheduled disability

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following supplementation. We find that claimant's right ankle

impairment is mild. We further find that claimant is capable of performing light work only and has sustained mild permanent impairment from the low back injury.

CONCLUSIONS AND OPINION

We adopt the Referee's conclusions of law and opinion on the premature claim closure issue.

Extent of scheduled disability

The criterion for rating scheduled permanent disability is the permanent loss of use or function of the injured member due to the compensable injury. ORS 656.214(2). Dr. Anderson rated claimant's permanent impairment as mild. However, that rating appeared to address both low back and right ankle impairment. Nevertheless, we are persuaded by claimant's testimony regarding his ankle problems that the loss of use or function of his foot due to the ankle injury is indeed mild.

Although claimant cites other evidence suggesting his ankle impairment to be more severe, we are not so persuaded. Dr. Anderson, in a September 22, 1987 chart note, reported that his examination revealed restricted motion with pain at the extremes. However, it is unclear whether the report addressed right ankle motion or low back motion. Moreover, that report fails to quantify the degree of motion loss and is, therefore, less useful than it might have been in our determination of loss of use or function. A physical capacity evaluation report, which merely described claimant's ankle limitation as "significant," suffers from similar lack of clarity. Given our finding that claimant's ankle impairment was mild, we conclude that he was adequately compensated by the Determination Order award of 10 percent scheduled disability for the loss of use or function of his right foot.

Extent of unscheduled disability

The criterion for rating unscheduled permanent disability is the permanent loss of earning capacity due to the compensable injury. ORS 656.214(5). In determining the loss of earning capacity, we consider medical and lay evidence of physical impairment resulting from the compensable injury and all of the relevant social and vocational factors set forth in former OAR 436-30-380 et seq. We apply these rules as guidelines, not as restrictive mechanical formulas. Harwell v. Argonaut Insurance Co., 296 Or 505, 510 (1984); Fraijo v. Fred N. Bay News Co., 59 Or App 260, 269 (1982).

Based on our de novo review of the medical and lay evidence, we find that claimant has sustained a mild permanent impairment from the low back injury, which has prevented him from returning to his job-at-injury as a front-end loader operator. Claimant's 49 years of age and his primarily manual work experience further impact his earning capacity. After considering the aforementioned factors, we conclude that claimant would be adequately compensated by a 25 percent unscheduled permanent disability award for his compensable low back injury. Accordingly, we modify the Referee's order.

The insurer's counsel is entitled to a reasonable, client-paid fee for services rendered on Board review. OAR 438-15-020(2). However, we cannot authorize a client-paid fee

unless the insurer's counsel files an executed attorney retainer agreement. OAR 438-15-010(1). Because no such agreement has been received to date, a client-paid fee shall not be authorized.

ORDER

The Referee's order dated January 15, 1988 is modified in part and affirmed in part. In addition to the 10 percent (32 degrees) unscheduled permanent disability awarded by Determination Order, claimant is awarded 15 percent (48 degrees) unscheduled permanent disability, giving him a total unscheduled award to date of 25 percent (80 degrees) unscheduled permanent disability for a low back injury. Claimant's attorney is awarded 25 percent of the increased compensation created by this order, not to exceed $3,800.

ROGER D. McCOMMON, JR., Claimant
CONDEROGA SUPPLY CO. dba
Chase Mechanical Service, Employer
Larry A. Dawson, Claimant's Attorney
Michael Esler, Attorney
Les Huntsinger (SAIF), Defense Attorney
Carl M. Davis, Ass't. Attorney General

WCB 85-11207 & 85-13700
September 2, 1988
Order on Review

Reviewed by Board Members Ferris and Crider.

Barry Butcher ("Butcher"), styling himself "intervenor," requests review of those portions of Referee Fink's order that: (1) excluded evidence on claimant's alleged corporate ownership and management responsibilities; (2) set aside that portion of the Workers' Compensation Department's Proposed and Final Order which found claimant was doing business as Conderoga Supply; and (3) found that claimant was a subject employee of a noncomplying employer. We affirm.

ISSUES

1. Whether the Referee committed reversible error by excluding evidence regarding claimant's alleged corporate ownership and management responsibilities.

2. Whether claimant was an officer or director of Conderoga Supply Co. and owner of a substantial interest in that corporation.

3. If claimant was not an officer or director and did not own a substantial interest in Conderoga Supply, was claimant a subject employee of that corporation.

FINDINGS OF FACT

Early in 1984, Butcher, a certified public accountant, hired claimant, a plumber, to do plumbing work on some new houses that he was constructing. At the time, claimant was having extreme difficulties with creditors and drug abuse. These problems came to the attention of Butcher who suggested to claimant that he use Butcher's dormant corporation, Conderoga Supply Co. ("Conderoga"), to shield his plumbing equipment, inventory and personal vehicle from creditors' liens. Butcher did not make this suggestion out of any sense of Christian charity, but rather, to exploit claimant for personal gain.

On August 18, 1977, Conderoga was incorporated by Butcher. He and his father were the officers and directors. At no time on or prior to November 6, 1984 was claimant ever an officer or director of Conderoga. At all times prior to its sale in early 1985, Butcher owned one-third interest; his father owned one-third interest; and, although he was unaware of it until one day before hearing, William Alexander owned one-third interest.

In May and June of 1984 claimant entered a drug abuse treatment program for alcohol and cocaine addiction.

On June 11, 1984, Butcher and his father held a corporate meeting regarding the future of Conderoga. Butcher's father agreed that he would give his stock to claimant since the stock had no value; he also agreed to tender his resignation as president of the corporation.

On July 25, 1984, claimant agreed to transfer all of his ownership interest in his plumbing equipment, inventory and personal vehicle to Conderoga Supply with the understanding that Butcher would sell the corporation to him at some time in the future. Claimant received no ownership interest in Conderoga. While working for Conderoga, Butcher paid claimant $500 every two weeks and paid claimant's monthly house payments. Claimant bid on plumbing jobs and hired employees to assist him in the work. Those employees were also paid by Butcher.

Contrary to his intent as expressed at the June 11, 1984 corporate meeting, Butcher's father never did actually transfer his one-third ownership interest in Conderoga to claimant; neither did William Alexander. Finally, Butcher himself never transferred his one-third interest to claimant. At no time were any of these three ownership interests transferred to claimant. Therefore, on November 6, 1984, when claimant injured his low back, he was not a director or officer of Conderoga and did not have a substantial ownership in the corporation. In fact, he had no ownership at all, merely a promise of future ownership.

On November 6, 1984, claimant strained his low back while setting solar panels in a rooftop installation. He felt immediate low back pain and was taken to emergency medical care at a nearby hospital. When claimant was injured, he was working as an employee of Conderoga.

On December 20, 1984, Butcher alone signed a letter offering to sell all of the stock of Conderoga to Chuck Jones.

In January 1985 Butcher sold Conderoga to Mr. Jones. Since Jones would not buy Conderoga without claimant's continued employment, claimant agreed to the sale of his plumbing equipment, inventory and vehicle along with the corporation.

Butcher alone signed every negotiated check on the Conderoga account, including checks written well after the sale of assets to Mr. Jones.

On August 9, 1985, Butcher alone applied for reinstatement of Conderoga's corporate status after it had been involuntarily dissolved on December 6, 1984.

On September 5, 1985, the Workers' Compensation Department issued a Proposed and Final Order which found that

claimant had been doing business as a sole proprietor which employed subject workers from May 15, 1984 to January 2, 1985. The Order further declared that during the aforementioned time period, Conderoga was a noncomplying employer. In a separate letter to the SAIF Corporation, the Department referred claimant's injury claim for processing with the recommendation that it be denied since claimant was not a subject employee of Conderoga at the time of the alleged injury.

On September 20, 1985, SAIF denied claimant's injury claim on the ground that on November 6, 1984, he was not a subject employee of Conderoga.

Based upon the substance of his testimony, we agree with the Referee that claimant was an entirely credible witness. We also agree that Butcher's testimony contained numerous irrevocable inconsistencies, indicating both half truths and outright untruths. Therefore, we find Butcher to be entirely not credible and refuse to rely upon any of his testimony in reaching our decision in this matter. We also find that William Alexander's testimony was neither credible nor reliable.

CONCLUSIONS OF LAW

Exclusion of evidence

The Referee sustained objections to certain questions directed to claimant because he believed that all evidence necessary to make a decision regarding the ownership and management of Conderoga had been presented. We agree.

To place within reasonable limits the course and conduct of a hearing, a Referee may properly restrict needless repetition of testimony. Van Der Hout v. Johnson, 251 Or 435, 442 (1968).

Claimant was asked on a number of occasions by Butcher's counsel whether he sold his tools to Conderoga in return for stock. Repeatedly, claimant testified that there had never been any discussion of a stock transfer. Instead, his understanding of the transaction was that sometime in the future Butcher would sell the corporation to claimant. Repeated questioning of claimant in this regard was redundant. Further questioning was properly precluded by the Referee.

The remaining questions, objections to which the Referee sustained, pertained to Butcher's and claimant's understanding of whose responsibility it was to obtain workers' compensation insurance for Conderoga. Again, we find that the Referee did not abuse his discretion in forbidding the questioning. Ample evidence was presented by both parties concerning the ownership and control of Conderoga. Testimony related to claimant's understanding was either irrelevant or redundant. There was no error.

Whether claimant was a subject worker of Conderoga

After giving consideration to all the evidence, the Referee concluded that claimant was neither an owner nor a corporate officer of Conderoga, and was a subject worker of that noncomplying employer. We agree.

ORS 656.027 states that:

"All workers are subject to ORS 656.001 to 656.794 except those nonsubject workers described in the following subsections:"

"(9) A corporate officer who is also a director of the corporation and has a substantial ownership interest in the corporation, regardless of the nature of the work performed by such officer." See OAR 436-50-050(1).

OAR 436-50-050(1)(a) states that a "'Director' means a person authorized to serve as a director by the incorporators in the Articles of Incorporation or elected and qualified as a director in accordance with the Articles of Incorporation or bylaws."

OAR 436-50-050(1)(b) states that a "'substantial ownership' means a percentage of ownership equal to or greater than the average percentage of ownership of all stockholders or 10 percent, whichever is less."

Since January 26, 1979, Conderoga had maintained a checking account with the Canadian Imperial Bank of Commerce (CIBC). On June 11, 1984, a proprietary interest in Conderoga was allegedly transferred to claimant. On June 16, 1984, however, a document was filed with CIBC which indicated otherwise. (Ex. I-1). This document was signed by the president and secretary of Conderoga, who were identified as individuals other than claimant. At hearing, Butcher offered two CIBC forms purportedly signed by claimant on September 11, 1984 as president of Conderoga. (Exs. 11 and 12). Claimant, however, denied that he understood the forms, if in fact he signed them at all, which he did not remember doing. These forms were never filed with the bank. On November 15, 1984, a bank form identical to the one purportedly signed by claimant was actually filed with CIBC. (I-13-6). It designated Butcher as president and his father as secretary of Conderoga. It listed the directors as "N/A."

No explanation was offered at hearing by Butcher to explain why his father was acting as secretary after he allegedly ended his interest and investment with Conderoga on June 11, 1984 nor to explain why his father, who purportedly gave away his ownership interest and resigned as an officer and director of Conderoga on June 11, 1984, nevertheless filed an assumed business name registration with the state on July 31, 1984 listing himself as authorized representative for Conderoga. (Ex. I-5). In fact, other than the two September 1984 bank forms which were never filed with CIBC, there is no document to indicate that claimant was ever an officer or director of Conderoga.

No credible evidence was offered to establish that claimant was authorized to serve as a director by the incorporators in the Articles of Incorporation of Conderoga or elected and qualified as a director in accordance with its Articles of Incorporation or bylaws. We find that he was not.

Butcher described his role with Conderoga as simply that

of accountant and personal advisor to claimant. He stated that all his aid to claimant was merely an act of Christian charity. He also stated that he was uninvolved and uninformed concerning claimant's jobs. Nonetheless, Butcher alone signed a letter dated December 20, 1984 offering to sell all of the stock of Conderoga to Chuck Jones. Mr. Jones testified that when he was approached by Butcher about buying Conderoga he was told that the company belonged to Butcher and his father. Jones dealt exclusively with Butcher in regard to the sale of the company. Jones also contradicted Butcher by stating that Butcher alone prepared spread sheets showing the relative position of each Conderoga job as of the date of the sale to Jones.

Butcher also was untruthful concerning the purpose of money borrowed from the Beaver State Bank. He testified that he borrowed the money for the purpose of loaning it to Conderoga for financing the Parklawn Apartment job, where claimant was eventually injured. The bank records showed that the loan was used to finance a home that Butcher was building for resale, a personal project in which Conderoga was not involved. In fact, he partially repaid himself directly from that loan, used Conderoga's money to repay the Beaver State Bank and assigned to himself as further loan repayment payments from the Parklawn owner in the form of the right to receive $8,200 in rent from certain apartments, i.e. rent credits.

Butcher so thoroughly impeached himself at hearing that we find his entire testimony not credible. He gave false testimony about the purpose of the Beaver State Bank loan; he was untruthful about ever submitting the September 1984 forms to the CIBC; he convinced his business associate William Alexander to testify that in 1984 he had transferred to McCommon an interest in Conderoga that Alexander only learned he owned the day before hearing.

On November 6, 1984, when claimant injured his back while setting solar panels on a rooftop, he was a subject worker of Conderoga Supply. He was neither an officer nor a director of Conderoga. At the time, he had no ownership interest at all in Conderoga. Claimant's statements from time to time to various individuals that he was a part owner of the company were based upon his understanding that eventually he would become an owner. In July 1984, at Butcher's urging, claimant transferred all of his plumbing equipment and inventory to Conderoga. He received nothing in return but a shield from creditors and the promise of future company ownership. No transfer of assets by claimant for an ownership interest or gift of ownership was ever made. Therefore, at the time of injury claimant was merely a subject worker of Conderoga.

ORDER

The Referee's order dated April 15, 1987 is affirmed. Claimant's attorney is awarded an assessed fee of $1,000 for his services on Board review, to be paid by the SAIF Corporation on behalf of the noncomplying employer.

LONNIE A. RUSH, Claimant
Vick & Gutzler, Claimant's Attorneys
Scheminske & Lyons, Defense Attorneys

WCB 87-09727
September 2, 1988
Order on Review

Reviewed by Board Members Crider and Johnson.

Claimant requests review of Referee Bethlahmy's order that upheld the insurer's "de facto" denial of his medical services claim for a low back condition. We reverse.

ISSUES

1. Whether the medical services claim is barred by the doctrine of res judicata.

2. If not, whether claimant's condition requiring medical services is causally related to his compensable injury.

FINDINGS OF FACT

Claimant sustained a compensable injury to his low back on June 23, 1981, when he was lowering a pump off a truck onto the ground. He developed low back symptoms which extended down both legs. Claimant had experienced prior intermittent low back symptoms over several years. He filed an injury claim for a low back strain which was accepted by the insurer.

A March 25, 1982 Determination Order awarded claimant temporary disability benefits and 10 percent unscheduled permanent partial disability for injury to his low back. Claimant requested a hearing on the extent of his permanent disability.

In an off-the-job incident in September 1982, claimant bent over to pick up a horseshoe and suffered increased pain.

Herniated discs at L3-4 and L4-5 were diagnosed in December 1982. Claimant subsequently filed a claim for aggravation which was denied by the insurer. Claimant requested a hearing on the denial.

A hearing was held on July 6, 1983. The issues at hearing were the compensability of the aggravation claim; in the alternative, the extent of claimant's low back disability; and offset of overpaid temporary disability compensation against any additional award of permanent disability.

The issues were resolved by Opinion and Order issued July 22, 1983. The Referee first noted that the parties agreed that claimant's condition had worsened subsequent to the last award of compensation on March 25, 1982. The Referee concluded, however, that claimant failed to prove a causal connection between that worsening and his June 23, 1981 injury. He, therefore, upheld the insurer's aggravation denial. He then concluded that claimant was entitled to an additional award of 10 percent disability, for a total award of 20 percent unscheduled permanent partial disability. He further granted the insurer's request for an offset. No appeal was taken from this order.

On March 21, 1984, the insurer issued a denial of payment for a medical billing. Claimant requested a hearing on the denial. By order dated December 3, 1984, a Referee concluded

that claimant's hearing request was barred by the doctrine of res judicata. The Referee based his decision upon the fact that the billing was in existence at the time of the July 6, 1983 hearing and should have been raised at that time.

In April 1985, claimant began treating with Dr. Berardi, chiropractor, for low back pain radiating to both legs. Dr. Berardi diagnosed lumbar strain syndrome and intervertebral disk syndrome. He treated claimant ten to twelve times. The insurer paid for those treatments.

Claimant returned to Dr. Berardi in February 1987 for additional treatments. At the time, he was experiencing increased symptoms again involving his low back and legs. The insurer received Dr. Berardi's bills for these treatments but did not pay or deny them. On June 23, 1987, claimant filed a request for hearing challenging the insurer's "de facto" denial of Dr. Berardi's bills.

Claimant's current condition requiring treatment is causally related to his 1981 injury.

CONCLUSIONS OF LAW AND OPINION

Res Judicata

In North Clackamas School Dist. v. White, 305 Or 48, 52 (1988), the Supreme Court acknowledged the applicability of res judicata principles to workers' compensation cases. In White, the Court referred to the preclusive effect on the claim as "claim preclusion" and the preclusive effect on an issue as "issue preclusion." We conclude that neither claim preclusion nor issue preclusion is applicable to claimant's medical services claim.

We first consider the question of issue preclusion. The rule of issue preclusion holds that, if a claim is litigated to final judgment, the decision on a particular issue or determinative fact is conclusive in a later or different action between the same parties if the determination was essential to the judgment. White, supra, 305 Or at 53. This analysis requires that we examine the issues decided in the prior claims.

The issues at the July 6, 1983 hearing included aggravation, extent of permanent disability and offset. The only issue with any potential preclusive effect is the aggravation issue. The July 22, 1983 order found that claimant's condition had worsened but that he had failed to prove that the worsening was causally related to the compensable 1981 injury. The order did not conclude that claimant's then-condition, in toto, was not causally related to his compensable 1981 injury. In fact, the prior order granted an increased award of permanent disability, thereby affirming that claimant suffers permanent disability as a result of his compensable 1981 injury. Consequently, with respect to the July 22, 1983 order, the rule of issue preclusion has no application to the medical services question presented here.

The December 1984 order dealt with a contested billing for medical services which had been provided in January 1983. The December 1984 order concluded that, having failed to raise the contested billing at the July 1983 hearing, claimant was barred from subsequently litigating the claim. This is a claim

preclusion analysis. Under the circumstances, the December 1984 order could have no issue preclusive effect in the case presently before us.

Turning next to a claim preclusion analysis, we note that claimant did not begin treating with Dr. Berardi until April 1985. It is, therefore, apparent that neither the July 1983 order nor the December 1984 order could have any claim preclusive effect. We conclude that the present claim is not barred by application of res judicata principles.

Compensability

Dr. Berardi's treatments are compensable if claimant's low back and leg condition continues to be causally related to the 1981 injury. ORS 656.245; see Jordan v. SAIF, 86 Or App 29 (1987). The compensable injury need not be the sole cause or the most significant cause of the need for treatment, but only a material contributing cause. Van Blokland v. Oregon Health Sciences University, 87 Or App 694, 698 (1987).

The medical evidence as to the cause of claimant's current symptoms comes solely from Dr. Berardi. Dr. Berardi testified that the 1981 injury continues to play a material role in the condition for which claimant is being treated. The insurer argues that Dr. Berardi originally opined that the condition for which he was treating claimant was caused by claimant's herniated discs, and that it was only after Dr. Berardi discovered that the herniated discs were not compensable that he related claimant's condition in material part to the 1981 injury. We do not agree.

Dr. Berardi initially diagnosed both lumbar strain syndrome and intervertebral disk syndrome. (Tr. 43). He testified that claimant's intervertebral disk syndrome and neuralgia problem were a degeneration of the thoracolumbar strain. Moreover, the crux of Dr. Berardi's testimony is that claimant's current symptom complex includes elements of both a chronic lumbar strain and disc dysfunction and that the chronic strain has contributed to the disc dysfunction. In sum, Dr. Berardi's testimony supports a finding that the compensable 1981 injury is a material contributing cause of his current symptom complex and need for treatment. See Jordan v. SAIF, supra.

Claimant's testimony supports the same conclusion. He testified that he has experienced the same low back and leg symptoms since the 1981 injury. His testimony, together with Dr. Berardi's opinions, lead us to conclude that claimant's present symptom complex is related to the 1981 injury, and that treatment of it is compensable.

ORDER

The Referee's order dated January 12, 1988 is reversed. The insurer's denial of claimant's medical services claim is set aside. The insurer is directed to process the claim according to the law. For services at the hearing and on Board review, claimant's attorney is awarded $1,750 to be paid by the insurer. A client-paid fee, not to exceed $1,669.50 is approved.

JANET STANFILL, Claimant
Edward C. Olson, Defense Attorney

WCB 86-03527
September 2, 1988
Order of Remand

Claimant, pro se, requests review of Referee Menashe's order that dismissed her request for hearing on the ground that she failed to appear at the hearing. In letters to the Board, claimant has attempted to explain why she was unable to appear at the hearing. She did not have an opportunity to present this information to the Referee. We treat claimant's letters as a request for remand. See Judy A. Britton, 37 Van Natta 1262 (1985). We remand the case to the Referee for further evidence taking and reconsideration.

ISSUE

Whether the case should be remanded for a determination of whether claimant had good cause for failing to appear at the hearing.

FINDINGS OF FACT

Claimant filed an aggravation claim which was denied by the insurer on March 13, 1986. Claimant filed a request for hearing later the same month. After several postponements, the hearing was set for August 15, 1987. A hearing notice was mailed to claimant on May 8, 1987. Claimant did not appear and she was not then represented by an attorney. The insurer moved for an order of dismissal which was granted by the Referee. The Referee had no opportunity to hear from claimant prior to issuing the order of dismissal.

After the Referee dismissed the case, claimant wrote the Board stating that she was unable to attend the hearing because she had entered the hospital two days before it was held. She also indicated that she had contacted the Hearings Division the day before the hearing and requested that the hearing be postponed.

OPINION AND CONCLUSIONS

A request for hearing may be dismissed if the party which requested the hearing fails to appear at the hearing without good cause. Former OAR 438-06-070 (since amended and renumbered OAR 438-06-071). In correspondence to the Board, claimant has presented information which indicates that she may have had good cause for failing to appear at her hearing. She has not had opportunity to present this evidence to the Referee. We conclude that the record in this case has been incompletely developed and remand the case to the Referee for further evidence taking and reconsideration. ORS 656.295(5).

ORDER

The Referee's order dated June 19, 1987 is vacated and the case is remanded to the Referee for further evidence taking and reconsideration. If the Referee determines that good cause existed for claimant's failure to appear at the June 11, 1987 hearing, the Referee shall proceed with a hearing on the merits of claimant's claim.

LEE R. COFFMAN, Claimant
Francesconi & Associates, Claimant
Nancy Marque (SAIF), Defense Attorney

WCB 87-14199
September 7, 1988
Order on Review

Reviewed by Board Members Ferris and Crider.

Claimant requests review of those portions of Referee Brazeau's order that: (1) awarded an additional 30 percent (96 degrees) unscheduled permanent disability for a conversion reaction disorder, beyond a Determination Order award of 30 percent (96 degrees), for a total unscheduled permanent disability award of 60 percent (192 degrees); and (2) declined to grant an award of permanent total disability.

The Board affirms and adopts the order of the Referee.

ISSUE

The extent of claimant's unscheduled permanent disability for a conversion reaction disorder, including whether he is permanently and totally disabled.

FINDINGS OF FACT

The Board adopts the Referee's findings and makes the following additional findings.

Claimant sustained a compensable conversion reaction disorder, which results in intermittent black out spells, headaches, unstable emotions, lack of coordination and general disorientation. Nonetheless, he has normal spatial orientation, intelligence, problem recognition and self-correction, reading comprehension, and the ability to perform mental computations. At the hearing, while testifying on his own behalf, he demonstrated the ability to recall and to orally present his thoughts in an organized fashion. He has moderate permanent impairment as a result of his compensable conversion reaction disorder.

Claimant is not permanently incapacitated from regularly performing work at a gainful and suitable occupation.

CONCLUSIONS OF LAW

The Board adopts the Referee's opinion and conclusions.

ORDER

The Referee's order dated February 8, 1988, as supplemented herein, is affirmed.

ARLENE CONVERSE, Claimant
Pozzi, et al., Claimant's Attorneys
Marshall J. Yager, Defense Attorney

Own Motion 87-0764M
September 7, 1988
Own Motion Order

Claimant originally requested that the Board exercise its own motion authority and reopen her claim for an alleged worsening of her October 25, 1973 industrial injury. Claimant's aggravation rights have expired. The insurer issued a denial of medical benefits under ORS 656.245 which claimant appealed to the Hearings Division. The Board postponed action on the own motion request until resolution of the pending hearing.

By stipulation dated April 4, 1988, the insurer agreed to accept responsibility for claimant's condition which resulted in hospitalization and surgery in October 1987. However, the insurer recommends the request for temporary total disability benefits be denied as claimant's condition has not materially worsened and claimant has not been a member of the work force recently.

The Board finds that claimant's condition did worsen sufficiently to render her disabled from gainful employment. We also note that claimant helped her husband run a home for retired veterans until February 1987 when her doctor told her she should no longer perform that type of work. Pursuant to ORS 656.278(1)(a), we may exercise our "Own Motion" authority when we find that there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. In such cases, we are authorized to award temporary disability compensation commencing from the time the worker is actually hospitalized or undergoes outpatient surgery. We conclude claimant is entitled to compensation for temporary total disability from October 5, 1987 in accordance with the recently enacted workers' compensation law. Andy Webb, 40 Van Natta 586 (June 22, 1988). Closure of this claim will be done by the insurer pursuant to OAR 438-12-055. The Board is unable to consider claimant's possible entitlement to compensation for permanent total disability under the provisions of the current own motion law. Orville Shipman, 40 Van Natta 537 (June 8, 1988).

Claimant's claim is hereby reopened with temporary total disability compensation to commence October 5, 1987 and to continue until claimant returns to her regular work at her regular wage or is medically stationary, whichever is earlier. Claimant's attorney is awarded 25% of the additional compensation granted by this order, not to exceed $700 as a reasonable attorney's fee. Reimbursement from the Reopened Claims Reserve is authorized to the extent allowed under ORS 656.625 and OAR 436, Division 45. When appropriate, the claim shall be closed by the insurer pursuant to OAR 438-12-055.

IT IS SO ORDERED.

LISA J. GIPE, Claimant
Vick & Gutzler, Claimant's Attorneys
Cooney, Moscato & Crew, Defense Attorneys
Acker, et al., Defense Attorneys
Rankin, et al., Defense Attorneys

WCB 86-13251, 86-13252, 86-15830 & 86-16627
September 7, 1988
Order on Review

Reviewed by Board Members Ferris and Crider.

Liberty Northwest Insurance Corporation, requests review of Referee Galton's order that set aside its denial of compensability and responsibility for claimant's neck and shoulder condition. On review, Liberty contends that claimant's claim is properly characterized as an accidental injury claim and is barred because of untimely filing. Liberty further contends that claimant's neck and shoulder condition is not compensable and, even if it is compensable, that Liberty is not responsible for the condition. We affirm.

ISSUES

1) Characterization of claimant's neck/shoulder claim and timeliness of claim filing.

2) Compensability.

3) Responsibility as between Fred Meyer, Inc. in its self-insured capacity, Fred Meyer as insured by Liberty Northwest, or Christian Supply and its insurer, Liberty Northwest.

FINDINGS OF FACT

We adopt as our findings the four paragraphs under "Findings of Fact" on Page 2 of the Referee's Opinion and Order and the first seven paragraphs on Page 3 of the Opinion and Order, and we make the following supplemental findings.

Fred Meyer was self-insured when claimant began her employment there in September 1983. On February 1, 1984 Fred Meyer became insured for workers' compensation claims by Liberty Northwest.

Claimant had no specific traumatic injury/incident regarding her neck/shoulder during her employment with Christian Supply.

Claimant was not told by any physician that her neck/shoulder condition was work-related until July 1986.

Claimant's off-work activities between September 1983 and July 1986, although on occasion productive of temporary symptom increases, did not contribute to her neck/shoulder condition.

Claimant's work at Fred Meyer caused her neck/shoulder condition for which she received treatment in late 1984 and again in 1986.

Claimant's work at Christian Supply, although occasionally productive of temporary symptom increases, did not actually worsen her neck/shoulder condition.

OPINION AND CONCLUSIONS

We agree with the Referee's decision, and the supporting analysis, that claimant's claims herein are occupational disease claims. Because claimant was not advised by a physician until July 1986 that her neck/shoulder condition was work-related, her occupational disease claims are not time-barred. See ORS 656.807 (1).

We also agree with the Referee's decision regarding compensability and responsibility. Like the Referee, we find claimant entirely credible and we find the opinion of Dr. Gill, with support from claimant's treating physician, Dr. Leistikow, more persuasive than the opinion of Dr. Horniman. Dr. Gill obtained a more detailed history than Dr. Horniman regarding claimant's work at Fred Meyer, especially with respect to her work in the freight room. Further, concluding that claimant's claim is not genuine (Ex. 27, page 6), Dr. Horniman has misconstrued some

of the factual history. He opined that claimant's neck pain arose spontaneously when she awoke in the morning. The terminology used by Dr. Horniman suggests that claimant's neck problems began upon arising from bed in the morning. Yet, this is not consistent with the history claimant gave Dr. Horniman. She told him that after she began working for Fred Meyer on the cash register "it" -- which we construe to refer to claimant's work -- bothered her neck and that her neck problems got worse when she went to work in the freight room (Ex. 27, Page 2). In other words, claimant's neck problems began at work and, not surpisingly, she subsequently experienced stiffness in her neck upon arising in the morning. We also note that Dr. Horniman concluded that claimant's symptoms predated her employment at Fred Meyer (Ex. 27, Page 8). Again, he misconstrued the pertinent historical information. The May 1984 chart note on which he relied refers to headaches preceding claimant's employment at Fred Meyer. However, the claim herein is for claimant's neck/shoulder problems and the May 1984 chart note does not indicate, nor does any other evidence in the record indicate, that claimant had any neck/shoulder problems prior to her employment at Fred Meyer.

Regarding the question of responsibility, the evidence establishes that claimant's work at Christian Supply caused nothing more than occasional transitory symptom increases. Said work did not cause any actual worsening of claimant's neck condition. Thus, responsibility for claimant's neck/shoulder condition does not lie with Christian Supply. See Spurlock v International Paper, 89 Or App 461, 465-466 (1988). As between Fred Meyer in its self-insured capacity and Fred Meyer insured by Liberty, we agree with the Referee that responsibility lies with Liberty. The evidence establishes that no disability or need for medical services arose regarding claimant's neck/shoulder until after Liberty came on the risk. See SAIF v. Carey, 63 Or App 68, 70 (1983); Progress Quarries v. Vaandering, 80 Or App 160, 163 (1986).

ORDER

The Referee's April 28, 1987 order is affirmed. For services on Board review, claimant's attorney is awarded an assessed fee, payable by Liberty Northwest in its capacity as insurer for Fred Meyer, in the amount of $500. A client-paid fee, payable from Fred Meyer in its self-insured capacity to its counsel, is approved, not to exceed $100. A client-paid fee, payable from Christian Supply and its insurer, Liberty Northwest to its counsel, is approved, not to exceed $105.

ALLEN L. HALES, Claimant
S. David Eves, Claimant's Attorney
Meyers & Terrall, Defense Attorneys

WCB 86-10030 & 86-13682
September 7, 1988
Order on Review

Reviewed by Board Members Crider and Ferris.

The insurer requests review of those portions of Referee Michael Johnson's order which: (1) found that claimant's injury claim should not be barred for untimely filing; and (2) set aside the insurer's denial of his claim for an injury to the left index finger. We affirm.

ISSUES

1. Timeliness of claim filing.

2. Compensability of left index finger injury.

FINDINGS OF FACT

Claimant, a janitorial custodian, sustained a left index finger injury sometime in late January or early February of 1986, when a needle from a cactus plant located in an office he was cleaning stuck into the lower dorsal aspect of his finger. He removed a portion of the needle and, though his finger hurt a little, he continued to work, believing that he would not require medical attention. He removed other portions of the needle a week later and the finger eventually healed. Claimant did not notify the employer of the industrial accident within 30 days of the accident.

In March 1986 claimant was taken off work and treated for an unrelated, compensable injury to both elbows and forearms. Meanwhile, he had developed a tender lump on the dorsal aspect of the left index finger, and the finger pain was worsening. On May 22, 1986, claimant reported the cactus incident to Dr. Neumann, the treating physician for the elbow condition. Neumann noted a tender lump on the finger and some discomfort with finger motion.

In late May 1986 Dr. Neumann recommended surgery to remove the lump. Claimant filed a claim for the finger condition at some point prior to June 11, 1986. (See Ex. 3-3). The insurer denied the claim on June 24, 1986 and again on September 24, 1986. The denials stated that the claim was neither timely filed nor compensable.

On November 6, 1986, a cactus needle was surgically removed from the affected finger. Claimant had no further finger problems after surgery.

We find that the cactus accident was a material contributing cause of claimant's need for treatment.

CONCLUSIONS OF LAW AND OPINION

Timeliness of Claim

In relevant part, ORS 656.265(1) provides that a worker must notify the employer of an accident resulting in an injury within 30 days after the accident. However, failure to give timely notice does not bar a claim if: (1) notice is given within one year of the accident and the worker establishes that he had good cause for failure to give timely notice; or (2) the insurer or self-insured employer has not been prejudiced by failure to receive notice. ORS 656.265(4)(a), (4)(c).

1. Good Cause

Whether claimant had good cause for failure to notify employer within the statutory time is a factual question the answer to which depends upon the circumstances of each case. Wilson v. State Acc. Ins. Fund, 3 Or App 573, 576 (1970); Riddel v. Sears, Roebuck & Co., 8 Or App 438, 441 (1972). Claimant bears the burden of proving good cause. Id.

Claimant's finger injury appeared minor and did not prevent him from working. Indeed, claimant believed that he had completely removed the cactus needle soon after the accident occurred. The wound eventually healed and he was able to use the finger. Claimant developed the lump and worsening pain only after more than 30 days had elapsed since the accident. He then notified the employer. We are persuaded that claimant did not realize he had a problem until more than 30 days after the accident. We conclude, therefore, that these facts are sufficient to establish good cause for failure to give timely notice of the accident. Consequently, his claim is not barred.

2. Lack of Prejudice

Late filing of notice is also excused if the insurer has not been prejudiced by failure to receive timely notice. The insurer has the burden of proving prejudice. Inkley v. Forest Fiber Products Co., 288 Or 337, 348 (1980); Ford v. SAIF, 71 Or App 825, 831, rev den 299 Or 118 (1985); Satterfield v. Compensation Dept., 1 Or App 524, 529 (1970). Specifically, the insurer must prove actual prejudice which occurred after expiration of the 30-day notice period. Grimes v. SAIF, 87 Or App 597, 601 (1987); Ford v. SAIF, supra, 71 Or App at 828; McNett v. Roy-Ladd Const. Co., 46 Or App 601, 605, rev den 289 Or 588 (1980).

The insurer contends that, had it received timely notice of the accident, it could have mitigated its damages by taking claimant to the emergency room for evaluation and possible treatment. However, claimant testified that, after removing portions of the cactus needle from his finger, the finger healed and he was able to use it. His testimony suggests that the healing began approximately a week or two after the accident. Given that the injury was minor and had apparently healed before the expiration of the 30-day notice period, we view the insurer's contention as mere supposition. Even assuming, arguendo, that the insurer had taken claimant to the emergency room for treatment, there is no persuasive evidence that the mode of treatment would have been substantially different from the surgical excision that was eventually performed.

In addition, we are not persuaded that the lack of timely notice resulted in any loss of relevant evidence. Specifically, we are not persuaded that an earlier investigation of the accident would have yielded any more relevant information than was ultimately uncovered. We conclude that the insurer has failed to sustain its burden of proving actual prejudice.

Compensability

To establish compensability, claimant must prove by a preponderance of the evidence that the compensable injury materially contributed to his need for treatment. See Hutcheson v. Weyerhaeuser, 288 Or 51, 56 (1979); Milburn v. Weyerhaeuser Company, 88 Or App 375, 378 (1987). That standard implies that the injury need not be the sole cause or the most significant cause of the need for treatment. See Lobato v. SAIF, 75 Or App 488, 492 (1985); Von Blokland v. Oregon Health Sciences University, 87 Or App 694, 698 (1987).

Here, claimant testified to the cactus accident. The Referee found claimant credible based on demeanor. We defer to the Referee's determination of credibility, when it is based on demeanor. Coastal Farm Supply v. Hultberg, 84 Or App 282, 285

(1987). Claimant's testimony was further supported by hospital records identifying the foreign object which was removed as a cactus needle. We find that the cactus incident was a significant cause of claimant's need for treatment, and thus conclude that the incident materially contributed to his need for treatment. The claim is compensable.

ORDER

The Referee's order dated February 20, 1987, as corrected on February 23, 1987, is affirmed. Claimant's attorney is awarded an assessed fee of $500, to be paid by the insurer. The Board approves a client-paid fee not to exceed $229.50.

SUSAN K. TEETERS, Claimant
Roll, et al., Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB 86-02975
September 7, 1988
Order on Review

Reviewed by Board Members Crider and Ferris.

Claimant requests review of Referee Leahy's order that: (1) upheld denials of compensability of claimant's aggravation claim for her back condition and her claim for a bilateral wrist condition; (2) found that claimant's psychological claim had not been prematurely closed; (3) declined to award temporary disability from July 25, 1984 to October 23, 1984; (5) declined to assess penalties and attorney fees for alleged unreasonable claims processing; (6) declined to grant permanent total disability; (7) affirmed a total award to date of 45 percent (144 degrees) unscheduled permanent disability for a low back injury; (8) declined to award any scheduled permanent disability for loss of use or function of her wrists or left leg; and (9) found that the insurer had overpaid claimant's temporary disability. We affirm in part and reverse in part. Claimant has also moved to supplement the hearing record. We treat this motion as a request to remand to the Referee for the taking of additional evidence.

ISSUES

The bases for the request for remand are to include in the record:

(1) an October 23, 1984 Hearing Request filed to challenge an August 8, 1984 Determination Order; and

(2) 30 pages of documents concerning time loss payments from 1980 through 1987.

The substantive issues on review are:

(1) aggravation of claimant's compensable back condition;

(2) compensability of claimant's bilateral wrist condition;

(3) premature closure of claimant's mental stress claim;

(4) entitlement to temporary disability from July 25, 1984 to October 23, 1984;

(5) penalties and attorney fees on the issues of interim compensation and premature closure;

(6) extent of scheduled and unscheduled permanent disability; and

(7) overpayment of temporary disability.

FINDINGS OF FACT

Claimant, 44 at hearing, compensably injured her low back on October 13, 1980. On November 25, 1980, she underwent a myelogram; selective L5 nerve root block; and a laminectomy, diskoidectomy and foraminotomy of L5-6. A January 6, 1983 Determination Order awarded 25 percent unscheduled permanent disability for her low back. A Stipulation issued on April 24, 1983 gave her an additional 15 percent unscheduled permanent disability. A Determination Order issued on August 22, 1985 awarded her an additional 5 percent, for a total of 45 percent unscheduled permanent disability to date.

Another Determination Order, issued August 8, 1984, awarded claimant temporary disability for a period ending July 19, 1984, but no additional permanent disability. Neither the record in this case nor the Workers' Compensation Board's Hearings Division files contain a request for hearing challenging the order.

On July 24, 1984, claimant began exhibiting anxiety symptoms. By October 5, 1984, she felt "too anxious to be able to [return to work]."

In mid-October 1984, claimant worked for four days as a part-time restaurant hostess. She did not keep the job, for reasons which are unclear from the record. She was hospitalized on October 23, 1984, for evaluation of her mental condition. At that time, the insurer began to pay interim compensation.

Claimant's symptoms have included general anxiety, "panic attacks," disorientation and short term memory loss. In addition, she suffers from insomnia and loss of appetite. Her family physician, Dr. Wolfe, has cautioned her about excessive weight loss.

Claimant's claim for her mental condition was denied by the insurer in May, 1985. That denial was set aside by a prior order on March 21, 1986. That order is final.

On October 2, 1985, claimant sneezed, causing renewed pain in her low back. This was a symptomatic flare-up but not a worsening of her underlying condition. She spent two weeks in bed, and then underwent a period of rest and therapy for her back. On October 17, 1985, Dr. Wolfe wrote to the insurer saying claimant had suffered a "re-exacerbation" of her job injury on October 2, 1985 and was no longer medically stationary. He also reported that claimant was unable to work in any capacity. The report was received by the insurer on October 22, 1985.

Claimant was examined by Dr. Olmscheid, neurologist, on January 21, 1986, on referral from Dr. Wolfe. The doctors gave differing diagnoses for her condition. However, there were objective physical findings that her back condition had worsened and was affecting her leg. She had reduced nerve conduction, weakness in all muscle groups of the leg, and atrophy of the calf.

On January 27, 1986, the insurer issued a denial of claimant's aggravation claim for her low back condition.

Claimant had developed a sore wrist condition. She had fallen and injured her left wrist because of her low back condition, the exacerbation of which rendered her unsteady on her feet. The insurer accepted the wrist strain which resulted from the falls.

Claimant saw Dr. Tremaine, orthopedic surgeon, who treated her wrist with injections and casting of the left hand. This afforded her some relief of her symptoms.

On June 10, 1986, claimant was examined by Dr. Parvaresh, psychiatrist. Her emotional condition had improved since his examination which had preceded the hearing on her psychological claim.

Dr. Nye, hand surgeon, examined claimant on June 20, 1986. He opined that claimant had a long history of deQuervain's tenosynovitis, and recommended surgical release.

A second opinion was sought from Dr. Button, hand surgeon, on July 14, 1986. He did not oppose surgery.

On July 23, 1986, Dr. Nye performed a surgical release on claimant's right wrist. The same procedure was performed on the left wrist on August 13, 1986. The surgeries did not alleviate claimant's symptoms.

On August 25, 1986, the insurer issued a partial denial of compensability of claimant's deQuervain's tenosynovitis. The condition is not related to her work activities or compensable injury.

Claimant was examined by Dr. Turco, psychiatrist, on August 28, 1986.

Claimant treats once a month with Dr. Petroske, psychiatrist, for depression and anxiety. He maintained the opinion from April 24, 1986 up and through January 1, 1987 that claimant's mental condition had not become medically stationary.

Claimant was medically stationary by August 28, 1986. Her psychological condition is not anticipated to improve with further treatment or time. Her ongoing treatment, while necessary, is palliative.

On October 8, 1986, a Determination Order issued closing claimant's aggravation claim for her psychological condition. It contained an award of temporary disability through August 28, 1986, but no additional permanent partial disability beyond the 45 percent granted by the prior Orders and Stipulation.

The insurer paid temporary disability compensation through October 8, 1986. It paid $1,160.88 for temporary disability after August 28, 1986.

The hearing was held on January 28, 1987. The record was held open pending submission of documentation by the insurer to substantiate a claimed overpayment of temporary disability.

Those documents were received and considered by the Referee, who authorized offset of the contested amount from future awards. The documents are in the Board's file on review.

Claimant's past work history includes jobs as a grocery checker, restaurant hostess, apartment manager, clerical worker and electronic assembly worker. Some of these positions required lifting which is now beyond her limitations.

Claimant is capable of light work. She can stand, sit and walk with opportunities to alternate every hour. She can lift 15 pounds. Her psychological condition does not impair her ability to work.

Claimant's mother receives treatment for chronic depression. Claimant's fraternal twin has also received psychiatric care.

CONCLUSIONS OF LAW AND OPINION

Remand: Hearing Request

Claimant requests remand in order to include in the record a copy of a hearing request said to have been filed challenging the 1984 Determination Order. The Board may remand a case to the Referee if it finds that the record has been incompletely, improperly or otherwise insufficiently developed. ORS 656.295(5). Generally this may be done only if the evidence is unavailable by due diligence. See Bernard L. Osborn, 37 Van Natta 1054 (1985). In this case the evidence was available, and so far as claimant's attorney was aware, may have been sent to the Hearings Division. However, this case has an extensive procedural history, and in 1986 a hearing on some issues was held, while the rest were preserved for another time. There is no evidence that the hearing request in question was dismissed. The request for hearing on an August 8, 1984 Determination Order, did not survive as a part of the record which was transferred from the first hearing file to the second, so there is also no evidence that the hearing request was received. We recognize the difficulty of the situation, but we are not persuaded that the request was unobtainable with due diligence prior to the second hearing.

An alternative to remand does exist. The Board may take administrative notice of facts "capable of accurate and ready determination by resort to sources whose accuracy cannot reasonably be questioned." ORS 40.065(2) (OER 201(b)). To date this has been limited by the courts to orders of the Board or of a Referee, or to stipulations by the parties. Groshong v. Montgomery Ward Co, 73 Or App 403 (1985). See Dwane Kester, 38 Van Natta 1417 (1986); Robert K. McDonald, 37 Van Natta 674 (1985); Dennis Fraser, 35 Van Natta 271 (1983).

A Request for Hearing is not an agency order. It is, however, a document which has legal significance in preserving or disposing of a claim. In that way it is similar to an Order or a Stipulation. Also, it is not evidence, as a job description in the Dictionary of Occupational Titles is. See Groshong, supra. Rather, it has only procedural significance which enables an "evaluation of the evidence." Thomas A. Whittle, 36 Van Natta 343 (1984). In the abstract, then, the Board may be able to take administrative notice of the Request for Hearing.

However, we cannot take administrative notice of this

request because it is not present in any file of the Workers' Compensation Board. Claimant's attorney has provided a photocopy of the request and attests that it was mailed. At the time claimant contends it was mailed, however, claimant had a different attorney. Her current attorney does not possess the requisite knowledge to permit him to attest that the request was in fact mailed, or to permit us to conclude that it was. Because we are without evidence that the request was timely made, we deny claimant's first request for remand.

Remand: Time Loss Documentation

Claimant requests remand in order to include in the record time loss records for the years 1980 through 1987. As set forth above, the Board cannot remand for inclusion in the record such evidence as was available by due diligence at the time of hearing. Osborn, supra. In this case, the parties agreed that the record would be held open to allow for submission of documents pertaining to an alleged overpayment of temporary disability. Copies of four checks were subsequently submitted from the insurer on February 9, 1987. These checks apparently refer to an October 8, 1986 Determination Order (Ex. 135) which terminated claimant's temporary total disability on August 28, 1986. Three of the checks are dated during the intervening period, and equal the amount of the alleged overpayment. We find that these are the documents for which the record was held open, and that they were duly received.

There is no evidence as to what might be contained in the documents to which claimant now refers. However, no issue concerning time loss for any periods except from July 25, 1984 to October 23, 1984 and from August 28, 1986 to October 8, 1986 was raised at hearing. Therefore, the vast majority of the records claimant wishes to introduce could have no bearing on any issue before us. Moreover, the records for the period from 1980 to 1987 must have been available with due diligence at the time of hearing and could have been produced. The request for remand to admit them is denied.

Low Back Condition: Aggravation

The insurer contends that claimant has not perfected an aggravation claim for her low back condition. A physician's report requesting additional medical services for a worsened condition can constitute an aggravation claim. Krajacic v. Blazing Orchards, 84 Or App 127, remanded 304 Or 436 (1987), adhered to 90 Or App 593 (1988). The report must put the insurer on notice that treatment for more than continuing conditions is indicated.

We find a letter from Dr. Wolfe sufficient to state a claim for an aggravation. An August 22, 1985 Determination Order had found claimant medically stationary as of June 11, 1985. On October 17, 1985, Dr. Wolfe wrote to the insurer, stating that a sneeze on October 2, 1985 had definitely worsened claimant's on-the-job injury and sciatica. He went on to say that she was not medically stationary, and was receiving physical therapy.

To reopen a claim because of aggravation, claimant must prove that: (1) a worsening of her condition renders her more disabled, i.e. less able to work, than at the time of her last arrangement of compensation; and (2) there exists a causal relationship between her worsened condition and the compensable

injury. Smith v. SAIF, 302 Or 396 (1986); Stepp v. SAIF, 78 Or App 439 (1986). The court has held that, as a matter of law, there is always a worsening when, as a result of a flare-up, claimant is totally disabled for 14 days or more. Gwynn v. SAIF, 304 Or 345 (1987), on remand 91 Or App 88 (1988).

In this case, claimant suffered a flare-up when she sneezed. Her doctor described this as "ups and downs" and the Orthopaedic Consultants said that it was an intermittent exacerbation common to claimant. Nonetheless, she was bedridden for 14 days, and Dr. Wolfe said at the time that she could not work in any capacity. We must conclude, therefore, that claimant suffered a compensable aggravation of her low back condition. We therefore set aside the insurer's denial, and remand it for acceptance.

deQuervain's Tenosynovitis: Compensability

To prove compensability of her deQuervain's tenosynovitis, claimant must show that it is more likely than not that her compensable injury was a material contributing cause of the condition. Grable v. Weyerhaeuser, 291 Or 387 (1981). The compensable injury need not be the sole or even the principle cause of the condition. Aquillon v. CNA Insurance, 60 Or App 231 (1982). However, claimant must establish the probability of a material relationship, not merely the possibility. Gormley v. SAIF, 52 Or App 1055 (1981). Because this is a complex medical issue, we rely upon expert medical opinion. Kassahn v. Publishers Paper, 76 Or App 105 (1985).

Dr. Button stated without elaboration that he did not believe that claimant's condition was related to her compensable injury. He did concede that she could have sprained her wrists in a fall, but did not consider that a common cause of the disease. Dr. Nye summarily agreed with Dr. Button's report. We understand the report to admit the possibility of a causal connection between the falls and development of deQuervain's tenosynovitis. Mere possibility will not sustain claimant's burden of proof, however. We conclude that claimant has not shown her deQuervain's condition to be causally related to her low back condition.

Mental Condition: Premature Closure

A condition is "medically stationary" when "no further material improvement would reasonably be expected from medical treatment, or the passage of time." ORS 656.005(17). It is claimant's burden to prove that the preponderance of the evidence indicates a different medically stationary date than the date on which her claim was closed. Brad T. Gribble, 37 Van Natta 92 (1987). Due to the complex nature of claimant's mental condition, we rely upon expert medical opinion. Kassahn v. Publishers Paper, 76 Or App 105 (1985).

Claimant was examined prior to closure by two psychiatrists, Drs. Turco and Parvaresh. They each provided a detailed evaluation of claimant, and each found her to be medically stationary. The bases for their separate conclusions included their own testing, her infrequent treatment schedule, and her limited need for medication. Dr. Turco noted that claimant's family history includes a strong trait for mental illness, which makes ongoing palliative care reasonable. Both doctors concluded that she was medically stationary and psychologically capable of regular work.

Only claimant's psychiatrist, Dr. Petroske, has reported on claimant's condition since the October, 1986 Determination Order. His report is cursory. He states, but does not explain, that claimant is not psychiatrically medically stationary, and is unemployable.

Absent persuasive reason to do so, we give greater weight to the opinion of claimant's treating physician. Weiland v. SAIF, 62 Or App 810 (1983). In this case, we are persuaded to do otherwise. Dr. Petroske's reports are too short and conclusory to permit us to rely upon them. The reports of the examining physicians, on the other hand, address and explain the complex factors affecting claimant's condition. We conclude that claimant has not borne her burden of proving that her mental condition is not medically stationary.

Time Loss: 7/24/84 - 10/23/84

Claimant was not working due to her low back condition during the spring of 1984, and was receiving temporary disability payments. Those payments were terminated as of July 19, 1984, on the authority of the Determination Order.

Claimant went to Dr. Wolfe with symptoms of anxiety and depression on July 24, 1984. He made tentative diagnoses of the conditions in September, 1984 and treated her conservatively. His chart note on October 5, 1984 indicates that claimant wanted to return to work, but felt "too anxious to be able to do so." However, claimant did in fact return to work for a short time as a part-time hostess in a restaurant. She was again not working when, on October 23, 1984, she checked into a hospital for psychiatric evaluation.

In order to be entitled to interim compensation, claimant must establish that as a result of her compensable injury she has lost time from work or has diminished earning capacity. Bono v. SAIF, 298 Or 405 (1984). Claimant was unavailable for work, and so had diminished earning capacity, when she was admitted to the hospital for evaluation on October 23, 1984. She contends that she was also unable to work beginning on July 24, 1984, when she first exhibited symptoms of anxiety and depression and began receiving treatment for them. There is little in the record, however, to suggest that she was unable to work prior to October 23, 1984. One chart note does say that she is too anxious to work, but the note one week later says that she has in fact been working. The fact that, except for a period of four days, claimant did not work is not dispositive. The test is whether she had lost time from work or suffered reduced earning capacity. Claimant has not proven that she could not work because of her mental condition during the three months in question. Therefore, she is not entitled to temporary disability benefits for that time.

Penalties and Fees

Because we find that claimant is not owed any temporary disability for the period in question, and that her psychological claim was not prematurely closed, the issue of penalties and attorney fees is moot.

Psychological, Low Back, Left Leg: Extent of Disability

Because we remand this case to the insurer for acceptance and processing of claimant's low back aggravation claim, we cannot reach these issues.

Overpayment

At hearing, the insurer requested authority to offset an alleged overpayment of temporary disability against future awards. Following the hearing, the insurer provided proof of overpayment in the amount of $1,160.88. We have reviewed the documentation, and concur with the Referee that the overpayment was made. We affirm his authorization to offset that amount. However, we specifically limit that authority to offset against future awards of permanent disability.

ORDER

The Referee's order dated May 14, 1987 is affirmed and reversed. The insurer's denial of claimant's aggravation claim for her low back condition is set aside and the claim is remanded to the insurer for processing in accordance with the law. The Referee's order is otherwise affirmed. Claimant's attorney is awarded an assessed fee of $500, to be paid by the insurer, for services in setting aside the denial.

RONALD F. WALSH, Claimant
Pozzi, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 86-13266
September 7, 1988
Amended Order on Review (Remanding)

On August 12, 1988, we found that claimant was entitled to offer evidence concerning a post-hearing low back surgery and post-operative medical reports. Therefore, the case was remanded to the Presiding Referee for further action consistent with our order.

Upon further reflection, we have concluded that our prior order lacked specificity. Consequently, we add the following conclusions and instructions to our August 12, 1988 order.

To begin, the Referee's June 8, 1987 order is vacated and this case is remanded to the Presiding Referee for the taking of additional evidence concerning claimant's post-hearing surgery and medical findings. It shall be within the Presiding Referee's discretion to refer the case to another Referee, should he so desire.

On remand, both parties shall be entitled to present evidence regarding the issue of whether claimant's condition is causally related to his compensable injury and whether the insurer's September 3, 1986 denial of claimant's aggravation claim should be set aside. This evidence may be presented in any manner that will afford substantial justice and insure a complete and accurate record of all examination and testimony.

Upon reclosure of the record, the Referee shall consider the additional evidence, as well as the record previously developed, and proceed to determine the compensability of the aforementioned aggravation claim. Thereafter, the Referee shall issue a final, appealable Opinion and Order.

Accordingly, our August 12, 1988 order is withdrawn. As supplemented herein, we adhere to and republish our prior order, effective this date.

IT IS SO ORDERED.

SANDRA L. WALSH, Claimant
Welch, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 86-13211
September 7, 1988
Order on Review

Reviewed by Board Members Johnson and Ferris.

The self-insured employer requests review of those portions of Referee Podnar's order which: (1) set aside its partial denial of further treatment and disability associated with claimant's respiratory condition; and (2) assessed a penalty and attorney fee for the employer's alleged improper claims processing. We affirm.

ISSUES

(1) Claims processing.

(2) Penalties and attorney fees.

FINDINGS OF FACT

Claimant, a medical records clerk, has a history of asthma dating back to the early 1970's. In March 1986, she developed breathing difficulties and a sore throat. She was taken off work for a week and treated conservatively by Dr. Gore, her long-time treating physician. Dr. Gore and Dr. Keppel, a consulting lung disease specialist, initially diagnosed an exacerbation of the underlying asthma condition from exposure to carbon forms at work. Claimant was released for modified work with a restriction against further exposure to carbon forms.

Claimant filed an occupational disease claim for "upper respiratory difficulty" in May 1986. Dr. Gore completed a Form 827 (First Medical Report) with a diagnosis of an "exacerbation of reactive airway disease." The employer accepted the claim through issuance of a formal notice (Form 1502) sometime prior to September 1986.

In June 1986, claimant underwent a mecholyl challenge test, the results of which indicated the absence of underlying reactive airways disease. In July 1986, she submitted to an independent medical examination by Dr. Mantanaro, an allergist. Mantanaro found no evidence of an active asthmatic airways disease, but, instead, diagnosed an upper and lower respiratory irritation from exposure to the carbon forms at work. Mantanaro felt that claimant was "medically stable" and had returned to her preexposure level. Drs. Keppel and Gore essentially concurred, though Gore felt that claimant's symptoms had not yet returned to preexposure level.

Claimant's medical bills and time loss benefits were paid by the employer. On September 2, 1986, the employer issued a partial denial, wherein it accepted the "temporary flare-up of [claimant's] preexisting upper and lower respiratory disease" but denied the "compensability of any further treatment of [her]

preexisting upper and lower respiratory disease or any disability associated with that preexisting condition." The claim was closed by Determination Order on September 22, 1986 with no permanent disability award. The condition denied by the employer was not considered in the determination of permanent disability.

CONCLUSIONS AND OPINION

The Referee set aside the partial denial and remanded the claim to the employer for further processing until closure, thereby rescinding the Determination Order. The Referee also assessed a penalty and attorney fee for improper claims processing.

In setting aside the denial, the Referee reasoned that the employer improperly sought to circumvent the claim closure process by attempting to terminate future responsibility for the accepted respiratory condition before the extent of disability from the condition had been determined. We agree with the Referee's decision and rationale.

Roller v. Weyerhaeuser Co., 67 Or App 583, amplified 68 Or App 743, rev den 297 Or 601 (1984), is controlling authority in this case. In that case, the court was faced with the issue of whether an insurer or self-insured employer could issue a denial of future responsibility for a compensable condition before the extent of the claimant's disability had been determined. The claimant in Roller sustained an industrial injury to his head and leg. His disability was diagnosed as diabetes mellitus. The employer accepted the diabetes claim and provided benefits for several months. The employer then issued a partial denial, stating that it continued to accept responsibility for the results of the industrial injury, but denied future responsibility for the diabetes condition. The claim was not closed. The court held that the denial was improper because it effectively circumvented the statutory procedures of claim closure and determination of extent of disability. Id. at 586-87.

The facts of this case are similar to those in Roller. We are persuaded that the accepted condition was the temporary flare-up of claimant's preexisting respiratory disease. We are also persuaded that, prior to claim closure, the employer sought to deny further responsibility for that preexisting disease.

Whereas the employer in Roller never submitted the claim for closure, this employer submitted the claim for closure after issuance of the denial. However, this distinction is rendered insignificant by the Evaluation Section's refusal to consider the denied condition. Thus, issuance of the denial letter effectively preempted the Division's determination of extent of disability resulting from the accepted respiratory condition. This claim should have been processed to closure, either administratively or through the Evaluation Section, prior to issuance of the denial. See former ORS 656.268(3). Because the employer failed to do so, we conclude that the denial was improper.

We further conclude that the preclosure denial was unreasonable. It is well-established that an insurer or self-insured employer may not terminate future responsibility for a claim before the extent of the accepted condition had been determined pursuant to the statutory procedures for claim closure. See Webb v. SAIF, 83 Or App 386 (1987); Davison v. SAIF,

80 Or App 541, recon 82 Or App 546 (1986); Roller, supra; Arthur E. Matthews, 39 Van Natta 361 (1987). Given the clear proscription of preclosure denials similar to that involved here, we conclude that a penalty and attorney fee was properly assessed.

Claimant's counsel is statutorily entitled to a reasonable, carrier-paid attorney fee for services rendered on Board review. See ORS 656.382(2). Such a fee is defined as an "assessed fee." OAR 438-15-005(2). However, we cannot authorize an assessed fee unless claimant's counsel files a statement of services. See OAR 438-15-010(5). Because no statement of services has been received to date, an assessed fee shall not be authorized.

ORDER

The Referee's order dated June 9, 1987 is affirmed. A client-paid fee, not to exceed $160, is approved.

DOROTHA M.CLARKE, Claimant
Merrill Schneider & Associates, Claimant's Attorneys
Roberts, et al., Defense Attorney

WCB TP-88009
September 9, 1988
Order Approving Request

The paying agency's counsel seeks authorization of a client-paid fee for services before the Board which culminated in our July 18, 1988 Third Party Order. The request is granted.

FINDINGS

On May 17, 1988, claimant petitioned the Board to resolve a dispute concerning a proposed compromise of a third party action. See ORS 656.587. On June 29, 1988, the paying agency's final response was filed with the Board.

On July 18, 1988, we issued a Third Party Order, approving the proposed third party settlement offer and directing claimant's attorney to distribute the proceeds in accordance with ORS 656.593(1). Our order did not address the issue of a client-paid fee. The July 18, 1988 order has not been appealed, abated, stayed or republished.

On August 17, 1988, the paying agency's counsel sought authorization of a client-paid fee for services rendered before the Board. Included with the request was an executed retainer agreement and statement of services.

CONCLUSIONS

Board authorization is required before an attorney for a paying agency can charge for legal services rendered in a third party case. See Thomas McBroom (Dec'd), 40 Van Natta 831 (August 5, 1988). In McBroom, our prior third party order had not addressed either the paying agency's entitlement to, or the amount of, a client-paid fee. Therefore, we reasoned that we retained jurisdiction to consider the request for authorization.

In McBroom, we acknowledged that the Board's rules do not expressly address the filing of statements of services in third party proceedings. However, we noted that statements of services in Own Motion matters are due within 30 days after

mailing of the Board's order and statements of services on Board review are due within 15 days after the filing of the last brief. See OAR 438-15-027(1), (c), (d).

Since the request in McBroom had been submitted nearly 6 months after the filing of the last brief, some 50 days after the issuance of our Third Party Order and approximately 20 days after the paying agency's appeal, we considered it untimely. Consequently, we declined to authorize the request.

Here, the paying agency's counsel's request was submitted approximately 50 days after the filing of the last brief and 30 days after the issuance of our July 18, 1988 Third Party Order. Thus, the submission is not in keeping with the filing requirement for statements of services on Board review, but does meet the filing requirement for Own Motion proceedings. Inasmuch as our rules do not specify the filing requirements for a statement of services in third party cases, we conclude that this request for authorization of a client-paid fee, submitted within 30 days of the Board's Third Party Order, is timely.

After reviewing the statement of services and the attorney retainer agreement submitted by the paying agency's counsel, and considering the factors set forth in OAR 438-15-010(6), we approve a client-paid fee not to exceed $1,000.

IT IS SO ORDERED.

RETA GULLATT, Claimant
Welch, et al., Claimant's Attorneys
EBI, Insurance Carrier

Own Motion 88-0370M
September 9, 1988
Own Motion Order

The insurer has submitted to the Board claimant's claim for an alleged worsening of her September 12, 1979 industrial injury. Claimant's aggravation rights have expired. The insurer opposes reopening of this claim as it contends claimant has removed herself from the work force.

Pursuant to ORS 656.278(1)(a), we may exercise our "Own Motion" authority when we find that there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. In such cases, we are authorized to award temporary disability compensation commencing from the time the worker is actually hospitalized or undergoes outpatient surgery.

Claimant was hospitalized on February 29, 1988 for her compensable condition. We are persuaded that her condition worsened sufficiently to render her disabled from gainful employment and qualify her for benefits pursuant to ORS 656.278. The insurer questions her entitlement to temporary total disability compensation due to the fact that claimant was not working prior to her aggravation. The evidence indicates that claimant was employed as a camp hostess between the months of April and November each year. She was not paid for this work, although she was given free use of a room and ultilities. We conclude on this evidence that claimant has not removed herself from the work force and is entitled to benefits commencing with her hospitalization in February 1988.

Accordingly, claimant's claim is reopened with temporary

total disability compensation to commence February 29, 1988 and to continue until claimant returns to her regular work at her regular wage or is medically stationary, whichever is earlier. Reimbursement from the Reopened Claims Reserve is authorized to the extent allowed under ORS 656.625 and OAR 436, Division 45. When appropriate, the claim shall be closed by the insurer pursuant to OAR 438-12-055.

IT IS SO ORDERED.

ROBERT D. JANINI, Claimant
Durham, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 87-11480
September 9, 1988
Order Denying Request

The insurer's counsel seeks Board authorization of a client-paid fee for services rendered on review which culminated in our April 25, 1988 Order on Review. The request is denied.

FINDINGS

Claimant requested Board review of the Referee's January 15, 1988 order. On March 8, 1988, claimant filed his appellant's brief. On March 22, 1988, the insurer filed its respondent's brief. On March 24, 1988, claimant filed his reply brief.

On April 22, 1988, the Board received the insurer's counsel's request for authorization of a client-paid fee for services rendered on Board review. Included with this request was an executed attorney retainer agreement and a statement of services.

On April 25, 1988, the Board issued its Order on Review, affirming and adopting the Referee's order. At that time, the insurer's counsel's request had not reached the record. The Board's order further stated that since no statement of service had been received from the insurer's counsel, no client-paid fee would be approved. The April 25, 1988 order has not been appealed, abated, stayed, or republished.

On July 15, 1988, the insurer's counsel reiterated its request for authorization of a client-paid fee. Counsel further advised that a second request had been submitted on April 29, 1988. The Board has no record of receiving the April 29, 1988 request. On August 2, 1988, the insurer's counsel again requested Board authorization.

CONCLUSIONS

We recently addressed the question of whether the Board has jurisdiction to consider a request for authorization of a client-paid fee where the Board's order on the merits has become final by operation of law. Jane E. Stanley, 40 Van Natta 831 (July 18, 1988). In Stanley, the request was submitted approximately three months after the issuance of our final, unappealed order. Since our prior order had neither addressed the issue of the employer's counsel's entitlement to, or the amount of, a client-paid fee, we concluded that we had jurisdiction to consider the request for authorization. However, because the request was untimely submitted under OAR 438-15-027(1)(d) (which requires statement of services for proceedings on Board review to be filed within 15 days after the filing of the last brief) and

since our order on the merits had become final by operation of law, we declined to authorize the employer's counsel's request.

Here, our April 25, 1988 order addressed the issue of the insurer's counsel's entitlement to a client-paid fee. Thus, in accordance with the Stanley holding, our authority to consider the request for authorization of a client-paid fee is contingent upon our retaining jurisdiction over the April 25, 1988 order. Yet, inasmuch as the April 25, 1988 order has neither been appealed, abated, stayed nor republished, it has become final by operation of law. ORS 656.295(8); International Paper Co. v. Wright, 80 Or App 444, 447 (1986). Consequently, we lack jurisdiction to address the insurer's counsel's request.

As previously noted, the insurer's counsel's request for authorization, statement of services, and executed retainer agreement were received prior to the issuance of our April 25, 1988 order. However, these materials did not reach the record before our Order on Review issued. In any event, this submission was received while we still had jurisdiction to abate, amend, or reconsider the April 25, 1988 order. As stated in Betty J. Eyler, 40 Van Natta 977 (August 5, 1988), we make every effort to promptly process requests under such circumstances. Unfortunately, in this instance, the 30-day period to further consider our Order on Review passed without Board action.

Because the April 25, 1988 Order on Review addressed the insurer's counsel's entitlement to a client-paid fee and has become final by operation of law, we lack jurisdiction to consider the insurer's counsel's request for authorization of a client-paid fee. In reaching this conclusion, we wish to stress that we are neither questioning the insurer's counsel's entitlement to, nor the amount of, a requested client-paid fee. We are merely stating that, for the reasons discussed above, we are unable to consider the request.

IT IS SO ORDERED.

STEVEN S. LITTLE, Claimant
Linda Friedman Ramirez, Public Defender
Max Rae, Claimant's Attorney
Schwabe, et al., Defense Attorneys

WCB 87-00081 & 87-04234
September 9, 1988
Order on Review

Reviewed by Board Members Johnson and Crider.

Claimant requests review of that portion of Referee Seymour's order which upheld the insurer's denial of his aggravation claim for a low back condition. The insurer cross-requests review of that portion of the order which assessed a penalty-related attorney fee for the alleged unreasonable denial of aggravation. On review, the issues are aggravation and penalty-related attorney fees.

We reverse that portion of the Referee's order which upheld the aggravation denial, and we affirm with a supplemental comment the Referee's assessment of a penalty-related attorney fee.

FINDINGS OF FACT

Claimant fell and compensably injured his low back on August 16, 1984. The diagnosis was a lumbar strain, and he began conservative treatment with Dr. McDonald. He was initially

released for modified work, but eventually lost three weeks of work during the following month. Dr. McDonald released him for light work beginning September 24, 1984, and declared him medically stationary as of that date, with no permanent impairment. The claim was closed by Notice of Closure on November 5, 1984 with no permanent disability award. There was no request for a Determination Order.

Although claimant was never formally released for regular work, he was expected to resume regular work after a few weeks of light work. From September 28, 1984 through July/August 1986, claimant worked for a number of employers. The jobs, which ranged from sedentary to medium/heavy labor, required lifting, pushing, twisting, and bending motions involving his back. He experienced occasional back discomfort, but was able to perform his duties.

Claimant was unemployed after July/August 1986. He did not require medical treatment from September 24, 1984 through December 8, 1986. In December 1986, claimant experienced increased low back symptoms which rendered him unable to perform any of the previous jobs he has held since 1984. The 1984 industrial injury was a material contributing cause of this increased symptomatology. On December 8, 1986, claimant saw Dr. Stearns, a chiropractor, who authorized time loss and began conservative treatment. We find that claimant was totally disabled from December 8, 1986 through more than 14 days thereafter.

On January 27, 1987, the insurer denied claimant's aggravation claim on the grounds that his compensable condition had not materially worsened and that his current complaints were not related to his 1984 industrial injury.

Prior to the denial, the insurer had medical reports from Dr. Stearns and Dr. Collada, a consulting neurosurgeon who examined claimant once on January 8, 1987. Dr. Stearns reported that claimant was experiencing increasing lumbar pain attributable to the 1984 industrial injury, and authorized time loss. Dr. Collada reported that claimant was subject to recurrent strain-type symptoms and recommended back conditioning exercises, anti-inflammatory agents, vocational rehabilitation, and "chiropractic care as a palliative modality." Based on these reports, the insurer had no legitimate doubt of its liability for aggravation, prior to the denial. Claimant's counsel raised the reasonableness of denial issue in a February 20, 1987 letter to the Referee, a copy of which was sent to the insurer's counsel.

CONCLUSIONS OF LAW AND OPINION

Aggravation

The Referee upheld the aggravation denial, reasoning that claimant's compensable condition had not worsened since claim closure in November 1984. We disagree and, instead, find the aggravation claim compensable.

To establish a compensable aggravation, claimant must prove, inter alia, that his condition has worsened since his last award of compensation, so that he is more disabled, meaning less able to work, either temporarily or permanently. ORS 656.273(1); Smith v. SAIF, 302 Or 396, 399 (1986). Increased symptoms, in and of themselves, do not establish a worsened condition unless they

result in additional loss of earning capacity. Smith v. SAIF, supra, 302 Or at 401. However, increased symptoms resulting in more than 14 consecutive days of total disability establish a worsened condition as a matter of law. See Gwynn v. SAIF, 304 Or 345, 353 (1987); Morgan v. Silvercrest Industries, 91 Or App 649, 652 (1988).

On review, the insurer concedes that claimant's industrial injury was a material contributing cause of the symptoms that required treatment in December 1986. See Grable v. Weyerhaeuser Company, 291 Or 387, 400-401 (1981). Therefore, the dispositive inquiry is whether claimant's symptoms in December 1986 represented a worsened condition, i.e., rendered claimant more disabled than he was at the time of claim closure in November 1984. Because claimant received no prior award of permanent disability for her compensable injury, any loss of earning capacity resulting from increased symptoms would establish a worsening.

The medical opinions are divided on the ultimate question of whether claimant's condition had worsened. Dr. Stearns, the treating physician since December 1986, opined that claimant was experiencing a worsening of lumbar pain attributable to the industrial injury. Dr. Collada and Dr. McDonald, the original treating physician who also performed an independent medical examination in March 1987, opined that there was no worsening of the compensable condition. Drs. Collada and McDonald acknowledged, however, that claimant would continue to experience recurrent strain-type symptoms.

We find that claimant has established a worsened condition as a matter of law. Dr. Stearns authorized time loss from work beginning December 8, 1986. That authorization remained in effect through the first week of January 1987. The record is devoid of persuasive medical evidence that claimant was able to work during that period of time. Indeed, claimant was not examined by any other physician until January 8, 1987, when Dr. Collada declared him medically stationary. Assuming, arguendo, that claimant was medically stationary on January 8, 1987, this record nevertheless persuades us that he was totally disabled for more than 14 days, beginning December 8, 1986. We conclude, therefore, that claimant has established a worsening as a matter of law. See Gwynn v. SAIF, supra; Morgan v. Silvercrest Industries, supra. Accordingly, we conclude that the aggravation claim was compensable.

Attorney Fee

The Referee also assessed a penalty-related attorney fee for the insurer's alleged unreasonable denial of aggravation. A penalty was not assessed for the denial because the insurer had already been assessed with the maximum penalty to which both parties had stipulated prior to hearing. We agree with the Referee's assessment of the attorney fee.

In his January 8, 1987, Dr. Collada recommended chiropractic care as a palliative modality, thereby suggesting that claimant was medically stationary. However, he offered no express opinion to that effect and failed to address the question of whether claimant had sustained a worsening of disabling symptoms sufficient to warrant a reopening of the claim. Reading

the reports of Drs. Stearns and Collada together, we find that the insurer had no legitimate doubt of its liability for aggravation. Accordingly, we conclude that the denial was unreasonable and a penalty-related attorney fee was properly assessed. See Petersen v. SAIF, 78 Or App 167, 172, rev den 301 Or 193 (1986).

ORDER

The Referee's order dated May 21, 1987 is reversed in part and affirmed in part. That portion of the order which upheld the insurer's aggravation denial, dated January 27, 1987, is reversed. That denial is set aside and the claim is remanded to the insurer for processing according to law. An assessed fee of $1,550 for services rendered at hearing and $550 for services rendered on Board review is approved. The remainder of the Referee's order is affirmed. The Board approves a client-paid fee not to exceed $2,004.

JEANETTE M. McMICHAEL, Claimant
Bloom, Marandas & Sly, Claimant's Attorneys
Mark Bronstein (SAIF), Defense Attorney

WCB 86-15422
September 9, 1988
Order on Review

Reviewed by Board Members Crider and Ferris.

Claimant requests review of Referee Podnar's order that upheld the SAIF Corporation's denial of claimant's medical services claim for exercise therapy for her low back condition. On review, the issue is medical services.

We reverse.

FINDINGS OF FACT

Claimant sustained a herniated lumbar disc in a compensable injury on October 4, 1985. The treating physician, Dr. Misko, neurosurgeon, prescribed conventional physical therapy in May 1986, but the therapy increased claimant's pain to such an extent that she was not able to continue the treatment. Claimant underwent an unsuccessful fusion surgery in August 1986 and continued to experience significant post-surgery low back pain.

In October 1986, Dr. Misko prescribed a conditioning program through an unlicensed physical rehabilitation provider. At that time, he outlined treatment goals and recommended thrice-weekly sessions. Claimant's conditioning program included swimming, whirlpool therapy and stationary biking. Her exercise activities were supervised by an unlicensed counselor with a degree in physical education. Dr. Misko was not present during claimant's exercise sessions, but he received monthly progress reports and discussed claimant's progress with her on an ongoing basis. A chiropractor on location at the facility for more than half of claimant's visits occasionally asked about her treatment. However, the chiropractor is not a principal or employee of the provider, and claimant has never been his patient.

Claimant's condition improved as a result of her conditioning program, and Dr. Misko authorized continued participation through March 16, 1987. SAIF initially paid for the program. However, on March 9, 1987, it issued a denial of further conditioning services with the provider, and claimant requested a hearing. At that time, claimant's residual low back pain and unsuccessful fusion surgery remained a major obstacle to

conventional physical therapy. Claimant discontinued the conditioning program on or before March 12, 1987, and her condition has since deteriorated.

Claimant was a credible witness. We are persuaded that she benefited from the conditioning program in a way she could not have benefited from conventional physical therapy. We are further persuaded that the conditioning program was provided under the "direct control and supervision" of Dr. Misko as that term was then used in OAR 436-10-050(2).

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant benefited from the conditioning program in a way she could not have benefited from conventional physical therapy. Nevertheless, he concluded that the program was not compensable because it was not provided in accordance with former OAR 436-10-050(2). Under that rule, attending physicians "may prescribe treatment . . . by persons not licensed to provide a medical service" only if such persons "work under the direct control and supervision of the attending physician."

On review, claimant contends that the "direct control and supervision" requirement does not apply to the type of restorative services at issue in this case. In support of her contention, she notes that the requirement only applies to "medical services" as that term is defined by former OAR 436-10-005(16), i.e., "surgical, chiropractic, dental, hospital, nursing, ambulance, or other related services; also any drugs, medicines, crutch, prosthesis, brace, support or physical restorative device." (emphasis added). Claimant contends that physical restorative services are not included within this definition because: (1) they are not specifically listed in the definition; and (2) the language "or other related services" does not encompass restorative therapy as the services listed prior to that language are directed at treatment rather than restoration. Claimant further argues that treating physical restorative services as "medical services" would result in an unreasonable burden on attending physicians who would be required to provide on-site supervision of those services under OAR 436-10-005(9).

We are not persuaded by claimant's argument. The rules found in OAR 436 Division 10 were enacted to carry out ORS 656.245, and the definition of "medical services" in that statute specifically includes physical restorative services. See former OAR 436-10-003. Furthermore, we note that although OAR 436-10-005(16) does not specifically list physical therapy as a "medical service", it is clearly treated as such elsewhere in the rules. See former OAR 436-10-040(4)(a). It, therefore, follows that physical therapy is the type of "other related services" referenced in OAR 436-10-005(16). This, in turn, strongly suggests that other restorative services, including the conditioning program in this case, are also encompassed within the term "other related services." Finally, we note that the services in this case were rendered prior to the March 16, 1987 effective date of OAR 436-10-005(9), the on-site requirement alluded to by claimant. We, therefore, decline to consider that requirement in interpreting the law applicable to this case.

In light of the above discussion, we are persuaded that the conditioning program at issue in this case is the type of "other

related services" referenced in OAR 436-10-005(16). Accordingly, we conclude that claimant's program is subject to the "direct control and supervision" requirement of OAR 436-10-005(16).

We, therefore, turn to claimant's contention that Dr. Misko exercised the requisite amount of "direct control and supervision" over her conditioning program. We have previously interpreted this language to require, at a minimum, a referral by the attending physician, his or her recommendations regarding the frequency of treatment, and at least some subsequent contact between the attending physician and the therapist, designed to monitor both the activities of the therapist and the progress of the patient. See Verna B. Herb, 37 Van Natta 1247 (1985).

Here, claimant's conditioning program was provided pursuant to treating physician Misko's prescription and treatment plan. Moreover, Dr. Misko received monthly progress reports from claimant's therapist and discussed her progress with her on an ongoing basis. Given these facts, we are persuaded that his involvement constitutes the type of direct supervision and control contemplated by OAR 436-10-050. See Verna B. Herb, supra.

As we have concluded that the treatment at issue meets the requirements of OAR 436-10-050, it is not necessary for us to address claimant's contention that those requirements are invalid because they exceed the Director's authority. Accordingly, we reverse the Referee's order and set aside SAIF's denial of claimant's conditioning program.

ORDER

The Referee's order dated July 10, 1987 is reversed. SAIF Corporation's denial is set aside and the claim is remanded to SAIF for processing according to law. For services at hearing and on Board review, claimant's attorney is awarded an assessed fee of $2,000, to be paid by the SAIF Corporation.

CLEO M. RIGGS, Claimant
Pozzi, et al., Claimant's Attorneys
Norman Cole (SAIF), Defense Attorney
Cummins, et al., Defense Attorneys
David O. Horne, Defense Attorney

WCB 86-07558, 86-11426 & 87-02089
September 9, 1988
Order on Review

Reviewed by Board Members Johnson and Crider.

Boise Cascade Corporation, in its self-insured capacity, requests review of that portion of Referee Shebley's order that set aside its denial of claimant's occupational disease claim for a lung condition called calcified pleural plaquing. We affirm the Referee's order.

ISSUES

1. The timeliness of claimant's claims against SAIF Corporation and Boise Cascade Corporation.

2. The compensability of claimant's lung condition, calcified pleural plaquing.

3. Responsibility for claimant's condition.

FINDINGS OF FACT

Claimant has a condition known as calcified pleural plaquing, a scarring of the linings of the lungs caused by inhalation of asbestos dust. Claimant was first exposed to significant concentrations of asbestos dust between February 1944 and July 1947 while he was in the Navy and was repairing ships damaged in the war. From 1947 to the time of the hearing in February 1987, claimant worked as a millwright. He worked for Firtex Insulating Company from 1947 to 1955, for Crown Zellerbach from 1955 through April 30, 1964 and for Boise Cascade Corporation from May 1, 1964 through the date of the hearing.

Crown Zellerbach was a contributing employer under the pre-1965 workers' compensation system and thus was covered by the Industrial Accident Fund (now SAIF Corporation). Boise Cascade did not contribute to the Industrial Accident Fund from May 1, 1964 through December 31, 1965 and thus was without workers' compensation coverage during that period. After coverage was mandated by the 1965 revision of the Workers' Compensation Law, Boise Cascade was insured by Wausau Insurance Company from January 1, 1966 through November 15, 1967. Thereafter it has been self-insured. Firtex Insulating Company was not made a party to this proceeding.

As a millwright, claimant frequently had to disturb or remove asbestos insulation on pipes or pieces of machinery to work on them. As a result, he was exposed to airborne asbestos particles on nearly a daily basis until the mid-1970s. At that time, Boise Cascade began to provide respiratory protection for its workers and to replace asbestos insulation with insulation made of other materials. Because of these changes, claimant was exposed only to low levels of airborne asbestos particles on an occasional basis from the mid-1970s through the date of the hearing.

In late 1964, claimant began to experience chest pain due to the formation of pleural plaques. (See Tr. 42, 60-61, 98). He first sought medical attention for this pain on November 28, 1964. (See Ex 16A, 16B). Thereafter, he experienced periodic episodes of chest pain and was evaluated for a number of potential ailments. He was first told by a physician that his pleural plaques were related to his occupational exposure to asbestos in February 1986. (See Ex. 43-6; Tr. 16). He filed a claim against Boise Cascade in its self-insured capacity on March 18, 1986 and filed claims against SAIF and Wausau later the same year.

Calcified pleural plaquing is a progressive scarring of the linings of the lungs caused by inhalation of asbestos dust. It takes approximately 20 years from the date of a given exposure for pleural plaques resulting from that exposure to become visible on x-ray. Tissue damage caused by the exposure, however, is present at least one year before it becomes calcified and thus becomes visible. (See Tr. 90, 104-05, 111-13). No curative medical treatment currently is possible for the condition.

Claimant's exposure to asbestos dust in the military was the major cause of the onset of his condition. (Tr. 102-03). The concentrations of asbestos dust to which claimant was exposed during his employment as a millwright from 1947 to the mid 1970s were sufficient to cause pleural plaques. His exposure to asbestos dust in his work as a millwright was the major cause of a worsening of his underlying condition. (See Tr. 43-44, 108-09). Claimant's exposure

to asbestos dust in his work as a millwright up to and including February 19, 1968 had contributed to the worsening of his underlying condition by the date of the hearing. (See Tr. 109).

Claimant has missed no time from work because of his condition and he continued to perform his regular work at the time of the hearing. The condition, however, has resulted in a mild decrease in exercise capacity. (Tr. 41, 64, 110-11). Claimant has also received pain medications for his condition. (Tr. 32).

CONCLUSIONS OF LAW

Timeliness

When claimant filed his occupational disease claims in 1986, ORS 656.807(4) provided:

> "(4) All occupational disease claims for silicosis, asbestosis or asbestos-related diseases are void unless a claim is filed within 40 years after the last exposure in employment subject to the Workers' Compensation Law and within 180 days from the date the claimant either becomes disabled or is informed by a physician that the claimant is suffering from silicosis, asbestosis or asbestos-related diseases, whichever is later."

Claimant suffers from an "asbestos-related disease" and it is undisputed that his claims were timely if the above provision is applicable. Boise Cascade and SAIF contend, however, that the timeliness of claimant's claims should be gauged by the law as it was in 1964. At that time, the law provided only a three-year limitation period for all occupational disease claims except those for silicosis or radiation injury. See Or Laws 1959, ch 351, § 2. The special 40-year limitation for asbestosis and asbestos-related diseases was not added until 1981. Or Laws 1981, ch 535, § 47. SAIF contends that claimant's claim against it was untimely because claimant did not file the claim within three years of April 30, 1964, when claimant was last employed under SAIF coverage. Boise Cascade contends that claimant's claim against it was untimely because claimant did not file the claim within three years of November 28, 1964, when claimant first sought medical evaluation for chest pain due to his pleural plaques.

Although objectionable on a number of grounds, the short answer to the above arguments is provided by Argonaut Insurance Companies v. Eder, 72 Or App 54 (1985). In that case, the court ruled that the 40-year limitation for asbestosis and asbestos-related diseases was retroactive. The timeliness of claimant's claims, therefore, must be gauged by the 40-year limitation of former ORS 656.807(4) and, under that limitation, they were timely.

Compensability

To establish a compensable occupational disease, claimant has the burden of proving that his employment as a millwright was the major contributing cause of the onset or a pathological worsening of a condition which required medical

services or resulted in disability. See former ORS 656.802(1)(a); 656.804; former 656.005(8); Dethlefs v. Hyster Co., 295 Or 298, 310 (1983); Blakely v. SAIF, 89 Or App 653, 656 (1988). It is undisputed that claimant's employment as a millwright was the major contributing cause of a pathological worsening of his pleural plaques. Boise Cascade contends, however, that the plaques are not a compensable occupational disease because they have never resulted in temporary disability and no curative medical treatment is currently possible for them. In support of its position, Boise Cascade cites Brown v. SAIF, 79 Or App 205, rev den 301 Or 666 (1986).

In Brown, the claimant was exposed to asbestos dust over a two-year period and thereafter became concerned that his health may have been compromised. He filed an occupational disease claim against his employer and underwent a number of medical examinations and tests which revealed no evidence of existing disease. Given these facts, the court held that the claimant had not sustained a compensable occupational disease because there was no evidence of "any change in his physical condition" or "actual physical or mental harm." Id. at 208-09.

We reject Boise Cascade's argument because of important differences between Brown and the present case. Unlike the claimant in Brown, the claimant in the present case has sustained actual damage to the tissues of his body. This damage has caused discomfort, has required medical evaluation and palliative treatment and has resulted in some measure of physical impairment. Claimant has proven, therefore, that his condition required medical services and, ostensibly, that it has resulted in disability. He thus has proven a compensable occupational disease. See Collins v. Hygenic Corp. of Oregon, 86 Or App 484, 488 & n.3 (1987).

Responsibility

Responsiblity for occupational diseases is governed by the "last injurious exposure rule." Bracke v. Baza'r, Inc., 293 Or 239, 246 (1982). Under that rule, the last carrier whose employment materially contributed to a worsening of the claimant's compensable condition is liable for the whole condition. Id. at 244. Actually, as pointed out in Bracke, reference to the rule as if it were unitary is somewhat misleading; there are at least two last injurious exposure rules. Id. at 245 & n.1. One is a rule of proof; the other is a rule of liability assignment. Id.

The rule of proof operates primarily in favor of the claimant by relieving him of the burden of proving actual medical causation against any particular employer or insurer. Id. at 246. Under that rule, medical causation (and thus a prima facie case of responsibility) is deemed proven against the carrier on the risk during the last period of potentially causal employment prior to the date of disability. Id. at 248-49. Potentially causal employment is employment involving conditions which could cause the claimed disease over some indefinite period of time; proof of actual medical causation is not requried. Fossum v. SAIF, 293 Or 252, 256 (1982); Meyer v. SAIF, 71 Or App 371, 374 (1984), rev den 299 Or 203 (1985). The date of disability is the date upon which the claimant is disabled by the condition or, if not disabled, first receives medical services for his compensable condition. See id. at 248 & n.4; United Pacific Insurance Co. v. Harris, 63 Or App 256, 260, rev den 295 Or 730 (1983).

The rule of liability assignment operates primarily in favor of the carrier deemed responsible under the rule of proof. See Bracke v. Baza'r, Inc., supra, 293 Or at 249-50. But see Runft v. SAIF, 303 Or 493 (1987) (a carrier may not assert the rule of liability assignment to defeat a claimant's right to compensation). Under the rule of liability assignment, the carrier deemed responsible under the rule of proof may shift responsibility to a prior carrier by showing that conditions during the later carrier's period of employment did not actually contribute to a worsening of the claimant's compensable condition, see Fossum v. SAIF, supra, 293 Or at 256 n.1; FMC Corp. v. Liberty Mutual Insurance Co., 70 Or App 370, 374 (1984), modified, 73 Or App 223, rev den 299 Or 203 (1985), or to a subsequent carrier by showing that conditions during the subsequent carrier's period of employment actually did contribute to a worsening of the claimant's compensable condition. See Bracke v. Baza'r, Inc., supra, 293 Or at 250-51; see also Boise Cascade Corp. v. Starbuck, 296 Or 238, 243 (1984).

In the present case, the application of the rule of proof creates somewhat of a problem. The date of disability in this case was November 28, 1964, the date upon which claimant first received medical services for his compensable condition. Claimant was employed by Boise Cascade on that date and was being exposed to concentrations of asbestos dust which could cause pleural plaques over an indefinite period of time. Under the rule of proof, therefore, the workers' compensation carrier on the risk on the date of disability should be responsible. The problem is that Boise Cascade was not contributing to the Industrial Accident Fund on that date and thus was not subject to the Workers' Compensation Law. The Board has no jurisdiction to assign responsibility to a nonsubject employer. This raises the question of how the rule of proof applies in this case, if at all.

The answer to this question is found in Progress Quarries v. Vaandering, 80 Or App 160 (1986). In that case, the last employer with potentially causal conditions prior to the date of disability was an out-of-state employer and thus was not subject to Oregon Workers' Compensation Law. Id. at 164. The last prior Oregon employer with potentially causal conditions argued that the out-of-state employer was responsible under the last injurious exposure rule of proof and that for the Oregon employer to be responsible the claimant had to show that he had sought and been finally denied benefits from the out-of-state employer. Id. at 164-65. The court rejected this argument and concluded that to yield consistent results the rule of proof must be applied without considering potentially causal out-of-state employment. Id. at 165-66.

There is no meaningful distinction between the present case and Vaandering. Boise Cascade was the last employer with potentially causal conditions prior to claimant's date of disability. Like the out-of-state employer in Vaandering, however, Boise Cascade was not subject to Oregon Workers' Compenation Law during the period when claimant was exposed to those potentially causal conditions. The rationale of Vaandering thus applies with equal force to the present case and we conclude that the same rule should apply. Under that rule, the first Oregon carrier with potentially causal conditions prior to the date of disability is responsible under the last injurious exposure rule of proof. That carrier is SAIF. As discussed

earlier, however, SAIF may invoke the last injurious exposure rule of liability assignment to shift responsibility to subsequent carriers subject to Oregon Workers' Compensation Law, namely Wausau and Boise Cascade in its self-insured capacity.

Based upon the evidence presented in this case, we found that pleural plaques caused by inhalation of asbestos dust take approximately 20 years to become visible on x-ray. Tissue damage is present at least one year before that. Given these facts, it is more probable than not that the asbestos which claimant inhaled 19 or more years before the date of the hearing had contributed to a worsening of his underlying condition by that date. The hearing was held on February 19, 1987. Subtracting 19 years from that date yields a date of February 19, 1968. The carrier on the risk on that date was Boise Cascade in its self-insured capacity. Under the last injurious exposure rule of liability assignment, therefore, Boise Cascade is responsible for claimant's condition.

ORDER

The Referee's order dated April 9, 1987 is affirmed. Claimant's attorney is awarded $725 for services on Board review, to be paid by Boise Cascade Corporation. Counsel for Boise Cascade Corporation in its self-insured capacity is authorized to charge a client-paid fee of up to $1,310 for services on Board review.

JAMES V. BACHLEDA, Claimant
Colleen Maxwell and Nelson Maxwell dba
MAXWELL CONSTRUCTION, Employer
Merrily McCabe (SAIF), Defense Attorney

WCB 87-11364
September 16, 1988
Order on Review

Reviewed by Board Members Ferris and Crider.

The alleged noncomplying employers request review of Referee Uffelman's order that dismissed their request for hearing. The issue is whether the Referee was correct in dismissing the employers' hearing request. We affirm.

FINDINGS OF FACT

On May 20, 1987, the Workers' Compensation Department (Department), by Proposed and Final Order, found the employers to be noncomplying from September 15, 1986 to November 3, 1986. The noncomplying employers did not appeal that order. Subsequently, the Department referred claimant's injury claim to the SAIF Corporation for processing.

We take administrative notice of the following facts: (1) on July 15, 1985, the noncomplying employers mailed a letter to SAIF requesting a hearing regarding the compensability of claimant's injury; (2) SAIF received that request on July 17, 1987 and forwarded it to the Board who received it on July 23, 1987; (3) on October 21, 1987, the Board mailed a copy of the hearing notice to the noncomplying employers; and (4) there is no indication from the record that that notice was not received by the noncomplying employers.

On both December 7, 1987 and December 8, 1987, SAIF's counsel placed telephone calls to the noncomplying employers and left messages advising them of the December 9, 1987 hearing date.

Notwithstanding these multiple hearing notices, the noncomplying employers failed to appear at hearing. Therefore, on December 18, 1987, Referee Uffelman issued an Order of Dismissal.

On January 5, 1988, the noncomplying employers requested review of the Referee's order. No briefs, however, were filed.

CONCLUSIONS OF LAW

The Referee dismissed the noncomplying employers' hearing request regarding the compensability of claimant's injury claim due to their failure to appear at hearing. We agree.

Former OAR 438-06-070 stated that:

> "Failure of a party to appear at a hearing without good cause constitutes a waiver of appearance. If the party failing to appear is the party that requested the hearing, the request for hearing may be dismissed unless good cause is shown and the other party is not prejudiced thereby."

Since the noncomplying employers requested the hearing, did not appear, and have not shown good cause for their absence, the Referee correctly issued an Order of Dismissal.

ORDER

The Referee's order dated December 18, 1987 is affirmed.

ROBERT D. BURNS, Claimant
Cowling & Heysell, Claimant's Attorneys
Luvaas, Cobb, et al., Defense Attorneys

WCB 86-12488
September 16, 1988
Order on Reconsideration

On May 12, 1988, we issued an Order of Abatement withdrawing our Order on Review of April 29, 1988 for reconsideration. In our initial order, we treated additional evidence included in the insurer's brief on review, but not otherwise in the hearing record, as a request for remand and denied that request. We then affirmed Referee Mongrain's order that set aside the insurer's partial denial of claimant's medical services claim for surgery for his current low back condition.

On reconsideration, the insurer moves to delete the additional evidence from its brief on review. In addition, it contends that the Board did not provide de novo review of the medical services issue in this case and requests that it do so on reconsideration. Claimant has not filed a response to the insurer's motion.

Contrary to the insurer's contention, we reviewed the entire record in this case de novo before issuing our initial order. On reconsideration, we adhere to our initial decision affirming the order of the Referee. However, we note that our initial order was issued prior to the recent decision in Armstrong v. Asten-Hill Company, 90 Or App 200 (1988). We provide the following supplementary discussion in compliance with that decision.

FINDINGS OF FACT

Claimant, 42 years old at the time of hearing, sustained

a compensable low back injury in May 1976. That injury led to two surgical procedures in 1978 for a herniated L4-5 disc. X-rays taken in 1978 also demonstrated a slight left midline bulge at the L3-4 level. Since 1978, claimant has experienced persistent low back and leg pain, particularly on the left side. His injury claim was closed with an award of permanent and total disability.

A myelogram performed in June 1981 demonstrated a herniated disc at the L3-4 level on the left and post-operative degenerative changes at L4-5. Additional diagnostic studies in 1985 and 1986 confirmed these findings and also demonstrated degenerative changes at the L5-S1 and L2-3 levels.

Dr. Campagna, neurosurgeon, recommended surgery for the L3-4 disc herniation. The insurer denied the request for surgery on the ground that the herniation was not related to the 1976 injury. Claimant requested a hearing.

Claimant credibly testified regarding his injury and subsequent symptomatic history and post-injury activity. He has sustained no additional back injuries since May 1976, and he has not worked or engaged in anything other than sedentary activities since 1978.

We are persuaded that claimant's 1976 back injury and resulting L4-5 disc condition materially contributed to his current L3-4 disc herniation.

CONCLUSIONS OF LAW AND OPINION

In order to prevail on his medical services claim, claimant must prove that his compensable back injury remains a material contributing factor to his current L3-4 disc herniation. Aquillon v. CNA Insurance, 60 Or App 231 (1982); Patitucci v. Boise Cascade Corp. 8 Or App 503, 507 (1972). This causal relationship is the type of complex medical question that requires expert medical analysis. See Uris v. Compensation Department, 247 Or 420, 424-26 (1965); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985). The relevant medical opinions are set forth in paragraph two of the "Findings" section of the Referee's order. On review, the insurer contends that the Referee erred in deferring to the opinions of Drs. Narus and Campagna over that of Dr. Baker.

After de novo review of the record, we are persuaded that the Referee properly deferred to the opinion of Drs. Narus and Campagna that claimant's 1976 back injury materially contributed to his current condition. Although their reports are somewhat conclusory, the record as a whole is more consistent with their opinion than the "wear and tear" theory advanced by Dr. Baker.

In particular, x-rays taken shortly after the 1978 injury revealed a slight left mid-line bulge at the L3-4 level, and Dr. Baker failed to explain why this objective finding is not significant in light of the subsequent development of a distinct herniation. Furthermore, it is less likely that claimant's condition is totally attributable to accumulative "wear and tear" given his relatively young age, his limitation to sedentary activities and his fairly constant level of symptoms.

Accordingly, we defer to the opinion of Drs. Narus and Campagna and affirm the Referee's order.

Finally, we note that claimant's brief on review was of no assistance to us in the review process because it was not submitted in a timely manner. See OAR 438-11-015 & 438-11-020. An untimely brief does not qualify as "legal representation" as that term is used in ORS 656.382(2). See Shirley M. Brown, 40 Van Natta 879 (July 27, 1988). Moreover, the record does not otherwise document "legal representation" short of briefing that would support an attorney fee award on review. Accordingly, claimant's counsel is not entitled to an insurer-paid attorney fee on review. Id.

ORDER

The Referee's order dated March 27, 1987 is affirmed.

JAMES R. CARTER, Claimant
Welch, et al., Claimant's Attorneys
Schwabe, et al., Defense Attorneys
Nelson, et al., Defense Attorneys

WCB 86-17612 & 86-06201
September 16, 1988
Order on Reconsideration

On March 21, 1988 we issued on Order of Abatement stating that we had decided to reconsider our Order on Review of February 19, 1988. In our initial order, we affirmed Referee Lipton's order that: (1) set aside Liberty Northwest Insurance Company's denial of claimant's aggravation claim for a cervical condition; and (2) upheld a denial of claimant's "new injury" claim for the same condition issued by Maryland Casualty Company.

On reconsideration, Liberty Northwest and claimant contend that the Board improperly affirmed the Referee's order without commenting on alleged errors in the findings of fact and reasoning. We have received Maryland Casualty's response to the motion for reconsideration.

The sole issue is responsibility. On reconsideration, we adhere to our initial decision affirming the order of the Referee. We note that our initial order was issued prior to the recent decision in Armstrong v. Asten-Hill Company, 90 Or App 200 (1988). We provide the following supplementary discussion in accordance with that decision.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" and make the following additional findings.

Liberty Northwest was on the risk at the time of claimant's cervical injury in July 1985. At that time, claimant experienced right shoulder and neck pain and right arm numbness.

Following claim closure in April 1986, claimant experienced gradually worsening neck pain and also developed pain and numbness in his left arm. These symptoms increased markedly after his October 1986 lifting incident. Maryland Casualty was on the risk at the time of the latter lifting incident.

Nerve conduction tests performed in October 1986 by Dr. Aversano, neurologist, demonstrated a slowing of the ulnar motor conduction velocity across the left elbow.

After de novo review of the medical and lay evidence, we

find that claimant's current condition is due to a chronic denervation of the muscles supplied from the C-8 and T-1 fibers. Furthermore, we are not persuaded that claimant's employment with Maryland Casualty's insured independently contributed to a worsening of that condition. We, instead, find that claimant's current condition is a residual of his multi-level fusion surgery.

CONCLUSIONS OF LAW AND OPINION

In successive injury cases, responsibility rests with the insurer on the risk at the time of the most recent injury that independently contributed to the causation of the claimant's current condition. Hensel Phelps Construction v. Mirich, 81 Or App 290, 293-294 (1986); Smith v. Ed's Pancake House, 27 Or App 361 (1976). If a worker proves that a condition is materially related to one or more industrial injuries, a prima facie case is made out against the insurer on the risk at the time of the most recent injury. Boise Cascade Corp. v. Starbuck, 296 Or 238, 244-245 (1984); Edward Anselmi, 39 Van Natta 793, 794 (1987). Cf. Champion International v. Castilleja, 91 Or App 556 (June 22, 1988). That insurer can then shift responsibility to an earlier insurer joined in the lawsuit by demonstrating that claimant's most recent injury did not independently contribute to a worsening of the underlying condition. Id.

Here, claimant's most recent injury was the October 1986 lifting incident with Maryland Casualty's insured. Therefore, Maryland Casualty is responsible for claimant's current cervical condition unless it demonstrates that the 1986 lifting incident did not independently contribute to a worsening of that condition.

The record contains medical opinions addressing the responsibility issue from Dr. Stolzberg, neurologist, Dr. Peterson, neurologist, Dr. Plance, chiropractor, and claimant's treating physician, Dr. Sirounian, D.O. These opinions are summarized at Pages 3 and 4 of the Referee's Opinion and Order.

The Referee was persuaded by Dr. Stolzberg's opinion that claimant's current condition was the result of the sequelae of his July 1985 injury with Liberty Northwest's insured and the related multi-level fusion surgery. Accordingly, he concluded that Liberty Northwest was responsible for claimant's current condition.

After de novo review of the record, we conclude that there are persuasive reasons to defer to the opinion of Dr. Stolzberg. See Weiland v. SAIF, 64 Or App 810, 814 (1983); Nancy E. Cudaback, 38 Van Natta 423 (1986). First, this case involves a complicated disc and nerve root injury. As a specialist in this area, Dr. Stolzberg's opinion should be given deference over that of Drs. Plance and Sirounian. See Donald L. Oxford, 38 Van Natta 1297 (1986). Furthermore, Dr. Stolzberg is the only specialist who has had the opportunity to examine claimant both at the time of the initial injury and after the October 1986 incident. See Kienow Food Stores v. Lyster, 79 Or App 416, 421 (1986).

Moreover, Dr. Stolzberg's opinion is well-reasoned and consistent with the record as a whole. See Somers v. SAIF, 77 Or App 259, 263 (1986). In particular, he conducted studies supporting his diagnosis of chronic denervation of the muscles

supplied by C-8 and T-1 fibers. In addition, he explained that claimant's left arm weakness and Dr. Aversano's nerve conduction study findings were consistent with this diagnosis. He further explained that this condition was typical of the type of multi-level fusion surgery performed on claimant.

By comparison, Dr. Peterson's opinion is not well-reasoned. After initially agreeing with Dr. Stolzberg, Dr. Peterson changed her opinion based on claimant's testimony that he did not experience left arm symptoms prior to the October 1986 incident. However, claimant provided a different symptomatic history when he was examined by Dr. Sirounian in October 1986. Specifically, he reported slowly increasing pain, numbness and parathesia from the neck to the left hand which markedly increased after the lifting incident on October 6, 1986. In light of the Referee's finding that claimant is a poor historian, we are persuaded that Dr. Sirounian's report provides the more accurate record of claimant's symptomatic history. As a result, we find that Dr. Peterson's revised opinion is based on an inaccurate history and is, therefore, entitled to little weight. Partridge v. SAIF, 57 Or App 163 (1982).

For the reasons discussed above, we defer to Dr. Stolzberg's opinion and find that the October 1986 lifting incident did not independently contribute to a worsening of claimant's current cervical condition. Accordingly, we affirm the Referee's order assigning responsibility to Liberty Northwest.

ORDER

The Referee's order dated March 23, 1987 is affirmed. The Board approves a client-paid fee, not to exceed $1,038, to be paid from Maryland Casualty Co. to its counsel.

CRAIG P. DOUGLASS, Claimant
Richardson, et al., Claimant's Attorneys
Annala, et al., Defense Attorneys
Carroll Smith (SAIF), Defense Attorney
Carl Davis, Assistant Attorney General

WCB 87-05457, 87-01491 & 87-05027
September 16, 1988
Order on Review

Reviewed by Board Members Johnson and Crider.

Claimant requests review of Refereree Podnar's order which set aside the SAIF Corporation's acceptance of his injury claim, issued on behalf of the noncomplying employers. We reverse.

ISSUE

Compensability of claimant's right knee injury.

FINDINGS OF FACT

On October 23, 1986, claimant was injured while constructing mountain trails for McCann Construction, his employer. When a large rock slid beneath him, he grabbed a nearby stump to keep from falling, thereby injuring his right knee and ribs. He was able to continue work at light-duty jobs until the construction project terminated on October 31, 1986. During that time, claimant limped and his knee occasionally snapped.

On October 25 and 26, claimant engaged in remodeling his home. He borrowed a jackhammer from his employer and used it to break up his cement sidewalk. He also participated in loading and

unloading the cement slabs and did some cement finishing work. The jackhammering and lifting required knee strength; the finishing work required some kneeling and stooping. The more difficult work was performed by friends and paid help.

On November 12, 1986, Dr. Higgins diagnosed work-related right pectoralis muscle strain and a possible torn medial meniscus of the right knee. There is no medical evidence to the contrary. However, claimant did not inform Dr. Higgins of his weekend remodeling activities.

On December 9, 1986, claimant filed a claim for injury to his right knee and ribs.

On January 12, 1987, by Proposed and Final Order, the Workers' Compensation Department declared Gerald McCann, dba, McCann Construction to be noncomplying. At that time, claimant's claim was referred to the SAIF Corporation for processing.

In a letter to the Workers' Compensation Department dated February 3, 1987, McCann requested a hearing on the issues of whether he was a complying employer, whether claimant was a subject worker and the compensability of the claim. As far as the record reveals, that letter was not sent to either SAIF or claimant.

On March 27, 1987, Dr. Higgins performed a right knee arthroscopy with transarthroscopic partial medial meniscectomy and a femoral trochlear shave.

On April 3, 1987, SAIF, the processing agent, accepted claimant's claim for his right knee injury.

On April 7, 1987, SAIF notified McCann that he could request a hearing within 60 days if he wished to contest the compensability of claimant's injury claim.

At no time did McCann ever mail a formal denial of claimant's injury claim to claimant. Nor did he inform claimant of his hearing rights.

At hearing, McCann conceded that he was a noncomplying employer and did not contest the Proposed and Final Order.

CONCLUSIONS OF LAW

The Referee held that it was claimant's burden to prove the compensability of his injury claim by a preponderance of the evidence. The Referee concluded that claimant failed in his burden, reasoning that the slipping and grabbing of the stump should have been more of a dramatic event than was noticed by claimant's coworker. Also, the Referee found that weekend remodeling activities were not consistent with claimant's claimed injury. He set aside SAIF's acceptance of the claim. We disagree.

A denial must, inter alia, inform the claimant of hearing rights and be mailed to the claimant. Former ORS 656.262(8). In Derryberry v. Dokey, 91 Or App 533, 536 (1988), the noncomplying employer mailed a letter to the Workers' Compensation Department requesting a hearing on the issues of whether they were complying employers, whether claimant was a

subject worker and the compensability of the claim. That letter was never sent to either SAIF or the claimant. Id. At hearing, the noncomplying employer asserted that this letter to the Department denied claimant's claim. Id. However, since the letter made no mention of hearing rights and was never mailed to claimant, it was not a denial. Id. at 537. The court found that since SAIF properly accepted the claim and no party had ever properly denied it, claimant was entitled to compensation. Id.

In the present case, the facts are similar. In a letter to the Workers' Compensation Department dated February 3, 1987, the noncomplying employer requested a hearing on the issues of whether he was a complying employer, whether claimant was a subject worker and the compensability of the claim. All issues except compensability were waived at hearing. Therefore, Derryberry v. Dokey, supra, is controlling. The letter seeking a hearing was not sent to SAIF or to claimant. Since the letter made no mention of hearing rights and, so far as the record reveals, was never mailed to claimant, it was not a denial. Because SAIF properly accepted the claim and no party ever properly denied it, claimant is entitled to compensation.

ORDER

The Referee's order dated August 6, 1987 is reversed. The SAIF Corporation's Notice of Claim acceptance is reinstated and the claim is remanded to SAIF for processing according to law. Claimant's attorney is awarded an assessed fee of $1,400, to be paid by the SAIF Corporation, as processing agent for the noncomplying employer.

FLORENCIO M. GARRIDO, Claimant
Vick & Gutzler, Claimant's Attorneys
Norman Cole (SAIF), Defense Attorney
Larry Dawson, Defense Attorney

WCB 86-09270 & 86-17115
September 16, 1988
Order on Review

Reviewed by Board Members Ferris and Crider.

The insurer for New Leaf Greenhouse, Inc. ("New Leaf") requests review of Referee Michael Johnson's order that set aside its denial of responsibility for claimant's aggravation claim. On review, the issue is responsibility. We affirm.

FINDINGS OF FACT

On September 2, 1982, claimant, 29 years of age at hearing, compensably injured his low back while employed with New Leaf. On November 8, 1982, that claim was closed without an award of permanent disability. On February 9, 1983, Dr. Simpson, claimant's treating chiropractor, advised the insurer that on November 29, 1982 claimant had aggravated his condition. On May 11, 1983, that claim was again closed without an award of permanent disability. On May 20, 1983, claimant changed treating chiropractors to Dr. Cannon who diagnosed chronic thoracic paravertebral myofascitis due to chronic subluxation of T8 and lumbar facet syndrome with resulting sciatic neuritis. He advised the insurer that claimant's condition had worsened. As a result, the insurer reopened the claim.

On October 21, 1983, Dr. Cannon restricted claimant from bending or kneeling but permitted him to lift without limit. He rated claimant's physical impairment at 10 percent

On November 4, 1983, a Determination Order awarded claimant 25 percent unscheduled disability resulting from injury to his low back. On December 15, 1983, that Determination Order was reaffirmed by a second Determination Order.

In March 1984 claimant's injury claim was reoponed once again and ultimately closed on December 24, 1984 by stipulation which awarded claimant an additional 7.5 percent unscheduled disability.

From March until June 1984 claimant engaged in agricultural work, including fertilizing and hoeing blueberry bushes. He continued to experience pain in his lower back at the waist on the left side but missed no time from work. For approximately three weeks in June and July 1984, he picked strawberries for various Oregon employers. Claimant's low back pain remained unchanged during this period. In September 1984 he worked for approximately 20 days picking apples in Washington. He missed no time from that employment, but the low back pain was unchanged.

Claimant continued to treat with Dr. Cannon for low back and left leg pain on a regular basis until October 25, 1985.

In February 1985 claimant began working for Cascadian Landscapers ("Cascadian"). He worked for approximately five to six months and was then laid off for the winter. Following his 1985 layoff at Cascadian, claimant again went to Washington to pick apples. When he returned to Oregon, he became employed for four to five weeks in November and December 1985 making holly wreaths. In late December 1985 claimant went to Mexico. In January 1986 he returned to Oregon and collected unemployment benefits. On February 2, 1986, claimant was rehired by Cascadian. The work for Cascadian involved planting trees and plants and installing irrigation systems. The work was heavy and involved the use of a shovel for planting the trees. The trees weighed as much as 200 pounds apiece.

On May 5, 1986, claimant aggravated his low back condition while digging ditches with a shovel. He felt pain in the left side of his low back with some pain radiating into his left leg. This was the same type of pain that had plagued him since his compensable 1982 injury. As a result of that pain, claimant returned to the care of Dr. Cannon for the first time since October 25, 1985. Although claimant had sought no treatment from Dr. Cannon for approximately six months, he had never been symptom free.

Claimant left work on May 5, 1986 and remained off for two weeks. On May 20, 1986, he again aggravated his low back condition while helping to unload 200 pound trees with 2 to 3 coworkers by moving them from the truck and standing them upright in the loading tractor. He also unloaded between 75 and 100 plants which weighed between 5 and 15 pounds apiece. After moving the truck, claimant jumped three to four feet from the cab to the ground. When he hit the ground, he felt an immediate hot sensation in his low back. Claimant, however, continued to work, connecting irrigation pipe already laid in the ground for the remainder of his shift. The following day, he returned to work but left due to low back pain after half an hour and sought further treatment from Dr. Cannon. Claimant remained off work for approximately two weeks before returning to his regular duties at

Cascadian, where he was employed on a full-time basis at the time of hearing.

On June 16, 1986, New Leaf's insurer denied responsibility for claimant's aggravation claim.

On December 22, 1986, Cascadian's insurer denied responsibility for claimant's new injury claim and requested the designation of a paying agent pursuant to 656.307.

On February 25, 1987, the Workers' Compensation Department issued an "Order Designating Paying Agent Pursuant to ORS 656.307."

The two incidents at Cascadian on May 5 and May 20, 1986 caused a temporary symptomatic worsening but did not independently contribute to any worsening of claimant's condition.

Claimant was an honest witness and is credible in every respect, although he is not a good historian.

CONCLUSIONS OF LAW

The Referee concluded that claimant had experienced a mere aggravation of his 1982 injury. We agree.

In an aggravation/new injury context, allocation of responsibility is dependent on whether claimant's present condition is a continuation of his original injury or the result of a subsequent incident that independently contributed to his condition in a material way. CECO Corp. v. Bailey, 71 Or App 782, 785 (1985). To shift responsibility to a subsequent employer/insurer, the evidence must establish that a subsequent incident independently contributed to the causation of the disabling condition, i.e. to a worsening of the underlying condition. See Hensel Phelps Construction v. Mirich, 81 Or App 290 (1986). If the second incident merely aggravates the effects of the first and results in a second period of disability without independently contributing to claimant's condition, the first insurer remains responsible. Smith v. Ed's Pancake House, 27 Or App 361 (1976); Wayne N. Gentry, 39 Van Natta 35 (1987).

Claimant has had constant left-sided low back pain and occasional left leg pain since his compensable 1982 injury. Although claimant did not treat with Dr. Cannon from October 25, 1985 until May 5, 1986, he has never been symptom free since the 1982 injury.

On March 4, 1987, Dr. Cannon reported that claimant had not suffered a new injury with Cascadian but rather a reinjury of the previously injured low back tissues which caused a worsening of symptoms. He explained that claimant's 1982 injury caused his low back soft tissue to become weaker, stiffer and more sensitive. Subjecting those tissues to the extreme stresses of the heavy labor performed by claimant at Cascadian, in his opinion, only increased the inflammation process.

Claimant suffered a back strain in 1982, followed by a period of work with continuing symptoms which indicated that the original condition persisted; this culminated in a second period of disability precipitated by digging ditches and unloading trees for Cascadia. Since those activities at Cascadia did not

independently contribute to the causation of claimant's disability, there was no new injury, but rather, an aggravation of his preexisting condition.

ORDER

The Referee's order dated May 14, 1987 is affirmed. A client-paid fee, not to exceed $900, is approved, to be paid by Northwest Farm Bureau to its counsel.

ALVA L. HACKE, Claimant
Brink, et al., Claimant's Attorneys
Davis & Bostwick, Defense Attorneys
Norman Cole (SAIF), Defense Attorney
Acker, et al., Defense Attorneys
Schwabe, et al., Defense Attorneys

WCB 86-14779, 87-11890, 87-14689 & 87-18777
September 16, 1988
Order on Review

Reviewed by Board Members Johnson and Crider.

The SAIF Corporation requests review of Referee Shebley's order that: (1) set aside SAIF's denial of claimant's left knee injury claim, and ordered SAIF to pay medical services and time loss associated with claimant's January 1980 left knee surgery; (2) set aside Underwriter Adjusting Company's denial of claimant's occupational disease claim for his current bilateral degenerative knee condition; and (3) upheld denials of claimant's occupational disease claims for the same condition issued by SAIF, Liberty Northwest Insurance Corporation and Pacific Indemnity Company.

On review, SAIF contends that claimant's left knee injury claim is barred due to his failure to provide timely notice of the injury. If the Board finds that the claim is not barred, SAIF contends that the injury did not materially contribute to claimant's subsequent surgery and related time loss in January 1980. Alternatively, SAIF argues that Underwriters should be responsible for all injury-related medical services and time loss as the insurer responsible for claimant's degenerative knee condition.

On review, Underwriters argues that claimant's occupational disease claim is not compensable because he has not demonstrated that he suffers from an occupational disease, or that work activities were the major contributing cause of a worsening of his condition. If the Board finds that the condition is compensable, Underwriters contends that SAIF is responsible.

On review, the issues are whether claimant's injury claim is barred for failure to provide timely notice, medical services, temporary total disability, compensability of claimant's current bilateral degenerative knee condition, and responsibility for that condition.

We affirm the Referee's order.

FINDINGS

We adopt the findings of fact contained in the Referee's order. We make the following additional findings.

At the time of claimant's ski accident in April 1981, he felt a tearing sensation in his left knee and experienced increased pain and effusion. He was admitted to the hospital in

December 1981 for evaluation for further knee surgery. Surgery was scheduled but subsequently cancelled due to an unrelated cardiac episode.

Claimant credibly and reliably testified regarding the events surrounding his December 15, 1979 left knee injury. We are persuaded that claimant reported that injury to his immediate supervisor a short time after it occurred. We also find that this injury materially contributed to claimant's need for surgery and related time loss in January 1980.

Claimant did not engage in any routine, strenuous off-work activity while he was working for the employer. Claimant's bilateral knee condition did not preexist his work for the employer. Claimant's work activities were the major contributing factor of the onset of that condition.

Claimant's left and right knee condition became disabling no later than July 1978 and August 1980, respectively. SAIF was on the risk when claimant's condition became disabling. Claimant's work activities after Underwriters came on the risk independently contributed to a worsening of his bilateral knee condition.

CONCLUSIONS AND OPINION

Issues Related to 1979 Injury

We first address SAIF's contentions regarding claimant's December 1979 left knee injury and related medical services and time loss.

SAIF first argues that claimant's injury claim is barred as a result of his failure to provide the employer with timely notice of the injury. Claimant did not provide written notice of his injury until he formally filed an injury claim in 1987. Although he should have provided written notice within 30 days of his injury, his claim is not barred for failure to satisfy this requirement if the employer otherwise had knowledge of the injury. ORS 656.265; Inkley v. Forest Fiber Products, 288 Or 337, 348 (1980).

SAIF contends that the Referee erred in finding that claimant reported his injury to the employer in a timely fashion. We disagree. Claimant testified that he told his immediate supervisor about the injury when he requested a few days off to recuperate shortly after the incident. The Referee observed claimant's demeanor and found his testimony on this question to be credible and reliable. Furthermore, the record does not otherwise persuade us that claimant's recollection is not accurate. We recognize that claimant has demonstrated a poor memory regarding his symptomatic history, and we are aware that his supervisor at the time of the injury does not recall his reporting the injury. However, the fact that the injury resulted in time loss, which must have been approved by the employer, strongly supports claimant's testimony.

In light of these factors, we defer to the Referee's credibility finding. See Humphrey v. SAIF, 58 Or App 360, 363 (1982). Accordingly, we find that claimant reported his injury in a timely fashion, and we affirm the Referee's decision that claimant's injury claim is not barred for lack of timely notice.

SAIF next contends that the Referee erred in concluding that claimant's January 1980 left knee surgery and associated time loss were compensably related to his December 1979 injury. In particular, it notes that there is no medical opinion supporting the requisite causal relationship, and it contends that expert medical evidence is required in light of potential alternative contributing factors.

Where a claimant is asking for payment of medical treatment and related time loss for a condition allegedly resulting from a prior compensable injury, the test is whether or not the compensable industrial injury remains a material contributing factor to the current need for care. Aquillon v. CNA Insurance, 60 Or App 231 (1982); Patitucci v. Boise Cascade Corp., 8 Or App 503 (1972). Under the facts of this case, we do not agree with SAIF's contention that this causal relationship involves the type of complex medical question that requires expert medical opinion. Furthermore, we note that the presence of other contributing factors does not defeat claimant's claim so long as the injury also materially contributed to the need for surgery.

Moreover, the record indicates that claimant sought no medical treatment for his knee for the seven-month period preceding the December 1979 injury. Finally, the treating surgeon, Dr. Wells, reported that claimant experienced a significant increase in symptoms following the injury, and that symptomatic exacerbation continued up to the time of the January 1980 surgery. In light of these factors, and the absence of contrary medical opinion, we agree with the Referee's finding that the December 1979 injury played a material role in his need for surgery in January 1980.

Finally, SAIF contends that Underwriters is responsible for claimant's 1980 surgery and associated time loss as the insurer responsible for claimant's current bilateral knee condition. SAIF makes this argument even though the surgery was performed before Underwriters came on the risk in February 1986. In support of its position, SAIF relies on the Board's decision in Edward Anselmi, 39 Van Natta 793 (1987).

The Anselmi decision does not support SAIF's position. In that case, claimant sought reimbursement for medical services and time loss related to a compensable condition, and the Referee allocated responsibility among three successive insurers for the specific period each was on the risk. The Board reversed the Referee and assigned responsibility to the most recent insurer. Contrary to SAIF's assertion, the medical services and time loss at issue in Anselmi were incurred after the last insurer came on the risk. Therefore, that decision does not support SAIF's contention that Underwriters is "retroactively" responsible for treatment rendered and time loss incurred prior to the time it came on the risk.

Instead, responsibility for claimant's injury remains with SAIF unless and until work activities after it went off the risk independently contributed to a worsening of claimant's injury-related condition. See Boise Cascade v. Starbuck, 296 Or 238, 243 (1984); Hensel Phelps Construction v. Mirich, 81 Or App 290, 293-294 (1986). Assuming that Underwriters is responsible for claimant's current bilateral knee condition, it assumed

responsibility for that condition after it came on the risk in February 1986. It is not responsible for medical services and time loss incurred prior to that time.

In accord with the above discussion, we affirm that part of the Referee's order that set aside SAIF's denial of claimant's injury claim and directed SAIF to pay medical services and time loss associated with the January 1980 left knee surgery.

Current Bilateral Knee Condition

We turn to Underwriters' contentions regarding claimant's occupational disease claim for his current bilateral knee condition.

We first address Underwriters' contention that the Referee erred in finding claimant's occupational disease claim compensable. In particular, it argues that claimant has not demonstrated that he suffers from an occupational disease or that work activities were the major contributing cause of a worsening of his condition. We disagree.

In order to establish the compensability of his occupational disease, claimant must prove that his work activity for the employer, when compared to nonwork activities, was the major contributing cause of his bilateral knee condition. Dethlefs v. Hyster Co., 295 Or 298, 310 (1983); Devereaux v. North Pacific Ins. Co., supra. If claimant's condition preexisted his employment, he must prove that his work activities were the major contributing cause of a worsening of his condition resulting in an increase in pain to the extent that it caused disability or required medical services. See Wheeler v. Boise Cascade Corp., 298 Or 452, 457 (1985); Devereaux v. North Pacific Ins. Co., supra; SAIF v. Gygi, 55 Or App 570 (1982). If claimant's condition did not preexist his employment, he must prove that his work activities were the major contributing cause of the onset of the condition itself. Devereaux v. North Pacific Ins. Co., supra; SAIF v. Gygi, supra. Finally, the residuals of claimant's 1979 left knee injury are considered in determining whether work activities were the major contributing cause of his current condition. Kepford v. Weyerhauser, 77 Or App 363 (1986).

The Referee found that claimant's degenerative knee disease was not a preexisting condition so that claimant was not required to demonstrate a worsening of the condition. He further found that claimant had established that her work activities were the major contributing factor of her current disability and need for treatment. Accordingly, he concluded that claimant had established the compensability of his occupational disease claim. We agree with the Referee's findings and conclusions on this issue.

In reaching this decision, we are aware that some portion of claimant's condition may be attributable to the natural progression of his degenerative disease and his off-work activities. In particular, we note claimant's ski injury in April 1981, at which time claimant felt a tear in his left knee and experienced increased pain and effusion. However, the opinion of the treating surgeon, Dr. Wells, strongly supports a finding that claimant's work activities were the major contributing cause of his current condition. Dr. Wells opined that claimant's work activity was "the significant contributing factor to the deterioration of (claimant's) knee" and "a significant factor in

the deterioration and worsening of his knee condition." We note that Dr. Wells was fully aware of claimant's 1981 skiing accident at the time he rendered that opinion.

We recognize that Dr. Wells did not use the exact words "the major contributing cause" in discussing the relationship between claimant's current condition and his work activities. However a physician may lend sufficient support to a claimant's occupational disease claim without necessarily using the words "major contributing cause." If the physician's opinion supports compensability and is accompanied by other persuasive evidence, the claim may be found compensable. McClendon v. Nabisco Brands, Inc., 77 Or App 412 (1986). Here, Dr. Well's opinion strongly supports compensability. Moreover, when his opinion is considered along with the record as a whole, we are persuaded that claimant's work is the major cause of his current symptoms. In particular, we note the absence of contrary medical opinion, the progressive objective worsening of claimant's condition prior to the April 1981 skiing incident, the strenuous nature of claimant's daily work activities and the absence of comparable strenuous off-work activity. Accordingly, we are persuaded that claimant's work activities were the major cause of his condition and we affirm the Referee on this issue.

Finally, we address Underwriters' contention that the Referee erred in finding it responsible for claimant's current bilateral knee condition. In the case of occupational diseases, the last injurious exposure rule fixes responsibility, in the first instance, with the insurer on the risk at the onset of disability if work conditions with that employer could have contributed to the disability. Bracke v. Baza'r, Inc., 293 Or 239, 247-248 (1982); Spurlock v. International Paper Co., 89 Or App 461, 465 (1988). However, responsibility is properly reassigned to a later insurer if subsequent work activities independently contribute to a worsening of the condition. Spurlock, supra at 465; Bracke, supra, at 250-251. Whether a condition has worsened is generally a complex medical question requiring expert medical analysis. See Uris v. Compensation Department, 247 Or 420, 424-26 (1965).

Here, the onset or claimant's left knee disability occurred no later than July 1978, when Dr. Wells performed the first arthroscopy of that knee. See Bracke v. Baza'r, supra, at 244, 248; United Pacific Insurance Co. v. Harris, 63 Or App 256 (1983). The onset of claimant's right knee disability occurred no later than August 1980, when Dr. Wells performed a partial arthroscopic medial meniscectomy on that knee. Id. SAIF was on the risk in July 1978 and August 1980. Accordingly, SAIF remains responsible unless subsequent work activities independently contributed to a worsening of claimant's condition.

Underwriters came on the risk in February 1986. The Referee assigned responsibility to Underwriters after finding that it was more probable than not that claimant's condition continued to worsen as a result of post-February 1986 work activities.

The record supports the Referee's decision. In particular, medical reports from the treating surgeon, Dr. Wells, indicate that claimant's condition continued to worsen after Underwriters came on the risk. See Uris v. Compensation Department, supra. Dr. Wells warned claimant when he first began treating him that prolonged standing, lifting, carrying or climbing would adversely affect his knee condition. Claimant's

work continued to involve these types of activities after Underwriters came on the risk. Furthermore, Dr. Wells reported in May 1986 that claimant was under a tremendous amount of pressure from his employer to "push harder", and that he was experiencing progressively increasing knee trouble as a result of his job activities. Moreover, claimant's increasing complaints resulted in further right knee surgery in May 1986. Finally, Dr. Wells opined in July 1986 that claimant was "unable to compensate any more for the extensive restrictive degeneration of his knees."

In light of these factors, we agree with the Referee's finding that claimant's work activities after February 1986 independently contributed to a worsening of his bilateral knee condition. Accordingly, we affirm the Referee's assignment of responsibility to Underwriters.

ORDER

The Referee's order dated December 14, 1987 is affirmed. Claimant's attorney is awarded an assessed fee of $1,000 for services on Board review, to be paid by the SAIF Corporation. We approve a client-paid fee for Underwriters Adjusting Company for services on Board review, not to exceed $971.00. We approve a client-paid fee for Pacific Indemnity Company for services on Board review, not to exceed $667.50. Finally, we approve a client-paid fee for Liberty Northwest for services on Board review, not to exceed $323.

JOHN E. HEADRICK, Claimant
Scheminske & Lyons, Defense Attorneys

WCB TP-88013
September 16, 1988
Third Party Partial Distribution Order

The paying agency has petitioned the Board to resolve a dispute concerning a proposed settlement of a third party action. See ORS 656.587. Should we find the settlement offer reasonable, the third party asserts that the paying agency has failed to establish its entitlement to a lien for anticipated future expenditures. See ORS 656.593(1)(c), (d).

We approve the settlement offer and find that the paying agency is entitled to receive reimbursement for its actual claim costs. However, the paying agency's request to receive reimbursement for future claim costs is deferred as premature.

FINDINGS

In February 1987, while performing his employment duties as a security guard, claimant was involved in a motor vehicle accident. His condition was subsequently diagnosed as lumbosacral strain/sprain and thoraco-cervical strain/sprain. He was released to work, and, in fact, returned to his next scheduled shift after the accident. His claim for "contusions, pinched nerves" was accepted by the paying agency.

In June 1987 claimant's condition was considered medically stationary by Dr. Saalfeld, his treating chiropractor. Finding no permanent impairment, Saalfeld instructed claimant to return for treatments on a "PRN basis." As long as claimant remains involved in heavy work activities, Saalfeld believes that he will require ongoing palliative treatments on a monthly basis.

Claimant and the third party have agreed to settle his potential cause of action for $3,111.32. The paying agency's current lien totals $1,067.73. This sum consists of medical benefits, primarily chiropractic treatments. There is no indication that the claim has been closed, either administratively or through the issuance of a Determination Order.

The paying agency projects reasonably to be expected future medical expenses of $1,584. This projection is based on Dr. Saalfeld's current charges of $44 per monthly visit multiplied by 36 months.

Prior to his compensable low back injury, claimant received chiropractic treatments approximately once every three months. These treatments were apparently related to the extensive walking activities necessitated by his job as a security guard. Following the stabilization of his compensable condition, claimant has received treatments about once a month. However, his work activities have recently changed, resulting in a reduction of his previous extensive walking requirements. Therefore, claimant anticipates that his need for chiropractic treatments will return to its pre-injury level.

We find the settlement offer to be reasonable. We further find that the paying agency is entitled to recover its actual claim costs. Because the claim has not been closed, the reimbursement request for future claim costs is premature.

CONTENTIONS

Contending that claimant will require ongoing monthly palliative chiropractic treatments as long as he continues to perform heavy work activities, the paying agency projects reasonably to be expected future expenditures of $1,584. When these future claim costs are combined with its actual claim costs of $1,067.73, the paying agency's lien totals $2,651.73. Consequently, it refuses to approve any settlement offer which does not result in its retaining a share of the proceeds equal to its entire lien.

The third party contends that the $3,111.32 settlement offer is reasonable. If we concur, the third party further asserts that the paying agency's lien should be limited to its current claim costs.

CONCLUSIONS

Pursuant to ORS 656.587, the Board is authorized to resolve disputes concerning the approval of any compromise of a third party action. In exercising this authority, we employ our independent judgment to determine whether the compromise is reasonable. Natasha D. Lenhart, 38 Van Natta 1496 (1986).

Generally, we will approve settlements negotiated between a claimant/plaintiff and a third party defendant, unless the settlement appears to be grossly unreasonable. Kathryn I. Looney, 39 Van Natta 1140 (1987), Steven B. Lubitz, 39 Van Natta 809 (1987), Virginia Merrill, 35 Van Natta 251 (1983), Rose Hestkind, 35 Van Natta 250 (1983).

After reviewing this record and applying the aforementioned standards, we find the proposed settlement reasonable. Consequently, we approve the settlement offer of $3,111.32.

We turn to the issue concerning the distribution of proceeds from the third party settlement.

When the worker elects to recover damages from the third party, the proceeds of any recovery shall be distributed as set forth in ORS 656.593(1). That is, costs and attorney fees incurred shall be initially disbursed. ORS 656.593(1)(a). Then, the worker shall receive at least 33-1/3 percent of the balance of the recovery. ORS 656.593(1)(b). The paying agency shall be paid and retain the balance of the recovery 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. ORS 656.593(1)(c). Any remaining balance shall be paid to the worker. ORS 656.593(1)(d).

Since claimant incurred neither litigation costs nor attorney fees in reaching this settlement, no disbursement from the settlement proceeds for these expenses will be necessary. See ORS 656.593(1)(a). Thus, claimant shall receive at least 33 1/3 percent of the $3,111.32, or $1,037.11. See ORS 656.593(1)(b). When claimant's initial share is deducted from the settlement proceeds, a balance of $2,074.21 remains.

This remaining balance is subject to the paying agency's lien. See ORS 656.593(1)(c). There is no contention concerning the agency's claim for its actual costs incurred to date. Therefore, we conclude that $1,067.73 of the remaining balance shall be promptly disbursed to the paying agency in reimbursement for its actual claim costs.

Following the disbursement for the paying agency's actual claim costs, the remaining balance of the proceeds from the third party settlement equals $1,006.48. This balance shall be held in trust pending a final determination of the extent of claimant's permanent disability, if any.

We reach this decision because the record fails to establish that the claim has been closed either by means of a notice of closure or through the issuance of a Determination Order. See ORS 656.268(2), (3). Inasmuch as there has not been a final order determining the extent of claimant's disability arising out of his compensable injury, we deem it appropriate to defer ruling on the question of the paying agency's entitlement to a lien for anticipated future expenditures. See John T. Elicker, 40 Van Natta 68 (1988); Robert B. Williams, 37 Van Natta 711 (1985).

Accordingly, the settlement offer of $3,111.32 is approved. Pursuant to ORS 656.593(1)(b) and (3), the third party is directed to disburse $1,037.11 of this amount to claimant. The third party is further directed to disburse $1,067.73 to the paying agency, as reimbursement for its actual claim costs incurred to date. The remaining balance of the proceeds, $1,006.48, shall be held by the third party's counsel in trust pending a final determination concerning the extent of claimant's permanent disability. Upon final resolution of the disability issue and assuming a dispute continues to exist, the parties shall notify the Board of their respective positions. Thereafter, the Board will order distribution of the remaining balance. A

client-paid fee, payable from the third party to its counsel is approved, not to exceed $1,342.

IT IS SO ORDERED.

ALVIN D. HEALON, Claimant
Brian R. Whitehead, Claimant's Attorney
Roberts, et al., Defense Attorneys

WCB 87-07078
September 16, 1988
Second Order of Dismissal

The insurer's counsel seeks reconsideration of that portion of our August 18, 1988 Order of Dismissal that approved a client-paid fee for services rendered in this matter, not to exceed $750. Counsel asserts that we "inadvertently approved a lesser fee" than the $1,250.50 fee requested by his statement of services. In addition, counsel submits a statement of services from another attorney in the firm concerning this case and requests Board approval of those charges.

Our approval of a fee less than that previously requested was not made "inadvertently." Rather, after reviewing the statement of service and retainer agreement, and considering the factors set forth in OAR 438-15-010(6), we found a client-paid fee, not in excess of $750, to be reasonable. Our failure to make specific findings does not mean that the aforementioned analysis was not applied. See Kenneth E. Choquette, 37 Van Natta 927, 928 (1985).

Consequently, on reconsideration, we continue to find a client-paid fee for the first counsel, not to exceed $750, to be reasonable. We turn to the second request for authorization.

After review of the statement of services from the second counsel and the previously submitted retainer agreement, and considering the factors set forth in OAR 438-15-010(6), we approve a client-paid fee to be paid by the insurer to its second counsel, not to exceed $488. In reaching our determination of this reasonable fee, we note that counsel has set forth 2 "estimated additional hours" of "time devoted to case." Inasmuch as this case has been dismissed pursuant to our prior approval of the parties' stipulation, we do not consider such a request to be reasonable. Consequently, that portion of the request has not been approved.

Accordingly, our August 18, 1988 order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our August 18, 1988 order in its entirety. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

ARTHUR M. JENSEN, Claimant
Rasmussen & Henry, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney
Beers, et al., Defense Attorneys

Own Motion No. N/A
September 16, 1988
Denial of Consent to Issuance of Order Designating a Paying Agent (ORS 656.307)

The Compliance Division has notified the Board that it is prepared to issue an order designating a paying agent under ORS 656.307 and OAR 436-60-180. Each of the insurers have provided their written acknowledgment that the only issue is responsibility for claimant's otherwise compensable claim. Claimant's aggravation rights under his EBI claim have expired. Thus, this claim is subject to ORS 656.278.

Pursuant to OAR 438-12-032(3), the Board shall notify the Compliance Division that it consents to the order designating a paying agent, if it finds that the claimant would be entitled to own motion relief if the own motion insurer is the party responsible for payment of compensation. The Board may exercise its own motion jurisdiction if there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. ORS 656.278(1)(a). In such cases, the Board may authorize the payment of temporary disability compensation from the time the worker is actually hospitalized or undergoes outpatient surgery until the worker's condition becomes medically stationary, as determined by the Board. id.

The record fails to establish that there has been a worsening of claimant's compensable injury requiring either inpatient or outpatient surgery or other treatment requiring hospitalization. The evidence also indicates that claimant has retired from the work force as of 1981. Consequently, claimant would not be entitled to own motion relief if the own motion insurer is found responsible for claimant's current condition.

Because the Board presently lacks Own Motion jurisdiction to award temporary disability compensation, it is without authority to consent to an order designating a paying agent. However, since responsibility for claimant's current condition is the only issue in dispute, the Board recommends the issuance of an order designating a paying agent pursuant to ORS 656.307(1)(b) for the payment of claimant's medical services. See OAR 436-60-180(14).

IT IS SO ORDERED.

HARRY A. JOERS, Claimant
Roll, et al., Claimant's Attorneys
Scheminske & Lyons, Defense Attorneys
Acker, et al., Defense Attorneys

WCB 86-16915 & 86-14634
September 16, 1988
Interim Order on Remand

On March 21, 1988, the Board issued an Order on Review in this matter, which, inter alia, affirmed the Referee's evidentiary ruling admitting a certain medical report into evidence and declining to leave the record open for cross-examination of the report's author, despite the author's failure to appear at the hearing as commanded by subpoena. Shortly thereafter, Farmers' Insurance Group requested reconsideration of our order. On April 19, 1988, we abated our order and allowed Liberty Northwest Insurance Corporation an opportunity to respond. Having received Liberty Northwest's response, we proceed to reconsider our Order on Review.

Here, Farmers' attorney submitted his exhibits for inclusion into the record on January 6, 1987. His exhibits did not include Exhibit 4B, which was a medical report that Farmers had previously solicited from Dr. Buttler, a chiropractor. Two days later, Liberty Northwest's attorney requested discovery from Farmers' attorney. On January 16, 1987, Farmers' attorney served Buttler with a subpoena to appear and testify at the upcoming hearing. On January 23, 1987, Liberty Northwest's attorney submitted her exhibits, including Exhibit 4B, for inclusion into the record.

At the hearing, which convened on January 27, 1987, Dr. Buttler failed to appear. Consequently, Farmers' attorney objected to the admission of Exhibit 4B. The Referee overruled

the objection and admitted Exhibit 4B into evidence. At the close of the hearing, Farmers' attorney requested the Referee to leave the record open for cross-examination of Buttler. The Referee declined, however, and closed the record.

Should we determine that a case has been improperly, incompletely, or otherwise insufficiently developed, we may remand to the Hearings Division for further evidence taking, correction, or other necessary action. ORS 656.295(5).

In our view, substantial justice was not achieved by the Referee's refusal to allow Farmers an opportunity to conduct a cross-examination of Dr. Buttler. See ORS 656.283(7). Regardless of whether Farmers initially solicited Exhibit 4B, it lawfully subpoened Buttler in a timely fashion, i.e., eight days before the hearing. Consequently, the Referee's refusal to allow Farmers an opportunity to cross-examine Buttler resulted in an insufficiently developed record. ORS 656.295(5). Remand is, therefore, appropriate.

Accordingly, our Order on Review is hereby vacated and set aside and this case is remanded to the Hearings Division with instructions to allow the insurers an opportunity to conduct their respective examinations of Dr. Buttler. Thus, Farmers' attorney shall be permitted to conduct a cross-examination of Buttler and Liberty Northwest's attorney shall be entitled to a redirect examination. These examinations may be conducted in any manner that will afford substanial justice and ensure a complete and accurate record.

After Dr. Buttler's examinations have been conducted and submitted, the Referee shall provide an interim order on remand, discussing the effect, if any, the additional examinations have had upon his prior order. Once the Board receives the additional examinations, copies will be mailed to the parties and a briefing schedule will be implemented.

IT IS SO ORDERED.

PETER KOLLN, Claimant
Welch, et al., Claimant's Attorneys
Thomas Sheridan (SAIF), Defense Attorney

WCB 88-03244
September 16, 1988
Order of Dismissal

Claimant has requested review of Referee Leahy's order dated July 22, 1988. We have reviewed the request to determine whether we have jurisdiction to consider the matter. We conclude that we lack jurisdiction.

FINDINGS

The Referee's order issued July 22, 1988. Claimant's request for review, contained in a letter carrying a postmark date of August 21, 1988, was received by the Board on August 24, 1988. The request, which was neither mailed by registered nor certified mail, did not include an acknowledgment of service or a certificate of personal service by mail upon the employer, the SAIF Corporation, or its counsel.

On August 25, 1988, the Board mailed a computer-generated letter to the parties acknowledging the request. Receipt of this acknowledgment constitutes the employer's and SAIF's first notice of claimant's request for Board review.

The request for Board review was filed more than 30 days after the Referee's order. Furthermore, neither the employer nor its representatives received notice of the request within 30 days of the date of the Referee's order.

CONCLUSIONS

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). 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. Argonaut Insurance Co. v. King, 63 Or App 847, 852 (1983).

If filing of a request for Board review of a Referee's order is accomplished by mailing, it shall be presumed that the request was mailed on the date shown on a receipt for registered or certified mail bearing the stamp of the United States Postal Service showing the date of mailing. OAR 438-05-046(1)(b). If the request is not mailed by registered or certified mail and the request is actually received by the Board after the date for filing, it shall be presumed that the mailing was untimely unless the filing party establishes that the mailing was timely. Id.

Here, claimant's request for Board review of the Referee's July 22, 1988 order was neither mailed by registered nor certified mail. Since the request was actually received by the Board on August 24, 1988, after the date for filing, it is presumed to be untimely until claimant establishes that the mailing was timely. See OAR 438-05-046(1)(b).

Assuming arguendo that claimant could establish that his request for Board review was timely mailed to the Board, the record suggests that the employer's and SAIF's actual notice of the request for review occurred sometime after the Board mailed its August 25, 1988 acknowledgment letter. Therefore, the record fails to establish that either the employer or its representatives were provided with a copy, or received actual knowledge of, claimant's request for Board review within 30 days of the Referee's July 22, 1988 order.

Under such circumstances, we lack jurisdiction to review the Referee's order, which has become final by operation of law. See ORS 656.289(3); 656.295(2); Argonaut Insurance v. King, supra.

We are mindful that claimant has requested review without benefit of legal representation. We further realize that an unrepresented party is not expected to be familiar with administrative and procedural requirements of the Workers' Compensation Law. Yet, we are not free to relax a jurisdictional requirement, particularly in view of Argonaut Insurance Co. v. King, supra. See 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.

WILLIAM L. McARTHUR, Claimant
Michael B. Dye, Claimant's Attorney
Garrett, et al., Defense Attorneys

WCB 87-01260
September 16, 1988
Order on Review

Reviewed by Board Members Johnson and Crider.

The insurer requests review of Referee Holtan's order that assessed a penalty and associated attorney fee for late payment of temporary total disability.

ISSUE

On review, the issue is penalties and attorney fees.

FINDINGS

We adopt the findings of fact contained in the "Findings and Opinion" section of the Referee's order.

CONCLUSIONS AND OPINION

We affirm the Referee's order, as supplemented by the following discussion of the applicable law.

If an insurer unreasonably delays payment of temporary disability benefits, it is liable for an additional amount, up to 25 percent of the benefits then due, plus a reasonable attorney fee. See ORS 656.262(10) and 656.382(1). A penalty for late payment of temporary disability is assessed against the entire amount due and not just against the amount due for days beyond the 14 day grace period. Catherine A. Medina, 39 Van Natta 384 (1987).

An insurer must pay temporary disability compensation ordered by a referee within 14 days of the issuance of the order, regardless of whether it believes that the order is legally or factually correct. ORS 656.262(4); OAR 436-60-150(3)(e); Hutchinson v. Louisiana Pacific, 67 Or App 577, 581 (1984). The duty to pay the awarded compensation arises immediately from the referee's order. That duty is not stayed pending a request for reconsideration of the order, and it continues until the order is abated by the referee or reversed by the Board or the courts. ORS 656.313(1); Hutchinson, supra., at f.n. 4; cf. Benjamin G. Parker, 38 Van Natta 836, 837 (1987) (Board order not stayed pending order on reconsideration). Moreover, a subsequent order of abatement does not retroactively extinguish the insurer's duty to pay benefits due and owing on the date of the abatement. Hutchinson, supra.; cf. Georgia-Pacific Corporation v. Piwowar, 86 Or App 82, at 86 (1987), aff'd, 305 Or 494 (1988) (subsequent reversal of award by determination order does not extinguish duty to pay compensation due and unpaid under the determination order on the date of the reversal).

We note that claimant's attorney is not entitled to an insurer-paid fee on Board review for prevailing on the penalty and attorney fee issue. Penalties and attorney fees are not "compensation" within the meaning of ORS 656.382(2). See Saxton v. SAIF, 80 Or App 631 (1986); Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

Finally, the insurer's attorney has requested that the Board approve a client-paid fee for services on Board review in

the amount of $729. In determining a reasonable attorney fee in this case, we have considered the factors set forth in OAR 438-15-010(6). In particular, we note that the insurer's attorney did not succeed in overturning the Referee's order on Board review. Moreover, the basic argument presented in its brief was not relevant to the issue on review. Accordingly, we conclude that a client-paid fee of $350 adequately compensates the insurer's attorney for services on Board review.

ORDER

The Referee's order dated December 4, 1987 is affirmed. The Board approves a client-paid fee for the insurer's attorney not to exceed $350.

DAVID F. PALKI, Claimant
Michael M. Bruce, Claimant's Attorney
Brian L. Pocock, Defense Attorney

WCB 85-04994
September 16, 1988
Order on Review

Reviewed by Board Members Crider and Johnson.

Claimant requests review of that portion of Referee Nichols' order that increased her unscheduled permanent disability award for a low back condition from 30 percent (96 degrees), as awarded by Determination Order, to 50 percent (160 degrees). On review, the issue is extent of unscheduled permanent disability.

We modify.

FINDINGS OF FACT

We adopt the findings of fact in the "Summary of Evidence" section of the Referee's order, with the following additional findings.

Claimant has a substantial degree of disabling pain which increases with activity. In particular, he cannot remain on his feet for extended periods of time, and experiences constant low back pain which increases at the end of the day and escalates to severe if he bends or twists too quickly. His pain severely restricts his recreational activities and his ability to do chores around his home, including general repairs, gathering firewood and hauling trash.

Claimant's vocational counselor identified various transferable work skills. Claimant chose to forego vocational assistance in favor of returning to college to earn a college degree. However, he was forced to discontinue his schooling because he was unable to tolerate sitting through classes. Claimant currently works for a few hours each day as an assistant high school baseball coach.

Claimant has sustained moderately severe permanent partial disability as a result of his compensable back injury. His impairment prevents him from returning to his job at injury or any other job he has performed in the past. He is, instead, restricted to light work which allows him to change positions frequently and avoid bending, squatting, climbing, kneeling or twisting. Moreover, he is capable of performing such light work for no more than four hours each day, on a good day.

CONCLUSIONS OF LAW AND OPINION

The amount of claimant's unscheduled permanent partial disability is based on loss of earning capacity due to his compensable back injury, as reflected by his physical impairment and relevant social and vocational factors. See ORS 656.214(5); OAR 436-30-380 et seq.

The record contains ratings of claimant's physical impairment from Dr. Davis, the treating physician, and Southern Oregon Pain Center. The latter rating was performed prior to claimant's increased symptoms and surgery in January 1986, whereas Dr. Davis' evaluation was performed in October 1986 after claimant had become medically stationary following surgery. Accordingly, we find that Dr. Davis' rating provides the more reliable evaluation of claimant's permanent disability.

Dr. Davis rated claimant's permanent disability as moderate to severe. This evaluation is consistent with claimant's credible testimony of substantial disabling pain which increases with activity. After considering Dr. Davis' opinion and claimant's testimony, we are persuaded that he has sustained a moderately severe degree of physical impairment as a result of his back injury.

In addition to this physical impairment, we also consider relevant social and vocational factors. Claimant is only 34 years of age and has some transferable skills. However, Dr. Davis has permanently restricted him to light work allowing frequent change of positions and no bending, squatting, climbing, kneeling or twisting. As a result, claimant is no longer able to perform his job at injury or any job he has held in the past. In addition, Dr. Davis further opined that claimant was only capable of working a maximum of four hours per day, on a good day.

After considering all of the factors discussed above, we conclude that an award of 70 percent unscheduled permanent disability adequately compensates claimant for his low back injury. Accordingly, we modify the Referee's order and award claimant an additional 20 percent unscheduled permanent disability.

ORDER

The Referee's order dated July 1, 1987 is modified. In addition to the 30 percent (96 degrees) unscheduled permanent disability awarded by Determination Order and the 20 percent (64 degrees) awarded by the Referee, claimant is awarded 20 percent (64 degrees) unscheduled permanent disability, for a total award of 70 percent (224 degrees) for his back injury. Claimant's attorney is awarded a fee of 25 percent of the increase in compensation due claimant as a result of this order, to be paid from said increase. However, the total of this fee and any fee awarded at hearing regarding this issue shall not exceed $3,800. We approve a client-paid fee for the self-insured employer's attorney, not exceeding $500.

EMMA SMITH, Claimant
Vick & Gutzler, Claimant's Attorneys
Cummins, et al., Defense Attorneys

WCB 87-02224
September 16, 1988
Order on Review

Reviewed by Board Members Crider and Johnson.

The self-insured employer requests review of that portion of Referee Leahy's order which: (1) set aside its preclosure denial of further chiropractic treatment for claimant's low back condition. The issues raised by the employer on review are: (1) the Referee's interpretation of its denial; and (2) whether claimant proved her chiropractic treatments were reasonable and necessary. In her brief, claimant contends that the Referee erred in declining to assess a penalty for an alleged unreasonable denial.

FINDINGS OF FACT

Claimant, 58 at hearing, is a long-haul truck driver. She suffered a back strain on September 3, 1983, while lifting boxes. She filed a claim which was accepted by the employer as nondisabling.

Claimant initially treated with Dr. Neal, internist, who prescribed medication. On September 24, 1983, she began treating with Dr. Pettigrew, chiropractor. Both diagnosed back strain.

Claimant continued regular treatments with Dr. Pettigrew, and also saw other chiropractors as she drove across the country. In April 1985, claimant changed treating chiropractors and began treating with Dr. Lumsden. She saw him twice per week from April to September 1985, and then about once per week until June 1987. Treatments were for low back pain, and neck pain which resulted in headaches.

Claimant has not worked full time since November 1983.

On December 10, 1986, the Independant Chiropractic Consultants (ICC) performed an independent medical examination. On January 6, 1987, the employer denied responsibility for further chiropractic treatments, stating that her pain was no longer attributable to her 1983 injury. This conclusion was based on the report from ICC.

CONCLUSIONS OF LAW AND OPINION

The Referee decided that the employer denied compensability. The employer disagrees, contending that it denied only the reasonableness and necessity of further chiropractic treatments. We read the employer's denial to cover more than reasonableness and necessity of further treatments. It denies compensability by denying all current and future treatment for her condition.

A partial denial of a previously accepted inseparable condition, issued while the claim is still in open status, is impermissible. Guerrero v. Stayton Canning Co., 92 Or App 209 (July 20,1988); Roller v. Weyerhaeuser, 67 Or App 583 (1984); Safstrom v. Riedel International, 65 Or App 728 (1983). It may be that the industrial injury has resolved. However, the unilateral termination of medical services on the ground that claimant's need for treatment is unrelated to the industrial exposure is, "de

facto," claim closure. The claim cannot be closed except by closure as outlined in ORS 656.268. The employer's denial does not suffice as a statutory notice of claim closure. Consequently, the denial is set aside and the claim is remanded to the employer for processing according to law. Roller v. Weyerhaeuser, supra.

Claimant requests penalties for the employer's alleged unreasonable denial of medical benefits. Notwithstanding the persuasive reasoning expressed by ICC, the employer's preclosure denial was impermissible. Therefore, we assess a penalty of 25 percent of claimant's bills for chiropractic services from January 6, 1987, the date of the employer's invalid denial, through July 7, 1987, the date of hearing.

ORDER

The Referee's order dated July 13, 1987 is affirmed and modified. The self-insured employer is assessed a penalty for an invalid preclosure denial equal to 25 percent of the bills for claimant's chiropractic treatments due between January 6, 1987 and July 7, 1987. The remainder of the Referee's order is affirmed. Claimant's attorney is awarded an assessed fee of $1,100 for services on Board review, to be paid by the employer. The Board approves a client-paid fee not to exceed $204.50.

DARRELL E. BREYMIER, Claimant
Neal H. Douglas and Roger A. Hennagin, dba, NEAL DOUGLAS TRUCKING, Employer
Samuel A. Hall, Jr., Claimant's Attorney
Lester Huntsinger (SAIF), Defense Attorney

WCB 86-11667
September 19, 1988
Order on Review

Reviewed by Board Members Crider and Ferris.

Claimant requests review of Referee Galton's order that: (1) denied claimant's motion to dismiss the noncomplying employer's request for hearing on timeliness grounds; and (2) set aside the SAIF Corporation's Notice of Claim acceptance, on behalf of the noncomplying employer. We reverse.

ISSUE

1. Compensability of claimant's injury claim.

FINDINGS OF FACT

On December 24, 1985, claimant was driving a truck with two loaded trailers for his employer. While maneuvering through a sweeping curve on an icy road, the rear trailer lost traction. The truck slid through an underpass, off the side of the road and tore out 70 feet of guard rail before abruptly coming to a stop. Damage to the tractor was minor. Damage to the trailers included a bent tongue on the conversion gear between the trailers, a severed landing gear, and two to three destroyed tire rims. The impact of the trailers with the guard rail caused a substantial jolt to the tractor.

Prior to the December 24, 1985 accident, claimant had never received medical treatment for back pain. In May 1985, claimant complained to his employer that the truck seat was causing him low back pain. As a result, the employer installed an air seat. Thereafter, claimant's back pain resolved without medical treatment. He was symptom free between May 1985 and December 1985.

Following the December 24, 1985 accident, claimant did not immediately develop symptoms. He gradually felt increasing pain in his low back coupled with a tingling down the left leg. By January 1, 1986, claimant's physical activity was substantially limited due to low back pain.

Claimant began treating with Dr. Rendleman, who diagnosed lower back strain/sprain with possible disc herniation. Based on claimant's description of the accident, he found the condition to be work related.

The employer had personal knowledge of claimant's intent to file a workers' compensation claim on or about January 12, 1986. Claimant filed a claim on January 15, 1986.

On April 11, 1986, the Department issued a Proposed and Final Order finding the employer to be noncomplying from March 3, 1985 to March 31, 1986. The noncomplying employer did not appeal that order. The claim was subsequently forwarded to SAIF for processing.

On June 13, 1986, SAIF mailed copies of its Notice of Claim acceptance to claimant and the employer. The employer was informed by SAIF that if he believed claimant did not sustain a compensable injury while in his employ, he had the right to request a hearing. SAIF's notice said that the request needed to be directed in writing to the Workers' Compensation Board within 60 days of the June 13 letter.

On July 25, 1986, the employer mailed a letter to SAIF formally requesting a hearing. That request was received by SAIF on August 4, 1986. SAIF forwarded the hearing request to the Board, which received it on August 22, 1986. Claimant did not receive a copy of that request for hearing.

The noncomplying employer never mailed to claimant a denial of his injury claim; nor did the noncomplying employer ever advise claimant of his statutory rights to appeal such a denial.

CONCLUSIONS OF LAW

The Referee overruled claimant's objection to the employer's hearing request on timeliness grounds, reasoning that it was SAIF's obligation to forward the employer's misdirected hearing request to the Board and, therefore, that timely receipt by SAIF constituted timely receipt by the Board.

Turning to the merits, the Referee found claimant's claim not compensable. The basis for his finding was a combination of claimant's lack of credibility and the employer's "complete" credibility. He reasoned that the medical evidence, which established a causal connection between the December 24, 1985 accident and claimant's back condition, was not persuasive since it was based on the "unreliable" history given by claimant. The Referee further found that, despite any medical evidence to support its case for noncompensability, the employer had still carried its burden of proof by a "significant preponderance of evidence."

We disagree with the Referee's reasoning and reverse. Subsequent to the issuance of the Referee's order, the Court of Appeals issued its decision in Derryberry v. Dokey, 91 Or App 533

(1988). In light of the Derryberry decision, we decline to address either the issue of the timeliness of the noncomplying employer's appeal of SAIF's acceptance or the compensability of claimant's injury claim on the merits.

A denial must, inter alia, inform the claimant of hearing rights and be mailed to the claimant. Former ORS 656.262(8). In Derryberry v. Dokey, supra at 536, the noncomplying employer mailed a letter to the Workers' Compensation Department requesting a hearing on the issues of whether they were complying employers, whether claimant was a subject worker and the compensability of the claim. That letter was never sent to either SAIF or the claimant. Id. At hearing, the noncomplying employer asserted that this letter to the Department denied claimant's claim. Id. However, since the letter made no mention of hearing rights and was never mailed to claimant, it was not a denial. Id. at 537. The court found that since SAIF properly accepted the claim and no party had ever properly denied it, claimant was entitled to compensation. Id.

In the present case, the facts are similar. In a letter to SAIF dated July 25, 1986, which was forwarded to the Workers' Compensation Board and received by it on August 22, 1986, the noncomplying employer requested a hearing on the issue of the compensability of claimant's injury claim. As in Derryberry v. Dokey, supra, that letter was not sent to claimant. Since the letter made no mention of hearing rights and, so far as the record reveals, was never mailed to claimant, it was not a denial. Because SAIF properly accepted the claim and no party ever properly denied it, claimant is entitled to compensation.

ORDER

The Referee's order dated May 15, 1987 is reversed. The SAIF Corporation's Notice of Claim acceptance is reinstated and the claim is remanded to SAIF for processing according to law. Claimant's attorney is awarded an assessed fee of $1,700 for his services at hearing and on Board review, to be paid by the SAIF Corporation on behalf of the noncomplying employer.

DONALD HOWELL, Claimant
Doblie & Associates, Claimant's Attorneys
Cowling & Heysell, Defense Attorneys

Own Motion 88-0357M
September 19, 1988
Consent to Issuance of Order Designating a Paying Agent (ORS 656.307)

The Compliance Division has notified the Board that it is prepared to issue an order designating a paying agent under ORS 656.307 and OAR 436-60-180. Each of the employers/insurers have provided their written acknowledgment that the only issue is responsibility for claimant's otherwise compensable claim. Claimant's aggravation rights under his claim with Industrial Indemnity have expired. Thus, that claim is subject to ORS 656.278.

Pursuant to OAR 438-12-032(3), the Board shall notify the Compliance Division that it consents to the order designating a paying agent, if it finds that the claimant would be entitled to own motion relief if the own motion insurer is the party responsible for payment of compensation. The Board may exercise its own motion jurisdiction if there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment

requiring hospitalization. ORS 656.278(1)(a). In such cases, the Board may authorize the payment of temporary disability compensation from the time the worker is actually hospitalized or undergoes outpatient surgery until the worker's condition becomes medically stationary, as determined by the Board. id.

The record establishes that there has been a worsening of claimant's compensable injury requiring either inpatient or outpatient surgery or other treatment requiring hospitalization. Inasmuch as claimant would be entitled to own motion relief from May 5, 1988 if the own motion insurer is found responsible for claimant's current condition, the Board consents to the order designating a paying agent. Furthermore, for the purposes of ORS 656.625 and OAR 436, Division 45, this consent constitutes an order reopening a claim under ORS 656.278 and the Board's rules if the designated paying agent is an own motion insurer. See OAR 438-12-032(3).

CORNELIA V. WATSON, Claimant
Roll, et al., Claimant's Attorneys
Thomas Sheridan (SAIF), Defense Attorney

WCB 86-01248
September 19, 1988
Order on Review

Reviewed by Board Members Ferris and Crider.

Claimant requests review of Referee Fink's order that: (1) declined to grant permanent total disability; and (2) increased claimant's unscheduled permanent disability award for a low back and hip injury from 40 percent (128 degrees), as awarded by a Determination Order, to 60 percent (192 degrees). We affirm.

ISSUES

1. Whether claimant is permanently totally disabled.

2. If claimant is not permanently totally disabled, whether claimant is entitled to an increased award of permanent partial disability.

FINDINGS OF FACT

Claimant, 48 years old as of the date of hearing, is a Philippine national who has lived in this country for 10 to 15 years. She was compensably injured on November 9, 1984, while working as a cherry sorter on a seasonal basis. Her injury occurred when she fell from a wooden platform landing on her back and left hip. She reported pain in her low back, left buttock, left hip and left leg. Her treating physician was Dr. Schwartz, orthopedic surgeon. He diagnosed sciatica and strain of the left hip. His treatment throughout her claim has been conservative in nature.

Claimant was enrolled in the Northwest Pain Center during the summer of 1985. She benefited only minimally from the program.

Dr. Schwartz released claimant to return to light-duty work in February 1986. She worked for two hours before complaints of pain caused her to quit. Her work site was subsequently modified by the addition of a nonslip rubber comfort mat, a special orthopedic chair, and special shoes. She attempted to return to work again in January 1987. She terminated this attempt after one-half hour due to complaints of pain.

In August 1986, Dr. Schwartz reported that claimant could sit for up to two hours at a time or six total hours in a day; that she could stand for one-half hour at a time or one hour in a day; that she could walk for one-half hour at a time or one hour in a day; and that she could lift up to 10 pounds frequently and 10 to 20 pounds occasionally.

By the date of hearing, claimant was also complaining of upper back, left arm and chest pain. She has been seen in the hospital emergency room several times due to temporary symptomatic exacerbations.

Claimant was examined by Dr. Wittkopp, psychiatrist, in March 1985 and by Dr. Campbell, psychologist, in July 1986. Claimant has a histrionic personality with dependent features. Her present psychological condition was not caused by her compensable injury.

Testing indicates that claimant has low average or deficit intellectual functioning. She is illiterate in both English and her native language.

In addition to work as a cherry sorter, claimant has worked as a tree planter. Due to her injury, she is no longer able to perform tree planting work. She is now capable of performing only light or sedentary work activities. Her impairment as a result of the compensable injury is in the mild to mildly moderate range.

Claimant is not a credible witness.

CONCLUSIONS OF LAW AND OPINION

Permanent Total Disability

Permanent total disability can be established by proving total incapacity from a medical standpoint alone, or where medical incapacity is not total, by proving permanent total disability based upon the worker's less-than-total impairment combined with such nonmedical factors as age, education, adaptability, emotional conditions, and the state of the labor market. Wilson v. Weyerhaeuser, 30 Or App 403, 409 (1977).

Claimant alleges physical complaints which, if accurate, are sufficient to support a finding of total incapacity based upon such physical factors alone. However, the Referee concluded that claimant was not a credible witness. His credibility evaluation was based upon observation of claimant. Generally, in exercising de novo review, we defer to the Referee's determination of credibility due to the Referee's opportunity to observe the witness. Humphrey v. SAIF, 58 Or App 360, 363 (1982). We do so here. Cf. Avalos v. Bowyer, 89 Or App 546 (1988).

The Referee also concluded that there existed a paucity of objective findings to support claimant's physical complaints. We agree. Dr. Schwartz reported that, based solely upon the objective findings, claimant was not permanently incapacitated from performing regular work. He imposed physical restrictions which would allow claimant to perform light or sedentary work. The Northwest Pain Center found that claimant was physically capable of carrying on sedentary to light-work activity. Considering Dr. Schwartz' recommended restrictions and the report

by the Northwest Pain Center physicians, we are persuaded that claimant is capable of performing light or sedentary work. We conclude that claimant is not permanently totally disabled based upon medical factors alone.

Turning to an "odd-lot" analysis, claimant has the burden of proving that she is unemployable at even light or sedentary jobs, given the nonmedical factors present in her case. Welch v. Banister Pipeline, 70 Or App 699, 701 (1984). In this regard, claimant's narrow work history, her limited education and her reduced intellectual capabilities weigh in favor of a finding of permanent total disability. At the same time, however, her treating physician has released her to return to her regular work. Further, no medical opinion suggests that claimant is physically unable to resume her former employment or other similar work.

We acknowledge that claimant unsuccessfully attempted to return to work. We are unpersuaded, however, that she is unable to return to her regular work or other similar work, notwithstanding her two brief return-to-work attempts. As reported by Dr. Schwartz after he learned of her failed return-to-work attempts:

> "When I released this patient to work to the present job description, essentially I was stating that I saw no physical reason that she could not try to work at that position. I had no great expectations of her trying to be able to do it."

The record indicates that the employer offered to install a cot at claimant's work site so that claimant could lie down to rest when necessary. However, claimant did not return to work. Again, as reported by Dr. Schwartz:

> "I cannot think of any more adjustments or changes in her job description or the environment of her work place that would make the likelihood of her return any greater. I feel that [the employer] has gone out of their way in an attempt to keep this patient gainfully employed. I feel this patient is never going to be able to be gainfully employed....More plainly put, I think this patient views herself as being unable to work and therefore is unable to work."

A claimant who seeks benefits for permanent total disability must establish that she is willing to seek regular gainful employment and has made reasonable efforts to do so. ORS 656.206(3). Here, claimant's asserted belief that she hurts too much to return to work is neither credible nor supported by the medical reports. See Willamette Poultry Co. v. Wilson, 60 Or App 755, 760-61 (1982). We conclude that claimant has not made reasonable efforts to return to her regular work or other similar work on either a full-time or part-time basis.

Permanent Partial Disability

The criterion for rating unscheduled permanent

disability is the permanent loss of earning capacity due to the compensable injury or condition. ORS 656.214(5). In determining the loss of earning capacity, we consider medical and lay evidence of physical impairment resulting from the compensable injury 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. Harwell v. Argonaut Insurance Co., 296 Or 505, 510 (1984); Fraijo v. Fred N. Bay News Co., 59 Or App 260, 269 (1982).

Dr. Stewart, orthopedic surgeon, examined claimant in October 1985 and reported that her impairment was minimal. Dr. Schwartz indicated his concurrence with this report. However, the fact that Dr. Schwartz restricted claimant from sitting or standing more than one-half hour at a time and from lifting more than 20 pounds indicates a greater than minimal impairment. We are more persuaded by Dr. Schwartz' particular activity restrictions than we are by his "check-the-box" concurrence with Dr. Stewart's report. We conclude that claimant's impairment is mildly moderate. Claimant's age, limited education, work history, and low to deficit mental capacity all adversely affect her earning capacity. After considering these factors, we conclude that the 60 percent (192 degrees) awarded by the Referee adequately compensates claimant for her compensable injury.

ORDER

The Referee's order dated May 13, 1987 is affirmed.

KENNETH J. GRAVES, Claimant
Robert Chapman, Claimant's Attorney
Chuck Lisle (SAIF), Defense Attorney

WCB 86-17021
September 20, 1988
Order on Review

Reviewed by Board Members Ferris and Johnson.

Claimant requests review of Referee Mongrain's order that: (1) affirmed a Determination Order which awarded him 20 percent (64 degrees) unscheduled permanent disability for his back condition; (2) denied his request for travel expenses to attend the hearing; and (3) refused claimant's motion to hold the record open for receipt of additional evidence. On review, the issues are reimbursement of expenses extent and admission of evidence. We affirm.

FINDINGS OF FACT

Claimant, 60, was employed as a heavy truck mechanic when he sustained a compensable low back injury in May, 1986. He was treated by Dr. Campagna, neurosurgeon, who diagnosed a herniated L4 disc, with secondary nerve root compression at L5. Claimant had surgery on June 2, 1986 to remove the L4 disc.

Claimant's symptoms improved following surgery. Dr. Campagna reported claimant's range of motion in his back was normal, with no weakness or atrophy. He opined that claimant was recovering satisfactorily, and anticipated releasing claimant to return to work in early September.

Claimant continued to have back and leg pain with activity, however, and consulted Dr. Dunn, neurosurgeon, in August

1986. Dr. Dunn prescribed physical therapy, and ordered a CT scan. The physical therapy improved claimant's symptoms. The CT scan showed a protrusion at L5-S1, for which Dr. Dunn recommended a chemonucleolysis procedure. Claimant decided to forego the procedure. Dr. Dunn then reported on September 25, 1986 that claimant was medically stationary and his claim could be closed. Dr. Dunn further opined that claimant could "return to employment."

Claimant moved to Honolulu, Hawaii in October 1986. Before the SAIF Corporation was aware of claimant's decision to move, his case was referred for vocational assistance. Claimant's employer agreed to rehire him for either his regular position or light duty. Following claimant's relocation, his vocational file was closed, and a Determination Order issued on November 18, 1986. Claimant was awarded 20 percent (64 degrees) unscheduled permanent disability.

Claimant was examined once in Honolulu by Dr. Taniguchi, a neurosurgeon to whom he had been referred by Dr. Dunn. Dr. Taniguchi reported claimant had low back and leg ache with exertion, but that it was tolerable. Claimant was more concerned about a problem of leg weakness, for which Dr. Taniguchi referred him to an orthopedist.

In Hawaii, claimant applied for a number of jobs, including security guard, maintenance worker, stock clerk, and forklift and truck mechanic.

Claimant returned from Hawaii to Medford to attend his June 1987 hearing. When he returned, he was examined by Dr. Dunn, who completed a physical capacities evaluation. This report was not completed before the hearing.

Claimant has a 12th grade education, and has worked virtually all of his adult life as a heavy duty mechanic on buses and trucks. This work involved heavy lifting, as well as lying on a "creeper" under the vehicles. Claimant is no longer capable of either activity.

The evidence indicates that a 20 percent unscheduled permanent disability award appropriately compensates claimant for the permanent loss of earning capacity attributable to his compensable injury.

CONCLUSIONS OF LAW AND OPINION

The Referee denied claimant's request for reimbursement of travel expenses to the hearing. Claimant cited OAR 436-60-070(2)(b) in support of his request. That rule provides:

> "(1) The worker shall be notified at the time of claim acceptance that travel, prescriptions and other compensable injury related services paid by the worker will be reimbursed by the insurer upon request.
>
> "(2) For the purpose of this rule:
> . . . . .
> "(b) meals, lodging, public transportation or use of a private vehicle required to . . . collect compensation benefits . . . shall be deemed in compliance with this section. . ."

We hold that claimant's costs in attending a workers' compensation hearing scheduled at his request is not a "compensable injury related service." The act of attending a contested case hearing is a matter concerning litigation. Unless there is a specific requirement to the contrary, costs of litigation are to be borne by the parties. In this case, claimant requested a hearing which presumably was set in the county in which he resided at injury. See ORS 656.283(5). His subsequent move to Hawaii was an act of his own volition, beyond the control of SAIF or the employer. We affirm the Referee on this issue.

On the issue of extent of disability, the Referee found that claimant had not proven that he has suffered a greater loss of earning capacity than that represented by the 20 percent awarded by Determination Order. We agree.

There is no medical report in the record which expressly evaluates claimant's residual capacity or rates his impairment. However, Dr. Dunn, his treating physician, released him to "return to employment," without elaboration. Dr. Taniguchi did not disagree with Dr. Dunn's assessment. The reports are not specific, but they can be read as suggestive of impairment.

A physician's report is not absolutely necessary. The worker's testimony may (or may not) carry the worker's burden of proving the extent of his disability. Garbutt v. SAIF, 297 Or 148 (1984). In this case, claimant's testimony is not extensive, but it does indicate that he has permanent impairment. He testified that he thought he would be capable of carrying a 10-25 pound bag of groceries approximately half a block before the onset of pain symptoms. He also testified that he would have difficulty doing the heavy mechanics necessary in the job at injury, primarily because the employer did not have hydraulic lifts for the vehicles. As a result, it was necessary for claimant to recline on a "creeper" and work under the vehicles. Claimant felt that the position, and the loss of leverage when working at that angle, would be too much for him.

On the other hand, claimant has been looking for work since he moved to Hawaii. He testified that the kinds of jobs he had been applying for include forklift and truck mechanic. The record is devoid of any evidence whether the work conditions were enough different that claimant would be able to do those jobs, or otherwise resolving this inconsistency in claimant's testimony.

In rating the extent of claimant's unscheduled disability, we consider the medical and lay evidence of his physical impairment from the injury, and all the relevant social and vocational factors set forth in OAR 436-36-380 et seq. We apply these rules as guidelines only. Harwell v. Argonaut Ins., 296 Or 505 (1984). Following our de novo review of the evidence, including claimant's testimony, we are persuaded that claimant's compensable injury has resulted in permanent impairment as well as a permanent loss of earning capacity. After considering the aforementioned guidelines, we conclude that 20 percent unscheduled permanent partial disability adequately compensates claimant for his low back condition.

The Referee denied claimant's motion to hold the hearing open to receive a report and physical capacities evaluation from Dr. Dunn. We affirm. Claimant requested the initial hearing on extent of disability. He was aware of what the evidence,

including his doctor's reports, indicated. While it was not feasible to return to Dr. Dunn for an evaluation because of his move to Hawaii, claimant could have obtained an evaluation and impairment rating from another doctor, for timely submission into the record. The Referee's decision was appropriate to achieve substantial justice. The late exhibits were not considered on review.

ORDER

The Referee's order dated July 30, 1987 is affirmed.

JOHN C. HANSEN, Claimant
Michael B. Dye, Claimant's Attorney
Schwabe, et al., Defense Attorneys

WCB 86-13107
September 20, 1988
Order on Review

Reviewed by Board Members Johnson and Ferris.

Claimant requests review of Referee Holtan's order that: (1) upheld the insurer's partial denial of claimant's medical services claim for chiropractic treatment of a low back condition in excess of the Medical Director's guidelines; and (2) declined to assess a penalty and attorney fee for the insurer's alleged unreasonable denial of that claim.

ISSUES

On review, the issues are medical services, penalties and attorney fees.

FINDINGS

We adopt the findings of fact included in the "Background" section of the Referee's order, with the exception of his finding regarding the onset of claimant's left leg pain. We make the following additional findings.

Claimant was an essentially credible witness but had a poor memory regarding his symptomatic history and treatment.

Claimant had no back problems prior to the onset of his symptoms in June 1985. At that time, he had been working as a framer for the employer for three years.

Chiropractor DeShaw has treated claimant for his back problems on a regular basis since February 1986. Prior to 1987, claimant received scheduled treatments 10 to 15 times per month. Since early 1987, he has received scheduled treatments eight times per month.

Claimant was laid off from his job at injury in March 1986 and remained unemployed for several months. In June 1986, he began a new job for a different employer which required him to stand all day, stoop and bend while he operated a paint spray gun.

Claimant's low back and left leg pain significantly decreased during his period of unemployment in 1985. After returning to work, he experienced a work-related exacerbation of these symptoms in August 1986, along with new pain in his left leg. His condition improved after a week off, but his low back pain increased when he returned to work.

At the time of the insurer's denial in September 1986, claimant was experiencing intermittent low back and bilateral leg pain. Subsequent diagnostic tests performed in October 1986 demonstrated two small posterior lumbar disc protrusions. These studies were interpreted as essentially normal by the consulting radiologist.

Claimant has continued to experience roughly the same degree of waxing and waning low back pain throughout the course of his treatment with Dr. DeShaw. Dr. DeShaw's treatments provide some temporary relief of his symptoms. Until recently, the effects of the treatments have lasted two to three days. Several months prior to hearing the effects began lasting a week to 10 days.

After de novo review of the record, we find that claimant has no significant objective findings of neurological or orthopedic impairment. Furthermore, we are not persuaded that the additional treatments provided by Dr. DeShaw materially contributed to the resolution of claimant's leg pain. Neither are we persuaded that those additional treatments provided any overall improvement in his back condition or were necessary to enable claimant to continue working.

CONCLUSIONS AND OPINION

The Referee concluded that treatment from Dr. DeShaw, in excess of two per month, was not reasonable and necessary. Accordingly, he upheld the insurer's denial and declined to award a penalty and attorney fee.

After de novo review of the record, we affirm the order of the Referee, as supplemented by the following discussion of applicable legal principles.

A claimant is entitled to all reasonable and necessary curative or palliative medical care required for recovery from a compensable injury or for relief of pain. See ORS 656.245(1); West v. SAIF, 74 Or App 317, 320 (1985); Wetzel v. Goodwin Bros., 50 Or App 101, (1981); McGarry v. SAIF, 24 Or App 883, 888 (1976). For example, palliative chiropractic treatment, on an as-needed basis, is compensable where it is necessary to relieve severe pain and permit claimant to work. West v. SAIF, supra, 320-21. Claimant has the burden of proving that the treatment is reasonable and necessary. McGarry v. SAIF, supra.

In determining what is reasonable and necessary, the Board may consider the frequency of treatment. James v. Kemper Ins. Co., 81 Or App 80 (1986); Stephen C. Marr, 38 Van Natta 1304 (1986). Guidelines issued by the Workers' Compensation Division identify two visits per month, after the initial 60 days, as the usual frequency of medical services. OAR 436-10-040(2)(a). However, a claimant is entitled to treatment in excess of the administrative guidelines if he or she proves that the treatment is necessary to the process of recovery. James v. Kemper, supra, 82-84; West v. SAIF, supra, 320; Kemp v. Worker's Comp. Dept., 65 Or App 659, 669 (1983), modified, 67 Or App 270, rev den 297 Or 227 (1984).

Although the Board generally gives greater weight to the conclusions of a treating physician, it will not so defer when there are persuasive reasons to do otherwise. Weiland v. SAIF, 64 Or App 810, 814 (1983); Nancy E. Cudaback, 37 Van Natta 1580,

withdrawn on other grounds 37 Van Natta 1596 (1985), republished 38 Van Natta 423 (1986).

ORDER

The Referee's order dated June 9, 1987 is affirmed. Client-paid fee, not to exceed $362, is approved.

Board Member Crider, dissenting:

I dissent from that portion of the Board s order which affirms a denial of chiropractic treatment which is purely prospective in nature.

Claimant received a course of chiropractic treatment for his back. On September 12, 1986, the insurer issued a denial which stated that "As to (sic) this date of this letter we are only being responsible for payment of only two visits per month." The insurer paid for chiropractic treatments through the date of the denial but, relying on the denial, refused to pay for them thereafter.

The denial is void and should be set aside. As the majority declines to do so, I dissent for the reasons stated in my dissenting opinion in June Jelen, 40 Van Natta 1175 (WCB No. 87-03457, issued this date).

JUNE JELEN, Claimant
Emmons, et al., Claimant's Attorneys
Acker, et al., Defense Attorneys

WCB 87-03457
September 20, 1988
Order on Review

Reviewed by Board Members Ferris and Johnson.

Claimant requests review of Referee Brazeau's order that: (1) upheld the insurer's denial of claimant's chiropractic treatments in excess of two visits per month; (2) declined to assess penalties and attorney fees for the insurer's alleged unreasonable denial; and (3) declined to award additional temporary disability compensation. On review the issues are frequency of chiropractic treatments; penalties and attorney fees; and temporary disability compensation.

The Board affirms and adopts the order of the Referee.

ORDER

The Referee's order dated October 13, 1987 is affirmed. A client-paid fee, not to exceed $646, is approved.

Board Member Crider, dissenting:

I dissent from that portion of the Board's order which affirms a denial of chiropractic treatment which is purely prospective in nature.

Claimant suffered injury to her back on July 16, 1986 and began treating with a chiropractor. She filed a workers' compensation claim. On October 31, 1986, the insurer accepted the claim as nondisabling.

On February 18, 1987, the insurer had claimant evaluated by Dr. Keist, orthopedist. He opined that claimant was medically stationary; that she needed palliative treatment only; and that thrice

per week treatment was not reasonable and necessary. On that basis, the insurer issued a denial reading as follows:

> "As it would appear that your present need for treatment is merely for palliative treatment, which by Workers' Compensation Department standards is two times per month, this letter is to advise you that we will only be paying for palliative care as of the date of this letter. Any medical treatment over and above the palliative care guidelines are respectfully denied."

The insurer paid for chiropractic treatments through the date of the denial. After receiving the denial claimant stopped going to her chiropractor.

At the time the denial issued, there was no outstanding unpaid billing for any medical service. Thus, the denial was addressed to no particular service for any particular condition. Rather, the denial purported to preclude all future medical benefits of a particular type (chiropractic in excess of twice per month) based on an assessment of claimant's needs as of the date of the Keist exam. Even if Dr. Keist had opined that claimant's condition as of that time required but twice per month treatment, rather than that claimant's condition needed but palliative treatment, and assuming that his opinion was correct, it did not warrant a denial of future services.

A claim for medical services is generally made in the form of a medical bill or a request for authorization of treatment addressed to the insurer. Billie J. Eubanks, 35 Van Natta 131 (1983). Claims, in the form of billings, must be promptly paid or denied. OAR 436-10-100. If denied, the worker may request a hearing. ORS 656.245(2). Here, the insurer has accepted all claims for medical services filed through the date of the denial. The denial purports to address all post-March 3, 1986 chiropractic treatment. There having been no claim made for post-March 3, 1986 treatment, the denial can be read only as a denial of future medical benefits.

Yet, an injured worker is entitled to all reasonable and necessary medical services for a compensable injury. ORS 656.245(1). The nature of treatment which is reasonable depends upon the claimant's condition at the time the treatment is rendered; what will be reasonable in the future cannot be foreseen. Thus, the res judicata effect of a denial is limited to pre-denial services. Leonard A. Chambers, 40 Van Natta 117 (1988). See also, North Clackamas School District v. White, 305 Or 48, modified, 305 Or 468 (1988). A denial of care in the future is void; and any denial of treatment in reliance on such a denial must be set aside. Thomas A. Beasley, 37 Van Natta 1514 (1985).

In Thomas A. Beasley, supra, the insurer denied claimant's "current treatment" at a time when the insurer had paid for all treatment claimed and the claimant was, in fact, receiving no treatment. The Board held that such a denial was void and of no effect upon claimant's right to future treatment. A denial of services premised on claimant's failure to challenge the denial was set aside. When, as here, the claimant does challenge the initial prospective denial, it must be set aside. To do otherwise is not only to permit, but to validate, the improper practice of issuing meaningless denials for the purpose of convincing injured workers and health care providers that further treatment will not be reimbursed.

In urging that the denial be set aside, I voice no opinion on the claimant's need for treatment either prior to or after the issuance of the denial. Obviously, by setting aside the denial, we would make no judgment about the propriety of a denial that might be issued with respect to services actually rendered and billed to the insurer. See e.g., Coronda Johnson, 39 Van Natta 1171 (1987), in which we set aside a broad denial and upheld a narrower denial issued at a later time.

ANTON V. MORTENSEN, Claimant
Miller, Nash, et al., Defense Attorneys

WCB 87-05699
September 20, 1988
Order on Review (Remanding)

Reviewed by Board Members Johnson and Crider.

Claimant, pro se, requests review of Referee Foster's order that dismissed claimant's request for hearing from a Determination Order as untimely filed. On review, the issue is jurisdiction. We reverse and remand.

FINDINGS OF FACT

On April 13, 1987, through his hearing counsel, claimant filed a request for hearing concerning a November 28, 1984 Determination Order. The Determination Order had issued following the completion of claimant's vocational rehabilitation program.

The self-insured employer objected to the hearing request, contending that the one-year statutory period in which to appeal the Determination Order had passed. Thus, the employer moved for dismissal of claimant's hearing request.

In response to the employer's motion, claimant submitted two affidavits. One, from Ms. Carraher, a supervisor of evaluators for the Evaluation Division, now called the Evaluation Section. A second, from claimant himself.

Ms. Carraher stated that claimant's file contained a copy of a Determination Order dated November 28, 1984. In addition, the file copy indicated that claimant's copy of the order had been mailed to him at a Milwaukie, Oregon address. The city and street address accurately reflects claimant's residence. However, the Evaluation Section's file lists a zip code of "97222," whereas the zip code for claimant's residence is "97267."

After explaining processing procedures for Determination Orders, Ms. Carraher admitted that she had no personal knowledge as to whether the Determination Order had been mailed to claimant or whether it was received by him. Furthermore, she acknowledged that nothing in the file would indicate whether the Determination Order was mailed to claimant or received by him. However, she asserted that it was the usual and customary practice of the Evaluation Section to mail Determination Orders to the parties on the date indicated on the order.

In his affidavit, claimant stated that he received notice of the November 28, 1984 Determination Order in March 1987, when he was contacted by his "then-attorney." He further declared that he "had never seen, received or otherwise in any way become aware of the existence of such a Determination Order or of any appeal rights therefore until March 1987."

The record concerning whether the November 28, 1984

Determination Order was mailed to all interested parties is incompletely and insufficiently developed.

CONCLUSIONS OF LAW

The Referee reasoned that there were no factual issues to be resolved. Consequently, concluding that claimant's hearing request was untimely as a matter of law, the Referee granted the employer's motion to dismiss. We disagree.

At the time of the November 28, 1984 Determination Order, former ORS 656.268(6) provided as follows:

> "[T]he Evaluation Division shall mail a copy of the determination to all interested parties. Any such party may request a hearing under ORS 656.283 on the determination made under subsection (4) of this section within one year after copies of the determination are mailed."

In addition, former ORS 656.319(4) stated that a hearing on objections to a determination under ORS 656.268(3) should not be granted unless a request for hearing was filed within one year after the copies of the determination were mailed to the parties. Determinations under former ORS 656.268(3) pertained to "notice of closures" issued by insurers/employers.

Here, the Determination Order issued following completion of claimant's vocational rehabilitation program, in accordance with former ORS 656.268(5). Inasmuch as the determination was not made under former ORS 656.268(3), we conclude that former ORS 656.319(4) is of uncertain applicability. See Shaw v. SAIF, 63 Or App 239, 244, n. 3 (1983).

In any event, the issue revolves around whether copies of the November 28, 1984 Determination Order were mailed "to all interested parties" pursuant to former ORS 656.268(6), and, even if they were, whether a copy was received by claimant at his residence. Concerning the latter portion of the issue, we have been unable to uncover case precedent concerning the effect of nonreceipt of a Determination Order on the time for challenging the order. Lacking directly applicable authority, we rely on the case law regarding requests for hearing from denials.

Turning to that authority, we note that we have previously determined that mailing alone does not trigger the running of the statutory time period. Instead, the notice must actually be delivered to claimant. Charles H. Whiddon, 39 Van Natta 407, on recon 39 Van Natta 811 (1987). In Whiddon, we distinguished Cowart v. SAIF, 86 Or App 748 (1987), where the court stated that "[t]he date of mailing, not receipt, starts the running of the 60 days." We noted that the claimant in Cowart received the denial well before the expiration of the 60 days.

The Supreme Court discussed this issue in Norton v. Compensation Department, 252 Or 75 (1968), observing that the rule holding that the time within which to request a hearing runs from the date of mailing is sensible given the presumption that mailing will bring about actual notice. The Court noted that the denial at issue had actually been received well inside the 60 day period and thus that the presumption worked properly in that case. The

Court specifically reserved the question of nonreceipt or an untimely receipt, stating as follows:

> "It is, of course, conceivable that the mailing of the notice of denial will not bring notice of the denial to the workman within 60 days after the denial or will not bring notice within a reasonably substantial time after the mailing, all through no fault of the workman. What relief can be granted to the workman in such event will have to depend upon the particular circumstances of each case." 255 Or at 78.

The answer, we believe, is that if the facts rebut the presumption that mailing produces actual delivery of notice, then the statutory period does not begin to run until the date of successful mailing or actual notice. In arriving at this conclusion, we note that limitation statutes are based on the premise that when something is mailed, it is received. Yet, nonreceipt may either disprove mailing, reflect mailing to a wrong address, or suggest processing errors, either by the sender or the postal service.

Consequently, we conclude that if a Determination Order is not received at a claimant's residence, the presumption of actual delivery of notice has been rebutted. Under such circumstances, we would consider it inappropriate to foreclose a claimant from requesting a hearing concerning the order, provided that the request was filed within one year of the claimant's actual notice of the order.

Here, the record is insufficient to resolve the issue of whether copies of the November 28, 1984 Determination Order were mailed to "all interested parties." The affidavit from the Evaluation Section supervisor sets forth the Section's usual and customary business practices in processing Determination Orders. See OEC 311(1)(j); OEC 311(1)(m). Yet, this submission does not establish that a copy of the November 28, 1984 Determination Order was mailed to claimant at his correct address. In this regard, we note that although the street and city address recorded in the Evaluation Section's file coincide with claimant's residence, the zip codes vary. Specifically, the Evaluation Section's file indicates "97222," while claimant's actual zip code is "97267."

When this information is combined with claimant's unrebutted assertion that his first notice of the Determination Order occurred in March 1987, we are unable to determine from this record whether copies of the November 28, 1984 order were mailed to "all interested parties" as required by former ORS 656.268(6) and, even if they were, whether a copy was received by claimant at his residence. We further conclude that resolution of this issue can best be achieved through the introduction of additional evidence at a hearing.

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. ORS 656.295(5). Considering the aforementioned circumstances, we conclude that remand is an appropriate action.

Accordingly, the Referee's dismissal order is vacated and this matter is remanded to the Hearings Division with instructions to schedule a hearing. At the hearing, the parties shall be entitled to present additional evidence concerning the jurisdictional issue discussed above. In addition, the parties may present evidence regarding the merits of claimant's hearing request. Thereafter, the Referee shall issue a final order addressing both the jurisdictional and substantive issues.

ORDER

The Referee's order dated September 8, 1987, as amended September 10, 1987, is reversed. This matter is remanded to the Hearings Division for further proceedings consistent with this order.

ALLASANDRA W. O'REILLY, Claimant
Foss, et al., Attorneys
Dennis Ulsted (SAIF), Defense Attorney
Atherly, et al., Defense Attorneys
William F. Gary, Assistant Attorney General

WCB 87-17487, 87-17488 & 87-18557
September 20, 1988
Order Denying Motion to Dismiss

The SAIF Corporation, as insurer for Coos-Curry Council of Governments, Hours & Ours, and Bassett-Hyland Energy Company, has moved the Board for an order dismissing claimant's request for review on the ground that all parties did not receive timely notice of the request. The motion is denied.

FINDINGS

The parties to the hearing were claimant, her counsel, and three potentially responsible employers, all of whom were insured by SAIF. SAIF's in-house counsel represented Coos-Curry Council of Governments. Legal counsel for the other employers, Hours & Ours and Bassett-Hyland Energy Company, was assigned to outside attorneys. On April 13, 1988, the Referee issued an order upholding SAIF's denials of claimant's claims for compensation.

Claimant, pro se, requested Board review of the Referee's order. The request, which was mailed to the Board by certified mail on May 9, 1988, did not include an acknowledgment of service or a certificate of personal service by mail upon the other parties at the hearing. Although the request indicated that copies had been provided to SAIF and Coos-Curry, neither party received a copy of it.

On May 11, 1988, the Board mailed a computer-generated letter to claimant, the employers, and their attorneys acknowledging the request. Counsel for Hours & Ours received the acknowledgment on May 12, 1988. Coos-Curry also received the acknowledgment on May 12, 1988. Bassett-Hyland has no record of receiving the acknowledgment until June 23, 1988, when it received a copy from its counsel. Its counsel received the Board's acknowledgment letter at the firm's Post Office Box. Bassett-Hyland's counsel "suspect[s]" that the acknowledgment was received during the "May 14 - 15 weekend," because, to the best of his recollection, he gained actual knowledge of the letter on Monday May 16, 1988. However, he has no independent recollection of when the notice was received. His "suspicion" is based solely on the fact that his first time slip on the case was made out on May 16. SAIF first received notice of the request on May 17, 1988, when its claim examiner was sent a copy of the acknowledgment by one of its outside counsels.

The request for Board review was filed within 30 days of the Referee's order. Furthermore, all of the parties received actual notice of the request within 30 days after the date of the Referee's order.

CONCLUSIONS

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). 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. Argonaut Insurance Co. v. King, 63 Or App 847, 852 (1983).

"Party" means a claimant for compensation, the employer of the injured worker at the time of injury and the insurer, if any, of such employer. ORS 656.005(19). Attorneys are not included within the statutory definition of "party." Robert Casperson, 38 Van Natta 420, 421 (1986). Yet, 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, supra, page 850-51; Nollen v. SAIF, 23 Or App 420, 423 (1975), rev den (1976); Robert C. Jaques, 39 Van Natta 299 (1987).

Here, the 30th day after the Referee's April 13, 1988 order was May 13, 1988. Claimant's request for Board review was filed May 9, 1988. Thus, the request was timely. See ORS 656.289(3). However, the record fails to establish that copies of the request for review were mailed to all parties to the proceeding before the Referee. See ORS 656.295(2). Therefore, in order for the Board to retain jurisdiction, the parties must have received actual notice of the request within the statutory period. See Zurich Ins. Co. v. Diversified Risk Management, 300 Or 47, 51 (1985); Argonaut Insurance Co. v. King, supra.

We conclude that each of the three employers received actual notice of the request within 30 days of the Referee's April 13, 1988 order. This conclusion is based on the following analysis.

Coos-Curry received a copy of the Board's letter acknowledging the request for review on May 12, 1988. Although its insurer, SAIF, did not receive actual notice until May 17, 1988, there is no contention that SAIF has been prejudiced by not directly receiving a copy of claimant's request for review or the Board's acknowledgment. Absent such a finding, we hold that Coos-Curry's timely actual notice of the request for review is adequate compliance with ORS 656.295(2) insofar as the notice pertains to its interests. Argonaut Insurance Co. v. King, supra, pages 850-51; Nollen v. SAIF, supra.

Hours & Ours received a copy of the Board's acknowledgment letter, but does not recall the date. In any event, its counsel received the acknowledgment letter on May 12, 1988, which is within the statutory 30-day period. Lacking a showing of prejudice, we find that this actual notice of the request for review is adequate compliance with ORS 656.295(2)

insofar as the notice pertains to Hours & Ours' interest. Argonaut Insurance Co. v. King, supra, pages 850-51; Nollen v. SAIF, supra.

Bassett-Hyland did not receive notice of the request for review until June 23, 1988, when it received a copy of its counsel's file. As previously discussed, SAIF's first notice of the request occurred on May 17, 1988. Thus, both Bassett-Hyland and its insurer received actual notice of the request for Board review more than 30 days after the Referee's April 13, 1988 order.

The record is unclear concerning when Bassett-Hyland's counsel received actual notice of the request for review. Its counsel states that, to the best of his recollection, he received actual knowledge of the request on Monday May 16, 1988, when he reviewed the Board's acknowledgment letter. Yet, the date of counsel for Bassett-Hyland's notice of the request cannot be conclusively determined because the Board's letter was not date-stamped by his office. Moreover, it is unclear when the acknowledgment was deposited in Bassett-Hyland's counsel's Post Office Box. Rather than being received during the "May 14 - 15 weekend," as counsel for Bassett-Hyland suspects, it is entirely possible that the May 11, 1988 acknowledgment was deposited by, at least, Friday May 13, 1988, which is within 30 days of the Referee's April 13, 1988 order.

As a moving party, Bassett-Hyland has the burden of proof. See Glenn L. Woodraska, 40 Van Natta 1091 (August 30, 1988); Tim J. McAuliffe, 37 Van Natta 76 (1985). After conducting our review of this record, we conclude that it has failed to establish that its counsel did not receive a copy of the Board's acknowledgment letter on or before May 13, 1988. Consequently, we find that it is more probable than not that counsel for Bassett-Hyland received actual notice of claimant's request for review within the statutory 30-day period. Furthermore, lacking a showing of prejudice, we hold that this timely actual notice of the request for review is adequate compliance with ORS 656.295(2) insofar as the notice pertains to Bassett-Hyland's interests. Argonaut Insurance Co. v. King, supra, pages 850-51; Nollen v. SAIF, supra.

Accordingly, the motion to dismiss is denied. Inasmuch as the briefing schedule was tolled pending our decision concerning this motion, a new schedule shall be implemented. Therefore, claimant's appellant's brief shall be due 14 days from the date of this order. The insurers' respondent's briefs shall be due 14 days from the date of mailing of claimant's brief. Claimant's reply brief, if any, shall be due 7 days from the date of mailing of the latest timely submitted respondent's brief. Thereafter, this case will be docketed for review.

JAMES C. PERSHALL, Claimant
David C. Force, Claimant's Attorney
Cowling & Heysell, Defense Attorneys

WCB 86-11016
September 20, 1988
Order on Review

Reviewed by Board Members Johnson and Crider.

Claimant requests review of Referee Quillinan's order that upheld the insurer's denial of claimant's aggravation claim for a cervical condition. The insurer cross-requests review, arguing that the Referee erred in assessing a penalty for the late provision of medical documents to claimant's attorney. We affirm in part and reverse in part.

ISSUE

The issues on review are aggravation and the imposition of a penalty for the late provision of medical documents where no compensation was due.

FACTS

Claimant compensably injured his right foot and cervical spine on November 20, 1982, while working as a millwright. He slipped while standing on a ladder and dropped a section of movable grating on his foot. Initially he was treated for a contused right foot. On December 3, 1982, he sought emergency treatment for his cervical condition. Dr. Peterson, emergency room physician, diagnosed cervical osteoarthritis with subluxation of C3-4. X-rays revealed a possible preexisting cervical subluxation, marked cervical spine degeneration with a goose neck configuration and narrowing at the interspaces.

On December 3, 1982, claimant was referred to Dr. Woolpert, orthopedic surgeon. Dr. Woolpert diagnosed chronic degenerative cervical change and an old subluxation which probably was aggravated by his fall. Claimant was treated conservatively with a rigid neck brace. He was thereafter hospitalized due to morning numbness in his left arm. Claimant was treated with cervical traction. Dr. Streitz, orthopedist, examined claimant during his hospitalization. He diagnosed severe degenerative arthrosis of the cervical spine, with subluxation at C5-6. Dr. Streitz recommended conservative treatment until claimant's cervical strain-like symptoms and nonlocalized radicular symptoms subsided.

On January 21, 1983, the insurer partially denied claimant's preexisting cervical degenerative disease.

On February 8, 1983, Dr. Martinez, surgeon, examined claimant and diagnosed an unstable anterior subluxation of the C5-6 vertebrae. Claimant had subtle signs of spinal cord compression. Dr. Martinez recommended a tomography of the cervical spine and a skull tong reduction, followed by posterior cervical wiring and fusion. Dr. Woolpert concurred.

On February 25, 1983, claimant underwent a posterior cervical wiring and fusion at C5-6. In March 1983 claimant suffered from post-surgery tongue, left side thumb, and index finger numbness. He was treated conservatively with a hard neck collar.

In April 1983, claimant had left upper limb function difficulties, including left hand grip weakness, left decreased bicep and tricep jerk reflexes, and hyperesthesia involving the left thumb and index finger. X-rays revealed a persistent subluxation of C5 over C6.

The January 21, 1983 partial denial of claimant's cervical condition was set aside by a prior Referee's May 31, 1983 order.

In June 1983, claimant continued to experience left hand weakness, and numbness of the left forearm. However, his neck pain had nearly subsided and his overall condition had improved.

Claimant continued to experience persistent cervical radiculopathy in June 1983. He was deemed medically stationary even though his subluxation persisted.

Claimant's claim was closed by Determination Order dated November 3, 1983, awarding 25 percent (80 degrees) unscheduled permanent disability resulting from his neck injury, and 40 percent (76.80 degrees) scheduled disability due to the loss of use of his left arm.

On May 29, 1984, claimant was evaluated by the Southern Oregon Pain Center. The evaluating physicians recommended that claimant participate in a body mechanics course designed to maintain his self-care function. Further, they found claimant's left upper extremity to be almost nonfunctional.

On January 27, 1984, claimant began experiencing moderate to severe cervical radiculopathy. Dr. Sacks released claimant from work.

An extent hearing was held on November 7, 1984. The Referee's order dated January 24, 1985, found claimant permanently and totally disabled. By Order on Review, dated August 29, 1985, the Board reversed the Referee and reduced claimant's unscheduled permanent disability award to 75 percent. It made no change in the scheduled award. On May 21, 1986, the Court of Appeals affirmed without opinion. On September 16, 1986, the Supreme Court denied claimant's petition for review.

On September 10, 1985, claimant was examined by Dr. Wheeler, internist. Dr. Wheeler diagnosed neurologic dysfunction as a result of claimant's cervical condition, but noted that his exaggerated and inappropriate responses made it difficult to determine the exact nature of his impairments.

In January 1986, claimant underwent right hip replacement surgery as a result of a preexisting condition, replacing an earlier hip prosthesis. Dr. Patterson, neurologist, performed a pre-op neurological examination. He recommended an EMG to determine whether claimant had an entrapment neuropathy in his arm.

In June 1986, claimant began treating wit Dr. Gombert, surgeon, due to headaches and right arm pain. Dr. Gombert requested reopening of claimant's claim on July 9, 1986, due to a worsening of his condition.

On August 4, 1986, the employer denied claimant's aggravation claim on the ground that his compensable condition had not worsened.

On November 7, 1986, Dr. Wilson, neurologist, conducted an independent medical examination. Dr. Wilson concluded that claimant's condition had not changed.

A February 1987 nere conduction study showed increased neuropathy.

Claimant has not worked since he suffered his compensable injury.

Claimant's condition has not worsened.

CONCLUSIONS OF LAW

The Referee affirmed the employer's denial and found that claimant's condition had not worsened. She found that claimant's symptoms and condition had not changed since the last arrangement of compensation. Further, claimant's symptoms were the same ones he described at his extent hearing in November 1984.

Aggravation

In order to prevail on his aggravation claim, claimant must prove that his underlying condition or symptoms have worsened since August 29, 1985, the date of the last award or arrangement of compensation so that he has suffered an additional loss of earning capacity, and that the worsening is related to the compensable injury. Smith v. SAIF, 302 Or 396 (1986); Hoke v. Libby, McNeil & Libby, 73 Or App 44 (1985). In cases of scheduled disability, more disabled means an increased loss or use of that body part. International Paper Co. v. Turner, 84 Or App 248, 250 n.1 (1987).

Claimant argues that the continuous worsening of the neurological function in his arms had increased sufficiently to warrant an aggravation. He relies on the opinions of Dr. Gombert, Dr. Wilson, and Dr. Patterson to support his claim.

Dr. Gombert opined that claimant had suffered an aggravation as a result of increased neck pain, headaches, and right arm numbness. Objective findings revealed left forearm muscle atrophy, decreased bicepital and tricepital reflexes, and a severe loss of left hand grip power. He found that claimant's complaints were consistent with the x-ray findings, which revealed an increasing amount of inter-vertebral disc space narrowing at C5-6 since 1983. However, Dr. Gombert's February 1987 x-ray of claimant's cervical neck indicated little change overall since June 1986.

Dr. Patterson conducted a nerve conduction study which revealed that claimant suffered from severe bilateral carpal tunnel syndrome. His report does not indicate whether this condition is related to claimant's compensable injury.

Dr. Wilson testified by deposition. He concurred with Dr. Patterson's interpretation of left carpal tunnel syndrome. However, he did not find that the nerve studies demonstrated a right carpal tunnel syndrome, but rather a problem in the neck or elbow. He further opined that claimant had a cervical radiculopathy, which would progressively worsen. Dr. Wilson further found that claimant's EMG findings were not consistent with his left arm weakness, glove anesthesia or hyperesthesia, and attention tremor. Dr. Wilson viewed claimant's cervical x-rays of February 1987, and noted no measurable change as compared to his earlier x-rays. Further, he found that claimant had shown no clinical deterioration since claim closure.

Claimant testified that his condition was worse than it had been at the time of his 1985 hearing. Specifically, he suffers from neck pain, headaches, right arm numbness, tremors in his left hand, and dizziness associated with falling. He takes prescription and over-the-counter medication to control his pain.

The insurer contends that these symptoms are exactly the

same as those he testified to at his January 1985 extent hearing. We agree that the symptoms are similar.

In view of the complexity of claimant's condition, we consider a well-reasoned and thorough analysis critical to the relative persuasiveness of a physician's opinion. Somers v. SAIF, 77 Or App 259 (1986).

We are unpersuaded by Dr. Gombert's opinion that claimant suffered an aggravation. We note that Dr. Gombert did not begin treating claimant until June 1986, four years after his injury and almost one year following his last arrangement of compensation. Further, Dr. Gombert's opinion was based solely on claimant's history, as evidenced by his June 3, 1986 chart note. There is no indication that Dr. Gombert reviewed claimant's medical report. Additionally, the medical evidence establishes no relationship between the radiculopathy symptoms and the compensable condition. Dr. Wilson's opinion is couched in terms of mere possibility that claimant's carpal tunnel or median nerve impingement is related to his compensable condition, and, Dr. Patterson's opinion offers no explanation as to the cause of claimant's radiculopathy.

Accordingly, we conclude that claimant has failed to prove that his condition has worsened. Further, he has failed to prove that the radiculopathy symptoms are related to his compensable injury or have resulted in additional loss of earning capacity or additional loss of function or use of either arm.

Penalty

The Referee assessed a $100 penalty and a $100 attorney fee against the insurer for its late transmittal of a medical report to claimant's attorney, because it offered no explanation for its action, and therefore was unreasonable. We disagree on the assessment of a penalty.

Attorney fees can be awarded for disclosure violations and are not contingent on "amount then due." They are payable by virtue of unreasonable delay alone. Penalties, on the other hand, can only be assessed when there is an amount "then due" on which to assess such penalty. ORS 656.262(10); OAR 438-07-015(2); Mischel v. Portland General Electric, 89 or App 140 (1987). Here, there was no amount then due upon which to assess a penalty, and therefore such an assessment was improper.

ORDER

The Referee's order dated May 14, 1987 is affirmed in part and reversed in part. The insurer's aggravation denial is upheld. The Board approves a client-paid fee to the insurer's attorney, not to exceed $937.

PENNY C. STOUT, Claimant
Max Rae, Claimant's Attorney
Gail Gage (SAIF), Defense Attorney

WCB 87-01516
September 20, 1988
Order on Review

Reviewed by Board Members Johnson and Ferris.

Claimant requests review of Referee Howell's order that: (1) upheld the SAIF Corporation's denial of her occupational disease claim for bilateral hand, forearm and arm conditions; (2) declined to assess penalties and attorney fees for

an alleged unreasonable denial; and (3) denied claimant's motion to keep the record open for receipt of an additional report from claimant's treating physician.

ISSUES

(1) Compensability.

(2) Penalties and attorney fees.

(3) The Referee's evidentiary ruling.

(4) Remand.

FINDINGS OF FACT

The Board adopts the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The Board affirms and adopts the Referee's conclusions of law, and makes the following comments regarding the Referee's evidentiary ruling and claimant's request for remand.

Claimant requested an Expedited Hearing under OAR 438-06-011. This request includes a representation that claimant is prepared to proceed with a hearing upon not less than ten days notice. Claimant chose this avenue, rather than the usual docketing procedure. The Referee noted, when ruling on the motion for continuance, that the evidence claimant desired to obtain was reasonably obtainable before the hearing, given the facts of this case, the claim must stand or fall on the evidence available at the time of the hearing. Her request to leave the record open was properly denied. The Referee did not exceed his discretion.

Claimant now contends that the record was insufficiently developed because it did not include the report from her treating physician for which she sought to hold the record open. That report was to have countered the diagnostic tests which indicated normal nerve conduction in claimant's wrists and hands. That is a diagnostic issue. Because we affirm the Referee's finding that claimant has not sustained her burden of proof of causal connection, our decision would not be altered by diagnostic reports. Claimant's motion for remand is denied.

ORDER

The Referee's order dated April 29, 1987 is affirmed.

BRYON K. THOMAS, Claimant
Harper, Leo & Associates, Claimant's Attorneys
Scheminske & Lyons, Defense Attorneys

WCB 86-16743
September 20, 1988
Order on Review

Reviewed by Board Members Ferris and Johnson.

Claimant requests review of Referee Knapp's order that: (1) upheld the insurer's denial of claimant's aggravation claim for his right ankle; and (2) upheld the insurer's partial denial of claimant's current left knee condition. The issues on review are aggravation and compensability. Because claimant did not file an appellant's brief, the insurer chose not to submit a respondent's brief. We affirm.

FINDINGS OF FACT

On August 10, 1984, claimant, a then 21-year-old laborer, was compensably injured when he caught his right foot between the grates over a floor drain, inverting his ankle. Claimant sought treatment that day from Dr. Endicott, MD, who diagnosed ankle sprain, authorized time loss and initiated conservative care that included rest, physical therapy and use of a brace. Claimant was released to regular work on October 15, 1984.

However, claimant changed treating physicians and began treating with Dr. Hoff, orthopedist. Dr. Hoff noted ankle instability and recommended surgery. Reconstructive ligament surgery was performed in February 1985. Dr. Hoff declared claimant medically stationary on July 23, 1985 and released him for modified work. He restricted claimant to walking and standing four to five hours per day, with rest periods, and no lifting over 25 pounds.

Claimant returned to work with the employer as a quality control inspector on August 12, 1985. He experienced pain and swelling in his foot, which caused him to miss work on August 13. He worked on August 14, but reported to the employer on August 15 that he was ill and did not work. Claimant was terminated on August 16 because of excessive absenteeism. Vocational assistance which had been instituted in November 1985 was then terminated because claimant had left suitable employment for reasons not related to his injury.

Claimant's claim was closed on August 23, 1985 with a 20 percent scheduled permanent disability award. Claimant requested a hearing on extent and vocational rehabilitation.

Dr. Hoff saw claimant on September 3, 1985. His symptoms and examination findings were unchanged.

Dr. Hoff next saw claimant on September 25, 1985. An injection was administered which provided temporary relief. Dr. Hoff saw claimant again on October 10 and October 28, 1985. He found greater restriction of ankle dorsiflexion and different pain location, but had no further treatment to offer.

Dr. Hoff saw claimant again on December 10, 1985 and January 7, 1986 with complaints of increased pain. Examination findings remained unchanged.

On January 8, 1986, claimant dismissed his hearing request pursuant to Stipulated Order. In return, he received an additional 15 percent scheduled permanent disability. Vocational rehabilitation was not pursued.

Dr. Hoff saw claimant in February and March 1986. On March 25, 1986, he reported that claimant's condition had deteriorated since his July 1985 work release, and that the aggravation had occurred around August 1, 1985. Claimant filed a claim for aggravation.

Claimant was examined by Dr. McNeill, orthopedist, on May 27, 1986. He found no worsening, but a great deal of functional overlay.

The insurer denied claimant's aggravation claim on May 29, 1986.

On June 2, 1986, Dr. Hoff reported to the insurer that claimant's condition had been aggravated by his return to work in August 1985, but that he had remained stationary since September 3, 1985, and the previous restrictions remained the same.

On August 25, 1986, Dr. Hoff reported claimant was complaining about pain in his left knee, which claimant attributed to his August 1984 injury. On October 13, 1986, Dr. Hoff reported that claimant had reinjured his right ankle when his left knee gave way, causing him to invert his ankle. The doctor noted tenderness and some loss of sensation in the ankle. He diagnosed the left leg symptoms as caused by scar tissue in the knee.

On November 7, 1986, the insurer denied compensability of claimant's left knee condition.

Dr. McNeill reexamined claimant regarding his left knee condition on December 2, 1986. Dr. McNeill doubted a connection between the condition and the industrial injury.

Claimant has a prior history of ankle injuries since childhood. He has, at different times, given different accounts of these injuries.

CONCLUSIONS OF LAW AND OPINION

Claimant bears the burden of proving by a preponderance of the evidence the validity of his claims. Hutcheson v. Weyerhaeuser, 288 Or 51 (1979). He contends that the insurer's denials for his right ankle aggravation and left knee condition should be overturned and vocational rehabilitation allowed. The insurer contends that claimant waived his right to vocational rehabilitation, and is estopped to claim right ankle aggravation occurring in 1985, by virtue of the Stipulated Order signed in January 1986. The insurer also contends that claimant has not borne his burden of proof for his left knee condition.

The Referee found that claimant had not carried his burden of proof regarding his left knee condition. We agree, and adopt the Referee's conclusions of law and opinion on this issue.

The Referee found that claimant's claim for aggravation of his right ankle injury failed because the condition had not worsened since the last arrangement of compensation, January 8, 1986. We agree with the Referee. The evidence indicates he was worse before the Stipulated Order, not after. Claimant has not carried his burden of proof.

The Board affirms the order of the Referee.

ORDER

The Referee's order dated August 26, 1987 is affirmed.

PAUL D. THOMPSON, Claimant
S. David Eves, Claimant's Attorney
Garrett, et al., Defense Attorneys

WCB 86-09118
September 20, 1988
Order of Dismissal

The insurer requests review of Referee Seymour's order that awarded claimant's attorney $750 as a reasonable attorney fee for services rendered prior to hearing in obtaining rescission of the insurer's denial of medical services. The issue is attorney fees. We dismiss the request for review for lack of jurisdiction.

ISSUE

Whether the Board has jurisdiction to address the issue of the amount of an attorney fee awarded by the Referee under ORS 656.386(1).

FINDINGS OF FACT

Claimant had a carpal tunnel condition which was accepted by the insurer. On June 20, 1986, a Determination Order issued which awarded no permanent partial disability. Claimant requested a hearing on the Determination Order. The insurer subsequently issued two denial letters of medical benefits from which claimant filed supplemental requests for hearing.

Approximately four months later, on March 24, 1987, the insurer rescinded its denials. This rescission occurred approximately one month prior to the scheduled hearing on the denials and the Determination Order. The parties subsequently settled the disability question. However, the parties could not agree on the amount of attorney fees which the insurer should pay for the setting aside of the denials. Consequently, in a summary determination pursuant to former OAR 438-47-015 [now OAR 438-15-030(1)], the Referee ordered that claimant's attorney be paid an attorney fee in the amount of $750.

The insurer timely filed a request for Board review of the Referee's order on the basis that the attorney fee award was excessive. No other issues were raised.

CONCLUSIONS OF LAW AND OPINION

On review, the parties argue only the merits of the Referee's attorney fee award. We conclude, however, that we lack jurisdiction to review the merits.

In Greenslitt v. City of Lake Oswego, 305 Or 530, 533-34 (1988), the Court ruled that when a claimant prevails before a Referee on the denial of a claim for compensation and the Referee awards the claimant's attorney a fee under ORS 656.386(1), the Board is without jurisdiction to entertain an appeal regarding the amount of the fee if the denial was not also appealed on the merits. Review of the attorney fee in such cases must instead be sought in the appropriate circuit court under ORS 656.388(2). Id. at 534.

The Referee in the present case awarded attorney fees for services rendered incident to the reversal of a denial of medical benefits. The Referee cited no authority for the award other than former OAR 438-47-015 [now OAR 438-15-030(1)]. The only authority for such a fee would be ORS 656.386(1). The insurer sought Board review. The only issue before the Board is

the amount of the attorney fee awarded by the Referee. Under these circumstances, the Supreme Court's decision in Greenslitt mandates dismissal of the insurer's request for review.

Inasmuch as the insurer's request 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); Matthew W. Johnson, 40 Van Natta 393 (1988).

IT IS SO ORDERED.

ELEANOR M. THURSTON, Claimant
Vick & Gutzler, Claimant's Attorneys
Nancy Meserow, Defense Attorney
Meyers & Terrall, Defense Attorneys

WCB 86-05028 & 86-15156
September 20, 1988
Order on Review

Reviewed by Board Members Crider and Ferris.

Wausau Insurance Company requests review of those portions of Referee Galton's order that: (1) set aside its denial of claimant's aggravation claim for allow back condition; and (2) upheld the self-insured employer's "new injury" denial for the same condition; and (3) directed it to pay one-half the costs relating to the deposition of claimant's treating physician. Although claimant has not formally cross-requested review, she argues that Wausau should be solely responsible for the costs of the aforementioned deposition. We reverse on the responsibility and deposition issues.

ISSUES

1. Whether claimant sustained a "new injury" or an aggravation of her February 1984 low back injury, as a result of her work activities in early 1986.

2. The proper apportionment of the costs relating to the deposition of claimant's treating physician.

FINDINGS OF FACT

Claimant began working for the employer as a bus driver in 1976. The employer was insured by Wausau until July 1985, when it became self-insured. In February 1984, while Wausau was at risk, claimant sustained a compensable low back injury. Shortly thereafter, she was examined by Dr. Mason, her treating surgeon. Mason diagnosed a herniated lumbar disc at L5-S1 and performed a lumbar laminectomy.

In June 1984, Mason noted that claimant was "asymptomatic" and that she had "resumed all of her normal activities . . . ." Claimant returned to her bus driving job in the fall of 1984, without apparent difficulty. In February 1985, she was reexamined by Mason reported that claimant was medically stationary with no significant neurological disability.

A Determination order closed the claim in April 1985, awarding claimant 5 percent unscheduled permanent disability.

In February 1986, claimant was unable to continue working due to renewed low back pain. She sought treatment from Mason, who noted inter alia:

> "This [claimant] has had a lumbar laminectomy in February of 1984 resulting in good relief of her pain and she has since returned to work driving a school bus. She was asymptomatic until one week ago. At that time, she had been driving on a steady basis and had some discomfort in the left hip."

After reviewing CTS scan results, Mason diagnosed trochanteric bursitis and opined that the bursitis condition was "a medical problem separate from the [previous] lumbar problem. . . . "

In September 1986, Mason reported that claimant's work activities in early 1986 had resulted in an aggravation of her 1984 injury. Subsequently, Mason was deposed. Asked to explain his report of September 1986, Mason testified:

> "What this letter states . . . is difficult to interpret because what we're dealing with is two separate medical phenomena occurring in a single patient.
>
> . . . [T]he activities that this patient has been undergoing during 1986 has [sic] been a significant cause for her bursitis which was ultimately the diagnosis made in February of 1986. The same activities . . . also very likely have had an effect on her lumbar spine. . . ."

On November 21, 1986, the employer submitted Exhibits 1 through 39 "for inclusion in the record." Exhibits 33 and 37 were reports written by Mason. On November 24, 1986, Wausau submitted, inter alia, Exhibit 37 "for additional inclusion in the record." On December 3, 1986, claimant notified Wausau that if it intended to rely on Exhibit 37, she wished to cross-examine Mason either by deposition or at the hearing. Shortly thereafter, Wausau informed claimant that it did not intend to rely on Exhibit 37. The next day, Mason was deposed. At the hearing, which took place on December 16, 1986, the employer offered into evidence Exhibits 1 through 39 and Mason's deposition. After receiving no objections, the Referee admitted all the exhibits offered by the employer.

Claimant credibly testified that following her 1984 injury she continued to experience low back, left hip, and left leg symptomatology.

CONCLUSIONS OF LAW

Finding claimant's testimony credible and reliable, the Referee concluded that Mason's opinion was based on an incorrect history. The Referee, therefore, found that claimant had sustained an aggravation, rather than a "new injury." We disagree.

In Hensel Phelps Construction v. Mirich, 81 Or App 290, 294 (1986), the court announced that if the "new injury" independently contributed to the causation of the worker's disabling condition (i.e., caused a worsening of her underlying condition), then responsibility for the condition would shift to the later employer/insurer.

As we understand Mason's opinion, he felt that

claimant's February 1986 work activities caused a worsening of her underlying lumbar disc condition. Those same work activities, according to Mason, caused a trochanteric bursitis condition. Mason felt that claimant's increased pain or symptomatology in February 1986, was a result of her trochanteric bursitis. Given Mason's opportunity to observe claimant both and after February 1986, we are persuaded by his well-reasoned and unrebutted opinion. See Kienow's Food Stores v. Lyster, 79 Or App 416 (1986); McClendon v. Nabisco Brands, 77 Or App 412 (1986).

In finding Mason's opinion persuasive, we do not agree with the Referee's finding that Mason had an incorrect history. Mason was claimant's treating surgeon. He examined claimant on several occasions following her compensable 1984 injury. On each occasion, he noted the status of her low back condition and how she was progressing. Mason's chart notes show that claimant was "asymptomatic" as early as June 1984. Furthermore, Mason testified that when he reexamined claimant in February 1986, he gathered a history that was consistent with his prior chart notes.

The Referee found that Mason's opinion was based upon an incorrect history apparently because he found that claimant credibly and reliably testified that she experienced continuing symptoms following her 1984 injury. Although we agree with the Referee that claimant was a credible witness, we do not agree that her testimony was reliable. Coastal Farm Supply v. Hultberg, 84 Or App 282 (1987) (A reviewing body is just as capable of evaluating the substance of a witness' testimony as is the Referee). Accordingly, we are more persuaded by claimant's history, as recorded in Mason's chart notes, than by her historical recollection recorded at the hearing.

After our de novo review, we find that claimant's February 1986 work activities independently contributed to her current low back condition, which includes both the worsening of her underlying lumbar disc condition and her trochanteric bursitis condition.

We turn to proper apportionment of costs associated with Dr. Mason's deposition. The Referee found that Wausau and the employer should be equally responsible for the costs associated with Mason's deposition, inasmuch as both had submitted Exhibit 37 for inclusion in the record. We disagree.

In Hanna v. McGrew Bros. Sawmill, 44 Or App 189, 95 (1980), the court stated:

> "The procedure of offering medical testimony through the medium of written reports does not alter the status of the witness when he is called for the purpose of cross-examination. He still remains the witness of the party offering the medical reports and that party is responsible for paying the fees and expenses incident to his appearance as a witness for cross-examination."

See also ORS 656.310(2).

Here, the employer, not Wausau, initially submitted Mason's reports for inclusion in the record. Consequently,

Wausau's subsequent submission for "additional inclusion" was redundant with respect to Exhibit 37. At the hearing, it was the employer, not Wausau, who actually offered Mason's reports and deposition into evidence. Under such circumstances, we find that the employer should be solely responsible for the cost of Mason's deposition.

Finally, claimant's counsel seeks Board authorization of an assessed fee for services on Board review. Claimant took the position on Board review that he had sustained a "new injury," not an aggravation. The "801" claim forms show that his stake in the outcome of that determination involves a higher rate of temporary disability compensation. Claimant's attorney filed a brief on Board review. Under such circumstances, we conclude that claimant's attorney is entitled to a reasonable assessed fee for services on Board review. See SAIF v. Phipps, 85 Or App 436 (1987).

ORDER

The Referee's order dated December 17, 1986 is reversed in part. That portion of the Referee's order that upheld the self-insured employer's "new injury" denial and ordered Wausau Insurance Company to pay claimant's attorney's fee is reversed. The employer's denial is set aside and remanded to the employer for processing according to law. The employer shall pay claimant's attorney's an assessed fee of $1,000 for services at hearing and $600 for services on Board review. Wausau's denial is reinstated and upheld. That portion of the Referee's order that directed Wausau to pay one-half the costs of Mason's deposition is reversed. The employer shall pay all the costs associated with Dr. Mason's deposition. All remaining portions of the Referee's order are affirmed. A client-paid fee, payable from the self-insured employer to its counsel is approved, not to exceed $192.50. Claimant's attorney is awarded an assessed fee of $600, to be paid by the self-insured employer.

RONALD L. WARNER, Claimant
Malagon & Moore, Claimant's Attorneys
Meyers & Terrall, Defense Attorneys
Kate Donnelly (SAIF), Defense Attorney

WCB 86-15041 & 86-10648
September 22, 1988
Order on Reconsideration

The SAIF Corporation requests that the Board abate its Order on Review dated August 26, 1988 and reconsider that portion of the order that required it, rather than the self-insured employer, to pay claimant's attorney a fee for services at the hearing level. It contends that the fact that its claim was in own motion status and thus that an order pursuant to former ORS 656.307 could not be issued should not affect the application of Karen J. Bates, 39 Van Natta 42 (1987).

We deny SAIF's request that we abate our order, but offer the following additional comments regarding the application of Bates in the present case. SAIF contends that the own motion status of its claim did not pose a threat to claimant's entitlement to receive compensation and thus that the Board erred in characterizing its denial as a denial of medical services. We disagree.

The issuance of a .307 order has the effect of establishing and securing a claimant's entitlement to receive compensation. See Petshow v. Farm Bureau Insurance Co., 76 Or App 563, 569 (1985), rev den 300 Or 722 (1986). When no .307 order

has been issued, the claimant's entitlement to receive compensation is at risk and the claimant must affirmatively prove such entitlement through the introduction of evidence at the hearing. This evidence may take the form of documents, testimony or stipulated facts, including carrier concessions. Regardless of the nature of the proof, however, the issue of the claimant's entitlement to receive compensation is not determined in such cases until it is decided by the Referee. Therefore, even if the carrier ultimately determined to be responsible never contests the claimant's entitlement to receive compensation, the claimant does not actually prevail against that carrier on that issue until the issuance of the Referee's Opinion and Order. The absence of a .307 order thus places the claimant's entitlement to receive compensation at risk against all of the potentially responsible carriers, including those which do not contest the issue. See Thomas S. Williamson, 39 Van Natta 1147 (1987).

The above reasoning, of course, applies as well to the situation presented in Bates as it does in the present case. Even in Bates, therefore, we could have ordered the responsible carrier to pay the claimant's attorney's fee. We chose to assess the fee against the nonresponsible carrier in that case as a way of encouraging carriers to comply with their duties under OAR 436-60-180 and to request or accede to the issuance of .307 orders when they do not seriously contest the claimant's entitlement to receive compensation. The prospect of being required to pay or relieved of paying the claimant's attorney's fee encourages carriers to consider carefully the bases of their denials, to abandon those bases which, while colorable, are unlikely to succeed and to request or accede to .307 orders when responsibility is the only real issue. By thus encouraging compliance with .307 procedures, the rule of Bates tends to discourage needless or lengthy interruptions in claimants' compensation payments. To the extent that Bates serves those purposes, we adhere to it.

In the present case, a .307 order was an impossibility by virtue of the own motion status of the SAIF claim. See former OAR 436-60-180(3). Application of the Bates rule, therefore, would not have encouraged the issuance of such an order. It would perhaps have encouraged the carriers to examine the bases of their denials more carefully. Absent the prospect of a .307 order, however, we conclude that this reason is insufficient to warrant extension of Bates to this case.

We note that the current version of OAR 436-60-180(3) (effective January 1, 1988) permits the issuance of .307 orders when one or more of the carriers' claims is in own motion status. This rule change obviously will require a reexamination of the application of Bates in cases to which the new rule applies as they come before us.

Appeal rights shall continue to run from the date of our original Order on Review.

IT IS SO ORDERED.

ORVILLE D. SHIPMAN, Claimant
Richard Sly, Claimant's Attorney
Lindsay, et al., Defense Attorneys

Own Motion 88-0525M
September 23, 1988
Own Motion Order

The insurer has submitted to the Board claimant's claim for an alleged worsening of his December 19, 1973 industrial injury. Claimant's aggravation rights have expired. The insurer has accepted responsibility for claimant's April 6, 1988 surgery, but recommends that the Board deny the request for temporary total disability compensation as it contends claimant has removed himself from the work force. Claimant contends he is permanently and totally disabled and, therefore, unable to be gainfully employed.

Pursuant to ORS 656.278(1)(a), we may exercise our "Own Motion" authority to award temporary disability benefits when we find that there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. Claimant's surgery in April 1988 does satisfy the medical requirements of ORS 656.278. However, current case law requires that the injured worker show some effort to remain a part of the work force. Claimant has not worked for several years. In 1984 he litigated the issue of permanent total disability before a Referee of the Hearings Division and later before the Workers' Compensation Board. At that time he was found to be 60 percent disabled although he contended then, and contends to this day, that he was permanently and totally disabled. Claimant, as did the worker in Dawkins v. Pacific Motor Trucking, 91 Or App 562 (1988), contends his withdrawal from the work force was not voluntary and was the result of his work-related disability. Dawkins states "[a] person who has withdrawn from the labor market, whether as a result of his injury or for other reasons, has no lost wages." See also, Cutright v. Weyerhaeuser Company, 299 Or 290 (1985), and Karr v. SAIF, 79 Or App 250 (1986). We conclude claimant is not entitled to compensation for temporary total disability during his recovery from surgery in April 1988. The request for own motion relief is hereby denied.

IT IS SO ORDERED.

DONALD S. WINCER, Claimant
Pozzi, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys

Own Motion 86-0406M
September 28, 1988
Own Motion Determination on Reconsideration

The insurer has requested reconsideration of that portion of our July 21, 1988 Own Motion Determination that granted claimant permanent total disability. On August 19, 1988, we abated our prior order to consider the request. Following further deliberation, we are prepared to respond.

The insurer contends that: (1) the Board lacked authority to grant permanent total disability; (2) the Board failed to apply the recently adopted "disability standards"; and (3) claimant is not permanently and totally disabled. We disagree with each of the insurer's assertions for the following reasons.

The insurer argues that our award of permanent total disability is "directly contrary" to our holdings in Orville D. Shipman, 40 Van Natta 537 (June 8, 1988), and Andy Webb, 40 Van Natta 586 (June 22, 1988). In Shipman, the claimant requested that we exercise our Own Motion relief and grant him permanent

total disability. We denied the request for lack of jurisdiction, reasoning that because the claimant's injury claim was closed, his 1987 Own Motion request must be considered under the present version of ORS 656.278(1)(a), which became effective January 1, 1988. Because our Own Motion authority is limited to granting temporary disability, we declined claimant's request for permanent total disability. We applied similar reasoning in Webb, where we declined to reopen the claimant's injury claim because he had neither undergone surgery nor been hospitalized for treatment concerning his compensable condition. See ORS 656.278(1)(a).

The present case is distinguishable. In Shipman and Webb, both claims were closed when, in 1988, we declined to grant the 1987 requests for Own Motion relief. Since the requests were pending on January 1, 1988, but the claims were not reopened as of that date, each was processed under the 1988 version of ORS 656.278(1)(a). See OAR 438-12-018.

Here, pursuant to our August 22, 1986 Own Motion Order, the claim was open when the insurer submitted it for closure in 1988. Inasmuch as the claim was reopened under ORS 656.278 on or before December 31, 1987, claim closure was conducted in accordance with the law and rules in effect on the date the claim was ordered reopened. See OAR 438-12-018. Thus, the current version of ORS 656.278(1)(a) did not apply.

Consistent with the aforementioned points and authorities, because the claim has now been closed, it follows that further requests for Own Motion relief are subject to the current version of ORS 656.278(1)(a). As previously discussed, our power is now limited to awarding temporary disability compensation under certain specified circumstances. See Shipman, supra; Webb, supra. Inasmuch as we lack authority to award permanent partial or permanent total disability, we conclude that we likewise are without power to reduce or eliminate such awards.

The insurer also contends that we failed to apply the Director's "disability standards" in reaching our determination. See OAR 436-35-001 et seq. The standards were adopted July 1, 1988, to be applied to all claims closed on or after that date. See OAR 436-35-003. In addition, they are to be applied by Referees at hearing and by the Board on review of the Referee's order. ORS 656.283(7); 656.295(5). Specifically, the standards shall apply to hearings conducted on and after July 1, 1988 concerning claims closed and evaluated by the Evaluation Section or by insurers/employers on and after July 1, 1988 where the claimant last became medically stationary on and after January 1, 1988. See OAR 438-10-005 (Effective July 1, 1988, WCB Admin. Order 2-1988).

Here, this matter does not pertain to a hearing concerning a claim closed and evaluated by the Evaluation Section or by insurers/employers. Moreover, our determination has been conducted pursuant to our Own Motion authority, rather than subject to our review powers under ORS 656.295. Consequently, we conclude that we are not expressly required to apply the "disability standards" in exercising our Own Motion authority.

However, the rules and standards contained in the statutes covering awards for temporary and permanent disability are not abrogated by ORS 656.278. See Edward Hines Lumber Co. v. Kephart, 81 Or App 43, 46 (1986). Therefore, for those cases where we retain jurisdiction to award permanent disability, it is our intention to use the standards as guidelines in evaluating claims.

In any event, even if the standards are expressly applicable, we note that they do not address entitlement to permanent total disability. Compare OAR 436-30-055. Thus, in reaching our determination that claimant is entitled to an award of permanent total disability, we analyzed this case under ORS 656.206.

Finally, in support of its contention that claimant is not permanently and totally disabled, the insurer has submitted a July 18, 1988 one-page report and chart note from Dr. Achterman, claimant's new treating physician. In a conclusory manner, Dr. Achterman indicates that he is "basically in agreement" with a prior consultant's report which suggests that claimant is physically capable of performing light work activities. Dr. Achterman further notes that since August 1987 "most" of claimant's complaints have related to pain unrelated to his claim.

We consider such a submission at this late date with some degree of skepticism, particularly when it was the insurer who submitted the claim for closure. Thus, we are not inclined to reopen the record under these circumstances.

We consider the present record to be sufficiently developed to reach our determination, as well as to sustain judicial review. Furthermore, other than the insurer's counsel's statement that the report and chart note from the new treating physician was "unsolicited," no explanation is provided as to why this "evidence" could not have been obtained and submitted prior to the issuance of our determination order.

Consequently, we decline to reopen the record for submission of this recent report. To hold otherwise would potentially expose us to an endless string of reconsideration requests and submissions of additional evidence, each designed to respond to conclusions reached by a previous Own Motion Order.

Even if we were to consider the new report and chart note, we would find them unpersuasive. As previously discussed, they are conclusory and devoid of analysis. Moreover, they are submitted by a physician who has apparently only recently begun treating claimant. Under such circumstances, we accord greater weight to the reports of Dr. Gritzka, claimant's former treating physician, because his opinions are based on a long-term association with claimant and his ailments.

After considering Dr. Gritzka's opinion, in conjunction with the work capacity evaluation provided by the Rehabilitation Institute of Oregon and claimant's social / vocational factors, we continue to conclude claimant is entitled to compensation for permanent total disability commencing January 20, 1988. See ORS 656.206.

Accordingly, the request for reconsideration is granted. As supplemented herein, we adhere to and republish our July 21, 1988 Own Motion Determination in its entirety, effective this date. However, in lieu of the attorney fee awarded in our July 21, 1988 order, claimant's attorney is awarded 25 percent of claimant's permanent total disability award, not to exceed $1,000, as a reasonable attorney's fee.

IT IS SO ORDERED.

JOSEPH B. BEAULIEU, Claimant
Frank J. Susak, Claimant's Attorney
Cliff, et al., Defense Attorneys
Schwabe, et al., Defense Attorneys

WCB 86-06544 & 86-12522
September 29, 1988
Order on Review

Reviewed by Board Members Crider and Johnson.

Industrial Indemnity Company requests review of those portions of Referee Fink's order that: (1) set aside its denial of claimant's aggravation claim for a low back and left hip condition; (2) upheld a denial of claimant's "new injury" claim for the same condition issued by Liberty Northwest Insurance Corporation; and (3) assessed an attorney fee for Industrial Indemnity's allegedly unreasonable delay in responding to requests for authorization of surgery. Liberty Northwest asserts in its brief that a post-hearing surgical report from claimant's treating physician is not properly before the Board on review. We reject Liberty Northwest's evidentiary contention while affirming the Referee on the merits.

ISSUES

1. Evidentiary question.

2. Responsibility for claimant's low back and left hip condition.

3. Attorney fees for alleged untimely claims processing.

FINDINGS OF FACT

Claimant was employed as a warehouseman when he suffered a compensable low back injury in September 1984 during a lifting incident. Industrial Indemnity was on the risk at the time.

Claimant was referred by his family physician to Dr. Tanabe, neurosurgeon. Dr. Tanabe subsequently performed surgery on a herniated disc at the L4-5 level on the left in October 1984.

Claimant returned to light duty work and continued to work at light duty work throughout 1985. He continued to have intermittent left hip pain when physically active. A Determination Order issued in August 1985, awarding claimant 5 percent unscheduled permanent disability.

Claimant discontinued treatment with Dr. Tanabe after February 1985. He testified that he had several periods of exacerbation during the year. He telephoned Industrial Indemnity to request authorization to see Dr. Tanabe. He believed that he needed authorization to see a physician because his claim was closed. However, he was unable to contact the proper person to get authorization.

Liberty Northwest came on the risk in January 1986. In mid to late February, claimant delivered a load of plumbing products by truck. He helped unload the lighter items. This required that he climb a ladder to and from the truck many times and lift packages weighing up to 25 pounds. He felt no sharp pains during the unloading process, but his low back and hip grew increasingly painful afterwards. He was much worse the next day.

Claimant reported that this pain was the same pain as before, but that this time it was lasting longer.

In April 1986, an MRI scan disclosed a reherniation at the

L4-5 level. Claimant's work activities while Liberty Northwest was on the risk did not contribute to his L4-5 reherniation.

Hearing was held on February 3, 1987. The record was held open for purposes of obtaining the deposition testimony of Dr. Becker. Claimant underwent a second L4-5 diskectomy three weeks later, on February 25, 1987. By letter dated March 30, 1987, counsel for Industrial Indemnity submitted Dr. Tanabe's surgical report to the Referee for inclusion in the record.

CONCLUSIONS OF LAW AND OPINION

Evidentiary Question

In its brief on review, Industrial Indemnity relies, in part, upon Dr. Tanabe's surgical report. Liberty Northwest argues that Dr. Tanabe's report was not admitted into the record, and, alternatively, that Dr. Tanabe's report does not support Industrial Indemnity's position.

The Referee's May 6, 1987 order makes no reference to Dr. Tanabe's report. Our review of the record discloses, however, that the report is numbered Exhibit 44 and is marked at the bottom as "admitted." We conclude that the report was in fact admitted into evidence by the Referee.

Liberty Northwest next argues that the report is not properly before the Board because it was obtainable with due diligence before the hearing. See Bernard L. Osborn, 37 Van Natta 1054, 1055 (1985), aff'd mem 80 Or App 152 (1986). Liberty Northwest's objection is untimely. The record indicates that Liberty Northwest was provided with a copy of the report and letter of submission. No objection was raised to the admission of the report at that time. We conclude that, having failed to preserve its objection to submission of the report, Liberty Northwest is precluded from raising the objection on review. See OEC 103(1); Thomas C. Whittle, 36 Van Natta 343, 345 (1984).

Responsibility

In successive injury cases, responsibility rests with the insurer on the risk at the time of the last employment that independently contributed to the causation of the disabling condition, i.e. to a worsening of the underlying condition. Hensel Phelps Const. Co. v. Mirich, 81 Or App 290, 294 (1987). Even a slight contribution to the causation of the disabling condition will be sufficient to shift responsibility to a latter employer. Mission Insurance Co. v. Dundon, 86 Or App 470, 472 (1987).

Industrial Indemnity relies upon the testimony of Dr. Pasquesi, orthopedic surgeon, to establish an independent contribution from claimant's employment while Liberty Northwest was on the risk. Dr. Pasquesi has examined claimant twice, once before February 1986 and once after that time. Dr. Pasquesi concludes that the February 1986 incident did independently contribute to a worsening of claimant's underlying condition.

Dr. Pasquesi's opinion is opposed by that of Dr. Tanabe. Dr. Tanabe feels that claimant experienced no new injury in February 1986 and that claimant's underlying condition was not materially worsened by the work he performed while Liberty Northwest was on the risk.

Industrial Indemnity contends that we should accept the opinion of Dr. Pasquesi over that of Dr. Tanabe. We decline to do so. Dr. Tanabe is claimant's treating physician. We generally attribute greater weight to the opinion of the treating physician, absent persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810, 814 (1983). Dr. Tanabe has treated claimant since shortly after his September 1984 injury. Dr. Tanabe performed the diskectomy on claimant in October 1984. We conclude that Dr. Tanabe is in a superior position to evaluate the causation of claimant's February 1986 symptoms. We also note that Dr. Pasquesi believed that claimant suffered a sudden onset of symptoms during his February 1986 unloading activities. This is not accurate. We, therefore, discount the persuasiveness of Dr. Pasquesi's opinion.

Industrial Indemnity further argues that the appearance of a reherniation at L4-5 as documented by Dr. Tanabe's post-surgery report establishes a worsening of claimant's condition. We agree. However, the causation of that worsening is still at issue. In this regard, while Dr. Tanabe reported pre-surgery that claimant exhibited "proof of another disc herniation at the same level," he nonetheless concluded that claimant's work activities while Liberty Northwest was on the risk did not materially worsen his underlying condition. Given the fact that Dr. Tanabe was aware of the probable herniation and still maintained his opinion of noncontribution, we conclude that claimant's February 1986 activities did not contribute even slightly to the causation of the reherniation. We find nothing in the surgery report itself to persuade us otherwise. We further find that claimant's testimony concerning recurrent symptoms during 1985 supports our conclusion.

Attorney fees for unreasonable claims processing

Dr. Tanabe requested authorization from Industrial Indemnity to perform surgery by letter dated October 6, 1986. Claimant's attorney subsequently sent letters to Industrial Indemnity's counsel on December 1, 1986 and January 5, 1987 requesting authorization for surgery. Surgery was not authorized until February 6, 1987, three days post-hearing. We conclude that the Referee's award of an attorney fee for unreasonable claims processing was proper. ORS 656.262(10); Wilma K. Anglin, 39 Van Natta 73, 75 (1987).

ORDER

The Referee's order dated May 6, 1987 is affirmed. A client-paid attorney fee payable to counsel for Liberty Northwest Insurance Corporation is approved in an amount not to exceed $2,072.

JAMES A. COOPER, Claimant
Hayner, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys
Rankin, et al., Attorneys

WCB TP-87022
September 29, 1988
Third Party Order

Claimant has petitioned the Board to resolve a dispute concerning the proper distribution of the proceeds from a third-party settlement. See ORS 656.593. Claimant contends that he was induced to assign his third party action to the paying agency by fraud or misrepresentation. See ORS 656.591. He further contends that his election to assign his third party action is void for lack of consideration. The paying agency responds that claimant's election was valid in all respects and that, because claim costs exceed the remaining balance of the

third-party recovery, claimant is not entitled to a share of the proceeds from the settlement. See ORS 656.591. In addition, the paying agency argues that claimant is estopped from challenging the validity of the assignment.

FINDINGS

Claimant suffered a compensable low back injury in November 1981. In June 1982, he was involved in an off-the-job automobile accident from which he suffered increased low back symptoms along with additional new symptoms.

By letter dated July 7, 1982, the paying agency advised claimant that, pursuant to law, he had two alternatives with regard to a third party action against the driver of the other automobile involved in the accident. Claimant was informed that he could elect either to pursue a third party recovery or he could assign his third party rights to the paying agency. Claimant was advised to contact the paying agency or seek legal advise if he had questions concerning his rights.

Accompanying the letter was a form to be used by claimant to elect between the following two options:

> "A. The undersigned elects to seek recovery against the party or parties who caused the accident and agrees to keep [the paying agency] advised of the progress and results of said suit and acknowledges that [the paying agency] has a lien upon the proceeds of such suit for moneys paid to the undersigned and for medical expenses paid.
>
> "B. The undersigned hereby represents that he has made no settlement with the party or parties responsible for [the] accident and elects to receive compensation from [the paying agency] under the Workers' Compensation Act of the State of Oregon and for this consideration hereby assigns and transfers unto [the paying agency] any and all rights or causes of action, claims or demands against any and all persons, firms or corporations arising out of the accident above described."

On August 26, 1982, claimant indicated his decision to elect Option "B" by signing a signature line thereunder. Claimant was not represented by an attorney at the time of his election.

The paying agency subsequently commenced a third party action. Trial of this lawsuit was scheduled for April 3, 1986. By letter dated March 14, 1986, counsel for the paying agency advised claimant that he represented the interests of the paying agency, not of claimant, in the pending lawsuit.

The lawsuit was subsequently settled before trial for $60,000. After deducting attorney fees, the paying agency's current and future claim costs exceeded the remaining balance of the third party settlement. Counsel for the paying agency notified claimant by letter dated April 17, 1986 that there were

no proceeds from the settlement left to distribute to claimant. Claimant was advised to contact his individual lawyer should he have any questions regarding the settlement and distribution of the proceeds therefrom.

Claimant subsequently retained counsel in conjunction with a separate workers' compensation matter. By letter dated October 19, 1987, claimant's counsel requested that the Board exercise its jurisdiction pursuant to ORS 656.593 and "determine if the monies received from claimant's personal injury action should be redistributed."

CONTENTIONS

Claimant contends that his election to assign his cause of action to the paying agency was procured by fraud or misrepresentation. Claimant asserts that he was led to believe that he would forfeit his right to continuing workers' compensation benefits on his claim unless he agreed to assign the cause of action to the paying agency. He argues that the language of the election form created this misconception. He further asserts by affidavit that an employee of the paying agency orally represented that he would forfeit his right to continuing benefits if he elected to pursue the third party action himself. Claimant further argues that his agreement to assign the action to the paying agency was not supported by consideration. By way of remedy, claimant requests that the Board award him the entire settlement proceeds. Alternatively, claimant argues that, pursuant to ORS 656.593(3), he is entitled to his statutory one-third share of the remaining balance of the proceeds, after deducting attorney fees and costs incurred in prosecuting the claim.

The paying agency denies that claimant was induced to assign his third party action to the agency by fraud or misrepresentation. The paying agency submits an affidavit from the claims representative responsible for claimant's file wherein she denies the oral misrepresentation asserted by claimant. The paying agency further contends that claimant did not challenge the validity of his election until 18 months following settlement, and, therefore, is estopped by the doctrine of laches from raising the issue at this time. Should the Board decide the merits in claimant's favor, the paying agency argues that the proper remedy is to award claimant his statutory one-third share of the remaining balance of the proceeds after payment of costs and attorney fees.

CONCLUSIONS

If a worker receives a compensable injury due to the negligence or wrong of a third person not in the same employ, the worker shall elect whether to recover damages from such third person. ORS 656.578. The proceeds of any damages recovered from a third person by the worker shall be subject to a lien of the paying agency for its share of the proceeds. ORS 656.593.

When the worker elects to recover damages from the third party, the proceeds of any recovery shall be distributed as set forth in ORS 656.593(1). Costs and attorney fees incurred shall be initially disbursed. ORS 656.593(1)(a). Then, the worker shall receive at least 33-1/3 percent of the balance of the recovery. ORS 656.593(1)(b). The paying agency shall be paid and

retain the balance of the recovery 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. ORS 656.593(1)(c). Any remaining balance shall be paid to the worker. ORS 656.593(1)(d).

The paying agency may require the worker to exercise the right of election provided in ORS 656.578 by serving a written demand by registered or certified mail or by personal service upon such worker. ORS 656.583(1). An election made pursuant to ORS 656.578 not to proceed against the employer or third person operates as an assignment to the paying agency of the cause of action, if any, of the worker against the third person, and the paying agency may bring action against such third person in the name of the injured worker. ORS 656.591(1). The worker is entitled to any sum recovered by the paying agency in excess of the expenses incurred in making such recovery and the amount expended by the paying agency for compensation, first aid or other medical-related service, together with the present worth of future monthly payments of compensation. ORS 656.591(2).

Here, claimant admittedly elected to assign his cause of action to the paying agency. Claimant asserts, however, that he was misled by the language of the election form into believing that he would continue to receive compensation benefits on his compensable claim only if he agreed to assign his third party action to the paying agency. Claimant argues that the following language from Option "B" caused him to be misled:

> "The undersigned ... elects to receive compensation from [the paying agency] under the Workers' Compensation Act of the State of Oregon and for this consideration hereby assigns and transfers unto [the paying agency] [his third party claim.]"

Claimant further asserts by affidavit that he was informed by a claims representative from the paying agency that if he checked Option "A" he would receive no further workers' compensation benefits. The claims representative in charge of claimant's file expressly denies, by affidavit, having made such a statement. A potential credibility question is thereby raised.

If, as argued by the parties, resolution of this case turns upon traditional contract notions, then it would be necessary for us to resolve this credibility dispute. Resolution of this dispute would require us to determine whether claimant had subjectively been misled by the election form and/or the claims representative's oral representations. See Whitlatch v. Bertagnolli, 45 Or App 985, 988 (1980) (requirement that hearer rely on the truth of the misrepresentation is essential element of actionable fraud). Under a contract analysis, if claimant was subjectively misled by the paying agency, then rescission of the election is appropriate. See Davenport v. Vlach, 81 Or App 553 (1986), rev den 302 Or 615 (1987) (fraudulent misrepresentation entitles party to rescind contract if done promptly). We conclude, however, that the parties' characterization of this matter as one involving a contractual dispute is incorrect.

We first note that workers' compensation law is purely

statutory. Eschliman v. GAB Business Service, 80 Or App 459, 460 (1986). The rights and obligations of the parties in a third party matter are established by the provisions of ORS 656.576 through 656.595. A worker's choice either to proceed himself against a third party or to assign his cause of action to the paying agency does not involve an exchange of promises between the parties such that a contract is created. Instead, the paying agency is given a statutory right to compel an election by the worker pursuant to ORS 656.583. It follows that the validity of that election is determined by statute rather than contract law.

Having concluded that traditional contract notions are inapplicable, we must determine under what circumstances, if any, claimant is statutorily entitled to revoke his prior election. Neither the statutes nor the administrative rules provide express guidance on this question. We conclude, however, that guidance can be found by analogizing to the insurer's statutory duty to accept or deny a claim for injury or occupational disease within 60 days. See ORS 656.262(6).

As is true of claimant's election here, the insurer's choice to accept or deny a claim carries multiple consequences to both parties but does not create a contract between the parties. In addition, once the insurer has "elected" to accept a claim, it is generally prohibited from later "rescinding" that acceptance. Bauman v. SAIF, 295 Or 788, 794 (1983). However, the Court in Bauman created a limited number of circumstances under which an insurer may "rescind" its prior choice to accept a claim. Pursuant to the Court's decision, an insurer may "rescind" its prior acceptance of a claim upon a showing of "fraud, misrepresentation or other illegal activity." Id.

We conclude, by analogy, that claimant may rescind his election upon a showing of fraud or misrepresentation. However, the question remains whether claimant must prove that he was misled in fact, as is required under a contract analysis. Whitlatch v. Bertagnolli, supra. Stated otherwise, we must determine whether the requisite elements of a "misrepresentation" in this context mirror those in a contractual context. Again, we look to the courts' discussion of the insurer's right to "rescind" its acceptance of a claim for guidance.

In Ebbtide Enterprises v. Tucker, 303 Or 459, 464 (1987), the Court held that, in order to support a rescission of an earlier acceptance, the insurer must show that the decision to accept the claim "could reasonably have been affected" if the true facts had been known. The insurer is not required to show that it in fact would have denied the claim with the correct information. Newport Elks Club v. Hays, 92 Or App 604 (1988).

Applying this standard to the third party matter before us, we conclude that claimant need only show that the election form was misleading and that his decision to assign his rights to the paying agency "could reasonably have been affected" if the true facts had been known. Claimant need not prove that he was, in fact, misled into assigning his third party action to the paying agency. See Newport Elks Club v. Hays, supra, 92 Or App at 607.

We find that the election form is misleading. Option "A" and Option "B", read together, strongly imply that in order to continue receiving benefits under his compensable claim, claimant

had to elect Option "B". Both parties agree that this is not a correct statement of the law. Moreover, it is readily apparent that claimant's election could have been influenced by the knowledge that he did not need to assign his third party action to the paying agency in order to continue to receive his workers' compensation benefits. We conclude that, absent a defense on the part of the paying agency, claimant is entitled to rescind his prior election.

The paying agency asserts such a defense. It contends that claimant "sat on his rights" for 18 months following settlement of the third party action; therefore, the paying agency argues, claimant should not be permitted to make a claim for redistribution of the proceeds of that settlement. This is essentially a laches argument. Assuming that a defense of laches is ever applicable in a workers' compensation matter, we conclude that the insurer has failed to show entitlement here. In order to constitute laches, the delay must result in substantial prejudice to the party asserting its protection to the extent that it would be inequitable to afford the relief sought. Stephan v. Equitable Sav. and Loan Ass'n, 268 Or 544, 569 (1974). No such prejudice has been shown here.

We conclude that claimant is entitled to rescind his prior election to assign his third party action to the paying agency. Because the third party action has already been settled by the paying agency, we find that the proceeds of that settlement should be redistributed in accordance with the statutory scheme established in ORS 656.593. The paying agency's costs and attorney fees incurred in obtaining the settlement should be treated as if they were incurred by claimant. See ORS 656.593(1)(a). Claimant shall receive 33-1/3 percent of the balance of the recovery. The paying agency shall retain the balance of the recovery to the extent that it is compensated for its accrued reimbursable expenditures, and for the present value of its reasonably to be expected future reimbursable expenditures. The remaining balance, if any, shall be paid to claimant.

IT IS SO ORDERED.

CHARLOTTE J. DAZA, Claimant
Malagon & Moore, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney

WCB 86-10179
September 29, 1988
Order on Review

Reviewed by Board Members Crider and Johnson.

Claimant requests review of Referee Nichols' order that affirmed an award by Determination Order of 20 percent (64 degrees) unscheduled permanent disability for a low back injury.

On review, the issue is extent of unscheduled permanent partial disability.

We modify the Referee's order.

FINDINGS OF FACT

On September 16, 1982, claimant sustained a compensable lumbar strain while working as a nurse's assistant in a nursing home. At that time, she was lifting a patient and heard a pop in her lower back. A short while later, she developed pain in her

low back, inner thighs, and posterior left leg and foot. On or around October 20, 1982, she aggravated her condition while supporting a patient at work.

Claimant received conservative treatment from Dr. Freeman, orthopedist. She returned to a modified, light-duty nursing position after her injury but quit in November 1982 to work as a cashier. She continued this job until March or April 1983, but has not worked since. A Determination Order, issued May 13, 1983, closed her injury claim with no award of permanent partial disability. Claimant did not appeal the order, and it became final as a matter of law.

Claimant received no further medical care until May 1985 when she sought treatment for low back and leg symptoms from Dr. Walborn, chiropractor. Since that time, she has continued to experience symptomatic flare-ups. She has also demonstrated minimal objective abnormalities, including: barely perceptible knee reflexes; positive bilateral Laseque's straight-leg-raise and Braggard's tests; and decreased sensitivity to pinprick in the medial left foot, thigh and calf. A June 1985 CT scan and July 1986 x-rays were normal.

Claimant's injury claim was reopened for aggravation pursuant to a December 1985 stipulation. A Determination Order, issued on May 31, 1986, reclosed the claim and awarded claimant 20 percent unscheduled permanent disability for her back condition.

Claimant was 40 years-old at the time of hearing. She has an 8th grade education with no GED. She can read and write but has some trouble with spelling. She has experience as a nurse assistant, cook, assembly line worker and cashier. She also has transferable skills for general sales work.

After de novo review of the medical and lay evidence, we find that claimant credibly testified regarding the general nature of her symptoms and limitations. Accordingly, we are persuaded that she continued to experience symptomatic flare-ups of low back and left leg pain after her claim was initially closed in May 1983. However, we find that she exaggerated the extent of her symptoms and limitations, both at hearing and in her conversations with Dr. Walborn. We further find that her chronic low back pain is mildly disabling and limits her to light work that allows her to alternate between sitting and standing.

CONCLUSIONS AND OPINION

In order to prevail on her claim for additional permanent disability, claimant must first prove that the condition resulting from the compensable injury has permanently worsened since the last award or arrangement of compensation. Stepp v. SAIF, 304 Or 375 (1987). Once claimant has established a permanent worsening, the amount of her disability is based on loss of earning capacity due to the compensable injury, as reflected by her physical impairment and relevant social and vocational factors. See ORS 656.214(5); OAR 436-30-380, et seq.

In regard to the threshhold requirement of a permanent worsening, claimant's last award of compensation was the May 1983 Determination Order that initially closed her claim with no award of permanent disability. Accordingly, if claimant demonstrates even a minimal degree of injury-related permanent impairment, she will have met the threshhold worsening requirement.

As discussed above, we are persuaded that claimant credibly testified that her injury-related pain interferes with her ability to sit and stand for prolonged periods of time. In support of this finding, we note that Dr. Walborn agreed that claimant's pain was disabling. We are aware that independent medical reports from Dr. Crist, M.D., and Dr. Schachner, M.D., indicate that claimant has sustained no injury-related permanent impairment. However, Dr. Crist based his opinion on a file review, and Dr. Schachner examined claimant on only one occasion. In contrast, treating physician Walborn has had greater opportunity to observe claimant's limitations. See Taylor v. SAIF, 75 Or App 583 (1985), Weiland v. SAIF, 64 Or App 810, 814 (1983).

Moreover, Dr. Walborn's opinion is better-reasoned and based on the most complete information. See Somers v. SAIF, 77 Or App 259, 263 (1986). In particular, Dr. Schachner relies heavily on the absence of objective findings on the one occasion he examined claimant. However, claimant has demonstrated objective findings at other times. More importantly, such findings are not a prerequisite where claimant experiences disabling pain which results in lost earning capacity. See Harwell v. Argonaut Insurance Co., 296 Or 505 (1984). Similarly, Dr. Crist's opinion is not persuasive because it is inconsistent with claimant's history of continuing symptomatic flare-ups following initial claim closure. Accordingly, we conclude that claimant has demonstrated the permanent impairment necessary to satisfy the threshold requirment of a permanent worsening. See Stepp v. SAIF, supra.

Turning to the specific amount of claimant's physical impairment, we note that claimant and Dr. Walborn reported a moderate amount of disabling pain. In particular, claimant testified that she "almost always" has problems with her back and could only stand continuously for 10 to 15 minutes and sit or walk continuously for 15 to 20 minutes. Dr. Walborn opined that claimant had sustained a permanent 40 percent low back disability due to chronic disabling pain. He also recommended that claimant limit herself to light sedentary work that accommodated her limitations on standing and sitting and involved no repetitive lifting and only occasional lifting over 10 pounds.

As discussed above, we are persuaded that claimant's testimony and Dr. Walborn's evaluation demonstrate some degree of disabling pain. However, we note that claimant exhibited numerous inconsistencies when Dr. Schachner examined her in July 1986. Furthermore, in a conversation with her vocational counselor in the fall of 1986, claimant acknowledged that it was hard to assess her physical limitations accurately because she was frightened to try things beyond a certain point. In addition, her testimony that she could not tolerate the prolonged standing associated with her cashier position is inconsistent with contemperaneous medical reports that she was experiencing no problems with that job. Finally, we note that claimant testified that she almost always has pain, whereas the medical record documents complaints of episodic pain.

As a result, we are persuaded that claimant exaggerated the extent of her limitations both at hearing and in her conversations with Dr. Walborn. As a result, we consider claimant's subjective limitations and Dr. Walborn's evaluation in light of that fact. Accordingly, we find that claimant's pain is mildly disabling and limits her to light work that allows her to alternate between sitting and standing.

In addition to this physical impairment, we also consider relevant social and vocational factors. These include claimant's lack of education and the mitigating effect of her transferable skills for work as a cashier or sales person. In regard to the latter, we note that claimant's physical limitations regarding prolonged sitting and standing will limit her ability to use her transferable skills for cashiering and sales work.

After considering all of the factors discussed above, we conclude that an award of 30 percent unscheduled permanent disability adequately compensates claimant for her low back injury. Accordingly, we modify the Referee's order and award claimant an additional 10 percent unscheduled permanent disability.

ORDER

The Referee's order dated April 23, 1987 is modified. In addition to the 20 percent (64 degrees) unscheduled permanent disability awarded by Determination Order, claimant is awarded 10 percent (32 degrees) unscheduled permanent disability for her low back injury. Claimant's attorney is awarded a fee of 25 percent of the increase in compensation due claimant as a result of this order, not to exceed $3,800, to be paid from the increased compensation.

FLOYD W. FARMER, Claimant
Grant, Ferguson, et al., Claimant's Attorneys
Davis & Bostwick, Defense Attorneys

WCB 86-00949
September 29, 1988
Order on Review

Reviewed by Board Members Crider and Johnson.

Claimant requests review of those portions of Referee Mongrain's order that: (1) declined to award permanent total disability; and (2) awarded 90 percent (288 degrees) unscheduled permanent disability for a back condition, in lieu of a Determination Order award of 35 percent (112 degrees).

The Board reverses the order of the Referee and grants claimant permanent total disability.

ISSUE

Whether claimant is permanently and totally disabled.

FINDINGS OF FACT

Claimant was 54 years of age at the hearing. He has a third or fourth grade education and is functionally illiterate. His employment history consists of manual labor or assembly line-type work, including jobs as a door assembler, cotton gin operator, and construction laborer. He has no training in lighter occupations.

In September 1984, claimant sustained a compensable bilateral hernia and back injury while working as a door assembler. The next month, he underwent corrective hernia surgery performed by Dr. Oehling, a surgeon. Approximately six weeks post-surgery, Oehling released him to regular work. He did not return to work, however, due to continuing pain.

In January 1985, claimant was examined by Dr. Bolton, an orthopedist. Bolton diagnosed a herniated lumbar disc with nerve root impression. That same month, claimant began treating with Dr. Coplen, a chiropractor.

In April 1985, Dr. Coplen referred claimant to Dr. Maurer, an orthopedist. Maurer performed a closing examination on November 11, 1985.

The insurer authorized vocational rehabilitation services in the Spring of 1985. Such services included a psychological assessment of claimant's vocational aptitudes performed by R. C. Taylor, psychologist.

A Determination Order issued in December 1985, awarded claimant 35 percent unscheduled permanent disability.

In January 1986, claimant's vocational counselor, Mr. Cope, referred him to an injured worker program for evaluation of his ability to perform cashier work. The evaluation was performed by Mr. Goldwaite, a work evaluation specialist. Shortly thereafter, claimant's vocational services were terminated because he allegedly failed to follow-up on a potential job. In August 1986, however, Mr. Cope recommended reinstatement of claimant's vocational services.

Claimant cannot bend or twist, climb stairs, or perform routine household chores. He cannot lift in excess of 20 pounds or sit in excess of 30 minutes. He has below average intellectual abilities and no experience or training in light duty occupations.

Claimant is permanently and totally disabled from regularly performing gainful and suitable employment.

Claimant was willing to seek regular gainful employment and made reasonable efforts to obtain such employment. Given his extent of permanent disability, it was futile for claimant to seek regular gainful employment.

CONCLUSIONS OF LAW

Under the "odd-lot" doctrine, a worker's physical impairment as well as contributing non-medical factors such as age, education, adaptability to lighter work, and emotional conditions can establish permanent total disability. Clark v. Boise Cascade Co., 72 Or App 397 (1985). Unless the "futility" exception applies, the worker has the burden of proving that he is willing to seek regular gainful employment and that he made reasonable efforts to obtain such employment. ORS 656.206(3); see also Butcher v. SAIF, 45 Or App 313, 318 (1983).

The Referee increased claimant's total award of unscheduled permanent disability to 90 percent. Finding that claimant was not motivated to return to work, however, the Referee declined to grant permanent total disability. We disagree.

Here, Dr. Coplen restricted claimant to sedentary or light work and no lifting in excess of 20 pounds. Similarly, Dr. Maurer opined, inter alia:

> "It remains quite unlikely . . . that [claimant] will be able to return to his previous employment.
>
> "I am recommending . . . that he be rehabilitated into an occupation that does not require more than 20 lbs. of lifting,

> or . . . any type of bending activities, [while] at the same allowing him to alternate between sitting and standing."

After testing claimant's vocational aptitude, Dr. Taylor reported that claimant had below average motor coordination skills, deficient verbal and numerical abilities, and "borderline general intellectual functioning." Likewise, Mr. Goldwaite reported, inter alia:

> "[I]t is felt that [claimant] does not have the . . . cognitive and arithmetical computation skills that would be required for successful work performance as a retail cashier. He would likely require extensive remedial education and a fairly lengthy training period before being expected to be employed competitively in the community as a cashier."

We are persuaded by the uncontradicted opinions of Coplen, Maurer, Taylor, and Goldwaite. Given claimant's advanced age, minimal education, limited intellectual functioning, and lack of experience or training in light duty occupations, he is unable to regularly perform work at a gainful and suitable occupation.

We are further persuaded by the testimony of Mr. McClean, a vocational expert, over that of Mr. Cope. Mr. Cope testified that claimant was employable with several proposed employers as a linen folder, cut-off saw operator, egg washer, or dumping machine operator. Yet, Mr. Cope conceded that such proposed jobs might need modifications and/or that claimant might need wage subsidy assistance. See Gettman v. SAIF, 289 Or App 609 (1980) (A worker's permanent total disability is evaluated at the time of the hearing). Mr. Cope further conceded that he had neither contacted any of the proposed employers to determine if work was actually available nor observed any of the proposed jobs to verify whether they were, in fact, within claimant's physical restrictions.

On the other hand, Mr. McClean testified that he had contacted all of the proposed employers and had personally observed the physical demands required in each job. According to McClean, each of the proposed jobs exceeded claimant's physical restrictions. In McClean's opinion, claimant had "lost his ability to perform gainful employment." Accordingly, we find that claimant falls within the "futility" exception to the statutory seek work requirement. See George M. Turner, 38 Van Natta 531, 536 (1985).

Moreover, independent of the application of the "futility" exception to this case, we find that claimant has proven that he was willing to seek regular gainful employment and that he made reasonable efforts to obtain such employment. ORS 656.206(3). That is, claimant sought work as a linen folder, but was informed by the employer that there was no available work. He also contacted several employers with cut-off saw work, only to discover that such jobs exceeded his bending and lifting restrictions.

As a final matter, claimant is entitled to permanent total disability effective November 11, 1985. On that date, Dr. Maurer performed a closing examination and opined that

claimant was medically stationary with limitations of no lifting beyond 10 pounds, no bending or twisting, and no sitting in excess of 30 minutes. We conclude that November 11, 1985, is the earliest date in which claimant became permanently and totally disabled. See Adams v. Edwards Heavy Equipment, Inc., 90 Or App 365, 370-71 (1988).

ORDER

The Referee's order dated December 24, 1986, is reversed. Claimant is awarded permanent total disability benefits effective November 11, 1985. The insurer is authorized to offset unscheduled permanent partial disability compensation paid after November 11, 1985, pursuant to the Determination Order and the Referee's Opinion and Order, against the compensation granted by this order. Pacific Motor Trucking Co. v. Yeager, 64 Or App 28, 31-32 (1983). Claimant's attorney is awarded 25 percent of the increased compensation granted by this order, provided that the total of fees approved by the Referee and the Board does not exceed $6,000 for services at hearing and on Board review.

LARRY A. FIRKUS, Claimant
Imperati, et al., Claimant's Attorneys
Mitchell, et al., Defense Attorneys
SAIF Corp Legal, Defense Attorney
Beers, et al., Defense Attorneys

WCB 86-16103, 86-08043 & 86-08042
September 29, 1988
Order on Review

Reviewed by Board Members Crider and Ferris.

The self-insured employer requests review of those portions of Referee Menashe's order that: (1) set aside its denials of claimant's aggravation and "new injury" claims for his current back condition; and (2) upheld the SAIF Corporation's aggravation denial of the same condition. We affirm.

ISSUES

1. Compensability of claimant's thoracic condition.

2. Responsibility for the same condition.

FINDINGS OF FACT

The Board adopts the Referee's factual findings. In addition, we make the following supplemental findings.

Altered body mechanics resulting from claimant's 1982 hand injury caused claimant to change the normal way he lifted and carried items. These altered body mechanics, combined with claimant's work activities, resulted in the development of a thoracic strain. Moreover, claimant's employment while the employer was self-insured was a material cause of the development of that thoracic condition.

CONCLUSIONS AND OPINION

We affirm and adopt the Referee's opinion with the following comments. The Referee found that claimant's last period of employment independently contributed to the causation of his condition. The employer was self-insured at the time. Relying upon Boise Cascade Corp. v. Starbuck, 296 Or 238 (1984) and Smith v. Ed's Pancake House, 27 Or App 361 (1976), the Referee assigned responsibility for claimant's condition to the self-insured

employer. The cases relied upon by the Referee involved application of the "last injurious exposure" rule.

The self-insured employer argues on review that prior to assignment of responsibility pursuant to application of the "last injurious exposure" rule, claimant must first prove a compensable claim. The employer further argues that claimant has failed to prove a compensable claim against it because he has not shown that his work activities with the employer while self-insured were "the major contributing cause" of his condition. See Weller v. Union Carbide Corporation, 288 Or 27 (1980).

The employer's argument fails for two reasons. First, "the major contributing cause" standard advanced by the employer is not applicable to this case. The "major contributing cause" standard applies to cases involving occupational diseases. Weller, supra. In this regard, claimant asserts that the thoracic condition followed as a consequence of his 1979 and 1982 injuries. The fact that claimant's thoracic condition developed over a period of time does not convert his claim to one for an occupational disease. In addition, there is no evidence in the record that claimant's thoracic condition results from a preexisting thoracic disease. Under these circumstance, claimant must prove that the work-related injury was a material cause of the condition. See Jeld-Wen, Inc. v. Page, 73 Or App 136, 139 (1985); cf. Kepford v. Weyerhaeuser Co., 77 Or App 363, 366-67 (1986). Claimant has carried his burden on this issue through the testimony of his treating physician, Dr. Pullella.

In addition, the employer's argument fails to take into account one of the two functions of the "last injurious exposure rule." The rule functions not only as a method of assigning responsibility, it also functions as a rule of proof. Pursuant to the rule, claimant need only show that his condition is work-related. Starbuck, supra, 296 Or at 244 (1984). Claimant is relieved of the burden of proving medical causation as to any specific insurer. Bracke v. Baza'r, 293 Or 239 (1982); Spurlock v. International Paper Co., 89 Or App 461 (1988).

Here, claimant has proven not only that his condition was work-related, but he has also proven that his on-the-job lifting activities while the employer was self-insured contributed independently to his thoracic condition. We conclude that the Referee correctly determined this issue.

Therefore, claimant has successfully defended against a carrier-initiated request for review attempting to disallow his compensation. Claimant's attorney would normally be entitled to an assessed fee for his services on Board review. See ORS 656.382(2). However, claimant's counsel failed to timely file his respondent's brief. Moreover, there is no evidence in the record that claimant's counsel provided legal representation short of briefing which would support an attorney fee award on review. See Dan W. Hedrick, 38 Van Natta 208 (1986), aff'd mem 83 Or App 275 (1987). We conclude that claimant's counsel is not entitled to the award of an assessed fee on review. Shirley M. Brown, 40 Van Natta 879 (July 27, 1988).

ORDER

The Referee's order dated March 31, 1987 is affirmed.

CELIA GARCIA, Claimant
Olson Law Firm, Claimant's Attorney
Cummins, et al., Defense Attorneys

WCB 85-07123
September 29, 1988
Order on Review

Reviewed by Board Members Johnson and Crider.

Claimant requests review of those portions of Referee Garaventa's order that: (1) declined to award scheduled permanent partial disability for her left knee injury; (2) upheld the self-insured employer's denial of chiropractic care as not reasonable and necessary; (3) declined to grant temporary total disability benefits in lieu of temporary partial disability benefits granted by the Determination Order; and (4) found that claimant's claim was not prematurely closed. We affirm.

ISSUES

1. Whether claimant is entitled to an award of scheduled permanent disability as a result of her October 29, 1984 compensable injury.

2. Whether claimant is entitled to temporary total disability benefits from March 28, 1985 through May 15, 1985.

3. Whether claimant's current chiropractic treatment is reasonable and necessary.

4. Whether the Determination Order of March 11, 1986, prematurely closed claimant's claim.

FINDINGS OF FACT

Claimant was 38 years old at the time of hearing. She has a seventh grade education, and her work history is comprised of cannery work. She compensably injured her left knee on October 29, 1984, when she slipped on a piece of broccoli and fell, landing on her left knee. The claim was accepted and benefits were paid.

Dr. Freeman, claimant's treating chiropractor, diagnosed a sprain and subluxation of the left knee and treated the injured knee with chiropractic manipulation.

Claimant continued to work from the date of her accident until March 28, 1985. Time loss was authorized by Dr. Freeman in a May 14, 1985 letter to the employer in which he stated that claimant had been unable to work since March 28, 1985. That letter was received by the employer on May 16, 1985. Dr. Freeman reported that claimant could do no heavy work and that she would be permanently restricted to doing sedentary, light or medium work. Claimant has not returned to work.

Dr. Freeman did not see claimant between March 15, 1985 and April 12, 1985. Claimant saw Dr. Freeman three times. During her appointments with Dr. Freeman, claimant complained of and received treatment for both legs, knees, right foot and neck.

Claimant incurred prior injuries to her left knee in 1977 and 1982. Claimant's 1982 injury continued to cause problems to the date of her present 1984 left knee injury.

On August 19, 1985, the Independent Chiropractic Consultants examined claimant.

On February 25, 1986, the employer denied continuing chiropractic treatment on the ground that it was not reasonable or necessary as a result of the October 29, 1984 left knee injury.

Claimant was medically stationary as of January 9, 1986. A March 11, 1986 Determination Order awarded temporary partial disability benefits from March 15, 1985 through May 15, 1985 and temporary total disability from May 16, 1985 through January 9, 1986. The Determination Order granted no permanent disability.

Claimant was not a credible witness.

OPINION AND CONCLUSIONS

Permanent Partial Disability

Claimant has the burden of proving a permanent loss of use or function as a result of her October 29, 1984 compensable left knee injury. See ORS 656.214(2)(c).

The Referee found that claimant was not a credible witness. We defer to the Referee's credibility finding as it is based upon her observation of claimant's demeanor at hearing. Humphrey v. SAIF, 58 Or App 360 (1982). Furthermore, her testimony is riddled with inconsistencies, and we conclude she is not credible. See Costal Farm Supply v. Hultberg, 84 Or App 382 (1987).

The Independent Chiropractic Consultants described their August 19, 1985 examination of claimant and review of radiographs in detail and concluded that there was no permanent impairment as a result of the 1984 injury.

The treating physician's opinion is generally entitled to greater weight lacking sufficient reasons to the contrary. Weiland v. SAIF, 64 Or App 810 (1983). In the present case, Dr. Freeman, claimant's treating chiropractor, is the only expert to present an opinion which could be construed to indicate a loss of function to the left knee.

Dr. Freeman's opinion, however, is not sufficient to support an award of permanent disability. He stated only that claimant has a "partial disability"; he gave no explanation or indication of the degree of impairment. Furthermore, Dr. Freeman's chart notes indicate he treated many areas of claimant's body, yet he did not attribute any impairment to a particular body part. Thus, his opinion is conclusory and not persuasive; it is insufficient to establish a permanent loss of function to claimant's left knee. Finally, Dr. Freeman does not indicate that he has any knowledge of claimant's prior left knee injuries so as to assess the permanent disability caused by the 1984 injury.

Consequently, claimant has failed to establish a permanent loss of use or function of her left knee as a result of her October 29, 1984 compensable injury.

Temporary Total Disability

Claimant seeks temporary total disability benefits rather than the temporary partial disability benefits as granted by the Determination Order for the period from March 28, 1985 through May 15, 1985. She relies on Dr. Freeman's May 14, 1985 letter wherein the doctor stated that claimant had been totally disabled since March 28, 1985.

Whether claimant is entitled to temporary total disability depends on whether a preponderance of the evidence shows that she was disabled from March 28, 1985 through May 15, 1985 due to her compensable claim. See ORS 656.210. A doctor's verification of an inability to work is evidence of disability, but it is not necessarily the only relevant evidence. See Garbutt v. SAIF, 297 Or 148 (1984). The entire record is relevant to whether claimant is entitled to temporary total disability.

In a June 16, 1986 letter to claimant's attorney, Dr. Freeman stated that his assessment that claimant was unable to work beginning on March 28, 1985 was based on his observations of claimant, on claimant's inability to move freely, and on claimant's experience of pain on palpitation.

This letter is not persuasive. According to his chart notes, Dr. Freeman did not see claimant between March 15, 1985 and April 12, 1985. His conclusion is based on purely subjective complaints of a claimant who is not credible. Furthermore, during her appointments with Dr. Freeman, claimant complained of pain not only in her left knee, but also in her right foot, neck, right knee and legs.

Based on the record, we cannot conclude that claimant has established an entitlement to temporary total disability between March 28, 1985 and May 15, 1985.

Reasonable and Necessary Medical Treatment

Claimant is entitled to all reasonable medical services, curative or palliative, so long as they are necessitated by the compensable injury. ORS 656.245(1); West v. SAIF, 74 Or App 317 (1985); Wetzel v. Goodwin Bros., 50 Or App 101 (1981). It is claimant's burden to prove the reasonableness and necessity of treatment. McGray v. SAIF, 24 Or App 1083 (1976).

Dr. Freeman's letter of April 14, 1986 states only that claimant needs ongoing care on a periodic basis. He neither explains that statement nor relates any need for treatment to claimant's compensable injury. His chart notes indicate that she was receiving treatment for many areas of her body. Therefore, claimant has failed to prove that continuing chiropractic care was reasonable and necessary.

Premature Claim Closure

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 (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 Section at the time of closure. Schuening v. J.R. Simplot, 84 Or App 622 (1987); Brown v. Jeld-Wen, Inc., 52 Or App 191 (1981).

At the time of closure the Evaluation Section had a November 27, 1985 report of the Independent Chiropractic Consultants indicating that claimant was medically stationary, a January 9, 1986 response from Dr. Freeman indicating his concurrence and a February 3, 1986 note by Dr. Freeman stating that any care claimant continued to receive was palliative. Therefore, the Evaluation Section closed the claim on March 11, 1986.

Claimant contends that Dr. Freeman misunderstood a portion of the Independent Chiropractic Consultant's report and on March 5, 1986 wrote that he felt claimant should continue to receive chiropractic care. However, even if we credit Dr. Freeman's medical opinion, a claimant may need on-going care but nonetheless be stationary. Thus, Dr. Freeman's March 5, 1986 opinion does not assist claimant in establishing that she was not medically stationary at the time of closure. Therefore, claimant's claim was not prematurely closed.

ORDER

The Referee's order dated March 31, 1987 is affirmed. The Board approves a client-paid fee, not to exceed $182.

ERNEST G. GILVIN, Claimant
Malagon & Moore, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney
Beers, Zimmerman & Rice, Defense Attorneys

WCB 86-14688, 86-14689 & 86-14690
September 29, 1988
Order on Review

Reviewed by Board Members Crider and Johnson.

Claimant requests review of Referee Leahy's order that: (1) affirmed a Determination Order which awarded claimant 10 percent (32 degrees) unscheduled permanent disability for an upper back and neck injury; (2) upheld the SAIF Corporation's denial of an aggravation claim for the same condition; (3) upheld EBI Companies' denial of claimant's "new injury" claim for the same condition; (4) determined claimant was neither entitled to interim compensation from September 8, 1985 to December 11, 1986 nor an associated penalty and attorney fee; and (5) declined to assess a penalty and attorney fee for alleged unreasonable claims processing. The issues are extent of permanent disability, responsibility, jurisdiction, temporary disability compensation, and penalties and attorney fees.

FINDINGS OF FACT

Claimant's first injury occurred in May 1984 while he was working as a painter for SAIF's insured. He lived in Cottage Grove, Oregon at the time. While lifting a piece of equipment, he injured his upper back and neck. SAIF accepted the claim. Claimant began receiving chiropractic treatment. He had pain at the base of his neck radiating into his right shoulder with an on-and-off tingling sensation in his right hand. He continued to work without restrictions. There was no closure at this time.

Claimant suffered a second injury three months later. This was a low back injury which was eventually closed with payment of temporary disability only.

Claimant continued to experience symptoms relating to his cervical condition. A cervical laminectomy at C6-7 was performed by Dr. Golden, neurosurgeon, in March 1986. In May, claimant was referred for vocational services. In July, Dr. Golden released claimant to modified work. He restricted claimant to lifting and carrying 25 to 50 pounds occasionally.

Claimant moved from Cottage Grove to Reedsport where he lived out of his van for two weeks. He then moved to Gold Beach and began working as a restaurant cook for EBI's insured.

Claimant had informed his vocational counselor that he might move to the coast. However, when he did move, he did not inform his counselor of his new address. When his counselor was unable to locate claimant, his vocational services ended.

On September 8, 1985, while working at the restaurant, claimant slipped. He grabbed a counter to avoid falling. He felt no immediate pain from this incident. However, he left work about one week later after noting left arm weakness. He subsequently filled out an EBI form titled "Supervisor's Report of Accident." The employer never forwarded this form to EBI. The employer went out of business shortly afterwards without notifying EBI of the claim. See ORS 656.262(3).

Claimant returned to Dr. Golden in late September. Dr. Golden referred claimant for x-rays. He subsequently released claimant to regular work in late October. Claimant testified that he sent the bill for this treatment to SAIF.

In November 1985, a Determination Order issued awarding claimant 10 percent permanent partial disability for his first injury while employed by SAIF's insured.

In December 1985, SAIF issued a denial of responsibility for claimant's current disability and medical treatment. SAIF suggested that claimant file a "new injury" claim with "your [sic] insurance carrier." SAIF sent a copy of the denial to "Aetna Fire and Casualty of Connecticut." This was an incorrect name for the restaurant's insurer. The correct insurer was a subsidiary of EBI Companies known as "Fire and Casualty of Connecticut."

EBI first learned of the claim in mid-January 1986, when SAIF sent the file to it. Included within the file was the SAIF denial which made reference to a new injury at EBI's insured. On January 21, 1986, EBI responded by first class letter to claimant requesting that he contact them to discuss the situation. This letter was sent to claimant's address in Gold Beach where SAIF had sent its denial letter the previous month. However, claimant had moved back to Cottage Grove earlier in January leaving no forwarding address so that he did not receive EBI's letter. EBI followed that letter up with another letter in mid-February to the same Gold Beach address. This letter was sent return receipt requested and was returned undelivered.

In March 1986, less than 60 days after receiving information from SAIF indicating the possible existence of a claim against its insured, EBI denied the claim on the basis of inability to procure supporting information. This denial letter was sent to the address listed on the form 801 claimant originally filed for his first injury. The letter was returned undelivered. EBI then attempted to contact claimant at a Saginaw, Oregon address found in claimant's vocational reports. Once again, the letter was returned undelivered.

EBI was finally able to contact claimant in October 1986 through the involvement of claimant's attorney. Claimant was living in Dorena, Oregon at the time.

Claimant was 43 years old at the time of hearing. He has a tenth grade education. His work experience has primarily involved painting and cooking. Claimant's impairment resulting from his May 1984 injury is in the minimal range.

Subsequent to September 1985, claimant has worked as a cook for a new employer and he has worked in a service station. He left both of these positions for reasons unrelated to his injury.

CONCLUSIONS OF LAW AND OPINION

Credibility and Reliability

The Referee found claimant's testimony "deliberately devious and unreliable" as well as "so confused and vague" as not to be believable. Portions of claimant's testimony, particular as regards his varying addresses during the periods in question, are confusing. However, we do not find his testimony so confusing as not to be believable. Further, it is unclear whether the Referee's finding of "deliberately devious" testimony by claimant is based on demeanor or content. In terms of content, we find nothing in the transcript to suggest that claimant was deliberately devious in his testimony. See Delmar J. Hultberg, 37 Van Natta 1679 (1985), aff'd 84 Or App 282 (1987).

Extent of Permanent Disability

Claimant asserts entitlement to an increased permanent disability award beyond the 10 percent awarded by the November 14, 1985 Determination Order. The Referee declined to award any additional disability. The Referee read Dr. Golden's mild "disability" rating literally as a disability rating, rather than as an impairment rating. He stated that because claimant did not seek an impairment rating, a disability rating could not be made using the administrative guidelines found at OAR 436-30-380 et seq. He found the 10 percent award fair, based upon the medical records.

On review, claimant argues that Dr. Golden meant to rate impairment as mild but instead mislabeled his rating as a disability rating. Claimant also argues that he is unable to return to his 20-year occupation of painting.

Dr. Golden released claimant to light to moderate work with a 50-pound lifting limitation in July 1985. He referred to claimant's "minor symptoms." We conclude that these restrictions are in line with a mild impairment rating and that Dr. Golden was, in fact, rating impairment as argued by claimant. We note, however, that Dr. Golden's reported impairment rating is dated twenty months prior to hearing. Claimant's right sided problems subsequently completely resolved.

Claimant's primary argument is that he is precluded as a result of his injury from working as a painter. We are not persuaded that this is correct. First, claimant testified that he has applied for several jobs as a painter. In addition, he had no problems performing the cooking job until the September 8, 1985 incident. He also worked in a gas station in the summer of 1986. He left this job

for reasons unrelated to his injuries. Furthermore, Dr. Golden indicated that the light to moderate work restrictions he placed on claimant were not permanent.

Considering these facts, and taking into consideration the relevant social and vocational factors set forth in OAR 436-30-380 et seq, we conclude that the 10 percent unscheduled permanent partial disability awarded to claimant adequately and appropriately compensates him for the permanent loss of earning capacity due to the industrial injury.

SAIF's December 1985 denial

The next issue we address involves SAIF's December 1985 denial. Claimant received the denial on December 4, 1985. Claimant requested review of the denial ten months later, in October 1986. We conclude that claimant has failed to timely challenge SAIF's denial and that he, therefore, is precluded from litigating any issues raised by that denial. ORS 656.319(1).

EBI's denials

We next address the remaining issues which involve claimant's restaurant injury and EBI's subsequent denials. Claimant argues that EBI was required to commence payment of interim compensation within 14 days of the employer's notice of the claim. Claimant also argues that the insurer was required to accept or deny the claim within 60 days of the employer's notice or knowledge of the claim. Claimant asserts that the employer had notice of his claim by September 14, 1985 at the latest -- the date on which he quit work at the restaurant.

Claimant is correct. An insurer is required by law to commence payment of interim compensation no later than the 14th day after the employer -- not the insurer -- has notice of the claim. ORS 656.262(4); Nix v. SAIF, 80 Or App 656 (1986), rev den 302 Or 158 (1987).

Claimant also asserts that he is entitled to a penalty and attorney fees for EBI's alleged unreasonable failure to pay interim compensation. ORS 656.262(10). EBI argues that its failure to pay interim compensation was not unreasonable because EBI had no knowledge of the claim until January 15, 1986 and because its failure to deny the claim earlier was due to claimant's conduct in not advising anyone with regard to his various addresses.

However, EBI first attempted to contact claimant on January 21, 1986, well beyond the 60-day limitation period. The reason EBI failed to respond earlier was the failure of its insured to notify it of the claim. Nevertheless, the employer's conduct is legally attributable to its insurer. See Nix v. SAIF, supra, at page 660. In Nix, the employer did not notify SAIF of the claim until almost three months following the accident. Consequently, interim compensation was not timely paid. The Referee awarded a penalty and attorney fees. The Board reversed, holding that an award of a penalty and attorney fees was not justified because the fact that claimant was unable to work due to his injury was not known to SAIF until the hearing. The court disagreed:

> "Although SAIF may have proceeded correctly after receiving notice of the claim, the fact remains that claimant was not served

> by the workers' compensation system as he had a right to be. Compensation was not paid within 14 days of the accident, because employer failed to report the accident within five days, as required by ORS 656.262(3). That conduct of the employer was unreasonable and is legally attributable to his insurer, SAIF. See Anfilofieff v. SAIF, 52 Or App 127, 627 P2d 1274 (1981)." 80 Or App at 660.

In accordance with the Nix holding, we conclude that claimant is entitled to an award of a penalty and attorney fees.

Pursuant to ORS 656.262(10), the penalty to be awarded is based upon "amounts then due." Claimant argues that he is entitled to interim compensation from September 8, 1985, the date of his work incident, to December 11, 1986, the date of EBI's final denial. The triggering event for commencement of payment of interim compensation is the date on which the employer has notice of the claim and the fact that claimant is missing work as a result of the injury. Claimant testified that he left work as a result of his injury on September 14, 1985. We accept this unrebutted testimony.

Interim compensation is generally payable until the insurer officially denies the claim. Here, however, claimant's treating physician, Dr. Golden, released claimant to regular work as of October 28, 1985. We have previously held that after being released to regular work, a claimant is no longer entitled to interim compensation. David C. Scott, 37 Van Natta 973 (1985); See also Bono v. SAIF, 298 Or 405 (1984). We adhere to that ruling.

Therefore, claimant is entitled to interim compensation from September 15, 1985 through October 27, 1985. We note that SAIF was ordered by Determination Order to pay temporary disability during this time period. EBI is nevertheless required to pay interim compensation for this overlapping period. See Steven E. Pace, 38 Van Natta 139, 143 (1986).

Claimant also raises several issues with regard to the EBI denial itself. He requests that the denial be set aside. He requests penalties and attorney fees for unreasonable denial. ORS 656.262(10). And he requests penalties and attorney fees for late denial. Id.

The Referee concluded that claimant's hearing request was untimely. We disagree.

Claimant requested a hearing on October 23, 1986. If EBI's March 11, 1986 denial triggered the statutory time limitation found in ORS 656.319(1), then the Referee was correct.

The Board has previously determined that mailing alone does not trigger the running of the statutory time period. The notice must actually be delivered to claimant. Charles H. Whiddon, 39 Van Natta 407, on recon 39 Van Natta 811 (1987). In Whiddon, we distinguished the Court of Appeals opinion in Cowart v. SAIF, 86 Or App 748 (1987). In Cowart, the court stated that "[t]he date of mailing, not receipt, starts the running of the 60 days." We noted that the claimant in Cowart received the denial well before the expiration of the 60 days. We continue to hold

that Cowart does not lessen the insurer's obligation to actually notify claimant of the denial pursuant to ORS 656.262(6) and ORS 656.319. We find this conclusion supported by statute and case law.

When the Supreme Court discussed this issue in Norton v. Compensation Department, 252 Or 75 (1968), the Court observed that the rule holding that the time within which to request a hearing runs from the date of mailing is sensible given the presumption that mailing will bring about actual notice. The Court noted that the denial at issue had actually been received well inside the 60 day period and thus that the presumption worked properly in that case. The Court specifically reserved the issue now before us, stating:

> "It is, of course, conceivable that the mailing of the notice of denial will not bring notice of the denial to the workman within 60 days after the denial or will not bring notice within a reasonably substantial time after the mailing, all through no fault of the workman. What relief can be granted to the workman in such event will have to depend upon the particular circumstances of each case." 255 Or at 78.

The answer, we believe, is that if the facts rebut the presumption that mailing produces actual delivery of notice, then the 60-day period does not begin to run until the date of successful mailing or actual notice.

We distinguish the instant case from that presented to the Court of Appeals in Anderson v. EBI Companies, 79 Or App 345 (1986). In Anderson, the insurer's denial letter was sent to the claimant's mother's house. At the time, the claimant was incarcerated. He was not released until approximately one month after the insurer mailed the letter. He did not request a hearing until a year after the denial was mailed. The court found that the claimant's hearing request was untimely. The court noted that the claimant had contacted the insurer earlier to request that all further correspondence be sent to his mother's house. We interpret the court's decision as holding that the statutory requirements may be satisfied by delivery to a claimant's home or to a place a claimant directs.

Here, by contrast, EBI's letters were never actually delivered to a place at which claimant resided nor to a place claimant directed. We conclude that the facts before us rebut the presumption that EBI's mailings produced actual delivery of notice. Under these circumstances, we hold that claimant's hearing request was timely.

Turning to the timeliness of EBI's denial, the employer had notice of the claim as of September 15, 1985. EBI's first denial was mailed March 11, 1986. This denial was untimely. Claimant is entitled to a penalty and attorney fee. The penalty is computed based upon "amounts then due." ORS 656.262(10). The "amounts then due" are the interim compensation benefits owing to claimant between September 15, 1985 and October 27, 1985. We have already assessed a penalty for this period resulting from EBI's unreasonable failure to pay interim compensation. We note that these combined penalties cannot exceed 25 percent of the compensation "then due." ORS 656.262(10); Marlene W. Ritchie, 37 Van Natta 1088, 1097 (1985).

Claimant also asserts that EBI's denial was unreasonable thereby giving rise to additional penalties and attorney fee. EBI attempted to investigate the claim but was unable to make contact with claimant due to his multiple moves without informing anyone of his new address. In October 1985, Dr. Golden reported a new injury at the restaurant based upon claimant's statement to that effect. However, he reported normal neurological functions and normal cervical spine x-rays. He released claimant to regular work. Under these circumstances, we conclude that EBI's denial was not unreasonable.

Finally, claimant argues that the Board should address the responsibility question or remand to the Referee to address the responsibility question. We have previously determined to affirm the Referee's conclusion that claimant's hearing request of the SAIF denial was untimely. Therefore, claimant can recover only if the restaurant incident while working for EBI's insured was a material contributing cause of his need for medical treatment or disability. Loehr v. Liberty Northwest Insurance Corp., 80 Or App 264 (1986).

Dr. Golden testified that he was basically incapable of distinguishing causally between the 1984 injury with SAIF's insured and the 1985 injury with EBI's insured. Moreover, he was uncertain whether claimant's present left-sided problems resulted from one of the two injuries or instead whether claimant had carpal tunnel syndrome. We note in this regard that immediately after the restaurant incident, claimant reported right-sided problems to Dr. Golden. The first medically-documented evidence of left-sided problems appears thirteen months following the incident. In the interim, claimant held two other jobs, both of which he left for nonmedical reasons.

Dr. Golden referred claimant to Dr. Mundall. Dr. Mundall subsequently noted that claimant's symptoms, as he related them, worsened after his second job, but he could find no objective evidence of a re-injury. We find that claimant has failed to prove that a new injury occurred at the restaurant.

ORDER

The Referee's order dated June 29, 1987, as corrected June 30, 1987, is affirmed in part and reversed in part. That portion of the order that declined to award interim compensation is reversed. Claimant is awarded interim compensation from September 15, 1985 to October 28, 1985, to be paid by EBI. As a penalty for its failure to timely pay interim compensation and for failing to timely accept or deny, EBI is assessed a penalty equal to 25 percent of the interim compensation awarded by this order. For prevailing on the penalty issues, claimant's attorney is awarded a fee of $500, to be paid by EBI. Claimant's attorney is further allowed 25 percent of the additional compensation granted by this order, not to exceed $3,800, as a reasonable attorney fee. The remainder of the Referee's order is affirmed.

DAVID D. GRIMES, Claimant
William H. Skalak, Claimant's Attorneys
Ruth Cinniger (SAIF), Defense Attorney

WCB 85-00302
September 29, 1988
Order on Remand

This matter is before the Board on remand from the Court of Appeals. Grimes v. SAIF, 87 Or App 597 (1987). The court reversed the Board's order in David D. Grimes, 38 Van Natta 1038 (1986), which found that claimant's injury claim had not been timely filed. Inasmuch as the Board made no finding concerning compensability, the court remanded for a determination of that

issue. Finding that the record did not contain all the exhibits admitted into evidence at the hearing, the Board remanded the matter to the Presiding Referee. On March 24, 1988, the Referee determined that the record was complete and referred the matter back to the Board. Upon further review, we agree that the record has been completely developed. Therefore, we proceed with our review.

ISSUE

Whether claimant sustained a compensable neck injury in August 1984.

FINDINGS OF FACT

Claimant, a journeyman carpenter, injured his neck while standing on a piece of horizontal rebar in early August 1984. The rebar had been wired together in a grid to provide structural support for a concrete wall. When the rebar suddenly dropped from 6 to 12 inches, claimant experienced immediate neck pain. He swore and grabbed his neck, but continued working. A co-worker, Fletcher, observed the injury. Claimant did not immediately report the injury.

On August 16, 1984, claimant sought medical treatment at a hospital for neck pain of two weeks duration. He did not report any trauma or on-the-job injury.

The following month, claimant went river rafting. He did not sustain any injuries or increased neck pain while rafting.

After consulting a chiropractor, he returned to the hospital on November 27, 1984. He reported that he was "unsure" how his neck symptoms began.

Two days later, claimant was interviewed at the Western States Chiropractic College Clinic. He reported that he had sustained an injury in August 1984, after falling six inches.

In December 1984, claimant was examined by Dr. Tahir, a neurosurgeon. Tahir diagnosed a herniated cervical disc and on December 11, 1984, performed a hemilaminectomy and discectomy at C5-6.

The following day, claimant filed a claim for an occupational injury to his neck. The date of occupational injury was listed as "8-15-84."

On December 19, 1984, claimant's supervisor, Mr. Nevins, wrote a handwritten memorandum concerning the circumstances of claimant's August 1984 injury.

On December 28, 1984, the SAIF Corporation denied the claim on the basis of timeliness and compensability.

We find that claimant suffered a neck injury as a result of a fall which occurred while he was performing his work activities in August 1984.

CONCLUSIONS OF LAW

A "compensable injury" is an accidental injury arising

out of and in the course of employment requiring medical services or resulting in disability or death. Former ORS 656.005(8)(a).

The Referee found that claimant sustained a compensable neck injury in early August 1984. We agree.

SAIF argues that the claim is not compensable because claimant was not a consistent historian regarding: (1) the on-the-job nature of the alleged injury; (2) the date of the alleged injury; and (3) the manner in which the alleged injury occurred.

We find that claimant was initially reluctant to report an on-the-job injury primarily because he feared losing his job. Regardless of whether his fear was justified, it explains his initial failure to report an on-the-job injury.

Although we acknowledge some minor inconsistencies in the record, we find that overall claimant consistently stated that he had injured his neck in early August 1984. On August 16, 1984, he reported that he had experienced neck pain for two weeks. On November 27, 1984, he reported that his problem started in August 1984. On November 29, 1984, he reported that his neck pain began in August 1984, and that two weeks later he was seen at a hospital. Likewise, at the hearing, claimant credibly testified that he had injured his neck in early August 1984.

After claimant overcame his initial reluctance to report an on-the-job injury, he consistently stated that he injured his neck when a piece of rebar on which he was standing dropped from 6 to 12 inches. The only contrary history is found in Nivens' handwritten note recorded on December 19, 1984. The note provides that claimant called Nivens on December 6, 1984, and reported that a piece of rebar fell against his neck. We are more persuaded by the balance of the record, including claimant's credible testimony, than by Nivens' written recollection of what claimant allegedly reported. Moreover, Nivens testified that he had no independent recollection of his conversation with claimant. He could not recall whether he spoke with claimant by telephone or in person.

SAIF also asserts that claimant injured his neck in September 1984, while river rafting. We find, however, no evidence rebutting claimant's credible testimony that he did not suffer any injuries while rafting. Consequently, we consider SAIF's assertion to be mere speculation and unpersuasive.

Accordingly, after our de novo review of medical and lay evidence, we conclude that claimant sustained a compensable neck injury in early August 1984.

ORDER

The SAIF Corporation's denial of claimant's neck injury claim is set aside. The claim is remanded to SAIF for processing according to law.

ELLEN L. HAMEL, Claimant
Olson Law Firm, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 86-02446
September 29, 1988
Order on Review

Reviewed by Board Members Ferris and Crider.

The SAIF Corporation requests review of Referee Michael Johnson's order that set aside its partial denial of claimant's bilateral knee condition. Should we find the condition not compensable, we must address the following additional issues which the Referee found were moot: (1) whether claimant's claim was prematurely closed; (2) whether claimant is entitled to an increase in scheduled permanent disability, for loss of use or function of her right foot, over the 10 percent (13.5 degrees) awarded by Determination Order, and (3) whether SAIF should be allowed to offset an alleged overpayment of temporary disability compensation.

On review, the issues are compensability, premature closure, extent of permanent disability, and offset.

We reverse on the compensability issue, conclude that the claim was not prematurely closed, affirm claimant's current award of 10 percent scheduled permanent disability, and grant the requested offset.

FINDINGS OF FACT

In June 1984, claimant compensably injured her right toes while employed as a food production worker. She sought treatment from Dr. Winkler, a family practitioner and general surgeon. Winkler diagnosed a contusion and possible fracture of claimant's first and second right toes and placed her in a short-leg walking cast for approximately six weeks.

When claimant's cast was removed, she continued to experience pain and stiffness in her right toes. She also experienced new symptoms related to a right ankle tendinitis condition which developed as a result of the casting of her leg and her use of crutches. Dr. Winkler treated her right toe and ankle condition with pain and anti-inflammatory medication. The claim was closed by a December 24, 1985 Determination Order awarding 10 percent scheduled permanent disability for loss of use or function of the right foot.

In April 1985, approximately eight months after her right-leg cast was removed, claimant developed pain and swelling in her left knee. She began experiencing similar symptoms in her right knee in October 1985, approximately fifteen months after her cast was removed. Dr. Winkler continued treating claimant's symptom complex with pain medication and anti-inflammatory drugs. In November 1986, SAIF issued partial denials of claimant's left and right knee conditions.

Claimant requested a hearing on both the partial denial and the December 1985 Determination Order. At hearing, SAIF requested authorization to offset an alleged $810.95 overpayment of temporary disability compensation against any future award of permanent partial disability. Claimant contested the offset, arguing that she was not medically stationary during the period she received the compensation at issue. However, she stipulated

that SAIF's calculation of the amount at issue was correct, and that an offset would be appropriate if the October 14, 1985 medically stationary date was affirmed.

Claimant credibly testified regarding the onset and nature of her symptoms. At the time of hearing, she continued to experience pain, swelling, and weakness in her knees, right ankle and right great toe, as well as minimal loss of motion in her right great toe.

We are not persuaded that claimant's bilateral knee condition is causally related to her compensable right foot condition. Furthermore, we find that claimant was medically stationary when her claim was closed in December 1985. Finally, we are persuaded that claimant's compensable injury resulted in a minimal loss of motion in her right great toe and a moderate level of disabling pain and weakness in her right ankle.

CONCLUSIONS AND OPINION

Compensability

In order to establish a compensable knee condition, claimant must prove that it is more likely than not that her compensable right foot condition materially contributed to her current bilateral knee problems. Williams v. Gates, McDonald & Co., 300 Or 278 (1985); Hutcheson v. Weyerhauser Co., 288 Or 51 (1979). The Referee concluded that claimant had demonstrated the requisite causal relationship by her credible testimony and treating physician Winkler's supporting opinion. After de novo review of the record, we disagree and conclude that claimant has not carried her burden of proof on this issue.

In reaching this decision, we are not disputing the Referee's finding that claimant was a credible witness. However, the causation issue in this case is the type of complex medical question that requires expert medical analysis. See Uris v. Compensation Department, 247 Or 420, 424-26 (1965); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985). Although claimant's credible lay testimony is by no means rejected, the medical opinions are accorded significant probative value.

As noted above, treating physician Winkler relates claimant's knee condition to her right foot problems. Dr. Winkler is a family practitioner and general surgeon. He reported that casting of claimant's right leg and her use of crutches had produced right ankle tendinitis and right leg weakness. He opined that this pain and weakness had initially caused claimant to place undue pressure on her left leg, which produced inflammation and pain in her left knee. He further opined that claimant's right knee pain developed in much the same way as she recovered from the tendinitis and began shifting her weight back to her right leg.

On review, SAIF relies on contrary independent medical opinions rendered by Drs. Erkkila and Martens, orthopedic surgeons, and Dr. Norton, M.D. Drs. Erkkila and Martens examined claimant in October 1985 and October 1986, respectively. Dr. Norton based his opinion on a file review in November 1986. All three doctors opined that claimant's knee condition was not related to her compensable injury or subsequent treatment. Dr. Martens further opined that claimant's knee pain was attributable to the normal aging process, and Dr. Norton noted

that claimant had leg bowing which can accelerate degenerative changes in the knees. Dr. Norton also explained that the alleged gait abnormalities noted by Dr. Winkler would not have put abnormal stress on the knees.

We conclude that there are persuasive reasons to defer to the opinions of Drs. Erkkila, Martens and Norton, rather than the opinion of the treating physician. See Taylor v. SAIF, 75 Or App 583 (1985); Nancy E. Cudaback, 38 Van Natta 423 (1986). First, Erkkila and Martens are orthopedic surgeons with special training and experience in diagnosing musculoskeletal conditions. While we recognize that Dr. Winkler is competent to offer an opinion with regard to an orthopedic problem, in this case we give greater weight to the opinion of physicians specializing in orthopedics. See Thomas v. Liberty Mutual Ins. Corp., 73 Or App 128 (1985); Abbot v. SAIF, 45 Or App 657 (1980); Martin E. Tripp, 39 Van Natta 546 (1986).Moreover, Dr. Winkler's contrary opinion is not well-reasoned. See Somers v. SAIF, 77 Or App 259, 263 (1986). In particular, he fails to explain why claimant's knees did not become symptomatic until many months after her cast was removed.

Accordingly, we conclude that claimant's knee condition is not compensable, and we reverse the Referee's order. As a result, we address additional issues raised at the hearing.

Premature Closure

Claimant contends that her claim was prematurely closed by the December 1985 Determination Order. In order to prevail on this issue, she must demonstrate that she was not medically stationary on the date of closure. Scheuning v. J. R. Simplot & Company, 84 Or App 622, 625 (1987). "Medically stationary" means that "no further material improvement would reasonably be expected from medical treatment or the passage of time." ORS 656.005(17). The fact that a treating physician "hopes" for further material improvement is not a reasonable expectation within the meaning of ORS 656.005(17). See Emery v. Adjustco, 82 Or App 101, 106 (1986).

On review, claimant relies on Dr. Winkler's opinion that she was not medically stationary until September 4, 1986. SAIF relies on Dr. Erkkila's opinion that claimant was medically stationary as of October 14, 1985. We conclude that there are persuasive reasons to defer to Dr. Erkkila's opinion. See Taylor v. SAIF, supra; Somers v. SAIF, supra; Nancy E. Cudaback, supra. In particular, Dr. Winkler based his contrary opinion on the fact that claimant continued to experience right foot and bilateral knee symptoms following claim closure. We note that his opinion is not persuasive to the extent it is based on claimant's noncompensable knee symptoms.

Moreover, even Dr. Winkler acknowledged that claimant's condition remained essentially unchanged between claim closure and September 4, 1986, the date Winkler eventually found claimant medically stationary. This fact indicates that, at the time of claim closure, no further material improvement in claimant's condition could reasonably be expected from medical treatment or the passage of time.

Accordingly, we defer to Dr. Erkkila's opinion and find that claimant was medically stationary at the time of claim closure. We, therefore, conclude that his claim was not prematurely closed by the December 1985 Determination Order.

Extent of Scheduled Permanent Disability

Claimant contends that she is entitled to a greater award of permanent disability for her compensable right foot injury. The criterion for rating scheduled disability is the permanent loss of use or function of a body part due to the compensable injury. ORS 656.214(2). To date, she has received an award of 10 percent scheduled permanent disability for loss of use or function of her right foot. Her disability is the result of the combined effect of mechanical impairment, disabling pain and weakness.

In regard to claimant's mechanical impairment, we defer to Dr. Martens' October 1986 examination report. At that time, claimant demonstrated full range of right ankle motion and minimal loss of active and passive flexion in the right great toe. Based on these findings, Dr. Martens opined that claimant had sustained minimal functional loss in the right great toe, and no loss of function in the right ankle.

We recognize that Dr. Martens' report is not entirely consistent with Dr. Winkler's October 16, 1986 report which discusses claimant's inability to flex her foot because of her chronic tendinitis. However, Dr. Winkler's report does not refer to current examination findings, and the record does not otherwise document loss in ankle range of motion after March 1986. By comparison, Dr. Martens' October 1986 examination report is based on the most recent documented examination findings in the record. We conclude that this is a persuasive reason to defer to his opinion over that of Dr. Winkler. See Taylor v. SAIF, supra; Somers v. SAIF, supra; Nancy E. Cudaback, supra. Similarly, we are not persuaded by other conflicting assessments of mechancal impairment made by Drs. Norton and Erkkila because Dr. Martens' report is more consistent with the most recent documented examination findings. See Somers v. SAIF, supra.

Turning to disabling pain and weakness, we rely on Dr. Winkler's characterization of claimant's pain as "moderate", as well as claimant's testimony that her right ankle would give out if she ran, walked too fast, or walked over uneven terrain. We also consider claimant's testimony that her right foot condition prevents her from standing or walking for prolonged periods of time. However, we note that she also attributed her problems with prolonged standing and walking to her noncompensable knee condition. Furthermore, Dr. Winkler acknowledged that claimant's limitations were the result of the cumulative effect of both the foot and the knee conditions. Finally, Dr. Martens opined that future work restrictions were attributable to claimant's knee problems, rather than her foot condition.

Accordingly, we are persuaded that a significant portion of claimant's disabling pain and weakness is attributable to her noncompensable knee condition and should, therefore, not be considered in rating her compensable right foot disability. In light of this fact, we find that claimant's pain and weakness is moderately disabling.

After considering the combined effect of claimant's moderate pain and weakness and minimal loss of toe mobility, we conclude that her current award of 10 percent scheduled permanent disability adequately compensates her for the loss of use or function of her right foot.

Offset

Finally, we address SAIF's request to offset an alleged $810.95 overpayment of temporary disability compensation. Claimant stipulated that SAIF's calculation of the amount of overpaid temporary disability compensation was correct and that the requested offset would be appropriate if the October 14, 1985 medically stationary date was affirmed. As discussed above, we are persuaded that claimant was medically stationary on that date. Accordingly, we authorize the requested offset.

ORDER

The Referee's order dated February 6, 1987 is reversed. The SAIF Corporation's denials of claimant's right and left knee conditions are reinstated and upheld. The December 24, 1985 Determination Order is affirmed. SAIF is granted an offset, in the amount of $810.95, against any future permanent partial disability awarded on this claim.

JACK K. KYLE, Claimant
Phil H. Ringle, Jr., Claimant's Attorney
Acker, et al., Defense Attorneys

WCB 87-05239
September 29, 1988
Order on Review

Reviewed by Board Members Crider and Johnson.

Claimant requests review of Referee Podnar's order that upheld the insurer's denial of compensability of claimant's left knee condition. We reverse.

ISSUES

(1) Whether claimant was acting in the course and scope of his employment when he was injured; and

(2) Penalties and attorney fees for unreasonable denial of compensability.

FINDINGS OF FACT

Claimant filed a claim for injuries sustained during a ski race on March 14, 1987. The insurer denied the claim as beyond the course and scope of employment.

Claimant worked for the employer as a ski instructor at a ski resort. Each day claimant was scheduled to work, he was required to report for duty at 8:30 a.m. and sign in. Ordinarily, he and other instructors had no particular tasks to perform until 10:15 at which time they were required to show up for the first line up of the day. At the line up, students were divided by the Director into ability groups and instructors were assigned. Those instructors who were assigned a class began teaching. Those who were not assigned a task were free to ski or engage in such activities as drinking coffee or playing cards in the ski lodge. They were not permitted, however, to leave the employer's premises until the end of the working day, generally about 4:30 p.m. If an instructor was to leave the premises without permission, discipline, including termination, could result.

Additional lineups occurred regularly later each day. At that time, an instructor was again required to appear and might be assigned a class. An instructor might also be called in at any

time during the day to teach an individual or a group. Instructors also performed minor tasks from time to time when not teaching such as setting up meeting areas, doing errands or setting up courses.

On March 14, 1987, claimant checked in and assisted in early set-up operations around the lodge. He requested permission of his supervisor to enter a ski race taking place on the employer's slopes. Permission was not granted until the supervisor determined that he would not be needed to teach. Claimant assisted with the morning lineup. He was then permitted to go participate, but instructed to report back to the supervisor immediately after the race in case instructors were needed for private instruction.

Claimant paid his own entry fee for the race. On his second of two runs down the race course, he sustained an injury.

His activity while racing was work-connected.

CONCLUSIONS OF LAW AND OPINION

The Referee based his decision that this claim was not compensable on the law governing when recreational or social activities are within the scope of employment. We disagree that this is the appropriate law. Instead, we find that the proper analogy is between claimant and other on-call employees; the proper test, the unitary work connection test.

The issue before us is whether claimant's injury "arose out of and in the course of employment." ORS 656.005(8)(a). The ultimate question under the statute is whether "the relationship between the injury and the employment [is] sufficient that the injury should be compensable . . ." Rogers v. SAIF, 289 Or 633 642 (1980). The following factors have been identified by the court as helpful in determining whether an injury is work-related:

> "(1) Was the activity for the benefit of the employer;
>
> (2) Was the activity contemplated by the employer and employee either at the time of hiring or later;
>
> (3) Was the activity an ordinary risk of, and incidental to, the employment;
>
> (4) Was the employee paid for the activity;
>
> (5) Was the activity on the employer's premises;
>
> (6) Was the activity directed by or acquiesced in by the employer; and
>
> (7) Was the employee on a personal mission of his own.

All of the factors may be considered, and no one factor is dispositive. Mellis v. McEwen, Hanna, Gisvold, 74 Or App 571, 575, rev den 300 Or 249 (1985).

Here, claimant was on the employer's premises; he was, in fact, required to stay on the premises, ready to work, from 8:30 am to 4:30 pm. He had no regularly scheduled breaks (and might on some days get no breaks at all). His breaks were the times when he was not working. During those times, he had limited things that he could do: ski, or sit in the lodge. He had to remain on call for the employer even then. Thus, when he was injured while skiing, he was engaged in an activity in which the employer expected him to engage, given the requirement that he remain on the employer's premises. We conclude that, under claimant's work conditions, there was sufficient work connection to make the claim compensable.

Claimant's case is analogous, not to the recreational cases cited by both parties, but to the on-call employee cases. See e.g., Rogers v. SAIF, 289 Or 633 (1980)(fight while on-call but off-premises in a small town); Wallace v. Green Thumb, Inc., 296 Or 79 (1983)(injury while cooking own dinner on premises); William D. Anderson, 38 Van Natta 194 (1986)(injury while whiling away the hours on premises). All of these employees were on round-the-clock call, and were hurt while involved in personal activities while on call. Claimant in this case was not on 24-hour call. However, the same principles are involved. He had to do something with his time; his choice of activities was limited by his obligation to his employer; the choice he made was one anticipated and allowed by the employer.

Also analogous are cases in which employees are hurt during slack time on their regular shift. Employees engaged in activities in their work area are covered if injured, even though they are not working. Larson, The Law of Workmen's Compensation, sec. 21.74 (1985). Likewise, injuries suffered while a worker is engaging in recreational activities on the worksite are generally compensable, even without employer sponsorship. Larson, sec. 22.11. In this case, we find that claimant's skiing should be treated like such breaktime recreation.

Claimant requests penalties and attorney fees for an unreasonable denial. Although we find the claim compensable, the facts of the case make it close enough that we cannot say the insurer was unreasonable in denying it. We note that claimant himself argued his case under a line of cases which led the Referee to conclude that the claim was not compensable.

ORDER

The Referee's order dated July 28, 19876 is reversed. The insurer's denial is set aside and the claim is remanded to the insurer for processing according to law. Claimant's attorney is awarded an assessed fee of $2,000, to be paid by the insurer.

LUCY LINN, Claimant
Lee Ann Clark, dba, SHEAR SUNSHINE, Employer
John J. Lannan, Claimant's Attorney
Davis & Bostwick, Defense Attorneys
Les Huntsinger (SAIF), Defense Attorney
Carl Davis, Assistant Attorney General

WCB 85-07139
September 29, 1988
Order on Review

Reviewed by Board Members Johnson and Crider.

Claimant requests review of that portion of Referee Fink's order that found claimant's injury claim not compensable. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

On March 13, 1985, claimant, a dog groomer, completed a Form 801 stating that she had strained her low back while lifting dogs at work on January 11, 1985. On March 13, 1985, claimant filed an injury claim form with her employer. On April 4, 1985, the employer signed the injury claim form and stated under the heading entitled DESCRIBE ACCIDENT FULLY; "NO INJURY EVER REPORTED. CLAIMANT WORKED ONE MONTH AFTER ALLEGED INJURY WITHOUT COMPLAINT OR DISABILITY. I DENY CLAIM."

On April 17, 1985, by Proposed and Final Order, the Workers' Compensation Department (Department) declared the employer to be noncomplying from April 1, 1984 to March 9, 1985 and claimant to be a subject employee on January 11, 1985.

On April 25, 1985, the employer appealed the Department's April 17, 1985 order, contesting the issues of subjectivity and compensability. A copy of that letter was mailed to claimant; it did not, however, advise claimant of any hearing rights.

On May 2, 1985, the SAIF Corporation accepted claimant's injury claim and notified the employer by letter that if she believed that claimant did not sustain a compensable injury while in her employ, she had the right to request a hearing.

On May 17, 1985, the employer requested a hearing with the Workers' Compensation Board on the issue of compensability. That letter was not mailed to claimant.

The employer never mailed to claimant a denial of her injury claim which advised her of her statutory hearing rights.

The requests for hearing on the Proposed and Final Order and on SAIF's acceptance of the claim were consolidated for hearing. The Referee, after hearing, issued an order affirming the Proposed and Final Order declaring the employer to be noncomplying for a period including January 11, 1985 and setting aside SAIF's acceptance of the claim.

Claimant requested review of the order. She filed a brief addressing the compensability issue only. The employer did not file a brief either responding to claimant's arguments or challenging that portion of the order that found it noncomplying.

CONCLUSIONS OF LAW

The Referee concluded that the employer was noncomplying and that claimant did not sustain a compensable injury while employed by the employer. Accordingly, he set aside SAIF's acceptance of claimant's claim for workers' compensation benefits. We disagree and decide the compensability of claimant's injury claim on procedural grounds, without reaching the merits.

Compliance

We do not address the compliance issue on the merits. The employer has taken no steps to challenge the Referee's conclusion that it was noncomplying during the pertinent time period. Therefore, we decline to discuss the compliance issue. The Board affirms the Referee's order as to that issue.

Compensability

A denial must, inter alia, inform the claimant of hearing rights and be mailed to the claimant. Former ORS 656.262(8). In Derryberry v. Dokey, 91 Or App 533, 536 (1988), the noncomplying employer mailed a letter to the Workers' Compensation Department requesting a hearing on the issues of whether they were complying employers, whether claimant was a subject worker and the compensability of the claim. That letter was never sent to either SAIF or the claimant. Id. At hearing, the noncomplying employer asserted that this letter to the Department denied claimant's claim. Id. However, since the letter made no mention of hearing rights and was never mailed to claimant, it was not a denial. Id. at 537. The court found that since SAIF properly accepted the claim and no party had ever properly denied it, claimant was entitled to compensation. Id.

In the present case, the facts are similar. In a letter to the Workers' Compensation Department dated April 25, 1985, the noncomplying employer disputed the compensability of claimant's injury claim. A copy of that letter was mailed to claimant; it did not, however, advise claimant of her statutory hearing rights. On May 17, 1985, the noncomplying employer again disputed the compensability of claimant's injury claim by requesting a hearing with the Workers' Compensation Board regarding SAIF's decision to accept the claim. The noncomplying employer did not mail claimant a copy of that letter. As in Derryberry v. Dokey, supra, neither letter advised claimant of her statutory hearing rights. Since the letters made no mention of hearing rights, they were not denials. Because SAIF properly accepted the claim and no party ever properly denied it, claimant is entitled to compensation.

ORDER

The Referee's order dated November 10, 1986 is affirmed in part and reversed in part. The Referee's order which found claimant's injury claim not compensable is reversed. The claim is remanded to the SAIF Corporation for processing according to law. The remainder of the Referee's order is affirmed. Claimant's counsel is awarded an assessed fee of $600, to be paid by the SAIF Corporation on behalf of the noncomplying employer.

MARIETTE A. LOISEAU, Claimant
Peter O. Hansen, Claimant's Attorney
SAIF Corp Legal, Defense Attorney

WCB 87-03169 & 86-05145
September 29, 1988
Order on Review

Reviewed by Board Members Johnson and Crider.

Claimant requests review of those portions of Referee Galton's order which: (1) upheld the SAIF Corporation's denial of claimant's occupational disease claim for carpal tunnel syndrome; (2) declined to award additional unscheduled permanent partial disability for a neck and low back condition, whereas a Determination Order had awarded 20 percent (64 degrees) unscheduled disability and the parties stipulated to an additional 5 percent (16 degrees) unscheduled disability, for a total of 25 percent (80 degrees) unscheduled disability; and (3) awarded 15 percent (22.5 degrees) scheduled permanent disability award for loss of use or function of the leg, whereas a Determination Order had awarded no permanent disability. On review, claimant challenges the partial denial, the Referee's refusal to admit into

evidence a medical report, and seeks greater permanent partial disability than that granted in the Determination Order. We affirm.

ISSUES

(1) Extent of unscheduled and scheduled permanent partial disability.

(2) Compensability of claimant's carpal tunnel syndrome.

(3) Whether the Referee erred in refusing to admit the June 3, 1987 report of Dr. Long.

FINDINGS OF FACT

Claimant, age 59 at the time of hearing, suffered a compensable lumbar, cervical, and leg injury when she slipped on some water and nearly fell to the floor while working as a day care teacher.

Claimant had worked as a day care teacher for nearly ten years. In this capacity she was required to prepare fine motor and gross motor activities for 15 preschool aged children. She assisted the children in these activities. Three evenings per week she took home paper work and prepared lesson plans. Additionally, claimant was responsible for preparing meals and snacks and clean-up. She also picked up children to comfort them when needed.

Claimant initially treated with Dr. Freistat, osteopath. He diagnosed lumbar, cervical, and left hip adductor muscle strains. She was treated conservatively. Her treatment consisted of physical therapy, injections, and a back brace. In January 1982, she returned to a four day work schedule. Lumbar x-rays revealed a possible mild spondylolisthesis of L5 on S1. A CT scan was normal. In April 1982 she returned to a regular work schedule.

On June 15, 1982, Dr. Pasquesi, orthopedist, conducted an independent medical examination. He recommended claim closure.

Claimant's claim was closed by Determination Order dated June 29, 1982, which awarded only temporary total and partial disability benefits.

On August 22, 1982, Dr. Heusch, osteopath, examined claimant and recommended a formal weight reduction and exercise program.

In March 1983, Dr. Silver, neurologist, conducted a neurosurgical consultation. X-rays were normal. A myelogram revealed a small central disc protrusion at L4-5. A CT scan was normal.

On April 15, 1983, claimant underwent nerve conduction studies and an EMG performed by Dr. Anderson. The studies were normal.

On May 20, 1983, Dr. Ragsdale, orthopedist, examined claimant. He also recommended a weight reduction and exercise program.

Claimant's claim was reopened on June 3, 1983 due to an aggravation. The claim was thereafter closed by Determination Order dated June 30, 1983, which awarded 20 percent unscheduled permanent partial disability for her low back. On January 9, 1984, the parties stipulated to an additional 5 percent permanent disability, for a total award equaling 25 percent unscheduled permanent partial disability.

On December 8, 1983, Dr. Kemple, rheumatologist and internist, conducted an independent medical examination. He diagnosed chronic low back pain with peripheral arthralgias, increased alkaline phosphatase and borderline hypertension with increased second heart sound, unrelated to her compensable injuries.

In July 1984, Dr. Reynolds, surgeon, examined claimant. He diagnosed chronic lumbosacral strain with pain radiation down both legs to the feet. An EMG and bone scan were normal. Claimant was treated with physical therapy, a back corset, an at home exercise program, and a course in body mechanics. A December 1984 CT scan of the lumbar spine revealed a circumferential disc bulging at L3-4, but no frank herniation, and a narrowed dural sac without extrinsic compression at L5-S1.

On April 1, 1985, Dr. Grewe, neurosurgeon, in consultation with Dr. Reynolds, examined claimant. Claimant demonstrated physical findings consistent with possible cervical nerve root compression, positive Tinel sign at the wrists, sensory loss in the first three fingers of the right hand, suggesting involvement at C5-6, and lumbar nerve root compression. An EMG showed some mild neuropathic changes in the right abductor pollicis brevis muscle, evidence of a mild to moderate right median nerve compromise in the carpal tunnel, slight slowing of the left median nerve in the carpal tunnel, and possible minimal ulnar nerve compromise at the elbow. A myelogram revealed a minimal blunting of the left nerve root at C5-6. Thereafter, claimant's attorney filed an aggravation claim based on the results of her myelogram. SAIF issued an aggravation denial.

On September 11, 1985, Dr. Grewe reported that claimant suffered from bilateral carpal tunnel syndrome, minimal nerve root compression suspected at C5-6, and L-5 nerve root injury, without evidence of disc herniation.

In September 1985, claimant voluntarily requested an assignment as an assistant teacher, resulting in a salary reduction from $1070 to $958 per month. Her duties as an assistant were essentially the same, but she had fewer responsibilities and was not required to prepare lessons and due paperwork.

On January 15, 1986, Dr. Button, hand surgeon, conducted an independent medical examination. He diagnosed chronic back syndrome and bilateral symptomatic carpal tunnel syndromes.

On March 12, 1986, SAIF denied the compensability of claimant's carpal tunnel syndrome on the basis that her work activities were not the major contributing factor in its development.

In May 1986, claimant voluntarily reduced her work week to four days per week. As a result her salary was reduced to $784 per month.

Pursuant to a prior Referee's April 21, 1986 order, claimant's neck and back aggravation claim was found compensable and her claim was reopened.

A July 1986 lumbar magnetic resonance imaging test revealed mild degenerative disc disease at L4-5, with slight central bulging of the annulus.

Claimant's claim was closed by Determination Order dated July 17, 1986, awarding only temporary total disability.

At claimant's December 18, 1986 hearing, she presented a claim, alleging carpal tunnel syndrome as an occupational disease. The Referee continued the case. SAIF denied the claim.

Claimant suffers from a mild lumbar and cervical condition.

Claimant also has a 14 percent impairment of her left leg.

Claimant's carpal tunnel condition is idiopathic.

Claimant's attorney believed that the so-called "seven-day rule" for submission of additional hearing evidence was applicable to this case. Pursuant to that rule, she submitted a June 3, 1987 medical report from Dr. Long to the Referee and the insurer on June 4, 1987. At the June 5, 1987 hearing, the insurer objected to the admission of the report because it had been submitted after the normal ten-day deadline. The Referee determined that claimant's attorney did not explain her failure in submitting Dr. Long's report within the normal ten-day deadline, and therefore refused to admit the exhibit into evidence.

CONCLUSIONS OF LAW

EVIDENCE

Claimant contends that the Referee erred in refusing to admit Dr. Long's report into evidence. We disagree.

The administrative rules governing admission of evidence at hearing are set forth in former OAR 438-07-005(3)(b) and (4). Prior to April 15, 1987, claimants were generally required to submit evidence at least ten days prior to hearing. However, under the so-called "seven-day rule" a party could include evidence not meeting the ten-day deadline so long as it was submitted by the party within seven days of receipt. Moreover, additional evidence not meeting either the ten-day deadline or the "seven-day rule" was admissible at the discretion of the Referee. In exercising this discretion, referees were required to consider factors of surprise and prejudice and determine whether good cause had been shown for the failure to file within the ten-day deadline.

A temporary administrative rule repealing the special "seven-day rule" became effective for a six-month period beginning April 15, 1987. This temporary rule otherwise mirrored the requirements discussed in the previous paragraph, except that Referees were no longer required to consider factors of surprise or prejudice in exercising their discretion to admit evidence not submitted within the ten-day deadline.

The original administrative rule became effective again after the sunsetting of the temporary rule on October 15, 1987. On November 16, 1987, the prior temporary administrative rule became effective again as a permanent rule. See Dorothy L. Packard, 40 Van Natta 823 (1988).

Claimant's attorney argues that the "seven-day rule" should be applied to his case because it was in effect on December 18, 1986, the date of claimant's originally scheduled hearing, and therefore the Referee should have admitted the exhibit. We note that claimant's attorney makes this argument even though admitting at hearing that the "seven-day rule" was no longer applicable. In the alternative, he argues that the Referee abused his discretion when he refused to admit Dr. Long's medical report into evidence.

The originally scheduled hearing was not conducted on December 18, 1986. Instead, claimant's case was continued and placed into inactive status due to the presentation of her occupational disease claim at hearing. The claim remained in this status until SAIF denied the claim on March 12, 1986. At this time, the occupational disease claim was processed under a separate WCB number. The two cases were consolidated and set for hearing June 5, 1987.

On June 4, 1987, claimant's attorney submitted a June 3, 1987 report of Dr. Long. Claimant had been evaluated by Dr. Long in February, 1987. At the June 5, 1987, hearing, her attorney acknowledged that she had known of Dr. Long's pending medical report early in the year, and that she had been advised by her legal assistant that the report would be forthcoming as soon as Dr. Long obtained 1985 test results to utilize in his report. She then offered no explanation for failing to submit Dr. Long's medical report until the day before hearing.

We conclude that the Referee did not abuse his discretion in refusing to admit Dr. Long's medical report. We note that the "seven-day rule" was not in effect when claimant's attorney obtained the report from Dr. Long on June 3, 1987. Furthermore, the Referee questioned claimant's attorney as to the reasons for the delay in obtaining the report containing new evidence. Claimant's attorney offered no reason whatsoever for the delay, but instead acknowledged that the report could have been generated and obtained in February, 1987. Under these circumstances, we conclude that the Referee did not abuse his discretion in refusing to admit Dr. Long's medical report.

COMPENSABILITY

Based on the totality of the evidence, the Referee was unable to conclude that claimant had met her burden of proof. He found the medical evidence to be unconvincing. Further, he found claimant to be a partially credible and reliable witness who seriously overexaggerated her symptoms and overfocused upon them.

To establish a compensable occupational disease, claimant must prove that her work activities were the major contributing cause of either the onset or worsening of her disease. ORS 656.802(1)(a); Dethlefs v Hyster Co., 295 Or 298 (1983); Blakely v SAIF, 89 Or App 653 (1988).

There is no evidence indicating that claimant suffered

from carpal tunnel syndrome prior to her work for the employer. Claimant's symptoms first appeared in 1985 when she began experiencing numbness and tingling in her hands which prevented her from performing certain duties required of her in the capacity of a teacher. Her primary difficulty was with the paperwork she took home to work on during the evenings. As a result, she changed positions from teacher to assistant teacher, decreasing her overall responsibilities and paperwork activities. She has not been able to bowl or sew since the onset of symptoms in 1985. Accordingly, we find that claimant's condition did not preexist her employment exposure. To establish the compensability of her condition, therefore, claimant must prove that her work activities were the major contributing cause of the onset of her condition.

In view of the complexity of claimant's condition, we consider a well-reasoned and thorough analysis critical to the relative persuasiveness of a physician's opinion. See Somers v. SAIF, 77 Or App 259 (1986); Loehr v. Liberty Northwest Insurance Corp., 80 Or App 264 (1986); Moe v. Ceiling Systems, 44 Or App 429 (1980). See also Karl J. Wild, 37 Van Natta 491 (1985) (A physician with three different opinions about etiology of claimant's condition is assigned little weight).

The medical evidence is conflicting and unpersuasive. Dr. Button opined that claimant's work activities could not be considered a material contributing cause of her carpal tunnel syndrome. Instead, he felt that her condition was idiopathic as is common in women in claimant's age group. However, Dr. Button does not address the impact of claimant's work activities as a teacher or as an assistant teacher, or her non work activities on the development of the disease.

Dr. Frank, claimant's surgeon, could not determine whether claimant's work activities were the major contributing cause of the development of her carpal tunnel syndrome. We agree with the Referee that the medical reports of both Dr. Button and Dr. Frank are conclusory and are not persuasive.

Dr. Grewe initially opined in a detailed and well reasoned medical report that claimant's activities were not the major contributor to her development of carpal tunnel syndrome. He found that her left sided symptoms were likely due to a combination of residuals from her cervical condition. Further, he noted that claimant's right sided symptoms were not substantiated with clinical findings, as evidenced by a lack of Tinel's sign, weakness, or muscle wasting. However, the EMG and nerve conduction studies indicated possible carpal tunnel involvement. Four months later Dr. Grewe changed his opinion without further examination results. He now states that claimant's work activities were a major contributing cause of her carpal tunnel syndrome. His change of opinion appears to be based on claimant's counsel's description of her job activities and statement that claimant had a decreased ability to participate in work activities as a result of her carpal tunnel syndrome.

As claimant's treating physician, Dr. Grewe's opinion would normally be accorded greater weight. However, we conclude that this unexplained reversal of his conclusion presents a persuasive reason to discount his opinion. Weiland v. SAIF, 64 Or App 810 (1983).

Considering all of the evidence in the record, we find that claimant has not sustained her burden of establishing a

causal connection between her employment and the onset of her carpal tunnel syndrome. Accordingly, we conclude that claimant's carpal tunnel syndrome is not compensable.

EXTENT OF DISABILITY

UNSCHEDULED DISABILITY

The Referee awarded no additional unscheduled permanent disability, but did award claimant 15 percent scheduled permanent disability for the loss of use or function of her left leg.

Claimant contends that she is entitled to a greater award of unscheduled disability because she has sustained a permanent loss of earning capacity due to her compensable injuries. She argues that she was demoted to assistant teacher and her salary was thereby reduced, because of her inability to fully participate in all activities required of a teacher.

Claimant testified that she took the position of assistant teacher in order to reduce her responsibilities and paperwork. Further, she believed that she could no longer handle the required paperwork due to the numbness and tingling in her hands.

Claimant's treating physician, Dr. Grewe, rated her cervical impairment at two percent. He rated her lumbar impairment at ten percent. A total unscheduled impairment, as a result of her compensable injury, equaling 12 percent. Dr. Reynolds, who also treated claimant, rated her impairment as mild.

Claimant initially was released to work a four day work week. After she successfully completed this trial period, she resumed the full responsibilities of a teacher and worked a forty hour week.

In March 1986, Dr. Grewe advised claimant's attorney that he was unaware that she had taken a less demanding position due primarily to the problems with her hands. He stated that he had no part in claimant's decision. Additionally he noted that if claimant's work load was reduced due to her left shoulder, arm, low back, and left extremity symptoms then he agreed that modified employment would be logical.

The criteria for rating the extent of unscheduled permanent partial disability is the permanent loss of earning capacity due to the compensable injury. ORS 656.214(5). In rating the extent of unscheduled permanent partial disability for claimant's lumbar and cervical condition, we consider the physical impairment as reflected in the medical record and lay testimony 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. Harwell v Argonaut Insurance Co., 296 Or 505 (1984).

Following our review of the medical and lay evidence, we conclude that claimant voluntarily accepted the position of assistant teacher due to her hand symptoms alone, a condition we found to be noncompensable. In this capacity, she is required to perform the same activities as a teacher, except for the paperwork. Under these circumstances, claimant's post-injury

wages are of little or no relevance in determining her loss of earning capacity. Ford v SAIF, 7 Or App 549 (1972). Claimant's back condition represents a mild impairment. Considering her education, work experience, adaptability to less strenuous occupations, and advancing age, we conclude that an award of 25 percent (80 degrees) unscheduled permanent disability adequately and appropriately compensates claimant for the permanent loss of earning capacity due to the compensable injury.

SCHEDULED DISABILITY

The criteria for the rating of scheduled disability is the permanent loss of use or function of the injured member due to the industrial injury. ORS 656.214(2). In determining the loss of use or function, we consider the medical and lay evidence in light of the rules set forth in OAR Chapter 436, Division 30. We apply these rules as guidelines, not as restrictive mechanical formulas. SAIF v Baer, 61 Or App 335 (1983). The rules, although not binding, are highly persuasive because they are based on accepted medical principles. Harwell v. Argonaut Insurance Co., 296 Or 505 (1984).

Claimant testified that she is unable to walk for longer than five to six minutes before her leg gives way and she is required to stop and rest.

Claimant's treating physician, Dr. Grewe, rated claimant's left lower extremity impairment, due to loss of use, at 14 percent. His rating was based on objective findings indicating a L5 nerve root loss of sensation equal to two percent, and a loss of strength equal to twelve percent. There is no contradictory medical evidence.

Dr. Grewe's impairment rating is supported by the evidence. His rating takes into account claimant's loss of strength. Following our de novo review of the medical and lay evidence, we conclude that an award of 15 percent scheduled permanent disability adequately and appropriately compensates claimant for the permanent loss of use or function of her left leg. We, therefore, decline to increase the award granted by the Referee.

ORDER

The Referee's order dated June 18, 1987 is affirmed.

ROBERT L. McMILLAN, Claimant
Pozzi, et al., Claimant's Attorneys
Schwabe, et al., Defense Attorneys

WCB 87-05821
September 29, 1988
Order on Review

Reviewed by Board Members Ferris and Johnson.

The self-insured employer requests review of Referee Mulder's order that awarded 65 percent (208 degrees) unscheduled permanent disability for pelvic and low back conditions, in lieu of a Determination Order award of 45 percent (67.5 degrees) scheduled permanent disability for loss of use or function of the left leg (hip). Claimant cross-requests review of that portion of the order that declined to grant him permanent total disability.

We reverse that portion of the Referee's order that

awarded unscheduled disability in lieu of the Determination Order award of scheduled disability.

ISSUES

1. Permanent total disability.

2. Extent of permanent disability, scheduled and unscheduled.

FINDINGS OF FACT

Claimant, a plant manager for a retail fertilizer firm, compensably injured his left hip on January 6, 1986 when he slipped and fell on ice. He was taken to the hospital where x-rays revealed an intertrochanteric fracture of the left proximal femur. The fracture line extended from the greater trochanter to the lesser trochanter at the base of the neck of the left hip. On January 7, 1986, claimant underwent surgery to secure internal fixation of the fracture with screws and a plate. The plate was positioned on the upper portion of the left femur. Claimant was released from work.

Subsequent x-rays revealed gradual stabilization of the fracture. After claimant resumed mobility, he had an obvious limp in an antalgic-type gait and developed pain in the low back, left buttock and groin. On August 2, 1986, claimant was released for part-time, light work with restrictions from lifting, sitting, standing, and walking on uneven surfaces.

Claimant became medically stationary on February 3, 1987. His claim was closed by Determination Order on March 16, 1987 with 45 percent scheduled permanent disability for loss of use and function of the left leg (hip).

On March 6, 1987, claimant underwent a coronary angiogram for suspected coronary artery disease, and subsequently developed right femoral deep-vein thrombosis. As a result, he was left with chronic venous insufficiency, pain and swelling in the right leg. The angiogram would have been performed even if claimant had not suffered the hip injury.

Due to left hip problems, claimant left his job sometime in late April of 1987. Since that time, he has made minimal or no efforts to seek work. Greater efforts to seek work would not have been futile.

At the time of hearing, claimant continued to experience pain in the left hip, low back and left buttock, though he no longer experienced symptoms of chronic insufficiency in the right leg. He had limitations on walking, sitting, lifting, climbing, stooping, bending, crawling, pushing and pulling. Walking caused a sharp pain localized in an area outside of and sightly below the hip joint. Bending caused back discomfort. He could not stand and balance on his left leg because the muscles in the left leg and hip cannot support him any longer. He also had problems ascending and descending stairs due to muscular problems in the left hip.

At the time of hearing, claimant was 64 years of age and had a GED. His prior work history is limited primarily to physical work in the retail fertilizer business. He has

experience in welding, repair and maintenance of equipment and machinery, and sales. He has worked as a plant manager for approximately 10 years. Most of his managerial duties involved physical labor.

We do not find that claimant is totally incapacitated on a physical or medical basis. He has sustained significant loss of left hip abduction, external rotation and internal rotation. He has moderately disabling pain in the left hip and has suffered a significant loss of muscular strength.

CONCLUSIONS AND OPINION

Permanent total disability

Claimant contends that he is entitled to an award of permanent total disability. We disagree. To prove his entitlement to permanent total disability, claimant must establish that he is unable to perform any work at a gainful and suitable occupation. ORS 656.206(1)(a); Harris v. SAIF, 292 Or 683, 695 (1982). The determination of permanent total disability status turns upon whether claimant is currently employable or able to sell his services on a regular basis in a hypothetically normal labor market. Id.

Here, claimant has not proven that he is totally incapacitated on a physical or medical basis. Although Dr. Sitz, an internist, opined in May and September of 1987 that claimant was unable to work, his opinion was partially based on the venous insufficiency in the right leg. That condition first became symptomatic after the compensable hip injury and was not related to the injury; therefore, it cannot be considered in our determination of permanent total disability. Fowler v. SAIF, 82 Or App 604, 607 (1986), rev den 303 Or 74 (1987). Consequently, Dr. Sitz' opinion is not persuasive.

Dr. Weeks has never opined that claimant is unable to work. In February of 1987, Weeks released him for light work. Weeks later restricted him to clerical indoor work. In October of 1987, Weeks reported that claimant could not perform clerical indoor work on a full-time basis, implying that he could perform such work on part-time basis. The ability to perform regular part-time work precludes a finding of permanent total disability. Georgia-Pacific Corp. v. Perry, 92 Or App 56, 58 (1988). Therefore, we do not find that he is totally incapacitated.

Consequently, claimant can prevail only by proving that he falls within the so-called "odd-lot" doctrine. Under that doctrine, an injured worker, capable of performing work of some kind, may still be permanently and totally disabled due to a combination of his physical condition and certain nonmedical factors, such as age, education, work experience, adaptability to nonphysical labor, mental capacity and emotional conditions. Clark v. Boise Cascade Corp., 72 Or App 397, 399 (1985). Because the injured worker has some capacity for employment, he is statutorily required to make reasonable efforts to find work, although he need not engage in job seeking activities that would be futile. ORS 656.206(3); Welch v. Bannister Pipeline, 70 Or App 699, 701 (1984), rev den 298 Or 470 (1985).

Here, claimant indicated that he was looking for a job that he could perform; however, he had not made any inquiries into

actual jobs. We find that he has made minimal or no efforts to seek work. We further find that such efforts would not have been futile. Although claimant can no longer perform much of the physical labor in his previous jobs, he has sales and managerial experience which could be applied in a part-time, nonphysical job. Because job seeking efforts would not have been futile, we conclude that claimant is not entitled to permanent total disability.

Extent of Permanent Disability

The Referee concluded that claimant was entitled to an unscheduled permanent disability award for symptoms in the left hip, pelvis and low back. Finding that claimant's left leg complaints were minimal, the Referee awarded him 65 percent unscheduled disability, in lieu of the Determination Order award of 45 percent scheduled disability. On review, the employer contends that claimant is not entitled to an unscheduled disability award. We agree.

1. Scheduled Disability v. Unscheduled Disability

The present law compensates permanent partial disability on two distinct principles. When the injury affects a part of the body specified in ORS 656.214, compensation is awarded for the permanent loss of use or function of the injured member or organ, in an amount fixed by law irrespective of the actual effect on the earning capacity of the particular worker. ORS 656.214(2). When permanent disability results from an injury to any other, "unscheduled," part of the body, compensation is measured by the loss of earning capacity. ORS 656.214(5). That loss is measured on the basis of medical, social and vocational factors. Id.

Here, it is undisputed that the left hip fracture line extended from the greater trochanter to the lesser trochanter. The trochanters are located at the top of the femur, the bone of the upper leg; the femur is not part of the pelvis. Therefore, an injury to the trochanters is a scheduled injury to the leg. See Sawyer v. SAIF, 29 Or App 573, 576 (1977); Donald A. Hacker, 37 Van Natta 706, 709 (1985). However, this scheduled injury has also caused disabling pain in unscheduled areas of the body, i.e., the low back and left buttock. Dr. Weeks explained that this pain is caused by the alteration of gait and other activities affected by the injured hip. Weeks rated claimant's impairment as moderate based on back problems, as well as hip problems. In addition, claimant testified that he can no longer bend or move equipment due to back symptoms.

Next, we must determine whether claimant is entitled to an unscheduled disability award for disabling consequences in unscheduled areas which are caused by his scheduled injury. The Supreme Court addressed this precise issue in Woodman v. Georgia-Pacific Corp., 289 Or 551 (1980), and developed the following three-part test:

> "First, the unscheduled disability must be 'independent' in the sense that it would be recognized as a disability impairing the claimant's earning capacity if there had been no loss of use or function in the scheduled member or organ....

"Second, the consequential loss in the unscheduled area is included in the scheduled formula when the medical expectation that it will accompany the scheduled loss is so great that its failure to occur would be an exceptional case.... [The unscheduled consequences] must be so intrinsic to the original injury (even if delayed) that their failure to follow it would be anomalous and surprising....

"Third, it is clear that these criteria of probability refer to injuries and their consequences in the relevant population group at large, not to the physical characteristics peculiar to the individual claimant." Id. at 558.

It is undisputed that the first part of the test is satisfied here. The back and buttock pain is independently disabling. Rather, the dispute concerns the second part of the test, i.e., whether the consequential disability in the unscheduled area should be included in the scheduled formula because, with regard to the relevant population group at large, the medical expectation that it will accompany the scheduled loss is so great that its failure to occur would be an exceptional case.

This case presents an issue of extent of disability and encompasses unscheduled disability, based on the theory of spreading disability. Claimant is the proponent of the theory and, therefore, has the burden of proof. See Hutcheson v. Weyerhaeuser, 288 Or 51, 55 (1979); Hart v. SAIF, 31 Or App 181, 184 (1977). The theory presented raises a complicated medical question; hence, although claimant's testimony is probative, resolution of this question largely turns on expert medical evidence. See Uris v. Compensation Department, 247 Or 420, 426 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985); Hart v. SAIF, supra.

To determine if claimant is entitled to an unscheduled award of compensation for disabling back and buttock symptoms, we must determine whether those symptoms are intrinsic to the left leg (hip) injury in terms of being an expected or unexpected consequence of the injury. The medical evidence most relevant to this question is Dr. Weeks' report. However, his report merely established a causal relationship between the back and buttock symptoms and the leg (hip) injury and its sequela, an altered gait. The record is devoid of any medical evidence concerning the dispositive question of whether the back and buttock symptoms are an expected or unexpected consequence of the hip injury. Dr. Weeks never addressed the question. Given the lack of relevant medical evidence on this point, we conclude that there is a failure of proof. Claimant is not entitled to an unscheduled award of compensation.

2. Extent of Scheduled Disability

Former OAR 436-30-330 and 436-30-340 set forth guidelines to assist in the determination of the permanent loss of use or function of an injured leg (hip). These rules are not

binding, see SAIF v. Baer, 61 Or App 335, 337-38, rev den 294 Or 749 (1983); however, they are highly persuasive because they are based on accepted medical principles. Loss of use or function does not necessarily correlate with mechanical impairment, although mechanical impairment is usually an important consideration. Boyce v. Sambo's Restaurant, 44 Or App 305, 308 (1980).

Former OAR 436-30-330(2) allows approximately 25 percent loss of the leg for claimant's loss of left hip abduction, external rotation and internal rotation. Claimant also has moderately disabling pain and a significant loss of muscular strength in the hip area. After considering the aforementioned guidelines, we conclude that claimant is adequately compensated by the Determination Order award of 45 percent scheduled permanent disability for the loss of use or function of the left leg (hip).

ORDER

The Referee's order dated January 7, 1988 is reversed in part and affirmed in part. The Determination Order dated March 16, 1987 is reinstated and affirmed. Claimant's attorney fee award based on the increased compensation is reversed. The remainder of the Referee's order is affirmed. The Board approves a client-paid fee not to exceed $914.

BARBARA J. MINOR, Claimant
Quintin B. Estell, Claimant's Attorney
Cliff, et al., Defense Attorneys

WCB 86-15430
September 29, 1988
Order on Review

Reviewed by Board Members Crider and Johnson.

Claimant requests review of those portions of Referee Garaventa's order that: (1) upheld the insurer's denial of claimant's occupational disease claim for her neck and right shoulder condition; and (2) excluded from the record certain medical documents offered by claimant. We affirm.

ISSUES

1. Whether claimant's neck and right shoulder condition is a compensable occupational disease.

2. Whether claimant's claim should be remanded for further taking of evidence.

FINDINGS OF FACT

On July 28, 1986, claimant, a 36-year-old machine operator for the employer filed a claim for neck, right shoulder and arm pain. Her job involved considerable movement and pressure with her hands and arms and substantial movement of the head and neck.

Claimant first noticed neck problems in December 1985 when she had the flu. She wore a neck brace for six weeks, after which she returned to work without restriction. No claim was filed for that condition.

On July 25, 1986, after two days off work, claimant felt a sudden pop and immediate pain when she turned her head while

rinsing dishes at home. Immediately prior to this incident, claimant had experienced no neck difficulty whatsoever. She contacted Dr. Stellflug, chiropractor, who treated claimant until December 1986. In January 1987 claimant changed attending physicians to Dr. Winkler.

On September 30, 1986, the insurer denied the compensability of claimant's neck and right shoulder claim.

On June 27, 1987, claimant was examined by Dr. Duncan, chiropractor, at the request of the insurer.

Claimant's repetitive work activities were not the major contributing cause of her neck and right shoulder symptoms. Also, no injury occurred on the job which materially contributed to claimant's symptoms.

At the July 7, 1987 hearing, claimant offered: (1) ten pages of chart notes by Dr. Winkler, dated January 9, 1987 through July 2, 1987; (2) a January 12, 1987 Change of Attending Physician form; and (3) a January 15, 1987 letter from Dr. Winkler to the insurer. The documents had not previously been provided to the insurer. The Referee excluded these documents from the record.

CONCLUSIONS OF LAW

The Referee concluded that: (1) since claimant's counsel had offered no reason or explanation to show why, with due diligence, the medical evidence from Dr. Winkler could not have been obtained and submitted timely, those documents were excluded from the record; and (2) claimant had failed to meet her burden of proof that her work activity as a machine operator for the employer was the major contributing cause of her neck, right shoulder and arm condition. We agree.

Remand

Claimant requests that we reverse the Referee's evidentiary ruling and either consider the excluded evidence ourselves or remand to the Referee to complete the record.

At hearing, claimant reported that she had retained Dr. Winkler as her treating physician in January 1987 for treatment of her back condition. Claimant's counsel represented that he was unaware that claimant had begun treating with Dr. Winkler and that, had he known, the proffered documents would have been obtained and submitted timely. The insurer objected to the admission of the documents on timeliness grounds and the Referee sustained the insurer's objection.

The rules of procedure in effect at the time of hearing required claimant's counsel to submit exhibits to the Referee and opposing counsel at least 10 days before hearing. Former OAR 438-07-005(3)(b). Admission of documents not submitted timely was within the Referee's discretion upon a showing of good cause. Former OAR 438-07-005(4).

We agree with the Referee that claimant's counsel offered no credible reason or explanation why said documents could not have been discovered and submitted into evidence with due diligence. Therefore, we find that the Referee acted within her discretion in excluding the exhibits.

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 for consideration of additional evidence, 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, 170 (1985). Claimant's claim has not been improperly, incompletely or otherwise insufficiently developed so as to warrant a remand for the further taking of evidence.

Compensability of claimant's neck and shoulder condition

If claimant's condition preexisted her employment, to establish her claim she must prove by a preponderance of the evidence that her work activities caused a worsening of her underlying condition resulting in an increase in pain to the extent that it caused disability or required medical services. Devereaux v. North Pacific Ins. Co., 74 Or App 388, 391 (1985). The work activities must be the major contributing cause of that worsening. Id. If the condition was not preexisting, she must prove that her work activities were the major contributing cause of the condition itself. Id.

No medical expert attributed claimant's neck and right shoulder condition to the repetitive nature of her work activities. Claimant also credibly testified that she was having no neck or right shoulder problems whatsoever prior to July 25, 1986. On that day, after almost two days off work, she was washing dishes over the sink. When she turned her head, she suddenly experienced excruciating neck pain.

Claimant treated with Dr. Stellflug, chiropractor, who diagnosed acute mild cervical spine sprain/strain with mild thoracic outlet syndrome. His diagnoses were based on a history of claimant injurying her neck and shoulder in an accident while at work. At hearing, claimant denied that any accident had occurred at work to cause her neck/shoulder problems. Based on the erroneous history, Dr. Stellflug opined that claimant's work activities were the major contributing cause of her neck and shoulder pain and the paresthesia in her right arm.

Dr. Duncan examined claimant once on behalf of the insurer and testified at hearing. His diagnoses of postural strain with muscular tension was based on the correct history that claimant had experienced no on-the-job accident and instead had injured her neck while washing dishes at home.

When there is a dispute between medical experts, more weight is given to those medical opinions which are both well-reasoned and based on complete information. Somers v. SAIF, 77 Or App 259 (1986); See Miller v. Granite Construction Co., 28 Or App 473 (1977).

We find that the opinion of Dr. Stellflug is both conclusory and based on an erroneous history of claimant's neck difficulties. Therefore, his opinion is not persuasive. On the other hand, Dr. Duncan's opinion is based on the correct factual history and is well-reasoned. Dr. Duncan explained the mechanics of a postural strain with muscular tension and also credibly opined that there was no objective evidence to support the diagnoses of cervical sprain or thoracic outlet syndrome.

Based on all of the evidence in the record, we conclude that claimant has failed to meet her burden of proving that her work activity as a machine operator was the major contributing cause of her neck, right shoulder and right arm condition.

ORDER

The Referee's order dated July 15, 1987 is affirmed.

BEVERLY C. MORGAN, Claimant
Peter O. Hansen, Claimant's Attorney
Cliff, et al., Defense Attorneys

WCB 85-02708
September 29, 1988
Order on Remand

This matter is before the Board on remand from the Court of Appeals. Morgan v. Silvercrest Industries, 91 Or App 649 (1988). The court has concluded that claimant's compensable wrist condition has worsened and that she has established an aggravation. Accordingly, the court has remanded for "further proceedings not inconsistent with opinion."

Pursuant to the court's mandate, the insurer's May 23, 1985 denial is set aside and claimant's aggravation claim is remanded to the insurer for processing according to law.

IT IS SO ORDERED.

SUSIE A. PERRY, Claimant
Connall & Lorenz, Claimant's Attorneys
Beers, et al., Defense Attorneys

WCB 88-04420
September 29, 1988
Order of Dismissal

Claimant, pro se, has requested review of Referee McGeorge's order dated August 3, 1988. We have reviewed the request to determine whether we have jurisdiction to consider the matter. We conclude that we lack jurisdiction.

FINDINGS

The Referee's order issued August 3, 1988. Claimant's request for review, dated August 30, 1988, was hand-delivered to the Board on September 7, 1988. The request did not include an acknowledgment of service or a certificate of personal service by mail upon the employer, its insurer, or its counsel. The request did indicate that a copy had been provided to claimant's attorney.

On September 13, 1988, the Board mailed a computer-generated letter to the parties acknowledging the request. Receipt of this acknowledgment constitutes the employer's and its representatives' first notice of claimant's request for Board review.

The request for Board review was filed more than 30 days after the Referee's order. Furthermore, neither the employer nor its representatives received notice of the request within 30 days of the date of the Referee's order.

CONCLUSIONS

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). 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. Argonaut Insurance Co. v. King, 63 Or App 847, 852 (1983).

"Filing means the physical delivery of a thing to any permanently staffed office of the Board, or the date of mailing. OAR 438-05-046(1)(a).

Here, the 30th day after the Referee's August 3, 1988 order was September 2, 1988. Claimant's request for Board review of the Referee's order was dated August 30, 1988, which is within 30 days of the order. However, the request was filed on September 7, 1988, which is more than 30 days from the date of the Referee's order. Consequently, the request for Board review is untimely. See ORS 656.289(3). Moreover, the record fails to establish that either the employer or its representatives were provided with a copy, or received actual knowledge, of claimant's request for Board review within 30 days of the Referee's August 3, 1988 order.

Under such circumstances, we lack jurisdiction to review the Referee's order, which has become final by operation of law. See ORS 656.289(3); 656.295(2); Argonaut Insurance v. King, supra.

We are mindful that claimant has apparently requested review without benefit of legal representation. We further realize that an unrepresented party is not expected to be familiar with administrative and procedural requirements of the Workers' Compensation Law. Yet, we are not free to relax a jurisdictional requirement, particularly in view of Argonaut Insurance Co. v. King, supra. See 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.

ART PROUTY, Claimant
Vick & Gutzler, Claimant's Attorneys
Cummins,et al., Defense Attorneys

WCB 87-10451
September 29, 1988
Order on Review

Reviewed by Board Members Johnson and Crider.

Claimant requests review of Referee Borchers' order that upheld the self-insured employer's denial of his medical services claim for rib resection surgery on the basis that the surgery was not reasonable and necessary medical treatment for his upper extremity condition. The employer cross-requests review of "all issues decided adversely to it." However, its brief on review requests affirmance of the order.

On review, the issue is medical services. We affirm.

FINDINGS OF FACT

Claimant, 47 years of age at haering, compensably injured his upper back, upper arms, shoulders and neck on February 6, 1971. He had no prior history of upper extremity injuries or problems. While slinging sheets of veneer from left to right, claimant experienced pain and weakness in the right

shoulder, neck and upper back areas. He filed an injury claim which was accepted by his employer. A Settlement Stipulation, dated September 24, 1974, awarded him 22.5 percent unscheduled permanent partial disability for a shoulder disability.

Since his injury, claimant has continued to suffer from intermittent symptomatic exacerbations associated with increased activity and overhead use of his arms. During these flare-ups, he experiences pain, muscle spasms and weakness in his shoulders, neck and forearms. His symptoms are bilateral but more severe on his right side and most severe in the right trapezius muscle. Claimant also initially demonstrated some loss of right hand grip strength, but clinical examinations have been normal in this regard since August 1974. Claimant has also experienced numbness with forward elevation, full abduction and external rotation of the arms.

A myelogram performed in August 1973 demonstrated no disc protrusion. Numerous cervical and upper thoracic x-rays taken since the injury have been normal, except for a loss of normal cervical lordotic curve and a list attributed to marked muscle spasm. In particular, claimant's x-rays have not demonstrated a prominant C7 transverse process or cervical rib.

Claimant's upper extremity condition has been variously diagnosed. Claimant's first treating chiropractor, Dr. Aasum, diagnosed neuralgia. The diagnoses made by the second treating chiropractor, Dr. Moore, included cervical sprain/strain, acute cervical myofascitis with radiculitis and paresthesia, and myofibrositis of the deltoid, upper trapezius and rotator cuff muscles. Both treating chiropractors related claimant's chronic symptoms to his 1971 work injury.

Dr. Pasquesi, orthopedic surgeon, performed a consulting examination in April 1974. He diagnosed a bilateral sclenus anticus syndrome or thoracic outlet syndrome and opined that claimant's current symptoms were attributable to a preexisting condition that had been aggravated and made symptomatic by his compensable injury in February 1971.

Claimant was referred to Dr. Tsai, neurosurgeon, for further evaluation in August 1974. He diagnosed cervical strain and indicated that claimant's condition was related to the 1971 work injury.

Claimant's family doctor referred him to Dr. Gerstner, general surgeon, in February 1971. Dr. Gerstner's examination findings included numbness with forward elevation, full abduction and external rotation of the arms. He diagnosed bilateral thoracic outlet compression syndrome with neural compression and related the condition to claimant's compensable injury.

Claimant was off work for five months in 1973. His condition had not resolved with various conservative therapies. Dr. Aasum, chiropractor, treated claimant's upper extremity condition from approximately November 1973 to May 1974, and Dr. Moore, chiropractor, treated claimant from 1980 to 1986. Claimant's treatment has included chiropractic manipulation, physical therapy and traction. Chiropractic treatment provides relief for short periods.

Claimant has also received treatment for intermittent

lumbar pain and a heart condition leading to double bypass surgery in April 1986. In addition, he currently demonstrates symptoms of chronic anxiety dating back to August 1978, including headaches, sleeping problems, nervousness, tension, irritability and depression. However, these problems are not related to the compensable work injury.

Dr. Gerstner recommended rib resection surgery after his examination in February 1987. By letter dated June 8, 1987, the employer denied claimant's request for approval of the proposed rib resection surgery.

In issuing its denial, the employer relied on the opinion of Dr. Schostal, neurologist, who conducted an independent medical examination in April 1987. Dr. Schostal disagreed with Dr. Gerstner's diagnosis of thoracic outlet syndrome and his recommendation of rib resection surgery. In contrast to Dr. Gerstner's examination findings, Dr. Schostal noted no tingling or weakness with hyperabduction maneuvers and no tingling with elevation of the arms. Furthermore, claimant did not demonstrate many of the findings characteristic of thoracic outlet syndrome, including: symptoms more prominent distally -- such as more prominent tingling in the median forearm, hypothenar pad and fourth and fifth digits of the right hand -- as opposed to more prominent symptoms in the shoulders and proximal portions of the forearm; unilateral rather than bilateral symptoms; numbness in the ulnar nerve or C8-T1 nerve root distribution; and weakness in the intrinsic hand muscles. Moreover, nerve conduction studies and an EMG conducted by Dr. Schostal revealed none of the abnormalities associated with thoracic outlet syndrome.

Dr. Gerstner subsequently documented his disagreement with Dr. Schostal's opinion but did not provide any further rationale for his own opinion. Dr. Porter, thoracic outlet syndrome specialist, agreed with Dr. Schostal's opinion after conducting an independent medical examination and file review in July 1987.

After de novo review of the record, we find that claimant was a credible witness.

We also find that claimant's compensable injury in February 1971 materially contributed to his current upper extremity condition. We further find that claimant's chronic upper extremity symptoms are most likely the result of myofascitis and/or myofibrositis, rather than a thoracic outlet syndrome. Accordingly, we find that the proposed rib resection surgery would not reasonably be expected to result in any material improvement in claimant's condition.

CONCLUSIONS AND OPINION

We adopt the Referee's opinion as supplemented by the discussion of the reports of Drs. Schostal and Porter at Page 2 of the Referee's order and the following comment.

We agree with the Referee's ultimate decision to uphold the employer's denial and her finding that the requested surgery was not reasonable and necessary. However, we note that this finding is inconsistent with her earlier finding, on page 3 of the Opinion and Order, that "the compensable injury is causally related and a material contributing factor to the need for the

requested surgery." (emphasis added.) We, instead, find that the compensable injury is causally related and a material contributing factor to claimant's chronic upper extremity condition. Yet, because we do not consider the requested surgery to be reasonable and necessary medical treatment, the denial shall be upheld.

ORDER

The Board affirms the Referee's order dated December 22, 1987. A client-paid fee, not to exceed $1,137, is approved.

D.E. RODRIGUEZ, Claimant
Marilyn K. O'Dell, Claimant's Attorney
E. Jay Perry, Defense Attorney

WCB 86-16114
September 29, 1988
Order on Review

Reviewed by Board Members Crider and Johnson.

The insurer requests review of Referee Peterson's order that set aside its denial of claimant's injury claim. The issue on review is compensability. We affirm.

FINDINGS OF FACT

We adopt the findings of fact made by the Referee on pages 1 and 2 of his Opinion and Order and add the following finding: Following his termination, claimant immediately gathered up his jacket and personal belongings and left the store.

CONCLUSIONS AND OPINION

We affirm and adopt the conclusion and opinion of the Referee with the following additional comment:

According to Larson, a worker is not automatically removed from the course of employment the instant he or she is fired, but coverage continues ". . . for a reasonable period while he winds up his affairs and leaves the premises." Larson, Workmen's Compensation Law, Section 26.10.

Here, claimant was injured on the employer's premises as he was leaving immediately after termination. We agree with the Referee that, at the time of the injury, claimant remained within the course of employment. The claim is, therefore, compensable.

ORDER

The Referee's order dated June 8, 1987, is affirmed. For services on Board review, claimant's attorney is awarded $1,200, to be paid by the insurer.

DALE E. SENTERS, Claimant
David C. Force, Claimant's Attorney
Dennis Ulsted (SAIF), Defense Attorney

WCB 84-10736
September 29, 1988
Order on Remand

This matter is before the Board on remand from the Court of Appeals. Senters v. SAIF, 91 Or App 704 (1988). The court has concluded that claimant's right hip condition resulted from his May 1984 compensable injury. Furthermore, claimant's hip surgery and tooth extraction have been found to be reasonable and necessary expenses associated with his compensable injury. Finally, the court has held that SAIF is responsible for Dr. Filarski's deposition. Accordingly, the court has remanded for "further proceedings not inconsistent with opinion."

Pursuant to the court's mandate, SAIF's August 16, 1985 and March 5, 1986 partial denials are set aside and the claims are remanded to SAIF for processing according to law. In addition, SAIF is directed to pay for all of Dr. Filarski's deposition.

IT IS SO ORDERED.

ROY W. SMEE, Claimant
Merrill Schneider, Claimant's Attorney
Schwabe, et al., Defense Attorneys

WCB 87-12683
September 29, 1988
Order on Review

Reviewed by Board Members Crider and Johnson.

The insurer requests review of those portions of Referee Galton's order that: (1) set aside its "de facto" denial of an aggravation claim relating to claimant's low back; and (2) assessed a penalty and associated attorney fee for the insurer's unreasonable failure to accept or deny the aggravation claim in timely fashion. In his respondent's brief, claimant contends that the Referee erred in: (1) failing to order the insurer to pay an award of permanent partial disability granted by Determination Order dated January 17, 1984; (2) assessing a penalty of 1 percent and an attorney fee of $25 for the insurer's unreasonable failure to pay the award; and (3) authorizing an offset of overpaid temporary disability compensation against temporary disability compensation awarded by the Referee. We affirm in part, reverse in part and modify.

ISSUES

1. Whether claimant's letter to the insurer dated September 22, 1986 or Dr. Deitchler's letter to the insurer dated October 31, 1986 constituted a claim for aggravation.

2. Whether the insurer unreasonably failed to issue an aggravation denial within 60 days after receiving the letter from claimant or Dr. Deitchler.

3. Whether claimant proved an aggravation of his low back condition in September 1986.

4. Whether the insurer should be required to pay claimant an award of 5 percent (16 degrees) unscheduled permanent partial disability granted by Determination Order dated January 17, 1984.

5. Whether a penalty of 1 percent and an attorney fee of $25 is adequate for the insurer's failure to pay the permanent disability award granted by the January 17, 1984 Determination Order.

6. Whether the Referee erred in authorizing the insurer to offset its outstanding temporary disability compensation overpayment against temporary disability compensation due on claimant's current aggravation claim.

FINDINGS OF FACT

Claimant compensably strained his low back in April 1981. His symptoms included pain in the left leg. The injury was treated conservatively and the claim was closed by Determination Order dated November 19, 1982 with an award of 10 percent (32 degrees) unscheduled permanent partial disability.

Claimant returned to work and in September 1983 experienced a marked flare-up of low back pain accompanied by left leg numbness. He left work again and the claim was reopened. After further conservative treatment, the aggravation claim was closed by Determination Order dated January 17, 1984. The order granted awards of temporary disability and 5 percent (16 degrees) unscheduled permanent partial disability. The order did not authorize deduction of overpaid temporary disability compensation from the permanent disability award.

Under the law in effect at the time, the value of the permanent disability award granted by the January 17, 1984 Determination Order was $1,360. The insurer calculated that it had overpaid temporary disability compensation in the amount of $1,470.14 and deducted it from the award, leaving an outstanding overpayment of $110.14. The insurer did not issue a check to claimant for the amount set by Determination Order instead, on March 15, 1984, the insurer requested that the Evaluation Division authorize deduction of overpaid temporary disability compensation from permanent partial disability compensation. The Evaluation Division issued an amended Determination Order dated March 23, 1984 which authorized such a deduction. At that time, the insurer wrote to claimant asking that he reimburse the insurer for the $110.14 overpayment.

Claimant returned to work for four months during the winter of 1984-85. He then left work for reasons not disclosed in the record. Claimant received three treatments from his treating chiropractor, Dr. Deitchler, between March 5 and April 3, 1985. He remained off work and received no further treatment until September 1986 when he experienced a severe exacerbation of low back and left leg pain. He resumed treatment with Dr. Deitchler on September 8, 1986 and treated three times per week during the rest of September, two times per week during much of October and about once per week through November 17, 1986. Although claimant was not working at the time of his flare-up of low back pain, he was physically capable of performing light work until September 8, 1986. He was incapable of performing any work from that date until at least November 17, 1986.

During his treatment with Dr. Deitchler, claimant wrote the insurer on September 22, 1986 stating: "This is to inform you that I am returning to Dr. Roy Deitchler with my back injury. I've developed severe pain again in my lower back -- the same place that this injury occurred." On October 31, 1986, Dr. Deitchler wrote the insurer stating in pertinent part:

> "[Claimant] re-entered this clinic on 9-8-86 with complaint of constant lower back symptoms with some of these symptoms radiating to the left thigh. This symptomatology relates to the patient [sic] old injury, and [claimant] states that there has not been any new or intervening injury but rather a gradual worsening of his symptoms over a period of the last three or four months."

The letter also indicated that claimant was receiving frequent treatments and that he was not medically stationary. The insurer received claimant's letter on September 24, 1986 and

Dr. Deitchler's letter on November 5, 1986. It issued no aggravation denial until December 16, 1987, the date of the hearing.

The Referee set aside the insurer's "de facto" denial of claimant's aggravation claim and remanded the claim to the insurer for processing and submission to the Evaluation Division for closure. He also held that claimant was entitled to temporary total disability compensation for the period from September 8 through November 17, 1986 and authorized the insurer to deduct its outstanding temporary disability compensation overpayment of $110.14 from this compensation.

OPINION AND CONCLUSIONS

Perfection of the Aggravation Claim

A physician's report which indicates that a claimant's condition has worsened and that the claimant is in need of further medical services or additional compensation is a claim for aggravation. ORS 656.273(1) & (3); Haret v. SAIF, 72 Or App 668, 671-72, rev den 299 Or 313 (1985). Dr. Deitchler's October 31, 1986 letter to the insurer indicated that claimant's condition had worsened, that claimant was receiving medical treatment for the first time in more than a year and that claimant was not medically stationary. That report, therefore, was a claim for aggravation. In view of this conclusion, we need not decide whether claimant's September 22, 1986 letter to the insurer would itself have constituted an aggravation claim.

Penalty and Attorney Fee for Late Denial

A penalty and attorney fee may be assessed under ORS 656.262(10) and 656.382(1) against a carrier which unreasonably delays acceptance or denial of a claim. The insurer received Dr. Deitchler's report and thus claimant's aggravation claim on November 5, 1986. Under ORS 656.273(6) and 656.262(6), it had 60 days within which to accept or deny the claim. The insurer, therefore, should have accepted or denied the claim by January 5, 1987 at the latest. It did not deny the claim until December 16, 1987.

In explanation of this lengthy delay, the insurer contends that it did not recognize Dr. Deitchler's report as an aggravation claim because the report did not state that claimant was not able to work. It contends that in Crooke v. Gresham Transfer, 88 Or App 246, 249 (1987), the court made medical verification of time loss an element of perfecting an aggravation claim. We disagree. The subject of Crooke was interim compensation on an aggravation claim, not the elements for perfecting an aggravation claim. Id. at 248. In addition, the Crooke opinion was not issued until November 12, 1987, long after the 60 day deadline for acceptance or denial of claimant's aggravation claim had expired. The opinion, therefore, could not have influenced the insurer's decision not to treat Dr. Deitchler's report as an aggravation claim. See Claude Sagraves, 38 Van Natta 828 (1986).

There being no other explanation for the insurer's delay, we conclude that the insurer's failure to accept or deny claimant's aggravation claim by January 5, 1987 was unreasonable and that a 25 percent penalty should be assessed under ORS

656.262(10) on all temporary disability compensation due on the claim through the date of the hearing. Also, considering the statement of services submitted by claimant's attorney and the factors enumerated in OAR 438-15-010(6), we conclude that an associated attorney fee of $250 should be assessed under ORS 656.382(1).

Aggravation

To establish a compensable aggravation under ORS 656.273(1), a claimant must prove a worsening of his condition and a causal relation between the worsening and a compensable injury or disease. Van Horn v. Jerry Jerzel, Inc., 66 Or App 457, 459, rev den 297 Or 82 (1984); Anderson v. West Union Village Square, 43 Or App 295, 297, modified on other grounds, 44 Or App 685 (1980).

To prove a worsening, a claimant must show a change in his condition since the last arrangement of compensation which entitles him to additional temporary or permanent disability compensation. Smith v. SAIF, 302 Or 396, 399-401 (1986). Proof may be provided by lay evidence; medical verification of increased disability is not required. Garbutt v. SAIF, 297 Or 148, 151-52 (1984). If the claimant has received an award of permanent partial disability for the compensable condition which anticipated future symptomatic flare-ups, an increase in symptoms alone is not a worsening unless the flare-up is more severe than anticpated by the award or the flare-up requires in-patient hospitalization or results in temporary total disability which exceeds 14 consecutive days. Gwynn v. SAIF, 304 Or 345, 352-53 (1987); see also International Paper Co. v. Turner, 304 Or 354, 358 (1987).

To prove a causal relation between the worsening and a compensable injury or disease, the claimant must show that the compensable injury or disease was a material contributing cause of the worsened condition. Grable v. Weyerhaeuser Co., 291 Or 387, 400-01 (1981).

Claimant received a total of 15 percent (48 degrees) unscheduled permanent partial disability for his low back condition. In September 1986, he experienced a symptomatic worsening of his compensable condition and temporarily became totally disabled. We are unable to conclude from the record in this case that claimant's permanent disability awards anticipated future symptomatic flare-ups. Claimant, therefore, has proven a compensable aggravation irrespective of the duration of his temporary total disability. See International Paper Co. v. Turner, supra, 304 Or at 358; Gwynn v. SAIF, supra, 304 Or at 352-53. In any event, we note that his temporary total disability exceeded 14 days. Claimant, therefore, has proven a compensable aggravation even if his permanent disability awards did anticipate future symptomatic flare-ups. Id. at 353.

The Referee awarded claimant's attorney an attorney fee of $750 on the aggravation issue. We affirm that award. Considering the statement of services submitted by claimant's attorney and the factors enumerated in OAR 438-15-010(6), we assess a fee of $500 for services on Board review on the aggravation issue.

Payment of the Permanent Partial Disability Award Granted by the January 17, 1984 Determination Order

A carrier has a duty to pay permanent partial disability awarded by Determination Order within 30 days of the date of the order. See ORS 656.230(2); former OAR 436-54-310(5)(a) (now 436-60-150(5)(a)); see also ORS 656.262(2). A carrier has no authority to offset overpaid temporary disability compensation against permanent disability awarded by Determination Order without authorization by the Evaluation Division. See former ORS 656.268(4) (now 656.268(10)); former OAR 436-54-320(1) (now 436-60-170); Forney v. Western States Plywood, 66 Or App 155, 160 (1983), aff'd, 297 Or 628 (1984). A carrier which withholds compensation due under a Determination Order must pay the compensation even if it later establishes that its action was substantively correct. C.D. English, 37 Van Natta 572, 573 (1985). The carrier, however, may be authorized to offset such compensation against future awards of permanent partial disability compensation. Id. at 574.

The Determination Order dated January 17, 1984 granted claimant an award of 5 percent (16 degrees) unscheduled permanent partial disability. The order did not authorize deduction of overpaid temporary disability compensation. The permanent disability award was due on February 16, 1984, 30 days after the date of the Determination Order. See ORS 656.230(2); former OAR 436-54-310(5)(a). The insurer did not pay the award. Instead, it unilaterally deducted a temporary disability compensation overpayment from the award, reducing it to zero. The insurer later requested authorization for its offset, but by that time the award was overdue. The insurer, therefore, improperly withheld payment of the award and will be ordered now to pay it. C.D. English, supra. However, it will be allowed to offset this payment against any future permanent partial disability awards granted on this claim. Id.

Penalties and Attorney Fees for Failure to Pay the Permanent Partial Disability Award

A penalty and attorney fee may be assessed under ORS 656.262(10) and 656.382(1) against a carrier which unreasonably refuses to pay compensation. The insurer has offered no explanation for its unauthorized unilateral offset and its refusal to pay the permanent partial disability award granted by the January 17, 1984 Determination Order. We conclude, therefore, that the insurer's actions were unreasonable and that a 25 percent penalty should be assessed on the unpaid permanent partial disability award. Considering the statement of services submitted by claimant's attorney and the factors enumerated in OAR 438-15-010(6), we assess an associated attorney fee of $300.

Offset of Overpaid Temporary Disability Compensation Against Future Temporary Disability Compensation

Overpaid temporary or permanent disability compensation may not be offset against current temporary disability compensation. Harold D. Bates, 38 Van Natta 992 (1986); see also A.G. McCullough, 39 Van Natta 135, 136 (1987); William J. Dale, 39 Van Natta 632, 633 (1987); cf. Forney v. Western States Plywood, supra, 66 Or App at 160 (invalidating former OAR 436-54-320(1)(a) which authorized carriers unilaterally to deduct overpaid compensation from temporary disability compensation in an amount

not to exceed 25 percent of each temporary disability payment). The Referee authorized an offset of $110.14 against temporary disability compensation due on claimant's current aggravation claim. The Referee erred in authorizing such an offset. Harold D. Bates, supra. However, the insurer shall be authorized to offset this compensation against any future awards of permanent partial disability granted on this claim.

ORDER

The Referee's order dated December 18, 1987 is affirmed in part, reversed in part and modified in part. Those portions of the order which denied claimant's request that the permanent partial disability award granted by the January 17, 1984 Determination Order be paid and that authorized an offset of overpaid temporary disability compensation against current temporary disability compensation are reversed. The insurer shall pay claimant the permanent partial disability award granted by the January 17, 1984 Determination Order. The insurer is authorized to offset overpaid temporary disability compensation in the amount of $1,470.14 against any future awards of permanent partial disability granted on this claim. That portion of the Referee's order which assessed a 1 percent penalty and $25 attorney fee for the insurer's unreasonable refusal to pay the permanent partial disability award granted by the January 17, 1984 Determination Order is modified. The insurer shall pay claimant a penalty of 25 percent of the award and an attorney fee of $300. That portion of the Referee's order which assessed a penalty of 25 percent of the temporary disability compensation due between September 8 and November 17, 1984 is also modified. The insurer shall pay a penalty of 25 percent of all temporary disability compensation payable on claimant's aggravation claim through the date of the hearing. The remainder of the Referee's order, including the attorney fee award of $750 on the aggravation issue, is affirmed. Claimant's attorney is awarded $500 for services on Board review on the aggravation issue, to be paid by the insurer. A client-paid fee of up to $636 for services on Board review is approved.

WILLIAM C. SMITH, Claimant
Malagon & Moore, Claimant's Attorneys
SAIF Corp Legal, Defense Attorney
James E. Griffin, Assistant Attorney General

WCB TP-88020
September 29, 1988
Third Party Distribution Order

The SAIF Corporation, as paying agency, and claimant have petitioned the Board for resolution of a dispute concerning the just and proper distribution of proceeds from a third party settlement. See ORS 656.593(3). Specifically, claimant asserts that SAIF and its insured "hindered the prosecution" of the third party action and, thus, SAIF's share of the settlement proceeds should be reduced. We conclude that a distribution in accordance with ORS 656.593(1) is "just and proper."

FINDINGS

In June 1985, while performing his employment duties as a log truck driver, claimant was injured in a motor vehicle accident. His claim was accepted and processed to closure.

Claimant engaged legal counsel to explore the possibility of bringing suit against the third party. Thereafter, an action for negligence was initiated. With SAIF's approval, claimant and the third party settled the action for $28,000.

After deducting claimant's attorney's statutory 1/3 share ($9,500) and litigation expenses ($325), a balance of $18,675 remains. From this balance, claimant's statutory 1/3 share ($6,225) is deducted, leaving a remaining balance of $12,450.

To date, SAIF has incurred claim costs totalling $22,170.22. These costs are comprised of medical benefits, temporary total disability compensation, and a 10 percent unscheduled permanent disability award. Because these costs exceed its anticipated share of the settlement proceeds, SAIF does not assert entitlement to a lien for future expenses.

Although claimant alleges that SAIF and its insured "wrecked" claimant's third party claim, the record fails to provide persuasive support for this assertion.

A distribution of the remaining balance of proceeds from the third party settlement to SAIF is just and proper.

CONTENTIONS

Claimant concedes that SAIF is entitled to a share of the remaining balance of proceeds from the third party settlement. However, asserting that SAIF and its insured "succeeded in wrecking the damages portion of claimant's third party claim," he argues that SAIF's share should be reduced. Claimant suggests $9,500 as a reasonable amount for SAIF's share.

In response, SAIF notes that the record fails to establish that claimant's third party claim was harmed by either SAIF or its insured. Moreover, assuming the record did support claimant's contention, SAIF submits that no authority exists to reduce its statutory distributive share.

CONCLUSIONS

Pursuant to ORS 656.578, if a worker receives a compensable injury due to the negligence or wrong of a third person, entitling the worker under ORS 656.154 to seek a remedy against such third person, such worker or, if death results from the injury, the other beneficiaries shall elect whether to recover damages from the third person. The proceeds of any damages recovered from a third person by the worker or beneficiaries shall be subject to a lien of the paying agency for its share of the proceeds. ORS 656.593(1).

If the worker or beneficiaries settle the third party claim with agency approval, 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); Estate of Troy Vance v. Williams, 84 Or App 616, 619-20 (1987). Any conflict as to what may be a "just and proper distribution" shall be resolved by the Board. ORS 656.593(3).

The statutory scheme for the allocation of damages is precise. Robert B. Williams, 38 Van Natta 119, 123 (1986), aff'd. Estate of Troy Vance v. Williams, supra. ORS 656.593(1) provides in exact detail how, and in what order, the proceeds of any damages shall be distributed. Pursuant to ORS 656.593(1)(a), costs and attorney fees incurred shall be initially disbursed. Then, the worker shall receive at least 33-1/3 percent of the balance of the recovery. ORS 656.593(1)(b). However, the amount

that the agency is "authorized to accept" from a third party settlement is less precise than the amount of its lien from damages recovered from a third party 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." Estate of Troy Vance v. Williams, supra. 84 Or App at page 620.

The statutory formula for distribution of a third party recovery obtained by judgment, ORS 656.593(1), is generally applicable to the distribution of a third party recovery obtained by settlement. Robert L. Cavil, 39 Van Natta 721 (1987).

Since it is the Board's policy to avoid making "equitable distributions on an ad hoc basis," we usually refrain from resolving distribution conflicts in a manner that would depart from the statutory formula. Marvin Thornton, 34 Van Natta 999, 1002 (1982). On rare occasions, circumstances may justify a departure from the statutory distribution formula. See Robert T. Gerlach, 36 Van Natta 293, 296 (1984) (Paying agency's lien reduced to "in effect, reconstruct an agreement the parties substantially entered into, but which subsequently fell apart primarily due to an unfortunate failure of communication.")

Here, circumstances do not justify our departure from the statutory distribution formula. To begin, the record fails to establish that either SAIF or its insured harmed claimant's cause of action against the third party. Claimant has submitted a June 6, 1988 letter from his counsel to SAIF's counsel, which states that SAIF and its insured "thoroughly succeeded in wrecking the damages portion of the claimant's third party claim," thereby forcing claimant to settle the claim for a reduced amount. Apparently, this assertion arose from the third party's defenses that: (1) a portion of claimant's medical bills were attributable to his October 1985 motor vehicle accident, which preceded his return to work following his June 1985 compensable injury; and (2) claimant's alleged depression did not become "an acute issue" until the April 1986 termination of his employment.

How SAIF and its insured hindered the prosecution of claimant's third party claim is not entirely clear. In any event, we find claimant's contentions to be unpersuasive. Other than his counsel's oblique and conclusory reference to SAIF and its insured's "wrecking" claimant's third party claim and his affidavit stating that claimant believes that SAIF and the employer hindered prosecution of his case, the record is devoid of evidence substantiating claimant's assertions. Moreover, the defenses raised by the third party appear to be a reasonable response to a claim that claimant's alleged injuries and damages are directly attributable to the third party's alleged negligence.

Even assuming that such a contention could be substantiated, claimant would be advocating a position which is available to any paying agency or claimant in a dispute involving the distribution of a third party recovery. i.e., it would be more equitable to order a distribution that results in his receiving a larger portion of the third party settlement.

We have previously reasoned that if such arguments were to prevail, in the long run the results would probably be random, standardless, and, thus, inequitable. Robert L. Cavil, supra, at page 722. We base this reasoning on the following principles.

Under the statutory distribution formula, the parties generally know where they stand. On the other hand, if the parties knew only that each would receive that portion of the settlement that the current Board then regarded as equitable, settlement of a third party action would at least be more difficult, if not impossible. Marvin Thornton, supra, at page 1002.

After further consideration of the aforementioned rationale, we continue to adhere to the policy espoused by the Thornton and Cavil decisions. Consequently, based on the reasoning set forth above, we conclude that distribution of the remaining balance of proceeds from the third party settlement ($12,450) is "just and proper." See ORS 656.593(3). Accordingly, claimant's attorney is directed to distribute the aforementioned sum to the SAIF Corporation forthwith.

IT IS SO ORDERED.

DELLA J. TRUEAX, Claimant
Thomas Sheridan (SAIF), Defense Attorney

WCB 87-05564
September 29, 1988
Order on Review

Reviewed by Board Members Crider and Ferris.

Claimant, pro se, requests review of Referee Leahy's order that: (1) affirmed a Determination Order that awarded 40 percent (19.2 degrees) scheduled permanent partial disability for loss of use or function of the left thumb and no permanent disability for the left hand; (2) found that claimant was not entitled to vocational assistance; (3) found that claimant's low back condition was not compensably related to her industrial injury; and (4) declined to rate the extent of unscheduled permanent disability, if any, relating to claimant's accepted left shoulder condition. No briefs were filed on review. On review, we modify the extent of scheduled disability award for the left thumb, reverse on the issue of rating claimant's left shoulder disability, and otherwise affirm.

ISSUES

1. Extent of scheduled left thumb disability.

2. Extent of scheduled left hand disability, if any.

3. Permanent disability benefits for claimant's accepted left shoulder condition.

4. Compensability of claimant's back condition.

5. Entitlement to vocational assistance.

FINDINGS OF FACT

Claimant was compensably injured on April 2, 1986 while employed as an aide in the direct care unit of a group home for mentally retarded adults. Claimant was overseeing a resident taking medication when the resident physically assaulted her. Claimant's left thumb was dislocated during the incident. Claimant was also struck in the right jaw, the right forearm, the back of the neck and the left shoulder. Claimant was seen the same day at the local hospital emergency room where x-rays were taken of her thumb and jaw. The x-rays were negative for fractures.

Claimant was examined by Dr. Butler, orthopedic surgeon, on April 4, 1986. Dr. Butler noted left thumb, right forearm, left scapula and cervical discomfort. He diagnosed dislocation of the metacarpophalangeal joint of the left thumb, with disruption of the volar capsule and the radial collateral ligament, along with multiple contusions. Claimant was placed in a thumb cast. Dr. Butler contemplated claimant's return to work upon removal of the cast.

The cast was removed by Dr. Butler on April 25, 1986. He noted that claimant complained of continuing shoulder soreness but that she had full active motion of the cervical spine and lumbar spine with no radicular pain. He predicted claimant would be able to return to work in two to three weeks.

On May 2, 1986 SAIF accepted a "probably rupture of radial collateral ligaments."

Claimant returned to light-duty work in July 1986.

When claimant continued to be symptomatic, she was referred by Dr. Butler to Dr. Button, a hand surgery specialist. Dr. Button requested authorization from SAIF to perform reconstructive surgery on the thumb. Surgery was authorized and subsequently performed by Dr. Button on August 11, 1986. On October 7, 1986, Dr. Button performed follow-up surgery to remove a wire from claimant's wrist. Dr. Button was unable to locate the wire. The wire was successfully removed in a second surgery performed on October 23, 1986.

On December 8, 1986, Dr. Button released claimant to return to work. His release was for light-duty work, if available, otherwise regular work. Claimant subsequently returned to light-duty work.

Claimant was attacked by a second patient on January 7, 1987. This attack occurred in a public bowling alley. Claimant subsequently quit work with the employer on January 9, 1987 due to fear for her safety. Other than a several day stint as a cherry picker during the summer of 1987, claimant had not returned to any employment as of the date of hearing.

Claimant was examined by Dr. Schwartz, orthopedic surgeon, on January 9, 1987. His examination at the time was limited to claimant's thumb.

Claimant requested vocational assistance by letter dated January 17, 1987. SAIF's response, if any, is not included in the record. Claimant did not request that the director consider the matter.

Claimant was awarded 40 percent scheduled permanent disability for loss of use of her left thumb by Determination Order dated March 11, 1987.

Dr. Schwartz reexamined claimant on April 22, 1987. Claimant's left shoulder was the subject of this examination. Dr. Schwartz diagnosed chronic posterior shoulder girdle strain. He referred her to physical therapy for the shoulder. Three months later, in July, Dr. Schwartz released claimant to light-duty work with limitations of lifting five pounds or more and limitations from repetitive pushing and pulling with her upper extremities.

Claimant commenced treating with Dr. Covert, chiropractor, on July 31, 1987. Dr. Covert noted complaints of mid-back, left shoulder and neck pain as well as headaches. He diagnosed traumatic thoracic and cervical strains with attendant lumbar strain.

The day before the hearing, on December 8, 1987, SAIF issued a partial denial of claimant's cervical, thoracic and lumbar conditions. SAIF indicated that claimant would continue to receive medical benefits for her left thumb and left shoulder conditions.

Claimant continues to experience difficulties with the use of her left thumb. Consequently, she has difficulty gripping objects and performing other tasks requiring fine manipulation with the left hand. She is not able to perform some household duties. When last tested by Dr. Button on February 13, 1987, claimant retained 35 percent range of motion in the metacarpophalangeal joint of her left thumb and 20 percent range of motion in the interphalangeal joint of her left thumb.

Claimant was 30 years of age as of the date of hearing. She completed the ninth grade and has obtained a GED. She has worked as a furniture assembler and as a waitress. Her left shoulder impairment as a result of her accepted shoulder condition is minimal. Her left shoulder condition does not limit her from performing any of her prior jobs. She is limited from performing these jobs as a result of her left thumb injury.

Claimant's current cervical, thoracic and lumbar spine complaints are not causally related to her April 2, 1986 injury.

CONCLUSIONS AND OPINION

Left Thumb Disability

The criteria for the rating of scheduled disability is the permanent loss of use or function of the injured member due to the industrial injury. ORS 656.214(2). Claimant must prove, by a preponderance of the evidence, that her loss of use or function in the left thumb entitles her to a greater award of scheduled permanent disability than the 40 percent previously awarded by Determination Order. See Hutcheson v. Weyerhaeuser Co., 288 Or 51, 56 (1979).

Guidelines to assist in the determination of the extent of permanent disability caused by a thumb injury are set forth in OAR 436-30-160 and 436-30-220. Although these rules are not binding, because they are based on accepted medical principles, they are highly persuasive. Harwell v. Argonaut Ins. Co., 296 Or 505 (1984).

Dr. Button has documented reduced ranges of motion in the metacarpophalangeal and interphalangeal joints such that claimant retains 35 percent range of motion of the former and 20 percent range of motion of the latter. These losses combined equate to a 50 percent loss of use of the thumb. See OAR 436-30-230(1). Claimant has suffered no loss of sensation. OAR 436-30-220(1). Whatever reduction in grip strength claimant has experienced results from decreased joint ranges of motion, and not from tissue loss, atrophy, or neurological impairment. Therefore, an additional allowance for loss of grip strength is not

included. OAR 436-30-220(5)(b). In sum, we conclude that claimant has suffered a 50 percent loss of use or function of her left thumb.

Left Hand Disability

At hearing, claimant alleged entitlement to a separate award for loss of use or function of her left hand. Claimant's only upper extremity injury was to her left thumb. Disabilities arising at or distal to the metacarpophalangeal joints of the digits are rated as a percentage of the respective thumb or finger. Only when the disability involves two or more digits is there a conversion to a rating for loss in the hand. ORS 656.214(4). Therefore, claimant is not entitled to a separate award for loss of use or function of her hand.

Left Shoulder

The Referee concluded that claimant's left shoulder condition had not been considered by the Evaluation Division. He found, therefore, that he lacked jurisdiction to rate permanent disability, if any, for that condition. By way of motion for reconsideration, SAIF argued that the Referee had authority to address the extent issue. Claimant, who had initiated the request at hearing for a left shoulder rating, responded that she had no objection to the Referee reconsidering his prior order to include an award for permanent left shoulder disability. The Referee took no further action in response to SAIF's motion.

The Referee cited no authority prohibiting him from addressing the extent of claimant's left shoulder condition. Nor can we find any such prohibition in the statutes or case law. The administrative rules contain a provision which states:

> "Except as provided in 438-08-020 [dealing with aggravation claims] issues of permanent disability shall not be adjudicated unless the claim has been once considered by Evaluation or the insurer under ORS 656.268." OAR 438-06-020.

The claim here has "been once considered by Evaluation." This consideration resulted in the March 11, 1987 Determination Order. Claimant's shoulder condition is a part of that claim, not the basis for a separate claim. We conclude that the Referee had jurisdiction to address the issue of the extent of claimant's left shoulder disability, if any.

The Referee did not rate the extent of disability relating to the shoulder condition. Nevertheless, the evidentiary record with regard to that condition is adequately developed. Both parties want the issue resolved in this proceeding. We conclude that it is appropriate for us to consider the extent of claimant's left shoulder disability, if any, resulting from her April 1986 injury. See Johnnie E. Jones, 37 Van Natta 1028, 1029 (1985).

The injury to claimant's shoulder involves an unscheduled area of the body. The criteria for rating of unscheduled disability is the permanent loss of earning capacity due to the compensable injury. ORS 656.214(5). Permanent loss of

earning capacity is rated based upon a combination of the worker's physical impairment, work experience, and other social and vocational factors. Id.; OAR 438-30-380 et seq. We apply the applicable administrative rules as guidelines, not as restrictive mechanical formulas. See Harwell v. Argonaut Insurance, 296 Or 510 (1984).

The Orthopaedic Consultants rated claimant's left shoulder impairment as minimal. While Dr. Schwartz limited claimant to very light work as of July 7, 1987, it is unclear whether that restriction resulted from claimant's thumb injury or her shoulder condition. In addition, Dr. Schwartz reported in October 1987 that he had no more specific suggestions for her treatment and he felt that her condition was "essentially fixed." We conclude that claimant's left shoulder impairment is minimal.

Claimant's relative youth is a moderately positive factor in assessing her ability to obtain and hold gainful employment. She has obtained a GED. The Orthopaedic Consultants opined that claimant could not return to her regular work. However, their report makes it apparent that this is due to her thumb injury rather than her shoulder condition. Claimant's minimal impairment suggests she may be limited from performing jobs requiring heavy physical labor. We conclude that an award of 5 percent permanent disability adequately compensates claimant for her loss of earning capacity resulting from her accepted shoulder condition.

Back Condition

In July 1987, claimant began treating with Dr. Covert, chiropractor, for a condition diagnosed as traumatic thoracic and cervical strain with attendant lumbar strain. Dr. Covert causally connected claimant's need for treatment with her April 1986 injury. However, the weight of the medical evidence opposes a causal connection between claimant's back complaints and her compensable injury.

Dr. Butler, who first examined claimant two days following the compensable incident, noted that claimant had full active range of motion of the cervical and lumbar spine with no radicular pains. In addition, the Orthopaedic Consultants reported in November 1987 that claimant denied any symptoms referable to the cervical, thoracic or lumbar spine. They were "at a loss to explain how these diagnoses were made in the first place." Dr. Covert did not commence treating claimant until fourteen months following the compensable incident. He opined that claimant's symptoms were related to the incident, but he offered no reasoned explanation of the causal connection. We conclude that claimant has failed to prove a causal connection between the compensable incident and her back complaints.

Vocational Rehabilitation

Claimant alleged entitlement to vocational services. The Referee found against claimant on the vocational assistance issue. He noted that claimant had been released to return to her regular work and that claimant had not cited any statute, rule or case law establishing her entitlement to such services.

ORS 656.283 requires that claimant must first apply to the director if she is dissatisfied with an action of the insurer

or self-insured employer regarding vocational assistance. The record does not indicate that claimant has done so. Consequently, we lack jurisdiction to address the vocational rehabilitation issue. See Robert D. Jackson, 40 Van Natta 51 (1988).

Therefore, in affirming the Referee's denial of relief on this issue, we do not decide whether or not claimant is entitled to vocational rehabilitaion services.

ORDER

The Referee's order dated December 28, 1987 is affirmed in part and modified in part. In addition to claimant's award by Determination Order of 40 percent (19.2 degrees) scheduled permanent partial disability for loss of use of the left thumb, she is awarded 10 percent (4.8 degrees) scheduled permanent disability, for a total award to date of 50 percent (24 degrees) scheduled left thumb disability. In addition, claimant is awarded 5 percent (16 degrees) unscheduled permanent partial disability for her left shoulder condition. The remainder of the Referee's order is affirmed.

SANDRA BRANHAM, Claimant
Charles Robinowitz, Claimant's Attorney
Mitchell, Lang & Smith, Defense Attorneys

WCB 85-15457 & 86-02091
September 30, 1988
Order on Review

Reviewed by Board Members Ferris and Crider.

Claimant requests review of those portions of Referee Leahy's order that: (1) upheld the self-insured employer's denial of medical services associated with a psychological condition; and (2) rejected her request for a penalty and attorney fee for the employer's late denial of those medical services. The employer cross-requests review of those portions of the order that: (1) assessed a penalty and attorney fee for the employer's failure to accept or deny medical bills, prescriptions, transportation and other expenses allegedly associated with a compensable back injury; (2) assessed a penalty and attorney fee for the employer's delay in disclosing medical and other information; and (3) assessed a penalty and attorney fee for the employer's alleged failure to submit complete medical information to the Evaluation Division.

ISSUES

1. The compensability of medical services associated with claimant's psychological condition.

2. Penalties and attorney fees for the employer's late denial of those medical services.

3. Penalties and attorney fees for the employer's failure to pay medical services allegedly associated with claimant's compensable low back condition.

4. Penalties and attorney fees for the employer's delay in disclosing medical and other information to claimant.

5. Penalties and attorney fees for the employer's alleged failure to submit complete medical information to the Evaluation Division.

FINDINGS OF FACT

Claimant worked for the employer as a loading dock clerk from September 8, 1980 through May 10, 1985. In this position, claimant performed a variety of clerical and secretarial tasks including answering phones, typing, filing and bookkeeping. Claimant got along well with her first supervisor, Donald Yeats.

On August 25, 1983, claimant compensably injured her low back when she slipped and fell down. The injury was treated conservatively and claimant returned to work on June 28, 1984. Her claim was closed by Determination Order dated January 17, 1985 with an award of 5 percent (16 degrees) unscheduled permanent partial disability.

While claimant was off work with her back injury, Donald Yeats died and was replaced by Timothy Ackerman. When claimant returned to work in June 1984, Ackerman assigned her to the "tracing desk." The precise nature of this position is not described in the record, but claimant did not perform well in it. Ackerman counseled claimant on several occasions regarding what he considered to be "bad work habits." Claimant's performance did not improve and Ackerman transferred her to a position in which she answered phones and filed. She performed well in that position.

In August 1984, claimant underwent a barium swallow test and peptic ulcer disease was diagnosed. The condition was treated for the next several months with cimetidine, a medication which inhibits the secretion of acid in the stomach.

Claimant compensably injured her low back a second time on February 27, 1985 when she lifted a mailing machine. She also experienced abdominal pain at the time of the accident and vomited a few minutes later. The day following the injury, claimant was admitted to the hospital and was examined by Dr. Wagner, an internist. He diagnosed a low back injury and possible esophageal tear or other abdominal injury. Claimant was then referred to other physicians for further evaluation. Dr. Sleven, a gastroenterologist, performed an endoscopic examination of claimant's esophagus, stomach and duodenum. He found two ulcers in the stomach which he biopsied and also diagnosed mild duodenitis and probable esophagitis. Claimant also underwent a CT scan of her low back which revealed no significant abnormalities. She was discharged from the hospital on March 3, 1985.

On March 26, 1985, claimant visited Dr. Sleven for a scheduled follow-up examination for her gastroesophageal condition. Claimant complained of continuing symptoms consistent with esophagitis and peptic ulcer disease. Dr. Sleven prescribed cimetidine. The employer was billed for claimant's hospitalization and the follow-up by Dr. Sleven and refused to pay the bill for Dr. Sleven's services which totalled $430. (See Ex. 30, 31, 61-1; Tr. 122). Of this amount, $25 was for the March 26 office visit. (Ex. 61-1). The employer never issued a formal denial.

Claimant returned to work with the employer on May 2, 1985. About that time, the employer was experiencing a business slowdown and had to lay off one of its clerical employees. According to the collective bargaining agreement between the employer and claimant's union, the employee with the least seniority would be laid off first. Claimant had more seniority than one other clerical employee. Management viewed this other employee as more proficient

than claimant and wanted to lay off claimant rather than the less senior employee. On May 10, 1985, Mr. Ackerman called claimant into his office for a meeting with himself and two other management employees. They explained the situation to claimant and asked her whether she would like to take a voluntary lay off. Claimant declined to do so and left the meeting emotionally upset.

After the May 10 meeting, claimant became extremely fearful that her employment was going to be terminated. (Tr. 71, 104-05). She became depressed and suicidal and did not return to work after May 10, 1985. On May 21, 1985, claimant visited her family physician, Dr. Holzgang, and told him about her psychological state. Dr. Holzgang referred her to Dr. Grass, a psychiatrist. The employer later refused to pay the charge for claimant's May 21 office visit with Dr. Holzgang without issuing a formal denial. (See Ex. 61-2; Tr. 122).

Claimant treated with Dr. Grass from May 1985 through the date of the hearing. The treatment consisted of weekly psychotherapy sessions and a variety of antidepressant medications and tranquilizers. Claimant has a mixed personality disorder with borderline, histrionic, and passive-aggressive features. (See Ex. 43-5, 54, 55-11, 57-5; Tr. 32). A personality disorder is a maladaptive pattern of perceiving, relating to and thinking about the environment or oneself. (See Ex. 68-18). Claimant's personality disorder resulted from a number of unpleasant childhood experiences and preexisted her work with the employer. (See Ex. 55-11, 58, 66-13; Tr. 23). A borderline personality is characterized by instability in and fluctuation of mood. (Ex. 66-13). A histrionic personality is characterized by a tendency to exaggerate and dramatize. (Ex. 43-5). A passive-aggressive personality is characterized by resistance to demands for adequate occupational and social functioning expressed through procrastination, stubbornness and inefficiency. (Ex. 43-6).

Claimant also has a biological manic-depressive mood disorder. (Ex. 67-23; Tr. 23, 32). This disorder is hereditary and is characterized by alternating periods of mania (i.e. euphoria, excitement and activity) and depression. (Ex. 67-23 to 24; Tr. 23-24). Mood shifts associated with this disorder usually occur independent of events in the person's life, but can be exacerbated by stressful events. (See Ex. 67-24; Tr. 24).

Claimant experienced a mental disorder in May 1985 called an adjustment reaction with mixed emotional features including anxiety and depression. (Ex. 43-5, 57-4). The disorder was caused by her personality disorder, her biological mood disorder, the disciplinary and corrective measures taken by her supervisor, Timothy Ackerman, beginning in June 1984, the meeting in May 1985 in which she was asked to take a voluntary layoff, her fear of losing her job, conflict with her mother and conflict with her teenage step-children. (See Ex. 43-5 to 6, 57-5 to 6, 58, 67-23 to 30, 68-15 to 21; Tr. 25-27, 30-34, 46-47, 71, 104-05). The disciplinary and corrective measures taken by Mr. Ackerman and the meeting in which claimant was asked to take a voluntary layoff were capable of producing stress in the average worker.

Claimant filed a request for hearing on the Determination Order associated with her first low back injury on December 16, 1985. The request demanded disclosure of medical and other information by the employer. On January 9, 1986, Dr. Grass mailed bills for claimant's psychotherapy sessions to the employer at

an address not reflected in the record. (See Ex. 44-1). Claimant filed a second request for hearing on February 12, 1986, raising the issue of the nonpayment of the bills submitted by Dr. Grass. The request included a demand for disclosure of medical and other information associated with the claim. Dr. Grass submitted his psychotherapy bills to the employer a second time on February 27, 1986. (See Ex. 44-1). The employer issued a denial of the bills on April 10, 1986. Claimant filed a third request for hearing on May 2, 1986 and again demanded disclosure of medical and other information from the employer. As of May 21, 1986, the employer had not complied with any of claimant's disclosure demands. (See Ex. 51).

On or about April 10, 1986, the employer submitted claimant's second low back claim for closure. (See Ex. 46, 50). In November 1985, Dr. Thomas, a consulting orthopedic surgeon, had stated that claimant was medically stationary from an orthopedic standpoint. (Ex. 40-2). On December 6, 1985, Dr. Keizer, claimant's treating orthopedic surgeon, indicated that claimant's condition had remained virtually the same during the previous six months and commented that he had no new treatment measures to offer. (See Ex. 4-7 to 8). The latest medical report submitted to the Evaluation Division by the employer was of an independent medical examination by Dr. Hayes, a consulting psychiatrist, dated December 23, 1985. (Ex. 52).

The only medical documents generated between December 23, 1985 and April 10, 1986 which were in the possession of the employer when it submitted the claim for closure were the bills for claimant's psychotherapy sessions with Dr. Grass, (see Ex. 44), bills for certain physical therapy treatments not otherwise specified in the record, (see Ex. 49), and prescription, transportation, and other expense reimbursement requests by claimant. (See Ex. 63, 64). The record does not indicate whether the employer submitted any of these bills to the Evaluation Division. The only other medical documents generated between December 1985 and April 1986 were chart notes by Dr. Grass, (Ex. 45-6 to 45-8), and Dr. Keizer. (Ex. 4-9). The employer did not receive Dr. Grass's chart notes until May 1986. (See Ex. 47). The record does not indicate when it received Dr. Keizer's chart notes.

On May 9, 1986, the Evaluation Division issued a Determination Order closing claimant's second low back claim and terminating claimant's entitlement to temporary total disability compensation as of April 9, 1986. A short time later, claimant requested reconsideration of the Determination Order and submitted copies of Dr. Keizer's medical records. (See Ex. 49). These records included his chart notes and a report dated May 6, 1986. (See Ex. 4-9 to 4-10, 48). A chart note dated April 23, 1986 recorded increasing left leg pain. (Ex. 4-10). The report dated May 6, 1986 stated that claimant was unable to work at any type of gainful employment and recommended treatment at a pain center. (Ex. 48). After receiving this additional information, the Evaluation Division rescinded the May 9, 1986 Determination Order on June 10, 1986 on the ground that the claim had not qualified for closure. (Ex. 53). The employer resumed claimant's temporary disability compensation payments at some point before June 17, 1986. (See Ex. 55-9; Tr. 75-76).

Claimant submitted her requests for reimbursement of prescription, mileage and other expenses in late 1985 and early 1986. (Ex. 63-3, 64-1). The employer had not accepted or denied the requests at the time of the hearing in August 1986. At some time not

specified in the record, claimant submitted bills of $28 for the services of Dr. Olson, an internist, and of $56 for the services of the Radiology Group to the employer for payment. (Tr. 127). The record gives no indication of the nature of the services associated with these bills.

OPINION AND CONCLUSIONS

Medical Services

Claimant presents three theories of compensability regarding the medical services associated with her psychological condition. First, she contends that the employer's failure to deny the services within 60 days renders them compensable as a matter of law. Second, she contends that the services are compensable because her psychological condition is compensable as an occupational disease. Third, she contends that the services are compensable because her psychological condition was caused in material part by her compensable low back condition.

Claimant's first theory was at one time embodied in an administrative rule. Former OAR 436-69-801(4) provided: "Failure to deny the claim within 60 days from the receipt of the first medical report shall render the insurer liable for the medical services prior to the denial." This rule was invalidated as inconsistent with ORS 656.262(6) and former ORS 656.262(9) (now subsection (10)) in Kemp v. Workers' Compensation Department, 65 Or App 659, 670 (1983), modified, 67 Or App 270, rev den 297 Or 227 (1984). No amendment to ORS chapter 656 since Kemp would support a revival of such a rule. We conclude, therefore, that claimant's first theory is without merit.

To establish the compensability of her psychological condition on an occupational disease theory, claimant has the burden of proving that the real events of her employment (other than actual or anticipated unemployment) were capable of causing stress and that this stress was the major contributing cause of either the onset or a worsening of her mental disorder. See former ORS 656.802(1)(a); McGarrah v. SAIF, 296 Or 145, 165-66 (1983); Elwood v. SAIF, 298 Or 429, 433 (1985); Leary v. Pacific Northwest Bell, 67 Or App 766, 768 (1984). This is a complex medical question requiring expert medical analysis. See Uris v. Compensation Department, 247 Or 420, 424-26 (1965); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985).

"Major contributing cause" means an activity or exposure or combination of activities or exposures which contributes more to the onset or worsening than all other activities or exposures combined. See McGarrah v. SAIF, supra, 296 Or at 166; Dethlefs v. Hyster Co., supra, 295 Or at 309-10; Clark v. Erdman Meat Packing, 88 Or App 1, 8 (1987). "Worsening" in the occupational disease context means pathological exacerbation of the underlying condition. See Wheeler v. Boise Cascade Corp., 298 Or 452, 457 (1985); Weller v. Union Carbide Corp., 288 Or 27, 31-35 (1979). In the psychological area, however, a worsening of the underlying condition must be inferred from a worsening of symptoms absent a satisfactory medical explanation to the contrary. SAIF v. Varner, 89 Or App 421, 424 (1988); Adsitt v. Clairmont Water District, 79 Or App 1, 7, rev den 301 Or 338, 301 Or 666 (1986).

The disciplinary and corrective measures taken with claimant by Mr. Ackerman and the meeting in which claimant was asked to take a voluntary layoff were real events which were capable of causing stress. Claimant testified that the meeting also involved

significant verbal and physical intimidation. We rejected this testimony in making our findings of fact because of claimant's histrionic personality and the contrary testimony of Mr. Ackerman. We, therefore, do not consider those alleged events in our analysis.

Claimant's mental disorder was an adjustment reaction with mixed emotional features. The medical record indicates that this mental disorder represented a worsening of her prexisting personality disorder and biological mood disorder. We are unable to conclude, however, that the stress arising from claimant's employment was the major contributing cause of her mental disorder. According to the medical record, the borderline aspect of claimant's preexisting personality disorder and her biological mood disorder were capable of producing anxiety and depression requiring medical treatment independent of the stressful events in claimant's life. To the extent that stressful events contributed to the worsening of claimant's psychological condition, the medical record indicates that noncompensable stressful events in the form of claimant's conflict with her mother and her step-children and her fear of unemployment contributed at least as much to the worsening as the stressful events associated with her employment. (See Ex. 57-5 to 6; Tr. 46-47). Consequently, we conclude that claimant has failed to prove the compensability of her psychological condition on an occupational disease theory.

Claimant's third theory is that her mental disorder was a compensable consequence of her low back injury. To establish the compensability of her psychological treatment on this theory, claimant must prove that her low back condition was a material contributing cause of the need for the treatment. See Grace v. SAIF, 76 Or App 511, 515 (1985); Jeld-Wen, Inc. v. Page, 73 Or App 136, 139 (1985). This also is a complex medical question requiring expert medical analysis. See Uris v. Compensation Department, supra, 247 Or 424-26; Kassahn v. Publishers Paper Co., supra, 76 Or App at 109. "Material contributing cause" means a substantial cause, but not necessarily the sole cause or even the most significant cause. See Van Blokland v. Oregon Health Sciences University, 87 Or App 694, 698 (1987); Lobato v. SAIF, 75 Or App 488, 492 (1985).

Two medical professionals indicated that claimant's need for psychological treatment was caused in part by her compensable low back injury: Dr. Grass, the treating psychiatrist and Dr. Wicher, a psychologist who attended claimant during a three-week pain center stay in late June and early July 1986. Two consulting psychiatrists, Drs. Parvaresh and Hayes, opined that there was no significant causal connection. We accept the opinions of Drs. Parvaresh and Hayes for the following reasons.

First, there is little if any mention of claimant's low back injury in Dr. Grass's treatment records from May 1985, when he assumed her treatment, until April 1986. (See Ex. 45). During that entire period, the psychotherapy sessions between claimant and Dr. Grass focused on the unpleasant childhood events which gave rise to claimant's underlying personality disorder. On April 22, 1986, claimant visited Dr. Grass's office and reviewed his records in preparation for a meeting with her attorney regarding her psychological claim. (Ex. 45-9). The following day, Dr. Grass reported that claimant was angry with him and felt "betrayed." He went on to state: "She had had the fantasy [sic] that I would be some sort of magical protector for her in this lawsuit and would portray her problems with her former employer in a compelling and paramount fashion in her record." (Ex. 45-9). A few days later, after a meeting with claimant's attorney, Dr. Grass began to opine

that "claimant's back injury and . . . the way in which her employer reacted to her during her injury" had caused a flare-up of her personality disorder and biological mood disorder. (Ex. 45-9). This sequence of events caused Drs. Parvaresh and Hayes to question the objectivity of Dr. Grass and the validity of his conclusions, (see Ex. 57-5 to 6, 58, 67-13 to 14 and 26 to 27, 68-20 to 21), and causes us to discount his opinion.

As for Dr. Wicher's opinion, between May 1985 and April 1986, claimant was not under active treatment for her low back condition. (See Ex. 4-7 to 9, 40-1, 64-1). On April 23, 1986, the same day that Dr. Grass reported that claimant was angry with him for not portraying her psychological condition as work related in his records, claimant returned to her treating orthopedist, Dr. Keizer, with complaints of increased left leg pain. (Ex. 4-10). Dr. Keizer then referred claimant to a pain center where she came in contact with Dr. Wicher. Claimant gave the pain center staff a history which attributed her psychological difficulties to her back problems and "harassment" by her employer. (See Ex. 55-7 to 11). Dr. Wicher relied upon this history in rendering her opinion. (See Ex. 60). We rejected this history in making our findings of fact. Dr. Wicher's opinion, therefore, is based on inaccurate history and is of little probative value. See Somers v. SAIF, 77 Or App 259, 263 (1986).

Drs. Parvaresh and Hayes opined that claimant's low back injury was not a material contributing cause of her psychological difficulties. Their opinions are based upon accurate history, are fully explained and are well-reasoned. We find them persuasive. See Somers v. SAIF, supra, 77 Or App at 263. We conclude, therefore, that claimant has failed to carry her burden of proving that her psychological difficulties are a compensable consequence of her low back injury. The employer's denial of claimant's psychological treatment was correct and shall be affirmed.

Penalties and Attorney Fees for Late Denial of Dr. Grass's Psychotherapy Bills

A carrier has a duty to accept or deny bills for rendered medical services within 60 days of receiving them. ORS 656.262(6); Billy J. Eubanks, 35 Van Natta 131, 135 (1983). Penalties and attorney fees may be assessed under ORS 656.262(10) and 656.382(1) against a carrier which "unreasonably delays acceptance or denial of a claim." The penalty is computed as a percentage of the compensation due. ORS 656.262(10). If the claim is noncompensable, no compensation is due and no penalty can be assessed. Ruby J. Stevens, 39 Van Natta 637, 638 (1987); John D. Ellis, 39 Van Natta 319, 320 (1987). An attorney fee may be assessed, however, regardless of whether a penalty can be assessed. See Mischel v. Portland General Electric Co., 89 Or App 140, 143 (1987); Spivey v. SAIF, 79 Or App 568, 572 (1986).

Claimant has failed to establish the compensability of the medical services provided by Dr. Grass. No compensation is due, therefore, and no penalty may be assessed. An attorney fee may be assessed, however, if the record establishes that the employer unreasonably failed to deny Dr. Grass's bills within 60 days of receiving them.

Dr. Grass mailed the bills for claimant's psychotherapy sessions to the employer at an address not reflected in the record on January 9, 1986. (See Ex. 44-1). Claimant filed a request for hearing on a "de facto" denial theory on February 12, 1986 and mailed

a copy of the request to the employer's Portland offices. Dr. Grass mailed the psychotherapy bills a second time on February 27, 1986 to the employer's offices in Jacksonville, Florida. (Ex. 44-1). At least the February 27 submission was received as evidenced by the employer's denial dated April 10, 1986. (Ex. 46). The employer's denial came within 60 days of the February 27 submission and thus was timely with respect to that submission. The denial also came within 60 days of claimant's request for hearing should that be construed as a claim for medical services. See ORS 656.005(6). We are unable to conclude from the record as developed whether the January 9 submission was ever received by the employer or, if so, when. We thus cannot conclude that the employer unreasonably delayed denial of that submission and there is no basis for assessing an attorney fee under ORS 656.382(1).

Penalties and Attorney Fees for Failure to Accept or Deny Medical Services Allegedly Related to Claimant's Low Back

Besides alleging the late denial of Dr. Grass's psychotherapy bills, claimant also alleged failure to accept or deny the following bills allegedly related to her compensable low back condition: (1) Dr. Sleven's bill of $430 for services rendered during claimant's March 1985 hospitalization and the subsequent follow-up office visit; (2) Dr. Holzgang's bill of $25 for claimant's May 21, 1985 office visit; (3) Dr. Olson's bill of $28 for services not specified in the record; (4) a bill of $56 from the Radiology Group for services not specified in the record; (5) prescription expenses; and (5) mileage, parking and telephone expenses.

Of these expenses, the record gives no indication of when the bills from Dr. Holzgang, Dr. Olson or the Radiology Group were received by the employer. (See Ex. 61-2, Tr. 75, 122, 127). In addition, the telephone expense incurred by claimant on June 2, 1986 and the transportation expenses incurred in connection with claimant's pain center treatment were not submitted to the employer until July 14, 1986, (see Ex. 64), less than 60 days before the hearing on August 26, 1986. Claimant has thus failed to establish that the employer delayed acceptance or denial of any of the above bills for more than 60 days and they cannot be considered in assessing a penalty or attorney fee.

The record does support the conclusion that the employer had received Dr. Sleven's bill and claimant's request for reimbursement of prescription expenses and the remaining transportation and telephone expenses at least 90 days before the hearing. (See Ex. 31, 63-3, 64-1). The employer issued no formal denial on any of these claims and offered no explanation for not doing so. We conclude, therefore, that the employer's failure to deny these claims was unreasonable and that a penalty should be assessed under ORS 656.262(10) on any expenses compensably related to claimant's low back condition as well as an attorney fee under ORS 656.382(1).

Dr. Sleven's examination after the February 1985 low back injury was performed to determine whether claimant had sustained an injury to her esophagus or other part of her abdomen. He found no evidence of acute injury and instead diagnosed two ulcers, duodenitis and probable esophagitis. The examination was necessary to determine the causal relation, if any, of claimant's abdominal pain to her back injury and was compensable on that basis. Clifford D. Howerton, 38 Van Natta 1425 (1986). Once the examination was completed and the

lack of a causal relation between the injury and the abdominal condition was established, however, subsequent treatment including the follow-up visit on March 26, 1985 was not compensable.

Regarding the prescription and transportation expenses, none of the following can be attributed to the compensable low back injury on the record as developed: (1) the medications prescribed by Drs. King, Cameron, Benson, Lee, Kedar, George and Grass (see Ex. 63); (2) other prescriptions for Monistat, A Pap #3, Tagamet (cimetidine), Erythromycin, Teldrin, Tussend, Nicorette, Premarin, Robitussin A-C, Doxepin and Sinequan (see Ex. 63); (3) the transportation expenses incurred in connection with Dr. Sleven's office visit, Dr. Grass's treatments and the visit to Dr. Stummne, (see Ex. 64); and (4) the telephone expenses listed by claimant. (See Ex. 64-2; Tr. 126).

We conclude that a penalty of 25 percent of the amount of Dr. Sleven's bill (less the $25 follow-up visit) and the prescription and transportation expenses not excluded in the previous paragraph is appropriate under the circumstances. Considering claimant's statement of services and the factors set forth in OAR 438-15-010(6), we assess an associated attorney fee of $300.

Penalties and Attorney Fees for the Employer's Delay in Disclosing Medical and Other Information to Claimant

Penalties and attorney fees may be assessed against a carrier which "unreasonably resists the payment of compensation." ORS 656.262(10); 656.382(1). Failure of a carrier to disclose documents pertaining to a claim within 15 days of a demand by the claimant may be considered unreasonable delay or refusal under ORS 656.262(10). OAR 438-07-015(2); Morgan v. Stimson Lumber Co., 288 Or 595, 604 (1980).

The record establishes that the employer did not comply with claimant's demands for disclosure within 15 days. Considering claimant's statement of services and the factors set forth in OAR 438-15-010(6), we conclude that an attorney fee of $100 is appropriate on this issue. A penalty would also be appropriate, but a full 25 percent penalty has already been assessed on all compensation due on this claim under the previous section of our order. See Rob Cohen, 39 Van Natta 649, 652 (1997); Marlene W. Ritchie, 37 Van Natta 1088, 1097 (1985).

Penalties and Attorney Fees for the Employer's Alleged Failure to Submit Complete Medical Information to the Evaluation Division

Under the law in effect at the time of the May 1986 Determination Order, a carrier had a duty to submit claims for permanently disabling conditions to the Evaluation Division for closure with copies of "all medical reports and reports of vocational rehabilitation agencies or counselors." Former ORS 656.268(2). Failure to submit complete information to the Evaluation Division can be considered unreasonable resistance to the payment of compensation if the failure results in the premature closure of a claim which delays receipt of temporary disability compensation otherwise due. Flora Pelcha, 34 Van Natta 1141, 1144 (1982).

The record indicates that the employer submitted all medical and vocational reports in its possession to the Evaluation Division when it submitted claimant's second low back claim for closure on or about April 10, 1986. Dr. Keizer's chart note of

April 23, 1986 and his report of May 6, 1986 were not in existence at that time and could not have been submitted by the employer. There is no evidence to indicate that either Dr. Keizer's chart notes or his May 6 report reached the employer in time for it to submit them to the Evaluation Division before the issuance of the May 9 Determination Order. After the Evaluation Division set aside the Determination Order, the employer promptly resumed payment of temporary disability compensation. Under these circumstances, we conclude that the employer did not violate its duties under former ORS 656.268 and that no penalty or associated attorney fee are warranted.

ORDER

The Referee's order dated December 9, 1986 is affirmed in part, reversed in part and modified in part. Those portions of the order that assessed a penalty for the disclosure violation and a penalty and attorney fee for the premature closure of claimant's February 1985 low back claim are reversed. That portion of the order which assessed a penalty and attorney fee for the employer's failure to accept or deny medical expenses associated with claimant's low back condition is modified. In lieu of the penalty assessed by the Referee, claimant is awarded a penalty of 25 percent of all of the medical expenses specified earlier in our order. In lieu of the attorney fee awarded by the Referee, claimant's attorney is awarded an attorney fee of $300. The remainder of the Referee's order is affirmed.

JOSEPH L. BUTTERFIELD, Claimant
Philip H. Garrow, Claimant's Attorney
Rick Barber (SAIF), Defense Attorney

WCB 86-16247
September 30, 1988
Order on Review

Reviewed by Board Members Crider and Johnson.

Claimant requests review of Referee Peterson's order that: (1) affirmed an award by Determination Order of 20 percent (38.4 degrees) scheduled permanent disability for loss of use or function of the right arm; and (2) declined to assess a penalty and attorney fee for the SAIF Corporation's alleged unreasonable delay in paying permanent partial disability.

ISSUES

On review, the issues are extent of scheduled permanent disability, penalties and attorney fees.

FINDINGS

We adopt the "Facts" found by the Referee, with the exception of his finding that "the insurer's records indicate that it . . . mailed a check to the claimant" on February 10, 1986. We also make the following additional findings of fact.

Claimant has lived at the same address in Bend for nearly ten years. He finally received payment of his permanent disability award in February 1987. At the time of hearing, the first check printed in February 1986 had not been cashed. SAIF offered no explanation as to what happened to that check, or to any check, after it was printed.

After de novo review of the record, we are persuaded

that SAIF did not deposit the February 1986 benefit check in the U.S. Mail, correctly addressed to claimant. We further find that this failure was due to an administrative oversight rather than any deliberate action on SAIF's part.

CONCLUSIONS AND OPINION

We adopt the Referee's opinion insofar as it pertains to the extent of permanent disability issue.

In regard to the penalty and attorney fee issue, the Referee found that SAIF had mailed an award check to claimant on February 10, 1986. Consequently, he declined to assess a penalty and attorney fee. As noted above, we disagree with the Referee's finding that SAIF timely mailed the February 1986 check. Furthermore, we conclude that claimant is entitled to a penalty and attorney fee for SAIF's failure to do so. Accordingly, we reverse the Referee on this issue.

Compensation awarded by a Determination Order is due no later than 30 days after the date of that order. OAR 436-60-150(5)(a). Benefits are deemed paid when deposited in the U.S. Mail addressed to the last known address of the worker. OAR 436-60-150. If an insurer unreasonably delays payment of compensation, it is liable for an additional amount, up to 25 percent of the amounts then due, plus a reasonable attorney fee. ORS. 656.262(10). Claimant is entitled to a penalty for late payment of compensation when the insurer does not provide a reasonable explanation for the delay. See George J. Kovarik, 38 Van Natta 1381 (1986).

As discussed above, we are not persuaded that SAIF mailed the February 1986 check in a timely manner, properly addressed to claimant at his last known address. The evidence submitted by SAIF merely establishes that a check was printed on February 10, 1986. SAIF cannot account for the check after that point, and has submitted no evidence regarding its normal procedure for handling checks prior to mailing. Moreover, the evidence fails to establish that the check printed on February 10, 1986 was properly addressed to claimant.

Finally, SAIF has not provided a reasonable explanation for its delay in mailing claimant's benefit check. Accordingly, we conclude that claimant is entitled to a penalty and associated attorney fee. In determining an appropriate penalty and fee, however, we are mindful that SAIF's conduct was unintentional. We also note that SAIF promptly issued a duplicate check when it was notified of the problem. Under these circumstances, we conclude that a 15 percent penalty is appropriate.

ORDER

The Referee's order dated July 1, 1987 is reversed in part. The SAIF Corporation is directed to pay claimant a penalty equal to 15 percent of the permanent partial disability award due under the Determination Order issued January 30, 1986. Claimant's attorney is awarded a $350 assessed fee concerning the penalty issue. The remainder of the Referee's order is affirmed.

PATRICIA G. FLORY, Claimant
Pitcher & Wright, Claimant's Attorneys
Acker, et al., Defense Attorneys

WCB 86-04802
September 30, 1988
Order on Review

Reviewed by Board Members Ferris and Johnson.

Claimant requests review of Referee Fink's order that upheld the insurer's denial of claimant's aggravation claim for her left wrist condition. On review, the issue is aggravation. We affirm the order of the Referee.

FINDINGS OF FACT

Claimant, 34, suffered a compensable injury to her left wrist on April 4, 1985 when she slipped and fell while working as a waitress. She immediately sought treatment. She received treatment for the next six months from Dr. Staver, which included medication, rest and physical therapy. Claimant was found medically stationary in September 1985, and her claim closed with no award of permanent disability.

Claimant was released to full time work by Dr. Staver in August 1985. Shortly thereafter, however, she was hospitalized for emergency surgery, and left her job in relation to that surgery. She did not work again until December 1985 when she took a job as a bartender in a pizza parlor.

On December 16, 1985, claimant sought treatment from Dr. Spina, orthopedist, for painful swelling in her left wrist. He diagnosed a post-traumatic ganglion cyst. In subsequent reports, Dr. Spina would not say with certainty that the cyst resulted from claimant's fall but felt that it was "likely so." He treated claimant with cortesone injections and pressure bandages, with only temporary relief. He sought approval from the insurer for surgery to remove the cyst. The insurer denied the request and the aggravation claim as not resulting from the compensable injury.

Claimant was evaluated by two other doctors. On February 18, 1986, Dr. Gripekoven diagnosed a ganglion which he related to her second employment. On May 13, 1986, Dr. Nye found claimant had slight soft swelling near her radial artery, which he felt could indicate a small underlying ganglion cyst. He found it "possible" that the cyst was secondary to the compensable injury.

CONCLUSIONS OF LAW AND OPINION

In order to prove aggravation, claimant has the burden of proving that her current condition is more probably than not a direct effect of her previous compensable injury. Bradshaw v. SAIF, 69 Or App 587 (1984). Her testimony may be probative. However, where the medical question is complex, there must be competent medical evidence. Uris v. Compensation Department, 247 Or 420 (1967); Kassahn v. Publishers Paper, 76 Or App 105 (1985).

Claimant received treatment from Dr. Staver for her accepted injury to her wrist. His chart notes contain no reference to a lump, bump or cyst. The only relevant note is to some tenderness at the site where the cyst later developed. Thus, the temporal link between the injury and the appearance of the cyst is weakened. When asked later, Dr. Staver opined that

ganglion cysts certainly can be caused by trauma but acknowledged that claimant did not appear to have one when he treated her.

Claimant began treatment with another orthopedist, Dr. Spina, when her cyst developed. In his initial report, he referred to it as a "post-traumatic ganglion cyst." Yet, his subsequent reports were far more equivocal. He wrote that he was "unable to definitively state whether" the cyst resulted from the injury. Dr. Spina further concluded that "ganglion cysts can arise spontaneously or as a result of injury. [Claimant] feels the problem is on the basis of her injury and I have no reason to either doubt this or support this claim. I . . . must remain an entirely impartial observer." His strongest opinion was that the cyst was "likely" a result of her fall.

Claimant was also evaluated by Dr. Nye, a hand surgeon. He opined that most ganglions are idiopathic. The portion of his diagnosis most helpful to claimant was that it was "possible" that she had a small ganglion cyst and "possible" that the cyst could be secondary to a fall.

Claimant's physician need not use magic words to prove a causal relationship between the compensable injury and claimant's current condition. McClendon v. Nabisco Brands, 77 Or App 412 (1986). However, claimant must prove more than just the possibility of causal connection. Gormley v. SAIF, 52 Or App 1055 (1981). We must conclude, based on this record, that the medical evidence does not establish with reasonable certainty that claimant's cyst is causally connected to her April 1985 injury.

ORDER

The Referee's order dated April 23, 1987 is affirmed.

THOMAS E. HARRISON, Claimant
Kirkpatrick & Zeitz, Claimant's Attorneys
Nelson, et al., Defense Attorneys
Alice M. Bartelt, Defense Attorney

WCB 85-03239 & 86-10283
September 30, 1988
Order on Review

Reviewed by Board Members Johnson and Crider

Liberty Northwest Insurance Corporation requests review of that portion of Referee Galton's order which set aside its denial of claimant's claim for a left shoulder injury. The sole issue is compensability. We affirm.

FINDINGS OF FACT

Claimant allegedly injured his left shoulder at work on January 10, 1985 while scraping up grease for the employer. A week later, he saw Dr. Fowler, a pulmonary disease specialist, with complaints of left shoulder pain radiating through the left arm and hand. The initial diagnosis was musculoskeletal strain. Claimant was taken off work and treated conservatively.

Three days prior to this alleged industrial injury, claimant was involved in a noncompensable car accident, the impact of which "dropped" him from his seat to the floor of the vehicle. Claimant did not sustain any significant injury, aside from a "stiff neck" relating to a two-year-old neck injury. The police traffic collision report indicated only that claimant had a two-year-old neck injury. Claimant did not seek medical attention after the accident.

During the two years following the alleged industrial injury, claimant was examined by a number of physicians, most of whom agreed that claimant's diagnosis was left biceps tendinitis and triceps tendinitis. Claimant never informed these physicians of the car accident in January 1985.

Claimant filed his claim for a left shoulder injury on January 16, 1985. The insurer denied the claim on January 30, 1985.

We find that claimant sustained an industrial injury to his left shoulder on January 10, 1985 and that the injury required medical treatment and resulted in disability.

CONCLUSIONS AND OPINION

The Referee set aside the Liberty Northwest's denial of the left shoulder injury claim, finding sufficient evidence to support claimant's allegation that he sustained an industrial injury to his left shoulder. We agree.

Claimant bears the burden of proving by a preponderance of the evidence that an industrial injury materially contributed to his disability or need for medical treatment. Hutcheson v. Weyerhaeuser, 288 Or 51, 56 (1979); Milburn v. Weyerhaeuser Company, 88 Or App 375, 378 (1987). Here, the central question is whether claimant's left shoulder condition resulted from the noncompensable car accident, rather than the alleged industrial injury.

Of all the physicians who examined claimant for his shoulder condition, only Dr. Fowler issued medical opinions on causation with knowledge that claimant had been involved in a car accident on January 7, 1985. Liberty Northwest sent Fowler a copy of the police traffic collision report on that accident, which indicated only that claimant had a two-year-old neck injury. Based on that report, Fowler opined that the car accident could have caused a derangement of the cervical spine and the presence of pain with extreme anterior flexion of the left shoulder. However, he felt it "unlikely" that the accident and associated neck injury was responsible for the tenderness in the muscles along the left scapula (shoulder blade), which he noted during his January 17, 1985 examination of claimant. Fowler then apparently reversed his opinion at a post-hearing deposition, during which he testified that, if he had known of the car accident during the January 17, 1985 examination, he would have ascribed the left shoulder condition to the accident rather than work activities.

We are not persuaded by Dr. Fowler's opinion for two reasons. First, the traffic collision report upon which he based his opinion documented only a two-year-old neck injury. The report provided no factual basis for Fowler's conclusion that the accident resulted in the left shoulder condition for which claimant sought treatment. That conclusion was speculative, and we discount its persuasiveness accordingly. Secondly, after initially opining that the car accident could not have caused some of the symptoms he noted during the initial examination, Fowler reversed his opinion at the deposition without explanation. There was no new information which justified Fowler's reversal of opinion. Consequently, the persuasiveness of his opinion is further diminished.

Given the lack of persuasive medical evidence, we rely instead on claimant's credible testimony. Claimant testified that he

felt something "pop" in his left shoulder during work activities, and sought medical attention when symptoms in the left shoulder and arm worsened. Although claimant did not inform his physicians of the car accident, we are persuaded that his failure to do so was reasonable in light of his testimony that the accident was minor and did not result in any significant injury. We conclude that claimant has proven by a preponderance of the evidence that he sustained an industrial injury and that the injury materially contributed to his disability and need for medical treatment.

ORDER

The Referee's order dated April 14, 1987 is affirmed. Claimant's attorney is awarded an assessed fee of $900, to be paid by Liberty Northwest Insurance Corporation.

RAUL A. HERRERA, Claimant
Pozzi, et al., Claimant's Attorneys
Daryl E. Klein, Defense Attorney
Acker, et al., Defense Attorneys

WCB 86-15787 & 86-15786
September 30, 1988
Order on Review

Reviewed by Board Members Crider and Johnson.

Liberty Northwest Insurance Company ("Liberty Northwest") requests review of those portions of Referee Lawrence's order that: (1) set aside its "de facto" denial of claimant's "new injury" claim for a back condition; (2) upheld the self-insured employer's ("Crown Zellerbach") medical services and aggravation denial for the same condition; and (3) awarded claimant's attorney an attorney fee for services at hearing.

The Board reverses on the issue of responsibility, but affirms on the issue of attorney fees.

ISSUES

1. Whether claimant's current need for medical treatment is compensable.

2. Whether claimant suffered a "new injury" in August 1986, thereby shifting responsibility for his current medical treatment from Crown Zellerbach to Liberty Northwest.

3. Whether the Referee correctly awarded claimant's attorney an insurer-paid attorney fee.

FINDINGS OF FACT

Claimant, 36 at hearing, compensably injured his back in August 1977, while working for Crown Zellerbach as a laborer. Two months later, he reported to Dr. Hazel, orthopedist, with complaints of back pain and radiculopathy into the left lower extremity. After an unsuccessful course of conservative treatment, claimant underwent a lumbar laminectomy and diskectomy in December 1977.

Due to continued low back and right buttock pain, claimant underwent a repeat myelogram in March 1978. Although the myelogram results showed a partial block at L4-5, claimant was not considered a good candidate for further surgery. A few months later, Hazel noted a recurrence of claimant's right leg and

buttocks pain. Thereafter, claimant underwent therapy and treatment at two pain clinics. In November 1979, claimant was rexamined by Hazel for complaints of pain in the neck, back, and testicles.

In December 1979, a Determination Order awarded claimant 10 percent unscheduled permanent disability. By stipulation, his total award was increased to 40 percent.

In October 1983, claimant began to treat with Dr. Chester, orthopedist. Chester diagnosed a deterioration of the L5-S1 disk space. Consequently, Crown Zellerbach reopened claimant's claim.

A Determination Order issued in May 1984, awarding no additional unscheduled permanent disability. A stipulation increased claimant's total award to 70 percent.

Claimant began working as a carpenter for Liberty Northwest's insured in November 1985. Apparently due to poor business, he initially worked for only a short period. In April 1986, he resumed nearly full time work. His back pain increased in August 1986, while attempting to avoid a falling plank. A few weeks later, he sought treatment from Dr. Wilson, orthopedist. Wilson noted low back pain with radiculopathy into the groin and legs. He started claimant on a program of physical therapy and took him off work. Claimant has not worked since that time.

Thereafter, claimant filed an aggravation claim against Crown Zellerbach and a "new injury" claim against Liberty Northwest. Crown Zellerbach timely denied reopening claimant's 1977 claim for an aggravation. Liberty Northwest apparently never issued a denial.

In September 1986, Dr. Wilson reported that claimant was suffering from nothing more than an exacerbation of his prior symptoms. Later, in response to a history provided by Crown Zellerbach's attorney, Wilson stated that the August 1986 injury had resulted in a worsening of his underlying condition.

Claimant was next examined by a panel of doctors at the Orthopaedic Consultants in November 1986. Included on the panel was Dr. Brown, orthopedist. The Consultants reported that claimant's work activities at Liberty Northwest's insured had not independently contributed to his current disability.

The following month, claimant was examined by the Western Medical Consultants. The Consultants were "unable" to provide an opinion concerning whether the August 1986 injury resulted in mere increased symptoms or a worsening of claimant's underlying back condition.

In January 1986, Dr. Brown reviewed the Western Medical Consultants' report and concluded that claimant's August 1986 injury had resulted in a "worsening of his underlying back condition."

That same month, Dr. Chester opined that claimant's current condition was causally related to his August 1977 injury.

At the hearing, Liberty Northwest's attorney conceded the issue of compensability, but not responsibility. Crown

Zellerbach's attorney conceded neither the issue of compensability nor responsibility.

Claimant experienced continuing back problems following his compensable 1977 injury.

The 1977 injury remains a material contributing cause of claimant's current need for medical services.

In August 1986, claimant suffered increased back pain and similar symptoms to those he had experienced earlier.

CONCLUSIONS OF LAW

Compensability

The Referee analyzed this case as involving solely an issue of responsibility between the two insurers. In our view, however, this case presents issues of both compensability and responsibility. Crown Zellerbach's denial did not concede the issue of compensability nor did its attorney at the hearing. Accordingly, the threshold issue is compensability. If compensability is satisfied, then the trier of fact must proceed to address the issue of responsibility. See Runft v. SAIF, 303 Or 493, 498-99 (1987).

Here, claimant's aggravation rights under ORS 656.273 had expired prior to the filing of his aggravation claim with Crown Zellerbach. Therefore, we lack jurisdiction on Board review to consider whether claimant sustained a compensable aggravation of his 1977 injury. See ORS 656.278. We retain jurisdiction, however, to consider whether claimant's 1977 injury materially contributed to his current need for medical services. See ORS 656.245(1). Further, inasmuch as Liberty Northwest's attorney conceded the issue of compensability, we need not consider whether claimant sustained a compensable claim while working for its insured.

A worker is entitled to medical services "for such period as the nature of the injury or the process of the recovery requires." ORS 656.245(1). Medical services are compensable so long as they are reasonably and necessarily incurred in the treatment of the injury. James v. Kemper Insurance Co., 81 Or App 80 (1986).

Claimant credibly testified that he "always" experienced back problems following his compensable 1977 injury. Although his pain increased in August 1986, he believed that it was generally in the "same area."

The medical evidence in this case is divided. Dr. Chester unequivocally opined that claimant's current condition was causally related to his 1977 injury, stating, inter alia:

> "My findings are such that the [claimant] does not have any signs of new injury, nor signs of a materially worsened condition. I, therefore, feel that he has sustained an aggravating injury and that this reflects back to the injury of 1977 as the basic source for this [claimant's] on-going problems."

Chester began treating claimant in 1983. Weiland v. SAIF, 64 Or App 810, 814 (1983). Moreover, Chester was the only physician to observe claimant at the critical times both both before and after his increased pain in August 1986. Kienow's Food Stores v. Lyster, 79 Or App 416, 421 (1986).

Unlike Dr. Chester, Drs. Wilson and Dr. Brown altered their opinions. In September 1986, Wilson opined, inter alia:

> "I have been treating [claimant] for some two weeks. His history is a long one and I certainly cannot state that his current injury is any more than an exacerbation of previous problems."

A few months later, Wilson changed his opinion based upon a medical history set forth in a letter from claimant's attorney. Although noting that claimant's symptoms were "very similar to those diagnosed in the past," Wilson understood that claimant had apparently worked for a significant number of months at Liberty Northwest's insured without difficulty prior to his increased pain in August 1986. Based on that history, Wilson "agreed" that the the August 1986 incident "caused a worsening of [claimant's] underlying condition." Wilson acknowledged, however, that claimant had given a different history.

We have found above that claimant credibly testified to continuing pain following his 1977 injury. We find little, if anything, in claimant's credible testimony to indicate that he worked without difficulty for a significant number of months prior to his increased pain in August 1986. Such a history does not accurately reflect the continuing nature of claimant's back problems. Accordingly, we are not persuaded by Wilson's later change of opinion. See Miller v. Granite Construction Co., 28 Or App 473 (1977).

As to Dr. Brown, he observed claimant on only one occasion as part of a panel of doctors at the Orthopaedic Consultants. After providing a detailed account of claimant's medical history, the Consultants opined, inter alia:

> "[C]laimant's condition has not worsened beyond that which has already been compensated."
>
> "[W]e find no evidence that the work activities at [Liberty Northwest's insured] contributed independently, or even slightly, to his current disability."

Two months later, Brown "reviewed all of the previous medical records" and concluded that the August 1986 incident had "produc[ed] a temporary contribution to worsening of [claimant's] underlying back condition." We attach little probative weight to Brown's later change of opinion, inasmuch as it was conclusory and unaccompanied by medical analysis. Moe v. Ceiling Systems, 44 Or App 429 (1980).

We conclude that claimant has proven a compensable medical services claim for treatment of his 1977 back injury.

Responsibility

Finding that the August 1986 incident had resulted in new symptoms, the Referee concluded that claimant had sustained a "new injury." We disagree.

In Hensel Phelps Construction v. Mirich, 81 Or App 290 (1986), the court announced that unless the "new injury" independently contributed to the worker's disability (i.e., caused a worsening of the underlying condition) then the first employer remained responsible.

Here, we found above that the opinion of Dr. Chester was persuasive. Chester opined that the "basic source" of claimant's continuing back problems was his 1977 injury. According to Chester, the August 1986 incident did not materially worsen claimant's condition. Furthermore, claimant credibly testified that he did not suffer any new symptoms as a result of the August 1986 incident, save to his mid-back. Indeed, claimant's symptoms after August 1986 were nearly identical to those he experienced earlier.

Under such circumstances, we conclude that the August 1986 incident did not independently contribute to claimant's disability. Therefore, Crown Zellerbach remains responsible for claimant's current need for medical services.

Attorney Fee

The Referee awarded claimant's attorney a $1,400 attorney fee for setting aside Liberty Northwest's "new injury" denial. We found above that compensability remained at issue and that Crown Zellerbach, not Liberty Northwest, was responsible for claimant's current back condition and need for medical services. Although claimant's attorney took the position that claimant had sustained a "new injury," he nonetheless expended efforts that resulted in claimant's continued entitlement to medical services.

Accordingly, claimant's attorney was entitled to an assessed fee for his services at hearing. OAR 438-15-035. After considering the factors set forth in OAR 438-15-010(6), we further conclude that the amount of the assessed fee awarded by the Referee was reasonable.

ORDER

The Referee's order dated February 24, 1987 is reversed in part and affirmed in part. That portion of the Referee's order that upheld Crown Zellerbach's denial is reversed. Crown Zellerbach's November 1986 denial is set aside insofar as it denied compensability and responsibility for claimant's current medical services. The medical services claim is remanded to Crown Zellerbach for processing according to law. The remainder of Crown Zellerbach's denial is upheld. That portion of the Referee's order that set aside Liberty Northwest's "de facto" denial is reversed. Liberty Northwest's "de facto" denial is upheld. Crown Zellerbach, rather than Liberty Northwest, is responsible for claimant's attorney fee award of $1,400, for services at the hearing. All remaining portions of the Referee's order are affirmed. Claimant's attorney is awarded an assessed fee of $1,517.50 for his services on Board review, also to be paid by Crown Zellerbach.

TRUDY E. HUGHES, Claimant
Malagon & Moore, Claimant's Attorneys
Cowling & Heysell, Defense Attorneys

WCB 87-00429
September 30, 1988
Interim Order of Remand

Claimant requests review of Referee Mongrain's order that upheld the insurer's denial of claimant's occupational disease claim for bilateral carpal tunnel syndrome.

Following our de novo review of the record, we note that the Referee admitted Exhibit 8A, a two-page March 31, 1987 letter from claimant's counsel to Dr. Young. The parties refer to this exhibit in their briefs. However, the record submitted to the Board does not contain a copy of this exhibit. The Board finds, therefore, that this case has been "improperly, incompletely or otherwise insufficiently developed" and remands the case to the Referee for correction of this deficiency in the record. ORS 656.295(5); Michael J. Bruno, 38 Van Natta 1019 (1986).

The Board retains jurisdiction over this matter. After inclusion of this exhibit into the record, the Referee is directed to issue an Order on Remand discussing the effect, if any, the exhibit has had upon his prior order. Upon receipt of the Referee's Order on Remand, the Board shall take this matter under advisement.

ORDER

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

WILLIAM L. JENNINGS, Claimant
W.D. Bates, Claimant's Attorney
Gail Gage (SAIF), Defense Attorney

WCB 86-05601
September 30, 1988
Order on Review

Reviewed by Board Members Johnson and Crider.

Claimant requests review of those portions of Referee Nichols' order that: (1) upheld the SAIF Corporation's denial of his aggravation claim for a back condition; (2) upheld SAIF's partial denial of compensability for his current low back condition; (3) upheld SAIF's "de facto" denial of certain medical billings; and (4) declined to assess penalties and attorney fees for SAIF's allegedly unreasonable claims processing.

ISSUES

1. Whether claimant sustained an aggravation of his compensable October 1980 back injury.

2. Whether claimant's current low back condition is compensable.

3. Whether certain medical billings for treatment of claimant's current low back condition are compensable.

4. Whether SAIF should be assessed penalties and attorney fees.

FINDINGS OF FACT

Claimant, a cannery worker, compensably injured his back in October 1980. The initial claim form shows that he reported an injury to his "back." On this same form, the employer reported

that claimant's "back started hurting between his shoulders." Two weeks later, claimant was examined by Dr. Robertson, an orthopedic surgeon. Robertson diagnosed a "lumbar strain" and noted that x-rays revealed obliteration of the sacroiliac joints. In December 1980, Robertson reexamined claimant and stated, inter alia:

> "Back continues to bother him with aching and pain in the low back with some radiation into his buttocks."

Shortly thereafter, claimant returned to modified work at the cannery. In March 1981, he was apparently discharged for an unauthorized absence from work. A Determination Order closed his claim in April 1981, awarding 5 percent unscheduled permanent disability for "injury to your low back." In August 1981, a stipulation increased his total award to 20 percent.

In July 1983, claimant's low back pain increased and he reported to Dr. Froehling, M.D. X-rays were suggestive of a pars defect at L5, and Froehling recommended a CT scan. CT scan results revealed no evidence of a pars defect, but did show some disc narrowing at L5 and S1, as well as bulging of the L4-5 vertebral disc. Two months later, Froehling reported that claimant had experienced constant low back pain since his compensable 1980 injury. Froehling concluded, inter alia:

> "My impression is that this man is going to continue to have mild to moderate low back pain of a chronic recurring nature that will be exacerbated by prolonged sitting and by heavy lifting. These activities should be avoided in the future."

Claimant apparently sought no further medical treatment until March 1986, when he was examined by Dr. Brookreson, his treating physician. Brookreson reported "continued back pain." X-rays and CT scan results revealed degenerative arthritic changes throughout claimant's entire spine. According to Brookreson, claimant's condition had worsened since 1983.

In April 1986, SAIF issued an aggravation denial asserting that claimant's condition had not worsened since the last arrangement of compensation. The following month, Brookreson revised his opinion and reported that claimant's condition had worsened since 1980.

In July 1986, through his counsel, claimant submitted a written request to SAIF for reimbursement of $927.75 in medical expenses associated with Brookreson's treatment. SAIF neither paid the $927.75 nor issued a denial.

The Orthopaedic Consultants examined claimant in September 1986. In recording claimant's history, the Consultants stated:

> "The [claimant's] initial reports of injury are quite specific with regard to the location of his complaints in the mid back region between T5 to T10. He first apparently reported low back difficulty sometime later and then, as he progressed,

he added in neck pain, buttock pain, radiating pain and foot numbness."

According to the Consultants, claimant had underlying degenerative changes of the spine that were neither caused nor aggravated by the compensable 1980 injury. In conclusion, the Consultants opined that there was no objective evidence of a worsening and that claimant required no further medical treatment.

In March 1987, Brookreson opined that claimat's residual disability "was directly related to his accident in October of 1980." Later that month, SAIF sought to "amend" its aggravation denial by issuing a partial denial of claimant's current low back condition.

Claimant's compensable 1980 injury resulted in pain between his shoulders and also from the middle part to the lower part of his back. After the 1981 stipulation, he became less able to bend, twist and sit. In addition, he began to experience new symptoms of numbness in the lower extremities. In late 1983 or early 1984, he worked as a flagman for a few days, but had to quit due to back pain. In August 1984, he began working as a bookkeeper for a new business venture. The business folded in May 1985 and he has not worked since.

Claimant's low back condition worsened after the August 1981 stipulation as a result of the October 1980 injury.

Claimant's current low back condition and resulting need for medical treatment are causally related to the October 1980 injury.

CONCLUSIONS OF LAW

Although the Referee found that claimant's condition had worsened, she concluded that he had failed to prove a causal relationship between his worsened condition and the compensable 1980 injury. In so doing, the Referee found that claimant's condition began as a thoracic strain and later spread into the lumbar area. We disagree.

In aggravation cases, the worker must prove: (1) a worsening of his condition that renders 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. Smith v. SAIF, 302 Or 396 (1986); Stepp v. SAIF, 78 Or App 438 (1986); ORS 656.273(1). If, however, the worker's alleged worsening is a symptomatic flareup, then the fact finder must determine whether the flareup was greater than that contemplated at the time of the last arrangement of compensation. See Gwynn v. SAIF, 304 Or 345, on rem 91 Or App 84, 88 (1988).

Unlike the situation in Gwynn, which involved a symptomatic flareup of the worker's condition, claimant alleges an objective worsening of his compensable October 1980 low back condition. Exs. 16b & 17. We, therefore, need not inquire into whether claimant's alleged worsening was contemplated at the time of the August 1981 stipulation. Rather, we confine our aggravation analysis to the two-part test announced in Stepp and Smith.

Prior to the August 1981 stipulation, claimant was able to continue working at the cannery, albeit with modifications. After the stipulation, however, he was unable to work as a flagman due to back pain. In addition, claimant testified that he was less able to bend, twist and sit following the 1981 stipulation. He also began to experience numbness in his lower extremities. After comparing x-rays and CT scan results, Brookreson opined that claimant's low back condition had worsened since 1980. Under such circumstances, we agree with the Referee insofar as she found that claimant's low back condition had worsened.

We turn to the question of causation. Brookreson felt that claimant's worsened condition was the "direct result" of his compensable 1980 injury. Given Brookreson's superior opportunity to observe claimant beginning at the time of his worsening, we find his opinion persuasive. See Weiland v. SAIF, 64 Or App 810 (1983). In contrast, we find the opinion of the Consultants unpersuasive. The Consultants reported that claimant's initial medical reports noted only "mid back" complaints. In fact, however, Robertson diagnosed a "lumbar strain" and noted sacroiliac joint obliteration only two weeks after claimant's compensable 1980 injury. Absent from the Consultant's report is any acknowledgment of Robertson's initial findings concerning claimant's low back. The Consultants opinion is, therefore, based on an incomplete and inaccurate history. See Moe v. Ceiling Systems, Inc., 44 Or App 429 (1980); Hammons v. Perini Corp., 43 Or App 299 (1979).

Accordingly, we find that claimant's low back condition worsened after the last arrangement of compensation as a result of his compensable 1980 injury. Claimant has proven his claim for aggravation and the compensability of his current low back condition. Further, inasmuch as the $927.75 in medical billings are associated with Brookreson's treatment of claimant's worsened condition, we find that those billings are compensable.

Lastly, we turn to the issue of penalties and attorney fees. An insurer or employer shall furnish written notice of acceptance or denial of a "claim" within 60 days after the employer has notice or knowledge of the claim. ORS 656.262(6). A "claim" is defined as "a written request for compensation from a subject worker or someone on the worker's behalf . . . ." ORS 656.005(7). If an insurer or employer unreasonably delays acceptance or denial of a claim it shall be liable for penalties and attorney fees. ORS 656.262(10).

In July 1986, claimant's attorney wrote SAIF and requested reimbursement for medical billings associated with Brookreson's treatment. Claimant testified that he never received reimbursement from SAIF. SAIF never issued a denial of medical services. Inasmuch as SAIF has provided no excuse for its failure to accept or deny claimant's claim for medical services, it shall be assessed penalties and attorney fees.

ORDER

The Referee's order dated June 27, 1987 is reversed. The SAIF Corporation's denials, including its "de facto" denial, are set aside, and claimant's aggravation and medical services claims are remanded to SAIF for processing according to law. For its unreasonable claims processing, SAIF is further directed to

pay claimant 25 percent of the $927.75 in unpaid medical billings as a penalty and $225 as a reasonable attorney fee. Claimant's attorney is awarded an assessed fee of $2,262.50 for services at the hearing and on Board review, to be paid by the SAIF Corporation.

SHARON E. MACK, Claimant
Burt, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 86-00840
September 30, 1988
Order on Review

Reviewed by Board Members Johnson and Crider.

The self-insured employer requests review of Referee Michael Johnson's order that set aside its denial of claimant's low back injury claim. On review, the issue is compensability.

The Board affirms the order of the Referee.

FINDINGS OF FACT

We adopt the findings of fact in the "Facts" and "Findings of Fact" sections of the Referee's order, with the exception of his finding that claimant did not identify back pain as a reason for leaving work on August 15, 1985. We make the following additional findings.

Prior to the August 15, 1985 work incident, claimant had experienced some minor discomfort in her back as a result of standing on an unstable wire mesh platform.

Claimant identified back pain as one of the reasons for leaving work on August 15, 1985. Her symptoms continued to worsen after she left work on that date. She sought treatment from Dr. Azhar, her family physician, on August 20, 1985. He diagnosed cervical and lumbar strain, superimposed on degenerative disc disease. He authorized time loss, and he and his partner, Dr. Reynold's, M.D., provided conservative treatment.

Claimant filed an injury claim regarding the August 1985 incident. The employer denied the claim, and claimant requested a hearing. At the time of hearing, she continued to experience low back pain and left leg symptoms.

CONCLUSIONS OF LAW AND OPINION

As a threshold issue, claimant must prove that she did, in fact, experience a sudden increase in back pain at work on August 15, 1985. She must then demonstrate that her current condition is compensable as either an injury or an occupational disease. If her condition is properly characterized as an injury, claimant must demonstrate that her work injury materially contributed to her current low back and left leg symptoms. Jameson v. SAIF, 63 Or App 553 (1983). If her condition is, instead, characterized as an occupational disease, she must demonstrate that work activities were the major contributing cause of a worsening of her condition when compared to nonwork activities. See former ORS 656.802(1)(a); Dethlefs v. Hyster Co., 295 Or 298, 310 (1983); Devereaux v. North Pacific Ins. Co., 74 Or App 388 (1985).

In regard to the threshold issue, the employer argues that claimant's symptomatic flare-up was unrelated to her work activity and

was, instead, precipitated by personal activities occurring after she left work on August 15, 1985. In support of its contention, the employer notes that its first aid records and the testimony and log of claimant's floor supervisor demonstrate that claimant left work on that date because of menstrual cramps. The Referee was aware of this evidence and found that "[e]ven though claimant informed the plant nurse of another reason for her departure from the plant . . . claimant did have an onset of pain" associated with the bean processing incident.

As noted above, we do not agree with the Referee's finding that claimant did not identify back pain as a reason for leaving work on August 15, 1985. Claimant testified that she left work after informing her floor supervisor and the first aid nurse that she had started her menstrual period and was experiencing back pain. The Referee found claimant credible. Moreover, it is entirely plausible that the floor supervisor and first aid nurse equated claimant's back pain with her menstrual cramps and only reported the latter. We note that the floor supervisor acknowledged this possibility in his testimony. Accordingly, we conclude that claimant did identify back pain as a reason for leaving work on August 15, 1985.

This finding, and the record as a whole, support the Referee's ultimate conclusion that claimant experienced increased back pain as she processed beans at the employer's plant. Claimant credibly testified to the sudden onset of back pain after pushing beans on a conveyor belt at the employer's plant on August 15, 1985. Her testimony is consistent with the symptomatic history she gave to the physicians who treated and evaluated her. The record does not, otherwise, justify setting aside the Referee's credibility finding. See Humphrey v. SAIF, 58 Or App 360 (1982). Accordingly, we accept claimant's version of the onset of her symptoms, and we agree with the Referee on this issue.

We turn to the proper characterization of the incident as an injury or an occupational disease. An occupational disease is distinguished from an injury both by the fact that the former cannot honestly be said to be unexpected, and the fact that an occupational disease is gradual rather than "sudden in onset." James v. SAIF, 290 Or 343, 348 (1981); Clark v. Erdman Meat Packing, 88 Or App 1 (1987); O'Neal v. Sisters of Providence, 22 Or App 9, 16 (1975). In determining whether claimant's condition was "sudden in onset", we consider whether the condition occurred as a result of a "discrete period" of work activity or exposure. Valtinson v. SAIF, 56 Or App 184, 188 (1982). For example, the Court of Appeals characterized a condition as an injury where the initial onset of symptoms occurred within a discrete period of time and continued to gradually worsen over a period of several weeks. Donald Drake Co. v. Lundmark, 63 Or App 261 (1983). Conversely, the court found that a condition was an occupational disease where claimant had periodic back problems followed by a work-related increase in symptoms but did not seek treatment until four months after the work incident. Wausau Insurance Co. v. Huhnholz, 85 Or App 199 (1987).

The Referee analyzed the incident as an injury, whereas the employer argues that it is properly characterized as an occupational disease. Specifically, the employer argues that the August 15, 1985 incident was part of a gradual onset of symptoms that began several days before that incident. In support of its position, the employer contends that claimant gave Drs. Azhar and Spady a history of gradually increasing symptoms, and that she did not even mention the specific bean pushing incident until she was examined by Dr. Spady in October 1985.

The record indicates that claimant did experience some minor discomfort in her back prior to the bean processing incident on August 15, 1985. In addition, she continued to experience a gradual increase in her symptoms after that incident. However, contrary to the employer's assertion, the record indicates that claimant reported the specific bean processing incident to Dr. Azhar when he first examined her on August 20, 1985. Furthermore, that incident was associated with the onset of a significant increase in back pain within a discrete period of time, claimant was unable to continue working because of this symptomatic flare-up, and she sought medical treatment a few days after the incident. Finally, claimant's condition is not an expected and recognized inherent hazard of continued exposure to conditions of her employment.

In light of these factors, we agree with the Referee's characterization of the August 15, 1985 work incident as an injury rather than an occupational disease. See Lundmark, supra. Compare Huhnholz, supra. Accordingly, claimant must demonstrate that her work injury materially contributed to her current condition. Jameson v. SAIF, supra.

The medical opinion on this issue is divided. Dr. Reynolds, claimant's current treating physician, indicated that her condition was materially related to the work incident. The opinions of claimant's former treating physicians, Dr. Gallagher, orthopedist, and Dr. Azhar, M.D., also support a compensable relationship. On the other hand, Dr. Spady, orthopedist, opined that claimant's condition was not materially related to the work incident.

We defer to the opinion of claimant's current treating physician, Dr. Reynolds. He has had significant opportunity to observe claimant, whereas Dr. Spady has only examined her on one occasion. See Weiland v. SAIF, 64 Or App 810, 814 (1983). In addition, Dr. Reynolds' opinion is consistent with the opinions of Drs. Gallagher and Azhar, claimant's former treating physicians. Moreover, Dr. Spady's contrary opinion is not well-reasoned. See Somers v. SAIF, 77 Or App 259, 263 (1986). Although he denies a work relationship, he notes that "a causal relationship between the present symptoms and the work activity is based only on the fact that any work would probably have induced symptoms." We find that the latter statement actually supports a compensable relationship.

We, therefore, agree with the Referee's conclusion that claimant's current condition is compensably related to her August 15, 1985 work injury. Accordingly, we affirm the Referee's order setting aside the employer's denial of claimant's injury claim.

ORDER

The Referee's order dated April 3, 1987 is affirmed. Claimant's attorney is awarded an assessed fee of $400, to be paid by the self-insured employer. The Board approves a client-paid fee, not to exceed $150.

GARRIE C. MATHEWS, Claimant
Welch, Bruun, et al., Claimant's Attorneys
David Smith (SAIF), Defense Attorney

WCB 86-10418
September 30, 1988
Order on Review

Reviewed by Board Members Crider and Ferris.

Claimant requests review of Referee Leahy's order that found that the SAIF Corporation had not wrongfully withheld certain permanent disability benefits. On review, claimant contends that SAIF has not paid claimant's permanent disability award as directed by a Determination Order and a Stipulation. We agree.

FINDINGS OF FACT

In September 1980 claimant compensably injured his left wrist and shoulder. The diagnosis was sprains and strains in the wrist and hand. Subsequently, DeQuervain's stenosing tenosynovitis was diagnosed. In December 1980, release surgery was performed, eventually followed by an upper dorsal sympathectomy.

An October 7, 1982 Determination Order initially closed the claim. Claimant was awarded temporary total disability benefits and 20 percent unscheduled permanent partial disability for his upper or mid back condition. The permanent disability award, which amounted to $5,440 was paid by SAIF. The Determination Order was not appealed.

The claim was reopened in January 1984. Thereafter, a March 1, 1985 Determination Order closed the claim, awarding temporary disability. The order additionally awarded "20 percent unscheduled disability resulting primarily from injury to your psychological[sic], and 142.5 degrees for 95 percent loss of your left forearm." The order further noted that the permanent partial disability award totaled $19,690, and was in lieu of the October 7, 1982 Determination Order. Finally, the Determination Order provided that the award replaced "any prior award for this body part in this claim." (Emphasis added). Claimant requested a hearing.

The "Evaluator's Worksheet" completed prior to the March 1, 1985 Determination Order, stated that the permanent disability award was in lieu of the October 7, 1982 order. Additionally, the worksheet indicated that claimant was entitled to a "combined total" of 20 percent unscheduled disability for claimant's shoulder/back and psychiatric conditions.

On March 25, 1985, SAIF advised claimant that he was entitled to an additional $14,250. This amount represented claimant's scheduled permanent disability award.

On April 2, 1986, a Stipulated Order issued. The order directed SAIF to pay "in a lump sum, an additional 20 [percent] (64 degrees; $5,440) for unscheduled psychiatric disability for a total award of permanent partial disability for psychiatric disability of 40 [percent]," and "95 [percent] (182.4 degrees) for left arm disabilty and that SAIF may offset against the left arm settlement the 95 [percent] (142.5 degrees) left forearm disability already paid under Determination Order of March 1, 1985 and the same amounting to an additional 39.9 degrees ($3,990) payable to claimant." The order further stated that the "issues related to claimant's protest of SAIF's deduction of $5,440 from

his award of March 1, 1985 to recapture the award made to claimant by his award of October 7, 1982 is specifically preserved." Thereafter, SAIF did not pay the additional 20 percent award.

On January 20, 1987, an evaluator from the Evaluation Division agreed with SAIF's statement that claimant was entitled only to a total permanent disability award of 20 percent unscheduled disability. Since the 20 percent permanent disability awarded by the 1982 Determination order had previously been paid, the evaluator concurred with SAIF's position that no additional unscheduled permanent disabilty award was due.

We find that SAIF should have paid claimant the 20 percent unscheduled permanent disability as awarded by the March 1985 Determination Order and the April 1986 stipulated order. We further find that its failure to do so was unreasonable.

CONCLUSIONS OF LAW

The Referee agreed with SAIF's contention, relying on Frank R. Herman, 38 Van Natta 1293 (1986). In Herman, the Board examined the Evaluation Division's worksheet to interpret what the Division had intended to award the claimant. The Referee concluded that the evaluator's worksheet and the evaluator's explanation indicated that claimant received the award from SAIF that was contemplated by the Evaluation Division. We disagree.

The October 1982 Determination Order awarded unscheduled disability for a back condition. Upon the issuance of the order, SAIF had one year to contend that an error had been made. There is no indication that a request for reconsideration was made to the Evaluation Division or that a hearing request was filed. Having failed to do so, the parties are bound by the Determination Order, however wrong it might have been. Johnson v. Industrial Indemnity, 66 Or App 640 (1984). In other words, the order became final by operation of law. Albert Nacoste, 37 Van Natta 76, 77 (1985). Therefore, claimant is entitled to 20 percent unscheduled permanent partial disability for his back condition alone.

The March 1985 Determination Order awarded 20 percent unscheduled permanent disability for psychological disability, stating that the award was in lieu of the October 1982 order. As discussed above, the October 1982 order had become final and could not be changed. Additionally, the March 1985 Determination Order provided that it replaced any prior award for "this body part." Yet, at the time of the March 1985 Determination Order, there had not yet been an award for claimant's psychiatric condition. Moreover, the Stipulated Order awarded an additional 20 percent for unscheduled psychiatric disability for a total award of 40 percent unscheduled permanent disability.

After reviewing the worksheet and the evaluator's subsequent statement, we agree that the Evaluation Division had intended to award claimant a total of 20 percent unscheduled disability for psychiatric and back disability, and 95 percent scheduled permanent disabilty for loss of use of function of the left forearm. However, because the first Determination Order was not appealed, claimant is entitled to the 20 percent unscheduled permanent disability for the back. Furthermore, he is entitled to the 20 percent award for psychiatric disability as granted by the second Determination Order and subsequently confirmed by the Stipulated Order.

Finally, we conclude that because the Stipulation specifically provided that SAIF would pay additional permanent partial disability, SAIF's failure to pay the compensation was unreasonable. Thus, SAIF shall pay as a penalty 25 percent of the unscheduled permanent award and an associated attorney fee. See ORS 656.262(10). Under the circumstances of this case and in light of the factors enumerated in ORS 438-15-010(6) we conclude that an appropriate attorney fee is $500.

ORDER

The Referee's order dated April 14, 1987 is reversed. The SAIF Corporation is directed to pay claimant 20 percent (64 degrees) unscheduled permanent partial disability. Claimant's attorney is awarded 25 percent of this increased compensation, not to exceed $3,800. For its unreasonable failure to pay compensation, the SAIF Corporation is directed to pay a penalty equal to 25 percent of the aforementioned award and an insurer-paid attorney fee of $500.

ALONZA NETTLES, Claimant
Samuel Hall, Jr., Claimant's Attorney
Cummins, et al., Defense Attorneys

WCB 86-14983
September 30, 1988
Order on Review

Reviewed by Board Members Ferris and Johnson.

Claimant requests review of those portions of Referee Brown's order that: (1) upheld the insurer's denial of claimant's inguinal hernia injury claim; and (2) declined to assess penalties and attorney fees for an untimely denial. On review, the issues are compensability and penalties and attorney fees.

We affirm those portions of the Referee's order that upheld the insurer's denial and declined to assess a penalty. However, we reverse that portion of the order finding no entitlement to attorney fees.

FINDINGS OF FACT

We adopt the Referee's "Findings" with the following supplementation.

On August 7, 1986, claimant filed a claim, alleging that he had sustained a compensable inguinal hernia injury that day. The employer completed its portion of the claim on August 11, 1986. On August 20, 1986, the insurer's representative authorized interim compensation. Compensation was paid until October 20, 1986, when the insurer denied the claim.

The insurer's denial issued more than 60 days after the employer's notice or knowledge of the claim. We find that the insurer unreasonably delayed the issuance of its denial.

CONCLUSIONS OF LAW

We adopt the Referee's "Opinion" with the following supplementation.

The Referee upheld the insurer's denial. The Referee further concluded that the denial was untimely. Yet, finding no proof of any amount due and unpaid beyond the 60 days allowed by statute for a response, the Referee declined to assess penalties and attorney fees for an untimely denial.

We agree that there were no "amounts then due" upon which to base a penalty. However, we conclude that claimant was entitled to attorney fees for the late denial.

Written notice of acceptance or denial of the claim shall be furnished to the claimant by the insurer within 60 days after the employer has notice or knowledge of the claim. ORS 656.262(6). If the insurer unreasonably delays acceptance or denial of a claim, 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 656.382. ORS 656.262 (10)

Here, the insurer failed to issue its denial within 60 days after the employer's notice or knowledge of the claim. Consequently, claimant is entitled to penalties and attorney fees for the insurer's untimely denial. Yet, since claimant received interim compensation until the date of the insurer's denial, there are no amounts "then due" upon which to base a penalty. Kosanke v. SAIF, 41 Or App 17, 21 (1979).

Although claimant is not entitled to a penalty, attorney fees for an untimely denial are appropriate. See Mischel v. Portland General Electric Company, 89 Or App 140 (1987). After review of the statement of services, as submitted by claimant's counsel, and considering the factors enumerated in OAR 438-15-010(6), we conclude that a reasonable fee is $300.

ORDER

The Referee's order dated March 5, 1987 is affirmed in part and reversed in part. For services concerning the untimely denial issue at both levels, claimant's attorney is awarded $300 as a reasonable attorney fee, to be paid by the insurer. The remainder of the Referee's order is affirmed. A client-paid fee, not to exceed $245.50, is approved.

JAMES O'LEARY, Claimant
Pozzi, et al., Claimant's Attorneys
Davis & Bostwick, Defense Attorneys

WCB 87-12542 & 87-12541
September 30, 1988
Interim Order of Remand

The insurer requests review of Referee Podnar's order that set aside its partial denial of chiropractic treatments for claimant's back condition.

Following our de novo review of the record, we note that the Referee admitted into evidence Exhibits 1 through 11 in WCB Case Number 87-12541, and Exhibits 1 through 17 in WCB Case Number 87-12542. The parties' briefs refer to several of the exhibits in WCB Case Number 87-12542. However, the record on review contains none of the exhibits received under that case number.

Pursuant to ORS 656.295(5), we may remand to the Referee for further evidence taking, correction or other necessary action when we determine that a case has been improperly, incompletely, or otherwise insufficiently developed. We conclude that the omission of Exhibits 1 through 17 in WCB Case Number 87-12542 constitutes an improper, incomplete, or otherwise insufficient development of this case.

Accordingly, we retain jurisdiction over this matter and remand to the Referee to reconsider this matter in light of our discovery. Should the Referee conclude that a hearing is necessary to

identify the aforementioned exhibits and include them in the record, he is directed to initiate the appropriate proceedings. The Referee is further directed to issue an Order on Remand discussing the effect, if any, the exhibits have had on his prior order. Upon receipt of the Referee's Order on Remand, the Board shall take this matter under advisement.

MELODY M. SCHNEIDER, Claimant
Charles D. Maier, Claimant's Attorney
Merrily McCabe (SAIF), Defense Attorney

WCB 86-14902
September 30, 1988
Order on Review

Reviewed by Board Members Ferris and Crider.

Claimant requests review of Referee Seymour's order that: (1) upheld the SAIF Corporation's denial of claimant's medical services claim for a neck and low back condition; (2) declined to assess a penalty and attorney fee for that denial; and (3) affirmed a Determination Order awarding no permanent disability for claimant's compensable neck and back injury. On review, the issues are medical services, penalties, attorney fees and extent of unscheduled permanent disability.

We affirm the Referee's order.

FINDINGS OF FACT

Claimant has a history of cervical, thoracic and lumbar sprain and strain attributable to off-work car accidents in 1980 and 1983. Since that time, claimant has not been totally free of neck pain, and she has continued to experience periodic flare-ups of back pain.

In December 1985, claimant reinjured her spine in a compensable work injury with SAIF's insured. She had received no treatment for her neck or back condition during the preceding year. The injury occurred when claimant fell down a flight of stairs, after which she experienced immediate neck pain. A short time later, she developed thoracic and lumbar pain, along with sensory loss in her face and upper and lower extremities. Her symptoms were variously diagnosed as a strain and/or sprain, soft tissue injury, intervertebral disk displacement and back contusion.

After initial emergency room treatment, claimant came under the care of Dr. Utter, chiropractor. She became medically stationary on August 22, 1986, but continued to experience frequent flare-ups of neck and back pain. Dr. Utter provided palliative care on an as-needed basis. A Determination Order, issued October 23, 1986, closed her claim with no award of permanent disability.

Meanwhile, claimant sustained yet another injury to her neck and back in an off-work automobile accident on October 6, 1986. Following that accident, she experienced increased pain in her cervical, thoracic and lumbar spine. Dr. Utter diagnosed cervical cranial syndrome with attendant cervical disc displacement and associated whip lash type syndrome, acute paravertebral myofascitis and lumbosacral joint injury. He provided curative chiropractic treatment until claimant became medically stationary on January 17, 1987.

Thereafter, claimant continued to experience symptomatic flare-ups of neck and back pain. Dr. Utter provided palliative

care for these symptoms which he billed to SAIF. On March 19, 1987, SAIF formally denied responsibility for any neck and low back treatment and disability, on or after October 6, 1986, resulting from the conditions diagnosed by Dr. Utter at the time of claimant's October 1986 car accident.

Claimant requested a hearing on this denial and the October 1986 Determination Order.

We find that claimant's current need for neck and low back treatment is not materially related to her compensable injury. We also find that SAIF acted reasonably in issuing its March 19, 1987 denial. Finally, we are not persuaded that claimant has sustained any permanent disability as a result of her compensable injury.

CONCLUSIONS OF LAW AND OPINION

Medical Services

Claimant's current neck and low back treatment is compensable if her December 1985 work injury remains a material contributing cause of her need for that treatment. See Grable v. Weyerhaeuser, 291 Or 387 (1981). The Referee found that claimant's current neck and low back symptoms were attributable to her off-work car accident in October 1986. Accordingly, he concluded that SAIF was not responsible for Dr. Utter's treatment of those conditions. On review, claimant contends that the Referee erred in his findings and ultimate conclusion.

The lay evidence suggests a temporal relationship between claimant's current neck and low back symptoms and her compensable injury. However, this issue involves the type of complex medical question requiring expert medical analysis. See Uris v. Compensation Department, 247 Or 420, 424-26 (1965); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985).

The medical opinions of Drs. Utter and Stevens address this issue. Dr. Utter is claimant's treating chiropractor. Dr. Stevens, M.D., performed an independent medical examination in May 1987. He was claimant's treating physician after her 1980 and 1983 car accidents, and he evaluated her condition following her industrial injury in 1985.

Both doctors reported that claimant's current neck condition is not related to her compensable injury. We, therefore, conclude that claimant has not carried her burden of proof in regard to her neck treatment.

Turning to claimant's low back treatment, Dr. Utter's April 22, 1987 report identifies a material relationship between that treatment and the December 1985 injury. However, the findings which he notes in support of his opinion are inconsistent with findings in his prior reports, including his January 17, 1986 thermographic evaluation, his October 21, 1986 report to the insurer at risk for the 1986 car accident, and his January 17, 1987 impairment rating. In particular, the latter two reports identify permanent thoracolumbar impairment from the 1986 car accident, whereas Dr. Utter opined that there was no permanent impairment to these areas in his April 22, 1987 report. In light of these inconsistencies, we give little weight to the opinion Dr. Utter expressed in the latter report.

Turning to Dr. Stevens' May 1987 report, he found it impossible to document "objectively measurable impairment" associated with any of claimant's injuries but opined that "obviously a lot of jerking, twisting, and contusing [sic] spraining episodes to various joints are additive over a period of years." While it is true that this general statement is consistent with claimant's position, we find it insufficient to satisfy claimant's burden of proof on this issue.

In light of the above discussion, we are not persuaded that claimant's December 1985 injury remains a material contributing factor of her current need for neck and low back treatment. Accordingly, we affirm the Referee's order upholding SAIF's denial of that treatment.

Penalties and Attorney Fees

We adopt the Referee's opinion concerning this issue.

Extent of Unscheduled Permanent Partial Disability

Claimant contends that the Referee erred in finding that she was not entitled to an award of permanent partial disability for her December 1985 work injury. In order to prevail on this issue, she must demonstrate that she has a permanent loss of earning capacity due to the compensable injury. ORS 656.214(5).

The record contains no persuasive medical opinion relating claimant's limitations to her compensable injury. Two panels of independent medical reviewers examined claimant and found no permanent impairment as a result of her compensable injury. As discussed above, Dr. Stevens' May 1987 report included the observation that repeated traumas would be additive over a period of years. However, while this may be true as a general rule, it is not, necessarily, true in this particular instance. A case in point is Dr. Stevens' own finding that claimant's current neck symptoms are attributable to her earlier car accidents rather than accumulative effect of all of her injuries.

Finally, in his August 22, 1986 report, Dr. Utter attributes no permanent impairment to the compensable injury other than a sensory loss in the mid-thoracic spine. Moreover, he gives no further explanation of the nature of this sensory loss, and the record does not otherwise persuade us that it contributes in any way to claimant's limitations. Moreover, his January 17, 1987 impairment rating suggests that claimant's limitations are related to her October 1986 car injury.

We are aware of lay evidence in the record suggesting a temporal relationship between claimant's limitations and the compensable injury. We are also aware that claimant testified that her work injury contributed to her current restrictions. However, we are generally hesitant to infer causation from a temporary relationship, alone. See Allie v. SAIF, 79 Or App 284, 288 (1986). Furthermore, given claimant's prior and subsequent noncompensable neck and back injuries, her lay opinion regarding the causation of her symptoms is not sufficient grounds to support a disability award.

Accordingly, we are not persuaded that claimant sustained any permanent loss of earning capacity as a result of her compensable injury.

ORDER

The Referee's order dated July 16, 1987 is affirmed.

VANCE I. SHATTUCK, Claimant
Pozzi, et al., Claimant's Attorneys
Roberts, et al., Defense Attorneys

WCB 84-10562
September 30, 1988
Order on Review

Reviewed by Board Members Crider and Ferris.

Claimant requests review of Referee Fink's order that: (1) declined to grant permanent total disability; and (2) increased claimant's unscheduled permanent disability for a neck injury from 40 percent (128 degrees) to 75 percent (240 degrees). The self-insured employer cross-requests review of of that portion of the Referee's order which increased claimant's permanent disability to 75 percent, seeking a reduction of benefits. We affirm.

ISSUES

1. Whether claimant is permanently and totally disabled.

2. If claimant is not permanently and totally disabled, whether claimant is entitled to an increase or a decrease in unscheduled permanent disability.

FINDINGS OF FACT

Claimant, 52, was educated through the seventh grade but is functionally illiterate. Most of his work experience has involved heavy physical labor.

Claimant worked for the employer for approximately 20 years. On January 3, 1983, he sustained a compensable injury to his entire back, from cervical to lumbar areas, while breaking excess metal from a casting with a sledge hammer. Dr. Berkeley, neurological surgeon, diagnosed severe cervical spondylosis at the C4-5 and C5-6 levels.

On June 23, 1983, the employer denied responsibility for claimant's cervical spine condition.

On December 29, 1983, a prior Referee found claimant's cervical claim compensable.

On February 8, 1984, Dr. Berkeley performed an anterior cervical diskectomy and interbody fusion at the C4-5 and C5-6 levels.

On August 3, 1984, a Determination Order awarded claimant 40 percent unscheduled permanent disability and 5 percent scheduled permanent disability for the loss of function of his left hand.

On November 5, 1984, claimant began an authorized training program in vending machine repair. On November 5, 1985, claimant successfully completed that program. Throughout the training program, claimant experienced no physical difficulties and was able to perform all the duties of a vending machine repairman. On April 18, 1986, claimant's vocational assistance was terminated. Since that time, claimant has remained unemployed.

Claimant is employable and can perform light duty work. He is also physically able to perform the duties of a vending machine repairman, which does not require holding the head in a flexed position for prolonged periods of time.

Claimant's testimony regarding both the nature of the vocational training he received and his inability to perform the duties of a vending machine repairman was not credible.

CONCLUSIONS OF LAW

The Referee concluded that claimant was physically able to perform the duties of a vending machine repairman and was otherwise employable. Therefore, he concluded that claimant was not permanently and totally disabled, but raised claimant's unscheduled permanent partial disability award to 75 percent. We agree with his conclusion and adopt his Opinion portion of the order with the following supplementation.

Permanent total disability may result from less than total physical incapacity when combined with nonmedical conditions, including age, training, aptitude, adaptability to nonphysical labor, mental capacity, emotional condition, as well as conditions of the labor market. Wilson v. Weyerhaeuser, 30 Or App 403, 409 (1977). To establish permanent total disability, claimant must demonstrate that, as a consequence of his compensable injury, he has been rendered unable to sell his services on a regular basis in a hypothetically normal labor market. Id. Claimant has the burden of proving his permanent total disability status and must 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).

ORDER

The Referee's order dated April 23, 1987 is affirmed. The Board approves a client-paid fee, not to exceed $160.00.

WOODIE R. STRIPLIN, Claimant
Vick & Gutzler, Claimant's Attorneys
Kevin L. Mannix, Defense Attorney

WCB 87-12406
September 30, 1988
Order on Review

Reviewed by Board Members Crider and Johnson.

The self-insured employer requests review of Referee Huff's order that set aside its partial denial of claimant's chiropractic treatments as not reasonable or necessary and as being unrelated to his compensable low back injury. Although not raised by the parties, we also examine the employer's denial to determine whether it is an impermissible preclosure denial. See Roller v. Weyerhaeuser Co., 67 Or App 583, 586-87, on reconsideration 68 Or App 743, rev den 297 Or 601 (1984). We conclude that the denial is procedurally improper; therefore, we do not reach the merits of the claim.

FINDINGS OF FACT

Claimant, 57 years old, sustained a compensable low back injury on December 8, 1984, while employed as a paper machine operator. Claimant continued to work until December 21, 1984, when he began to have pain down his left leg. Claimant then

sought treatment with Dr. Llewellyn, chiropractor, who took him off work.

Claimant had experienced two prior back injuries in the 1960's, both of which resolved within a few weeks.

X-rays taken in December 1984 establish that claimant had preexisting mild to mildly moderate degenerative disc disease at the L5-S1 level.

Dr. Llewellyn diagnosed lumbosacral strain, lumbar subluxation and radiculitis lumbosacral. He treated claimant with spinal manipulation, ultrasonic massage and restriction of activities. Claimant was off work until January 15, 1985 and then was released for modified work. His leg pain had resolved by the time he returned to work. The claim has never been closed.

Claimant experienced an exacerbation on June 5, 1985. He reported no precipitating trauma. Dr. Llewellyn took claimant off work for three to five days.

Claimant reported to Dr. Llewellyn on July 15, 1985 with an additional exacerbation. Claimant related this exacerbation to a specific work incident on July 13, 1985. Dr. Llewellyn recorded "worsened severe low back pain" but, nevertheless, returned claimant to work on a continued modified basis.

On July 21, 1985, Dr. Llewellyn took claimant off work once again. Claimant returned to light-duty work on August 26, 1985. He was then released to resume regular work on October 9, 1985.

Claimant worked for the next 11 months without time loss from work. He continued to treat regularly with Dr. Llewellyn one to three times per week.

In September 1986, claimant experienced another exacerbation. He reported moderately severe low back pain to Dr. Llewellyn. He again cited no precipitating trauma. Instead, he related a worsening over the prior weekend. Dr. Llewellyn advised that he "take it easy."

Similarly, in April 1987, claimant reported to Dr. Llewellyn with complaints of increased severe low back pain. The pain came on suddenly during the night. He felt good when he went to bed the night before. Dr. Llewellyn released him to work the next day with restrictions as to lifting, repetitive bending, and other stressful low back activities.

Again, in May 1987, claimant visited Dr. Llewellyn complaining of "severe and worsened low back pain." No traumatic event was implicated in this exacerbation. Dr. Llewellyn treated claimant with manipulation and ultrasonic sonation. Claimant returned to work with instructions to avoid stressful activities involving his low back. He was scheduled for a follow-up visit later that same day.

For a one-month period in June/July 1987, claimant went without treatments from Dr. Llewellyn. This lapse in treatment was due to the fact that claimant was "doing all right" in addition to the fact that he went on vacation.

On July 28, 1987, the employer's counsel sent claimant a letter which stated:

"On December 8, 1984, you filed a claim for an industrial injury to your low back which occured [sic] while you were employed by [the employer]. You are now seeking reimbursement for chiropractic treatment.

"We deny all further chiropractic care in that it is not reasonable, necessary, or attributable to our industrial injury of December 8, 1984. All chiropractic care obtained prior to this date will be paid for. However we will not make payments for any chiropractic care past this date."

Claimant received no chiropractic treatments during August, September and October 1987.

Claimant's December 1984 injury is not a material contributing cause of his current need for medical services. His current need for chiropractic services is related solely to his preexisting degenerative condition.

CONCLUSIONS OF LAW AND OPINION

On review, the parties argue only the question whether claimant's current condition for which he is receiving treatment is causally related to his compensable claim. However, in the course of our de novo review, we are not limited to the issues presented by the parties. Rather, we may make any disposition of the case that we determine to be appropriate. ORS 656.295(6); Destael v. Nicolai Co., 80 Or App 596, 600-01 (1986).

The employer argues that claimant's ongoing chiropractic care is not related to his compensable 1984 injury. We have found as fact that claimant's ongoing low back symptoms are solely related to his noncompensable degenerative condition. However, notwithstanding this finding, the employer is prohibited from issuing its partial denial so long as the accepted claim is in open status. See Guerrero v. Stayton Canning Co., 92 Or App 209, 212-13 (1988), and the cases cited therein. The evidence indicates that the claim was still open as of the date of the denial. The employer's partial denial is therefore procedurally improper.

ORDER

The Referee's order dated December 11, 1987 is affirmed as supplemented herein. For services on Board review, claimant's attorney is awarded an assessed fee of $405, to be paid by the self-insured employer. A client-paid fee not to exceed $500 is approved.

JOETTE M. WHISTLER, Claimant
Robert L. Burns, Claimant's Attorney
Gail M. Gage (SAIF), Defense Attorney

WCB 86-10541
September 30, 1988
Order on Review

Reviewed by Board Members Johnson and Crider.

Claimant requests review of Referee Galton's order that affirmed a Determination Order which declined to award unscheduled permanent partial disability for a neck, back and left shoulder injury. On review, claimant contends that she is entitled to an award of unscheduled permanent disability. We agree and modify.

FINDINGS OF FACT

In September 1985 claimant compensably injured her back, neck and shoulder, when she was struck from behind by a sheep. Dr. Jura, M.D., diagnosed an acute left cervical and thoracic strain. Dr. Martens, orthopedist, reported that claimant exhibited significant functional overlay characterized by marked over-reaction and contortions when attempting range of motions of the shoulder. He nevertheless declined to find her stationary and recommended neurological follow-up. Dr. Brett, neurosurgeon, diagnosed a probable cervical disc protrusion at C6-7 with evidence of a radiculopathy. Claimant declined to undergo a myelogram.

In February 1986 claimant began treatment with Dr. Dinneen, orthopedist. On February 13, 1986, Dr. Dinneen released claimant to regular work without any restrictions or limitations and no permanent impairment.

In March 1986 claimant was examined by Dr. Storino, neurologist, at the Callahan Center. No longer complaining of pain or arm paresthesias, claimant had an excellent shoulder, cervical and back range of motion. She was asymptomatic and found medically stationary.

A April 10, 1986 Determination Order awarded temporary total disabilty, but no permanent partial disability. A second Determination Order issued April 21, 1986, affirming the prior award.

Claimant was 43 years old at the time of hearing and has a high school education. At the time of her injury, she worked for a livestock auction. She has also worked as a housewife, hostess, and waitress. Sewing and yard work causes her neck to stiffen, prompting headaches, as well as tingling and numbness in her shoulder and arms.

Claimant was employed as a waitress in December 1986 and January 1987. However, the lifting of trays caused her to experience numbness and tingling in her left arm. Thereafter, she stopped working as a waitress.

We find that claimant has experienced permanent impairment as a result of her compensable injury. We consider the extent of her permanent impairment to be in the minimal range. The combination of claimant's lack of transferable skills and her permanent physical limitations have culminated in in a permanent loss of earning capacity.

CONCLUSIONS OF LAW

Although claimant seemed materially overfocused upon her physical symptomatology, the Referee concluded that, based on his observations of claimant's attitude, appeareance and demeanor, she was essentially credible. The Referee further noted that medically verified permanent impairment is not a condition precedent to granting an unscheduled permanent disability award. However, inasmuch as he found the evidence insufficient to support any permanent impairment due to the compensable injury, the Referee held that claimant was not entitled to a permanent disability award. We disagree.

The criteria for rating extent of disability is the permanent loss of earning capacity due to the compensable injury. ORS 656.214(5); Barrett v. D & H Drywall, 300 Or 553, 555 (1986). Earning capacity is the ability to obtain and hold gainful employment taking into consideration age, education, training, skills and work experience. ORS 656.214(5).

In rating the extent of unscheduled permanent disability, we consider the relevant social and vocational factors as set forth above and 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); Fraijo v. Fred S. Bay News Co., 50 Or App 260 (1982).

Objective medical evidence is not the only evidence considered in our evaluation. A claimant's lay testimony may or may not carry the claimant's burden of proving the extent of her disability. Garbutt v. SAIF, 297 Or 148, 151 (1984).

Following our de novo review of the medical and lay evidence, including the Referee's finding that claimant was a reliable and credible witness although she seemed materially overfocused upon her physical symptomatology, we are persuaded that claimant has suffered permanent impairment as a result of her compensable injury which has permanently reduced her earning capacity. Consequently, we conclude that she is entitled to an award of unscheduled permanent disability.

Although she declined to undergo a myelogram, claimant was diagnosed as suffering from a protruding disc at C6-7. Furthermore, despite the resolution of her disabling symptoms while not working, claimant's symptoms promptly reappeared when she returned to waitress work. The reemergence of these disabling symptoms compelled her to leave work as a result of her compensable injury. Therefore, we find that claimant's lack of marketable and transferable skills, coupled with the permanent residuals of her compensable injury, have resulted in a permanent loss of earning capacity.

Accordingly, after completing our review and considering the above mentioned guidelines, we conclude that an award of 10 percent (32 degrees) unscheduled permanent partial disabiltiy adequately compensates claimant for her compensable injury.

ORDER

The Referee's order dated May 1, 1987 is modified. Claimant is awarded 10 percent (32 degrees) unscheduled permanent partial disability for her compensable back, neck and shoulder condition. Claimant's attorney is awarded 25 percent of the increased compensation created by this order not to exceed $3,800.

FRANCES M. WING, Claimant
Douglas L. Minson, Claimant
SAIF Corp Legal, Defense Attorney

WCB 86-17604
September 30, 1988
Order on Review

Reviewed by Board Members Johnson and Crider.

The SAIF Corporation requests review of those portions of Referee Podnar's order that: (1) set aside its denial of claimant's cervical condition; and (2) found that claimant's low back injury was prematurely closed. We affirm.

ISSUES

The issues on review are compensability and premature claim closure.

FINDINGS OF FACT

Claimant, age 39 at the time of hearing, worked for the employer as a drill press operator when she compensably injured her back in October 1984. She was initially treated conservatively with medication and physical therapy.

Claimant treated with Dr. Thomas, orthopedic surgeon, for her low back complaints. He recommended physical therapy which was discontinued when claimant complained of neck and shoulder pain and headaches following her treatment.

In November 1985, claimant was hospitalized due to back, leg and neck pain. A myelogram revealed a herniated lumbar disc. She was treated conservatively.

In December 1985, Dr. Nash, a neurosurgeon, repaired her ruptured L4-5 intervertebral disc. Claimant's low back improved post-surgically with the aid of physical rehabilitation. In May 1986 she continued to experience ongoing cervical and right shoulder pain. Dr. Nash referred her to Dr. Thomas for evaluation of her cervical condition.

On May 30, 1986, the Orthopaedic Consultants conducted an independent medical examination. The Consultants diagnosed protruded intervertebral disc, L4-5, postoperative excision, laminotomy and excision L4-5 intervertebral disc, muscle tension headaches and psychological factors interfering with recovery. They recommended psychiatric evaluation. Additionally, they found claimant's orthopedic and neurological status stationary. Dr. Thomas concurred.

In June 1986, claimant had a moderately marked degree of lumbosacral paraspinous muscle spasm. A CT scan was normal. She continued to treat with Dr. Thomas for ongoing cervical and arm pain.

In October 1986, a cervical MRI revealed mild to moderate disk protrusions at C5-6 and C6-7. Claimant continued to suffer from radicular symptoms. Dr. Thomas referred her to Dr. Nash and recommended a myelogram.

Dr. Nash hospitalized claimant on October 21, 1986 due to ongoing cervical neuroradiculopathy. Objective findings demonstrated restriction of right lateral rotation and flexion of the neck, diminished right tricep reflex, a modest degree of motor weakness of the right digital extensors, tenderness of the posterior spinous process of C5-6-7, and marked bilateral trapezius muscle spasms. A cervical myelogram and CT scan revealed central disk bulges at C5-6 and C6-7. Claimant was referred to Dr. Berkeley for an independent neurosurgical evaluation and opinion.

A November 19, 1986 Determination Order awarded claimant 20 percent (64 degrees) unscheduled permanent partial disability as a result of her low back injury.

On December 2, 1986, Dr. Berkeley, neurosurgeon, examined

claimant. He recommended anterior cervical discectomy and interbody fusion at C5-6 and C6-7. Dr. Nash concurred.

On December 12, 1986, the Orthopaedic Consultants reexamined claimant. They diagnosed chronic cervical strain syndrome with right upper extremity symptoms, muscle contraction headaches, and postoperative lumbar laminectomy and discectomy. They did not recommend cervical surgery.

On February 18, 1987, SAIF denied compensability of claimant's cervical condition, aggravation and surgery.

Claimant had no neck and back problems prior to her October 1984 compensable injury. Additionally, she had no intervening injuries between her injury and the beginning of her cervical symptomatology.

Claimant is credible.

Claimant suffered from neck and shoulder pain and headaches early in September 1985. Her cervical condition resulted from her on-the-job slip and near fall in October 1984. Claimant's cervical condition was not stationary at the time of claim closure.

CONCLUSIONS OF LAW

The Referee found that claimant's cervical condition was a consequence of her compensable injury. Further, he found that her cervical symptomatology presented soon after her injury. He also found that claimant's claim was closed prematurely because claimant's physicians had recommended further diagnostic studies which revealed the cervical disc condition prior to the issuance of the Determination Order. We agree.

To establish compensability, claimant must prove that her industrial injury materially contributed to her disability and the need for medical attention. Hutcheson v. Weyerhaeuser, 288 Or 51 (1979); Milburn v. Weyerhaeuser Co., 88 Or App 375 (1988).

Claimant credibly testified that she experienced neck pain at the time of her 1984 injury. She stated that she had informed her doctors all along, but they treated only her severe and debilitating low back symptoms. Further, she believed that her lumbar surgery would alleviate all back pain she had been experiencing.

The causation issue in this case presents a complex medical question. Hence, although claimant's credible testimony is probative, resolution of the issue largely turns on the medical evidence. Uris v. Compensation Dept., 247 Or 420 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105 (1985).

Dr. Berkeley and claimant's treating physician, Dr. Nash, support her contention that her cervical condition resulted from her compensable injury. Dr. Berkeley stated that her cervical symptoms increased in intensity with the passage of time which ultimately necessitated surgical intervention. He found it within reasonable medical probability that her spondylotic lesions with ruptured discs at C5-6 and C6-7 were directly related to her compensable injury. Dr. Nash stated that claimant had advised him throughout her treatment that she had ongoing cervical pain and right shoulder radiation which began immediately after her injury.

Further, the Orthopaedic Consultants stated that if claimant did have neck symptoms starting at the time of or soon after the 1984 injury, then it would be medically probable that a material relationship existed between her continuing neck and arm symptoms and her compensable injury.

The medical evidence persuades us that claimant's cervical condition was present since the time of her injury and therefore a consequence of that injury. Accordingly, claimant has proven that the October 1984 injury materially contributed to her cervical condition.

A worker's claim shall not be closed if his condition has not become medically stationary. ORS 656.268(1). "Medically stationary" is defined as "no further material improvement would reasonably be expected from medical treatment, or the passage of time." ORS 656.005(17).

Here, Dr. Nash admitted claimant into the hospital for the purpose of treating her cervical pain and for further diagnostic studies. Dr. Nash reported that her cervical condition was related to her compensable injury. Approximately one week later, a Determination Order closed her claim. On December 2, 1986, Dr. Berkeley reported claimant's need for surgery due to her prolapsed cervical discs at C5-6 and C6-7. Dr. Nash concurred.

Following our de novo review of the lay and medical evidence, including evidence that became available after claim closure, we are persuaded that claimant's condition was not medically stationary. Claimant's treating physicians expected further material improvement in claimant's cervical condition. Both physicians recommended surgery. Accordingly, we agree with the Referee that claimant's claim was prematurely closed by the November 1986 Determination Order.

ORDER

The Referee's order dated August 5, 1987 is affirmed. For services on Board review, claimant's attorney is awarded an assessed fee of $625, to be paid by the SAIF Corporation.

TORIA S. BENSON, Claimant
Roberts, et al., Defense Attorneys

WCB 85-14056 & 84-01712
July 5, 1988
Order of Abatement

The self-insured employer has requested reconsideration of our Order on Review dated June 21, 1988. In order to allow time for claimant to respond and for the Board to consider the request, our Order on Review is abated and withdrawn, effective this date. Claimant is allowed 14 days from the date of this order in which to file a response. Thereafter, this matter shall be taken under advisement.

IT IS SO ORDERED.

ELSIE L. HOBKIRK, Claimant
Roberts, et al., Claimant's Attorneys
Rick Barber (SAIF), Defense Attorney

WCB 85-12353
August 3, 1988
Order of Abatement

Claimant has requested reconsideration of our Order on Reconsideration dated July 5, 1988, which denied the SAIF Corporation's request for authorization to offset permanent partial disability benefits paid pursuant to a Determination Order against permanent total disability benefits payable over the same period under a Referee's order. Specifically, claimant submits that we failed to award an assessed fee for his counsel's services concerning the offset issue.

In order to allow sufficient time to consider claimant's request for an attorney fee, the Board abates and withdraws its Order on Reconsideration. The SAIF Corporation is requested to file a response to claimant's request within ten days. Thereafter, we will take this matter under advisement.

IT IS SO ORDERED.

GERALDINE Y. KENDALL, Claimant
Olson Law Firm, Claimant's Attorney
Schwabe, et al., Defense Attorneys
Nelson, et al., Defense Attorneys

WCB 86-16940 & 86-12256
August 26, 1988
Order of Abatement

Claimant requests reconsideration of that portion of our July 19, 1988 Order on Review which declined to award an insurer-paid fee for services performed in litigating this claim. Counsel for United Employers Insurance seeks Board authorization of a client-paid fee for services rendered on review.

In order to allow sufficient time to consider the matter of whether or not claimant's attorney is entitled to a fee for services on review, our July 21, 1988 Order on Review is withdrawn and abated. The insurers are allowed 10 days from the date of this order to file a written response to claimant's motion. Thereafter, we shall take this matter under advisement.

IT IS SO ORDERED.

GEORGE F. MORRIS, Claimant
Borneman & Rossi, Claimant's Attorneys
Roberts, et al., Defense Attorneys
Rankin, et al., Defense Attorneys

WCB 87-03440 & 87-11137
July 8, 1988
Order of Abatement

Liberty Northwest Insurance Corporation has requested reconsideration of our Order on Review dated June 10, 1988 which found it responsible for claimant's upper back and neck condition. Counsel for the other insurer, Industrial Indemnity Company, has filed a response to this request. In addition, both insurers have requested reconsideration of that portion of the Board's order that failed to authorize counsel for either insurer to charge a client-paid fee for services on Board review. The Board has received a statement of services from counsel for Liberty Northwest, but not from counsel for Industrial Indemnity.

In order to allow sufficient time to consider the insurer's requests, the Board stays and abates its Order on Review, effective this date. Counsel for Industrial Indemnity is

requested to file a statement of services rendered on Board review within seven days of the date of this order.

IT IS SO ORDERED.

DELORES PRESTON, Claimant
Starr & Vinson, Claimant's Attorneys
Cowling & Heysell, Defense Attorneys

Own Motion 88-0130M
August 1, 1988
Order of Abatement

The insurer requests that the Board abate its July 5, 1988 Own Motion Order to allow the parties to submit settlement documents to the Hearings Division. Claimant joins in the insurer's request for abatement of the Board's order. We conclude it would be appropriate to withdraw and abate our Own Motion Order effective this date.

IT IS SO ORDERED.

DALE L. TICHENOR, Claimant
Olson Law Firm, Claimant's Attorney
Foss, Whitty, et al., Defense Attorneys
Marcus Ward, Defense Attorney
Charles Lisle (SAIF), Defense Attorney
Schwabe, et al., Defense Attorneys

WCB 87-14700, 87-1498, 87-14699 & 87-17319
August 22, 1988
Order of Abatement

Claimant has requested reconsideration of that portion of our July 21, 1988 Order on Review which failed to award claimant's attorney a fee for services performed on review.

In order to allow sufficient time to consider the matter, our July 21, 1988 Order on Review is withdrawn and abated. The other parties are requested to submit their respective positions within ten days from the date of this order. Thereafter, we shall take this matter under advisement.

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 the Beneficiaries of Jong J. Ahn, Claimants.

AHN et al,
Petitioners,

v.

FRITO-LAY, INC.,
Respondent.

(WCB 85-00438; CA A44113)

Judicial Review from Workers' Compensation Board.

Argued and submitted February 1, 1988.

James L. Edmunson, Eugene, argued the cause for petitioners.With him on the brief were Karen M. Werner and Malagon & Moore, Eugene.

Kenneth L. Kleinsmith, Portland, argued the cause for respondent. With him on the brief was Meyers & Terrall, Portland.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

BUTTLER, P. J.

Reversed and remanded for determination of benefits due under ORS 656.218.

BUTTLER, P. J.

In this workers' compensation case, claimants are the children of the deceased worker. In *Frito-Lay, Inc. v. Ahn,* 84 Or App 427, 734 P2d 15 (1987), we affirmed without opinion the Board's determination that the worker was suffering from an injury-related emotional condition. While that decision was pending, the worker committed suicide. On this review, we decide what impact the suicide has on claimants' entitlement to benefits under ORS 656.204 and ORS 656.218.

ORS 656.156(1) 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."

A beneficiary is not entitled to benefits for injury or death which results from the deliberate intention of the worker. In two recent cases, we discussed the standard of proof required to establish the compensability of a suicide. In *McGill v. SAIF,* 81 Or App 210, 724 P2d 905, *rev den* 302 Or 461 (1986), we ostensibly rejected the "irresistible impulse" test, to the extent that it suggests an element of delerium, frenzy or abruptness. We adopted the "chain-of-causation" rule, essentially as framed by the Supreme Court of Texas in *Saunders v. Texas Employers' Ins. Ass'n,* 526 SW2d 515, 517 (Tex 1975).

We agreed with the Texas court's reasoning that the essence of the test is whether an uncontrollable impulse resulted from an impairment of the worker's reasoning facilities which would cause the suicidal act to be an involuntary one. We held that a suicide is compensable if it resulted from work-related stress which produced a mental derangement that impaired the worker's ability to resist the compulsion to take his own life. In such a case, the suicide cannot be said to have arisen from a "deliberate intention." *McGill v. SAIF, supra,* 81 Or App at 214, 214 n 1, 215. In *McGill,* there was no dispute but that the suicide arose from a compensable depressive disorder. We found that the decedent was suffering from a depressive disorder that caused a mental derangement which rendered him incapable of forming a deliberate intent to commit suicide and therefore held that the suicide was, therefore, compensable.

In *Sullivan v. Banister Pipeline AM,* 86 Or App 334, 739 P2d 597, *rev den* 304 Or 280 (1987), the claimant sought benefits for hospitalization and treatment resulting from a suicide attempt. We found that a compensable injury was the material cause of the claimant's depressive disorder and the suicide attempt. We stated, however, that, in order to prove that the suicide attempt was not the result of a deliberate intention, the claimant had to establish that the depression was a mental derangement that impaired his ability to resist the compulsion to take his own life. The evidence showed that the claimant's psychiatric condition impaired his ability to think rationally and that the suicide attempt was an "impulsive act" with very little thought given to it and was strongly influenced by emotional factors. On that evidence, we held that the suicide attempt was not the result of a deliberate intention.

The "chain-of-causation" test as we have framed it in *McGill* and *Sullivan* requires (1) that the worker suffer from a work-related psychological condition which (2) causes or is itself a mental derangement that (3) impairs the worker's ability to resist the compulsion to take his own life. The medical evidence here does not establish any relationship between the worker's compensable emotional disturbance and her inability to resist the compulsion to take her own life. Dr. Johnson, the worker's treating physician, believed that the worker decided to take her own life after concluding that it was the only means of dealing with her problems, many of which were unrelated to work. In his view, the worker "planned her suicide, with the expectation that those left behind would be better off because of the insurance money and that she would be better off because she would no longer have the problems she had."

Although Johnson's reports show that the worker's mental state was one of the problems that led her to the decision to commit suicide, Johnson did not venture to state, and there is no other evidence, that the worker's compensable emotional disturbance affected her ability to reason and thereby prevented her from resisting the compulsion to take her own life. Claimants have not sustained their burden, and we conclude that the worker's death was a result of a deliberate intention to commit suicide.

Employer asserts, and the Board held, that claimants are precluded by ORS 656.156(1) from recovering *any* benefits, even those related to compensable conditions, *i.e.*, those not attributable to the suicide. We understand the statute to apply only to benefits for injury or death resulting from the deliberate act. Although claimants are not entitled to benefits for the worker's deliberate suicide, they are still entitled to benefits related to the worker's compensable shoulder and psychiatric conditions, pursuant to ORS 656.218.[1] Because the Board determined otherwise, it did not decide what those benefits are.

Reversed and remanded for determination of benefits due under ORS 656.218.

[1] ORS 656.218(1) provides:

"In case of the death of a worker entitled to compensation, whether eligibility therefor or the amount thereof have been determined, payments shall be made for the period during which the worker, if surviving, would have been entitled thereto."

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of
M. Rae Hanna, Claimant.

HANNA,
Petitioner,

v.

FAIRVIEW HOSPITAL et al,
Respondents.

(WCB 86-05727; CA A45886)

Judicial Review from Workers' Compensation Board.

Argued and submitted April 1, 1988.

Peter McSwain, Portland, argued the cause for petitioner. On the brief were James L. Francesconi and Francesconi & Associates, P.C., Portland.

Darrell E. Bewley, Assistant Attorney General, Salem, argued the cause for respondent. With him on the brief were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

BUTTLER, P. J.

Affirmed.

BUTTLER, P. J.

On claimant's petition for review in this workers' compensation case, we conclude that the Board's opinion is supported by substantial evidence on the whole record; therefore we affirm. *George v. Richard's Food Center,* 90 Or App 639, 752 P2d 1309 (1988).

In *Fromme v. Fred Meyer, Inc.*, 89 Or App 397, 749 P2d 590, *rev allowed* 305 Or 467 (1988), we held that the legislature's 1987 amendment of ORS 656.236(2), Or Laws 1987, ch 250, § 4, is not retroactive and does not apply to cases filed in the Court of Appeals before September 27, 1987. The petition in this case was filed on September 29, 1987. The question we now consider is the substantive import of the amendment and whether it has the effect of overruling the Supreme Court's holding in *Compton v. Weyerhaeuser Co.*, 302 Or 366, 730 P2d 540 (1986), that costs on judicial review may be assessed against a claimant in a workers' compensation case pursuant to ORS 20.120.[1]

The legislature amended ORS 656.236(2) by adding the emphasized language:

> "Except as provided in ORS 656.506 and 656.538, none of the cost of workers' compensation to employers under ORS 656.001 to 656.794, *or in the court review of any claim therefor,* shall be charged to a subject worker." (Emphasis supplied.)

In *Fromme* we posed, but did not answer, the question whether the word "cost" in ORS 656.236(2), as amended, means the same thing as "costs" as used in ORS 20.120. We now address that issue in deciding whether the amendment has the effect of superseding ORS 20.120 in workers' compensation cases, thereby overruling *Compton.*

ORS 656.236(2) excludes payments made under ORS 656.506 and ORS 656.538 from the rule that the cost of workers' compensation cannot be charged against the worker. Those sections deal with assessments against employers and

workers for the Retroactive Reserve, the Workers' Reemployment Reserve and the Handicapped Workers' Reserve. Contributions made under those provisions are considered to be part of the "cost of workers' compensation," which suggests that the "cost of workers' compensation" means the cost of funding workers' compensation benefits or of securing workers' compensation coverage for employes. An employer would be prohibited, for example, from charging to any worker the premiums paid for workers' compensation insurance.

The legislature's addition of the phrase "or in the court review of any claim therefor" in ORS 656.236(2) creates confusion. The employer incurs no cost of funding workers' compensation benefits or securing workers' compensation coverage in the court review of a workers' compensation claim. The only "cost" is the legal expense associated with defending against the claim. In the context of the added language, the statute makes sense only if, in addition to the meaning previously discussed, the "cost of workers' compensation to employers" is also read to mean the "legal costs on court review of a claim for workers' compensation." We should attempt to give the new language a reasonable meaning rather than no meaning at all. *See 1000 Friends of Oregon v. Wasco County Court,* 299 Or 344, 358, 703 P2d 207 (1985); *Burt v.*

[1] ORS 20.120 provides:

> "When the decision of an officer, tribunal, or court of inferior jurisdiction is brought before a court for review, such review shall, for all the purposes of costs or disbursements, be deemed an appeal to such court upon errors in law, and costs therein shall be allowed and recovered accordingly."

Blumenauer, 84 Or App 144, 147, 733 P2d 462, *rev den* 304 Or 405 (1987). Inserting the new language purporting to deal with costs in a judicial review in ORS 656.236 creates a patent ambiguity, requiring resort to the legislative history to determine what the legislature intended.

The legislative minutes leave no doubt that the amendment was intended to overrule *Compton v. Weyerhaeuser Co., supra,* by providing that no court costs shall be charged to a worker in the court review of any claim. Minutes, Senate Committee on Labor, May 13, 1987, p 7; Minutes, House Committee on Labor, April 3, 1987, p 2. Accordingly, we conclude that the word "cost" in ORS 656.236, as amended by Or Laws 1987, ch 250, § 4, has two meanings, depending on the context in which it is used in the statute, and that the amended statute requires that no costs be assessed against a claimant in judicial review of a workers' compensation case. Given that meaning, the amended statute supersedes ORS 20.120, just as the APA provision, ORS 183.497, supersedes it when judicial review is sought under the

APA. *See Shetterly, Irick & Shetterly v. Emp. Div.*, 302 Or 139, 727 P2d 117 (1986). Because the petition for review in this case was filed after the effective date of the amendment, no costs may be assessed against claimant.

Affirmed.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

PACIFIC HOSPITAL ASSOCIATION,
Appellant,
v.
MARCHBANKS,
Respondent.

(16-87-00018; CA A43926)

Appeal from Circuit Court, Lane County.

Jack L. Mattison, Judge.

Argued and submitted December 22, 1987.

R. Scott Taylor, Eugene, argued the cause and filed the brief for appellant.

Kevin L. Mannix, Salem, argued the cause and filed the brief for respondent.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

WARREN, J.

Affirmed.

WARREN, J.

Defendant was insured by plaintiff through a group health insurance policy. He filed a workers' compensation claim against his employer. The claim was denied and, pur-

suant to ORS 656.313(3), plaintiff was required to and did pay defendant's medical bills that were part of his workers' compensation claim.

Under the terms of the health insurance contract, plaintiff required that defendant execute a loan receipt agreement which provided that, if any money for medical expenses were received by defendant from his employer or its workers' compensation insurance company, whether by way of compromise, settlement or judgment, he would repay or cause the employer or its insurance company to repay plaintiff to the extent that plaintiff had made payments for covered medical expenses.

Defendant apparently entered into a disputed claim settlement with his employer and its workers' compensation insurer for his compensation claim.[1] Plaintiff brought this action, seeking reimbursement for medical bills paid pending the resolution of the denied claim.

ORS 656.313(3) provides:

> "If an insurer or self-insured employer denies the compensability of all or any portion of a claim submitted for medical services, the insurer or self-insured employer shall send notice of the denial to each provider of such medical services and to any provider of health insurance for the injured worker. After receiving notice of the denial, a medical service provider may submit medical reports and bills for the disputed medical services to the provider of health insurance for the injured worker. *The health insurance provider shall pay all such bills in accordance with the limits, terms and conditions of the policy.* If the injured worker has no health insurance, such bills may be submitted to the injured worker. *A provider of disputed medical services shall make no further effort to collect disputed medical service bills from the injured worker until the issue of compensability of the medical services has been finally determined.* When the compensability issue has been finally determined or *when disposition of the claim has been made pursuant to ORS 656.289(4) [disputed claim settlement], the insurer or self-insured employer shall notify each affected medical service provider and each affected health insurance provider of the results of the determination, including the results of proceedings under ORS 656.289(4) and the amount of any settlement.* If the services are determined to be compensable, the insurer or self-insured employer shall reimburse each health insurance provider for the amount of claims paid by the health insurance provider pursuant to this section. Such reimbursement shall be in addition to compensation or medical benefits the worker receives. Medical service reimbursement shall be paid directly to the health insurance provider. As used in this subsection, 'health insurance' has the meaning for that term provided in ORS 731.162." (Emphasis supplied.)

The trial court dismissed the case, reasoning that the matter could only be resolved through arbitration, pursuant to ORS 656.289(4), which provides:

> "Notwithstanding ORS 656.236, in any case where there is a bona fide dispute over compensability of a claim, the parties

[1] The settlement agreement is not part of the record and we do not know its terms. Neither do we know whether defendant received any money in the settlement. The complaint does not allege that he did.

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 [a disputed claim settlement] 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." (Emphasis supplied.)

We agree with the circuit court's disposition. When there is a disputed claim settlement and the amount in dispute is at least $2,000, ORS 656.289(4) requires arbitration. The statutory scheme assumes that, when the worker has health insurance, the ultimate dispute as to who is responsible for medical bills does not involve the worker, but is between the

health insurance and medical service providers and the workers' compensation insurer or the self-insured employer. If the claim is determined to be compensable, the workers' compensation insurer or self-insured employer pays the bills. If the claim is determined not to be compensable, the health insurance provider pays the bills. ORS 656.313(3). If there is a disputed claim settlement, the workers' compensation insurer or self-employer and the medical service and health insurance providers are to resolve, through arbitration, any dispute which they might have concerning responsibility for and payment of medical bills. Plaintiff seeks to avoid the application of ORS 656.289(4) by attempting to collect unreimbursed medical expenses from the worker directly. That would thwart the legislative plan to keep the worker out of the dispute and to protect him from being left responsible for those expenses.

When the provisions of an insurance contract are inconsistent with pertinent statutes, the provisions of the statutes control. *Garrow v. Pennsylvania Gen. Ins. Co.*, 288 Or 215, 603 P2d 1175 (1979); *see Peterson v. State Farm Ins. Co.*, 238 Or 106, 393 P2d 651 (1964). The legislature has provided an integrated system for the resolution of disputes between workers' compensation insurance carriers and medical service and health insurance providers when a workers' compensation claim is settled by disputed claim settlement. It has provided that disputes as to the payment of medical bills *shall* be settled by arbitration among those parties. The loan receipt agreement attempts to involve the worker in the process and to that extent is contrary to the legislative policy. The contract is unenforceable to the extent that it allows plaintiff to seek reimbursement for medical expenses from defendant directly. We conclude that arbitration is the exclusive method available to plaintiff for resolving the question of liability for medical expenses. The trial court's dismissal of this action was therefore proper.

Affirmed.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Feliz Enriquez, Claimant.
OREGON HUMAN DEVELOPMENT et al,
Petitioners,
v.
ENRIQUEZ,
Respondent.
(WCB 85-04350; CA A44220)

Judicial Review from Workers' Compensation Board.

Argued and submitted March 14, 1988.

Allan M. Muir, Portland, argued the cause for petitioners. With him on the brief were William H. Replogle and Schwabe, Williamson & Wyatt, Portland.

Kenneth D. Peterson, Hermiston, argued the cause and submitted the brief for respondent.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

WARREN, J.

Affirmed.

WARREN, J.

Claimant suffered a head injury when he was allegedly assaulted without provocation by Gentry, a co-worker, while attending a conference. EBI accepted the worker's compensation claim in August, 1984. In January, 1985, employer received information that, in fact, claimant had been struck while attempting to steal money won by Gentry in a card game. EBI issued a denial of the claim on March 8, 1985, on the ground that claimant had misrepresented the cause of the injury and that it was not compensable. The referee allowed the denial, but the Board reversed. On review, EBI contends that it has established that claimant misrepresented facts material to his claim or, in the alternative, that claimant was engaged in an illegal activity, both of which allegedly justify a "backup denial" under the rule set forth in *Bauman v. SAIF,* 295 Or 788, 794, 670 P2d 1027 (1983):

> "If * * * the insurer officially notifies the claimant that the claim has been accepted the insurer may not, after the sixty days have elapsed, deny the compensability of the claim unless there is a showing of fraud, misrepresentation or other illegal activity."

Neither claimant nor Gentry appeared at the hearing. EBI relied on the written statement of Gentry and the testimony of Willocks, a "witness." On *de novo* review, we agree with the Board that EBI has not established that claimant misrepresented material facts as to the cause of his injury, and we adopt the Board's findings:

> "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 witten 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 to 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."

For the same reasons, we agree with the Board that EBI has not established that claimant was engaged in illegal activity at the time of his injury, even assuming that the facts which EBI's evidence could prove could constitute the type of "illegal activity" for which the court in *Bauman* intended to create an exception to the rule against backup denials.

Affirmed.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Joanne C. Krause, Claimant.

VIP'S RESTAURANT et al,
Petitioners,

v.

KRAUSE,
Respondent.

(WCB 86-05815; CA A42526)

Judicial Review from Workers' Compensation Board.

On petitioners' petition for reconsideration filed March 16, 1988; on respondent's petition for reconsideration filed March 30, 1988. Former opinion filed January 13, 1988. 89 Or App 214, 748 P2d 164.

Craig A. Staples and Roberts, Reinisch & Klor, P.C., Portland, for petitioners Vip's Restaurant and EBI Companies.

Charles S. Tauman and Bennett, Hartman, Tauman & Reynolds, P.C., Portland, for petitioner Joanne C. Krause.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

WARREN, J.

Vip's and EBI's petition for reconsideration allowed; claimant's petition for reconsideration denied; former opinion adhered to.

WARREN, J.

Claimant has filed a petition for review of our decision, 89 Or App 214, 748 P2d 164 (1988), reversing the Board's award of attorney fees. Vip's Restaurant and EBI Companies seek review of our decision affirming the Board's determination that Vip's was required to pay temporary total disability after it was held to be responsible for the claim and until the Evaluation Division determined that claimant was medically stationary. We allow only Vip's and EBI's petition for reconsideration. ORAP 10.10. We adhere to our opinion and write only to address Vip's and EBI's contention that they could not have sought claim closure before EBI was determined to be the responsible insurer, because SAIF had been designated the paying agent.

First, there is no indication in the record that SAIF had been designated as the paying agent. Second, even assuming that it had been, nothing prevented EBI, as a potentionally responsible insurer, from seeking a determination order any time after claimant became medically stationary. ORS 656.268.

Vip's and EBI's petition for reconsideration allowed; claimant's petition for reconsideration denied; former opinion adhered to.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Sheila C. Owsley (Karbonski), Claimant.

SAFEWAY STORES,
Petitioner,
v.
OWSLEY (KARBONSKI),
Respondent.

(WCB 85-13054; CA A44758)

Judicial Review from Workers' Compensation Board.

Argued and submitted March 18, 1988.

Kenneth L. Kleinsmith, Portland, argued the cause for petitioner. With him on the brief was Robert J. Radler, Portland.

Larry Schucht, Portland, argued the cause for respondent. On the brief was Marianne Bottini, Portland.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

WARREN, J.

Reversed; denial reinstated.

WARREN, J.

Employer seeks review of an order of the Workers'

Compensation Board affirming and adopting the referee's determination that claimant is entitled to benefits for temporary total disability and to a penalty and attorney fees for employer's alleged unreasonable termination of benefits.

Claimant suffered a compensable injury to her little finger at a time when she was earning $3.67 per hour. After two surgeries, she returned to work part-time, and employer began paying temporary partial disability benefits. In January, 1985, and in June, 1985, claimant received increases in her hourly pay as a result of union contract requirements. On August 7, 1985, she was fired for reasons unrelated to her claim. At that time, she was still working part-time, at an hourly wage of $5.08. Her total weekly wages were more than before the injury. Employer paid temporary partial disability benefits through August 3, 1985.

On October 3, 1985, after having received a request from claimant for temporary partial disability benefits, employer issued a partial denial of benefits for time loss after August 3, 1985, on the ground that, if claimant had not been fired, her weekly wages after that date would have exceeded her weekly wages at the time of the injury and that, therefore, she was not entitled to benefits under the terms of OAR 436-60-030. On December 6, 1985, the claim was closed with an award of temporary total disability from November 29, 1984, through December 16, 1984, and temporary partial disability from December 17, 1984, through September 17, 1985. Employer did not pay any benefits for the period between August 3, and September 17, 1985.

The Board, in adopting the referee's opinion, determined that employer was not authorized to terminate benefits unilaterally when claimant was fired. It awarded benefits for temporary partial disability based on her wages at the time of the injury. It also assessed a penalty and attorney fees for employer's alleged unreasonable termination of benefits.

Claimant's attorney stated at the hearing that claimant was seeking benefits for time loss after August 7, 1985, the date when she was terminated, but was not challenging the amount of temporary partial disability paid before that date.

Despite that, the Board determined that employer owed claimant benefits for temporary partial disability for the week before she was terminated. Employer contends that the Board should not have reached that issue, because claimant waived it. We conclude that the Board was free to make any disposition of the case that it deemed appropriate. *Destael v. Nicolai,* 80 Or App 596, 600, 723 P2d 348 (1986); *Russell v. A & D Terminals,* 50 Or App 27, 31, 621 P2d 1221 (1981). It had before it the general issue of entitlement to temporary partial disability benefits and could properly consider whether benefits for the period before claimant's termination had been calculated correctly.

ORS 656.212 provides:

> "When the disability is or becomes partial only and is temporary in character, the worker shall receive for a period not exceeding two years that proportion of the payments provided for temporary total disability which the loss of earning power at any kind of work bears to the earning power existing at the time of the occurrence of the injury."

The formula for calculating benefits for temporary partial disability is in OAR 436-60-030, which, at the relevant time, provided, in part:

> "(1) The rate of temporary partial disability compensation due a worker shall be determined by:
>
> "(a) Subtracting the post-injury wage earnings available from any kind of work; from
>
> "(b) the wage earnings from the employment at the time of, and giving rise to the injuries; then
>
> "(c) dividing the difference by the wage earnings in subsection (b) to arrive at the percentage of loss of earning power; then
>
> "(d) multiplying the current temporary total disability compensation rate by the percentage of loss of earning power.
>
> "(2) *If the post-injury wage earnings are equal to or greater than the wage earnings at the time of injury, no temporary disability compensation is due."* (Emphasis supplied.)

Employer contends that claimant was not entitled to benefits as they are calculated under the rule and that it could therefore properly stop paying benefits.

Assuming for the moment that claimant had not been

fired, we must first determine whether she would have been entitled to benefits for temporary partial disability. In our view, that issue has been resolved against claimant in *Fink v. Metropolitan Public Defender,* 67 Or App 79, 676 P2d 934, *rev den* 296 Or 829 (1984), where we upheld a previous version of OAR 436-60-030, then codified as OAR 436-54-225. We stated that the rule was consistent with ORS 656.212 and required the conclusion that a claimant whose weekly wage at the time of partial disability is greater than at the time of the injury could not recover benefits for temporary partial disability despite the fact that the claimant was not working as many hours as she had been working before the injury. We held that "earning power" as used in ORS 656.212 refers to a worker's pre-injury wages. We rejected the "hours of work" concept as relevant to the question of diminished "earning power." We stated that the relevant inquiry is not whether the claimant was able to work as many hours as before the injury, but whether the claimant's actual earnings had been diminished:

> "We construe ORS 656.212 to provide that compensation for temporary partial disability of a worker who is recovering from a compensable injury but is nonetheless capable of earning wages and is employed is to be proportionate to the decrease in the worker's actual earnings.
>
> "The formula established by *former* OAR 436-54-225 for computing loss of earning power comports with our construction of ORS 656.212. The rule provided for an adjustment of the compensation to be paid for the difference between the wages the worker would have received for temporary total disability under ORS 656.210 [which is computed on the basis of the claimant's actual wages at the time of the injury]. If a claimant's post-injury wages exceed the claimant's pre-injury wages, the claimant suffers no loss of earning power and is not entitled to temporary partial disability benefits."

Although *Fink* involved interim compensation, the same analysis is applicable here. Claimant's weekly wages were more during the period for which she seeks compensation

than at the time of the injury. Therefore, she is not entitled to benefits for temporary partial disability. The Board's order determining otherwise and assessing a penalty and related attorney fees is therefore reversed, and employer's denial is reinstated.

We reject claimant's contention that employer was

required to begin paying temporary partial disability benefits again after she was fired. *See Noffsinger v. Yoncalla Timber Products,* 88 Or App 118, 745 P2d 245 (1987), *rev den* 305 Or 102 (1988); *Nix v. SAIF,* 80 Or App 656, 723 P2d 366, *rev den* 302 Or 158 (1986). Even assuming that claimant's termination did not preclude recovery of benefits for temporary partial disability, she would have been entitled only to the amount that she could have received on account of her disability had she not been fired. In this case, that is nothing.

Reversed; denial reinstated.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Lawrence N. Sullivan, Claimant.

SULLIVAN,
Petitioner - Cross-Respondent,

v.

BANISTER PIPELINE AMERICAN et al,
Respondents - Cross-Petitioners.

(84-09511; CA A43658 (Control))

In the Matter of the Compensation of Lawrence N. Sullivan, Claimant.

SULLIVAN,
Petitioner,

v.

BANISTER PIPELINE et al,
Respondents.

(85-14645; A43949)

Judicial Review from Workers' Compensation Board.

Argued and submitted February 1, 1988.

James L. Edmunson, Eugene, argued the cause for petitioner - cross-respondent. With him on the briefs were Karen M. Werner and Malagon & Moore, Eugene.

Richard Wm. Davis, Portland, argued the cause for respondents - cross-petitioners. With him on the brief were Davis, Bostwick, Scheminske & Lyons, Portland.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

ROSSMAN, J.

On petitions, reversed as to determination that claimant's psychological condition is not compensable; otherwise

affirmed on petition and remanded for determination of whether claimant was medically stationary at time of February, 1986, determination order; reversed on cross-petition.

ROSSMAN, J.

This is the third in a series of worker's compensation cases involving the same claimant. In our first decision, we held that claimant's left knee injury claim had not been prematurely closed on April 28, 1981, and that he had not experienced an aggravation of that claim. *Sullivan v. Argonaut Ins. Co.*, 73 Or App 694, 700 P2d 274 (1985). In our second decision, we held that claimant's depression and attempted suicide were an aggravation of his compensable injury and, therefore, that hospitalization and treatment resulting from his attempted suicide were compensable. *Sullivan v. Banister Pipeline AM*, 86 Or App 334, 739 P2d 597 (1987).

Claimant now seeks review of Board determination that his depression and alcohol abuse treatment are not compensable. He also seeks a determination that the claim was prematurely closed in March, 1985, and in February, 1986. Additionally, he seeks penalties and attorney fees for employer's alleged unreasonable denial of vocational rehabilitation. Employer cross-petitions, asserting that it is entitled to offset an award of permanent partial disability made for a shoulder condition in a March, 1985, determination order against an overpayment of temporary total disability made after claimant became medically stationary on the left knee claim.

It would serve no purpose for us to recite all the details of this proceeding. We will detail them only as necessary to discussion of the various issues on review. Claimant asserts that his psychological condition is compensable. Initially, the referee decided that the expenses for hospitalization and treatment resulting from a suicide attempt were not compensable. We reserved the question of the compensability of claimant's general psychological condition. In *Sullivan v. Banister Pipeline AM, supra*, we found, on *de novo* review, that claimant's industrial injury was a material cause of his depression and that the depression and suicide attempt were an aggravation of the compensable injury. We necessarily decided that the psychological condition is compensable. The Board erred in holding that the psychological condition is not compensable.

Claimant seeks a determination that his alcohol-related problems are compensably related to the compensable

injury and psychological problem. Employer contends that claimant waived a claim for the alcohol condition when he failed to raise it when the suicide attempt claim was litigated. Even assuming that the question was not waived, we find, on *de novo* review, that the evidence does not establish a relationship between claimant's alcohol-related problems and his compensable conditions. We therefore affirm the Board's determination that the alcohol treatment is not compensable.

In March, 1985, after the claim for the psychological condition had been filed, but before it had been determined to be compensable, the Evaluation Division issued a determina-

tion order which awarded benefits for a compensable right shoulder condition but did not consider claimant's psychological condition. The evidence shows that claimant's psychological condition was not medically stationary at that time. In view of our holding that the psychological condition is compensable, we conclude that the determination order was premature.

After a referee determined that the psychological condition was compensable, the Evaluation Division issued a second determination order in February, 1986, awarding claimant 25 percent permanent partial disability for the psychological condition. Because the Board reversed the referee's determination as to the compensability of the psychological condition, it treated the March, 1985, determination order as dispositive and did not consider the question whether the 1986 order was premature. We remand the case to the Board for consideration of that issue.

The record shows that, after 12 months of unsuccessful services, employer suspended vocational assistance until claimant had received professional treatment for his alcohol problem. The evidence is that he has refused to participate in alcohol rehabilitation and that alcohol abuse is a major obstacle to vocational rehabilitation. We conclude that employer acted reasonably in suspending vocational assistance. We therefore affirm the Board on that issue.

Employer cross-petitions, seeking an offset for an overpayment of temporary total disability on the left knee claim. That claim was originally closed by a determination order on April 28, 1981, with an award of temporary total disability from September 19, 1980, through March 31, 1981.

On April 26, 1982, a referee determined that the claim had been prematurely closed. On August 26, 1983, the Evaluation Division issued an order that claimant was stationary as of August 5, 1983, and that he was entitled to temporary total disability benefits from September 19, 1980, through August 5, 1983. The Board reversed the referee and held that claimant had become medically stationary on March 31, 1981. We affirmed that determination. *Sullivan v. Argonaut Ins. Co., supra.*

Employer paid temporary total disability from September 19, 1980, through September 28, 1983, resulting in the overpayment at issue. In March, 1985, the Evaluation Division issued an order awarding permanent partial disability for the right shoulder and authorizing an offset of the overpayment. Employer offset the full amount of the award. We have now held that the March, 1985, determination order was premature. The question of whether employer is entitled to offset the award made in that determination order is also permature.

We are left with only the general question whether employer should be allowed to offset the overpayment against future awards. The Board held that, by virtue of ORS 656.313(2), employer was not entitled to offset most of the overpayment. ORS 656.313(2) provides, in part:

> "(1) Filing by an employer or the insurer of a request for reversal or court appeal shall not stay payment of compensation to a claimant.

"(2) If the Board or court subsequently orders that compensation to the claimant should not have been allowed or should have been awarded in a lesser amount than awarded, the claimant shall not be obligated to repay any such compensation which was paid pending the review or appeal."

We have interpreted that statute to prohibit an employer from recovering, by offset against a later award, benefits that are or should have been paid pending the employer's appeal of and pursuant to an award that is later determined to be excessive. *See SAIF v. Casteel,* 74 Or App 566, 703 P2d 1039 (1985), *remanded on other grounds,* 301 Or 151, 719 P2d 853 (1986); *Hutchinson v. Louisiana Pacific Corp.,* 67 Or App 577, 581, 679 P2d 338, *rev den* 297 Or 340 (1984). Here, however, not all of the overpayment was made pending appeal of and pursuant to an award. Employer paid

benefits from September 19, 1980, through September 28, 1983. The Evaluation Division determined on August 26, 1983, that claimant was medically stationary on August 5, 1983. The Board properly authorized an offset for any portion of the overpayment after the medically stationary date. Additionally, employer made payments after the April 28, 1981, determination order holding that claimant had become medically stationary on March 31, 1981, and before the referee's order of April 26, 1982, holding that the April 28, 1981, determination order was premature. The payments made between those dates were not made pursuant to and pending review of an award of compensation. Employer is entitled to an additional offset of the overpayment made from March 31, 1981, through April 26, 1982.

On the petitions, reversed as to the determination that claimant's psychological condition is not compensable; otherwise affirmed on the petitions and remanded for a determination of whether claimant was medically stationary at the time of the February, 1986, determination order; reversed on cross-petition.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

VAN OSDOL,
Appellant,
v.
KNAPPTON CORPORATION,
Respondent.

(A8401-00492; CA A41879)

Appeal from Circuit Court, Multnomah County.

Richard L. Unis, Judge.

Argued and submitted February 17, 1988.

Raymond L. Conboy, Portland, argued the cause for appellant. With him on the brief were Jan Thomas Baisch and Pozzi, Wilson, Atchison, O'Leary & Conboy, Portland.

John R. Faust, Jr., Portland, argued the cause for

respondent. With him on the brief were Schwabe, Williamson & Wyatt, Portland.

Before Richardson, Presiding Judge, and Warren and Rossman, Judges.

ROSSMAN, J.

Reversed and remanded with instructions to set aside judgment in favor of Knappton Corporation and enter judgment for plaintiff against Knappton.

Warren, J., dissenting.

ROSSMAN, J.

This action is before us for the second time. In the previous appeal, 73 Or App 684, 699 P2d 1176 (1985), Knappton Corporation (Knappton) had been granted a summary judgment on the ground that *respondeat superior* did not apply and, therefore, that it was not liable for the negligence of its employe, Eubanks. We reversed. On remand, the trial court denied plaintiff's motion for directed verdict on his claim against Knappton, and the jury found for Knappton. Plaintiff appeals, contending that the court erred in denying his motion for a directed verdict. We reverse with instructions to grant plaintiff's motion.

The facts were undisputed on the summary judgment motion and, on remand, the testimony at the trial regarding the employment was essentially the same.

Plaintiff was injured in an automobile accident and brought an action against the other driver Eubanks and Eubank's employer, Knappton. Eubanks was a dispatcher for Knappton. He lived in Castle Rock, Washington. For two and a half years before the accident, his normal place of employment was Rainier. Three days before the accident, Eubanks was instructed by his supervisor to go to Astoria to fill in for the operations manager, who was on vacation. The superior gave him the alternative to stay overnight in Astoria, in which case Knappton would pay for his lodging, or to commute from his home in Washington, in which case Knappton would reimburse him 20 cents a mile from Rainier to Astoria. Eubanks' hours of employment in Astoria were not set, but he usually tried to be at work by 7 a.m. He was on 24-hour call. On the day of the accident, he was driving his own car from his home to Astoria. The accident occurred at about 6:45 a.m. on U.S. Highway 30, 15 miles east of Astoria.

Plaintiff moved for a directed verdict on the issue of *respondeat superior*. The trial court stated that it would have ruled as a matter of law that there was an agency but believed that our first opinion, and Supreme Court authorities, made the issue a question for the jury. The jury found that Eubanks was not acting within the course and scope of his employment when the accident occurred, and judgment was entered

against Eubanks alone.[1] The trial judge denied plaintiff's

[1] Before the jury returned its verdict, plaintiff and Eubanks settled.

motion for a judgment *nov.* Plaintiff's assignment of error is that he was entitled to a directed verdict that Knappton is liable for the acts of Eubanks.[2]

The threshhold question is whether the trial court was correct in determining that the law of the case prevented it from directing a verdict in favor of plaintiff. The law of the case principle precludes relitigation or reconsideration of a point of law decided on appeal at an earlier stage of the same case. *Koch v. So. Pac. Transp. Co.,* 274 Or 499, 512, 547 P2d 589 (1976); *Public Market Co. v. Portland,* 179 Or 367, 373, 170 P2d 586 (1946). In our first opinion, we stated:

> "In this case, and in spite of [the supervisor's] testimony—some of it only legal conclusions—to the contrary, a jury could find that Eubanks' trip was at his employer's direction and on his employer's business. The fact that he was away from his usual place of business and was being paid for his mileage, together with the fact that the accident occurred at a time when, had he been at his usual place of work, Eubanks would have been on the job, would support such a conclusion. Summary judgment was inappropriate." 73 Or App at 687.

The question is whether that language required submitting the issue of *respondeat superior* to the jury or determined only that Knappton was not entitled to summary judgment.

To conclude that our earlier decision required sending the issue to the jury would be to ignore that the issue arose from a summary judgment granted on *Knappton's* motion. Summary judgment can only be granted when there is no genuine issue of any material fact and the *moving* party is entitled to judgment as a matter of law. ORCP 47C. Even if facts are undisputed, if the inferences arising from them are susceptible to more than one reasonable conclusion, summary judgment should not be granted. *See Chesterman v. Barmon,* 82 Or App 1, 727 P2d 130 (1986), *aff'd* 305 Or 439, ___ P2d ___ (1988). Knappton was the moving party and argued that, as a matter of law, the facts showed that *it was not liable* for

Eubanks' actions. We rejected that position, noting that the undisputed facts gave rise to inferences besides those relied on by Knappton. Nothing was before us that would have permitted us to determine that Knappton *was* liable as a matter of law. Our holding did not prevent plaintiff from raising the issue at trial by a motion for directed verdict.

Accordingly, we turn to the issue presented by plaintiff's assignment of error. Both parties treat the question of whether *respondeat superior* liability can be imposed as a matter of law as an issue of first impression. Although neither we nor the parties have found a case imposing liability on a directed verdict, we have held that an employe can be held, as a matter of law, to be acting within the scope of employment. In *Calif. Cas. Ins. v. David Douglas School Dist.,* 71 Or App 549, 693 P2d 54, *on reconsideration* 74 Or App 270, 702 P2d 1115, *rev den* 300 Or 249 (1985), an employee of the school district was required to supervise an evening dance at the school. He was entitled either to compensation for eating dinner near the school or for his mileage to and from the school. On his way to the dance, he was involved in an accident. We held:

[2] Knappton argues that plaintiff did not preserve the error by a proper motion for directed verdict. ORCP 63A. We conclude that the record shows that plaintiff put the issue before the trial judge.

> "The material facts are undisputed. The finder could not reasonably draw conflicting inferences from the facts. Whether [the employe] acted within the course and scope of his employment is a question of law." 74 Or App at 273. (Footnote omitted.)

Here, also, the material facts are undisputed. If the only reasonable conclusion arising from those facts is that Eubanks was acting within the scope of his employment, plaintiff has met his burden, and a directed verdict should have been granted. *See Tiedemann v. Radiation Therapy Consultants,* 299 Or 238, 245, 701 P2d 440 (1985).

The general rule is that an employe is not within the scope of his employment while going to or from his work. *Heide/Parker v. T.C.I., Incorporated,* 264 Or 535, 539, 506 P2d 717 (1973). However, an exception arises when there is some involvement of the employer or some facet of the employe's task which makes the travel work-related or employer-sponsored. *Runyan v. Pickerd,* 86 Or App 542, 547, 740 P2d 209, *rev den* 304 Or 279 (1987). The facts show that the exception applies here.

Eubanks was on 24-hour call by Knappton. His regular place of employment was Rainier. His sole reason for traveling beyond Rainier to Astoria on that morning was that his supervisor had directed him to do so to fill in for another Knappton employee. The trip to Astoria was undertaken solely for Knappton's purpose and at its direction. The travel was quite different from his daily commute. We hold, as a matter of law, that Eubanks was acting within the scope of his employment. *See Calif. Cas. Ins. v. David Douglas School Dist., supra,* 74 Or App at 274; *see also Stanfield v. Laccoarce,* 284 Or 651, 655, 588 P2d 1271 (1978). Plaintiff's motion for directed verdict should have been granted.

The dissent is wrong in saying that "Eubanks was employed only to supervise, not to drive or to make a trip beyond his regular work day." 91 Or App at 505. Knappton recognized that the trip from Rainier to Astoria was beyond Eubanks' regular work day. It paid him 20 cents a mile for the 50 miles between those two cities; it did not pay him mileage from his home in Castle Rock to Rainier. The fact that he chose to drive and did not stay overnight in Astoria does not negate the fact that the drive, if chosen, was a employer-sponsored commute. *See Calif. Cas. Ins. v. David Douglas School Dist., supra,* 74 Or App at 273 n 5.

Reversed and remanded with instructions to set aside judgment in favor of Knappton Corporation and enter judgment for plaintiff against Knappton Corporation.

WARREN, J., dissenting.

I agree with the majority that evidence may be offered which provides a basis to decide that an employe is acting within the scope of his employment even though he is going to or coming from work. However, I disagree with the majority's conclusion that, as a matter of law, Eubanks' travel was work related or employer sponsored and, as a matter of law, took him outside the coming and going rule. The determination of whether Eubanks was merely on his way to work or was acting within the scope of his employment is a question of fact which was properly left for the jury to decide.

The majority treats two facts, change in work place and mileage reimbursement, as legally controlling. Those facts are relevant, but neither, in isolation or in combination, is determinative of the issue of scope of employment. Other facts make the issue a question for the jury.

Despite the change in work place, the accident occurred when Eubanks was driving *to* work, not while he was *at* work. The majority relies on *Calif. Cas. Ins. v. David Douglas School Dist.*, 71 Or App 549, 693 P2d 54, *on reconsideration* 74 Or App 270, 702 P2d 1115, *rev den* 300 Or 249 (1985), for the conclusion that Eubanks' conduct was within the scope of his employment as a matter of law. That reliance is misplaced, because the evidence in this case is different. There, the employe's job included making an additional trip back to school to supervise an evening dance. In this case, Eubanks was employed only to supervise, not to drive or to make a trip beyond his regular work day. Further, he was on the road, not because his employer required him to be, but because he elected to drive rather than to stay in Astoria. Presumably, he made that decision for his own convenience and not, as the majority states, "solely for Knappton's purpose and at its direction." 91 Or App at 504.

On the facts proved, the jury was not compelled to conclude that Eubanks was within the scope of his employment. Because more than one reasonable conclusion can be drawn from the facts, the issue was properly submitted to the jury for its resolution. *See Stanfield v. Laccoarce*, 284 Or 651, 655, 588 P2d 1271 (1978).

I dissent.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

BLUMHAGEN,
Appellant,
v.
CLACKAMAS COUNTY et al,
Respondents.

(82-10-196; CA A39129)

Appeal from Circuit Court, Clackamas County.

Sid Brockley, Judge.

Argued and submitted May 8, 1987.

Robert E. Nelson, Gresham, argued the cause and filed the brief for appellant.

Miles A. Ward, Assistant County Counsel, Oregon City, argued the cause for respondents. With him on the brief was Clackamas County Counsel, Oregon City.

Before Buttler, Presiding Judge, and Rossman and Deits, Judges.

DEITS, J.

Affirmed.

DEITS, J.

In this unlawful employment practice case, plaintiff argues that defendants violated the Handicapped Persons' Civil Rights Act by discharging her and failing to reinstate her to her former position as a deputy sheriff or, in the alternative, to another "available and suitable" position after she sustained a compensable on-the-job injury. ORS 659.415; ORS 659.420; ORS 659.425.[1] The trial court found for defendants, and plaintiff appeals.[2] We review *de novo, Brown v. City of Portland,* 80 Or App 464, 722 P2d 1282, *rev den* 302 Or 460 (1986), and affirm.

Plaintiff was employed as a deputy sheriff 103, which is the civil service classification for the patrol deputy position. While on duty, she sustained a permanent injury in an automobile accident. As a result of the injury, she suffers headaches and occasional numbness in her left arm which affects her ability to hold and grasp things. Her treating physician and a consulting physician advised defendants that she would always be susceptible to serious injury to her head and neck and that, due to that condition, she should not be reinstated to her former position as a patrol deputy, which requires that she be able to work in the field on patrol, or to any other position where she could sustain a blow to her head or neck.[3] There was evidence that, while on patrol, a deputy is always subject to the threat of violence and injury.

Plaintiff's physician advised defendants that she could do clerical work. At the physician's request, defendants assigned her to a light duty desk officer position, which is a temporary position that rotates every 30 to 60 days but can be extended. It is staffed by officers who are temporarily disabled or are suffering from "burnout." In February, 1982, after nine months assignment as a desk officer, plaintiff was notified that, due to the temporary nature of the position and her

permanent disability, she would be laid off from her position as a deputy sheriff 103.[4]

After receiving the layoff notice, plaintiff demanded reinstatement to her former position or another suitable position, pursuant to ORS 659.415 and ORS 659.420. Defendants discussed alternatives to layoff with her and extended the date of layoff until May 31, 1982. Two months after plaintiff was laid off, she was offered a position as a community service officer (CSO) in the department. The CSO provides backup for desk officers by taking telephone reports and dealing with walk-in complaints. Unlike the desk officer, the CSO does not wear a uniform and cannot make arrests. The position does

[1] Plaintiff presented evidence on four other claims. After she rested, the court struck all four claims, and plaintiff also assigns error to those rulings. We hold that the trial court properly struck those claims.

[2] This case was tried before ORS 659.121(2) was amended to allow for jury trials at the request of any party. Or Laws 1987, ch 822, § 1.

[3] On the basis of opinions of plaintiff's doctors that she could not return to her position as a patrol deputy, plaintiff was awarded permanent partial disability by the Worker's Compensation Board.

[4] Although plaintiff argues that she was not laid off, but was terminated, we concur with the trial court's determination that she was laid off.

not have the same degree of responsibility as the patrol deputy and pays approximately half the salary. Two months after the offer (during which time defendants held the position open for her), she accepted it.

Plaintiff argues that defendants violated ORS 659.415(1) by not reinstating her as a deputy sheriff 103. That statute provides that a worker who sustains an injury shall be reinstated upon demand, "provided that the position is available and the worker is not disabled from performing the duties of such position." Here, plaintiff has not presented evidence which shows that she is physically capable of performing the duties of a patrol deputy.[5] Rather, the evidence establishes that plaintiff cannot perform all of the duties of a patrol deputy, because she has a permanent condition that renders her susceptible to further injury and prevents her from working in the field on patrol. In fact, plaintiff testified that she feels the same physically now as she did in 1982 and that, in the light of her disability, it would be unfair to other deputies on patrol to return her to her former position. We find that plaintiff is not able to perform the duties of her former job and

hold that defendants did not unlawfully refuse to reinstate her to her former position.

Plaintiff next asserts that defendants violated ORS 659.420 by failing to reemploy her in another position which was "available and suitable." ORS 659.420(1) provides:

> "A worker who has sustained a compensable injury and is disabled from performing the duties of the worker's former regular employment shall, upon demand, be reemployed by the worker's employer at employment which is available and suitable."

Plaintiff contends that, although her present position as a CSO was available, it is not suitable, because of the substantial difference in salary, duties and responsibilities between it and her former position. In *Carney v. Guard Publishing Co.*, 48 Or App 147, 152, 616 P2d 548, *mod* 48 Or App 927, 630 P2d 867, *rev den* 290 Or 171 (1980), we recognized that, although the policy of the Handicapped Persons' Civil Rights Act is "the fullest employment of handicapped persons which is compatible with the reasonable demands of the job * * *, [a]n employer's statutory duty to reemploy injured workers is not absolute." The act does not demand that an employer create positions or substitute an injured employe for a non-injured one. *Carney v. Guard Publishing Co., supra.* Neither is an employer obligated to offer a selection of equally suitable jobs or hold its offer open for an unreasonable period of time. *Carney v. Guard Publishing Co., supra.* The relevant factors in determining whether a position is suitable include the employe's educational background and work experience, previous salary, previous level of responsibility, record with the employer, the nature and severity of the disability and the

[5] Under the statute, a doctor's certificate approving an employe's return to the position is *prima facie* evidence that the worker is able to perform the duties. At the same time as plaintiff, several other patrol deputies received layoff notices. The layoff dates for plaintiff and the other deputies were extended a number of times to allow them to present additional medical evidence concerning their physical fitness to perform the job. Those employes who brought in physician's certificates stating that they were fit to return to work were retained, and those who did not were laid off.

employer's size, diversity and hiring needs. *Carney v. Guard Publishing Co., supra.*[6]

As a CSO, plaintiff performs some of the duties and uses some of the skills that she acquired as a deputy sheriff

103. The duties of the position are consistent with her physician's opinion of her capabilities. Although her salary as a CSO is half that of a deputy sheriff 103, and she does not have the same level of responsibility that she previously had, there were no other positions which were "available and suitable" between the time when she was laid off and when she accepted the CSO position.

At the time plaintiff was laid off, there were a limited number of one- and two-year job assignments in the sheriff's department which rotated among the patrol deputies.[7] Plaintiff argues that those positions, unlike the CSO position, were suitable, because they offered duties and compensation which were comparable to her former position and were basically office positions. However, on this record, we cannot discern whether any of those positions was available at the time when plaintiff was offered the CSO position. More importantly, because those positions rotate among patrol deputies, they require the basic deputy sheriff 103 classification and an ability to return to patrol work. Because plaintiff is not physically capable of working in a patrol position, these positions are not suitable. There were also clerical positions within the department; however, those positions are comparable to the CSO position in salary and would afford her even less responsibility and fewer duties relative to her skills than the CSO position.[8]

After plaintiff accepted the CSO position, defendants created several new positions in the property room, which did not require the deputy sheriff 103 status and offered a higher salary. Plaintiff applied for one of the positions, but was not hired. However, once defendants offered plaintiff the CSO position, their statutory duty to afford her preference in hiring expired. *Carney v. Guard Publishing Co., supra,* 48 Or App at

152. We hold that, due to the specialized and limited hiring needs of the department, the CSO position is suitable and that defendants did not violate ORS 659.420.

[6] Although this portion of the decision in *Carney* was withdrawn, because the appellant had withdrawn the argument, our discussion is still helpful as guidance in this case. In addition, the current administrative rules of the Bureau of Labor and Industries, adopted in 1983, also include these factors. OAR 839-06-145. Although the rules are not specifically applicable to this case, which concerns events that occurred in 1982, the courts have used them for guidance. *See Knapp v. City of North Bend,* 304 Or 34, 741 P2d 505 (1987).

[7] Only one of those positions does not rotate. That position is in crime analysis; it does not rotate because the individual in that position has received special training and developed expertise.

[8] In her brief, plaintiff states that there were other positions in the department, such as records clerk and storage clerk. However, there was no evidence of a records clerk position within the department, and the evidence was that the department did not have a storage clerk position. There was a position in central dispatch; however, on this record we cannot determine if it was available when plaintiff was offered the CSO position or whether she was qualified for the dispatch position. Additionally, there was evidence of a position in animal control. Other than the existence of the position, there is no evidence to indicate whether plaintiff wanted the position, if she was qualified for it or if it was available.

Plaintiff's final argument is that defendants unlawfully discriminated against her when they laid her off from her position as a patrol deputy. ORS 659.425(1)(a)(c) provides:

> "For the purposes of ORS 659.400 to 659.435, it is an unlawful employment practice for any employer to refuse to hire, employ, or promote, to bar or discharge from employment or to discriminate in compensation or in terms, conditions or privileges of employment because:
>
> "An individual has a physical or mental impairment which, with reasonable accommodation by the employer, does not prevent the performance of the work involved;
>
> "An individual is regarded as having a physical or mental impairment."

In determining whether a discharge for a physical impairment constitutes an unlawful employment practice, we must consider whether the employe is actually prevented by the impairment from adequately performing the duties of the position and, if so, whether the employe could perform the duties of the position if the employer made reasonable accommodations. ORS 659.425(1)(a)(c).

In determining whether an employe is prevented due to an impairment from adequately performing work duties,

> "[o]ur *de novo* inquiry is whether there is a reasonable probability at the *time of discharge,* plaintiff would be unable to perform the job in a manner which would not endanger himself or others." *Brown v. City of Portland, supra,* 80 Or App at 469. (Emphasis supplied.)

See also Quinn v. Southern Pacific Transportation Co., 76 Or App 617, 632, 711 P2d 139 (1985), *rev den* 300 Or 546 (1986). On the basis of the medical evidence, the degree of danger inherent in the deputy sheriff 103 position and plaintiff's statements, we find that, at the time plaintiff was laid off, there was a reasonable probability that plaintiff was unable to perform the patrol duties of the position without risk of injury to herself or others.

Plaintiff argues that, even if she cannot perform the

patrol duties of a deputy sheriff 103, she can perform the duties involved in the other positions which require the 103 status and which rotate. She argues that allowing her to work in one of those positions or to rotate among all of them, without having to rotate into a patrol position, would be a reasonable accommodation by defendants.

ORS 625.425 imposes an affirmative duty on the employer to make "reasonable accommodation" for an employe's physical or mental impairment. However, the evidence demonstrates that plaintiff's suggested accommodation would not result in the modification of one position to suit plaintiff's needs. Rather, due to the limited number of positions which rotate, plaintiff's suggestion would have a serious impact on the department's entire rotation program. The program allows patrol deputies who are suffering from "burnout" to find relief and remain on the job in a temporary position at their normal salary. It also allows deputies to be trained in all areas of the department. The evidence, including statements

by plaintiff's own witness, is that rotating positions within the department promotes morale. We find that defendants' rotation program is a reasonable and legitimate means to guarantee effective police work. *See Simon v. St. Louis County,* 563 F Supp 76, 81 (ED Mo 1983), *aff'd* 735 F2d 1082 (8th Cir 1984). In the circumstances of this case, requiring defendants to make one of the positions permanent, or to allow plaintiff to rotate among all the positions without rotating into a patrol position, would impose an "undue hardship" on the program and, therefore, would not be a reasonable accommodation. OAR 839-06-205(8); OAR 839-06-245.[9]

Affirmed.

[9] In defining "reasonable accommodation," we adopt the "undue hardship" standard defined in the administrative rules adopted by the Bureau of Labor and Industries. OAR 839-06-205(8).

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Edward D. Lucas, Claimant.

LUCAS,
Petitioner,

v.

CLARK et al,
Respondents.

(WCB 85-08631; CA A45786)

Judicial Review from Workers' Compensation Board.

Argued and submitted May 11, 1988.

James L. Edmunson, Eugene, argued the cause for petitioner. With him on the brief were Karen M. Werner and Malagon & Moore, Eugene.

Christine Chute, Assistant Attorney General, Salem, argued the cause for respondents. With her on the brief were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

Before Warden, Presiding Judge, and Graber, Judge, and Riggs, Judge Pro Tempore.

PER CURIAM

Remanded for reconsideration.

PER CURIAM

Claimant seeks review of a Workers' Compensation Board order that affirmed the referee and upheld the denial of his aggravation claim for a back condition. We review for substantial evidence. ORS 656.298(6); ORS 183.482(7) and (8). Because neither the Board order nor the referee's opinion and order which it affirmed are adequate for judicial review, *see Armstrong v. Asten-Hill Co.,* 90 Or App 200, 752 P2d 312 (1988), we remand to the Board for reconsideration. On remand, the Board also should reconsider this case in the light

of *Gwynn v. SAIF*, 304 Or 345, 745 P2d 775 (1987), *on remand* 91 Or App 84, ___ P2d ___ (1988), and *International Paper Co. v. Turner*, 304 Or 354, 745 P2d 780 (1987), *on remand* 91 Or App 91, ___ P2d ___ (1988).

Remanded for reconsideration.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of LINDA L. BEARD, Claimant.

SHIPP et al,
Petitioners,

v.

BEARD,
Respondent.

(WCB 86-00068; CA A45095)

Judicial Review from Workers' Compensation Board.

Argued and submitted March 16, 1988.

Paul L. Roess, Portland, argued the cause for petitioners. With him on the brief was Acker, Underwood & Smith, Portland.

Marianne Bottini, Portland, argued the cause for respondent. On the brief were Larry D. Schucht and Bottini, Bottini & Lehner, Portland.

Before Warden, Presiding Judge, and Van Hoomissen and Graber, Judges.

PER CURIAM

Remanded for reconsideration.

PER CURIAM

Employer and its insurance carrier seek review of a Workers' Compensation Board order. The petition for judicial review was filed on July 24, 1987, and we therefore review for substantial evidence. Or Laws 1987, ch 884, § 12a; *Armstrong v. Asten-Hill Co.*, 90 Or App 200, 205, 752 P2d 312 (1988). Because the Board order is inadequate for judicial review under the standards in *Armstrong*, we remand to the Board for reconsideration.

Remanded for reconsideration.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Maria R. Porras, Claimant.

PORRAS,
Petitioner,

v.

CASTLE & COOKE, INC.,
Respondent.

(WCB 84-11249; CA A45400)

Judicial Review from Workers' Compensation Board.

Argued and submitted March 16, 1988.

Darren L. Otto, Salem, argued the cause and filed the brief for petitioner.

Allan M. Muir, Portland, argued the cause for respondent. With him on the brief were Delbert J. Brenneman and Schwabe, Williamson & Wyatt, Portland.

Before Warden, Presiding Judge, and Van Hoomissen and Graber, Judges.

PER CURIAM

Remanded for reconsideration.

PER CURIAM

Claimant seeks review of a Workers' Compensation Board order that affirmed the portion of the referee's order awarding her 85 percent unscheduled permanent partial disability and modified the portion of the referee's order regarding the date she became medically stationary. The petition for judicial review was filed on August 19, 1987. The scope of review, therefore, requires us to determine if the Board order is supported by substantial evidence in the record. *Armstrong v. Asten-Hill Co.*, 90 Or App 200, 205, 752 P2d 312 (1988). Because the Board order is inadequate for judicial review under the standards in *Armstrong*,[1] we remand to the Board for reconsideration.

Remanded for reconsideration.

[1] The portion of the referee's order that the Board affirmed is also inadequate for judicial review.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Charmaine A. Frazier, Claimant.

FRAZIER,
Petitioner,

v.

UNITED PACIFIC INSURANCE et al,
Respondents.

(WCB 85-07844; CA A43670)

Judicial Review from Workers' Compensation Board.

Argued and submitted January 11, 1988.

Gary K. Jensen, Eugene, argued the cause and filed the brief for petitioner.

Brian L. Pocock, Eugene, argued the cause and filed the brief for respondents.

Before Warden, Presiding Judge, and Joseph, Chief Judge, and Van Hoomissen, Judge.

JOSEPH, C. J.

Affirmed.

Warden, P. J., dissenting.

JOSEPH, C. J.

Claimant seeks review of a Workers' Compensation Board order that reversed the referee's order holding an injury compensable. On *de novo* review, *former* ORS 656.298, we affirm.

Claimant testified that, in April, 1985, while employed as a shim packer on the swing shift, she pulled a wire from an overhead guide pipe to wrap around a bundle and the pipe, which weighed seven pounds, fell. She said that it struck her on the head, arm and hand. That occurred 15 minutes before her lunch break. She said that she went outside, vomited and returned to an adjacent work station for a few minutes but did not work. She went home during her lunch break and never returned to work. A co-worker, working nearby, heard the pipe hit the floor, turned, saw the pipe on the floor and claimant with her hand on her head and then heard her say, "Ouch." Claimant's supervisor heard about the accident within minutes of its occurrence and talked to claimant at the work station. She testified that, as she approached the station, unobserved by claimant, she noticed claimant rubbing her head. Claimant told her that she had been hit on the head but that she was "okay," and declined any assistance. Claimant told her mother about the accident when she got home. Her mother testified that she had looked drawn and pale then.

Claimant claims to have suffered nausea, dizziness and headaches. Four days after the accident, she sought medical advice. Dr. Byerly, her family physician, found no objective

signs of injury but, and only on the basis of the symptoms related by claimant, diagnosed a contusion of the head and cervical vertebrae. Dr. Serbu, a neurosurgeon, examined claimant in June. He also found no objective signs of any injury. Employer denied her claim, and she requested a hearing.

The referee determined that claimant was not a reliable witness:

> "Her testimony attempts to place the pipe in a specific location that, by her admission, she did not pay any attention to prior to the time it fell. Her testimony regarding placement and method of attachment amounts to nothing more than a guess. Claimant's testimony is inconsistent with the

> remainder of her testimony concerning where she had to reach to pull the wire down. She had no opportunity to observe it after it had been replaced, until the day of the hearing."

Nonetheless, the referee reasoned that "[j]ust because she is not reliable does not mean she is not credible." He then concluded that her testimony regarding the mechanics of the pipe's attachment to the ceiling was irrelevant, because there was no doubt that the pipe fell. He declined to accept the testimony of the plant manager that, given the location of the pipe, it could not possibly have hit claimant, because he concluded that the measurements which the manager made were unreliable. The referee held that claimant had met her burden of proving compensability by a preponderance of the evidence.

The precise basis for the Board's reversal is not clear, but it was, at least in part, the lack of objective medical evidence of any injury. Claimant repeatedly complained to her mother of headaches, dizziness and nausea after the supposed accident. Byerly found no cuts, bumps or other objective findings; neither did Serbu. There is, in fact, nothing in the record except claimant's testimony that she suffered any injury whatsoever. Furthermore, although there is evidence that the pipe fell to the floor, the evidence that claimant was hit is, to say the best of it, in equipoise.

It is worth noting that, contrary to what the dissent says, claimant did not even say so much as "ouch" until *after* the pipe had fallen to the floor and the co-worker had turned around and had seen the pipe on the floor. Claimant and her co-worker laughed about the incident; she told her supervisor that she was all right; and she did not report any physical symptoms of injury before leaving the mill during the lunch hour. The foreman's drawing of the workplace area, including measurements, and the testimony about attempts to re-create the accident make it very unlikely that anything happened in the way that claimant described it. The absence of any objective medical evidence of an injury, taken with the extremely weak evidence that claimant was hit by the pipe, persuades us that she has not proved entitlement to compensation.

Affirmed.

WARDEN, P. J., dissenting.

I would hold that claimant met her burden of proving a compensable injury, and therefore I dissent.

The Board's reversal was based in part on the lack of objective medical evidence of an injury. Claimant repeatedly complained of headaches, dizziness and nausea since the time of the accident. She went to Dr. Byerly when her symptoms failed to subside after four days. That he found no cuts, bumps or other objective findings is not dispositive; she had come to him for treatment, and her statement was given to aid him in making a diagnosis. The history she gave to Serbu was consistent with that given Dr. Byerly and with her testimony. There is no doubt that the pipe fell, that she exclaimed when it did and that she was rubbing her head immediately afterward. That there was no objective medical evidence of injury is not enough for employer to deny the claim, when there is no reason to doubt that the incident causing injury occurred.

I quote the Board's other apparent ground for reversal:

> "Claimant's strongest evidence comes from her coworker Ms. Davis [the co-worker]. However, Ms. Davis stated that claimant initially told her she was struck in the arm and hand. It was not until later that claimant told her she was struck in the head. No evidence was offered why claimant may have altered the location where she was struck."

The record does not support these recitals. Davis testified:

> "Q. Okay. What did she look like to you, what did she do, what was she doing after it fell?
>
> "A. She had her hand by — on her head.
>
> "Q. She had her hand — on her head.
>
> "A. And said, 'Ouch!' and said it hit her hand too.

I agree with the findings and conclusions made by the referee, who had the opportunity to observe the witnesses as well as the scene of the accident and, therefore, I respectfully dissent.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of
Stephen L. Dokey, Claimant.

DERRYBERRY et al,
Petitioners,

v.

DOKEY et al,
Respondents.

(WCB 83-11194; CA A42841)

Judicial Review from Workers' Compensation Board.

Argued and submitted December 14, 1987.

Allan Muir, Portland, argued the cause for petitioners. On the brief were Ridgeway K. Foley, Jr., P.C., Brian M. Perko,

Christopher B. Rounds and Schwabe, Williamson & Wyatt, Portland.

David R. Barrow, Portland, argued the cause for respondent Dokey. With him on the brief were David R. Barrow, J. Michael Casey and Victor Calzaretta, 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 Warden, Presiding Judge, and Joseph, Chief Judge,* and Van Hoomissen, Judge.

JOSEPH, C. J.

Affirmed.

* Joseph, C. J., *vice* Young, J., deceased.

JOSEPH, C. J.

The Derryberrys seek review of an order of the Workers' Compensation Board, which found that they are noncomplying employers and held that *Bauman v. SAIF,* 295 Or 788, 670 P2d 1027 (1983), prevents them from denying the compensability of a claim which SAIF, acting pursuant to its obligation to process claims on behalf of noncomplying employers, had accepted. We review *de novo* and, for reasons different from those stated in the Board's order, affirm the Board.

The Derryberrys own and operate furniture stores and a trucking business. Mrs. Derryberry called SAIF in July, 1983, to request workers' compensation insurance coverage. The person to whom she spoke told her that there would be "no problem" in obtaining insurance coverage. They received an application and mailed it to SAIF in August, 1983. Mrs. Derryberry was aware of language in the application that coverage would not be effective until it was accepted by SAIF; she did not believe that the language meant anything. Instead, she believed that she had a binder for coverage, effective when SAIF received the application. SAIF contends that it never received the application. In a telephone conversation on August 31, 1983, a SAIF employe told Mr. Derryberry that SAIF would not insure them.

On August 23, 1983, the Derryberrys hired claimant and his wife to load, unload and deliver furniture. On August 26, claimant allegedly injured his back, arms, neck and shoulders while unloading merchandise at the Derryberrys' warehouse. On September 23, claimant filed a claim with SAIF. The compliance division of the Workers' Compensation Department (Department) initiated an investigation of the Derryberrys the same day. The investigator spoke to the Derryberrys and informed them of the injury and claim.

On October 12, the Department sent the Derryberrys an order of noncompliance. SAIF accepted the claim on October 26, 1983. *See* ORS 656.054(1).[1] It notified the Derryberrys of the acceptance on October 27, 1983, and informed them that they were entitled to a hearing on the issue of

[1] All citations in this opinion are to the statutes in effect at times pertinent to the facts.

compensability, if they requested it within 60 days. *See former* OAR 436-80-060(1)(d). In a letter to the Department dated November 4, 1983, the Derryberrys requested a hearing on the issues of whether they were complying employers, whether claimant was a subject worker and the compensability of the claim. As far as the record reveals, that letter was not sent to SAIF or to claimant.

The hearing was held in May, 1984, and the record was closed in January, 1985. The referee concluded that the Derryberrys were noncomplying employers and that claimant's claim was compensable. On review, the Board agreed that the Derryberrys were noncomplying but found that the claim is not compensable on its facts. The Board concluded, however, that *Bauman v. SAIF, supra,* precludes denial of the previously accepted claim.[2]

If the Derryberrys were noncomplying employers, SAIF had authority to accept the claim. They contend that SAIF gave an oral binder when a SAIF employe told Mrs. Derryberry that "there would be no problem obtaining coverage." We disagree. SAIF did not promise coverage but, if anything, said only that there "would be" no problem in obtaining coverage. That statement is not sufficiently definite to give rise to a promissory estoppel. After reviewing the whole record, we agree with the Board that the Derryberrys are noncomplying employers.

The next issue has been presented as whether the rule in *Bauman v. SAIF, supra,* applies to noncomplying employers. We need not address that issue, however, because the Derryberrys never properly denied the claim. A denial must, *inter alia,* inform the claimant of hearing rights and be mailed to the claimant. *Former* ORS 656.262(8). The Derryberrys assert that their November 4, 1983, letter to the Department denied the claim. That letter makes no mention of hearing rights and, so far as the record reveals, was never

mailed to claimant. It was not a denial.[3] Because SAIF properly accepted the claim and no party has ever properly denied it, claimant is entitled to compensation.[4]

Affirmed.

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[2] One Board member dissented from the part of the Board's order applying *Bauman*, arguing that that application violates the Derryberrys' due process rights.

[3] SAIF also never denied the claim.

[4] The Derryberrys claim that application of *Bauman* would result in a denial of due process. *See* n 2, *supra.* Because *Bauman* is not the basis of our decision, we need not address the due process argument. The effect of our decision is to make the Derryberrys liable for a claim which they never accepted or agreed with. That is the consequence, however, of their failure to obtain workers' compensation insurance. *See* ORS 656.054(1).

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
James R. Salyers, Claimant.

LIBERTY NORTHWEST
INSURANCE CORPORATION et al,
Petitioners,

v.

SALYERS,
Respondent.

(WCB No. 85-15982; CA A43801)

Judicial Review from Workers' Compensation Board.

Argued and submitted January 11, 1988.

E. Jay Perry, Eugene, argued the cause and filed the brief for petitioners.

James L. Edmunson, Eugene, argued the cause for respondent. With him on the brief were Karen M. Werner, and Malagon & Moore, Eugene.

Before Warden, Presiding Judge, and Joseph, Chief Judge, and Van Hoomissen, Judge.

JOSEPH, C. J.

Affirmed.

JOSEPH, C. J.

Employer seeks review of a Workers' Compensation Board order affirming the referee's decision to set aside denial of claimant's injury claim. We affirm.

On Friday, June 7, 1985, claimant, while helping to lift a 300-pound log at work, felt a tearing and burning sensation in his left arm. Later that day, he underwent a routine performance evaluation by his supervisor but did not mention the incident. He also failed to tell his wife.[1] The next day, while attempting to carry a television from the house to his car, he felt the same tearing and burning sensation in the arm. His wife took him to the hospital, where pain medication and application of ice were prescribed. At work on the following Monday, claimant told his supervisor that he had injured his arm on Friday while lifting the log. He contends that he also told the supervisor about the television carrying incident. The supervisor advised him to file a compensation claim.

Claimant's family doctor diagnosed a ruptured bicep tendon and referred him to a specialist, Dr. Butters, who performed surgery to repair the tendon and provided follow-up care. Initially, claimant did not file a compensation claim. Instead, he filed a claim under an insurance policy which covered medical expenses and disability. He did not file a

[1] Claimant had a stormy relationship with his wife and had moved out of the family home a number of times. She first suggested to employer that he might not have made a full disclosure. The marriage was dissolved shortly after claimant's surgery.

compensation claim until July 3, 1985. After surgery was recommended, he mentioned the injury to a different supervisor, who insisted that he file a claim. Claimant testified that he was hesitant to do that, because employer had a policy of discouraging workers' compensation claims and terminating employes who filed them. However, he had previously filed two claims without suffering any such repercussion. He missed no work after the injury until the surgery.

Employer accepted the claim in August, 1985. In December, 1985, employer issued a retroactive denial of the claim, based on a claim of fraud, misrepresentation or other illegality, after claimant's ex-wife reported that he was injured only from lifting the television set and that the on-the-job injury had not occurred. At the hearing on the denial, the

referee found all the witnesses credible and that the evidence was in equipoise. Therefore, because employer had failed to carry its burden of proof by a preponderance of the evidence, the claim was held to be compensable.

An employer may issue a late denial of an accepted claim only on a showing of fraud, misrepresentation or other illegality, *Bauman v. SAIF*, 295 Or 788, 794, 670 P2d 1027 (1983), and has the burden of establishing, by a preponderance of the evidence, the basis for the denial. *Parker v. North Pacific Ins. Co.*, 73 Or App 790, 793, 700 P2d 255 (1985); *Parker v. D.R. Johnson Lumber Co.*, 70 Or App 683, 687, 690 P2d 1087 (1984). Employer contends that claimant intentionally failed to disclose the home injury to his physicians and that his failure to disclose is sufficiently material to justify a backup denial under *Bauman*. We disagree. The employer's burden is to show that knowledge of the nondisclosed injury "could reasonably have affected" its decision to accept the claim. *Ebbtide Enterprises v. Tucker*, 303 Or 459, 464, 738 P2d 194 (1987). It has not done that.

Although much of the testimony was in conflict, the referee did not find one side more credible than the other, and we are loathe simply to second-guess him. *See Havice v. SAIF*, 80 Or App 448, 452, 722 P2d 742 (1986). On *de novo* review, we are not persuaded that knowledge of the television carrying incident would have affected the decision to accept the claim. Claimant has never denied that the incident happened. The evidence indicates that he merely considered it a consequence of the on-the-job incident. In addition, he had missed no work and stood to gain little, if anything, from nondisclosure.[2]

We hold that employer has not established a sufficient basis for a backup denial. For that reason, it was not necessary for claimant to establish the compensability of the claim, which had already been accepted. *Parker v. North Pacific Ins. Co., supra*, 73 Or App at 793; *Parker v. D.R. Johnson, supra*, 70 Or App at 687.

Affirmed.

[2] All of the medical expenses were covered by his private insurance.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Victorio R. Castilleja, Claimant.

CHAMPION INTERNATIONAL et al,
Petitioners,

v.

CASTILLEJA et al,
Respondents.

(WCB 84-00697, 84-05900; CA A41822)

Judicial Review from Workers' Compensation Board.

Argued and submitted December 4, 1987.

Jerald P. Keene, Portland, argued the cause for petitioners. With him on the brief was Roberts, Reinisch & Klor, P.C., Portland.

Patric J. Doherty, Portland, argued the cause for respondent Cascade Steel Corporation. With him on the brief were Ronald W. Atwood and Rankin, VavRosky, Doherty, MacColl & Mersereau, Portland.

Bruce D. Smith, Salem, waived appearance for respondent Victorio R. Castilleja.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

BUTTLER, P. J.

Reversed; referee's order reinstated.

BUTTLER, P. J.

Champion International seeks review of a decision of the Workers' Compensation Board reversing the referee and determining that it, and not Cascade, is responsible for claimant's present back condition.

Claimant experienced a compensable nondisabling low-back injury in 1979 while working for Champion. In 1980, he began work for Cascade, which required heavy lifting. Shortly thereafter, he began consulting a chiropractor for back pain. His claim against Champion was closed in March, 1981. In December, 1981, at Cascade, he reportedly experienced pain in his right leg and hip, without a new injury. In February, 1982, while lifting a heavy object, he sustained a compensable right inguinal strain, for which he underwent surgery. Following the surgery, he suffered severe pain in his right buttock. He returned to light-duty work until he was required by company policy to go off work in September, 1983. In April, 1984, claimant's treating physician diagnosed a herniated disc. Both employers denied responsibility for that condition. The Workers' Compensation Department issued an order under ORS 656.307, directing payment of time loss by Champion. Surgical and pathology reports following back surgery in July, 1984, were inconclusive as to the cause of claimant's present back difficulties.

A detailed recitation of the medical evidence would not aid in understanding the legal basis for our decision. On *de novo* review, we find that the evidence does not establish which employment was the more likely cause of claimant's current disability. The question presented is how to determine which of two successive employers is responsible.

The dispute centers around the significance of language contained in the Supreme Court's opinion in *Boise Cascade Corp. v. Starbuck,* 296 Or 238, 244, 675 P2d 1044 (1984):

> "In the situation where a compensable injury at one employment contributes to a disability occurring during a later employment involving work conditions capable of causing the disability, but which did not contribute to the disability, the first employer is liable. In *Bracke* [*v. Baza'r,* 293 Or 239, 646 P2d 1330 (1982)], the disability was caused by and arose during the first employment. Even though the conditions of the later employment were capable of causing the

> disability, the later employer was not liable because the employment did not contribute to the disability. In the case at bar, as well, the later employment did not contribute to the disability; responsibility is properly placed upon the employer whose employment caused the disability.
>
> "The last injurious exposure rule is not intended to transfer liability from an employer whose employment caused a disability to a later employer whose employment did not. Once a worker proves that the disability is work-related, he or she need not prove that any one employment caused the disability. The rule accomplishes that and makes liable the last employer whose conditions of employment might have caused the disability. However, the rule does not prevent a worker from proving that an earlier employment caused the disability; nor does it prevent an employer from proving that the claimant's disability was caused by a different employment or that the disability did not arise from any work-related injury.
>
> "In a procedural context, if a worker presents substantial evidence of successive work-related injuries causing disability, a prima facie case for recovery from the last employer is made out. Either or any employer against whom a claim is made still can present evidence to prove that the cause of the worker's disability is another employment or a cause unrelated to the employment. In such a case, the trier of fact decides the case on the basis of the evidence presented. *If the trier of fact is convinced that the disability was caused by successive work-related injuries but is unconvinced that any one employment is the more likely cause of the disability, the finding is for the worker against the last employer whose employment may have caused the disability.* On the other hand, if the trier of fact is convinced that the disability was caused by an earlier injury, or was not work related, such a finding may be made." (Emphasis supplied; footnote omitted.)

The referee relied on the second quoted paragraph in assigning responsibility to Cascade, because working conditions there "might have caused the disability." On reconsideration, he adhered to his decision, but stated that the evidence showed a new injury at Cascade. On review, the Board initially affirmed, relying, however, on the last quoted paragraph from *Starbuck.* It found that the evidence did not show which employment more likely contributed to claimant's disability and held that responsibility should be assigned to Cascade, because working conditions there "may" have caused claimant's disability. On reconsideration, the Board

reversed itself, relying on the second quoted paragraph, which it understood to mean that, if there is no proof that the later employment actually contributed to the cause of the claimant's disability, liability would remain with the first employer.

Obviously, there is confusion as to the proper application of the "last injurious exposure" rule in injury cases, as distinguished from occupational disease cases, which began with the court's decision in *Bracke v. Baza'r,* 293 Or 239, 646 P2d 1330 (1982). Until then, that rule had been applied only in disease cases, and its purpose was to alleviate the burden on a claimant of proving which of several employers caused the disease. The claim could be asserted against the last employer where the working conditions *could* have caused the disease. That kind of problem does not exist in *injury* cases; a worker presumably knows when he has sustained a physical injury.

A problem only somewhat analogous to disease cases arises in "successive injury" cases, in which we consistently applied the rule in *Smith v. Ed's Pancake House,* 27 Or App 361, 556 P2d 158 (1976),[1] to determine whether a claimant's disability was an aggravation of an injury at an earlier employment or was a new injury. Answering that question determined which employer was responsible.

However, since *Starbuck,* it has been assumed that the court meant what it said in *Bracke*—that the last injurious exposure rule applies to injury claims as well as disease claims, at least when the question is one of responsibility. In that context, the question is not what the worker must prove; compensability is conceded. The question is what the evidence must show in order to decide which employer is responsible. When, as here, the trier of fact is convinced that the disability was caused by successive work-related exposures but is unconvinced that any one employment is the more likely cause of the disability, the rule operates to place liability on the last employer.[2] *Boise Cascade Corp. v. Starbuck, supra,* 296 Or at

245; *Crowe v. Jel-Wen,* 77 Or App 81, 712 P2d 145 (1985), *rev den* 301 Or 76 (1986).

Here, the evidence does not establish which of the two employments actually caused claimant's present disability. It does show, however, that the employment at Cascade could have contributed to the cause of the disability. Accordingly, we apply the rule of responsibility as the Supreme Court has framed it and hold that Cascade is responsible.

Reversed; referee's order reinstated.

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[1] Under that test, if the work at the second employer independently contributed to a claimant's disability, that employer is responsible.

[2] It should be noted, however, that in *Runft v. SAIF,* 303 Or 493, 500, 739 P2d 12 (1987), the Supreme Court held that an employer against whom a claim for occupational disease is asserted may not rely on the rule unless it brings in the employer that it claims is responsible. Although that holding presumably applies to successive injury cases, 303 Or at 499 n 2, it presents no problem here. Both employers are in the proceeding.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Roland L. Dawkins, Claimant.

DAWKINS,
Petitioner,

v.

PACIFIC MOTOR TRUCKING,
Respondent.

(WCB 85-11265; CA A43907)

Judicial Review from Workers' Compensation Board.

Argued and submitted January 15, 1988.

Randy M. Elmer and Vick & Gutzler, Salem, filed the brief for petitioner.

Thomas W. Sondag, Portland, argued the cause for respondent. With him on the brief was Spears, Lubersky, Campbell, Bledsoe, Anderson & Young, Portland.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

BUTTLER, P. J.

Affirmed.

BUTTLER, P. J.

The sole issue in this workers' compensation case is whether claimant is entitled to temporary total disability (TTD) compensation for time loss which occurred after he had suffered an aggravation of a compensable injury that had forced him to leave the labor market. We affirm the Board's order that claimant is not entitled to TTD.

Claimant is a 61-year-old truck driver who was seriously injured in a job-related accident in August, 1982. He underwent surgery to relieve a subdural hematoma. In June, 1983, two of claimant's doctors determined that, although his condition had deteriorated since the accident, he was medically stationary. At that time, he suffered from a movement disorder, agitation and loss of stamina.

In February, 1984, a determination order awarded claimant permanent partial disability of 176 degrees for 55 percent unscheduled disability resulting from his head injury. He did not seek review and, in March, 1984, stipulated with employer to an additional disability award of 30 percent, for a total of 85 percent unscheduled disability. In April, 1984, he entered a vocational rehabilitation program which he did not complete, because his counselor determined that his physical limitations, poor memory and fatigue would prevent him from doing so. He has not worked since 1982.

In July, 1985, his doctor concluded that claimant's condition had worsened since January, 1984. An aggravation

claim was filed and, in April, 1986, employer reopened the claim for payment of medical services but denied time loss benefits. The Evaluation Division found claimant to be medically stationary as of March 20, 1986, and awarded him benefits for permanent total disability as of that date and denied the claim for time loss benefits from July 26, 1985 to March 20, 1986. On June 6, 1986, a hearing was held on the denied portion of his claim. At that time, he was drawing disability benefits from Social Security and from his union, but he was not receiving any retirement benefits. On the advice of his doctors, he has not sought work since his accident in 1982. The referee ruled that claimant is not entitled to time loss, relying on *Cutwright v. Weyerhaeuser Co.*, 299 Or 290, 702 P2d 403 (1985), and *Karr v. SAIF*, 79 Or App 250, 719 P2d 35, *rev den* 301 Or 765 (1986). The Board affirmed.

Claimant contends that his withdrawal from the labor market should not preclude an award of temporary total disability, because it was involuntary and was the result of his work-related disability.[1] As we held in *Karr v. SAIF, supra*, a claimant who withdraws from the work force is not entitled to those benefits, which are awarded for lost wages. ORS 656.210(1). *Sykes v. Weyerhaeuser Company*, 90 Or App 41, 750 P2d 1171 (1988). A person who has withdrawn from the labor market, whether as a result of his injury or for other reasons, has no lost wages. It may be that claimant's original claim was prematurely closed or that his award was inadequate; however, neither of those questions is presented here.

Affirmed.

[1] If claimant was forced by his injuries to withdraw from the labor force, then he should have sought to modify the date on which he was entitled to *permanent* total disability. In this case, no such issue has been raised.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Tony Fazzolari, Claimant.

FAZZOLARI,
Petitioner,

v.

UNITED BEER DISTRIBUTORS et al,
Respondents.

(WCB 85-16090; CA A45497)

Judicial Review from Workers' Compensation Board.

Argued and submitted April 1, 1988.

Robert L. Burns, Gresham, argued the cause and filed the brief for petitioner.

Randy G. Rice, Portland, argued the cause and filed the brief for respondents.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

WARREN, J.

Remanded for proceedings not inconsistent with this opinion.

WARREN, J.

In this workers' compensation case, claimant's attending physician released him to work without restriction on March 22, 1985; at the same time he noted that claimant was not medically stationary. Claimant did not actually return to work until after August 12, 1985, because he did not believe that he could work before then.

On August 23, 1985, claimant's physician reported that he was medically stationary. The Evaluation Division issued a determination order on October 30, 1985, granting time loss through March 22, 1985. EBI had already paid time loss through September 2, 1985, and sought a determination that it was entitled to an offset of the payments against future benefits. The Board allowed an offset for all benefits paid after March 22, 1985, when claimant was released for work, and claimant seeks review.

At the pertinent time, ORS 656.268 provided:

> "(1) One 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. *Claims shall not be closed nor temporary disability compensation terminated if the worker's condition has not become medically stationary* or if the worker is enrolled and actively engaged in training according to rules adopted pursuant to ORS 656.340 and 656.726, provided however, that temporary disability compensation shall be proportionately reduced by any sums earned during the training.
>
> "(2) When the injured worker's condition resulting from a disabling injury has become medically stationary, unless the injured worker is enrolled and actively engaged in training, the insurer or self-insured employer shall so notify the Evaluation Division, the worker, and the employer, if any, and request the claim be examined and further compensation, if any, be determined. A copy of all medical reports and reports of vocational rehabilitation agencies or counselors shall be furnished to the Evaluation Division and to the worker and to the employer, if requested by the worker or employer. *If the attending physician has not approved the worker's return to the worker's regular employment, the insurer or self-insured employer must continue to make temporary total disability payments until termination of such payments is authorized* following examination of the medical reports submitted to the

> Evaluation Division under this section. If the attending physician has approved the worker's return to the worker's regular employment and there is a labor dispute in progress at the place of employment, the worker may refuse to return to that employment without loss of any vocational assistance provided by this chapter." (Emphasis supplied.)

As we stated in *Vip's Restaurant v. Krause*, 89 Or App 214, 748 P2d 164 (1988), ORS 656.268 deals only with the processing of

claims. The Board, in adopting the referee's order authorizing the offset, reasoned:

> "The statute permits a workers' compensation carrier to terminate temporary disability benefits when a claimant's attending physician approves his return to regular work * * *."

The statute does not permit unilateral termination of temporary total disability benefits, unless the claimant is *both* medically stationary and released for work. Here, employer continued to pay temporary total disability benefits after claimant was released for work on March 22, 1985, and after he was determined to be medically stationary on August 23, 1985. There is no question but that employer is entitled to offset the benefits which it paid after claimant was *both* released to work and medically stationary. The question is whether it may also offset what it paid after claimant had been released for work but before he became medically stationary.

Had claimant returned to work when released on March 22, 1985, employer would have been entitled to deduct his wages from the temporary benefits that it was required to pay. OAR 436-60-030. Because claimant did not return to work, he had no wages to be deducted from his benefits, and employer paid them in full as it was required to do.

Temporary total disability benefits are awarded to replace wages lost by reason of a temporary disability. ORS 656.210; *Cutright v. Weyerhaeuser Co.*, 299 Or 290, 295, 702 P2d 403 (1985). An employer is entitled to an offset of benefits that have been paid only if the evidence shows that the claimant was not entitled to the benefits. Although a worker has been released for work, the factfinder may determine that he was still unable to work. The release does not conclusively establish that the claimant is able to work, although it is evidence to that effect. Here, however, the Board allowed the offset solely because claimant had been released for work and

paid no attention to whether he was actually disabled during that period. We remand to the Board to determine whether claimant was able to work after the time when he was released to work by the attending physician and before he was medically stationary. If he was, employer is entitled to an appropriate offset.

Remanded for proceedings not inconsistent with this opinion.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON
In the Matter of the Compensation of
Lloyd O. Fisher, Claimant.
NORTHRUP KING & COMPANY et al,
Petitioners,
v.
FISHER,
Respondent.
(WCB 85-13310; CA A42977)

Judicial Review from Workers' Compensation Board.

Argued and submitted January 11, 1988.

Jas J. Adams, Portland, argued the cause for petitioner. With him on the brief was Acker, Underwood & Smith, Portland.

Edward J. Harri, Salem, argued the cause for respondent. With him on the brief were Richard T. Kropp and Emmons, Kyle, Kropp, Kryger & Alexander, P.C., Albany.

Before Warden, Presiding Judge, and Joseph, Chief Judge, and Van Hoomissen, Judge.

VAN HOOMISSEN, J.

Affirmed.

VAN HOOMISSEN, J.

Northrup King & Company (employer) seeks review of a Workers' Compensation Board order holding that claimant was entitled to temporary total disability (TTD) benefits for the period during which he was incarcerated in prison. It contends that claimant was not a "worker" while he was incarcerated. We hold that, whether or not employer is correct, it could not terminate the benefits unilaterally. Therefore, we affirm.

Claimant suffered a compensable injury in September, 1984, while working for employer, which initially denied the claim but later accepted it. Claimant had bone-graft surgery in April, 1985. Two weeks after the surgery, claimant was extradited to Texas to serve a prison sentence. At the time of the transfer, claimant was not medically stationary or released for work. He was not found to be medically stationary at any time during his incarceration.

On October 3, 1985, employer sent claimant a notice at his home address advising him that his time-loss benefits were being terminated immediately and for the remainder of his incarceration. The letter instructed claimant to inform employer on his release and stated that his entitlement to time-loss benefits would then be determined.[1] Claimant was

[1] Employer also requested an offset for benefits already paid during claimant's incarceration. Because of their resolutions of the procedural question, neither the referee nor the Board considered the merits of the offset, and neither do we.

paroled in January, 1986, and his TTD benefits were restored as of January 24.

After his release, claimant sought a hearing on the propriety of the termination of benefits. The referee concluded that claimant should have continued to receive TTD. However, the referee expressly stated that that was not a finding of entitlement to benefits during incarceration, but a finding that unilateral termination was inappropriate. The referee declined to award penalties and attorney fees, because she found the suspension not to have been unreasonable

because it was based on advice from the Attorney General.[2] The Board affirmed the referee, agreeing that the unilateral termination was improper but that it was not unreasonable.

Claimant argues that we need not reach the question of his entitlement to benefits, because employer improperly terminated his benefits, ORS 656.268(1),(2), and that, therefore, we must affirm the Board. Employer argues that unilateral termination was appropriate, because claimant is not entitled to benefits because the Supreme Court authorized such unilateral terminations in *Cutright v. Weyerhaeuser Co.*, 299 Or 290, 702 P2d 403 (1985), and because prior authorization to terminate would have been superfluous and would have deprived employer of an effective remedy.

ORS 656.268(1) provides, in relevant part:

> "Claims shall not be closed nor temporary disability compensation terminated if the worker's condition has not become medically stationary * * *."

Once a claimant is medically stationary, *former* ORS 656.268(2)[3] specified the procedures to be followed:

> "When the injured worker's condition resulting from a disabling injury has become medically stationary, * * * the insurer or self-insured employer shall so notify the Evaluation Division, the worker, and the employer, if any, and request the claim be examined and further compensation, if any, be determined. * * * If the attending physician has not approved the worker's return to the worker's regular employment, the insurer or self-insured employer must continue to make temporary total disability payments until termination of such

> payments is authorized following examination of the medical reports submitted to the Evaluation Division under this section."

[2] The advice on which employer had based its decision to terminate TTD benefits stated, in relevant part:

> "TTD and TPD benefits are designed 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 * * *.' Incarcerated persons, like retired persons * * *, are not in the labor market because of their own actions. With few exceptions they are not entitled to receive TTD or TPD benefits.
>
> "* * * * *
>
> "Because time loss benefits are wage replacement, they should be treated as if they were wages. For claimants incarcerated in a Corrections Division institution, * * * time loss checks should be sent to the claimant with instructions to 'promptly surrender' the check to the corrections division." (Citations omitted; emphasis in original.)

[3] ORS 656.268 was amended by Or Laws 1987, ch 844, § 10.

Under those statutes, claimant was entitled to continue to receive TTD benefits until he was medically stationary and was released for work. *Fazzolari v. United Beer Distributors,* 91 Or App 592, ___ P2d ___ (1988). If employer believed that claimant was not entitled to benefits during his incarceration, it should have requested a hearing. ORS 656.283(1); *Austin v. Consolidated Freightways,* 74 Or App 680, 704 P2d 525, *rev den* 300 Or 332 (1985); *Jackson v. SAIF,* 7 Or App 109, 490 P2d 507 (1971).

Cutright v. Weyerhaeuser Co., supra, does not alter the result. In that case, the Supreme Court held that a claimant who has withdrawn from the workforce is not entitled to TTD. We do not decide whether a worker who is incarcerated is entitled to TTD. We decide only that benefits cannot be terminated unilaterally, except under the circumstances described in ORS 656.268.[4]

Affirmed.

[4] Claimant argues that the unilateral termination of benefits was unreasonable and that, therefore, he is entitled to penalties and attorney fees. However, because claimant did not file a cross-petition, we do not reach that issue.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Beverly C. Morgan, Claimant.

MORGAN,
Petitioner,

v.

SILVERCREST INDUSTRIES et al,
Respondents.

(WCB No. 85-02708; CA A41812)

Judicial Review from Workers' Compensation Board.

Argued and submitted October 9, 1987.

James L. Edmunson, Eugene, argued the cause for petitioner. With him on the brief was Karen M. Werner, and Malagon & Moore, Eugene.

John E. Snarkis, Portland, argued the cause and filed the brief for respondents.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

NEWMAN, J.

Reversed and remanded for further proceedings not inconsistent with this opinion.

NEWMAN, J.

Claimant seeks review of a Workers' Compensation Board order which denied her aggravation claim on the basis that she had failed to prove that her condition had worsened since the last arrangement of compensation. We review *de novo* and reverse and remand.

Claimant, age 26, developed bilateral work-related carpal tunnel syndrome when she worked in the carpenter shop of employer, a mobile home manufacturer. She had surgery in March, 1984, but continued to experience low-grade soft-tissue inflammation, for which there was no further treatment other than activity restriction. Claimant stopped working with power sanders, grinders or hammers, but she continued to use a power stapler. On February 19, 1985, her claim was closed by a determination order that awarded her temporary total disability and permanent partial disability of 5% loss of function in each forearm. As the evaluator's worksheet reveals, the award contemplated that, in the future, claimant would have chronic inflammation and consequent activity restrictions.[1]

Claimant requested a hearing, arguing that she was entitled to additional temporary total disability (due to errors in calculation) and additional permanent partial disability and penalties. In March, 1985, claimant complained to Dr. Ellison, her treating physician, about persistent symptoms, including pain and swelling in both hands, loss of dexterity in her hands and aching in her forearms. He identified her continued work activity as the cause of her symptoms and authorized time off from work, starting March 17, 1985. Dr. Button, who had previously examined claimant at insurer's request, reexamined claimant on April 17, 1985. He reported that, because her scores were exceedingly low, he believed that claimant was "not fully cooperating" in the pinch and grip tests. He also suggested that she might need to change her occupation in order to relieve her symptoms but concluded that she could be gainfully employed and that "no change in her impairment rating has occurred."

Insurer treated Ellison's report as an aggravation claim. On May 23, it refused to reopen the claim, although it continued to pay for medical treatment. It paid interim compensation, however, from March 17 through May 23. With Ellison's approval, claimant returned to work on July 2, 1985, as a lunch room supervisor, a position which required no repetitive arm or hand movements.

Before she received a hearing on the determination order, claimant filed an amended request in which she also protested the May 23 refusal to reopen. After a hearing in September, 1985, the referee affirmed the award of 5% permanent partial disability but found that there was no aggravation after the date of the determination order. The Board affirmed.

Claimant no longer argues that the permanent partial disability award was inadequate. She asserts that her compensable disabling wrist condition has worsened and that her claim should be reopened, because she has suffered increased loss of use and function after the date of the determination order. ORS 656.273. She seeks both temporary disability and additional permanent disability. Employer responds that the 1985 determination order contemplated both the symptoms from which she subsequently suffered and the need for activity restriction and that she has failed to prove a worsening.

[1] The undisputed medical evidence at the time of the award established that the only appropriate treatment for her chronic inflammation was activity restriction. *See International Paper Co. v. Turner*, 91 Or App 91, 93, ___ P2d ___ (1988).

After the parties filed their briefs here, the Supreme Court addressed the issue of when a "flare-up" of a compensable condition, anticipated at the time the existing award is calculated, will support an aggravation claim. *Gwynn v. SAIF,* 305 Or 354, 745 P2d 780 (1987). As we have interpreted that decision, a time loss greater than 14 days establishes a worsening as a matter of law, even if the original award contemplated that the claimant would experience a "flare-up" of the compensable condition if she engaged in certain activities. *International Paper Co. v. Turner, supra* n 1; *Gwynn v. SAIF,* 91 Or App 84, ___ P2d ___ (1988).

Claimant was off work for more than 14 days after the determination order of February 19, 1985, because of a flare-up of her wrist condition. Accordingly, she established an aggravation. We remand to the Board to determine claimant's entitlement to additional benefits.

Reversed and remanded for further proceedings not inconsistent with this opinion.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of
Elmira K. Satcher, Claimant.

WACKER SILTRONIC CORPORATION et al,
Petitioners - Cross-Respondents,

v.

SATCHER,
Respondent - Cross-Petitioner.

(WCB No. 85-07300; CA A41482)

Judicial Review from Workers' Compensation Board.

Argued and submitted October 9, 1987.

Jerald P. Keene, Portland, argued the cause for petitioners - cross-respondents. With him on the briefs were Roberts, Reinisch & Klor, P.C., Portland.

Patrick K. Mackin, Portland, argued the cause and filed the brief for respondent - cross-petitioner.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

NEWMAN, J.

Reversed and remanded on petition as to penalty for late denial; otherwise affirmed on petition and cross-petition.

NEWMAN, J.

Employer seeks review of a Worker's Compensation Board Order which affirmed the referee's order setting aside employer's denial of the claim and awarded a 25% penalty and attorney fees for late denial. Claimant cross-petitions and

seeks review of that portion of the Board order which affirmed the referee's finding that the denial was reasonable. On *de novo* review, we affirm in part and reverse in part.

The first issue is whether claimant sustained a work-related injury. Employer argues that he did not. The referee found that claimant strained his lower back on February 15, 1985, in an unwitnessed accident which occurred at work while he was handling boxes weighing approximately 40 to 50 pounds. At that time, he talked with a co-worker about his pain, requested a vacation day from his supervisor and got pain relievers from the company nurse. The next day, claimant again reported to the company nurse, who gave him a heating pad and placed him on "light duty." Claimant, however, could not do even light work, and his supervisor drove him to the hospital emergency room. The doctor there advised claimant to take three days off work.

Claimant then went to Dr. Cichoke, a chiropractor, who continued to have claimant stay off work, provided him treatment and gave him a back support. Employer deferred action on the claim. In March, claimant went to Dr. Scott, another chiropractor, who found a significantly diminished range of motion, stated that claimant's conditions were related to the February injury and authorized claimant to remain off work from March 25 to April 11. She released him for light work on April 11. In March, 1985, claimant was examined by Dr. Howell, an osteopath, at insurer's request. He stated that claimant was not a reliable historian, that he could find no objective evidence of musculoskeletal abnormalities and that "medical treatment is neither reasonable nor necessary."

In April, 1985, Dr. Ho, an osteopath, examined claimant at insurer's request. He found no evidence of orthopedic abnormality and believed that claimant's pain behavior was affected and exaggerated. In May, claimant went to the Northwest Pain Center Associates, where the two doctors who examined him observed a discrepancy between his subjective

complaints of pain and his behavior. They believed that his recovery was impeded by psychological influences. On the basis of the conflicting medical reports, employer denied the claim on June 14, 1985, approximately four months after it had notice of the original injury.

A hearing was held in January, 1986. The referee found that claimant was "essentially credible and reliable." He concluded that claimant had met his burden of proving that his back pain began at work on February 15, that the injury was consistent with his job and that there were no intervening causes of his pain. The referee acknowledged that claimant may have exaggerated the extent of his pain but emphasized that the only issue was the compensability of the injury. He concluded that employer's denial of the claim was reasonable, but unreasonably late. He then awarded claimant a 25% penalty on the amount of compensation due as of the time of the hearing and attorney fees.[1]

Employer argues that the referee erred in setting

[1] Employer does not challenge the award of attorney fees.

aside its denial of claimant's claim. We disagree. Claimant established that he suffered a back strain at work on February 15, 1988. Although the conflicting medical reports to which the employer directs us cast doubt on claimant's credibility, the referee observed claimant's demeanor and found him credible. We defer to that finding. *Havice v. SAIF,* 80 Or App 448, 722 P2d 742 (1986); *Condon v. City of Portland,* 52 Or App 1043, 629 P2d 1324, *rev den* 291 Or 662 (1981).[2]

Employer next argues that the Board erred when it ordered that the penalty for employer's unreasonably late denial should be based on the amount due at the time of the hearing, rather than on the amount due at the time of the denial. We agree. 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."

The statute requires that, to support a penalty which bears a reasonable relationship to the wrong done, there must be an unpaid amount "then due." If employer issued a late denial, but had paid interim compensation until then, there would be no "amounts then due" on which to base a penalty. *Whitman v. Industrial Indemnity Co.,* 73 Or App 73, 77, 697 P2d 999 (1985); *see also EBI Companies v. Thomas,* 66 Or App 105, 111, 672 P2d 1241 (1983).

The question here is whether the amounts "*then* due" for a late denial are calculated as of the time of the denial or as of the time of the hearing. Although we have never expressly addressed the point, we have assumed that "then" means at the time of the denial. *See Spivey v. SAIF,* 79 Or App 568, 720 P2d 755 (1986).[3] If "then due" were to mean at the time of the hearing, it would be inconsistent with the policy that a penalty must be proportionate to the wrong done. If the Board assesses the penalty for a *late* denial on the amount due as of the time of the hearing, the penalty would be calculated on the same amount as in the case of a penalty for an unreasonable denial. The statute does not authorize such a penalty.

Accordingly, we conclude that the amount "then due" for an unreasonably late denial should be determined as of the time of the denial. We remand to the Board to determine the amount that was due at that time and to assess an appropriate penalty.

Reversed and remanded on the petition as to the penalty for unreasonable late denial; otherwise affirmed on petition and cross-petition.

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[2] Claimant argues in his cross-petition, however, that employer's denial was unreasonable, because employer's own employes never questioned the fact of claimant's injury at the time of the accident. On the basis of the medical reports, we agree with the referee and the Board that employer could reasonably deny the claim.

[3] We remanded *Spivey* to the Board to determine "if there were any amounts due *at the time of SAIF's denial,* and if so, for a determination of the penalty." 79 Or App at 572. (Emphasis supplied.)

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
James E. Marek, Claimant.
BOISE CASCADE CORPORATION,
Petitioner,
v.
MAREK,
Respondent.
(WCB 85-09772; CA A42804)

Judicial Review from Workers' Compensation Board.

Argued and submitted December 7, 1987.

Jerry K. Brown, McMinnville, argued the cause for petitioner. On the brief were Hugh B. Webb, and Cummins, Cummins, Brown, Goodman & Fish, P.C., McMinnville.

James L. Edmunson, Eugene, argued the cause and filed the brief for respondent. With him on the brief were Karen M. Werner, and Malagon & Moore, Eugene.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

DEITS, J.

Affirmed.

DEITS, J.

Employer, Boise Cascade Corporation (Boise), seeks review of a Workers' Compensation Board order affirming the referee's order setting aside Boise's denial of claimant's aggravation claim. We affirm.

Claimant suffered a head injury in 1983, while working as a truck driver for Boise. Dr. Mundall, a neurologist, diagnosed the condition as post-traumatic headaches and prescribed medication. Claimant continued working after the injury, but was laid off in November, 1984. In August, 1984, he was found to be medically stationary and received an award of 10 percent unscheduled permanent partial disability. In April, 1985, he began work for Jasper Wood Treating Products (Jasper) as a forklift driver. In June, 1985, he returned to Mundall, who found no change in the underlying condition but indicated that his symptoms had worsened. In July, 1985, claimant lost his job at Jasper, because of absences from work due to severe headaches. He began receiving treatment for his headaches from Dr. Knox, a neurologist, who put claimant on total disability status from July through December, 1985. The medication that claimant received from Knox helped alleviate the headaches, and he returned to work as a truck driver in March, 1986.

Boise first argues that a worsening of symptoms without a worsening of the underlying condition is insufficient to establish an aggravation claim. We do not agree. To estab-

lish an aggravation claim, a claimant must show "worsened conditions resulting from the original injury." ORS 656.273. That does not mean that the underlying condition must have worsened; it is sufficient to show that the symptoms of the condition have worsened to the extent that the claimant is more disabled than at the time of the last arrangement of compensation. *Consolidated Freightways v. Foushee,* 78 Or App 509, 513, 717 P2d 633 (1986).

The evidence from Mundall and claimant shows that claimant suffered a worsening of symptoms in May, 1985, and thereafter, and that, as a result, he became more disabled than he had been when his claim was closed in August, 1984. Except for a few days following a treatment for his headaches, claimant did not miss work at Boise. However, between May and mid-July, 1985, he was off work one to two days a week due to

his headaches, and he eventually lost his job because of those absences. Knox concluded that claimant was temporarily totally disabled from July 15, 1985, through at least December 5, 1985.

Alternatively, Boise argues that if a worsening of symptoms is sufficient to establish an aggravation claim, claimant did not show an increase in disability but merely a waxing and waning of symptoms anticipated at the time of the original award.

The Supreme Court recently addressed the question of how to distinguish a new period of incapacity that justifies additional compensation from one that constitutes a flareup that was anticipated at the time of the original award. *Gwynn v. SAIF,* 304 Or 324, 353, 745 P2d 775 (1987). However, we do not need to determine whether the original award contemplated the flareup of symptoms, because claimant's new period of total disability exceeded 14 days. As held in *Gwynn,* even if the previous award anticipated a waxing and waning of symptoms, if a worker becomes totally disabled for more than 14 consecutive days, he has proven an aggravation and entitled to compensation for temporary disability and to a reevaluation of the extent of permanent disability. Accordingly, claimant is entitled to compensation for temporary disability and to a reevaluation of the extent of permanent disability.

Affirmed.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Dale E. Senters, Claimant.

SENTERS,
Petitioner,

v.

SAIF CORPORATION et al,
Respondents.

(WCB 84-10736; CA A44546)

Judicial Review from Workers' Compensation Board.

Argued and submitted May 11, 1988.

David B. Force, Eugene, 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 Virginia L. Linder, Solicitor General, Salem.

Before Warden, Presiding Judge, Graber, Judge, and Riggs, Judge pro tempore.

GRABER, J.

Reversed on claim for medical services and on deposition costs; remanded for further proceedings not inconsistent with this opinion.

GRABER, J.

In this workers' compensation case, the Board adopted the order of the referee, which affirmed two denials by SAIF Corporation (SAIF) and taxed deposition costs to claimant. Claimant petitions for review and assigns error to the denials of his separate claims for medical services and for disability and to the award of litigation costs to SAIF. We reverse as to the claim for medical services and the deposition costs.[1]

Claimant suffered a compensable neck and back injury on May 16, 1984, while working as a logger. He fell from a log and tumbled down a hill. X-rays showed a compression fracture of the C6 vertebra. No complaints were made or recorded at that time regarding claimant's right hip.

Claimant was taken off work for two weeks. On August 29, 1984, he was released for regular work and found to be medically stationary. A determination order, issued on October 3, 1984, awarded temporary total disability benefits from May 17 through October 3, 1984. Claimant filed a request

[1] Our review is *de novo*. We obtained jurisdiction of this case before Or Laws 1987, ch 884, § 12a, changed the standard of review in workers' compensation cases. *See Armstrong v. Asten-Hill Company*, 90 Or App 200, 752 P2d 312 (1988).

for hearing to challenge the lack of an award for permanent disability.

In February, 1985, claimant began to experience further trouble with his neck. On referral from his treating orthopedic physician, Dr. Filarski, he saw Dr. Mundall, who noted his inability to straighten and walk comfortably on his right leg. Mundall was unsure of the cause. Filarski then said that he had made no notation regarding claimant's awkward gait, although he had noticed it earlier. Because of claimant's lanky appearance and gawky gait, Filarski had simply assumed that he had a chronic internal rotation contracture of the right hip.

In July, 1985, Dr. Rockey evaluated claimant and found that he had sustained a fracture through his right acetabulum, causing formation of some loose bodies in the right hip. Also in July, Dr. Michels performed a CT scan of the hip joint and determined that there were loose bodies present.

Dr. Miller performed a right hip arthrogram. His impression was that there were degenerative changes, which were post-traumatic. Upon review of those findings, Filarski concluded that claimant's right hip problems were related to the 1984 fall; Rockey concurred. Claimant's hip pain became progressively worse, and surgery was recommended.

On August 16, 1985, SAIF issued a partial denial for medical services relating to the right hip. Claimant filed a supplemental request for hearing to challenge SAIF's denial.

A hearing was held on September 24, 1985, and the record was left open to receive further evidence. After the hearing, but before the deposition of Filarski, claimant was diagnosed as suffering from parathyroid disease, which causes a weakening of the bones. Filarski testified in deposition that it was not possible for that pre-existing condition to be the sole cause of claimant's hip condition.

In November, 1985, claimant was advised to have infected teeth extracted before surgery, to reduce the danger of infection. Although the extraction was medically prudent anyway, Filarski believed that it was necessary before surgery. On March 5, 1986, SAIF issued a denial for the expenses relating to the tooth extraction.

Filarski operated on claimant's right hip in April, 1986. Claimant's infected teeth had been extracted earlier. Filarski diagnosed a hip fracture and stated that his findings during surgery "totally support[ed] a traumatic injury mechanism dating back to May 16, 1984. Progressive reactive bone formation and synovitis probably [were] responsible for the apparent delayed symptoms." The pathology report supports those findings.

SAIF's expert, Dr. Norton, reviewed claimant's medical records, Filarski's deposition, and the surgery reports. He concluded that claimant's fall could not have contributed to the pathology in the hip and that claimant's hip problems could occur spontaneously as a result of the disease process, totally independently of trauma. Dr. Becker, who had examined claimant before the surgery, had reached the same conclusion.

Claimant must prove his claim by a preponderance of the evidence. *Lenox v. SAIF,* 54 Or App 551, 553, 635 P2d 406

(1981). The issue is whether his on-the-job injury was a material contributing cause of the hip condition. *Destael v. Nicolai Co.,* 80 Or App 596, 600, 723 P2d 348 (1986).

Filarski thought that claimant's right hip condition was related to his May, 1984, fall. The parathyroid disease simply made the result worse than it might have been otherwise. "A worker is entitled to compensation for the disabling results of work activity, even if a pre-existing condition also plays a causative role in the disability." *Taylor v. SAIF,* 75 Or App 583, 586, 706 P2d 1023 (1985). An injury need not be the sole, or even the principal, cause of a disabling condition if it contributed to the disability, because the employer takes the worker as he finds him. *Aquillon v. CNA Insurance,* 60 Or App 231, 236, 653 P2d 264, *rev den* 294 Or 460 (1982).

Norton, in contrast, believed that claimant's disease was the sole cause of his hip condition. That conclusion rested on two basic premises. First, Norton said that there was no persuasive evidence that an injury to the hip had occurred at all. However, claimant testified that his right hip was bruised after the fall and that he suffered no other injury to his right hip between May, 1984, and the time of the surgery. The referee found claimant generally credible, and we give substantial weight to that finding. *Pinkerton, Inc. v. Brandner,* 83 Or App 671, 674, 732 P2d 949 (1987). Claimant's testimony is supported by Filarski's observation that claimant had exhibited an unusual gait and by the nature of the accident, which involved falling and rolling down a hill. Because the primary concern immediately after the accident was claimant's potentially serious neck injury, we have no reason to question the failure to identify claimant's hip problem immediately.

Norton also relied on the delay in claimant's symptoms, stating that claimant could not have sustained a hip fracture in the fall without experiencing immediate disabling pain. Although that diagnosis might be correct in the usual patient, Filarski provided a cogent medical explanation for why claimant is different. He also treated claimant, observed him over a long period, and performed the surgery. Norton never examined claimant.

"When medical evidence is divided, we tend to give

greater weight to the conclusions of a claimant's treating physician, unless there are persuasive reasons not to do so." *Taylor v. SAIF, supra,* 75 Or App at 585. Here, Filarski was in a superior position to evaluate claimant's condition. *See Jordan v. SAIF,* 86 Or App 29, 33, 738 P2d 588 (1987). We find Filarski's analysis and conclusions to be more persuasive.

Claimant has shown by a preponderance of the evidence that his right hip condition resulted from his injuries in the May, 1984, incident. SAIF is responsible for all reasonable and necessary expenses associated with the on-the-job injury.

ORS 656.245; *Hansen v. Weyerhaeuser Company,* 89 Or App 349, 353, 749 P2d 1183 (1988). Those expenses include both the hip surgery and the tooth extraction. *See Van Blokland v. Oregon Health Sciences University,* 87 Or App 694, 698, 743 P2d 1136 (1987).

The final issue involves the expenses associated with the deposition of Filarski. The referee and the Board required that claimant pay 30 per cent of the cost, on the ground that the deposition was taken partly on his behalf. Filarksi was claimant's witness. The procedure under ORS 656.310(2) of offering medical testimony through a written report, subject to cross-examination,

> "does not alter the status of the witness when he is called for the purposes of cross-examination. He still remains the witness of the party offering the medical reports and that party is responsible for paying the fees and expenses incident to his appearance as a witness for cross-examination." *Hanna v. McGrew Bros. Sawmill,* 44 Or App 189, 195, 605 P2d 724, *mod* 45 Or App 757, 609 P2d 422 (1980).

Former ORS 656.236(2) did not prohibit the assessment of deposition costs to a claimant, as opposed to the insurer that made the argument in *Hanna.* The "costs" referred to in that section meant the cost of funding workers' compensation benefits or of securing coverage for employes. *See Hanna v. Fairview Hospital,* 91 Or App 448, ___ P2d ___ (1988); *see also Welch v. Banister Pipe Line,* 82 Or App 23, 727 P2d 140 (1986).

Nonetheless, the costs here are not required to be taxed, in whole or in part, to claimant. Because claimant prevails on the merits of his claim and because the deposition was taken at SAIF's request and primarily for its benefit, we hold that SAIF must pay for all of Filarski's deposition.

Reversed on the claim for medical services and on deposition costs; remanded for further proceedings not inconsistent with this opinion.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Jack T. Granby, Claimant.

GRANBY,
Petitioner,

v.

WEYERHAEUSER COMPANY,
Respondent.

(WCB 85-16108; CA A42752)

Judicial Review from Workers' Compensation Board.

Argued and submitted December 7, 1987.

Michael R. Stebbins, North Bend, argued the cause for petitioner. With him on the brief was Hayner, Stebbins & Coffey, North Bend.

Brian L. Pocock, Eugene, argued the cause and filed the brief for respondent.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

PER CURIAM

Reversed; attorney fees award reinstated.

PER CURIAM

Claimant seeks review of an order of the Workers' Compensation Board which reduced attorney fees awarded by the referee. He maintains that the Board lacked jurisdiction to modify the award. The attorney fees question is the sole issue before us on review.

Employer denied claimant's aggravation claim. The referee set aside the denial, ordered employer to accept the claim and awarded claimant $2,800 attorney fees. ORS 656.386(1). Employer sought review by the Workers' Compensation Board of the attorney fees award but not the finding of compensability. The Board reduced the award.

In *Greenslitt v. City of Lake Oswego*, 305 Or 530, ___ P2d ___ (1988), the Supreme Court held that, when a claimant has finally prevailed on the issue of compensability, disputes concerning the amount of attorney fees pursuant to ORS 656.386(1) must be settled by the circuit court as provided in ORS 656.388(2). Because compensability was not appealed to the Board, it was without authority to modify the attorney fees award. The circuit court was the proper forum.

Reversed; attorney fees award reinstated.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Marshall R. Mann, Claimant.

MANN,
Petitioner,

v.

SAIF CORPORATION et al,
Respondents.

(WCB 86-06228, WCB 86-08885; CA A44301)

Judicial Review from Workers' Compensation Board.

Argued and submitted March 2, 1988.

James L. Edmunson, Eugene, argued the cause for petitioner. With him on the brief were Karen M. Werner and Malagon & Moore, Eugene.

Darrell E. Bewley, Assistant Attorney General, Salem, argued the cause for respondents. With him on the brief were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

Before Warden, Presiding Judge, and Van Hoomissen and Graber, Judges.

PER CURIAM

Affirmed.

PER CURIAM

In this workers' compensation case, the issue is whether claimant's receipt of benefits under the Longshoremen's and Harbor Workers' Compensation Act (LHWCA), 33 USC §§ 901 *et seq*, excludes him from coverage under ORS chapter 656, Oregon's Workers' Compensation Law. The Workers' Compensation Board held that, under ORS 656.027(4), claimant is excluded from coverage. We affirm.

ORS 656.027(4) provides:

> "All workers are subject to ORS [chapter 656] except those nonsubject workers described in the following subsections:
>
> "* * * * *
>
> "(4) 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."

Because LHWCA, a "law[] of the United States," provides coverage for claimant's work-related disability,[1] he is not a subject worker under ORS chapter 656. ORS 656.027(4).

Affirmed.

[1] The parties do not dispute that claimant's disability is compensable under LHWCA.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Myron W. Rencehausen, Sr., Claimant.

WEYERHAEUSER COMPANY,
Petitioner,

v.

RENCEHAUSEN,
Respondent.

(WCB No. 86-11026; CA A43484)

Judicial Review from Workers' Compensation Board.

Argued and submitted November 18, 1987.

Daniel M. Spencer, Coos Bay, argued the cause for petitioner. With him on the brief was Foss, Whitty & Roess, Coos Bay.

Michael R. Stebbins, North Bend, argued the cause for respondent. With him on the brief was Hayner, Stebbins & Coffey, North Bend.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

PER CURIAM

Affirmed.

PER CURIAM

This is a companion case to *Weyerhaeuser Co. v. Rencehausen (A43268), 91 Or App 719, ___ P2d ___ (1988).* Employer refused to pay temporary total disability for the period April 1, 1985, to January 29, 1986, pending appeal of a referee's order to pay that compensation. A second referee ordered payment of the temporary total disability, pending appeal of the first referee's order, and awarded penalties and attorney fees to claimant. ORS 656.313. The Board affirmed. Employer seeks review. We affirm. *Weyerhaeuser Co. v. Nolan,* 89 Or App 90, 747 P2d 394 (1987), *rev den* 305 Or 595 (1988).

Affirmed.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Myron W. Rencehausen, Sr., Claimant.

WEYERHAEUSER COMPANY,
Petitioner,

v.

RENCEHAUSEN,
Respondent.

(WCB Nos. 84-12397, 85-04595 and 85-13561; CA A43268)

Judicial Review from Workers' Compensation Board.

Argued and submitted November 18, 1987.

Daniel M. Spencer, Coos Bay, argued the cause for petitioner. With him on the brief was Foss, Whitty & Roess, Coos Bay.

Michael R. Stebbins, North Bend, argued the cause for respondent. With him on the brief was Hayner, Stebbins & Coffey, North Bend.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

PER CURIAM

Affirmed.

PER CURIAM

This is a companion case to *Weyerhaeuser v. Rencehausen,* 91 Or App 717, ___ P2d ___ (1988). Employer seeks review of a Worker's Compensation Board order that it pay temporary total disability for the period April 1, 1985, to January 29, 1986, the date of the determination order on claimant's aggravation claim for a shoulder injury. It argues that the doctor's order that claimant was not released for work was insufficient to prove that claimant could not return to work after April 1, 1985. Accordingly, it asserts, "claimant received

100 percent of everything to which he was entitled under the law." We disagree.

On *de novo* review, we find that claimant was medically stationary with respect to his aggravated shoulder injury on January 16, 1983. We further find that, because of his shoulder injury, claimant's physician did not authorize him to return to work from April 1, 1985, until after the January 29, 1986, determination order. Accordingly, the board correctly ordered employer to pay claimant temporary total disability for that period.[1] ORS 656.268(2)(c)[2]; *see also* OAR 436-65-010(7).[3]

Affirmed.

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[1] It is not material that the referee also stated that payment of temporary total disability for the period April 1, 1985, to January 29, 1986, creates "an overpayment which the employer will be authorized to offset against any unpaid awards for permanent disability" and that "the employer is authorized to offset this temporary disability payment, which is an overpayment, against any unpaid awards or permanent disability." Whether or not employer is entitled to an offset, it is obligated to pay temporary total disability. *Fazzolari v. United Beer Distributors*, 91 Or App 592, ____ P2d ____ (1988).

[2] *Former* ORS 656.268(2) provides:

"If the attending physician has not approved the worker's return to the worker's regular employment, the insurer or self-insured employer must continue to make temporary total disability payments until termination of such payments is authorized following examination of the medical reports submitted to the Evaluation Division under this section."

[3] OAR 436-30-030(7) provides:

"A worker who has not been authorized by the worker's attending physician to return to regular employment shall be paid compensation until the determination order has been issued pursuant to ORS 656.268, unless the worker actually returned to work."

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Roy M. Johnston, Claimant.

JOHNSTON,
Petitioner,

v.

JAMES RIVER CORPORATION,
Respondent.

(WCB 85-13546; CA A46152)

Judicial Review from Workers' Compensation Board.

Argued and submitted May 11, 1988.

James L. Edmunson, Eugene, argued the cause for petitioner. With him on the brief were Karen M. Werner and Malagon & Moore, Eugene.

Brian L. Pocock, Eugene, argued the cause and filed the brief for respondent.

Before Warden, Presiding Judge, and Graber, Judge, and Riggs, Judge pro tempore.

PER CURIAM

Reversed and remanded.

PER CURIAM

In this workers' compensation case, we review under the standards stated in *Armstrong v. Asten-Hill Co.*, 90 Or App 200, 752 P2d 312 (1988).

The Workers' Compensation Board reversed the referee on the compensability issue. When the referee makes adequate findings and conclusions of law which the Board either affirms or specifically adopts, it is not necessary for the Board to reiterate those findings in support of its conclusion. *See George v. Richard's Food Center*, 90 Or App 639, 752 P2d 1309 (1988). When the Board reverses, adequate judicial review requires specific findings in the Board's opinion substantiating its contrary conclusion.

The Board's opinion refers to some of the evidentiary issues discussed in the referee's order without making findings sufficient for our review. We cannot tell why the Board reached a conclusion contrary to the referee's.

Reversed and remanded.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Howard J. Hunt, Claimant.

HUNT,
Petitioner - Cross-Respondent,
v.
GARRETT FREIGHTLINERS et al,
Respondents - Cross-Petitioners,
v.
FARMERS INSURANCE,
Respondent - Cross-Respondent.

(WCB 83-06115, 83-06552; CA A42731)

Judicial Review from Workers' Compensation Board.

Argued and submitted November 13, 1987.

J. Michael Casey, Portland, argued the cause for petitioner - cross-respondent. With him on the brief was Doblie & Associates, Portland.

Jerry K. Brown, McMinnville, argued the cause for respondents - cross-petitioners. With him on the brief was Cummins, Cummins, Brown, Goodman & Fish, P.C., McMinnville.

Jerald P. Keene, Portland, argued the cause for respondent - cross-respondent. With him on the brief was Roberts, Reinisch & Klor, P.C., Portland.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

BUTTLER, P.J.

Affirmed on petition and on cross-petition.

BUTTLER, P. J.

In this workers' compensation case, claimant seeks review of the Board's order which denied his request for insurer-paid attorney fees on the ground that his participation at the hearing was nominal only. Employer and its present insurer, Transport Insurance Company, cross-petition, asserting that the Board incorrectly affirmed the referee's determination that Transport Insurance Company and not Farmers Insurance is responsible for claimant's back condition. We affirm on the petition and on the cross-petition and write only to explain why there is no basis for insurer-paid attorney fees.

Although Farmers originally denied compensability on the claim, shortly thereafter both insurers entered into a stipulation agreeing to an order under ORS 656.307, indicating that responsibility was the only issue and designating one of the insurers as the paying agent. There is no indication, after the issuance of that order, that either insurer contested the compensability of the back claim. At the hearing, the parties, including claimant, agreed with the referee that the only issue was whether the back condition was a new injury or an aggravation. Claimant's attorney acknowledged that, although claimant's position was that the most recent insurer was responsible, the case was a contest between two insurance companies, and he was present only to protect his client's "rights."

The hearing record shows that claimant's attorney participated to establish that Transport Insurance Company was the responsible insurer. However, claimant's right to compensation was never at risk. For that reason, there is no basis for an award of insurer-paid attorney fees. *See Wilson v. Geddes,* 90 Or App 64, 750 P2d 1182 (1988); *Anfora v. Liberty Communications,* 88 Or App 30, 744 P2d 265 (1987); *Petshow v. Farm Bureau Ins. Co.,* 76 Or App 563, 710 P2d 781 (1985), *rev den* 300 Or 722 (1986).

Affirmed on petition and on cross-petition.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Glenn L. Perry, Claimant.

GEORGIA-PACIFIC CORPORATION,
Petitioner,

v.

PERRY,
Respondent.

(WCB 82-10387; WCB 85-14031; CA A44639)

Judicial Review from Workers' Compensation Board.

Argued and submitted May 2, 1988.

Jerald P. Keene, Portland, argued the cause for petitioner. With him on the brief was Roberts, Reinisch & Klor, P.C., Portland.

Nelson R. Hall, Portland, argued the cause for respondent. With him on the brief was Pozzi, Wilson, Atchison, O'Leary & Conboy, Portland.

Before Warren, Presiding Judge, and Rossman, Judge, and Riggs, Judge pro tempore.

WARREN, P. J.

Reversed and remanded with instructions to reinstate determination orders.

WARREN, P. J.

In this workers' compensation case, both the referee and the Board awarded benefits for permanent total disability. The record shows that claimant's attorney advised him to refuse vocational assistance. We review this case *de novo* to determine whether that refusal precludes an award of benefits in view of the requirement that a claimant who seeks benefits for permanent total disability must establish that he is willing to seek regular gainful employment and has made reasonable efforts to do so. ORS 656.206(3); *Willamette Poultry Co. v. Wilson,* 60 Or App 755, 654 P2d 1154 (1982) *rev den* 294 Or 569 (1983); *Waler v. SAIF,* 42 Or App 133, 600 P2d 442 (1979). We have, on occasion, not applied the "must seek work" requirement when the record shows that the effort would be futile. *Home Ins. Co. v. Hall,* 60 Or App 750, 654 P2d 1167 (1982) *rev den* 294 Or 536 (1983).

Claimant was almost 63 years of age at the time of the hearing. He has worked only in the logging industry for the last 40 years. He is now limited by his physical disabilities to light or sedentary work. He has not worked or looked for work since a compensable injury in March, 1982.

Claimant's attorney advised him to refuse to cooperate with employer's vocational assistance provider and instead sought the consultation of a private vocational expert. The expert conducted tests, evaluated claimant's ability and testified that, considering claimant's age, limited experience

and abilities, vocational rehabilitation was inappropriate and would not have returned claimant to "gainful full-time employment." The expert was mistaken that claimant must be able to return to *full-time* employment. If he is able to do regular part-time work, he is not permanently and totally disabled. In fact, the expert testified that claimant may have the ability to engage in part-time employment in some 60 job categories. We find, however, that those jobs are not available to him without vocational assistance, which he has refused, on his attorney's advice.

A finding of futility is reserved for the extreme situation where, for example, the record shows that the individual is physically totally disabled or is not capable of retraining. Considering claimant's physical limitations, age and other factors, he may be totally disabled. However, in view of the

fact that he is not totally disabled from a physical standpoint, it is impossible to know whether it would be futile for him to seek work without first determining, in a rehabilitation setting, what his abilities are. In view of his failure to cooperate with rehabilitation counselors and the scant record concerning the extent of his disability if it is not permanent and total, we reverse the Board and reinstate the determination orders awarding claimant 30 percent unscheduled disability for an injury to his neck and 40 percent scheduled disability for loss of the left leg.

Reversed and remanded with instructions to reinstate the determination orders.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of
A. G. McCullough, claimant.
WEYERHAEUSER COMPANY,
Petitioner,
v.
McCULLOUGH,
Respondent.
(WCB No. 85-02415; CA A43561)

Judicial Review from Workers' Compensation Board.

Argued and submitted December 7, 1987.

Daniel M. Spencer, Coos Bay, argued the cause for petitioner. With him on the brief was Foss, Whitty & Roess, Coos Bay.

Mike Stebbins, North Bend, argued the cause for respondent. With him on the brief was Hayner, Stebbins & Coffey, North Bend.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

NEWMAN, J.

Affirmed.

NEWMAN, J.

Employer petitions for review of an order and supplemental order of the Workers' Compensation Board that awarded temporary total disability through May 1, 1985, and denied employer's request for authorization to offset overpaid temporary total disability payments against permanent partial disability payments that employer had already paid. We affirm.

Claimant, a millwright, suffered a heart attack at work in November, 1982. He filed a claim, which employer denied. On December 7, 1984, the first referee found that the claim was compensable. Employer requested Board review. On January 24, 1985, while review was pending, employer told Dr. Henke, claimant's treating physician, that it had been "told [by your office] that [claimant] was considered medically stationary six months from the date of his heart attack." Employer asked the Evaluation Division to close the claim. It paid temporary total disability benefits from the date of the heart attack through May 12, 1983, only, although, after his heart attack, claimant had not returned to work nor had his attending physician authorized him to return to work.

On February 20, 1985, claimant requested a hearing, asserting that employer had unilaterally and prematurely terminated temporary total disability payments. On April 25, 1985, the second referee found that claimant was medically stationary on November 9, 1983, and awarded him temporary total disability through that date, which employer paid. The referee noted that there had as yet been no determination order. Claimant requested Board review.

After the second referee's order, and before the Board considered claimant's appeal from that order, the Board affirmed the first referee's order and awarded claimant permanent partial disability, which employer paid. On June 18, 1986, we reversed the Board, *Weyerhaeuser Co. v. McCullough,* 80 Or App 98, 720 P2d 769, *rev den* 302 Or 158 (1986), and held that the claim was not compensable.

Employer then moved that the Board dismiss claimant's petition for review of the second referee's order, because we had held that the claim was not compensable. The Board denied the motion, modified the second referee's order to

award claimant temporary total disability from November 10, 1983, through May 1, 1985, the date of the determination order, and denied employer's request for authority to offset "overpaid" temporary total disability payments against the permanent partial disability awarded that employer had paid.[1] Employer assigns those actions as errors.

Former ORS 656.268(2)[2] provided that, if the attending physician had not approved the worker's return to regular employment, the self-insured employer must continue to make temporary total disability payments until the Evaluation Division authorized termination of the payments. If the worker had not actually returned to work, nor been authorized

by his attending physician to return to regular employment, the employer must pay temporary total disability until there is a determination order. ORS 656.268; OAR 436-30-030(7);[3] *Fazzolari v. United Beer Distributors*, 91 Or App 592, ___ P2d ___ (1988). Here, employer had not paid temporary total disability for the period after November 9, 1983, even though claimant had not returned to work, his attending physician

had not authorized him to return to his regular employment and the Evaluation Division had not authorized employer to discontinue temporary total disability payments. Accordingly, the Board correctly modified the second referee's order.[4]

The Board also correctly denied employer's motion to dismiss. As the Board stated, this court's subsequent determination that the claim was not compensable "did not extinguish the question of whether the employer properly exercised its processing obligations during the period the claim was considered compensable." *See* ORS 656.313.

The Board also correctly refused to allow an offset of temporary total disability benefits against the award of permanent partial disability which had been paid under the determination order. Although, because the underlying claim was noncompensable, the award and payment of permanent partial disability resulted in an overpayment, employer had properly paid the award pending review of compensability. It may not recover it by either repayment or offset. ORS 656.313;[5] *United Medical Lab v. Bohnke*, 81 Or App 144, 724 P2d 884 (1986); *Hutchinson v. Louisiana-Pacific*, 67 Or App 577, 581, 679 P2d 338, *rev den* 297 Or 1370 (1984).

Affirmed.

[1] The Board referred to the determination order of May 1, 1985, and ruled that claimant was entitled to temporary disability benefits from November 10, 1983, "through May 1, 1985, the date of the first determination order." The determination order of May 1, 1985, had also provided that "deduction of overpaid temporary disability, if any, from unpaid permanent disability is approved." The Board also stated:

> "Anticipating today's decision, the employer has requested permission to offset the 'overpayment' created by this order against claimant's permanent disability award as granted by a post-hearing Determination Order. The request is rejected because the court's ultimate finding of noncompensability has rendered the request meaningless. The court's decision ensures that there will be no future permanent disability payments concerning this claim. Thus, even if we granted the request, there is no longer a permanent disability award against which to offset this so-called 'overpayment.' "

On reconsideration, the Board again refused to authorize an "offset."

[2] *Former* ORS 656.268(2) provided:

> "If the attending physician has not approved the worker's return to the worker's regular employment, the insurer or self-insured employer must continue to make temporary total disability payments until termination of such payments is authorized following examination of the medical reports submitted to the Evaluation Division under this section."

[3] *Former* OAR 436-30-030(7) provides:

> "A worker who has not been authorized by the worker's attending physician to return to regular employment shall be paid compensation until the determination order has been issued pursuant to ORS 656.268, unless the worker actually returned to work."

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Ana M. Guerrero, Claimant.

GUERRERO,
Petitioner - Cross-Respondent,

v.

STAYTON CANNING COMPANY,
Respondent - Cross-Petitioner.

(WCB No. 85-04520; CA A42870)

Judicial Review from Workers' Compensation Board.

Argued and submitted December 16, 1987.

Howard R. Nielsen, Portland, argued the cause and filed the brief for petitioner - cross-respondent.

Jerry K. Brown, McMinnville, argued the cause for respondent - cross-petitioner. With him on the brief was Cummins, Cummins, Brown, Goodman & Fish, P.C., McMinnville.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

NEWMAN, J.

Affirmed on petition and on cross-petition.

NEWMAN, J.

Claimant seeks review of a Workers' Compensation Board order insofar as it held that employer's partial denial on March 20, 1985, was applicable to medical care that she received after July 26, 1985. Employer cross-petitions for review, asserting that the Board erred in ruling that the denial was not effective on March 20, 1985. We affirm on the petition and on the cross-petition.

Claimant suffered a compensable injury to her back, hip, neck and shoulder on August 8, 1984, when she fell on the job. She continued to work until September 5, 1984, when Dr. Webb, her treating chiropractor, took her off work. Employer accepted her claim as disabling. Webb was also treating her for a compensable low back injury which she had suffered in August, 1980. Claimant continued to receive chiropractic treatments from Webb at least weekly. In March, 1985, a panel of independent medical examiners found no evidence of any diagnosable condition which it could attribute to the August, 1984, injury, concluded that claimant could be considered medically stationary with no residual impairment or work restrictions and advised that continuing chiropractic

On July 26, 1985, employer issued a notice of claim closure and referred the claim to the Evaluation Division. ORS 656.268(3). In August, 1985, claimant was examined by independent chiropractic consultants who considered her medically stationary without any residual impairment attributable to the August, 1984, injury and stated that no additional care was necessary. On September 11, 1985, the Division issued a determination order that did not award permanent disability. Claimant continued to complain of back pain and stiffness and continued to receive treatments once or twice a week from Webb.

The referee held that claimant's chiropractic treatments were not necessary or reasonably attributable to her

August, 1984, injury and upheld employer's March 20, 1985 denial, effective as of that date. The Board agreed with the referee but held that the denial was premature under *Roller v. Weyerhaeuser Co.*, 67 Or App 583, 679 P2d 341, *on reconsideration* 68 Or App 743, 683 P2d 554, *rev den* 297 Or 601 (1984), and *Safstrom v. Riedel International, Inc.*, 65 Or App 728, 672 P2d 392, *rev den* 297 Or 124 (1983).

On the petition, claimant assigns as error that the Board, after ruling that the 1985 partial denial was premature, treated that denial as effective after the notice of closure on July 26, 1985. She argues that, because, as the Board ruled, the denial was untimely, it was a nullity and the Board could not give any effect to it or rule on the merits. According to claimant, the Board's action rewarded employer for its improper processing of the claim and prevented her from receiving a determination on the merits of a "de facto" denial which, she asserts, employer never made.

The Board did not err in holding that employer's 1985 denial, although premature when issued, was effective after the notice of closure on July 26, 1985. Claimant refers us to no statute, rule or case law to support her argument that the Board lacked authority to decide the issue of compensability as if employer had denied her claim for medical treatment after the notice of closure. She has also failed to show how her right to a determination of the compensability of her claim was prejudiced. She asked for and received a full hearing on the compensabality of the chiropractic treatments received after March 20, 1985, including treatments received after the notice of closure. In fact, claimant does not challenge here the Board's ruling that the chiropractic treatments after July 26, 1985, were not compensable. We conclude that, in these circumstances, the Board had authority to consider that the 1985 denial was effective after the notice of closure.

On the cross-petition, employer argues that, because there was "over-whelming evidence that the ongoing [chiropractic] manipulations were not related to any condition resulting from Claimant's industrial injury," it should be able to issue a denial and stop payment for medical care, while it continued to process the claim for closure. We disagree. An employer may not issue a partial denial of a previously accepted inseparable condition while the claim is still open.

Roller v. Weyerhauser Co., supra; Safstrom v. Riedel International, Inc., supra.

Affirmed on petition and on cross-petition.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Frank E. Norelius, Claimant.

NORELIUS,
Petitioner,

v.

CONTINENTAL CAN CO., et al,
Respondents.

(WCB 82-10763; CA A42417)

Judicial Review from Workers' Compensation Board.

Argued and submitted December 21, 1987.

Robert K. Udziela, Portland, argued the cause for petitioner. With him on the brief were Daniel C. Dziuba, and Pozzi, Wilson, Atchison, O'Leary & Conboy, Portland.

Craig A. Staples, Portland, argued the cause and filed the brief for respondents.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

DEITS, J.

Denial of tinnitus claim reversed and referee's order reinstated; otherwise affirmed.

DEITS, J.

Claimant seeks review of an order of the Workers' Compensation Board reversing the referee's determination that his tinnitus claim was compensable and affirming the denial of his psychological disorder. On *de novo* review, we reverse the Board's denial of compensability of the tinnitus and otherwise affirm.

Claimant worked at employer's can factory from August, 1976, to July, 1982. Employes were required to wear hearing protection devices because of the loud noises in the factory. Claimant testified that the protection devices that he wore were not specially fitted, that he could still hear noise with them on and that he did not wear additional earmuffs. In April, 1982, he was sent home, because he had been staring at his hands for several minutes and had seemed to be disoriented at work for some time.

Several physicians examined claimant to determine the nature of his condition and whether it was work related. Three of the four doctors who examined him concluded that

he suffered from tinnitus. The referee determined that claimant had tinnitus, and the Board agreed but concluded that he had not met his burden of proving by a preponderance of the evidence that it was caused by his exposure to noise in the workplace. We disagree. Dr. Johnson, an otolaryngologist at Oregon Health Sciences University, explained that it is not possible to identify definitely the cause of tinnitus. He indicated, however, that many of the individuals treated have a history of noise exposure which, in his view, is the most logical cause of tinnitus. He concluded:

> "[Claimant] is a young man with normal hearing and tinnitus. It is reasonable to assume that the tinnitus resulted from high levels of noise exposure over a 7 to 8 year period of time."

Employer's insurance carrier had Dr. Myers examine claimant. Myers agreed that claimant has tinnitus, but indicated that he did not believe that noise exposure at the factory had contributed to it. However, he did not offer any other causal explanation. There was no evidence of any other possible nonwork causes. The doctors and technicians at the OHSU Tinnitus Clinic, where claimant receives treatment, indicate that it is their belief that exposure to loud noise at

work is the cause of his condition. We conclude that the preponderance of the evidence establishes that claimant's condition is work related and, therefore, compensable.

There is also conflicting medical evidence regarding claimant's psychological condition. Two of the three psychiatrists who examined him concluded that he was probably suffering from schizophrenia that was not work related. The third psychiatrist believed that he was suffering from depression that was related to the stress of his employment. The referee concluded that it was more likely that he was suffering from schizophrenia than from an emotional depressive disorder. In addition to the medical experts, the referee relied on uncontroverted lay testimony of claimant's behavior—staring at his hands, standing motionless for long periods of time and appearing "spaced out" and unaware of his physical environment—as more indicative of a thought disorder such as schizophrenia than of tinnitus-induced depression. We agree and conclude that claimant failed to meet his burden of proof that his psychological disorder is work related.

Denial of tinnitus claim reversed and referee's order reinstated; otherwise affirmed.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Lela K. Findlay, Claimant.

FINDLAY,
Petitioner,

v.

SAIF CORPORATION et al,
Respondents.

(WCB 85-08074; CA A42967)

Judicial Review from Workers' Compensation Board.

Argued and submitted January 8, 1988.

David C. Force, Eugene, 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 Virginia L. Linder, Solicitor General, Salem.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

DEITS, J.

Reversed and remanded with instructions to accept aggravation claim.

DEITS, J.

Claimant seeks review of an order of the Workers' Compensation Board affirming the referee's denial of her aggravation claim. ORS 656.273. On *de novo* review, we reverse.[1]

In February, 1979, while working as a respiratory therapist for employer, claimant suffered a compensable low back injury. By a February, 1980, determination order, she was awarded temporary partial disability and temporary total disability. She returned to work between October, 1979, and December, 1980, but continued to have lower back pain. In May, 1982, she was diagnosed as suffering from chronic lumbar strain and degenerative disc disease. In December, 1982, she underwent a bilateral posterolateral spinal fusion. The claim was reopened and then closed by a September 19, 1983, determination order which awarded her compensation for 10 percent unscheduled permanent partial disability. She returned to work without any significant problems except for occasional back pain, which she alleviated with baths, exercise and rest.

In August, 1984, employer transferred her to another position, which involved an increased amount of driving. She drove approximately 1,500 miles the first week in the new

[1] The petition for review in this case was filed on January 30, 1987, before the effective date of Or Laws 1987, ch 884, § 12.

position and, because of the transfer, did not have access to the van that she usually drove or to her waterbed. She again began to experience severe low back and leg pain, and her left leg occasionally became numb. She also experienced nausea in association with the pain and due to the vibration of the vehicle. Her usual methods for dealing with pain were ineffective. Her treating physician at the time, Dr. Nelson, prescribed medication, which alleviated some of her symptoms but left claimant too groggy to perform her duties. In November, 1984, because of her increased pain and nausea, and on the basis of Nelson's recommendation, claimant resigned. She filed an aggravation claim on November 19, 1984; SAIF denied it on May 17, 1985.

In order to establish an aggravation claim, claimant must show that her condition has worsened since the September, 1983, determination order, and that the worsening was materially caused by her 1979 injury. *DeMarco v. Johnson Acoustical,* 88 Or App 439, 745 P2d 815 (1987). The parties do not dispute that her condition has worsened. The only issue on review is whether claimant established that her current condition is causally related to her 1979 compensable injury.

To establish her claim, claimant offered the reports of Dr. Grimm, a neurologist, who treated her back pain before her 1982 surgery. Grimm stated that claimant's current condition, involving increased low back and leg pain and nausea, is consistent with the development of incisional neuromas located on the two surgical scars on the lower back. He stated:

> "These neuromas are strategically located such that virtually any persistent back activity, including pressure, driving and importantly, vibration (which also makes the patient very uncomfortable as well as nauseated) are at the heart of this difficulty.
>
> "These are certainly new and quite different developments from those cited by myself earlier in this decade and followed."

Grimm noted that applying pressure to the bottom of each surgical scar produced much of the back pain and nausea that claimant described and that, by injecting these areas with novacaine, he was able to relieve the symptoms.

The Board concluded that claimant did not prove that the 1979 injury caused her current problems.[2] It did not find Grimm's report persuasive, because Grimm did not sufficiently explain how the neuromas were related to the 1979 compensable injury. Although a more detailed medical explanation of the relationship between claimant's injury, the surgery and the development of neuromas would have been possible, the evidence from Grimm is sufficient to lead us to conclude that the neuromas resulted from the 1982 surgery, which was necessary because of claimant's compensable injury. In addition to the explanation in the report, Grimm concluded in a cover letter accompanying his report that the neuromas were a result of claimant's 1982 surgery, which was a consequence of her 1979 injury. He stated: "I have no doubt,

[2] The Board adopted the referee's opinion in its entirety.

based on my findings, that the situation is exactly as she says, *e.g.* that her condition has worsened and that it has done so as a consequence of the lumbosacral surgery done for a condition said to have originated from an on-the-job injury."

Grimm's conclusion and explanation was not rebutted by other evidence. SAIF offered the report of several doctors from Orthopaedic Consultants who examined claimant and concluded that her condition had not worsened since the last claim closure in September, 1983. They stated that, compared to a previous exam conducted by different doctors in their office in 1982, there had been an improvement in her condition. Nelson, claimant's treating physician at that time, concurred with the Orthopaedic Consultants' report. However, none of the doctors from Orthopaedic Consultants had previously examined her, nor did they offer any explanation for her increased symptoms of pain and nausea. They also did not discuss whether she had incisional neuromas or if neuromas could have caused her problems. Nelson noted that, because he had not treated claimant before her surgery and the final determination order, he could not render an opinion as to whether her condition had worsened. Accordingly, we conclude that claimant proved her aggravation claim.

Reversed and remanded with instructions to accept the aggravation claim.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Wilma A. Moore, Claimant.

MOORE,
Petitioner,
v.
DOUGLAS COUNTY et al,
Respondents.

(WCB 86-06466; CA A44242)

Judicial Review from Workers' Compensation Board.

Argued and submitted January 13, 1988.

James L. Edmunson, Eugene, argued the cause for petitioner. With him on the brief were Karen M. Werner, and 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, and Virginia L. Linder, Solicitor General, Salem.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

DEITS, J.

Reversed and remanded for acceptance of claim.

DEITS, J.

Claimant seeks review of an order of the Worker's Compensation Board affirming the referee's order denying compensation for her hepatitis claim. The issue is whether claimant proved that her exposure to hepatitis on the job was the medical cause of her condition. On *de novo* review, we find that she did and reverse.

Claimant worked as a registered nurse at the Douglas County Correctional Facility, where she provided medical and dental services to inmates. As a part of her job, she regularly came in contact with inmates' bodily fluids, including blood, mucus, semen and urine. A number of the inmates and the staff had hepatitis A or B. Hepatitis B may be transmitted only by contact with bodily fluids. Accidental needle pricks are a common source of exposure to the disease. On October, 26, 1985, claimant had assisted in a particularly bloody dental procedure, without the protection of gloves or mask. The next day, she accidentally pricked herself with the needle on one of the bloody syringes used in the procedure that had been soaking overnight.

The incubation period for hepatitis is 40 to 180 days, with symptoms manifesting themselves two to three months after exposure. In late December, 1985, claimant first noticed the symptoms of what she suspected was hepatitis. In February, 1986, Dr. Cervi-Skinner diagnosed hepatitis B. He reported:

> "As an employee of the Douglas County Correctional Institute, I am sure that [claimant] is exposed to numerous individuals that are potential carriers of the hepatitis B virus. * * * The patient did recall * * * puncturing her hand or finger while washing or working with some medical instruments. Apparently this was some time in October. The incubation period for hepatitis B is variable and it is most likely that an exposure in October will result in the active disease in 2-3 months.
>
> "* * * As to the place of contact by her history, occupation, and exposure to probable multiple individuals that are potential carriers of this virus, *it is only logical to assume that she did contract her hepatitis at her place of employment.* There is no question that health professionals are at a higher risk of contracting hepatitis B." (Emphasis supplied.)

Claimant testified that her off-the job activities from August 1, 1985, to February 26, 1986, did not expose her to persons with hepatitis, probable hepatitis agents or any type of activity that likely would have caused hepatitis. The referee expressly found her credible.

The referee found that claimant proved legal causation. However, he concluded that she had failed to prove medical causation on the ground that her doctor's opinion about the causal relationship was based on mere possibilities or speculation, rather than on a reasonable medical probability. The referee noted that Cervi-Skinner reported that "it is only logical to assume" that claimant contracted hepatitis at her place of work and concluded that "[t]he reported opinion, cast

in such terms does not establish causal relationship based on a reasonable medical probability."

We conclude that claimant established legal *and* medical causation. The evidence is uncontroverted that she regularly came in contact with bodily fluids of inmates which are potential sources of the hepatitis virus, that inmates and staff in her workplace had the disease, that claimant's needle prick incident was a potential means of contracting the virus and that her symptoms appeared within the incubation period for the disease after the incident. There was no evidence of any off-work exposure to the disease. Although Cervi-Skinner did not use the "magic words" "reasonable medical probability," the language he did use, in the context of the entire report and taken with the other evidence, is sufficient to establish that the medical cause of claimant's hepatitis was contact with the virus in the work place.

Reversed and remanded for acceptance of the claim.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Dennis Berliner, Claimant.

BERLINER,
Petitioner,

v.

WEYERHAEUSER COMPANY,
Respondent.

(WCB 85-12191; CA A43382)

Judicial review from Workers' Compensation Board.

Argued and submitted November 6, 1987; remanded to referee 90 Or App 450, 752 P2d 1246 (1988).

James L. Edmunson, Eugene, argued the cause for petitioner. With him on the brief were Karen M. Werner and Malagon & Moore, Eugene.

Paul Roess, Coos Bay, argued the cause for respondent. With him on the brief was Foss, Whitty & Roess, Coos Bay.

Before Warden, Presiding Judge, and Joseph, Chief Judge,* and Van Hoomissen, Judge.

JOSEPH, C. J.

Affirmed.

* Joseph, C. J., *vice* Young, J., deceased.

JOSEPH, C. J.

This case is before us after a remand to the referee for evidence taking. *Berliner v. Weyerhaeuser,* 90 Or App 450, 752 P2d 1246 (1988). The initial issue is whether the Workers' Compensation Board had authority to republish its October 8, 1986, order. We conclude that the Board had that authority and that, therefore, we have jurisdiction. On the merits, we affirm the Board.

We address the jurisdiction issue first. The facts and the procedural history are in our initial opinion and need not be restated here. The evidence taken by the referee on remand about whether the Board mailed its order of October 8, 1986, to claimant[1] consists primarily of the testimony of two persons who were on the Board when it republished the order. The essence of the evidence is that the Board followed regular, consistent, albeit informal, procedures in mailing documents but had no method of verifying whether those procedures were followed in a given case. The Board members testified that they believed that the procedures had not been followed completely, resulting in the October, 1986, order not being mailed, because they believed the affidavits of claimant and his attorney that they did not *receive* copies of the order.

We, and respondents for that matter, also believe the affidavits of claimant and his attorney, but the issue is whether the order was *mailed.* There are two possibilities. The first is that the Board mailed the order, but the Post Office failed to deliver it. If that is true, the Board lacked jurisdiction to republish, and we lack jurisdiction to review, because the order became final 30 days after it was mailed. ORS 656.295(8). It stretches credulity too much, however, to believe that the Board mailed two copies of the order,[2] one to claimant and one to his attorney, and that the Post Office lost *both* of them, while it was successfully handling the mailings to the other side. The more likely possibility is that the Board did not mail copies to claimant or to his attorney, even though they were mailed to employer and its attorney.

Although we presume that the Board's duty to mail and the Board's usual course of business were followed, OEC 311(1)(j); OEC 311(1)(m), we find that the presumptions have been overcome and that the 1986 order was not mailed to claimant. Accordingly, the Board acted properly in republishing the order, and we have jurisdiction over the petition for review.

We turn to the merits. The issue is whether a self-insured employer may set off from a permanent partial disability award a previous overpayment of temporary total disability when the determination order authorized a set off, but the referee's order made no mention of it.

Claimant suffered compensable injuries in 1975; he was unable to work until August, 1983. Employer continued to pay temporary total disability benefits after he returned to work, and claimant accepted them. An overpayment of approximately $7,000 resulted. On March 23, 1984, employer informed claimant that it would request authorization to set off the overpayment against any permanent partial disability award.

The Evaluation Division closed the claim by a determination order on December 17, 1984, which awarded 30 percent scheduled permanent partial disability and five percent unscheduled permanent partial disability and allowed

[1] Claimant is the only *party* claiming that he did not receive the order; his attorney asserts that he did not receive it either.

[2] Although only claimant's copy of the order is at issue, the order contains a paragraph stating that the order was sent to claimant and to his attorney.

employer to deduct "overpaid temporary disability, if any, from unpaid permanent disability." The total value of the determination order award was $4,370. Employer deducted all of it and informed claimant and his attorney that it was doing so. It also informed them, by letter, that there was a remaining overpayment balance of approximately $2,700. The letter did not mention anything about future set offs.

Claimant appealed the determination order. The *only* issue at that hearing was the extent of permanent disability. The set off issue was not raised by either party. The referee increased the award by approximately $2,000, and that award was not appealed to the Board.[3] Employer set off $2,000 of the

remaining overpayment balance against that increase. Claimant requested a hearing. The referee ruled that employer had no authority to set off the $2,000, but the Board reversed. It held that the set off was permissible, because the determination order authorization continued in effect until the whole overpayment was recovered.

Employers and insurers cannot set off overpayments without authorization from the Division, a referee or the Board. *Spivey v. SAIF,* 79 Or App 568, 571, 720 P2d 755 (1986); *Forney v. Western States Plywood,* 66 Or App 155, 160, 672 P2d 1376 (1983), *aff'd* 297 Or 628, 686 P2d 1027 (1984); *see* ORS 656.268(4).[4] No statute, rule or previous case addresses the issue of whether an authorization continues when an award is later increased.

We agree with the Board that the authorization continues in effect unless and until it is revoked[5] or until the overpayment is wholly recovered. Previous cases discussing set off problems concern maintaining control of set offs by the Workers' Compensation Department, rather than by employers or insurers. *See, e.g., Spivey v. SAIF, supra,* 79 Or App at 571; *Wilson v. SAIF,* 48 Or App 993, 997, 618 P2d 473 (1980). That concern is not involved here. Having the authorization remain in effect insures that a claimant will not receive more than he is entitled to receive. Claimant argues that it was incumbent on employer to request a specific new authorization if it intended to continue to set off the overpayment. The determination order authorized a deduction from "unpaid permanent disability." That is exactly what employer did. If claimant disagreed with the authorization, *he* should have raised *that* issue appropriately.[6]

Affirmed.[7]

[3] The referee increased the permanent partial disability award by $2,700, but 25 percent of that was awarded to claimant's attorney as attorney fees. Thus, approximately $2,000 was payable to claimant.

[4] After January 1, 1988, an insurer's notice of closure and determination may include adjustments to account for overpayments. Or Laws 1987, ch 884, § 10(10).

[5] We need not determine in this case either the circumstances under which or by whom an authorization may be revoked.

[6] Claimant also argues that the referee's order superseded the determination order and that, therefore, the determination order was no longer in effect when employer took the set off. The referee's order superseded the determination order only as to the issues which the referee addressed. Claimant's appeal raised only the extent of disability. On all other issues, the determination order remained in effect.

[7] Claimant's remaining arguments lack merit.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Henry P. Ritz, Claimant.

RITZ,
Petitioner,

v.

OREGON TITLE INSURANCE et al,
Respondents.

(WCB No. 85-12593; CA A44221)

Judicial Review from Workers' Compensation Board.

Argued and submitted March 2, 1988.

Robert K. Udziela, Portland, argued the cause for petitioner. With him on the brief was Pozzi, Wilson, Atchison, O'Leary & Conboy, Portland.

Edward C. Olson, Portland, argued the cause and filed the brief for respondents.

Before Warden, Presiding, Judge, and Joseph, Chief Judge, and Van Hoomissen, Judge.

JOSEPH, C. J.

Affirmed.

JOSEPH, C. J.

Claimant seeks review of the Workers' Compensation Board's order affirming the referee's denial of compensation. The sole issue is whether claimant was acting in the course of his employment when he was injured in a fire. We review *de novo* and affirm.

The referee considered the matter on these stipulated facts:

> "On June 23, 1985, [claimant] was President of the Oregon Title Insurance Company, the employer in this case. [Claimant] was also a member of the Board of Directors of a trade association called the Oregon Land Title Association, and his company was a member of that association.
>
> "A meeting of the Board of Directors of the Oregon Land Title Association was scheduled for the Kah-Nee-Ta Resort early on June 24, 1985, and [claimant] traveled to the Kah-Nee-Ta Resort area on June 23, 1985[,] for the purpose of being present at the meeting of the Board of Directors early the following morning. His expenses for attendance at the meeting were paid by his employer, and [claimant] would testify that his presence * * * and his company's membership in the association was a benefit to his employer * * *. [The] Vice-President-Secretary of [employer] was also scheduled to attend. The purpose of the * * * Association is to exchange information between member companies, and to address problems common to the members * * * in a coordinated way.
>
> "After arriving at the Kah-Nee-Ta Resort, * * * it came to [claimant's] attention that a grass fire was burning in an area

quite close to the Kah-Nee-Tah [*sic*] Resort buildings. He went to the dining room and saw the fire burning towards the lodge, which is a wooden building. Out of concern that the fire created an emergency and a threat to the Kah-Nee-Ta Resort and its occupants, [claimant] joined with several other people who were employees of the Kah-Nee-Ta Resort in attempting to suppress the fire. Due to a sudden shift in the wind and change in the direction of the fire, [claimant], and at least six other persons, were trapped by the fire, and in an attempt to escape this predicament, [he] was badly burned * * *.

"There were approximately 100 guests of the hotel in the area around the swimming pool."

An exhibit, to which the parties also stipulated, indicates that the resort management safely evacuated all guests

from the buildings and grounds and directed them to the parking lot. Eyewitnesses described the fire as "tree exploding" and "fast moving." Ultimately, 185 firefighters were used to control the blaze, which consumed more than 900 acres of range land.

The referee sustained the denial on the grounds that claimant's voluntary "untrained and unskilled" participation in the firefighting to save buildings was unreasonable and that his injuries did not arise out of or in the course of his employment. The Board adopted the referee's order and affirmed.

Claimant first argues that he is entitled to compensation under the traveling employe rule, because his firefighting activity was reasonable. Generally, traveling employes are considered to be within the scope of employment while they are away from their homes, except when they engage in a distinct departure from that employment. *Slaughter v. SAIF,* 60 Or App 610, 615, 654 P2d 1123 (1982); *Simons v. SWF Plywood Co.,* 26 Or App 137, 143, 552 P2d 268 (1976). Injuries are compensable only when they result "from activities reasonably related to the claimant's travel status." *Slaughter v. SAIF, supra,* 60 Or App at 616.

Claimant was not injured as a result of being trapped in the hotel or while escaping to safety but, rather, when he voluntarily left the lodge to fight the fire. We have held that injuries are compensable under the traveling employe rule if they arise from the activities of passing time in a tavern, *Slaughter v. SAIF, supra,* from traveling as a passenger from an airport to a motel, *Simons v. SWF Plywood Co., supra,* and from consuming alcohol during business related activities, coupled with the use of a hotel's recreational facilities. *Beneficiaries of McBroom v. Chamber of Commerce,* 77 Or App 700, 713 P2d 1095, *rev den* 301 Or 240 (1986).[1] Those activities were held to be reasonable, because they are typical of activities associated with traveling and doing business. That cannot be said about fighting a fire, at least when one elects to leave a building to encounter the danger. Assuming, without deciding, that claimant was in fact traveling in the course of his employment, we hold that firefighting was not reasonably related to

his travel status. Therefore, he was engaged in a distinct departure from his employment when he was injured. The

[1] We need not reconsider here some (possibly too) broad language in *McBroom.* 77 Or App at 704.

injuries lack a sufficient "unitary work-connection." *Rogers v. SAIF,* 289 Or 633, 642, 616 P2d 485 (1980).

Claimant contends, alternatively, that his injuries are compensable under a rescue or emergency doctrine, and he urges us to adopt Larson's theory of compensability:

> "Any emergency or rescue activity is within the course of employment if the employer has an interest in the rescue. Injury incurred in the rescue of a stranger is compensable if the conditions of employment place claimant in a position which requires him by ordinary standards of humanity to undertake the rescue." 1A Larson, *Workers' Compensation Law* 5-405, § 28.00 (1985).

We need not decide whether to adopt that theory, because claimant has failed to prove that it is applicable under the facts of this case.

Claimant does not argue that employer had an interest in the rescue of the resort buildings. Absent that interest, an emergency must involve grave danger to life or persons and not merely to property. 1A Larson, *Workers' Compensation Law* 5-432, § 28.24 (1985). Claimant contends that he acted out of a concern for the safety of the resort guests. Although there is evidence that the fire was spreading quickly, that 100 guests were around the swimming pool and that one of them expressed a fear for his safety, the record does not establish that the guests were near the fire or that claimant had knowledge that anyone was in imminent danger when he embarked on his firefighting effort. Instead, the evidence shows that the guests were timely and safely evacuated to the parking lot. Claimant has failed to carry his burden of proving that his firefighting efforts were directed at the rescue of persons and not property.[2] Accordingly, we hold that his injuries were not sustained out of or in the course of his employment.

Affirmed.

[2] Claimant cites *O'Leary v. Brown-Pacific-Maxon,* 340 US 504, 71 S Ct 470, 95 L Ed 483 (1951), for the proposition that his injuries are compensable under the rescue doctrine. The United States Supreme Court upheld compensation under the Longshoremen's Act to a worker who drowned in an attempt to rescue two drowning people. That holding is consistent with the rule that the rescue must involve an emergency endangering life or person and not property.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Judy J. Gornick, Claimant.

GORNICK,
Petitioner,

v.

SAIF CORPORATION et al,
Respondents.

(WCB 86-00831; CA A43930)

Judicial Review from Workers' Compensation Board.

Argued and submitted February 5, 1988.

Robert Udziela, Portland, argued the cause for petitioner. With him on the brief were Diana Craine, Portland, and Pozzi, Wilson, Atchison, O'Leary & Conboy, Portland.

Darrell E. Bewley, Assistant Attorney General, Salem, argued the cause for respondents. With him on the brief were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

Before Warden, Presiding Judge, and Joseph, Chief Judge, and Van Hoomissen, Judge.

VAN HOOMISSEN, J.

Reversed; referee's order reinstated.

Warden, P. J., dissenting.

VAN HOOMISSEN, J.

Claimant seeks review of an order of the Workers' Compensation Board, which reversed the referee's award of permanent total disability and awarded her 40 percent unscheduled disability. On *de novo* review, *former* ORS 656.298(6),[1] we reinstate the referee's award.

At the time of the hearing, claimant was 43 years old. She attended school for approximately ten years and earned a GED in 1972. She had worked at home most of her life. Between 1960 and 1969, she worked for short periods as a maid, a waitress and a clerk. She worked in a tree nursery from 1978 to March, 1980, when she suffered a compensable injury to her back. In May, 1980, Dr. Ordonez performed a laminectomy and discectomy. In May, 1981, claimant was released for work, with restrictions on lifting, bending and carrying. She returned to work clipping trees. In August, 1981, she fell at work, again injuring her back and causing back pain radiating into her right leg. She returned to Ordonez, who initially found significant functional overlay in her symptoms. However, a CT scan disclosed an extradural defect at L5-S1. At the request of SAIF, she was seen by Orthopaedic Consultants, who found her in pain, with little functional overlay, but with some exaggeration in stating her symptoms. Ordonez referred her to Dr. Brenneke, who found little functional overlay and stated that her pain was probably due to adhesions and compression of the nerve root at the area of her previous surgery. In April, 1982, Brenneke and Ordonez performed decompression and fusion surgery. In February, 1983, a determination order awarded her 40 percent permanent partial disability.

After surgery, claimant tried physical therapy and analgesics but was still in pain. In April, 1983, Brenneke referred her to the Northwest Pain Clinic. The clinic staff found that she was somaticly preoccupied and that her motivation for vocational rehabilitation, therapy and return to work was only fair. Dr. Cramer found that mechanical, as well as non-organic factors, contributed to her pain and recommended sedentary to light work. Dr. Yospe, a psychologist, found that she was somatic, that her motivation to return to

work was difficult to assess and that her motivation for rehabilitation was moderate. By all accounts, she was cooperative and participated well, if somewhat superficially.

[1] The petition for review was filed before July 20, 1987. *See Armstrong v. Asten-Hill*, 90 Or App 200, 203, 752 P2d 312 (1988).

After treatment at the pain center, claimant was better able to control her pain. She attempted some country dancing and took a part-time job teaching cake decoration, but she stopped those activities because of increased pain. In December, 1984, she again saw Brenneke. Although he initially recommended reopening her claim for an aggravation, he later stated that he was not necessarily recommending reopening. He noted that she was depressed and that the problem was her "ability to handle her pains." He thought that her condition might improve with treatment by Yospe. A referee set aside SAIF's denial of her aggravation claim.

Yospe saw claimant from February through April, 1985. He found her very depressed and felt that many of her physical symptoms had an emotional etiology. However, her depression improved with treatment. In August, 1985, Yospe found that she was psychologically stationary, although he continued to treat her.

In November, 1985, she was reevaluated by Orthopaedic Consultants, who found her to be medically stationary and suffering functional overlay with moderate loss of function due to her back injury. Dr. Klein, a psychiatrist, found her to be entrenching herself in a disabled role. In December, 1985, Ordonez also noted functional overlay, and Brenneke essentially agreed with those evaluations. In January, 1986, the claim was again closed, with no increase in award. Claimant was referred for vocational rehabilitation.

In February, 1986, claimant sought treatment for worsened pain, as shown by numbness and muscle spasms. The emergency room physician diagnosed post-lumbar disc surgery symptoms, probably hysterical in origin. In March, 1986, Yospe discontinued treatment, because he found that, although she continued to complain of chronic pain, she had not shown a return to depression. He believed that she could maintain herself psychologically.

In May, 1986, Brenneke concluded that claimant was unable to perform any significant work and was totally disabled. He explained that her condition had deteriorated, that

she had continuing and unremitting pain accentuated by everyday activities, that surgery was not feasible, that the pain clinic had not been able to treat her successfully and that Yospe had not been able to help her overcome the mental aspects of her chronic pain.

Claimant sought a redetermination of the extent of her disability. She testified concerning her pain and the restrictions which the pain placed on her activities. She also testified that, although she questioned whether she would be able to perform the work required, she had contacted 21 potential employers without success. The referee expressly found her testimony credible, noting that she was in obvious pain during the hearing. Claimant's rehabilitation counselor testified that she had some transferable skills and that there was a stable market in which she could find employment, although some employments might require site modification, and that pain might interfere with her performance. The referee awarded her permanent total disability. On review, the Board reversed the referee and awarded 40 percent unscheduled disability.

Permanent total disability[2] may result from less than total physical incapacity, when combined with nonmedical conditions, including "age, training, aptitude, adaptability to nonphysical labor, mental capacity, emotional condition, as well as conditions of the labor market." *Wilson v. Weyerhaeuser*, 30 Or App 403, 409, 567 P2d 567 (1977). Permanent total disability may be established by any evidence which demonstrates to the satisfaction of the trier of fact that, as a consequence of a compensable injury, the claimant has been rendered unable to sell her services on a regular basis in a hypothetically normal labor market. *Wilson v. Weyerhaeuser, supra.* Claimant has the burden of proving her permanent total disability status and must establish that she is willing to seek regular gainful employment and that she has made

reasonable efforts to obtain such employment. ORS 656.206(3).

Claimant's objective physical condition alone would limit her to sedentary work. However, claimant also suffers two psychological problems: depression and somatic preoccupation. The depression was profound before treatment by Yospe. His opinion is that she has come out of her severe depression and is stationary in that regard. However, a portion of claimant's physical pain is the result of somatic preoccupation. Somatic behavior is the process of transferring mental anxiety into physical discomfort, rather than dealing consciously with the anguish. *Steadman's Medical Dictionary* at 1476 (21st ed 1981). Before her injury, she had never suffered psychological problems. Medical opinion, except perhaps Dr. Klein's, is that her behavior results from claimant's psychological inability to address consciously the changes in her life brought about by her compensable injury. Hence, the psychological aspect of claimant's condition is compensable.

In the light of the medical evidence and because of claimant's age, physical limitations, lack of education and limited work experience, we conclude that she falls in the odd-lot category of permanent total disability. *See Ferguson v. Industrial Indemnity Co.*, 70 Or App 46, 687 P2d 1130 (1984). Moreover, she has adequately proven her willingness to seek gainful employment. *See* ORS 656.206(3). Her concern about her ability to work is realistic and not evidence of a lack of motivation.

Reversed; referee's order reinstated.

WARDEN, P. J., dissenting

The majority orders reinstatement of the referee's order, which awarded claimant permanent total disability. The majority concedes that "the medical evidence alone does not show that claimant is totally disabled," yet it concludes that because of her "age, physical limitations, lack of education and limited work experience," and because of her psycho-

[2] ORS 656.206(1)(a) defines permanent total disability as

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

logical problems which interfere with her ability to deal with her pain, claimant is in the odd-lot category. I disagree and, therefore, dissent.

The referee's own findings do not support the award.

At the time of the hearing, claimant was only 43 years old. She was limited in how much she could lift and carry to 20 pounds and restricted in some back movements; however, as the referee noted, Orthopaedic Consultants concluded that she could do light work, and her own treating orthopedic physician concluded that she could do sedentary work. She has had 10 years of formal education and has received a high school general equivalency degree. As the referee found, her work experience includes work as a waitress, a maid in a private home, a cashier and stock clerk, cake decorating and instructing, as well as nursery or farm labor that she was doing when she was injured. As for psychological problems, the referee found: "There are no psychological, or emotional residuals." The referee also observed: "The vocational counsellor was confident she could locate work claimant could do in the light or sedentary areas. She may be right."

Because claimant is still relatively young, is physically limited only in lifting and certain movements of her back, has education equivalent to a high school diploma, has had a variety of work experience and lacks psychological residuals and because the vocational counsellor believed she could find work for claimant that she could do within her limitations, I would not find her to be permanently totally disabled. Because she does not suggest that anything less than an award of permanent total disability would be acceptable to her, I would not consider whether her disability is greater than that already awarded but would affirm the order of the Board. Therefore, I dissent.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Leonard Sutton, Claimant.

EBI COMPANIES et al,
Petitioners,

v.

KEMPER GROUP/AMERICAN MOTORISTS INSURANCE COMPANY et al,
Respondents.

(WCB No. 87-17366; CA A46468)

Judicial Review from Workers' Compensation Board.

Argued and submitted June 10, 1988.

Randy G. Rice, Portland, argued the cause and filed the brief for petitioners.

Noreen K. Saltveit, Portland, argued the cause and filed the brief for respondent Kemper Insurance.

No appearance for respondent Leonard Sutton.

Before Warden, Presiding Judge, and Van Hoomissen and Graber, Judges.

VAN HOOMISSEN, J.

Affirmed.

VAN HOOMISSEN, J.

EBI Companies seeks review of a Board order which affirmed the referee's decision dismissing the case on the ground that the referee lacked jurisdiction to order Kemper Insurance to comply with two previous referees' orders directing Kemper to reimburse EBI for its claim costs under ORS 656.307. We affirm.

On May 8, 1985, an order was issued designating EBI as the paying agent pursuant to ORS 656.307. Following a hearing, Kemper was found to be the responsible insurer. On November 7, 1985, the first referee issued an order, providing, in part:

> "(5) Kemper shall reimburse EBI Companies for EBI's claim costs, if EBI has paid any, but shall not reimburse EBI Companies for the penalty and associated attorney fee awarded against EBI."

On January 24, 1986, counsel for Kemper filed a response to a motion for an order to show cause and an affidavit of Kemper's attorney stating:

> "Kemper Insurance has advised EBI-ORION that it will reimburse EBI-ORION for all amounts of time loss paid pursuant to such order designating paying agent."

On March 6, 1986, the second referee entered an order providing, in part:

> "(3) Pursuant to the '307' Order, Kemper shall reimburse EBI for its claim costs."

Kemper did not appeal or otherwise contest either of the referees' orders. It did not fully reimburse EBI, contending that EBI mismanaged claimant's claims and afforded claimant time loss to which he otherwise would not have been entitled. EBI requested a hearing, seeking full reimbursement. On February 5, 1987, the second referee issued an order, stating that the Hearings Division was without jurisdiction because:

> "(1) This case is separate from the prior dispute between these parties that was resolved by a final order. That final order cut off the Director's delegation of subject matter jurisdiction.
>
> "(2) The present issue is not a dispute concerning a claim over which the Hearings Division has jurisdiction.

> "(3) The present dispute is one specifically within the jurisdiction of the Director and the parties need to go to the Director first to seek relief. The parties cannot come first to the Hearing Division which lacks jurisdiction."

The referee concluded that the Director of the Compliance

Division had jurisdiction, pursuant to ORS 656.704(3). EBI petitioned for review.[1]

ORS 656.704(3) provides, in relevant part:

> "For the purpose of determining the respective authority of the director and the board to conduct hearings * * *, matters concerning a claim under ORS 656.001 to 656.794 are those matters in which a worker's right to receive compensation, or the amount thereof, are directly in issue."

A referee has jurisdiction only over matters concerning a claim. ORS 656.283; ORS 656.708. The worker in this case has already received his compensation and is no longer a party to the dispute. The only issue remaining is whether the responsible party in a .307 dispute must reimburse the designated paying agent. That question does not involve the worker's right to receive compensation or the amount thereof. The Board did not err in affirming the referee's ruling that he was without jurisdiction to order Kemper to reimburse EBI.

Affirmed.

[1] EBI also filed a request with the director to have the previous orders enforced. The director denied the request, holding that EBI had mismanaged the case. EBI requested a hearing. That matter is still before a referee. Kemper argues that this case is not properly before us, because EBI does not have a final order from which to petition for review. We disagree. EBI obtained a final order from the Board on appeal from the referee. The appeal of the director's decision which is now before the Board is a separate matter. EBI filed its petition in this court before filing with the director and filed with the director only to preserve its position if we were to affirm the Board on review.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Edward T. Crumley, Claimant.

CRUMLEY,
Petitioner,

v.

COMBUSTION ENGINEERING et al,
Respondents.

(WCB 85-12902; CA A44774)

Judicial Review from Workers' Compensation Board.

Argued and submitted February 1, 1988.

J. Michael Alexander, Salem, argued the cause for petitioner. With him on the brief was Burt, Swanson, Lathen, Alexander & McCann, Salem.

Mildred J. Carmack, Portland, argued the cause for respondents. With her on the brief was Schwabe, Williamson & Wyatt, Portland.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

WARREN, J.

Remanded for award of permanent total disability benefits; otherwise affirmed.

WARREN, J.

Claimant seeks review of an order of the Workers' Compensation Board affirming a determination of the referee that he is not entitled to an award of permanent total disability and that employer is entitled to an offset of benefits for temporary total disability paid during the time when claimant was receiving union disability retirement benefits.

Claimant suffered a serious compensable back injury in 1979. His back condition did not improve, despite various therapies and limitations on lifting. In March, 1981, after making several attempts to return to work, he began receiving union "disability retirement" benefits. In order to be eligible for those benefits, he had to establish to the satisfaction of the union that he was permanently and totally disabled. In April, 1981, the Evaluation Division issued a determination order awarding 40 percent permanent partial disability and temporary total disability through February 19, 1981. In September, claimant and employer agreed to an additional 52.875 percent, for a total award of 92.875 percent permanent partial disability.

Claimant's condition deteriorated, and in January, 1983, his treating physician reported that he was significantly worse and unemployable. Employer reopened the claim and began paying benefits for temporary total disability. Claimant underwent a fusion in May, 1983. He got little relief from that surgery and believes that his back condition has continued to deteriorate. In September, 1985, employer terminated benefits for temporary total disability on the ground that claimant had retired in March, 1981. *See Cutright v. Weyerhaueser,* 299 Or 290, 720 P2d 403 (1985); *Karr v. SAIF,* 79 Or App 250, 719 P2d 35, *rev den* 301 Or 765 (1986). In January, 1986, the Evaluation Division issued a determination order that did not award any additional disability benefits as a consequence of the January, 1983, reopening. Claimant requested a hearing.

At the hearing, claimant challenged employer's termination of temporary total disability benefits, asserting that he had not voluntarily retired, and sought additional benefits for permanent partial disability or permanent total disability. Employer sought authorization to offset temporary total disability benefits paid from the time when the claim was reopened in January, 1983, to September, 1985, when

employer terminated payment of temporary total disability benefits, against any additional permanent disability award. Employer stipulated at the hearing that claimant is presently permanently and totally disabled.

The Board, in adopting the referee's opinion, awarded an additional 7.125 percent permanent partial disability, for a total award of 100 percent. It determined, however, that claimant had retired in March, 1981, and that he therefore was not entitled to benefits for temporary total disability when the claim was reopened. The Board authorized employer to offset the resulting overpayment against the additional permanent disability award.

Claimant contends, first, that he has not left the

labor force, because the union benefits that he receives are for disability, not retirement. On *de novo* review, we find that claimant is retired and that the benefits he is receiving from his union are retirement benefits, although they are available only to those who retire because of total disability.

Claimant asserts that his withdrawal from the labor force should not preclude an award of temporary total disability, because it was involuntary, as a result of his work-related disability. As we held in *Karr v. SAIF, supra,* a claimant who withdraws from the work force is not entitled to benefits for temporary total disability. It matters not that the reason for the retirement is a work-related disability. Temporary total disability benefits are awarded for lost wages. *Cutright v. Weyerhaueser, supra;* ORS 656.210(1). A person who has retired, as a result of his injury or for any reason, has not lost wages. *Karr v. SAIF, supra.* We affirm the Board's determination that claimant was not entitled to benefits for temporary total disability after he retired and that employer is entitled to an offset for benefits paid after the claim was reopened in January, 1983.

The referee found, on the basis of the purported effect of the 1981 stipulated award of 92.875 percent permanent partial disability and employer's stipulation at the hearing that claimant is presently permanently and totally disabled, that he has experienced a worsening since the last award of compensation and that he therefore has sustained an aggravation so as to qualify for additional benefits under ORS 656.273.

Employer argues that the referee incorrectly treated the 1981 stipulation as having determined, as a matter of fact, that claimant was only 92.875 percent disabled at the time of the stipulation. Employer asserts that the stipulation was only a compromise award of compensation and did not constitute an agreement as to the actual level of claimant's disability. It contends that the evidence shows that, in fact, claimant was permanently and totally disabled at the time of the stipulation and that his condition therefore has not compensably worsened since that time so as to entitle him to additional benefits under ORS 656.273.

We hold that the 1981 stipulation constituted an agreement as to the extent of claimant's disability. Having agreed in 1981 that he was only 92.875 percent disabled, employer cannot now assert that he was totally disabled at that time. The evidence shows that his condition has worsened since 1981. Employer agrees that he is now totally disabled. We affirm the Board's determination that he is, in fact, permanently and totally disabled.

The Board, in affirming the referee, apparently concluded that, although claimant had sustained an aggravation and is permanently and totally disabled, his withdrawal from the labor market precluded, as a matter of law, a determination that he was entitled to benefits for permanent and total disability. Instead, it awarded additional benefits to equal 100 percent permanent partial disability. Although a retired worker cannot experience any time loss and is not, for that reason, entitled to benefits for temporary total disability, *Cutright v. Weyerhaeuser, supra,* 299 Or at 302, the referee con-

cluded, and the parties do not dispute, that a retired worker can obtain benefits for increased permanent partial disability related to a compensable injury. The question remains whether retirement precludes the worker from recovering benefits for permanent total disability.

In *Cutright v. Weyerhaeuser, supra,* the Supreme Court stated that the fact that the calculation of benefits for temporary total disability is based on a percentage of wages, ORS 656.210(1), indicates that the legislature intended that benefits for temporary total disability be wage replacement. That is shown, additionally, the court reasoned, by ORS

656.325, which requires an employer to cease paying temporary total disability when the injured worker refuses wage earning employment. The court stated that a person who is retired is like a person who refuses wage earning employment. The court reasoned that temporary disability benefits are maintenance benefits intended to provide support and to help replace lost income during the healing or recovery process. A person who is not working cannot lose earnings. The court held, therefore, that a person who has retired from the labor market cannot qualify for temporary total disability benefits.[1]

There is language in *Cutright v. Weyerhaeuser, supra,* which suggests that the court would use the same analysis to reach the conclusion that benefits for permanent total disability are not available to retired workers. The court noted that, like temporary total disability, benefits for permanent total disability are calculated on a percentage of wages. Like the person seeking temporary benefits, a person seeking benefits for permanent total disability must demonstrate a willingness to seek work. ORS 656.206(3).

There are distinctions, however, which we conclude lead to a different result. We have held, for example, that when the evidence shows that the claimant is completely incapacitated from a physical standpoint, he need not demonstrate an effort to become employed. *See Brech v. SAIF,* 72 Or App 388, 695 P2d 964 (1985). An award of *permanent* disability benefits, unlike an award of *temporary* benefits, anticipates that the disability will be permanent, and therefore cannot be considered merely as the replacement of lost income during the healing process. A person who becomes medically stationary at a level of permanent total disability is not expected to return to the job market. Benefits for permanent total disability continue after ordinary retirement age, indicating that they are not awarded only as wage replacement. The fact that the formula for calculating benefits is based on a percentage of wages does not convince us that wage replacement is the only objective of permanent total disability compensation. We do not understand that a person who retires and then becomes totally disabled as a result of a compensable condition should not be compensated the same as a person who becomes totally disabled and then retires. We find that claimant is totally disabled from a physical standpoint and

[1] We are, of course, bound by the Supreme Court's holding that benefits for temporary total disability are not available to a retired worker. We note, however, that the language of ORS 656.210(2) suggests that the legislature contemplated that there would be occasions when a worker who is not "available" for work would be eligible for benefits.

hold that he is entitled to benefits for permanent total disability.

Remanded for an award of permanent total disability benefits; otherwise affirmed.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

PALMER,
Appellant,
v.
THE BI-MART COMPANY, INC., et al,
Respondents.
(86-1166-J-1; CA A42770)

Appeal from Circuit Court, Jackson County.

L. A. Merryman, Circuit Judge.

Argued and submitted November 2, 1987.

Claudette L. Yost, Medford, argued the cause and filed the briefs for appellant.

Donald E. Johnson, Eugene, argued the cause for respondents. With him on the brief were Ralph F. Cobb and Luvaas, Richards and Fraser, P.C., Eugene.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

ROSSMAN, J.

Reversed and remanded.

ROSSMAN, J.

Plaintiff brought this action for employment discrimination, ORS 659.030, and for intentional infliction of emotional distress. The trial court granted summary judgment to defendants on both claims.[1] We reverse and remand.

Defendants have the burden of showing that there are no issues of material fact and that they are entitled to judgment as a matter of law. We take the facts in the light most favorable to plaintiff. *Seeborg v. General Motors Corporation,* 284 Or 695, 699, 588 P2d 1100 (1978). Plaintiff was a pharmacy clerk employed by defendant Bi-Mart. Defendant Millan was plaintiff's supervisor. Beginning in November, 1985, the supervisor engaged in a course of harassment of plaintiff verbally and through notes, including notes with abusive and sexually explicit wording.[2] Plaintiff complained

[1] Plaintiff also assigns as error the trial court's decision to bar plaintiff from personally recording the oral argument on defendant's motion for summary judgment and plaintiff's motion to set aside summary judgment. Because we are reversing the judgment on other grounds, we do not address that assignment of error.

[2] Plaintiff alleged that as part of the harassment, her supervisor passed her messages, typed on prescription labels, which included street slang for copulation and for male and female genitalia.

to Bi-Mart's management, but it did not remedy the situation. In April, 1986, plaintiff took sick leave and vacation time; on April 14, she filed a worker's compensation claim for "stress syndrome—due to pressure and harassment on the job" caused by the supervisor's conduct. On April 15, 1986, she filed this action in circuit court. Bi-Mart's insurer accepted the worker's compensation claim, and plaintiff received time loss and medical benefits.

On her discrimination claim, plaintiff sought recovery under ORS 659.121 for lost past and future wages, fringe benefits, medical expenses and attorney's fees.[3] On her outrageous conduct claim, she sought $150,000 for emotional distress, $75,000 in punitive damages, and attorney's fees.

Defendants contend that both of plaintiff's claims

are barred because, under ORS 656.018, worker's compensation provides plaintiff's exclusive remedy. ORS 656.018 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 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, except as specifically provided otherwise in ORS 656.001 to 656.794.
>
> "* * * * *
>
> "(3) The exemption from liability given an employer under this section is also extended to the employer's insurer, the department, and the employes, officers and directors of the employer, the employer's insurer and the department except that the exemption from liability shall not apply:
>
> "(a) Where the injury is proximately caused by wilful and unprovoked aggression by the person otherwise exempt under this subsection[.]"

ORS 656.156(2) provides:

> "If injury or death results to a worker from the deliberate intention of the employer of the worker to produce such injury or death, the worker, the widow, widower, child or dependent of the worker may take under ORS 656.001 to 656.794, and also have cause for action against the employer, as if such statutes had not been passed, for damages over the amount payable under those statutes."

We address the discrimination claim first. ORS 659.121 provides:

> "Any person claiming to be aggrieved by an unlawful employment practice prohibited by ORS 659.030 * * * may file a civil suit in circuit court for injunctive relief and the court may order such other equitable relief as may be appropriate,

[3] At oral argument, plaintiff conceded that, under ORS 659.121(1), she is not entitled to compensation for her medical expenses other than what she received as workers' compensation benefits. General damages are not available in an action under that section. *Holien v. Sears, Roebuck and Co.*, 298 Or 76, 95, 689 P2d 1292 (1984).

including but not limited to reinstatement or the hiring of employes with or without back pay."

Defendants contend that, because plaintiff has sustained one

injury for which she has been compensated[4] under the worker's compensation law, she has a "compensable injury" under ORS 656.005(7)(a), and therefore, under ORS 656.018, the employer is exempt from all liability flowing from that injury.

Plaintiff has suffered two distinct injuries. The first is to her right to a workplace free from sexual harassment, for which she has a remedy under the discrimination statute. *Holien v. Sears, Roebuck and Co., supra* n 3, 298 Or at 90. The second is a personal injury suffered in the workplace and compensable under the worker's compensation law. The legislature has created two separate statutory schemes to protect employes from those separate injuries.

The stated objectives of the two statutes preclude defendants' interpretation of the exclusivity provision. The first stated purpose of the worker's compensation law is

> "[t]o provide, regardless of fault, sure, prompt and complete medical treatment for injured workers and fair, adequate and reasonable income benefits to injured workers and their dependents[.]" ORS 656.012(2)(b).

The statute also states that it is intended to create a fair system of delivery of benefits to workers, to restore workers to self-sufficiency as soon as possible and to encourage employer safety measures. The legislature explicitly sought to correct the problem that the common law remedies for injuries on the job were inadequate. ORS 656.012(1).

In contrast, the purpose of the discrimination statute is

> "to encourage the fullest utilization of available manpower by removing arbitrary standards of race, religion, color, sex, marital status national origin or age as a barrier to employment of the inhabitants of this state; * * * To accomplish this purpose the Legislative Assembly intends * * * to provide:

> "* * * * *
>
> "An adequate remedy for persons aggrieved by certain acts of discrimination because of race, religion, color, sex, marital status or national origin or unreasonable acts of discrimination in employment based on age." ORS 659.022.

The policy of that statute is of fundamental importance. ORS 659.020(1) states:

> "It is declared to be the public policy of Oregon that practices of discrimination against any of its inhabitants because

[4] Defendants insist that plaintiff did not dispute that, as a matter of fact, she has been "fully compensated." That is incorrect. Her deposition testimony was that she had received worker's compensation benefits, apparently for medical expenses and time loss, and not full compensation for back wages. Time loss benefits are calculated on the basis of a formula, and may not equal actual wages lost. *See* ORS 656.210. On the other hand, relief available under ORS 659.121(1) includes injunctive relief and "such other equitable relief as may be appropriate," including back pay and reinstatement.

> of race, religion, color, sex, national origin, age or handicap are a matter of state concern and that such discrimination threatens not only the rights and privileges of its inhabitants but menaces the institutions and foundation of a free democratic state."

Given the stated policies and purposes of the two statutes, it is evident that the legislature did not intend that the objectives of the discrimination statute would be defeated by the exclusive remedy provision of the worker's compensation law. Accordingly, plaintiff is not barred from recovery for her discrimination injury by the worker's compensation law.[5] However, that recovery must be within the limits of ORS 659.121(1).

Defendants contend that plaintiff's tort claim for intentional infliction of emotional distress is also barred by the exclusivity provision, arguing that her injuries were neither caused by the "deliberate intention of the employer * * * to produce such injury" nor by the "wilful and unprovoked aggression" of an employe.

ORS 656.156(2) provides that, if a worker is injured because of "the deliberate intention of the employer of the worker to produce such injury," the worker may bring a separate action for the injury. Defendants argue that the facts alleged by plaintiff do not show a deliberate intention by Bi-Mart to cause harm to plaintiff. The facts are sufficient to support an inference that her supervisor had a specific intent to harm her. *See Bakker v. Baza'r, Inc.*, 275 Or 245, 253-4, 551

P2d 1269 (1976). The question is whether the conduct of that supervisor can be ascribed to Bi-Mart. Defendants contend that, even if Bi-Mart's failure to act on plaintiff's complaint constituted a ratification of the supervisor's conduct, mere ratification of the wrongful acts of an employee is not sufficient to make an employer liable. Defendants rely on *Bakker v. Baza'r, Inc., supra,* 275 Or at 253-4, and *Caline v. Maede,* 239 Or 239, 396 P2d 694 (1964).

In *Bakker,* the plaintiff alleged that a security guard employed by the employer had committed a battery. The court held that the employer's subsequent ratification of that act did not convert it into an intentional act of the employer. 275 Or at 254. In *Caline,* the court held that an employer's failure to correct conditions which had injured the worker twice before did not constitute a deliberate intention to harm the worker. 239 Or at 240. The situation in this case is quite different. Here, plaintiff alleges that Bi-Mart failed to stop a continuing course of intentional conduct aimed specifically at plaintiff after being informed of it. If proven, that is sufficient to permit a jury to find that the supervisor's actions reflect the deliberate intent of the employer. Therefore, plaintiff's action against Bi-Mart is not barred.

We turn to plaintiff's action against her supervisor. ORS 656.018(3)(a) provides that the exemption from liability granted to employes under ORS 656.018(3) does not apply

[5] All three courts which have addressed this question have reached similar conclusions. *Jones v. Los Angeles Com. College Dist.*, 198 Cal App 3d 794, 244 Cal Rptr 37 (1988); *Reese v. Sears, Roebuck and Co.*, 107 Wash 2d 563, 731 P2d 497 (1987); *Boscaglia v. Michigan Bell Tel. Co.*, 420 Mich 308, 362 NW2d 642 (1984).

when "the injury is proximately caused by wilful and unprovoked aggression by the person otherwise exempt under this subsection."[6] Defendants contend that the supervisor's conduct was not wilful and unprovoked aggression. They rely on *Virgil v. Walker,* 280 Or 607, 572 P2d 314 (1977), and *Duk Hwan Chung v. Fred Meyer, Inc.,* 276 Or 809, 556 P2d 683 (1976). In *Virgil,* the Supreme Court held that the term "wilful" in that statute means "deliberately and intentionally." 280 Or at 611. In *Chung,* the Supreme Court held that the "mere removal of a safety switch" is not an act of wilful and unprovoked aggression. 276 Or at 813.

It is clear that plaintiff has alleged the requisite

intent of the supervisor's conduct under *Virgil* and that his conduct was the direct cause of her harm. The question is whether the supervisor's acts constitute "aggression" within the meaning of the statute. Plaintiff stated that the supervisor engaged in a "wilful and wanton" course of conduct of sexual harassment "in the form of verbal and written sexual comments and innuendos designed to annoy, harass, intimidate and demean Plaintiff, such as explicit sexual and abusive language." "Aggression" is not defined in the statute; it has been defined as "an offensive action or procedure; esp[ecially]: a culpable unprovoked overt hostile attack." *Webster's Third New International Dictionary* 41 (1976). We doubt that the legislature intended to immunize conduct such as that alleged here, and we conclude that the facts are pleaded sufficient to constitute aggression within the meaning of the statute.

Defendants' remaining contention is that the discrimination statute preempts the tort of intentional infliction of emotional distress. It does not. The common law tort claim is not precluded simply because defendant's conduct might also have violated a statute designed to protect against employment discrimination. *Kofoid v. Woodard Hotels, Inc.,* 78 Or App 283, 288, 716 P2d 771 (1986); *Carsner v. Freightliner Corp.,* 69 Or App 666, 674, 688 P2d 398, *rev den* 298 Or 334 (1984).

Reversed and remanded.

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[6] Defendants contend that plaintiff did not raise the issue of the applicability of ORS 656.018(3)(a) below. However, defendants raised ORS 656.018(3) as a defense in their reply to plaintiff's response to defendants' motion for summary judgment. Accordingly, the question is properly before us.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Charles H. Whiddon, Claimant.

UNITED FOAM CORP.,
Petitioner - Cross-Respondent,

v.

WHIDDON,
Respondent - Cross-Petitioner,

BERTSECH MOBIL et al,
Respondents - Cross-Respondents.

(WCB Nos. 85-14081; 85-14106; CA A46136)

Judicial Review from Workers' Compensation Board.

On petitioner - cross-respondent's Motion for Remand filed April 8, 1988.

Patric J. Doherty and E. Kimbark MacColl, Jr., Portland, for motion.

Robert K. Udziela, and Pozzi, Wilson, Atchison, O'Leary & Conboy, Portland, on respondent - cross-petitioner's response to motion.

Darrell E. Bewley, Assistant Attorney General, and Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem, for respondents - cross-respondents.

Before Warden, Presiding Judge, and Joseph, Chief Judge, and Warren, Judge.

PER CURIAM

Motion denied.

PER CURIAM

Petitioner has moved for a remand to the Workers' Compensation Board for consideration of new evidence. SAIF objects on the ground that the law does not provide for a remand.

Before the effective date of Or Laws 1987, ch 844, § 12(a), ORS 656.298(6) read:

> "The court may remand the case to the referee for further evidence taking, correction or other necessary action. However, the court may hear additional evidence concerning disability that was not obtainable at the time of hearing * * *."

The 1987 act deleted that language and provided instead that "[r]eview shall be as provided in ORS 183.482(7) and (8)." Under the Administrative Procedures Act, remand for additional evidence taking is provided for in ORS 183.482(5). However, there is no specific provision for such a remand under the amended version of ORS 656.298(6).[1] Claimant sug-

[1] The amended version of the statute applies to all petitions for judicial review filed after July 20, 1987. *Armstrong v. Asten-Hill*, 90 Or App 200, 205, 752 P2d 312 (1988). This case was filed in November, 1987.

gests that, review of compensation cases now being governed by ORS 183.482(7) and (8), remand under ORS 183.482(5) should be allowed as part of that review scheme. However, the legislature eliminated a specific provision for remand and replaced it with only a specific reference to specific parts of the APA and without a reference to ORS 183.482(5). We conclude that the legislature intended only what it expressly said.

Motion denied.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of William B. Johnson, Claimant.

JOHNSON,
Petitioner,

v.

OREGON STATE UNIVERSITY et al,
Respondents.

(WCB 85-05078; CA A46395)

Judicial Review from Workers' Compensation Board.

Argued and submitted July 25, 1988.

S. David Eves, Corvallis, argued the cause and filed the brief for petitioner.

John A. Reuling, Jr., Assistant Attorney General, Salem, argued the cause for respondents. With him on the brief were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

PER CURIAM

Order modified to increase award to 40 percent permanent partial disability; affirmed as modified.

PER CURIAM

Claimant seeks review of an order of the Workers' Compensation Board reversing the referee's decision that he is still entitled to benefits for permanent total disability and finding that he is not entitled to an increased award of unscheduled permanent partial disability. We affirm the Board, except to correct a mathematical error in the Board's award of permanent partial disability. We agree with the parties that the Board clearly intended to award claimant an additional 48 degrees or 15 percent permanent partial disability, for a total award of 128 degrees or 40 percent permanent partial disability.

Order modified to increase award to 40 percent permanent partial disability; affirmed as modified.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

CHAVEZ,
Appellant - Cross-Respondent,
v.
BOISE CASCADE CORPORATION,
Respondent - Cross-Appellant.
(86-0774-J-2; CA A43559)

Appeal from Circuit Court, Jackson County.

L. L. Sawyer, Judge.

Argued and submitted January 20, 1988.

Daniel C. Thorndike, Medford, argued the cause for appellant - cross-respondent. With him on the briefs was Blackhurst, Hornecker, Hassen & Brian, Medford.

H. Scott Plouse, Medford, argued the cause and filed the brief for respondent - cross-appellant.

Before Warden, Presiding Judge, and Joseph, Chief Judge, and Van Hoomissen, Judge.

WARDEN, P. J.

Reversed and remanded on appeal; affirmed on cross-appeal.

WARDEN, P. J.

Plaintiff brought this action against his former employer, alleging that it had committed an unlawful employment practice under ORS 659.415 by not reinstating him to his former position of employment after he had sustained an injury compensable under the Workers' Compensation Act. The trial court granted defendant's motion for summary judgment on the ground that a final order of the Workers' Compensation Board precluded plaintiff from relitigating the issue of his ability to return to his prior employment.[1] Plaintiff appeals. Defendant cross-appeals, assigning as error the denial of its motion for an award of attorney fees. We reverse the summary judgment.[2]

Plaintiff contends that the trial court erred in applying the doctrine of collateral estoppel, which precludes a party from relitigating an issue that was actually litigated and determined in a previous action, if the determination was essential to the decision in that action. *North Clackamas School Dist. v. White, supra n 1,* 305 Or at 53; *State Farm Fire & Cas. v. Reuter,* 299 Or 155, 158, 700 P2d 236 (1985). Assuming that an administrative determination can be used as the basis for

[1] The trial court applied the doctrine commonly referred to as "collateral estoppel." The term "issue preclusion" also applies. *North Clackamas School Dist. v. White,* 305 Or 48, 50, 750 P2d 485, *modified on other grounds,* 305 Or 468, 752 P2d 1210 (1988).

[2] Because we reverse the judgment for defendant, we need not address the issue of its entitlement to attorney fees. Therefore, we affirm on the cross-appeal.

collateral estoppel in a later civil judicial proceeding, *but see Shannon v. Moffett*, 43 Or App 723, 604 P2d 407 (1979), *rev den* 288 Or 701 (1980), we examine the issue necessarily decided in the workers' compensation proceeding.

Plaintiff sustained a compensable low back injury while working for defendant in September, 1983. The sole issue in the workers' compensation proceeding was the extent of his permanent partial disability. ORS 656.214(5) provides, in pertinent part:

> "In all cases of injury resulting in permanent partial disability * * * the criteria for rating of disability shall be the permanent loss of earning capacity due to the compensable injury. Earning capacity is the ability to obtain and hold gainful employment in the broad field of general occupations,

> taking into consideration such factors as age, education, impairment and adaptability to perform a given job."

It follows that the only fact necessarily determined in the workers' compensation proceeding was that plaintiff's loss of "earning capacity" due to his compensable injury was 30 percent. The statement by the referee that plaintiff is not employable by defendant was not necessary to the determination that plaintiff was 30 percent disabled.

In this action, plaintiff contends that defendant violated ORS 659.415, which provides, in pertinent part:

> "(1) A worker who has sustained a compensable injury shall be reinstated by the worker's employer to the worker's former position of employment upon demand for such reinstatement, provided that the position is available and the worker is not disabled from performing the duties of such position. If the former position is not available, the worker shall be reinstated, in any other position which is available and suitable.
>
> "* * * * *
>
> "(3) Any violation of this section is an unlawful employment practice."

To determine the merits of plaintiff's claim, it will be necessary to decide whether plaintiff's former position is "available"[3] and, if it is, whether plaintiff is "disabled from performing the duties" of that position.[4] Resolution of those issues was not essential to the determination of plaintiff's extent of permanent partial disability under ORS 656.214, because a finding that plaintiff is permanently partially disabled does *not* mean, necessarily, that he is totally unable to work. *Edwards v. Emp. Div.*, 63 Or App 521, 525, 664 P2d 1151, *modified on other grounds* 64 Or App 845, 669 P2d 1187 (1983). On that basis, the trial court erred in concluding that the Workers' Compensation Board order precluded plaintiff from maintaining this action.

Reversed and remanded on appeal; affirmed on cross-appeal.

[3] To be "available," within the meaning of ORS 659.415, the former position must be "existing and vacant." *Knapp v. City of North Bend*, 304 Or 34, 37, 741 P2d 505 (1987).

[4] Plaintiff did not allege in his complaint that his former position was unavailable and that defendant failed to reinstate him to another "available and suitable" position. *See* ORS 659.415(1).

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

SPURGEON,
Appellant,
v.
STAYTON CANNING COMPANY
COOPERATIVE, INC.
Respondent.
(153,182; CA A42329)

Appeal from Circuit Court, Marion County.

Richard D. Barber, Judge.

Argued and submitted October 28, 1987.

Barbara J. Diamond, Portland, argued the cause for appellant. With her on the briefs were Henry H. Drummonds, Paul B. Gamson and Kulongoski, Durham, Drummonds & Colombo, Portland.

David H. Wilson, Jr., Portland, argued the cause for respondent. With him on the brief was Bullard, Korshoj, Smith & Jernstedt, P.C., Portland.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

NEWMAN, J.

Reversed and remanded.

NEWMAN, J.

Plaintiff appeals a judgment for defendant, her former employer, granted on the parties' cross motions for summary judgment. Plaintiff sued for reinstatement and damages, claiming that defendant had unlawfully refused to reinstate her after she had recovered from a compensable injury, ORS 659.415, and had discriminated against her because she had filed a workers' compensation claim. ORS 659.410. She assigns as errors that the court held that she was not entitled to reinstatement and that defendant did not discriminate against her and that it granted defendant's motion for summary judgment and denied her motion for summary judgment. She challenges the court's findings:

> "[T]he discharge of plaintiff was due to her disobedience of a call-in rule, and there is no evidence that there was any illegal motive in so discharging her. There is no connection between her discharge, and the fact that she filed a worker's compensation claim.
>
> "There was no discrimination under the statute.
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> "[T]he reinstatement statute is not operative to benefit plaintiff, inasmuch as she was discharged for reasons not connected with her injury or with her medical claim."

We reverse.

There is no dispute but that plaintiff sustained a

compensable injury and received workers' compensation benefits during a three-month period of disability. Defendant's employment rules required an employe to call in every week if she were absent due to an injury or other medical reason. The rules specified that, if an employe did not call in for a period of 10 days, she would be deemed to have abandoned her right to return to work.[1] Although plaintiff called in frequently before her doctor released her to return to work, she failed on one occasion to call in for more than 10 days and was discharged. Subsequently, her doctor released her for work, and she asked

defendant for reinstatement. Defendant refused, because she had been discharged.

Plaintiff argues that she, not defendant, is entitled to summary judgment because, as a matter of law, defendant could not discharge her for her failure to comply with the call-in requirement *before* her doctor had released her to return to work. First, she asserts that, as a matter of law, call-in rules for "pre-release" injured workers violate ORS 659.410 and ORS 659.415. She relies on OAR 839-06-130(2), which states:

> "At the time of the injured worker's demand for reinstatement/reemployment, the injured worker's former job or a suitable alternative may not be available. When this occurs, the injured worker must follow the employer's non-discriminatory and written reporting policy which has been effectively made known to the employer's workforce and is practiced by the employer, until the employer offers the injured worker his/her former job or a suitable alternative. If the employer has no such reporting policy, the injured worker must inform the employer of any change in his/her address and telephone number within ten days of the change."

She argues that, because the rule requires an employe to follow either the employer's reporting policy or one prescribed by the rule *after* having made demand for reinstatement, it prohibits an employer from requiring the worker to call in *before* being released to return to work. We disagree. The rule does not state that an employer cannot require injured workers to follow a call-in policy before being released for work.

Moreover, OAR 839-06-150(2) specifies that an injured worker can lose reinstatement rights under ORS 659.415 if:

> "(a) The employer discharges the worker for reasons not connected with the injury and for which others are or would be discharged, except as provided in subsections (3)(a) and (b) of this rule;
>
> "* * * * *
>
> "(d) The worker fails:
>
> "* * * * *
>
> "(B) To follow the employer's reporting policy or, in the absence of such policy, these rules reporting policy [sic]."

Both OAR 839-06-130(2) and OAR 839-06-150(2) recognize

[1] Employer's rule states:

"Call the Personnel Office *once every week* to report your status. Call at the times established by your plant. If a period of ten (10) days elapses without you having contacted the designated company representative, then you will be considered to have abandoned your right to be returned to work." (Emphasis in original.)

an employer's right to establish a reporting policy for its employes, but the policy may not discriminate against injured workers. ORS 659.410. If the employer does not have an applicable policy, OAR 839-06-130(2) simply sets minimum standards that the worker must meet.

Alternatively, plaintiff argues that, if defendant can enact a pre-release call-in policy, its policy is illegal as a matter of law, because it is "unreasonable" and was not "tailored to impinge as little as possible on an employe's statutory right to reinstatement." She contends that an unreasonable rule contravenes legislative policy to return injured workers to the job. Neither ORS 659.410, ORS 659.415 nor any Oregon case requires that an employer's personnel policies meet a "reasonableness" test. Rather, ORS 659.410 prohibits discriminatory treatment of injured workers.[2] Likewise, an employer's obligation to reinstate an injured worker does not depend on "reasonableness." If the worker recovers and demands reinstatement, the employer's obligation continues until the employe is reinstated or the right is otherwise extinguished. In a case where the worker has previously been terminated for failure to follow the employer's non-discriminatory call-in requirement, the worker is not entitled to reinstatement under ORS 659.415.[3] OAR 839-06-150(2); *see also Vaughn v. Pacific Northwest Bell Telephone,* 289 Or 73, 611 P2d 281 (1980).

Plaintiff also argues that she is entitled to summary judgment, because, as a matter of law, defendant's rule has an adverse impact on persons who have sustained on the job

injuries. A plaintiff may make a *prima facie* showing of discrimination by establishing that, regardless of the employer's motive or intent, an employer's facially neutral employment rule has the effect of screening out members of a protected class at a significantly higher rate than others. *See* OAR 839-05-020. Plaintiff, however, has made no such showing here. She argues that defendant's call-in policy had an adverse impact on workers who had sustained compensable injuries, because 50 were discharged during 1983-84 for violation of the call-in rule, as compared to 15 employes on medical leave terminated during the same period for the same violation. By themselves, those facts do not show whether defendant terminated injured workers in a different proportion than others. Accordingly, the court did not err when it denied summary judgment to plaintiff.

[2] ORS 659.410 provides:

"It is an unlawful employment practice for an employer to discriminate against a worker with respect to hire or tenure or any term or condition of employment because the worker has applied for benefits or invoked or utilized the procedures provided for in ORS 656.001 to 656.794 and 656.802 to 656.807, or of 659.400 to 659.435 or has given testimony under the provisions of such sections."

[3] ORS 659.415 provides:

"(1) A worker who has sustained a compensable injury shall be reinstated by the worker's employer to the worker's former position of employment upon demand for such reinstatement, provided that the position is available and the worker is not disabled from performing the duties of such position. If the former position is not available, the worker shall be reinstated in any other position which is available and suitable. A certificate by a duly licensed physician that the physician approves the worker's return to the worker's regular employment shall be *prima facie* evidence that the worker is able to perform such duties."

Plaintiff argues that, even if she is not entitled to summary judgment, defendant is not either, because there is a genuine issue of material fact whether she was disabled from calling in when required because of pain and depression that her medication caused. It is not disputed that she did not tell defendant, either at the time when it discharged her, when she was fully recovered and asked to be reinstated or at any intervening time, that she had been disabled from calling in. Nothing on the record shows that defendant had reason to know that plaintiff could not call in.[4] On this record, therefore, it is not material to the propriety of defendant's decision not to reinstate plaintiff whether she was disabled from calling in.

Plaintiff also asserts that the court erred in granting defendant summary judgment, because there is a genuine issue of whether defendant's motive in discharging her was that she sustained a compensable injury. Defendant's motive in terminating plaintiff is material to her claim under ORS 659.410. *See Palmer v. Central Oregon Irrigation Dist.*, 91 Or App 132, 137, 754 P2d 601 (1988). She testified by deposition that a supervisor told her that

> "the [call-in] policy was set up to terminate people, that 90 percent that were on disability—10 percent were reviewed, and the others were to be terminated."

She also testified that a clerical employe of defendant who had access to employe claims told her that "the policy was set up to terminate people when they are on disability." The clerical worker denied making that statement, and the supervisor denied that, when he spoke with plaintiff, he had told her that the purpose of the rule was to terminate injured employes. He suggested that plaintiff had misunderstood him and that he had merely told her that defendant terminated the great majority of workers who violated the call-in rule. Defendant also asserts that its rule is part of a comprehensive plan to return injured workers to the job as soon as possible and contends that the evidence offered by plaintiff is not probative on the issue of motive.

A factfinder could infer from the evidence a) that defendant enacted its rule to terminate injured workers, that plaintiff is an injured worker and a member of the class that ORS 659.410 protects and, on that basis, that defendant's motive was to terminate her because she had sustained a compensable injury; or b) that, regardless of defendant's reason for enacting its rule, it enforced it for the purpose of terminating plaintiff because she was an injured worker.[5] In any event, there is a genuine issue of fact as to defendant's motive in terminating plaintiff. An employer who terminates an employe for an unlawful reason cannot refuse the worker rein-

[4] Plaintiff does not assert that she told defendant that she did not call in because she was disabled. She states that she told her doctor to call defendant, but she admits that she does not know if he called and she did not ask defendant's employes whether they had received his call. The doctor does not recall whether he made a telephone call. Defendant denies receiving any call from him.

[5] On remand, plaintiff is not limited to the evidence or inferences discussed here. She may present evidence that shows that defendant terminated her because she was an injured worker. Similarly, plaintiff is not limited on remand to the evidence which she produced in the summary judgment proceeding on any of the other issues in the case.

statement on the basis that she has forfeited her rights under ORS 659.415. *See Williams v. Waterway Terminals Co.*, 298 Or 506, 693 P2d 1290 (1985). Accordingly, the court erred when it awarded summary judgment to defendant.

Reversed and remanded.

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)

On remand from the Oregon Supreme Court, *North Clackamas School Dist. v. White,* 305 Or 48, 750 P2d 485, *modified* 305 Or 468, 752 P2d 1210 (1988).

Judicial Review from Workers' Compensation Board.

Submitted on remand May 27, 1988.

Jerald P. Keene and Roberts, Reinisch & Klor, P.C., Portland for petitioner - cross-respondent.

Donald E. Beer and Galton, Popick & Scott, Portland, for respondent - cross-petitioner.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

PER CURIAM

Affirmed.

PER CURIAM

This case is on remand from the Supreme Court for determination of whether insurer's denial of the need for further medical care for claimant's hip condition was proper. *North Clackamas School Dist. v. White,* 305 Or 48, 750 P2d 485, *modified* 305 Or 468, 752 P2d 1210 (1988). In our previous opinion, 85 Or App 560, 737 P2d 649 (1987), we reversed the Workers' Compensation Board and held that claimant's medical benefits claim was barred by *res judicata.*

After *de novo* review of the record, we conclude that claimant's need for medical treatment for her hip condition is related to her industrial accident and is compensable.

Affirmed.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Gabino O. Orozco, Claimant.

OROZCO,
Petitioner,

v.

U&I GROUP, INC.,
Respondent.

(WCB 85-10736; CA A46716)

Judicial Review from Workers' Compensation Board.

Argued and submitted July 18, 1988.

Kenneth D. Peterson, Jr., Hermiston, argued the cause and filed the brief for petitioner.

Janet Schroer, Portland, argued the cause for respondent. On the brief were Ridgway K. Foley, Jr., P.C., and Schwabe, Williamson & Wyatt, Portland.

Before Warden, Presiding Judge, and Van Hoomissen and Graber, Judges.

PER CURIAM

Reversed and remanded for reconsideration. *Armstrong v. Asten-Hill,* 90 Or App 200, 752 P2d 312 (1988).

PER CURIAM

The petition for review in this workers' compensation case was filed on December 4, 1987. We therefore review for substantial evidence. *Armstrong v. Asten-Hill Co.,* 90 Or App 200, 752 P2d 312 (1988). The referee's order and the Board's order, which affirmed it without comment, are not adequate for judicial review. *Armstrong v. Asten-Hill Co., supra,* 90 Or App at 205.

Reversed and remanded for reconsideration.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Harold Turner, Claimant.

INTERNATIONAL PAPER COMPANY,
Petitioner,

v.

TURNER et al,
Respondents.

(WCB 83-09731; 84-02465; CA A39913)

Judicial Review from Workers' Compensation Board.

On respondent SAIF's and respondent Bohemia, Inc.'s motion for reconsideration filed May 26, 1988, and petitioner International Paper's petition for review filed May 31, 1988. Former opinion filed May 11, 1988, 91 Or App 91, 754 P2d 589.

Linda DeVries Grimms, Assistant Attorney General, Salem, Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem, for respondents on motion for reconsideration.

Paul L. Roess, Coos Bay, and Foss, Whitty & Roess, Coos Bay, for petitioner's petition for review.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

PER CURIAM

Reconsideration on petition for review denied; respondent's motion for reconsideration allowed; opinion modified and adhered to as modified.

PER CURIAM

International Paper Co. has filed a petition for review and SAIF and Bohemia, Inc., have filed a motion for reconsideration of our opinion. 91 Or App 91, 754 P2d 589 (1988). We deny reconsideration on the petition. We allow reconsideration on the motion for the purpose of modifying our opinion by expressly finding that claimant's present disability is due to an aggravation of a compensable injury which he suffered while he was employed by International Paper. The additional benefits due under our former opinion are payable by International Paper.

Reconsideration on petition for review denied; motion for reconsideration allowed; opinion modified and adhered to as modified.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Mary V. Scholl, Claimant.

STATE ACCIDENT INSURANCE FUND CORPORATION et al,
Petitioners,

v.

SCHOLL,
Respondent.

(WCB No. 84-13401; CA A42723)

Judicial Review from Workers' Compensation Board.

Argued and submitted February 5, 1988.

Christine Chute, Assistant Attorney General, Salem, argued the cause for petitioner. With her on the brief were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

James L. Edmunson, Eugene, argued the cause for respondent. With him on the brief were Karen M. Werner and Malagon & Moore, Eugene.

Before Warden, Presiding Judge, and Joseph, Chief Judge, and Van Hoomissen, Judge.

JOSEPH, C. J.

Affirmed.

JOSEPH, C. J.

SAIF seeks review of an award of permanent total disability, arguing that, because claimant has some physical capacity, it was error for the Board to excuse her from the requirement that she seek work. We affirm.

Claimant, age sixty-eight, worked in the 1930's as a seamstress and in the 1960's selling jewelry and household products. She had worked for employer for three years as a kitchen helper when she injured her back in 1978. Since that time she has not worked. The Board found:

> "Claimant is 68 years old with a 12th grade education. She has minimal work experience, a dull normal IQ and no transferable skills. Every doctor who examined claimant expressed the opinion that she was totally disabled except Dr. Pasquesi, who rated her disability as moderate. Mr. McNaught, the vocational expert, testified that even assuming that Dr. Pasquesi's physical assessment of claimant was correct he would still conclude that claimant was unemployable. He further stated that considering claimant's impairment and the other vocational factors that it would be futile for her to look for work. Based on our review of the record, we disagree with the referee's conclusion that claimant was not motivated to return to work and find that it would have been futile for her to have sought employment."

SAIF concedes that claimant is entitled to 100 percent unscheduled permanent disability, based on a combination of physical, social and vocational factors. Nonetheless, it argues that a claimant who seeks odd-lot permanent *total* disability should never be excused from the requirement of ORS 656.206(3) to prove that reasonable efforts have been made to seek employment. Under the odd-lot doctrine, even though a disabled person may be capable of performing work of some kind, she may still be totally disabled due to a combination of medical and non-medical considerations. *SAIF v. Simpson*, 88 Or App 638, 641, 746 P2d 257 (1987), *rev den* 305 Or 273 (1988); *Welch v. Banister Pipeline*, 70 Or App 699, 701, 690 P2d 1080 (1984), *rev den* 298 Or 470 (1985).

SAIF maintains that claimant actually retired from the work force and, for that reason, failed to seek employment. A claimant has the burden of proving that she is willing to seek regular gainful employment and that she has made

reasonable efforts to obtain such employment. ORS 656.206(3). However, a claimant may be excused from that requirement if she can establish that the search would be futile. *SAIF v. Simpson, supra; Madaras v. SAIF*, 76 Or App 207, 208, 707 P2d 1302 (1985). The Board held that it would

have been futile for claimant to have sought work. On *de novo* review, we agree that her physical incapacity in conjunction with her non-medical disabilities made a search futile. *See Crumley v. Combustion Engineering*, 92 Or App 439, ___ P2d ___ (1988).

Affirmed.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Karen L. Hays, Claimant.

NEWPORT ELKS CLUB et al,
Petitioners,

v.

HAYS,
Respondent.

(WCB 84-08586; CA A42910)

Judicial Review from Workers' Compensation Board.

Argued and submitted December 21, 1987.

Craig A. Staples, Portland, argued the cause for petitioners. With him on the brief was Roberts, Reinisch & Klor, P.C., Portland.

Martin J. McKeown, Eugene, argued the cause and filed the brief for respondent.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

RICHARDSON, P. J.

Reversed; referee's order reinstated.

RICHARDSON, P. J.

Employer seeks review of an order of the Workers' Compensation Board which reversed the referee's decision upholding employer's "backup denial." The issue is whether employer proved that claimant made a material misrepresentation that induced the initial acceptance of the claim. We conclude that it did and reverse.

Claimant began working for employer as a bartender in 1980. On October 12, 1983, she filed a workers' compensation claim, alleging that she had sustained an industrial injury about ten months earlier, in December, 1982. Employer accepted the claim on October 28, 1983. Beginning in December, 1983, claimant saw a variety of doctors regarding back and arm symptoms and other complaints. On July 24, 1984, employer issued a partial denial for certain of the symptoms and treatments, but said:

> "Your neck, upper back and left shoulder injuries, only, remain accepted."

Claimant continued receiving medical treatments for ailments, including her neck, back and arm. On December 20, 1984, employer issued the "backup" denial that is at issue:

> "Recently there was a decision adopted by the Supreme Court which held that a denial could be retracted after 60 days had elapsed, if there was a showing of 'fraud, misrepresentation or other illegal activity.' Therefore, we are respectfully denying any further workers' compensation benefits in relation to your alleged December 15, 1982 injury, for the following factual, legal and other reasons listed below:
>
> " 'There was never any injury occurring to you on or about December 15, 1982, while in the employment of the Newport Elks.' "

Claimant requested a hearing on the denial. The factual issues litigated were whether the injury for which claimant sought benefits actually occurred and whether, if it did not, the claim itself was a misrepresentation that induced employer's acceptance and payment of benefits. The referee found that the injury did not in fact occur and that claimant had given misleading information to several of the physicians whom she had consulted regarding the cause of her symptoms. The Board, reversing the referee, concluded:

> "Accepting the Referee's findings of fact, including his assessment of the credibility of the witnesses, we conclude that the insurer has not established by a preponderance of the evidence that its acceptance was *based* upon fraud, misrepresentation or other illegal activity. The inconsistencies relied upon by the insurer to make its case arose in large part after the acceptance and could not have formed a basis for acceptance." (Emphasis in original.)

The referee made explicit findings that claimant and the witnesses that she called regarding the occurrence of the injury were not credible. On *de novo* review of the record, we concur in the referee's findings. There is no need to detail the evidence or the findings of fact; suffice it to say that we also find that the injury did not happen.

It follows that claimant's statements on the claim form and to her doctors that she sustained an injury were, at the least, misrepresentations of fact. In *Ebbtide Enterprises v. Tucker*, 303 Or 459, 738 P2d 194 (1987), the court held that, in order to support a backup denial, the employer or insurer must show that there was fraud or misrepresentation and that the acceptance decision could reasonably have been affected if the true facts had been known. The employer is not required to show that it in fact would have denied the claim with the correct information.

The Board focused here on information contained in medical reports about examinations and treatments that occurred after employer's acceptance of the claim. That information, the Board concluded, came at a time and concerned events after the acceptance and therefore could not have misled the employer in making the decision. The misleading event or statement was the claim itself. The information which later came to light, in the form of inconsistent histories given by claimant to the various doctors, was one of the bases for establishing the initial misstatement that an industrial injury had occurred. It requires no elaboration to conclude that

employer's acceptance could have been influenced by having the information that no industrial injury had occurred. Employer was entitled to issue the backup denial.

The next issue is whether the claim, now in denied status, is compensable. Claimant also made a claim for elective surgery to her lower back. Both of the claims are based on

the alleged injury which we have found did not occur; consequently, neither is compensable.

Reversed; referee's order reinstated.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Ellen Lankford, Claimant.

LANKFORD,
Petitioner - Cross-Respondent,

v.

COMMODORE CORPORATION et al,
Respondents - Cross-Petitioners.

(WCB 83-11629; CA A37173)

Judicial Review from Workers' Compensation Board.

Argued and submitted March 2, 1988.

James L. Edmunson, Eugene, argued the cause for petitioner - cross-respondent. With him on the brief were Karen M. Werner and Malagon & Moore, Eugene.

Michael Bostwick, Portland, argued the cause for respondents - cross-petitioners. On the brief were Bradley R. Scheminske and Davis, Bostwick, Scheminske & Lyons, Portland.

Before Warden, Presiding Judge, and Van Hoomissen and Graber, Judges.

WARDEN, P. J.

Reversed on petition and referee's award of permanent total disability benefits reinstated; affirmed on cross-petition.

WARDEN, P. J.

In this workers' compensation case, claimant was awarded permanent total disability (PTD) benefits by a determination order. Employer requested a hearing, contending that claimant's failure to seek employment as a respite care provider disqualified her from receiving PTD benefits under ORS 656.206(3). In a labor market survey made on behalf of employer by Columbia Rehabilitation Consultants, Inc. (CRC), respite care is "defined as 'adult sitting,' designed to give the primary care giver an interval of rest or relief." The referee approved the PTD award, holding that the respite care

position was not gainful and suitable employment within the meaning of ORS 656.206. Employer sought Board review. The Board held that claimant was not entitled to PTD benefits, because she unreasonably had refused to seek employment as a respite care provider. The Board then awarded her 100 percent unscheduled permanent partial disability benefits. She petitions for review of the Board order, seeking reinstatement of the referee's award of PTD benefits. On *de novo* review,[1] we reverse the Board and reinstate the referee's award.[2]

The only issue presented is whether claimant's failure to seek a respite care position disqualifies her from PTD status under ORS 656.206(3). Only CRC could identify any job which claimant ostensibly was capable of performing, and that was respite care. CRC found no other possible jobs or occupations for her, and employer apparently concedes that she is not otherwise employable. No other persons who evaluated her found *any* job or vocation for which she was qualified and physically able to perform. In September, 1981, Orthopedic Consultants was of the opinion that her "ability to work is decidedly limited" and that it would "be most difficult indeed to adjust this sixty-one year old woman to any gainful occupation, though at some time in the future an effort should be made."

In April, 1982, Dr. MacClosky wrote that he did not

think "that rehabilitation at [claimant's] present age and disability level is a realistic goal, and she is not particularly interested in it." In April, 1983, Dr. Medved, of the Callahan Center, found that "[t]he probability of finding something that she can do or give her a direction is pretty nil. I would think that she might be able to work in some special sheltered workshop." In May, 1983, the Field Services Division of the Workers' Compensation Department concluded that "there is no work claimant can perform" and that "there are no areas where [claimant] could be gainfully employed." In June, 1984, vocational consultant Casebier wrote that she "could not identify any vocational goal within [claimant's] physical limitation."

ORS 656.206(3) provides that a claimant seeking PTD benefits "must establish that [she] is willing to seek regular gainful employment and that [she] has made reasonable efforts to obtain such employment." The Board, as noted, denied claimant PTD status, because she unreasonably had refused to seek work as a respite care provider. However, the record does not demonstrate that respite care work is available on a regular basis. Two employers included in CRC's labor market survey indicated that "on occasion" they need persons for simple respite care. Another indicated that it had no positions available, because it lacked funding to expand its current program. Another employer in the survey required respite care workers to do light housekeeping and cooking, tasks that are beyond claimant's physical capabilities.[3] The response from

[1] Or Laws 1987, ch 884, § 12a, does not apply to this case, because the petition for review was filed on September 10, 1985. *See Armstrong v. Asten-Hill Co.*, 90 Or App 200, 205, 752 P2d 312 (1988).

[2] Because we reinstate the referee's award of PTD benefits, employer's cross-petition need not be addressed. We therefore affirm on the cross-petition.

[3] We disagree with the Board's finding that claimant currently performs those duties in caring for her ex-husband, because the record clearly indicates that she does not.

the other employer in the survey is ambiguous regarding the regularity of its respite care jobs. We therefore are not persuaded that the work qualifies either as "regular" gainful employment within the meaning of ORS 656.206(3), *see Wiley v. SAIF*, 77 Or App 486, 491, *rev den* 301 Or 77 (1986), or as permanent part-time work sufficient to avoid a finding of PTD. *See Pournelle v. SAIF*, 70 Or App 56, 60, 687 P2d 1134 (1984). That being so, claimant's failure to seek a respite care position does not disqualify her from PTD status. *See Crumley v. Combustion Engineering*, 92 Or App 439, ___ P2d ___ (1988).

Reversed on petition and referee's award of permanent total disability benefits reinstated; affirmed on cross-petition.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

ROBINSON,
Appellant - Cross-Respondent,
v.
SCHOOL DISTRICT NO. 1 et al,
Respondents - Cross-Appellants.
(A8410-05856; CA A43410)

Appeal from Circuit Court, Multnomah County.

Clifford B. Olsen, Judge.

Argued and submitted March 29, 1988.

Robert K. Udziela, Portland, argued the cause for appellant - cross-respondent. With him on the briefs were Daniel C. Dziuba and Pozzi, Wilson, Atchison, O'Leary & Conboy, Portland.

James N. Westwood, Portland, argued the cause for respondents - cross-appellants. With him on the brief were Jeffery B. Millner and Miller, Nash, Wiener, Hager & Carlsen, Portland.

Before Warden, Presiding Judge, and Joseph, Chief Judge, and Van Hoomissen, Judge.

WARDEN, P. J.

Affirmed on appeal and on cross-appeal.

WARDEN, P. J.

Plaintiff alleges, *inter alia*, that defendants committed an unlawful employment practice under ORS 659.420 and discriminated against her on the basis of her race, gender and handicap and in retaliation for filing a workers' compensation claim. Defendants counterclaimed for attorney fees under ORS 659.121. After a trial to the court, judgment was entered in favor of defendants on plaintiff's claims. Defendants' claim for attorney fees was denied. Plaintiff appeals and defendants cross-appeal. We affirm.

Plaintiff, now 38 years old, is a black woman who began working as a teacher for defendants in 1971. She has suffered from a degenerative condition in her hips since she was a child. By 1979, her hip condition had deteriorated to the point that a total left hip arthoplasty was required. In February, 1980, and again in February, 1981, plaintiff was injured at work when she was run into by students. The injuries aggravated her hip condition, but she was able to continue teaching. She did, however, miss the last three weeks of the 1981 school year due to the injuries.

Defendants assigned plaintiff as a "loaned executive" to the United Way from August to November, 1981. She then worked until June, 1982, for defendants in a non-teaching position in which she helped create programs to assist students who were low achievers. No funding was available for that position beyond June, 1982. Plaintiff then requested that defendants place her in another non-teaching position with no student contact. She filed this action in October, 1984, seeking damages for lost wages and benefits and for reinstatement with defendants. She was not, however, offered reemployment until July, 1985, when a position in defendants' teacher support center became available. Plaintiff worked in that position from October, 1985, until June, 1986, when she began working for the Bonneville Power Administration, and in August she notified defendants that she was voluntarily resigning from the teacher support center position.

We first address plaintiff's claim brought under ORS 659.420,[1] which provides, in pertinent part:

> "(1) A worker who has sustained a compensable injury and is disabled from performing the duties of the worker's former regular employment shall, upon demand, be reemployed by the worker's employer at employment which is available and suitable.
>
> "* * * * *
>
> "(4) Any violation of this section is an unlawful employment practice."

Subsection (1) unambiguously requires that, on demand of an injured employe, the employer *must* offer the employe a suitable job when it becomes available. *Carney v. Guard Publishing Co.*, 48 Or App 147, 152, 616 P2d 548, *modified on other grounds*, 48 Or App 927, 630 P2d 867, *rev den* 290 Or 171 (1980); *see* OAR 839-06-100 to 839-06-165. Here, it is undisputed that plaintiff was disabled from performing the duties of her former teaching position, that she demanded reemployment with defendants in an available and suitable position and that defendants had positions that were available. The issue presented is whether any of the available positions were "suitable" within the meaning of ORS 659.420.

In enacting ORS 659.400 to ORS 659.435 (the Act), "the legislature intended the fullest employment of handicapped persons which is compatible with the reasonable demands of the job." *Montgomery Ward v. Bureau of Labor,*

[1] Plaintiff's race and gender discrimination claims lack merit and require no discussion.

280 Or 163, 168, 570 P2d 76 (1977); *see* ORS 659.405.[2] The legislature authorized the Bureau of Labor and Industries to establish rules interpreting the Act, ORS 659.103(1)(e); under that authority, the Bureau has promulgated OAR 839-06-145, which provides, in pertinent part:

> "(1) ORS 659.415 and 659.420 require employers to reinstate/reemploy the injured worker in work that is suitable. * * * In determining whether a particular job offer is suitable[,] the [Civil Rights] Division will consider the employer's size, diversity, nature and pattern of job openings and whether the injured worker is qualified to perform the job. Qualified means:
>
> "(a) The injured worker meets minimum standards used by the employer in filling a job(s);
>
> "(b) The injured worker has previously done the job in an acceptable manner; or
>
> "(c) The injured worker would be qualified for the job with the same training given a new hire in an entry level position;
>
> "(d) The Division will consider the injured worker qualified if he/she meets one of these provisions unless the employer can offer evidence to show that the worker is, in fact, not qualified."

Although the term "suitable" is not a highly technical one requiring a high degree of deference to the Bureau's expertise, the rule does provide a practical interpretation of the statutory term. We find persuasive the Bureau's interpretation of the term. *See Knapp v. City of North Bend,* 304 Or 34, 41, 741 P2d 505 (1987).

On *de novo* review of the record,[3] *Wincer v. Ind. Paper Stock Co.,* 48 Or App 859, 864, 618 P2d 15 (1980); ORS 19.125(3), we find that the available jobs either required student contact, which plaintiff testified that she would not have accepted, or an advanced degree or certification beyond that held by plaintiff, so that plaintiff was not "qualified" under OAR 839-06-145(1). Furthermore, the testimony that those requirements *generally* could have been waived by defendants was not persuasive. For those reasons, we conclude that defendants had no "suitable" positions available to offer plaintiff. Defendants therefore did not violate ORS 659.420, and we affirm the judgment for defendants on that claim.

The trial court denied defendants' claim for attorney fees under ORS 659.121, which provides, in pertinent part:

---

[2] ORS 659.405 provides:

> "(1) It is declared to be the public policy of Oregon to guarantee handicapped persons the fullest possible participation in the social and economic life of the state, to engage in remunerative employment, to use and enjoy places of public accomodation, resort or amusement, and to secure housing accomodations of their choice, without discrimination.
>
> "(2) The right to otherwise lawful employment without discrimination because of handicap where the reasonable demands of the position do not require such a distinction, and the right to use and enjoy places of public accomodation, resort or amusement, and to purchase or rental of property without discrimination because of handicap, are hereby recognized and declared to be the policy of the State of Oregon to protect these rights and ORS 659.400 to 659.435 shall be construed to effectuate such policy."

[3] The 1987 amendment to ORS 659.121(2), providing for trial by jury, does not apply to this case. *See* Or Laws 1987, ch 822, § 1.

> "In any suit brought under this subsection, the court may allow the prevailing party costs and reasonable fees at trial and on appeal."

In *Payne v. American-Strevell, Inc.*, 65 Or App 265, 268, 670 P2d 1065 (1983), we denied the defendant's petition for attorney fees brought under the same statute, because we did not find the plaintiff's claims to be "frivolous, unreasonable or without foundation." We make the same finding here and affirm the trial court's denial of defendants' claim for attorney fees. On the same basis, we also deny defendants' request for attorney fees on appeal.

Affirmed on appeal and on cross-appeal.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of William R. Rose, Claimant.

CASCADE CORPORATION,
Petitioner - Cross-Respondent,

v.

ROSE,
Respondent - Cross-Petitioner,

and

CPP SECURITY SERVICE et al,
Respondents.

(WCB 84-12425, 84-09803; CA A41753)

Judicial Review from Workers' Compensation Board.

Argued and submitted December 16, 1987.

Jerald P. Keene, Portland, argued the cause for petitioner - cross-respondent. With him on the briefs was Roberts, Reinisch & Klor, P.C., Portland.

Robert K. Udziela, Portland, argued the cause for respondent - cross-petitioner. With him on the brief was Pozzi, Wilson, Atchison, O'Leary & Conboy, Portland.

Stephen R. Frank, Portland, argued the cause for respondents. With him on the briefs was Tooze, Marshall, Shenker, Holloway & Duden, Portland.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

DEITS, J.

Affirmed on petition and on cross-petition.

DEITS, J.

Cascade Corporation (Cascade) seeks review of a Workers' Compensation Board order, issued in an ORS 656.307 proceeding, holding it responsible for claimant's aggravation claim. Claimant cross-petitions for review of the

Board's reversal of the referee's award of insurer-paid attorney fees. On *de novo* review, we affirm.

In April, 1982, claimant suffered a compensable injury to his right knee while employed by Cascade. His treating physician, Dr. Wells, repeatedly advised that he undergo arthroscopic surgery, but Cascade denied the request for surgery. In June, 1984, during a hearing on claimant's appeal from an order awarding him no permanent partial disability for his knee, Cascade withdrew its denial of the surgery. Claimant was awarded 20 percent permanent partial disability for his knee.

In July, 1984, while employed by CPP Security System, claimant again injured his right knee. He was treated by Dr. Kiest, an orthopedic surgeon, who recommended arthroscopy, which is used as a diagnostic tool and for treatment. He performed the arthroscopy and a contemporaneous medial meniscectomy to repair a chronically torn medial meniscus. Both Kiest and Wells, who viewed a videotape of the procedure, concluded that the 1984 injury necessitated the arthroscopy for diagnosis but that the meniscectomy was related only to the condition which resulted from the 1982 injury. Kiest noted that it was "nearly criminal" that the arthroscopy had not been performed in 1982 at the time of claimant's earlier injury, because it could have improved his chronic condition and lessened his degenerative problems. Both doctors agreed that the 1984 injury had caused bleeding and bruising but that it was a separate injury which did not contribute to the degenerative condition of the knee. As explained by Kiest:

> "It is rare that we can be as exact as I was in this. If the cartilage tears occurred recently, and by that I'd mean within a six month period of time, why the joint surfaces around the cartilage are not beat up. The cartilage hasn't been flipping back and forth and tearing up the joint surfaces, and all you will see will be torn cartilage itself * * *. The presence of frayed cartilage indicates that it has been there for some period of

> time, and the presence of wearing on the joint surfaces indicates it's been there some period of time."

CPP Security denied the claim on August 21, 1984, asserting that Cascade was the responsible employer. Cascade denied responsibility contending that claimant had suffered a new injury, not an aggravation of his 1982 injury. CPP Security subsequently amended its denial to accept the knee condition solely for the internal bleeding and bruising as a non-disabling injury. Claimant filed requests for hearing on each of the denials. On December 5, 1984, the Workers' Compensation Department, under ORS 656.307, ordered that claimant be paid compensation and directed that a hearing be held to determine responsibility for his knee condition and to resolve all the issues.

The referee concluded that the 1982 and 1984 injuries were distinct enough that they could be segregated causally and for the purpose of assigning responsibility. Accordingly, he allocated to CPP Security responsibility for the 1984 injury, including the arthroscopy as a diagnostic procedure, six weeks of temporary total disability compensation and any

permanent disability compensation resulting from that injury that might be assessed on claim closure. The referee held Cascade responsible for the meniscectomy, any temporary disability compensation in excess of six weeks after July 21, 1984, and any permanent disability resulting from the aggravation that might be assessed on claim closure. He also awarded attorney fees of $750 from each insurer. The Board affirmed the referee's allocation of responsibility, rendered each attorney fee from $750 to $500 and reversed the portion of the order providing that the attorney fees were to be insurer-paid.

Cascade argues that, before his 1984 injury, claimant's right knee had stabilized and that the new injury necessitated the surgery. Therefore, Cascade contends, the "last injurious exposure" rule should apply and the Board's apportionment of liability was improper. Under that rule, in a successive injury context, if an on-the-job injury at a prior employment and a second injury at a later employment each materially contribute to a disability, the later employer is liable. However, as explained in *Boise Cascade Corp. v. Starbuck*, 296 Or 238, 675 P2d 1044 (1984):

> "The last injurious exposure rule is not intended to transfer liability from an employer whose employment caused a disability to a later employer whose employment did not. Once a worker proves that the disability is work-related, he or she need not prove that any one employment caused the disability. The rule accomplishes that and makes liable the last employer whose conditions of employment might have caused the disability. However, the rule does not prevent a worker from proving that an earlier employment caused the disability; nor does it prevent an employer from proving that the claimant's disability was caused by a different employment or that the disability did not arise from any work-related injury."

On *de novo* review, we find that claimant's 1984 injury at CPP Security did not independently contribute to his chronic degenerative knee condition. Rather, the condition resulted solely from his 1982 injury. The injuries are distinct enough that they can be segregated in terms of causation and responsibility. The Board properly apportioned responsibility for the two injuries. Accordingly, we affirm the Board's order.

Claimant cross-petitions for review of the Board's reversal of the referee's award of insurer-paid attorney fees, arguing that, before the ORS 656.307 order, his attorney provided services directed at overturning the denials of compensation and, therefore, attorney fees should be insurer-paid under ORS 656.386, which provides, in pertinent part:

> "(1) In all cases involving accidental injuries where a claimant finally prevails in an appeal to the Court of Appeals or petition for review to the Supreme Court from an order or decision denying the claim for compensation, the court shall allow a reasonable attorney fee to the claimant's attorney. In such rejected cases where the claimant prevails finally in a hearing before the referee or in a review by the board itself, then the referee or board shall allow a reasonable attorney fee. Attorney fees provided for in this section shall be paid by the insurer or self-insured employer.
>
> "(2) In all other cases attorney fees shall continue to be

paid from the claimant's award of compensation except as otherwise provided in ORS 656.382."

Attorney fees in workers' compensation cases may be awarded only as authorized by statute. *Forney v. Western States Plywood,* 297 Or 628, 686 P2d 1027 (1984). In *Petshow v. Farm Bureau Ins. Co.,* 76 Or App 563, 710 P2d 781 (1985), *rev den* 300 Or 722 (1986), we held that ORS 656.386(1) does not authorize attorney fees for a claimant in an ORS 656.307 proceeding if the claimant's participation is only nominal. Although claimant's attorney did initiate review of the claim denials and performed services important in obtaining an ORS 656.307 hearing, the statute does not authorize insurer-paid attorney fees for those services, and claimant had no more than a nominal role at the hearing.

Affirmed on petition and on cross-petition.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON
In the Matter of the Compensation of
Denise A. Kalakay, Claimant.

KALAKAY,
Petitioner,

v.

CITY OF EUGENE,
Respondent.

(WCB 86-08667; CA A46467)

Judicial Review from Workers' Compensation Board.

Argued and submitted July 22, 1988.

Roger Ousey, Eugene, argued the cause and filed the brief for petitioner.

William H. Walters, Portland, argued the cause for respondent. With him on the brief were Brian B. Doherty and Miller, Nash, Wiener, Hager & Carlsen, Portland.

Before Warden, Presiding Judge, and Van Hoomissen and Graber, Judges.

PER CURIAM

Affirmed.

PER CURIAM

In this workers' compensation case, employer issued a denial of compensability of psychotherapy for claimant on March 12, 1985. The denial was received by claimant's roommate before March 25 at the correct address at the time for claimant and her roommate. Claimant did not personally receive the notice of denial. She filed a request for hearing on June 23, 1986, which the referee dismissed with prejudice because it was untimely filed. The Board affirmed the referee without comment, and claimant seeks review. We affirm. *Anderson v. EBI Companies,* 79 Or App 345, 349, 718 P2d 1383, *rev den* 301 Or 445 (1986).

Affirmed.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
John W. Benninger, Claimant.

BENNINGER,
Petitioner,

v.

WEYERHAEUSER COMPANY,
Respondent.

(WCB 86-12595; CA A46237)

Judicial Review from Workers' Compensation Board.

Argued and submitted June 13, 1988.

Karsten H. Rasmussen, Eugene, argued the cause for petitioner. With him on the brief was Eveleen Henry, Eugene.

Chess Trethewy, Salem, argued the cause for respondent. On the brief were Paul J. De Muniz, and Garrett, Seideman, Hemann, Robertson & De Muniz, P.C., Salem.

Before Richardson, Presiding Judge, and Newman, Judge, and Riggs, Judge pro tempore.

PER CURIAM

Reversed and remanded for reconsideration.

PER CURIAM

In this workers' compensation case, we review for substantial evidence. *Armstrong v. Asten-Hill Co.,* 90 Or App 200, 752 P2d 312 (1988).

The referee held, on the basis of detailed findings of fact, that claimant's lower back condition was compensable as a material worsening of a 1985 on-the-job injury. On *de novo* review, the Board reversed. The Board's order is inadequate for judicial review. Although the order concludes that claimant's condition is the result of an off-the-job injury, it contains inadequate findings or explanation to support that conclusion. "When the Board reverses, adequate judicial review requires specific findings in the Board's opinion substantiating its contrary conclusion." *Johnston v. James River Corporation,* 91 Or App 721, 756 P2d 696 (1988).

Reversed and remanded for reconsideration.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Gene M. Clarke, Claimant.

CLARKE,
Petitioner,

v.

LITTLE W LOGGING et al,
Respondents.

(WCB Nos. 85-14249 and 85-07940; CA A43590)

Judicial Review from Workers' Compensation Board.

Argued and submitted January 11, 1988.

James L. Edmunson, Eugene, argued the cause for petitioner. With him on the brief were Karen M. Werner and Malagon & Moore, Eugene.

E. Jay Perry, Eugene, argued the cause for respondents Little W. Logging and Liberty Northwest Insurance Co.

John A. Reuling, Jr., Assistant Attorney General, Salem, argued the cause for respondents Blue Mountain Forest Products and SAIF Corporation. With him on the brief were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General.

Before Joseph, Chief Judge, and Van Hoomissen and Graber,* Judges.

JOSEPH, C. J.

Reversed and remanded with instructions to enter order holding Blue Mountain and SAIF responsible.

* Graber, J., *vice* Warden, P. J.

JOSEPH, C. J.

Claimant seeks review of a Workers' Compensation Board order which affirmed the referee's determination that claimant had suffered a new injury at his last employment, Little W Logging (Little). The Board also found that the claim was untimely filed and denied benefits. Claimant contends that he has suffered an aggravation of a previous injury and that the previous employer, Blue Mountain Forest Products (Blue Mountain), is responsible. We agree with claimant and reverse.

Claimant first compensably injured his back on June 8, 1984, while logging for Blue Mountain. SAIF accepted the claim. He returned to work briefly in July, 1984, but stopped because of pain. Dr. White, claimant's treating physician, stated that he could not return to his former occupation. He was not found to be medically stationary until October, 1984, when he was examined by Orthopaedic Consultants. He received an award of five percent unscheduled permanent partial disability, which was later increased to twelve and one-half percent. After the original injury, claimant received con-

tinuous medical treatment, except for two months just before a June 26, 1985, visit to a chiropractor. He experienced no problems while working as a choker setter for two days in March or April, 1985.

Claimant did not work again until he began choker setting for Little. He had worked two to three hours when he slipped off a log and "jammed" his knee. He returned to work after the knee improved, but then his back became painful. He told his supervisor that he felt unable to continue working. He saw a chiropractor, Dr. Paradis, that day. Paradis stated that claimant's condition was the same one that he had treated before and that the incident at Little had contributed to and aggravated the *symptoms* of his low back problem. Orthopaedic Consultants examined claimant and found that he had suffered a symptomatic aggravation without any objective worsening of his back problem.

Claimant contends that he suffered an aggravation of his back injury and that SAIF, as the carrier for Blue Mountain, should compensate him. Further, he contends that, if he suffered a new injury at Little, his claim was filed timely, because he gave notice of the incident to his supervisor. Blue

Mountain argues that Little would be liable for a new injury if the claim had been filed in a timely manner. Little claims that Blue Mountain is responsible, because there is no evidence, except for claimant's testimony, that the fall at Little occurred and, even if it did, it did not independently contribute to a worsening of claimant's condition.

Although no one saw claimant fall, the referee found claimant's testimony, together with Paradis' conclusion that something had worsened claimant's symptoms, sufficient to prove that the Little incident had occurred. The referee found claimant credible, and we defer to that finding. *Havice v. SAIF,* 80 Or App 448, 452, 722 P2d 742 (1986).

The next question is whether the fall independently and materially contributed to a worsening of claimant's disability, which would constitute a new injury. Because we find that it did not, we need not discuss whether his new injury claim was filed in a timely manner.

After claimant first injured his back, he received chiropractic treatments until two months before the 1985 incident. He continued to have back pain after the 1984 claim was closed. Both Orthopaedic Consultants and Paradis stated that they thought that claimant had suffered an "aggravation" of the back condition. There is no evidence, however, that claimant's work at Little, including the fall, contributed independently to a worsening of his disability. Therefore, Blue Mountain remains the responsible employer. *SAIF v. Phipps,* 85 Or App 436, 438, 737 P2d 131 (1987); *Hensel Phelps Const. v. Mirich,* 81 Or App 290, 294, 724 P2d 919 (1986).

Reversed and remanded with instructions to enter an order holding Blue Mountain and SAIF responsible.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Lawrence W. Miller, Claimant.
LIBERTY NORTHWEST INSURANCE CORP.,
Petitioner,
v.
MILLER et al,
Respondents.
(WCB 86-09172, 86-09651; CA A46110)

Judicial Review from Workers' Compensation Board.

Argued and submitted June 24, 1988.

Phillip Nyburg, Roseburg, argued the cause and filed the brief for petitioner.

Darrell E. Bewley, Assistant Attorney General, Salem, argued the cause for respondent SAIF Corporation. With him on the brief were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

Elton T. Lafky, Salem, waived appearance for respondent Miller.

Before Warden, Presiding Judge, and Deits and Graber, Judges.

GRABER, J.

Reversed and remanded for reconsideration.

Warden, P. J., dissenting.

GRABER, J.

Liberty Northwest Insurance Corp. (Liberty) seeks review of an order of the Workers' Compensation Board that affirmed the referee's order. That order directed Liberty to accept, and approved SAIF's denial of, the claim. The sole issue is responsibility. On review for substantial evidence and errors of law, ORS 656.298(6), we reverse and remand.

On June 14, 1983, claimant compensably[1] injured his back while working for Bohemia, Inc., which was then insured by SAIF. He was off work for a short time. He returned to his job in February, 1984, but experienced more pain and missed more time from work. His back was treated conservatively and showed some improvement. Liberty replaced SAIF as Bohemia's insurer on July 1, 1984. In July, 1985, claimant returned to work for Bohemia, but the pain in his back gradually increased. It was bothering him so much by February 23, 1986, that he could no longer continue working.

Claimant filed a new claim, which both SAIF and Liberty denied, even though both insurers agreed that the claim was compensable. The referee and the Board concluded

[1] The parties, the referee, and the Board appear to agree, but do not explicitly state, that the 1983 injury was compensable.

that Liberty was responsible. Liberty argues on review that the referee and the Board failed to apply the correct legal analysis. We agree.

Liberty is responsible only if claimant's employment after July 1, 1984, independently contributed to a worsening of his condition. *Boise Cascade Corp. v. Starbuck*, 296 Or 238, 244, 675 P2d 1044 (1984); *Hensel Phelps Const. v. Mirich*, 81 Or App 290, 294, 724 P2d 919 (1986). Here, however, the referee and the Board applied only the second part of the test, that is, whether there was a worsening of the claimant's underlying back condition.[2] Accordingly, we remand to the

Board for application of the correct legal standard. *See* ORS 656.298(6); ORS 183.482(8).

Reversed and remanded for reconsideration.

WARDEN, J., dissenting.

The majority opinion correctly states the two requirements necessary to finding that Liberty is the responsible carrier: "if claimant's employment after July 1, 1984, independently contributed to a worsening of his condition." 93 Or App at 40. The majority then asserts, however, that neither the referee nor the Board considered the first requirement. The record indicates otherwise.

The February 13, 1987, referee's opinion held that claimant's underlying condition had worsened since July 1, 1984; that was based on medical reports from Dr. Warner. The referee states that he places more weight on Warner's opinion than on other medical testimony, because Warner is claimant's treating physician. His findings of fact also quote Warner:

> "There can be no question that since July 1984, his work subsequent to that time has indeed significantly contributed to his underlying condition and his current need for treatment and current time loss. He was performing job duties that were, in my opinion, beyond his ability recently in an effort to stay employed. There can be no question that these job duties have worsened his underlying condition."

Quotation of Warner's statements on worsening makes little sense unless he also adopted Warner's quoted opinion on causation. His opinion suggests no alternate explanation, and he expressly relied on Warner's opinion. Therefore, I would conclude that the referee addressed both requirements and made adequate findings on both. I would affirm the Board's affirmance of the referee, and I therefore dissent.

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[2] The dissent points out, correctly, that the *findings of fact* that the referee made and that the Board adopted *would* support a conclusion that claimant's employment after July 1, 1984, independently contributed to his condition. Neither the Board nor the referee, however, actually drew any conclusion about independent contribution from those findings or articulated any reasons why they would support such a conclusion. *See McCann v. OLCC*, 27 Or App 487, 503, 556 P2d 973, *rev den* (1977). That being so, the order is deficient, because we are not free to supply necessary conclusions that the Board has failed to make. *Armstrong v. Asten-Hill Co.*, 90 Or App 200, 752 P2d 312 (1988).

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Ernest E. Thompson, Claimant.

THOMPSON,
Petitioner,

v.

WEYERHAEUSER COMPANY,
Respondent.

(WCB 85-07828; CA A44762)

Judicial Review from Workers' Compensation Board.

Argued and submitted May 16, 1988.

Michael R. Stebbins, North Bend, argued the cause for petitioner. With him on the brief was Hayner, Stebbins & Coffey, North Bend.

Paul L. Roess, Portland, argued the cause for respondent. With him on the brief was Acker, Underwood & Smith, Portland.

Before Warden, Presiding Judge, and Graber, Judge, and Riggs, Judge pro tempore.

RIGGS, J., pro tempore.

Reversed in part and remanded to determine extent of disability; otherwise affirmed.

RIGGS, J., pro tempore

The issue in this workers' compensation case is the extent of claimant's left shoulder disability. The referee concluded that claimant had failed to prove that his Weyerhaeuser employment had caused his present shoulder disability, because "his subsequent employment [with a different employer] contributed independently to his present shoulder condition."[1] The Board affirmed the referee's order. On reconsideration, the Board explained that it had not affirmed on the basis of responsibility, but on the basis that claimant had failed to prove that there was "a material causal connection between his shoulder disability and his compensable injury." We review *de novo*[2] and reverse in part.[3]

[1] The parties argue about the applicability of *Runft v. SAIF*, 303 Or 493, 739 P2d 12 (1987), which was decided almost a year after the referee rendered his opinion and order in this case. In *Runft*, the court held that an employer's failure to involve a later employer prevents the former employer from using the last injurious exposure rule to avoid responsibility for a compensable injury. 303 Or at 504. Here, however, the issue is the extent of an accepted claim, rather than responsibility. Presumably for that reason, neither claimant nor Weyerhaeuser joined a later employer to the proceedings. *Runft* is simply inapposite.

[2] The petition for review in this case was filed on June 29, 1987. *See Armstrong v. Asten-Hill Co.*, 90 Or App 200, 205, 752 P2d 312 (1988).

[3] The Board also affirmed the referee's award of 15 per cent unscheduled low back disability. We affirm that portion of the order without discussion.

[4] Due to a series of events not relevant to our decision, the hearing concerning the extent of claimant's shoulder disability did not take place until February, 1986.

Claimant sustained injuries to his left shoulder, low back and left knee in April, 1980, while working for Weyerhaeuser. Those injuries were expressly accepted as compensable.[4] In early May, 1980, he saw Dr. Freudenberg, an orthopedist, complaining of pain in the left shoulder, especially in the anterior aspect. Freudenberg diagnosed bicipital tendinitis. He continued to treat claimant for his knee injury, but made no mention of the shoulder injury after a chart note dated May 19.

Claimant later saw Dr. Matteri, another orthopedist, and Dr. Bert, also an orthopedist, for knee and back problems. No mention was made of the left shoulder in the medical notes until May 22, 1984, when Matteri noted that claimant had complained about pain around the medial aspect of the scapula and tingling in two fingers. Matteri administered a

steroid on that date. His notes say that the shoulder problem "dates back to [claimant's] 1980 accident."

Claimant next sought treatment for his shoulder on October 23 and November 12, 1984, from Dr. Hearne, an internist. His chart notes indicate that claimant injured the shoulder in an industrial accident in April, 1984, and that later he had been seen by an orthopedist in Eugene. He diagnosed "[l]eft trapezius muscle pain, etiology unclear." He saw claimant again on August 20, 1985, when claimant was experiencing "left paracervical pain with radiation to the shoulder." He referred claimant to Dr. Bernstein, a neurologist, for further evaluation, noting that the symptoms were "suggestive of nerve root damage."[5]

In a letter to Hearne dated August 26, Bernstein noted that claimant's history was "complex," but cited only the April, 1980, injury. He diagnosed "[p]robable shoulder strain with a 'functional' thoracic outlet syndrome." Claimant saw Bernstein two more times in 1985. Bernstein testified by deposition that he believes that there is a causal connection between the 1980 injury and claimant's present shoulder problems. He also answered "yes," in writing, to the question whether claimant's physical limitations in 1986, including limitations on the use of his arms, were a result of the 1980 low back and shoulder injury to claimant's.

As noted, the Board found that claimant had failed to prove that his compensable injury at Weyerhaeuser caused his present shoulder disability. Employer argues that later work exposures are the cause. Although the question is close, we disagree with the Board and with employer[6] and find that

[5] Hearne later wrote that he could not remember the specifics of claimant's case and that the 1984 date in his chart notes may be a typographical error. He then suggested that Bernstein's records would likely be more accurate than his, because Bernstein performed a more comprehensive evaluation. Claimant testified that he was not employed in April and May, 1984. The referee expressly found that claimant was not injured in 1984, the Board affirmed, and we agree. We find that "1984" was a typographical error for "1980" in Hearne's chart.

[6] The time of events does not support employer as nicely as its argument would suggest. Claimant worked as a roustabout for a few months in late 1983; he reported no shoulder problems related to that work. His visit to Matteri, in which he complained of "some trouble with his left shoulder," came over six months after the end of the "roustabout" work. Claimant's work welding tailgates did not begin until several weeks *after* the complaint to Matteri. Thus, neither exposure excludes the 1980 injury as a material contributing cause of claimant's present shoulder disability.

claimant's 1980 injury is a material contributing cause of his present shoulder disability. ORS 656.214(5); *Destael v. Nicolai Co.*, 80 Or App 596, 600, 723 P2d 348 (1986).

Reversed in part and remanded to determine the extent of disability; otherwise affirmed.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Tony Fazzolari, Claimant.

FAZZOLARI,
Petitioner,

v.

UNITED BEER DISTRIBUTORS et al,
Respondents.

(WCB 85-16090; CA A45497)

Judicial Review from Workers' Compensation Board.

Argued and submitted April 1, 1988.

On petitioner's petition for reconsideration filed June 29, 1988. Remanded for proceedings not inconsistent with this opinion June 22, 1988, 91 Or App 592.

Randy G. Rice, Portland, for petition.

Before Buttler, Presiding Judge, and Warren and Rossman Judges.

WARREN, J.

Reconsideration allowed; former opinion adhered to.

WARREN, J.

Employer petitions for review of our opinion in *Fazzolari v. United Beer Distributors*, 91 Or App 592, 757 P2d 857 (1988). We treat the petition as a petition for reconsideration, ORAP 10.10, and allow reconsideration for the purpose of amplifying our opinion. Employer contends that we incorrectly stated that claimant did not return to work until after August 12, 1985, when, in fact, he returned to work immediately after he was released for work on March 22, 1985. We reviewed this matter under ORS 656.298(6) only for substantial evidence. Although there is some evidence to suggest that claimant returned to work when he was released for work in March, 1985, there is also evidence to support the referee's finding, which the Board affirmed, that claimant did not return to work until after August 12, 1985. We therefore adhere to our former opinion.

Reconsideration allowed; former opinion adhered to.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Lori G. Finch, Claimant.

FINCH,
Petitioner,

v.

STAYTON CANNING CO., et al,
Respondents.

(WCB No. 83-03809, 85-00155
& 85-13714; CA A42313)

Judicial Review from Workers' Compensation Board.

Argued and submitted December 23, 1987.

Edward J. Harri, Albany, argued the cause for petitioner. On the brief were J. David Kryger and Emmons, Kyle, Kropp, Kryger & Alexander, P.C., Albany.

Patric J. Doherty, Portland, argued the cause for respondent Stayton Canning Co. With him on the brief was Rankin, VavRosky, Doherty, MacColl & Mersereau, Portland.

Allan M. Muir, Portland, argued the cause for respondent Dave's U.S. Gas. With him on the brief were Christopher B. Rounds, Ridgeway K. Foley, Jr., P.C., and Schwabe, Williamson & Wyatt, Portland.

No appearance for respondent American States Insurance.

Jerald P. Keene, Portland, argued the cause for respondents Tom's Auto Body and National Surety Corp. With him on the brief was Roberts, Reinisch & Klor, P.C., Portland.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

NEWMAN, J.

Reversed and remanded to Board with instructions to determine responsibility and penalties.

NEWMAN, J.

Claimant seeks review of a Workers' Compensation Board order which affirmed the referee's order upholding the denials of compensability and refusing penalties for late denial by Tom's Auto Body (Tom's). The Board did not reach the issue of responsibility. We review *de novo,* hold the claim compensable and reverse and remand to the Board with instructions to determine the issues of responsibility and penalties.

For 13 days in November, 1982, claimant worked at Stayton Canning Company (Stayton) as a seasonal employe peeling onions. After a few days of work, she developed a

continuing pain at the base of her left wrist. She did not report the condition to her supervisor or seek medical attention then.

In December, 1982, claimant began to work at Dave's US Gas (Dave's) as a service station attendant. Her left wrist pain continued, although it did not worsen. On February 1, 1983, claimant consulted Dr. Ellison, who noted that "[s]he may have a little ulnar nerve irritation," and encouraged her to continue with normal activities, including work. Claimant filed a workers' compensation claim against Stayton, which it denied.

Claimant continued to work for Dave's until July, 1983. For a short time thereafter, she did light clerical work at a feed store in California. She returned to Oregon and, in November, 1983, she began to work for Tom's, sanding and masking cars. Claimant continued to experience pain and returned to Ellison in December, 1983. He ordered electrical studies, which revealed some medial entrapment of the wrist. In January, 1984, he diagnosed her condition as left carpal tunnel syndrome. He felt that her condition was medically stationary and not disabling and did not recommend surgical treatment.

In October, 1984, claimant filed a compensation claim against Dave's. At its request, Dr. Steele examined claimant in November, 1984. He diagnosed mild carpal tunnel syndrome but stated that it was medically stationary. He noted that the symptoms would probably recur if she "goes back to doing vigorous work with her left hand and wrist." He did not believe that claimant's work at Dave's contributed to

her condition, which he believed was precipitated by her job peeling onions at Stayton. Dave's denied the claim.

The referee consolidated the claims against Stayton and Dave's and held an initial hearing in June, 1985. At the employers' request, the referee continued the hearing for further evidence, principally to depose Ellison. Claimant then filed a claim against Tom's in July, 1985. Tom's denied it on December 17, 1985. At Tom's request, Dr. Nathan examined claimant. He also diagnosed mild carpal tunnel syndrome. He did not recommend surgery. He concluded that claimant's condition was idiopathic and that the work actvities had not aggravated it.

The referee consolidated all three claims and reopened the hearing in February, 1986, to determine compensability. He held that claimant's carpal tunnel syndrome was work-related but not compensable, because claimant had not yet lost time from work or required medical treatment other than diagnostic services. He did not reach the responsibility issue. He also held that, because no compensation was due, Tom's owed no penalties for late denial. Ellison's deposition was introduced into the record. The referee wrote:

> "I accept as true the testimony of Dr. Ellison that carpal tunnel syndrome is in itself merely a group of symptoms. The symptoms themselves are the disease, and without the symptoms there is no disease. * * * It is Dr. Ellison's opinion, with which I agree, that each symptomatic exposure permanently worsens the ability of the median nerve to get through the carpal tunnel unobstructed.

"It is Dr. Ellison's opinion, with which I agree, that initially, the symptoms started at Stayton Canning and therefore the disease started with work exposure at Stayton Canning. The symptoms increased at Dave's US Gas and therefore the disease worsened on a permanent basis, with the activity at Dave's US Gas. The symptoms further increased with the work exposure at Tom's Auto Body and thereby permanently worsened with the activity at Tom's Auto Body.

"Even with those findings, I do not believe that the claimant has shown a compensable disease. There will be no compensable carpal tunnel disease until such time as the claimant's work activities (or off the job activites) cause the claimant's condition to worsen to the point where she should

be taken off work or where surgery would be advisable. This has not yet happened.

"* * * * *

"In order for this to be a 'compensable injury' it must require medical services.

"While diagnostic services which are necessitated because of conditions which arise on the job * * * are medical services, all it does is entitle the claimant to have the diagnosis paid for by the employer.

"* * * * *

"[T]he only thing claimant is entitled to is payment for diagnostic services. There is no indication these services were not paid for by the various employers."

Claimant assigns as error that the Board affirmed the referee's ruling on compensability and penalties. She argues that, because she had shown that she had a work-related condition requiring medical services—either diagnostic or for treatment—she established a compensable claim. All three employers respond that claimant failed to prove the compensability of her claim, because it required no medical *treatment* and, therefore, presented only the "potential for a claim." Dave's and Stayton, relying on Nathan's opinion, also contend that claimant failed to prove that her carpal tunnel syndrome arose out of her employment. None of employers dispute the ruling of the referee that the symptoms are the disease.

We agree with the Board that the medical evidence in this record—and it is principally Ellison's extensive testimony—establishes that claimant's carpal tunnel syndrome was an occupational disease that her work at Stayton caused and that her employment both at Dave's and Tom's permanently worsened. We also find that her work was the major contributing cause of her disease. This case is unlike *AMFAC, Inc. v. Ingram*, 72 Or App 168, 694 P2d 1005 (1985), where the parties did not agree that the symptoms were the disease and the preponderance of the medical evidence established that the claimant had a pre-existing, asymptomatic carpal tunnel disease and that her work did not cause a worsening of that underlying condition.

The board erred, however, when it held that claim-

ant's occupational disease was not a compensable claim because it required only *diagnostic* medical services. ORS 656.005(8)(a) defines a compensable injury as "an accidental injury arising out of and in the course of employment requiring medical services or resulting in disability or death." As pertinent here, occupational diseases are considered "injuries." ORS 656.804; *Runft v. SAIF,* 303 Or 493, 498, 739 P2d 12 (1987). The statute does not define "medical services." *Former* ORS 656.005(8)(a) makes no distinction between diagnosis and treatment. If a claimant has symptoms and goes to a doctor, she ordinarily wants a diagnosis to learn what is wrong with her and what treatment, if any, is appropriate, and she wants treatment for relief from the disease. That no treatment is available for an injury or disease does not mean that a claimant is not injured or sick.

In *Brown v. SAIF,* 79 Or App 205, 717 P2d 1289, *rev den* 301 Or 666 (1986), the claimant was concerned about his health because he was exposed to asbestos at work. We held that he did not establish that he had a disease or was injured. In *Johnsen v. Hamilton Electric,* 90 Or App 161, 751 P2d 246 (1988), we held that, although the claimant had been exposed to asbestos, he did not have asbestosis or any other disease. In both *Brown* and *Johnsen,* we refused to hold compensable the claims for diagnostic medical services. In *Collins v. Hygenic Corp. of Oregon,* 86 Or App 484, 739 P2d 1073 (1987), however, the medical services, although only diagnostic, were required, because the claimant had suffered an injury and was entitled to know how badly he was hurt and if any treatment was appropriate. *See also Brooks v. D and R Timber,* 55 Or App 688, 692, 639 P2d 700 (1982). Similarly here, the diagnostic medical services are compensable because, on this record, claimant suffers from an occupational disease—carpal tunnel syndrome—and the medical services are required to determine what is wrong with her, even though no treatment is recommended.

Moreover, the referee assumed that an employer had paid for the diagnostic medical services and erroneously suggested that, therefore, the claim was not compensable. The test of compensability is whether the disease arises out of claimant's employment and requires medical services. ORS 656.802; *former* ORS 656.005(8)(a). To establish a compensable claim, claimant was not required to prove that none of her employers had paid for the services. Her claim for carpal tunnel syndrome is compensable.

It remains to be decided which employer is responsible and, if Tom's is responsible, whether it is liable for penalties for late denial. The medical evidence establishes that the disease started at Stayton and that work activities at both Dave's and Tom's worsened the underlying condition. The last injurious exposure rule for an occupational disease is applicable. Tom's also asserts, however, that the claim against it was untimely. Neither the referee nor the Board considered the issue of responsibility. Moreover, the Board's determination that no penalties were due from Tom's was, in the first instance, based on the erroneous ruling that the claim was not compensable.

Reversed and remanded to Board with instructions to determine responsibility and penalties.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Kathleen A. Overbey, Claimant.

OVERBEY,
Petitioner,

v.

KAISER HEALTH PLAN,
Respondent.

(WCB 86-05492; CA A42980)

Judicial Review from Workers' Compensation Board.

Argued and submitted January 22, 1988.

Ralph E. Wiser, III, Portland, argued the cause for petitioner. With him on the brief was Kulongoski, Durham, Drummonds & Colombo, Portland.

Craig E. Staples, Portland, argued the cause for respondent. With him on the brief was Roberts, Reinisch & Klor, P.C., Portland.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

NEWMAN, J.

Affirmed.

NEWMAN, J.

Claimant seeks review of a Workers' Compensation Board order that her compensation for temporary total disability (TTD) should be determined according to the parties'"intent at the time of hire," *former* OAR 436-60-020(4)(a), because at the time of her injury she was not "regularly employed" and had been employed less than four weeks. Claimant also assigns error to the Board's finding that she was not entitled to penalties and attorney fees. We affirm.

We review *de novo*. In October, 1985, claimant had an interview with Tomlinson, one of employer's supervisors, for an on-call radiology service clerk position. During the interview, claimant told Tomlinson that she was working 24 hours per week for Good Samaritan Hospital, but that, for financial reasons, she needed to work 40 hours per week. Tomlinson told claimant that, as a new employe in the on-call position, she would work 40 hours for two to three weeks during an orientation program but that he could not assure her of any specific number of hours of work thereafter. He told her that, as an on-call employe, she could continue to work for Good Samaritan and refuse work that employer offered to her without jeopardizing her position with employer. Tomlinson and claimant also discussed the availability of part-time employment at other facilities of employer. Claimant believed that she could work a total of 40 hours per week at various employer facilities after she completed the orientation program, although Tomlinson did not promise her such work.

Claimant knew that she would have to apply to the supervisor at each facility of employer to be hired at that facility.

In November, 1985, Tomlinson offered claimant the on-call radiology service clerk position. She accepted and resigned from her job at Good Samaritan. Tomlinson became her supervisor.

Claimant worked for five consecutive days during the first week of orientation. On the sixth day, she told employer that she had been injured on the fourth day of her employment. Employer accepted the workers' compensation claim. To determine her TTD, it applied *former* OAR 436-60-020(4)(a), which provided:

"The rate of compensation for workers employed with

unscheduled, irregular or no earnings shall be computed on the wages determined in the following manner:

"(a) Employed on call basis: Use average weekly earnings for past 26 weeks, if available, unless periods of extended gaps exist, then use no less than last 4 weeks of employment to arrive at average. *For workers employed less than 4 weeks use intent at time of hire as confirmed by employer and worker.*" (Emphasis supplied.)

It paid her TTD calculated on a 12-hour week, based on Tomlinson's estimate of the number of hours per week that claimant would work as an on-call employe after the orientation period ended. Claimant objected and contended that her TTD should be calculated based on a 40-hour work week. Employer reevaluated the claim and, on June 9, 1986, paid her TTD based on a re-estimate that she would work 16.15 hours per week, together with an amount to cover the difference for the period during which she had been underpaid.

The referee found:

"In this case claimant was regularly at work five days during the week in which she was injured. Her temporary total disability rate should be based upon her daily wage multiplied by five. To base the wage upon any other form of averages for other employees is not necessary and works to disadvantage claimant and flies in the face of the reality that she was regularly employed five days that week.

"I find that payment to her at a lesser rate was patently unreasonable. A penalty will be assessed.

"It is not necessary for me to reach the argument of intent of the parties as to how much time claimant would work in the on-call position. However, a review of the testimony leads me to conclude that claimant clearly had the impression that she could work 40 hours per week in this capacity. She was not so dissuaded by the employer even though she informed them of her desires."

The referee then ordered that employer pay TTD based on a 40-hour work week from the inception of the claim until closed. The referee also ordered that employer pay attorney fees and a penalty of 25% of the difference between the amounts that employer would have paid on the basis of a 40-hour work week and the amounts actually paid.

The Board reversed the referee's order. It ruled that

former OAR 436-60-020(4)(a) was applicable and that employer's method of calculating her compensation was reasonable under the circumstances. It found that the intent of the parties "most closely resembles" that to which employer testified, namely, that it "was to employ claimant first on a 40-hour work week for a limited orientation period, and thereafter on a schedule like that of other on-call employes, i.e., approximately 16 hours per week." It found that the parties intended that claimant's employment would be irregular. It recognized that claimant intended to work as many hours as possible but found that there was no evidence that she made arrangements with employer to work regularly 40 hours per week and that she knew that her hours would be irregular. It did not order that employer pay penalties or attorney fees.

Claimant argues that the Board's decision contravenes ORS 656.210(2):

> "(a) For the purposes of this section, the weekly wage of workers shall be ascertained by multiplying the daily wage the worker was receiving at the time of the injury:
>
> "(A) By 3, if the worker was regularly employed not more than three days a week.
>
> "(B) By 4, if the worker was regularly employed four days a week.
>
> "(C) By 5, if the worker was regularly employed five days a week.
>
> "(D) By 6, if the worker was regularly employed six days a week.
>
> "(E) By 7, if the worker was regularly employed seven days a week.
>
> "* * * * *
>
> "(c) As used in this subsection, 'regularly employed' means actual employment or availability for such employment. For workers not regularly employed and for workers with no remuneration or whose remuneration is not based solely upon daily or weekly wages, the director, by rule, may prescribe methods for establishing the workers' weekly wage."

She contends that ORS 656.210(2)(a)(C) applies to her, because she was "actually employed" and, therefore, "regularly employed" five days a week at the time of her injury. She argues that *former* OAR 436-60-020(4)(a), adopted pursuant

to ORS 656.210(2)(c), applied only where the worker is not "regularly employed" within the meaning of that section.

We find that, for the purposes of ORS 656.210(2)(a)(C), claimant was not "regularly employed" five days a week. In *Newkirk v. Curry Good Samaritan Center,* 90 Or App 208, 210, 751 P2d 1121 (1988), we found that an on-call employe injured during an orientation period was hired to work "irregular hours." We applied *former* OAR 436-60-020 to determine the claimant's TTD benefits. Here, as in *Newkirk,* the record shows that the parties intended that claimant's working hours would vary according to her availability and employer's needs. Accordingly, the Board did not err in finding that the parties intended that claimant's employment was

to be "irregular." Thus, the Board correctly concluded that *former* OAR 436-60-020(4)(a) applied and, because there is no dispute that claimant had been employed for less than four weeks, the parties' intent at the time of hire should govern the number of hours per week used to compute claimant's TTD.[1] We agree with the Board's finding of what the parties intended at the time of hire.

Claimant argues that the Board erred in deciding that she was not entitled to penalties and attorney fees for employer's "unreasonable computation of her time loss." 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."

Claimant, however, is not entitled to penalties or attorney fees. She does not contend that, if we find that she was not "regularly employed" five days a week, we should compute her TTD based on something other than a 16.15-hour work week. She argues, however, that employer should pay a penalty and attorney fees for the period during which employer paid her at the 12 hour rate, because it was a "guess" and, therefore, unreasonable. We disagree. The record reflects that Tomlinson made that estimate on the basis of his knowledge and experience in scheduling workers in that department for six years. We cannot say that it was unreasonable under the circumstances.

Affirmed.

[1] Not all employes who are designated as "on call" employes by their employers have "irregular" employment. In *Saiville v. EBI Companies*, 81 Or App 469, 472, 726 P2d 394, *rev den* 302 Or 461 (1986), we found that the claimant, an on-call employe, was "regularly employed" five days a week. He had worked five of the six days following the time he was hired until he was injured. However, that claimant was not employed during an orientation period at the time of injury, and the employer did not show that the claimant would have worked fewer than five days per week had he remained on the job.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of John D. Ellis, Claimant.

ELLIS,
Petitioner,
v.
McCALL INSULATION et al,
Respondents.

(WCB 85-03981; CA A43948)

Judicial Review from Workers' Compensation Board.

Argued and submitted January 13, 1988.

Karsten H. Rasmussen, Eugene, argued the cause for petitioner. On the brief was Steven C. Yates, Eugene.

Darrell E. Bewley, Assistant Attorney General, Salem, argued the cause for respondents. With him on the brief were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

DEITS, J.

Affirmed.

DEITS, J.

Claimant seeks review of a Workers' Compensation Board order which held that SAIF had issued a *de facto* denial of claimant's medical bills and that, therefore, the referee erred in ordering their payment.

Claimant suffered a compensable back injury in 1979 and was awarded 10 percent unscheduled disability in 1981. From the time of the injury, he received ongoing chiropractic care. SAIF paid for all of the treatments until January, 1985, when it paid for only two of eleven visits. In February, it paid for only two of twelve. After claimant changed chiropractors in July, 1985, no payments were made. SAIF never issued a formal denial and never advised claimant that the bills were no longer being paid. Claimant initiated this proceeding to require SAIF to pay the bills. SAIF defended by introducing evidence that the chiropractic treatments were not related to claimant's compensable injury.

The referee stated that, if the issues of the compensability and reasonableness of the medical services were before him, he would have ruled in SAIF's favor. However, he concluded that SAIF was obligated to pay the bills, because it had not properly denied responsibility for them. The Board reversed. It concluded that payment should not have been ordered because the continued treatments were not causally related to the injury and because SAIF had made a *de facto* denial.

An insurer is liable for medical services resulting from a compensable injury. ORS 656.245(1). If the insurer believes that the services are not reasonable and necessary, it can deny benefits for them. However, under ORS 656.262(6),[1] the claimant must be given written notice of a denial within 60 days after the employer has notice or knowledge of the claim, which in this instance would be the billing. Here, insurer did

not give written notice of denial to claimant; it simply refused to pay.

Both parties agree that there is no authority that SAIF's refusal to pay for medical services was a *de facto* denial. Claimant argues that SAIF's failure properly to deny the bill-

[1] 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."

ing requires that it pay for the medical services. Even assuming that each of the medical bills constituted a "claim," SAIF did not accept it, and its failure to accept or deny is not an acceptance under *Johnson v. Spectra Physics*, 303 Or 49, 733 P2d 1367 (1987), and *Richmond v. SAIF*, 85 Or App 444, 737 P2d 135, 87 Or App 401, 742 P2d 677, *rev den* 304 Or 547 (1987). On *de novo* review, we hold that the referee and Board properly concluded that claimant's continuing need for chiropractic services was not causally related to his compensable injury.

Claimant also requests penalties and attorney fees for SAIF's delay in denying the claim. However, even if the submission of the medical bills constitutes a claim, and SAIF was required to give written notice of acceptance or denial within 60 days under ORS 656.262(6), penalties can only be measured by "amounts then due." *Hutchinson v. Lousiana-Pacific Corp.*, 81 Or App 162, 724 P2d 894 (1986). In this case, there were no "amounts then due," because claimant's treatments were not related to his compensable injury.

ORS 656.262(10) allows the imposition of attorney fees if an insurer unreasonably delays or unreasonably refuses to pay compensation. *Mischel v. Portland General Electric*, 89 Or App 140, 747 P2d 410 (1987), *rev den* 305 Or 671 (1988). In the circumstances of this case, SAIF's refusal to pay and its delay were not unreasonable. *See Poole v. SAIF*, 69 Or App 503, 686 P2d 1063 (1984).

Affirmed.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Marvin C. Wright, Claimant.
and
In the Matter of the Complying Status of Theodore Bernards (dba Alderwood Homes), and Norman Bernards (dba Cascade Tractor and Implement Co.), Employers.
BERNARDS, dba Alderwood Homes,
Petitioner,
v.
WRIGHT et al,
Respondents.

(WCB 85-00868, 85-05797, 85-05798, 85-05799; CA A43730)

Judicial Review from Workers' Compensation Board.

Argued and submitted February 8, 1988.

Jerald P. Keene, Portland, argued the cause for petitioner Theodore Bernards. With him on the brief was Roberts, Reinisch & Klor, P.C., Portland.

Randy Elmer, Salem, argued the cause and filed the brief for respondent Marvin Wright.

Allan M. Muir, Portland, waived appearance for respondents Cascade Tractor and Implement Co., and Maryland Casualty Co.

No appearance for respondent Norman Bernards.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

DEITS, J.

Affirmed.

DEITS, J.

Petitioner seeks review of a Workers' Compensation Board order reversing a referee's decision which denied a claim for injuries sustained by claimant. On *de novo* review, we affirm.[1]

In August, 1984, petitioner asked claimant to assist him in painting the private residence of petitioner's brother, Norman Bernards, and the building that housed Bernards' business, Cascade Tractor and Implement Co. Claimant accepted the offer of work and petitioner agreed to pay claimant $8.00 per hour.[2] Petitioner provided all of the materials and equipment for the job, except that claimant used his pickup truck for transportation, including driving petitioner to the job site in the morning. He also used his own carpentry tools for the repair of a garage door on the residence.

On August 24, 1984, they began work on the residence. The next day, petitioner was unable to work on the project but instructed claimant to continue working on the Cascade Tractor building. They worked together on the Bernards' residence for the rest of the week. Claimant did not work for anyone else during that time. On August 27, 1984, claimant picked up petitioner in the morning. En route to the job site, they were involved in an automobile accident in which claimant was injured. Petitioner eventually paid claimant $232 for 29 hours of work, but did not withhold any amount for taxes or Social Security.

Claimant filed claims for compensation with petitioner, petitioner's business, Alderwood Homes, Inc., Norman Bernards and Cascade Tractor. The referee denied all claims, concluding that no employer-employe relationship existed between claimant and any of the parties and that, in any event, he was not within the course of his employment at the time of injury. The Board reversed the referee's decision in part and held that claimant was an employe of petitioner and

was acting within the scope of his employment at the time of the accident.[3]

[1] The petition for review in this case was filed on April 3, 1987, before the effective date of Or Laws 1987, ch 884, § 12a.

[2] Claimant had worked with petitioner on similar projects in the past and had been paid on an hourly basis for that work.

[3] Claimant does not challenge the Board's dismissal of his claims against Alderwood Homes, Inc., Norman Bernards and Cascade Tractor and Implement Co.

Petitioner assigns as error the Board's conclusion that an employer-employe relationship existed between petitioner and claimant under ORS 656.027. Petitioner contends that claimant was an independent contractor rather than a subject worker. The principal factors showing employment are the direct right or exercise of control, the method of payment, the furnishing of equipment and the right to terminate. 1C Larson, *Workers' Compensation Law* 8-40, § 44.00 (1986). Right of control is often the most important factor. *Woody v. Waibel,* 276 Or 189, 554 P2d 492 (1976). Employe status exists when the objective factors indicate that the employer had the right to control the details of the employe's work.

In this case, the employer did control the details of the claimant's work. Petitioner could terminate claimant's employment at any time. He had control over where and when the work would be performed. Further, he paid claimant on an hourly basis and, except for the carpentry tools and pickup, all the equipment necessary for the work was provided by petitioner. Although there was conflicting evidence, we find that the evidence indicating employe status outweigh that indicating that claimant was an independent contractor.

Petitioner also argues that claimant comes within the exclusion from workers' compensation coverage for sole proprietors. ORS 656.027(7). He relies on claimant's tax records for 1983 and 1984, which indicate that he reported some of his income in those years as income generated by a sole proprietorship. However, we do not find the tax records dispositive on the issue of claimant's status vis-a-vis petitioner for the work involved in this claim. Although his tax records indicate that some income generated in those years was profit from a sole proprietorship, the records also indicate that other income was in the form of wages, salaries and tips. Petitioner has failed to establish that the amounts he paid to claimant were reported by him as income from a sole proprietorship.

Petitioner also assigns as error the Board's conclusion that claimant was not excluded from coverage by the

"going and coming" rule. Under that rule, an employe injured while going to or coming from his place of work is not within the course of employment at the time of injury and is therefore excluded from workers' compensation coverage. *Jenkins v. Tandy Corp,* 86 Or App 133, 137, 738 P2d 985, *rev den* 304 Or 279 (1987). An employe is generally not within the rule if he is compensated by the employer for "travel time."[4] *Fenn v. Parker Construction Co.,* 6 Or App 412, 416, 487 P2d 894 (1971). We find that claimant was to be compensated for travel time en route to the job site. Accordingly, the injuries occurred during the course of his employment.

Affirmed.

[4] Both petitioner and claimant agree that claimant was to be compensated for some travel time. Claimant asserts that he was to be compensated for the time spent traveling to the job site; petitioner asserts that no firm agreement was reached on which travel direction claimant was to be compensated. Although the parties disagree over the direction, they agree that he was to be compensated in at least one direction.

IN THE SUPREME COURT OF THE
STATE OF OREGON

COOK,
dba Gresham Health Center
Nurse Practitioner Clinic,
Petitioner on Review,

v.

WORKERS' COMPENSATION DEPARTMENT,
Respondent on Review.

(WCD 6-1985; CA A38782; SC S34626)

In Banc

On review from the Court of Appeals.*

Argued and submitted March 3, 1988.

Vernon Cook, Gresham, argued the cause and filed the amended petition and supplement to amended petition on behalf of the Petitioner on Review.

Jerome Lidz, Chief Civil Attorney, Salem, argued the cause on behalf of the Respondent on Review.

GILLETTE, J.

The decision of the Court of Appeals is reversed. The rule, OAR 436-10-050(4), is declared invalid to the extent set out in this opinion.

Peterson, C. J., dissented and filed an opinion in which Jones, J., joined.

* Judicial review from Workers' Compensation Department. 85 Or App 219, 736 P2d 230, 87 Or App 486, 742 P2d 714 (1987).

GILLETTE, J.

Petitioner brought an original proceeding in the Court of Appeals challenging the validity of an administrative rule promulgated by the Workers' Compensation Department (the department).[1] The rule limits the circumstances under which an insurer or a self-insured employer may be required to

[1] ORS 183.400 provides, in part:

"(1) The validity of any rule may be determined upon a petition by any person to the Court of Appeals in the manner provided for review of orders in contested cases. The court shall have jurisdiction to review the validity of the rule whether or not the petitioner has first requested the agency to pass upon the validity of the rule in question, but not when the petitioner is a party to an order or a contested case in which the validity of the rule may be determined by a court.

"* * * * *

"(3) Judicial review of a rule shall be limited to an examination of:

"(a) The rule under review;

"(b) The statutory provisions authorizing the rule; and

"(c) Copies of all documents necessary to demonstrate compliance with applicable rulemaking procedures.

"(4) The court shall declare the rule invalid only if it finds that the rule:

"(a) Violates constitutional provisions;

"(b) Exceeds the statutory authority of the agency; or

"(c) Was adopted without compliance with applicable rulemaking procedures."

reimburse a nurse practitioner[2] who provides medical services relating to a compensable illness or injury. OAR 436-10-050(4).[3] Petitioner argues that a nurse practitioner is a "doc-

tor or physician" as those terms are defined by statute and that the department exceeded its authority in restricting reimbursement for nurse practitioners. Alternatively, she argues that the challenged rule violates Article I, section 20, of the Oregon Constitution and the Fourteenth Amendment to the United States Constitution, because it unreasonably differentiates between nurse practitioners and physician's assistants by imposing fewer restrictions on a physician's assistant's eligibility for reimbursement. We agree with the first argument.

The Court of Appeals initially upheld the rule without opinion. *Cook v. Workers' Compensation Department* 85 Or App 219, 736 P2d 230 (1987). On reconsideration, the court withdrew its decision because "[a] challenge to an administrative rule in this court is an original proceeding, and our determination of the rule's validity should, generally, be by written opinion." *Cook v. Workers' Compensation Department* 87 Or App 486, 487, 742 P2d 714 (1987). The court again upheld the challenged rule, stating that "[w]e have considered petitioner's arguments challenging the validity of OAR

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[2] ORS 678.010(4) defines "nurse practitioner" as "a registered nurse who has been certified by the [Oregon State B]oard [of Nursing] as qualified to practice in an expanded specialty role within the practice of nursing." *See generally* ORS 678.375 - 678.390.

The specialty began to receive formal educational recognition in 1965. Robinson, "The Nurse Practitioner: Expanding Your Limits," 36 RN Magazine No. 11 (November, 1973) 27, at 29. The effectiveness of such specialists in providing primary health care was first documented for the general health care community in Spritzer, *et al*, "The Burlington Randomized Trial of the Nurse Practitioner," 290 N. Engl. J. Med. 251 (1974).

[3] At the time relevant to this proceeding, OAR 436-10-050 read as follows:

"(1) Physicians licensed by the Board of Medical Examiners, the Board of Dental Examiners, the Board of Chiropractic Examiners, and the Board of Naturopathic Examiners may be designated as attending physicians.

"(2) Attending physicians may prescribe treatment to be carried out by persons licensed to provide a medical service, or by persons not licensed to provide a medical service who work under the direct control and supervision of the attending physician.

"(3) The insurer may pay for treatment by prayer or spiritual means.

"(4) A nurse practitioner who is a family nurse practitioner or an adult nurse practitioner as defined in OAR 851-30-002, and licensed under ORS 678.375, may provide such services as the license permits, and be reimbursed as provided by OAR 436-10-090(7), when the following conditions are met:

"(a) The insurer is not required to reimburse a nurse practitioner for treating a disabling injury or illness unless the worker has been referred for treatment by the worker's attending physician, who shall remain the attending physician.

"(b) The insurer is not required to pay for treatment prescribed by a nurse practitioner when that treatment is performed by a person not licensed to provide such treatment.

"(c) The nurse practitioner is not an attending physician and, therefore, cannot authorize time loss or do closing evaluation examinations and reports, or other similar functions which may be done only by an attending physician.

"(5) A physician assistant, registered under ORS 677.515, may provide services and be reimbursed as provided by OAR 436-10-090(7) only under the following conditions:

"(a) The physician assistant is approved for independent practice by the Board of Medical Examiners.

"(b) The physician assistant may prescribe treatment to be performed by others only when the person who is to provide the treatment is licensed to do so."

436-10-050 and find them to be without merit." *Id.* This court allowed review. We find that the department misinterpreted the pertinent provision of law and, therefore, exceeded its authority in promulgating the challenged rule. Accordingly, we reverse the Court of Appeals.

We first consider petitioner's argument that the department lacked the statutory authority to promulgate the challenged rule. *See Planned Parenthood Assn v. Dept. of Human Res.*, 297 Or 562, 565, 687 P2d 785 (1984). The director of the Workers' Compensation Department is vested with the general authority to promulgate rules "which are reasonably required in the performance of the director's duties" of administering, regulating and enforcing the workers' compensation laws. ORS 656.726(3)(a). The duty to administer the Workers' Compensation Law requires that the director apply the statutes to individual factual situations. That process necessarily involves interpretation of statutory terms, either by rule or by order in a contested case. It follows that the director had the *authority* to promulgate a rule interpreting the meaning of the statutory terms "doctor or physician." The question remains — was that interpretation correct?

For the purposes of the Workers' Compensation Law, the legislature has defined a "doctor or physician" as:

> "[*A*] *person* duly *licensed to practice one or more of the healing arts* in this state within the limits of the license of the licentiate. 'Attending physician' means a doctor or physician who is primarily responsible for the treatment of a worker's compensable injury. 'Consulting physician' means a doctor or physician who examines a worker or the worker's medical record to advise the attending physician regarding treatment of a worker's compensable injury." (Emphasis supplied.)

ORS 656.005(12). Although the department has the authority to interpret the statutory term, "doctor or physician," that interpretation must be consistent with the policy underlying the legislative enactment. An administrative agency may not, by its rules, amend, alter, enlarge or limit the terms of a statute. *U. of O. Co-oper. v. Dept. of Rev.*, 273 Or 539, 550, 542 P2d 900 (1975). The question before this court is whether the department's interpretation of the statutory language comports with the statutory intent. *Springfield Education Assn. v. School Dist.*, 290 Or 217, 228, 621 P2d 547 (1980).

When OAR 436-10-050 originally was promulgated in 1982, it authorized reimbursement for nurse practitioners who practiced in areas defined by the State Health Planning and Development Agency as medically underserved. The rule thus recognized the special, hybrid status of the nurse practitioner,

different both from a traditional nurse and a traditional doctor. In 1985, the rule was amended to delete that provision and add a provision that treatment by a nurse practitioner for a disabling illness or injury would be reimbursable only if the patient were referred to the nurse practitioner by the attending physician. Exhibit C to the 1985 amendment explains the agency's reasoning:

"There was considerable testimony from nurse practitioners regarding the proposed rule, and the testimony was unanimous in objecting to any limitation on nurse practitioners, be it geographical or scope of practice, or any limitation regarding the extent of an injury that they could treat and be reimbursed for by the system.

"The intent of the rule was to allow nurse practitioners to treat nondisabling injuries and treat disabling injuries only when the patients were referred by attending physicians who would remain attending physicians and were in control of the case. This would remove the geographic limitation and allow all adult nurse practitioners and family nurse practitioners to treat nondisabling injuries, but would not designate them as attending physicians and *it is the opinion of the department that the definition is defined in the statute and the department cannot expand the definition.* * * *." (Emphasis added).

It is apparent that the department concluded that nurse practitioners did not qualify as "doctors or physicians" under the statutory definition and therefore declined to permit their designation as attending physicians.[4] For the reasons that follow, we hold that the department was incorrect in so concluding and therefore erred in adopting a rule that excludes nurse practitioners from the statutory definitions of "physician" and "attending physician."

For the purposes of the Workers' Compensation Law, a "physician" or "doctor" is defined, in part, as a person "licensed to practice one or more of the healing arts." ORS 656.005(12). The issue before this court turns on the meaning

of the term, "healing arts." No Oregon statute or Supreme Court opinion defines that term, nor (so far as we can determine) does it have any special and immutable meaning either in medicine or in the law. Although the term is used in various contexts throughout the Oregon Revised Statutes, no clear meaning can be distilled from those provisions. Neither has our research with respect to other jurisdictions produced much help. What law we have been able to find is primarily statutory. A summary of laws from other jurisdictions appear in the Appendix.

The definition of "doctor or physician" in ORS 656.005(12) was added by the 1957 legislature and has not been amended. Or Laws 1957, ch 718, § 1. The definitions of "attending physician" and "consulting physician" were added in 1979. Or Laws 1979, ch 839, § 26. The legislative history does not include specific discussion of those definitions. Certainly, nothing in the legislative history demonstrates any legislative intent to limit the broad, generic meaning of the term, "healing arts."

The department argues that, at the time the language defining "doctor or physician" was added to the Workers' Compensation Law, the term, "healing arts," was defined in

[4] Under the workers' compensation scheme, it may be that the only practical benefit nurse practitioners will derive from the status of "doctor or physician" is the eligibility to be designated as an "attending physician." OAR 436-10-060(2) provides that a worker may have only one attending physician at a time, and that treatment by other physicians must be at the "request" of the attending physician. Treatment by nurse practitioners must be initiated by a "referral" from the attending physician. OAR 436-10-005(4).

ORS chapter 676, which dealt with the health professions generally. *Former* ORS 676.140 provided, in part:

> "Each board licensing any person to practice any healing art in this state shall file with the Secretary of State a list of all persons licensed by such board to practice such healing art, together with the last known address of each of such persons."

The department notes that a 1949 attorney general opinion responded to the Board of Nursing's inquiry whether they were subject to the requirements of *former* ORS 676.140. The attorney general concluded that nursing was not a "healing art." 24 AG Op 287 (1949). That conclusion was based on the predecessor to ORS 676.110, which then provided:

> "Any person practicing any of the healing arts or the corrective art of optometry who uses the title 'doctor' or any contraction thereof, 'clinic,' 'institute,' 'specialist' or any other assumed or artificial name or title, in connection with his business or profession, on any written or printed matter, or in connection with any advertising, billboards, signs or professional notices, shall add after his name or after any such

> assumed or artificial names, one of the following respective designations:
>
> "(1) In the case of a person practicing chiropody, the word 'chiropodist';
>
> "(2) In the case of a person practicing chiropractic, the word 'chiropractor' or the words 'chiropractic physician';
>
> "(3) In the case of a person practicing dentistry, the word 'dentist' or the words 'dental surgeon';
>
> "(4) In the case of a person practicing naturopathy, the word 'naturopath' or the words 'naturopathic physician';
>
> "(5) In the case of a person practicing the corrective art of optometry, the word 'optometrist';
>
> "(6) In the case of a person practicing osteopathy, the word 'osteopath' or ['']osteopathic physician and surgeon';
>
> "(7) In the case of a person practicing medicine or surgery, the word 'physician' or the word 'surgeon' or the words 'physician and surgeon';
>
> "(8) In the case of a person practicing veterinary medicine, the word 'veterinarian.' "

OCLA § 54-151.

The attorney general's opinion read the statute quoted above as an exclusive list of designations for practitioners of the healing arts. Because the statute did not refer to the practice of nursing, the attorney general concluded that nursing was not a "healing art" and, therefore, the Board of Nursing need not provide the secretary of state with a list of licensed nurses under the predecessor to *former* ORS 676.140. *See also* 33 AG Op 294 (1967) (limiting healing arts practitioners to those listed in ORS 676.110 for purposes of statute requiring that "the certificate of a person licensed in this state to practice any of the healing arts" accompany application for absentee ballot on grounds of physical disability).

The department relies on essentially the same reasoning as the two attorney general opinions cited above. It argues that, when the 1957 legislature used the term, "healing arts," it intended the term to encompass only those profes-

sions listed in the former version of ORS 676.110. We disagree.

We first note that, in 1957, ORS 676.110 did not

expressly purport to define all practitioners of the healing arts. It applied only to those practitioners of the healing arts

> "who use[d] the title 'doctor' * * *, 'clinic,' 'institute,' 'specialist' or any other assumed or artificial name or title, in connection with his business or profession, on any written or printed matter, or in connection with any advertising, billboards, signs or professional notices * * *."

Second, even if ORS 676.110 were intended to be an exhaustive list of healing arts practitioners for the purpose of advertising regulation, there is no indication that the 1957 legislature intended to incorporate that list into its definition of "doctor or physician" in an entirely unrelated workers' compensation provision.

The term "healing arts" is not a static concept, capable of only one definition, now and forever. Instead, it is an example of the familiar legislative penchant for using general terms like a bucket, allowing various concepts to fall in (or out) with the passage of time. What is a "healing art" may have differed between 1957 and today, just as, for example, the concept of "vehicle" changed between 1890 and the present. But the legislature need not constantly update each new addition to either class — the general terms are broad and flexible enough to adjust to changing circumstances. The question therefore is, do "nurse practitioners" do things that make them practitioners of the "healing arts"?

They do. Nurse practitioners are licensed to provide "primary health care," which is defined as "holistic health care which the client receives at the first point of contact with the health care system and is continuous and comprehensive." OAR 851-50-000(3)(k); (n). OAR 851-50-005(2) provides:

> "The nurse practitioner is *independently responsible and accountable for* the continuous and comprehensive management of a broad range of personal health services, which may include:
>
> "(a) Promotion and maintenance of health;
>
> "(b) Prevention of illness and disability;
>
> "(c) Management of health care during acute and chronic phases of illness;
>
> "(d) Guidance and counseling for both individuals and families;

> "(e) Consultation and/or collaboration with other health care providers and community resources;
>
> "(f) Referral to other health care providers and community resources." (Emphasis supplied.)

Nurse practitioners also are eligible to apply for prescription privileges upon completion of an approved course of pharmacology. OAR 851-50-120; 851-50-125.

Absent any indication to the contrary, we assume

that the legislature intended to give the term, "healing arts," its literal meaning, unless to do so would be so contrary to the statutory policy that it would bring about an absurd result. *Johnson v. Star Machinery Co.*, 270 Or 694, 703-4, 530 P2d 53 (1974). "Healing" is generally defined as "curative." *See, e.g.*, Webster's Third New International Dictionary (1971). A "healing art" would be commonly understood as the skill to treat disease or disability and, where the nature of the problem permits, to restore health. A nurse practitioner is qualified to provide comprehensive, independent medical care in the form of diagnosis, treatment, advice and referrals. Those services certainly fall within the commonly understood meaning of a "healing art." We conclude that the statutory definition of "doctor or physician" in ORS 656.005(12) includes a nurse practitioner.[5]

We turn to the question whether a nurse practitioner may be designated as an "attending physician" as that term is defined in ORS 656.005(12). An attending physician is a doctor or physician who is "primarily responsible for the treatment of a worker's compensable injury." ORS 656.005(12). ORS 656.245(3) allows a worker to "choose an attending doctor or physician within the State of Oregon." Those provisions appear to contemplate that a worker may select any doctor or

physician in the state to be the attending physician. The legislature has not demonstrated any intent to impose higher professional standards on attending physicians than it imposes on doctors and physicians. Thus, to be eligible for designation as an attending physician, a practitioner must be: (1) a "doctor or physician" under ORS 656.005(12); (2) capable of assuming primary responsibility for the treatment of the compensable condition; and (3) practicing in Oregon. We have already concluded that a nurse practitioner is included in the phrase, a "doctor or physician," as that term is used broadly in ORS 656.005(12). Nurse practitioners are licensed to provide primary health care and are, by rule, "independently responsible" for health services. We therefore hold that those nurse practioners who practice in Oregon are eligible to be designated as attending physicians.[6] To the extent that OAR 436-10-050 does not allow nurse practitioners to be designated as attending physicians, it is inconsistent with the legislative policy underlying ORS 656.005(12).

The decision of the Court of Appeals is reversed. The rule, OAR 436-10-050(4), is declared invalid to the extent set out in this opinion.

APPENDIX

The following is a breakdown of the way the term,

[5] Put another way, the legislature here has used certain terms ("doctor" and "physician") in a manner that varies from a dictionary definition or common understanding. The legislature has seen fit to define the two professional categories in question by description of what the categories do — "practice healing arts." By this loose description, other professional categories qualify under the description. It is as if the legislature sought to define a "duck" as a feathered bird, with a bill, two feet and two wings. It should come as no surprise that other winged fowl qualify under that description. Hence, for purposes of the definition, a turkey would be a duck, if only in the wisdom of the legislature and for the purposes of the statute in question.

[6] Petitioner has pointed out that nurse practitioners are paid at a lower rate than "physicians." OAR 436-10-090. Our holding should not be read as requiring that all "physicians" be paid at the same rate.

"healing arts," is used in other jurisdictions:

I. *Statutes that exclude nursing from definitions of the term, "healing arts."*

A. The following statutes define a "healing art" as one of several listed occupations which do not include nursing:

Connecticut: Conn Gen Stat Ann § 20-1 (West 1988) ("the practice of medicine, osteopathy, chiropractic, podiatry and natureopathy").

Florida: Fla Stat Ann § 456.32(2) (1981) (for purposes of referring patients to hypnotists, healing arts practitioners are limited to practitioners of "medicine, surgery, psychiatry, dentistry, osteopathic medicine, chiropractic, naturopathy,

podiatry, chiropody, and optometry"). *See also* Fla Stat Ann § 483.041(8) (West 1988) (dealing with health testing services) ("licensed practitioner of the healing arts" includes only a physician, a dentist, a podiatrist, or a naturopath).

New Mexico: NM Stat Ann § 59A-22-32(B)(2) (1978) (for purposes of health insurance contracts, "practitioner of the healing arts" includes only chiropractors, dentists, medical doctors and surgeons, and osteopaths). *See also* NM Stat Ann § 62-8-10 (applying the same definition to a statute prohibiting the termination of utility service to a residence in which a seriously ill person resides, if a practitioner of the healing arts certifies that termination of service might endanger that person's life).

Kentucky: "Healing art" includes "the practices of medicine, osteopathy, dentistry, chiropody (podiatry), optometry, and chiropractic, but does not include the practices of Christian Science or midwifery." Ky Rev Stat § 311.271(2)(a) (1983). The definition is not entirely clear, but it does not appear to include nursing.

B. The following statutes also exclude nursing from their definitions of the healing arts:

District of Columbia: DC Code Ann § 2-1301(2)(E) (1981) specifically excludes nursing from its definition of "the healing art."

Texas: Tex Rev Civ Stat Ann art 4590e, § 2 (Vernon 1976) defines "healing art" as "any system, treatment, operation, diagnosis, prescription or practice for the ascertainment, cure, relief, palliation, adjustment or correction of any human disease, ailment, deformity, injury or unhealthy or abnormal physical or mental condition." However, section 3 of that provision requires that all practitioners of "the healing art" use one of a list of legally required identifications. The listed identifications are appropriate only for practitioners of medicine, dentistry, chiropractic, optometry, chiropody and naturopathy. Nursing is not included.

II. *Statutes with broad, general definitions.*

These statutes generally define the term, "healing art," as the diagnosis and treatment of human disease or disability. Theoretically, that definition is broad enough to

encompass nursing, although it is not clear in any case whether it does so.

Kansas: Kan Stat Ann § 65-2802(a) (1985). Kansas does, however, have both a "Board of Healing Arts" and a "Board of Nursing."

Minnesota: Minn Stat Ann § 146.01 (West Supp 1988).

Nebraska: Neb Rev Stat § 71-101.01 (1986).

Nevada: Nev Rev Stat § 630.060(4)(b) (1983) (adds the requirement that "for the practice of which long periods of specialized education and training and a degree of specialized knowledge of an intellectual as well as physical nature are required"). *See also* Nev Rev Stat § 633.051 (same definition in chapter governing osteopathic medicine).

Oklahoma: Former Okla Stat Ann tit 59 § 702 (West 1971), *repealed by* Okla Laws 1973, c. 48.

Pennsylvania: 1 Pa Cons Stat Ann § 1991 (Purdon Supp 1988).

South Dakota: SD Codified Laws Ann § 36-2-1(3) (1986).

Tennessee: Tenn Code Ann § 63-1-102(2) (1986) (specifically includes practice of acupuncture).

Virginia: Va Code § 54-273 (Supp 1987).

DEFINITIONS FROM OTHER SOURCES

Ohio: An administrative rule governing habilitation centers for mentally retarded persons defines "practitioner of the healing arts" as "physicians, nurses, psychologists, occupational therapists, physical therapists, and speech pathologists/audiologists." OAC 5123:2-15-01(B)(9) (Baldwin 1988).

Illinois: Lyon by Lyon v. Hasbro Industries, Inc., 156 Ill App 3d 649, 509 NE2d 702 (1987), defined the term, "healing art," for the purposes of the state "healing art malpractice" statute. The court concluded that the phrase "by definition implies an entire branch of learning dealing with the restoration of physical or mental health," and that it was

broad enough to cover ambulance service. Thus, an allegation that the service negligently failed to provide equipment necessary to facilitate emergency health care was an allegation of "healing art malpractice." 509 NE2d at 706.

PETERSON, C. J., dissenting.

The question is whether the words "doctor" or "physician," as used in current ORS 656.005(12), include nurse practitioners. The answer to this question is "no." I base my conclusion largely upon an examination of the statutes in effect in 1957, when the legislation that first defined the terms "doctor" and "physician" in ORS chapter 656 was enacted.

The first sentence of current ORS 656.005(12) was enacted in 1957 as ORS 656.002(17). Or Laws 1957, ch 718, § 1(17). It read (and as part of current ORS 656.005(12) still reads): "'Doctor' or 'physician' means a person duly licensed to practice one or more of the healing arts in this state within the limits of the license of the licentiate." I shall show, by reference to (1) the meaning of "doctor" or "physician," (2) the meaning of "healing arts," and (3) the meaning of the phrase "duly licensed to practice * * * in this state within the limits of the license of the licentiate" that the legislature, in passing that legislation, had in mind the class of persons who could diagnose, prescribe and treat persons and who could use the title "doctor" or "physician," persons such as chiropractic physicians, naturopathic physicians, dentists, osteopathic physicians, chiropodists, and physicians and surgeons.

1. THE 1957 LEGISLATION

Prior to 1957, workers' compensation benefits were payable to a worker who "sustains a personal injury by accident arising out of and in the course of his employment caused by violent or external means." ORS 656.202(1) (1955). Labor organizations and others maintained that this definition was too restrictive. *See* Minutes, House Labor and Industries Committee (March 26, 1957; May 6 and 8, 1957).

In 1957, legislation was introduced to relax that definition. The legislation was introduced as House Bill 12. Minutes of the Labor and Industries Committee of the House of Representatives for May 6, 1957 contain this explanatory statement as to the measure's purpose:

> "George Brown [George Brown was Political Director of the Oregon AFL/CIO] explained that this bill has as its primary purpose the elimination of the definition of an accident relating it to violent external means. He briefly explained the amendments in the engrossed bill. It was agreed to hold this bill over to the next agenda, to give the Committee members time to study it."

The only specific reference in the legislative history to the language at issue in this case is the following:

> "Representative Lent moved to amend HB 12 as follows: * * * (17) 'Doctor' or 'Physician' means a person duly licensed to practice one or more of the healing arts in this state within the limits of the license of the licentiate. Motion carried."

Minutes, House Labor and Industries Committee (March 26, 1957). The legislative history does not show why Representative Lent proposed the amendment.

2. "DOCTOR" OR "PHYSICIAN" MEANS A DOCTOR OR PHYSICIAN.

The meaning of ORS 656.002(17), as passed in 1957, becomes clear when other sections of ORS chapter 656 (1957) and other statutes in ORS chapters 676 and 678 (1957) are compared. It is not inappropriate to observe first, however, that the plain meaning of ORS 656.002(17), as passed in 1957, likely was that "doctor" or "physician" meant doctors or physicians practicing one or more of the healing arts.

In 1957, nurses were forbidden from performing "acts

of diagnosis or prescription of therapeutic or corrective measures." The last sentence of *former* ORS 678.015 (1957) provided: "This section does not authorize a licensed professional nurse to perform acts of diagnosis or prescription of therapeutic or corrective measures."

Other sections of chapter 656 (1957) referred to the type of work that "doctors" and "physicians" were expected to perform under the Workers' Compensation Law.

One statute required a physician's report. *Former* ORS 656.272(1) in 1957 provided in part: "The physician who attends the workman shall file with the Commission a report on forms furnished by the commission." This form, now Department of Insurance and Finance Form 827, requires

diagnostic information, the type of information that only a doctor could furnish. *See* OAR 436-10-030.

Another 1957 workers' compensation statute, ORS 656.806, provided that "[a]s a prerequisite to employment in any case, a prospective employer may, by written direction, require any applicant for such employment to submit to a physical examination by a doctor to be designated by the State Industrial Accident Commission * * *." These statutes suggest that "doctor" or "physician" means a doctor or physician in the traditional sense, such as a medical doctor, osteopathic physician, chiropractic physician, naturopathic physician or podiatric physician.

Other sections of the 1957 Workers' Compensation Law confirm this analysis.

The 1957 Workmen's Compensation Occupational Disease Law, ORS 656.802 to 656.824, also contained provisions concerning physicians and doctors. *Former* ORS 656.810(1) provided for the appointment of "a medical board of review, which board of review shall have jurisdiction to pass upon and decide every issue involved in such [occupational disease] claim."

Former ORS 656.810(2) (1957) provided:

> "The medical board of review shall be appointed in the following manner:
>
> "(a) One doctor from the list provided for by ORS 656.820 shall be named by the commission.
>
> "(b) One doctor from said list shall be named by the claimant.
>
> "(c) The two doctors so named shall, within five days after being notified of their appointment, name a third doctor from said list. If the third doctor cannot be agreed upon, or for any other reason has not been named within such period of time, the commission shall immediately so notify the presiding judge of the circuit court of the county in which the claimant resides, or upon agreement of the claimant and the commission, the circuit judge of the county in which the claim arose. Upon receipt of such notice, such presiding judge shall forthwith name the third member of such board of review from said list."

The duties of the medical board of review were set

forth in *former* ORS 656.812 (1957). Subsection (2) required findings and "the answers to the following questions":

> "(a) Does claimant suffer from a disease or infection? If so, what?
>
> "(b) When was such disease or infection, if any, contracted, and approximately how long has claimant suffered therefrom?
>
> "(c) Is such disease or infection, if any, peculiar to the industrial process, trade or occupation in which claimant has been last employed?
>
> "(d) Has such disease or infection, if any, been caused by and did it arise out of and in the course of claimant's regular actual employment in such industrial process, trade or occupation?
>
> "(e) Is such disease, if any, disabling to the claimant?
>
> "(f) If so, to what degree is claimant disabled by such occupational disease?"

Nurses were not permitted to perform the type of work that *former* ORS 656.812(2) (quoted above) required, to diagnose the disease or infection, to decide whether the disease was related to the employment and to determine the extent of disability.

In sum, the statutes in ORS chapter 656 (1957) point to the conclusion that the "doctor" or "physician" referred to in ORS 656.002(17) (1957) were persons authorized to prescribe, diagnose, treat and evaluate injuries, illnesses and disease. Nurses had no such authority. If there is any remaining doubt, that doubt is dispelled by examining other statutes in the context of the "healing arts" language of ORS 656.002(17) (1957).

3. MEANING OF "PRACTICE OF THE HEALING ARTS."

The only 1957 statutes that speak of the "healing arts" are statutes concerning doctors or physicians—doctors or physicians who are called "doctors" or "physicians." ORS 676.110 (1957) provided:

> "Any person *practicing any of the healing arts* or the corrective art of optometry who uses the title 'doctor,' or any contraction thereof, 'clinic,' 'institute,' 'specialist' or any

> other assumed or artificial name or title, in connection with his business or profession, on any written or printed matter, or in connection with any advertising, billboards, signs or professional notices, shall add after his name, or after any such assumed or artificial names, one of the following respective designations in letters or print which shall be at least one-fourth the size of the largest letters used in the title or name, and in material, color, type or illumination to give display and legibility of at least one-fourth that of the title or name:
>
> "(1) In the case of a person practicing chiropody, the word 'chiropodist.'
>
> "(2) In the case of a person practicing chiropractic, the word 'chiropractor' or the words 'chiropractic physician.'
>
> "(3) In the case of a person practicing dentistry, the word 'dentist' or the words 'dental surgeon.'

"(4) In the case of a person practicing naturopathy, the word 'naturopath' or the words 'naturopathic physician.'

"(5) In the case of a person practicing the corrective art of optometry, the word 'optometrist.'

"(6) In the case of a person licensed to practice osteopathy and surgery by the Board of Medical Examiners of the State or Oregon, the word 'osteopath' or the words 'osteopathic physician' or 'osteopathic physician and surgeon.'

"(7) In the case of a person licensed to practice medicine and surgery by the Board of Medical Examiners of the State or Oregon, the word 'physician' or the word 'surgeon' or the words 'physician and surgeon.'

"(8) In the case of a person practicing veterinary medicine, the word 'veterinarian.' " (Emphasis added.)

From these statutes, I conclude that (1) "doctor" or "physician" meant a person who could call herself or himself a doctor or physician, and (2) that the "practice * * * of the healing arts" reference in ORS 656.002(17) (1957), likely was to the persons "practicing any of the healing arts" referred to in ORS 676.110 (1957)—medical doctors, chiropractic physicians, osteopathic physicians, naturopathic physicians, dentists and chiropodists.

4. MEANING OF "WITHIN THE LICENSE OF THE LICENTIATE."

Any remaining doubt is dispelled by the third referent—"within the limits of the license of the licentiate." That

very phrase appears in the 1957 ORS chapter concerning nurses, chapter 678, *but as a description of what nurses can do while working under the direction and control of a "licentiate."* ORS 678.031(4) in 1957 provided:

"ORS 678.010 to 678.160 [the statutes governing the nursing profession] shall not be construed to affect or prevent:

"* * * * *

"(4) Services and acts of technicians, assistants and other persons performed under the direction and control of persons duly licensed to practice medicine or surgery, osteopathy, dentistry, chiropractic, naturopathy or chiropody in this state within the limits of the license of the licentiate under whose direction and control the services and acts are performed; provided, that nothing in this Act shall be construed to permit any person who is not licensed under ORS 678.010 to 678.170 by the Oregon State Board of Nursing to do any act prohibited by subsection (2) of ORS 678.021."

The phrase "within the limits of the license of the licentiate" clearly refers to the antecedent class of licentiates — "persons duly licensed to practice medicine or surgery, osteopathy, dentistry, chiropractic, naturopathy or chiropody." I have little doubt that ORS 656.002(17) (1957) derives directly from ORS 678.031(4) (1957).

Supporting this conclusion is a 1949 opinion of the Attorney General which, in 1957, was still fairly recent. *See* 24 Op Att'y Gen 287 (Or 1949), discussed in the majority opinion at 306 Or at ___. *See also* 33 Op Att'y Gen 294 (Or 1967), mentioned in the majority opinion at 306 Or at ___.

I should add that construing ORS 656.002(17) (1957)

as would the majority, made doctors, in 1957, of dental hygienists, licensed practical nurses and masseurs as well as nurses.

5. CONCLUSION

From the foregoing study of the 1957 statutes, there can be no doubt that the source of the "healing arts" language of ORS 656.002(17) (1957) was ORS 676.110 (1957), and that the term "physician," as used in ORS 656.002(17) (1957) meant medical doctors, chiropractic physicians, osteopathic physicians, naturopathic physicians, dentists and chiropodists. Similarly, there can be no doubt that the "within

the license of the licentiate" language in the 1957 statute came from a nursing statute, ORS 678.031(4), a statute that precisely tracked ORS 676.110 (1957) in its specific reference to medical doctors, osteopathic physicians, chiropractic physicians, naturopathic physicians, chiropodists and dentists.

What has happened since 1957 to change or modify that legislative intent? The nurse practitioner statutes were enacted in 1975. What was the legislative intent in 1975? ORS 676.110 was still in effect. It still referred to the same class of healing arts-practitioner-podiatrists (formerly chiropodists), chiropractic physicians, dentists, naturopathic physicians, osteopathic physicians, and medical doctors.

The ORS 676.110 reference to "healing arts" was not deleted until 1983, when it was replaced with the term "health care profession." Or Laws 1983, ch 769, § 1. The changes were made at the request of the Oregon Board of Optometry.

ORS 678.031(4) (1957) — the statute that concerned the "license of the licentiate" — was amended in 1973, two years before the enactment of the nurse-practitioner legislation, in recognition of the enlarged role of nurses in diagnosing and treating persons with health problems. *See* ORS 678.010(5) (1973). In 1973 and 1975, however, as now, ORS chapter 678 contained a definition of "physician" as "a person licensed to practice under ORS chapter 677." ORS 678.010(4) (1973); ORS 678.010(5) (1975); ORS 678.010(5) (1987).

Nothing in the legislative history of Oregon Laws 1975, chapter 205 suggests that the legislature intended that nurse practitioners would be "doctors" or "physicians" under

the then or present version of ORS 656.005(12). Rather, as the definition of nurse practitioner provides:

[1] The 1983 legislature replaced the phrase "any of the healing arts or the corrective art of optometry" with the phrase "a health care profession." The explanation for the change is in a Senate Exhibit submitted by the Oregon Board of Optometry:

> " 'Health-care profession' is a more contemporary and descriptive term than is "Healing art" and the Oregon Board of Optometry is requesting a change in [the] statute to describe all health care professions by the same descriptive term.
>
> "Optometry is a profession which involves diagnosis and treatment of problems relating to human vision. Treatment involves the correction and prevention of problems and the restoration of health function. A dictionary defines 'heal' as 'to make sound or whole'; 'to restore health'; and to 'cause (an undesirable condition) to be overcome.' Optometry is, therefore a healing art."

Exhibit A, Senate Committee on Human Services and Aging (June 23, 1973) (statement of Oregon Board of Optometry).

> " 'Nurse practitioner' means a registered nurse who has been certified by the [Oregon State Board of Nursing] as qualified to practice in an expanded specialty role *within the practice of nursing.*"

ORS 678.010(4) (emphasis added).

The 1975 nurse practitioner statutes, ORS 678.375 to 678.410, suggest that the "expanded specialty role" consists primarily of the nurse practitioner's eligibility to apply for drug prescribing authority. These statutes did not make "doctors" or "physicians" out of nurse practitioners in any sense. Rather the 1975 legislation merely "expanded" the power, authority and rights of those in the "practice of nursing" who qualify as "nurse practitioners." The "practice of nursing" still "includes executing medical orders as prescribed by a physician or dentist." ORS 678.010(6). The distinction between physicians or doctors and nurses remains clear under the very chapter upon which the majority relies to set nurse practitioners apart from nurses and to class nurse practitioners as physicians. *See* ORS 678.010(5) (" 'Physician' means a person licensed to practice under ORS chapter 677.").

Nor did the addition of what is now the second sentence of ORS 656.005(12) (" 'Attending physician' means a doctor or physician who is primarily responsible for the treatment of a worker's compensable injury"), affect the issue before us. Pure and simple, nurses were not "doctors" or "physicians" under ORS 656.002(17) in 1957, and nothing has happened since then to suggest that the legislature meant to change the meaning of the first sentence of current ORS 656.005(12).

The majority reasons that the legislature intended to give the term "healing arts" its "literal meaning," 306 Or at ___. Under that reasoning, a host of other persons — physical therapists, radiologic technologists, audiologists, and dental hygienists — are "physicians" under ORS chapter 656.

The legislative intent is apparent and it is clear. The decision of the Court of Appeals should be affirmed.

Jones, J., joins in this dissent.

IN THE SUPREME COURT OF THE STATE OF OREGON

FRANK R. ECKLES,
dba Riverview Marina,
Petitioner on Review,
v.
STATE OF OREGON et al,
Respondents on Review.
(TC 143089; CA A35776; SC S32710)

In Banc

On review from the Court of Appeals.*

Argued and submitted September 2, 1986. Reassigned March 16, 1988.

Robert Mix, Corvallis, argued the cause and filed the petition for petitioner on review.

William F. Gary, Deputy Attorney General, Salem, argued the cause for respondent on review.

LENT, J.

The decision of the Court of Appeals and the judgment of the circuit court are affirmed in part and reversed in part. The case is remanded to the circuit court for further proceedings consistent with this opinion.

Peterson, C. J., concurred in part and dissented in part, and filed an opinion.

Gillette, J., concurred in part and specially concurred in part, and filed an opinion in which Linde, J., joined.

*Appeal from judgment of Marion County Circuit Court, Duane R. Ertsgaard, Judge. 77 Or App 726, 714 P2d 1119 (1986).

LENT, J.

At issue is the constitutionality of a legislative act that, *inter alia,* directed the State Treasurer to transfer $81 million from the Industrial Accident Fund (IAF) to the General Fund. Or Laws 1982 (Special Session 3), ch 2 (hereinafter the "Transfer Act"). We hold that the transfer breached a contract of the state, for which the state may be liable in a breach of contract action, but did not violate the state or federal constitutions. We also hold that section four of the Transfer Act, insofar as it retroactively amended ORS 656.634, violated Article I, section 21, of the Oregon Constitution.[1]

I.

The IAF is a statutory "trust fund exclusively for the uses and purposes declared in ORS 656.001 to 656.794," which relate to workers' compensation. ORS 656.634(1). Funds

[1] Article I, section 21, of the Oregon Constitution provides, in part, "No * * * law impairing the obligation of contracts shall ever be passed."

received by the State Accident Insurance Fund Corporation (SAIF) become part of the IAF, and the IAF is, in turn, the source for payments made by SAIF. ORS 656.632(2)-(3). SAIF, an "independent public corporation" governed by a board of directors appointed by the Governor, provides workers' compensation insurance to employers, who may also self-insure or insure with a private insurer. *See* ORS 656.407(1), 656.751(1), 656.752.

In September 1982, a special session of the Legislative Assembly determined that the IAF had a "surplus" of over $168 million. Or Laws 1982 (Special Session 3), ch 2, § 1(3). Facing the prospect of a state budget deficit, *see id.* § 1(10), the Legislative Assembly directed the State Treasurer to transfer $81 million of the IAF surplus to the General Fund on June 30, 1983. *Id.* § 2. The Treasurer transferred the funds on the appointed date.

Plaintiff, an employer insured by SAIF, thereafter brought this action for declaratory, injunctive and other relief.[2] Principally, he sought a declaration that the Transfer

Act was "null and void and unconstitutional" and a "mandatory injunction directing the defendants to forthwith pay into the [IAF] a sum equal to all losses" suffered by the IAF because of the transfer.[3] The state, in its answer to the complaint and in a motion for summary judgment, challenged plaintiff's "standing" to seek this relief. The circuit court denied the state's motion but, following a trial to the court, "dismissed" the complaint and entered judgment for defendants. In a letter opinion explaining the decision, the trial judge stated, "I find that Plaintiff has failed to establish any basis to invalidate the Transfer Act and that Plaintiff has no standing herein to do so." The Court of Appeals affirmed without opinion.

II.

Before we address the issue of plaintiff's "standing," two distinct concepts of "standing" must be distinguished. Ordinarily, "standing" means the right to obtain an adjudication. It is thus logically considered prior to consideration of

[2] Plaintiff named as defendants the State of Oregon, State Treasurer William Rutherford, the Department of Revenue and its Director, Richard Munn. Anthony Meeker is now State Treasurer, but no party has moved for substitution under ORAP 12.10. SAIF is not a party. We will collectively refer to defendants as "the state."

[3] The Legislative Assembly, obviously concerned about the constitutionality of the Transfer Act, also

> "levied against each independent public corporation created by statute for the purpose of writing workers' compensation insurance a franchise tax of 44.5 percent of accumulated, declared surplus. The tax shall be for the calendar year ending December 31, 1982, and shall be computed on the basis of unassigned funds (surplus), as reflected in the taxpayers' annual audited financial statement filed with the Insurance Commissioner for the year ending December 31, 1981."

Or Laws 1982 (Special Session 3), ch 3, § 1(1). The "tax" would generate a one-time payment of $81 million from the IAF to the General Fund. Plaintiff sought a declaration that this act was unconstitutional, but it does not take effect unless and until section two of the Transfer Act is declared invalid. Or Laws 1982 (Special Session 3), ch 3, § 2. Because we uphold the validity of section two, *see infra*, it is unnecessary to decide the validity of the "tax." We note, however, that this court has in the past held that a provision of law that takes effect only upon a judicial declaration of the invalidity of another provision of law violates Article I, section 21, of the Oregon Constitution, which provides that no law shall be passed, "the taking effect of which shall be made to depend upon any authority, except as provided in this Constitution." *Portland v. Coffey*, 67 Or 507, 513, 135 P 358 (1913).

the merits of a claim. To say that a plaintiff has "no standing" is to say that the plaintiff has no right to have a tribunal decide a claim under the law defining the requested relief, regardless whether another plaintiff has any such right. When this court has used the term "standing," the term has for the most part been used in this sense. *See, e.g., Lipscomb v. State Bd. of Higher Ed.*, 305 Or 472, 475-76, 753 P2d 939 (1988);

State v. Tanner, 304 Or 312, 316, 745 P2d 757 (1987).[4] We will so use the term in this opinion.

In contrast, "standing" is also sometimes used to refer to the existence of a substantive personal right. Used in this sense, "standing" is concerned with the merits of a claim. To say that a plaintiff has "no standing" is to say that no right of the plaintiff was violated, regardless whether the conduct of a defendant was in general unlawful or unlawful as to some other person. This use of "standing" should be avoided because it easily confuses the right to obtain an adjudication of a claim for relief with the right to obtain the relief itself.

One other source of confusion is the habit of treating standing as if it were a generic concept unrelated to the specific legal relief requested by a party. This court has noted on more than one occasion that whether a person is entitled to seek judicial relief depends upon the type of relief sought and commonly is governed by a specific statutory standard. *E.g., Benton County v. Friends of Benton County*, 294 Or 79, 82-84, 653 P2d 1249 (1982). A person with standing to seek one type of relief will not necessarily have standing to seek any other type of relief. Because plaintiff sought declaratory and injunctive relief, we must decide the issue of his standing by looking to the specific statutes and cases governing his right to seek these types of relief.[5]

Plaintiff demanded a judgment "[d]eclaring the [Transfer] Act * * * null and void and unconstitutional."[6] ORS 28.020 provides:

> "Any person * * * whose rights, status or other legal relations are affected by a constitution, statute, municipal charter, ordinance, contract or franchise may have determined any question of construction or validity arising under any such * * * constitution, statute, municipal charter, ordinance, contract or franchise and obtain a declaration of rights, status or other legal relations thereunder."

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[4] *Cf. Cabell et al. v. Cottage Grove et al.*, 170 Or 256, 261, 130 P2d 1013 (1943):

"The test of sufficiency of [a complaint for a declaratory judgment] is not whether it shows that the plaintiff is entitled to a declaration of rights in accordance with his theory, but whether he is entitled to a declaration of rights at all. Even though the plaintiff is on the wrong side of the controversy, if he states the existence of a controversy which should be settled by the court under the Declaratory Judgment Law [now ORS 28.010 to 28.160], he has stated a cause of suit."

[5] Plaintiff's argument that he has standing in this case because he had standing in another case, *State ex rel Eckles v. Woolley*, 302 Or 37, 726 P2d 918 (1986), in which he challenged the legal existence of SAIF, is thus not well taken. That case was a statutory action in the nature of a proceeding in *quo warranto* pursuant to ORS 30.510(3), which permits actions in the name of the state upon the relation of a private party.

[6] In his reply brief before the Court of Appeals, plaintiff insisted, apparently for tactical reasons, that his complaint sought only injunctive relief, but the quoted statement from the prayer of the complaint cannot be characterized as anything other than a request for declaratory relief.

The statute's reference to an effect on "rights, status or other legal relations" requires a plaintiff seeking declaratory relief to allege "some injury or other impact on a legally recognized interest beyond an abstract interest in the correct application or the validity of a law." *Budget Rent-A-Car v. Multnomah Co.*, 287 Or 93, 95, 597 P2d 1232 (1979). The interest perhaps most often recognized as sufficient for standing under ORS 28.020 is a present or foreseeable financial interest, such as that of a taxpayer, *e.g., Lipscomb v. State Bd. of Higher Ed., supra,* but many other interests have been recognized as well, including the interests of voters, *e.g., Webb v. Clatsop Co. School Dist. 3,* 188 Or 324, 331, 215 P2d 368 (1950), and of users of a road, *e.g., Rendler v. Lincoln Co.,* 302 Or 177, 182, 728 P2d 21 (1986). On the other hand, a taxpayer who alleged only an interest in the proper expenditure of public funds without alleging that the challenged government action would have an effect on his taxes was held to have no standing, *Gruber v. Lincoln Hospital District,* 285 Or 3, 8, 588 P2d 1281 (1979), and parents whose son had been murdered had no standing to obtain a declaration setting forth limits on the Governor's power to commute the death sentence of their child's murderer, *Eacret et ux v. Holmes,* 215 Or 121, 124-25, 333 P2d 741 (1958).

Plaintiff alleges that he is insured by SAIF and that the transfer of funds from the IAF will deprive him of various "property rights" in the IAF, which he identifies as "ownership rights," the "right to be insured," the "right to receive dividends" and the "right to have * * * premiums reduced by application of surplus funds." He also alleges that the transfer will impair his insurance contract with SAIF, which he asserts includes statutes in existence when the Transfer Act took effect. Whatever else may be included in the phrase "rights, status or other legal relations" in ORS 28.020, the phrase certainly includes property and contract rights. The state argues that plaintiff in fact has no "vested rights" in the IAF and that the transfer did not impair his

contract with SAIF, but those are arguments addressed to the merits of plaintiff's claims. That he has alleged that the transfer of funds from the IAF affected those rights is sufficient to establish his standing under ORS 28.020.

The analysis of plaintiff's standing to seek injunctive relief is much the same, although there is no governing statute. This court has held that standing to enjoin a governmental action requires an allegation that the challenged action injures the plaintiff in some special sense that goes beyond the injury the plaintiff would expect as a member of the general public. *See, e.g., Holland et al v. Grant County et al,* 208 Or 50, 54-55, 298 P2d 832 (1956); *Fields v. Wilson,* 186 Or 491, 496-98, 207 P2d 153 (1949); *cf. Budget Rent-A-Car v. Multnomah Co., supra,* 287 Or at 95. Plaintiff's allegations meet this standard because he has alleged legally cognizable injuries that he allegedly suffers as an employer insured with SAIF and not simply as a member of the public who is interested in seeing that the law is obeyed.

III.

Plaintiff challenges the validity of the Transfer Act on a number of state and federal grounds. We must first address the state grounds. *State v. Kennedy,* 295 Or 260, 262, 666 P2d 1316 (1983).

Plaintiff's first claim is that the Transfer Act is "illegal" because the IAF is a "trust fund" that may not be used for General Fund purposes. The IAF, though denominated a "trust fund" in ORS 656.634(1), is nonetheless a statutory "trust fund." ORS 656.632(1); *cf.* Or Const, Art VIII, § 2 (establishing a "Common School Fund"). Within constitutional limitations, the legislature may dispose of the assets of a statutory fund in any manner that it sees fit.[7] We therefore turn to plaintiff's constitutional arguments.

Article I, section 20, of the Oregon Constitution forbids granting "to any citizen or class of citizens privileges, or immunities, which, upon the same terms, shall not equally

belong to all citizens." Plaintiff argues that the Transfer Act violated section 20 because the Act took funds only from the IAF, which is used by SAIF and its insureds and claimants, and not from the assets of private workers' compensation insurers. In essence, the argument is that private insurers and their insureds and claimants are a "class" that is granted an immunity not available on the same terms to SAIF and its insureds and claimants. But SAIF, as a state entity, is not a "citizen" to which section 20 could apply, and the "classes" of private insurers, insureds and claimants on the one hand, and SAIF insureds and claimants on the other, are "classes" that exist only by virtue of the workers' compensation statutes. Plaintiff's Article I, section 20, argument is therefore untenable. *see State v. Freeland,* 295 Or 367, 375 & n 7, 667 P2d 509 (1983).[8]

The arguments on which plaintiff principally relies are those based on the state and federal constitutional provisions forbidding laws impairing the obligation of contracts. Article I, section 21, of the Oregon Constitution provides: "No ex-post facto law, or law impairing the obligation of contracts shall ever be passed * * *." Plaintiff identifies two contracts, the obligations of which he asserts were impaired by the Transfer Act: (1) the "charter granted by the legislature to SAIF" and (2) the "contract which has arisen between SAIF * * * and its insureds." Both of these "contracts" are said by plaintiff to include the laws in existence when the "contracts" were formed.

The "charter granted by the legislature to SAIF" cannot be characterized as a contract. The "charter" to which plaintiff refers is the legislative act that created SAIF, Oregon Laws 1979, chapter 829. Under that act, SAIF is an "independent public corporation" without "private investment or objective to operate for private profit." *State ex rel Eckles v. Woolley,* 302 Or 37, 49, 726 P2d 918 (1986). Its management is

[7] Plaintiff argues that the "common law," via "substantive due process," prevents the Legislative Assembly from transferring funds from the IAF to the General Fund. Although the Oregon Constitution adopted "the common law," it is expressly subject to subsequent legislation. *See* Or Const, Art XVIII, § 7; *State v. Hansen,* 304 Or 169, 172, 743 P2d 157 (1987).

[8] The Supreme Court of Utah has held that a tax imposed on that state's workers' compensation insurance fund, but not on private insurers, violated Utah and federal equal protection provisions because the state fund was not significantly different from a private insurance fund. *State Tax Com'n v. Department of Finance,* 576 P2d 1297 (Utah 1978). Even were Utah's workers' compensation insurance system substantially the same as Oregon's, we would not be persuaded by the Utah court's equal protection analysis, which is at odds with this court's equal privileges and immunities analysis under Article I, section 20.

exclusively governmental, consisting of a board of directors appointed by the Governor and subject to confirmation by the Senate. *Id.* This court in the past has characterized a corporate charter as "a contract between the corporation and its stockholders, and also between them and the State," *First Nat. Bank v. Multnomah State Bank,* 87 Or 423, 431-32, 170 P 534 (1918), and also between the state and the corporation, *see Schramm v. Bank of California,* 143 Or 546, 579, 20 P2d 1093 (1933), but these contractual relationships, if they exist at all, do not exist with respect to a corporation that has no stockholders and that is entirely controlled by the state.

Plaintiff did have a contract of insurance with SAIF. He offered this contract into evidence at trial but then withdrew the offer, perhaps because the state stipulated that he was insured by SAIF. The written terms of the contract are thus not in the record, but plaintiff does not rely on them in any event. Instead, he argues that the statutes in existence at the enactment of the Transfer Act are part of the contract. In particular, he relies on ORS 656.634, which dates from 1929 and which provided, prior to its 1982 amendment by the Transfer Act:

> "(1) The Industrial Accident Fund is a trust fund exclusively for the uses and purposes declared in ORS 656.001 to 656.794, except that this provision shall not be deemed to amend or impair the force or effect of any law of this state specifically authorizing the investment of moneys from the fund.
>
> "(2) The State of Oregon declares that it has no proprietary interest in the Industrial Accident Fund or in the contributions made to the fund by the state prior to June 4, 1929. The state disclaims any right to reclaim those contributions and waives any right of reclamation it may have had in that fund."[9]

Plaintiff contends that the transfer of IAF funds to the General Fund was contrary to ORS 656.634 and thereby impaired his contract with SAIF.

If the Transfer Act impaired a contractual obligation stated in ORS 656.634, the Act impaired an obligation of the state rather than an obligation of SAIF. Plaintiff does not point to any obligation of SAIF that SAIF has been excused from performing by virtue of the Act. But before considering whether ORS 656.634 states a contractual obligation of the state to employers insured by SAIF, we must first consider whether Article I, section 21, applies to state contracts.

Unlike many of the provisions in Article I of the Oregon Constitution, the provision in section 21 against impairing the obligation of contracts has its ultimate source not in the early state and colonial constitutions but in the Constitution of the United States, Article I, section 10, clause

[9] Section four of the Transfer Act amended ORS 656.634 by adding the following language to the beginning of subsection (2):

> "Subject to the right of the State of Oregon to direct legislatively the disposition of any surplus in excess of reserves and surplus deemed actuarially necessary according to recognized insurance principles, and necessary in addition thereto to assure continued fiscal soundness of the State Accident Insurance Fund Corporation both for current operations and for future capital needs * * *."

1, and the Northwest Ordinance of 1787. *See Hall v. Northwest Outward Bound School,* 280 Or 655, 659, 572 P2d 1007 (1977). Article II of the Northwest Ordinance provided, in part:

> "[N]o law ought ever to be made or have force in the said territory, that shall, in any manner whatever, interfere with or affect private contracts, or engagements, *bona fide,* and without fraud previously formed." (Emphasis in original.)

1 The Founders' Constitution 28 (Kurland & Lerner ed 1987). Apart from punctuation, this provision was adopted verbatim in Article I, section 2, of the 1845 Organic Law of the Provisional Government of Oregon. General Laws of Oregon 59 (Deady 1845-64). In an 1847 opinion, the Supreme Court of the Provisional Government stated that this prohibition of the Organic Law was "taken in the substance of its provisions from the Constitution of the United States." *Knighton v. Burns,* 10 Or 549, 550 (1847). When Article I, section 21, was adopted in 1859, language very similar to that of the federal constitutional provision was used: section 21 differs only in providing, "No * * * law impairing the obligation of contracts shall ever be passed," rather than, "No State shall * * * pass any * * * Law impairing the Obligation of Contracts."[10]

We infer from the similarity of language and from the parallels drawn between the constitutional provisions by the

predecessor of this court that the framers of the Oregon Constitution intended to incorporate the substance of the federal provision, as it was then interpreted by the Supreme Court of the United States, into the Oregon Constitution, though not necessarily every case decided under the federal provision.[11] Subsequent Supreme Court of the United States decisions, of course, do not control the interpretation of section 21, although those decisions may shed light on the early history of the federal provision, and thereby on the Oregon provision.

The federal provision was probably intended to apply only to private contracts. The similar prohibition in the Northwest Ordinance is explicitly limited to private contracts, and the immediate stimuli for the constitutional provision were state debtor relief laws, which many of the framers believed were impairing the credit of the new nation. *See* 3 The Founders' Constitution, *supra* at 391-402; Wright, The Contract Clause of the Constitution 4-5 (1938). But as early as *Fletcher v. Peck,* 10 US (6 Cranch) 87, 3 L Ed 162 (1810), the Supreme Court of the United States used the provision to prevent Georgia from nullifying its land grants, and in the famous case of *Trustees of Dartmouth College v. Woodward,* 17 US (4 Wheat) 518, 4 L Ed 629 (1819), the Court used the provision to prevent New Hampshire from changing the terms of a pre-independence royal charter that had been granted to Dartmouth College. *See also* 3 Story, *Commentaries on the Constitution* § 1385 (1833). Given this interpretation, Article

[10] The immediate source of Article I, section 21, like much of Article I, was the Indiana Constitution of 1851. Palmer, *The Sources of the Oregon Constitution,* 5 Or L Rev 200, 202 (1926).

[11] The federal constitutional provision, Article I, section 10, clause 1, was directly applicable to the states in 1859. Many of the federal constitutional analogues of other provisions of Article I of the Oregon Constitution were not applied to the states until the 20th century, and then only indirectly through the Fourteenth Amendment.

I, section 21, was very likely intended to apply to both state and private contracts. This court, though often failing to distinguish the Oregon constitutional provision from its federal counterpart, has interpreted Oregon's provision to apply to contracts of the state and its subdivisions. *E.g., Campbell et al. v. Aldrich et al.*, 159 Or 208, 213-14, 79 P2d 257 (1938); *O'Harra v. The City of Portland*, 3 Or 525, 526-27 (1869).

We now turn to the question whether ORS 656.634 forms the basis for a contractual obligation of the state to employers insured with SAIF. Courts usually have concluded that a state contractual obligation arises from legislation only

if the legislature has unambiguously expressed an intention to create the obligation. *See, e.g., Charles River Bridge v. Warren Bridge*, 36 US (11 Pet) 420, 544, 9 L Ed 773 (1837); *United States Trust Co. v. New Jersey*, 431 US 1, 17 n 14, 97 S Ct 1505, 52 L Ed 2d 92 (1977); *Campbell et al. v. Aldrich et al., supra*, 159 Or at 213-14. For example, if the Legislative Assembly had simply provided in ORS 656.634 that the IAF was to be used for the purposes stated in ORS 656.001 to 656.794, a contractual obligation probably could not have been inferred from the provision because it would have contained nothing indicative of a legislative commitment not to repeal or amend the statute in the future.[12] But the history of the IAF and ORS 656.634 shows that ORS 656.634 is more than a legislative direction for spending the IAF.

The IAF was created in 1913, when Oregon's workers' compensation system was initiated. Or Laws 1913, ch 112, § 20. A predecessor of SAIF, the State Industrial Accident Commission (SIAC), both administered the system and provided insurance to employers, who participated in the system voluntarily. *Id.* §§ 2-10. Funds received by SIAC from covered employers and workers were placed in the IAF, from which benefits to injured workers and covered employers were drawn. *Id.* § 20. The IAF also received contributions from the General Fund until 1923. Or Laws 1929, ch 172.

In 1927, the Legislative Assembly directed that $600,000 of the IAF be used to construct a state office building in Salem, the money plus interest to be repaid to the IAF out of the General Fund over a period of several years. Or Laws 1927, ch 322. Covered employers and workers brought an action to challenge this use of the IAF, contending that the IAF could be used only for workers' compensation purposes and that the act authorizing the investment of the funds created a state debt in excess of constitutional limitations. This court, after reversing itself on rehearing, held that the investment was valid, either because the state was "the absolute owner" of the IAF or because the state, if not "the absolute owner," at least had the authority to determine the proper

investment of the IAF. *Eastern & Western Lbr. Co. v. Patterson*, 124 Or 146, 147-48, 264 P 441 (1928), *rev'g on rehearing* 124 Or 112, 258 P 193 (1927).

[12] *Cf. Methodist Hosp. of Brooklyn v. State Ins. Fund*, 64 NY 2d 365, 476 NE2d 304, 310 (1985) (statutory directives regarding proper uses of insurance fund did not create a contractual obligation).

In reaction to the court decision, the Legislative Assembly at its next session enacted what has become ORS 656.634. Or Laws 1929, ch 172. The act, together with its preamble, provided:

> "Whereas a question has arisen over the right of the state of Oregon to use a part of the industrial accident fund for the purpose of constructing an office building for the state of Oregon, under chapter 322, General Laws of Oregon, 1927, and also as to whether or not the state of Oregon has any proprietary interest in the contributions heretofore made by said state to said fund, and the right to reclaim the same, which questions are said to have caused apprehension on the part of the employer and employe contributors to said fund as to the security and protection thereof, and to have caused threats of withdrawal from further support and contribution thereto by large contributors thereto; and
>
> "Whereas the state of Oregon has not made financial contributions to said fund since July 1, 1923, and the said fund since said date has been maintained entirely by the contributions of the employers and employes in hazardous employment, and all contributions heretofore made by the state have either been expended in the administration of said fund or have become a part of the catastrophe fund, rehabilitation fund or segregated accident fund, set aside for the payment of awards of benefits under the act, and said state contributions can no longer be identified; and
>
> "Whereas any uncertainty as to the security and protection of said fund or doubt as to the rights of the state therein militates against the fullest acceptance and the proper administration thereof, and it is for the interest of the state that confidence of the industrial interests of the state in the fullest measure be maintained in said fund; therefore
>
> "*Be it Enacted by the People of the State of Oregon:*
>
> "Section 1. The state of Oregon hereby does declare that the industrial accident fund created by the workmen's compensation act of Oregon, being chapter 112, General Laws of Oregon, 1913, as amended by various sessions of the legislature thereafter, be and the same is a trust fund for the uses and purposes declared in said act as so amended, and no other, and that the contributions to the said fund heretofore made by the

> state of Oregon have become an integral part of said fund and have either been expended or allocated to the catastrophe fund, rehabilitation fund or segregated accident fund, and the state of Oregon hereby does declare that it has no proprietary interest in said fund or in the contributions thereto heretofore made by said state, and hereby does disclaim any right to reclaim said contributions or any part thereof for its own use, and hereby does waive any such right of reclamation, if any it ever had, in or to any of said fund. This act shall not be deemed to amend or impair the force of said chapter 322, General Laws of Oregon, 1927, or to limit, restrict or control the investment of the sum of $600,000 of said accident fund for building purposes."

Apart from condensation of the act when it was incorporated into the Oregon Revised Statutes in 1953,[13] the only change in

[13] Oregon Laws 1953, chapter 3, repealed laws then in existence and reenacted them as the "Oregon Revised Statutes." Although textual changes were made, no substantive changes in the laws were intended. *See State of Oregon v. Holland*, 202 Or 656, 661-65, 277 P2d 386 (1954).

the act until it was amended by the Transfer Act was a 1967 amendment that provided that the act was not intended to limit the ability of the state to invest the IAF. Or Laws 1967, ch 335, § 55.

We need not pursue the extended arguments of the state and plaintiff over whether the IAF is a "trust fund," as it is described by the legislature, or a "statutorily dedicated fund," as the state insists that it is. There can be little doubt that the purpose of ORS 656.634 was to assure employers who insured with SIAC, and subsequently with SAIF, that the state would not do precisely what it did do in the Transfer Act. Moreover, the reason that the state made this assurance was to induce skeptical employers to participate in a state insurance system that was, and still is, voluntary in the sense that private employers need not obtain workers' compensation insurance from SAIF. We conclude that ORS 656.634 expressed a contractual promise of the state to employers who insured with SAIF that the state would not transfer IAF funds to the General Fund.

The question that follows from this conclusion is whether the Transfer Act, though contrary to the contract

formerly stated in ORS 656.634, is a law "impairing the obligation" of that contract. To answer this question, we must first describe the Act in more detail.

The Act is divided into five sections, but only sections two and four are important to our present inquiry.[14] Section two, the heart of the Act, directs the State Treasurer to transfer $81 million from the IAF to the General Fund:

> "(1) Notwithstanding any other statute, the State Accident Insurance Fund Corporation shall reduce its excess surplus in the Industrial Accident Fund by the amount of $81 million in the manner provided in this Act.
>
> "(2) Notwithstanding ORS 293.115(2)(d), or any other provision of law, the State Treasurer shall transfer $81 million from the Industrial Accident Fund into the General Fund on June 30, 1983. Any liquidation of investments necessary to accomplish this transfer shall be done in an orderly manner and at the most advantageous terms obtainable.
>
> "(3) The initiation of a judicial proceeding to challenge the legality of any part of this Act shall not stay implementation of the transfer procedures provided in this section, and no injunction, stay or restraining order prohibiting or delaying such transfer shall issue in such proceeding unless and until the transfer of funds required by this Act has been finally adjudicated to be invalid."

Section four modifies the contractual agreement stated in ORS 656.634 so as to permit the state to use surplus IAF funds for any purpose that the legislature directs. ORS 656.634 now provides, with the amendment made by section four italicized:

> "(1) The Industrial Accident Fund is a trust fund

[14] Section one of the Transfer Act is a statement of legislative findings and legal conclusions. Section five is an emergency clause. Section three, which amends ORS 656.526(2), prohibits SAIF from declaring a dividend to insured employers from surplus IAF funds until SAIF has made other payments of surplus funds authorized by law. We need not decide the validity of this last section because the outcome of this case hinges upon the validity of these "other payments."

exclusively for the uses and purposes declared in ORS 656.001 to 656.794, except that this provision shall not be deemed to amend or impair the force or effect of any law of this state specifically authorizing the investment of moneys from the fund.

"(2) *Subject to the right of the State of Oregon to direct legislatively the disposition of any surplus in excess of*

reserves and surplus deemed actuarially necessary according to recognized insurance principles, and necessary in addition thereto to assure continued fiscal soundness of the State Accident Insurance Fund Corporation both for current operations and for future capital needs, the State of Oregon declares that it has no proprietary interest in the Industrial Accident Fund or in the contributions made to the fund by the state prior to June 4, 1929. The state disclaims any right to reclaim those contributions and waives any right of reclamation it may have had in that fund."

If section four of the Transfer Act is a constitutionally valid modification of the state's contract with employers insured with SAIF, then section two is valid as well because the transfer made by section two is consistent with the modified contract. We therefore first analyze whether section four impairs the obligation of the contract formerly stated in ORS 656.634.

The Supreme Court of the United States, interpreting the federal contracts clause, early distinguished the obligation of a contract from the agreement stated in a contract. The obligation of a contract was the sum of the contractual duties imposed upon the contracting parties by the operation of law upon the contract. *See Ogden v. Saunders,* 25 US (12 Wheat) 213, 256-57, 6 L Ed 606 (1827). Justice Washington wrote in *Ogden:*

"[T]he error of those who controvert the constitutionality of the bankrupt law under consideration * * * has arisen from not distinguishing accurately between a law which impairs a contract, and one which impairs its obligation. A contract is defined by all to be an agreement to do, or not to do, some particular act; * * *. Any law, then, which enlarges, abridges, or in any manner changes, this [agreement] * * * necessarily impairs the contract * * *.

"* * * It is a law which impairs the obligation of contracts, and not the contracts themselves, which is interdicted. * * * What is it, then, which constitutes the obligation of a contract? * * * [I]t is the law which binds the parties to perform their agreement. The law, then, which has this binding obligation, must govern and control the contract, in every shape in which it is intended to bear upon it, whether it affects its validity, construction or discharge."

25 US (12 Wheat) at 256-57. In *Ogden,* the Court held that an insolvency law, which impaired a contractual agreement by

discharging a debt, did not impair the contractual obligation of the debtor because the contract was entered into after the insolvency law was enacted, and thus there had never been

any obligation to pay the debt in the circumstances in which the insolvency law applied.[15]

The contractual obligation with which the Court was concerned in *Ogden* was a private obligation. When the Court's definition of obligation is applied to contracts of a state, which makes the laws, the definition becomes circular because the contracts clause itself defines a state's contractual obligations. The Court avoided this difficulty by tacitly assuming that general principles of contract law were applicable to state contracts. Thus, the Court held that Georgia could not repeal a land grant that had been obtained through the bribery of a previous legislature:

> "[T]he legislature may have had ample proof that the original grant was obtained by practices which can never be too much reprobated, and which would have justified its abrogation, so far as respected those to whom crime was imputable. But the grant, when issued, conveyed an estate in fee-simple to the grantee, clothed with all the solemnities which law can bestow. This estate was transferrible [sic]; and those who purchased parts of it were not stained by that guilt which infected the original transaction. Their case is not distinguishable from the ordinary case of purchasers of a legal estate, without knowledge of any secret fraud which might have led to the emanation of the original grant. According to the well-known course of equity, their rights could not be affected by such fraud. Their situation was the same, their title was the same, with that of every other member of the community who holds land by regular conveyances from the original patentee."

Fletcher v. Peck, supra, 10 US (6 Cranch) at 134-35. Similarly,

the Court held that New Hampshire's amendment of a private college's charter was unconstitutional, the Court noting:

> "This [charter] is plainly a contract to which the donors, the trustees, and the crown (to whose rights and obligations New Hampshire succeeds), were the original parties. It is a contract made on a valuable consideration. It is a contract for the security and disposition of property. It is a contract, on the faith of which, real and personal estate has been conveyed to the corporation. It is, then, a contract within the letter of the constitution, and within its spirit also, * * *."

Trustees of Dartmouth College v. Woodward, supra, 17 US (4 Wheat) at 643-44; *see also New Jersey v. Wilson,* 11 US (7 Cranch) 164, 3 L Ed 303 (1812) (state's repeal of a tax exemption, which formed part of a land claims settlement with the Delaware Indians, violated the contracts clause); *cf. Huidekoper's Lessee v. Douglass,* 7 US (3 Cranch) 1, 70, 2 L Ed 347 (1805) ("This [legislative act] is a contract; and although a state is a party, it ought to be construed according to those well-established principles which regulate contracts generally.").

[15] The *Ogden* Court's definition of obligation is probably too broad in that perhaps every law would have the potential for impairing a contractual obligation so defined. It may be that legislation not specifically directed at altering contractual relationships is outside the scope of Article I, section 21, and the federal contracts clause, but this case does not require us to pursue the matter further. *Cf. Exxon Corp v. Eagerton,* 462 US 176, 190-92, 103 S Ct 2296, 76 L Ed 2d 497 (1983); *Hudson Water Co. v. McCarter,* 209 US 349, 357, 28 S Ct 529, 52 L Ed 828 (1908) ("One whose rights, such as they are, are subject to state restriction, cannot remove them from the power of the State by making a contract about them."); Note, *Rediscovering the Contract Clause,* 97 Harv L Rev 1414 (1984).

The Court, however, did not treat the states entirely as if they were private contracting parties. The Court relatively early developed the rule noted above that a state contract will not be inferred from legislation that does not unambiguously express an intention to create a contract. *See Charles River Bridge v. Warren Bridge, supra,* 36 US (11 Pet) at 544; *Providence Bank v. Billings,* 29 US (4 Pet) 514, 561, 7 L Ed 939 (1830); *accord Campbell et al. v. Aldrich et al., supra,* 159 Or at 213-14. Although the rule is concerned with the existence of a contractual agreement, rather than with the extent of the obligation created by an agreement, the effect of the rule is to eliminate the state's contractual obligation whenever there is doubt concerning the agreement.

Another early rule was, and is, that the contracts clause does not limit a state's power of eminent domain. *See West River Bridge Co. v. Dix,* 47 US (6 How) 507, 12 L Ed 535 (1848). In *West River Bridge Co.,* the Court held that Vermont's taking, with compensation, of a 100-year toll-bridge franchise granted by the Vermont legislature 48 years before did not violate the contracts clause. The Court recognized that the franchise created a contractual obligation that the state

could not impair but reasoned that the franchise was property like any other and thereby subject to taking through an eminent domain proceeding.[16]

In the late 19th century, the Supreme Court of the United States further limited the states' contractual obligations under the federal constitution through the rule that a state could not contract away its "police power," *i.e.,* that a state was under no obligation to keep agreements that were or had become contrary to certain aspects of public welfare. *See, e.g., Stone v. Mississippi,* 101 US 814, 25 L Ed 1079 (1880). More recently, employing a "balancing" analysis, the Court has stated that the contracts clause "must be accommodated to the inherent police power of the State 'to safeguard the vital interests of its people.'" *Energy Reserves Group v. Kansas Power & Light,* 459 US 400, 410, 103 S Ct 697, 74 L Ed 2d 569 (1983) (quoting *Home Bldg. & L. Assn. v. Blaisdell,* 290 US 398, 434, 54 S Ct 231, 78 L Ed 413 (1934)).[17] This court has in the past made similar statements with respect to both the Oregon and federal constitutions. *See, e.g., Campbell et al. v. Aldrich et al., supra,* 159 Or at 217; *Schramm v. Bank of California, supra,* 143 Or at 579. *But cf. Haberlach v. Tillamook Bank,* 134 Or 279, 289, 293 P 927 (1930). Exercise of the "police power," unlike exercise of the "eminent domain power," does not require compensation.

We find nothing in the history of Article I, section 21, including the early history of the federal contracts clause, from which we could infer that the disclaimer formerly stated in ORS 656.634 did not create a contractual obligation on the part of the state. A contractual obligation would exist under

[16] Years later, the Court explicitly held that the power of eminent domain was inalienable. *Pennsylvania Hospital v. Philadelphia,* 245 US 20, 38 S Ct 35, 62 L Ed 124 (1917).

[17] Because a state's self-interest is at stake when it impairs its own contractual obligations, the Court has been less willing than it has been with impairments of private contracts to conclude that such impairments are reasonable. *See United States Trust Co. v. New Jersey,* 431 US 1, 25-26, 97 S Ct 1505, 52 L Ed 2d 92 (1977).

general principles of contract law, and none of the special limitations on the contractual obligations of states, discussed above, are applicable. The need to resolve the financial crisis that induced the Legislative Assembly to pass the Transfer Act could perhaps be described as a "vital interest" of the

state, but we doubt that the "police power" doctrine could be stretched so far as to permit the state to disregard a financial guarantee to persons or corporations who participate in a state insurance system. In any event, this court has emphasized in recent years that the "police power" is indistinguishable from the state's inherent power to enact laws and regulations; the existence of that power cannot explain the extent to which the power is constitutionally limited. *See Dennehy v. Dept. of Rev.*, 305 Or 595, 604 n 3, ___ P2d ___ (1988). Moreover, the state cannot avoid a constitutional command by "balancing" it against another of the state's interests or obligations, such as protection of the "vital interests" of the people. *See Oregonian Publishing Co. v. O'Leary*, 303 Or 297, 305, 736 P2d 173 (1987). Limits on the contractual obligations of the state must be found within the language or history of Article I, section 21, itself.

Section four of the Transfer Act impairs the obligation of the contract formerly stated in ORS 656.634 because section four would eliminate that obligation with respect to surplus IAF funds. The state could use surplus IAF funds for any purpose that it chose, without contractual liability to employers insured by SAIF. Section four, then, violates Article I, section 21, of the Oregon Constitution insofar as it affects employers with SAIF insurance contracts entered into before the enactment of the Transfer Act. As to subsequent contracts, including renewals of contracts then in existence, section four is valid because ORS 656.634 as amended by section four would define, not impair, the state's contractual obligations to employers by reason of those contracts.[18]

The invalidity of section two of the Transfer Act does

not follow necessarily from the invalidity of section four.[19] Unlike section four of the Act, section two does not purport to change the terms of the state's contract but to mandate a breach of that contract. The distinction has an analogy in

[18] Future private contracts, as well, are not protected by the state and federal contracts clauses. *See Ogden v. Saunders*, 25 US (12 Wheat) 213, 6 L Ed 606 (1827); *Hibernia Securities Co. v. Pirie*, 149 Or 434, 457-58, 41 P2d 431 (1935); *accord Knighton v. Burns*, 10 Or 549, 552 (1847) (interpreting "contracts clause" in Oregon Provisional Government Organic Law, Art I, § 2). No law can impair the obligation of future contracts because the laws in existence when a contract is formed define the obligation of that contract. Preexisting contractual obligations, on the other hand, may be impaired by subsequent changes in the laws that modify those obligations. This interpretation of the contracts clauses is also supported by the records of the federal constitutional convention. The prohibition on laws impairing the obligation of contracts was originally stated as a prohibition on "retrospective laws." 3 The Founders' Constitution 393 (Kurland & Lerner ed 1987). Perhaps because of fears that "retrospective laws" would be interpreted to apply only to criminal laws, the prohibition was recast in its current form. *See id.*

[19] Although there is no severability provision in the Transfer Act, the legislature could not have intended to make the enactment of section two contingent upon the validity of section four. The transfer of funds mandated by section two was the *raison d'etre* of the Act. We conclude that the provisions are severable. *See* ORS 174.040; *City of Portland v. Dollarhide*, 300 Or 490, 503-05, 714 P2d 220 (1986).

private contract law in the distinction between a failure or refusal to perform according to the terms of a contract and an assertion of the invalidity or nonexistence of the contract terms under which that performance is specified. A failure or refusal to perform a contract is not inconsistent with recognition of the contract's validity. In deciding the validity of section two, we must decide whether Article I, section 21, prohibits the state from breaching its contracts. That is, does Article I, section 21, oblige specific performance of the state's contract or only compensation for its breach?

Ogden v. Saunders, supra, established that the obligation of a contract was to be understood as the legal duties imposed upon the contracting parties by the operation of law upon the contract. Ordinarily, parties to a contract are not obliged to perform the contract according to its terms; in lieu of performance, the breaching party may compensate the nonbreaching party for the failure to perform as directed by the contract. *See also* 3 Story, *supra,* § 1372 ("[I]t has been said, that the obligation of a contract consists in the power and efficacy of the law, which applies to, and enforces performance of it, or an equivalent for non-performance."). Specific performance is available only if other remedies are deemed to be inadequate to protect the nonbreaching party's contractual interests. *Cf.* Restatement (Second) Contracts §§ 359-60 (1979).[20]

Moreover, it has long been established that a state may, through eminent domain proceedings, violate or abrogate its contracts without impairing its contractual obligations. *See West River Bridge Co. v. Dix, supra.* In *West River Bridge Co.,* Vermont's condemnation of the plaintiffs' toll-

bridge franchise was, in effect, a breach of the franchise contract together with a payment of damages for the breach. Although the franchise contract created a contractual obligation, which Vermont could not constitutionally impair, that obligation was not an obligation of specific performance but of compensation. This eminent domain rule is somewhat akin to the rule in the general law of contracts that there is ordinarily no contractual obligation of specific performance. *See* Sterk, *The Continuity of Legislatures: Of Contracts and the Contracts Clause,* 88 Colum L Rev 647, 690-91 (1988). But the ability of the state to breach its contracts through the use of its power of eminent domain is not limited to those cases in which damages would be an adequate remedy under the general law of contracts. If the state agreed to lease a parcel of land and then chose to condemn the lessee's interest under the lease, neither Article I, section 21, nor the federal contracts clause would prohibit the state from doing so, even though specific performance of a contract involving the transfer of an interest in land is ordinarily required, *see* Restatement (Second) Contracts § 360, *comment e* (1979).

Given the general law of contractual obligations and the state's undoubted ability to breach its contracts through the use of its power of eminent domain, we conclude that the state is not obliged by Article I, section 21, to perform its

[20] *Cf.* Holmes, *The Path of the Law,* in Collected Legal Papers 175 (1920): "The duty to keep a contract at common law means a prediction that you must pay damages if you do not keep it — and nothing else."

contracts according to the terms of those contracts, at least where, as in this case, the contractual interests of the parties with whom the state has contracted are financial or property interests.[21] In such cases, Article I, section 21, protects contractual interests by obliging the state to compensate for its breach of those contracts.[22] In this respect, Article I, section 21, is consistent with Article I, section 18, of the Oregon Constitution, which prohibits the state from taking private

property for public use without payment of "just compensation."[23]

By directing the State Treasurer to transfer $81 million from the IAF to the General Fund, section two of the Transfer Act breached the state's contract with employers insured with SAIF. Unlike section four of the Act, however, section two does not alter retroactively the terms of that contract. Though the transfer breached the state's contract, the obligation of that contract remains. That obligation is to compensate employers for the breach. It is true that neither section two nor any other section of the Transfer Act makes provision for such compensation, but section two would not preclude compensation. As with a "taking" of private property, a breach of contract by the state is not unconstitutional simply because compensation is not offered in the legislation mandating the breach. *Cf. Suess Builders v. City of Beaverton,* 294 Or 254, 258 n 3, 656 P2d 306 (1982) (describing "inverse condemnation" action). Section two, then, does not impair the obligation of the state's contract and does not violate Article I, section 21, of the Oregon Constitution.

Plaintiff neither sought compensation nor produced any evidence that he had been damaged by the state's breach of contract.[24] He sought a declaratory judgment that the Transfer Act was "null and void and unconstitutional" and a "mandatory injunction" for the return to the IAF of the funds

[21] We need not and do not decide whether, where other contractual interests are at stake, the state would be obliged by Article I, section 21, to perform its contracts in accordance with the contract terms.

[22] *Cf.* Shakespeare, *The Merchant of Venice,* Act IV, Scene I, in The Complete Works of Shakespeare 280 (Kittredge ed 1936). Were specific performance required, the state, if it made an unwise or unfortunate bargain, might find itself in the position of Antonio, who, having agreed to forfeit a pound of his flesh upon failure to repay 3000 ducats, could not obtain mercy from Shylock even though friends offered to repay the debt many times over. Obligees with less of a point to prove than Shylock would nonetheless be in a position to extract an onerous settlement from the state.

[23] At least one author, writing on the federal contracts clause, argues that a "takings" analysis under the Fifth Amendment would be "a better conceptual vehicle for approaching certain government actions now dealt with under contract clause analysis." Note, *Takings Law and the Contract Clause: A Takings Law Approach to Legislative Modifications of Public Contracts,* 36 Stan L Rev 1447, 1449 (1984). "As in private contract cases, the goal should be protecting each party's expectations while enabling the parties to enter into superior transactions." *Id.* at 1461 (footnotes omitted).

[24] We cannot infer from the statutes alone that employers insured by SAIF were harmed by the transfer of funds. Nothing in the statutes makes employers liable to injured workers for shortfalls in the IAF. ORS 656.018(1)(a) provides that the liability of employers to injured employees is limited to maintaining workers' compensation coverage in accordance with the workers' compensation laws. *Cf. Moran v. State ex rel. Derryberry,* 534 P2d 1282, 1286-88 (Okla 1975) (because insured employers were liable for shortfalls in workers' compensation fund, transfer of funds violated Oklahoma Constitution's prohibition on laws impairing the obligation of contracts). Insured employers may benefit from premium reductions and dividends drawn from surplus IAF funds. *See* ORS 656.508 and 656.526. These benefits are set in the "discretion" of SAIF. *See id.* That "discretion" does not preclude a showing that insured employers were harmed by the transfer, but the existence of that harm cannot be presumed.

transferred. The state is not obliged by Article I, section 21, to return the funds to the IAF, but the circuit court erred in not awarding plaintiff a declaratory judgment that section four of the Transfer Act is unconstitutional insofar as it affects employers with SAIF insurance contracts that were in existence on or before the date of the enactment of the Transfer Act.

With respect to plaintiff's other Oregon claims, his failure to prove that he was damaged by the transfer of funds defeats his "takings" claim under Article I, section 18, of the Oregon Constitution. His claim that the Transfer Act deprives him of "due process" under Article I, section 10, of the Oregon Constitution misconceives that provision. *State v. Wagner*, 305 Or 115, 145-46, 752 P2d 1136 (1988); *Cole v. Dept. of Rev.*, 294 Or 188, 191, 655 P2d 171 (1982).

IV.

Having decided that section four of the Transfer Act is unconstitutional under the Oregon Constitution, we need only address plaintiff's federal claims with respect to section two of the Act. These claims fail for essentially the same reasons as do his claims under analogous provisions of the Oregon Constitution. His equal protection claim is premised upon an equality between SAIF and private insurers that does not exist. His "takings" and due process arguments fail for the absence of a showing of any "taking" or "deprivation." His contract claim under Article I, section 10, clause 1, of the Constitution of the United States also cannot be sustained without showing that the transfer of funds mandated by section two caused some harm to his contractual interests. *See Texaco, Inc. v. Short*, 454 US 516, 531, 102 S Ct 781, 70 L Ed 2d 738 (1982); *United States Trust Co. v. New Jersey, supra*, 431 US at 18-19.

The decision of the Court of Appeals and the judgment of the circuit court are affirmed in part and reversed in part. The case is remanded to the circuit court for further proceedings consistent with this opinion.

PETERSON, C. J., concurring in part and dissenting in part.

In large part, I agree with the majority. The majority is correct that

> "[t]here can be little doubt that the purpose of ORS 656.634 was to assure employers who insured with SIAC, and subsequently with SAIF, that the state would not do precisely what it did do in the Transfer Act. * * *"

and

> "ORS 656.634 expressed a contractual promise of the state to employers who insured with SAIF that the state would not transfer IAF funds to the General Fund." 306 Or at ___.

I would hold, however, that the passage of the 1982 law breached an existing contract between the State of Oregon on the one hand, and the employers and workers of Oregon on the other, entitling the plaintiff herein to relief, and that the 1982 law impaired the obligation of that contract under the

Oregon Constitution. I would order the $81 million repaid to SAIF.

The analysis is simple and straightforward:

Before the 1982 amendments, ORS 656.634[1] provided that "(1) The Industrial Accident Fund is a trust fund exclusively for the uses and purposes declared in ORS 656.001 to 656.794 * * *," and "(2) The State of Oregon declares that it has no proprietary interest in the Industrial Accident Fund * * *."

The "contract" between the state and employers who were insured by SAIF is found in part in ORS 656.526(1) and (2). Before the 1982 amendments, ORS 656.526 provided in relevant part:

> "(1) Periodically, the State Accident Insurance Fund Corporation shall determine the total liability existing against the Industrial Accident Fund.
>
> "(2) If, after the determination required by subsection (1) of this section, the State Accident Insurance Fund Corporation finds the Industrial Accident Fund, aside from the reserves deemed actuarially necessary according to recognized insurance principles, contains a surplus, the State Accident Insurance Fund Corporation in its discretion may declare a dividend to be paid to, or credited to the accounts of, employers who were insured by the State Accident Insurance Fund Corporation during all or part of the period for which the

> dividend is declared. Any dividend so declared shall give due consideration to the solvency of the Industrial Accident Fund, not be unfairly discriminatory and not be promised in advance of such declaration."

SAIF is a government insurance company. This is apparent from its name — State Accident *Insurance* Fund Corporation (ORS 656.751); from its purpose — SAIF "is created for the purpose of transacting workers' compensation insurance and reinsurance business" (ORS 656.752); and from its ORS 656.752 "functions" — those of any workers' compensation insurer: to "solicit employers," to collect the premiums of insured employers, to "receive and handle and process the claims of workers," to "furnish advice, services and excess workers' compensation and employer liability insurance," and to "provide reinsurance coverage to Oregon employers" (ORS 656.752).

The source of the contract between the state (through SAIF) and its insureds that is acutely relevant herein is ORS 656.526(1) and (2), set forth above. The statute sets forth the financial arrangements between SAIF and its insureds and workers. SAIF receives premiums from its insureds. Those premium dollars are to be handled as such moneys are required to be handled by insurers generally. Apart from its costs of operation, ORS 656.526 requires SAIF to conduct its affairs as follows:

First, SAIF must "determine the total liability existing against the [IAF]." ORS 656.526(1). Second, SAIF is required to determine reserves "deemed actuarially necessary

[1] Unless otherwise stated, all references are to the statutes in effect before the 1982 amendments.

according to recognized insurance principles." ORS 656.526(2). These two steps are designed to assure the payment of benefits to workers before any dividends are declared. Third, from the "surplus," the amount remaining after steps one and two, SAIF "in its discretion may * * * declare a dividend to be paid to, or credited to the accounts of, employers who were insured by [SAIF] during all or part of the period for which the dividend is declared." ORS 656.526(2).

The contract between SAIF and its insureds is essentially this: In return for the payment of premiums, SAIF is to use the premiums to pay its costs of operations, including claims; to set up appropriate reserves for payment of claims

"according to recognized insurance principles"; and "in its discretion," to declare dividends from the surplus.[2]

ORS 656.526(2) does not expressly state that SAIF will exercise good faith in deciding whether to "declare a dividend," but I have little doubt that it would be improper for SAIF to amass an unreasonably large surplus. In fact, the 1982 law makes this very point. The proposition that unreasonably large surpluses cannot be retained is driven home by section 1(8) of chapter 2 of the 1982 law, which provides:

> "As an independent public corporation, it is inappropriate and contrary to public policy for the State Accident Insurance Fund Corporation to continue to maintain a surplus so far exceeding the amount necessary for its statutory purposes." Or Laws 1982 (3d Special Session), ch 2, § 1(8).

Although that paragraph likely was included in the 1982 law as a justification for the transfer, the paragraph as well supports the proposition that SAIF, in discharging its obligation to its insureds under ORS 656.526(1), cannot "maintain a surplus * * * exceeding the amount necessary for its statutory purposes." Or Laws 1982 (3d Special Session), ch 2, § 1(8).

Moreover, the 1982 law confirms that such distributions were made. Section 1(4) expressly refers to SAIF's practice of paying dividends. It states: "Dividends for calendar years 1981 and 1982 have already been declared and paid."

As stated above, SAIF is a government insurance company. The state has "no proprietary interest" in the IAF. ORS 656.634(2). In some respects, its method of operation is akin to that of a mutual insurance company. Its insureds contribute to the creation of a fund to pay claims and costs of operation, and to establish reserves. Ultimately, surplus funds are divided among the insureds by the payment of dividends. That seems to be the goal of ORS 656.526(2).

The law involving mutual insurance companies is analogous. The general rule is that the surplus of a mutual insurance company belongs to its policyholders, with distribution to be made according to the governing statutes, *See* 2

Couch on Insurance 2d 692, § 19:24 (rev ed 1984). Often, as here, decisions concerning dividends are left to the "discretion" of the board.

[2] The statutes concerning SAIF's reserve accounts include ORS 656.635 to 656.644. Reserves for paying awards and benefits are governed by ORS 656.636. Creation of "other reserves * * * as are deemed necessary" is governed by ORS 656.640. The statutory source of the fund for disbursement of "surplus to employers as required by ORS 656.526" is ORS 646.642.

ORS 656.526 appears to enact for SAIF the general rule concerning declaration of dividends by insurers. The board determines how much of the surplus should be retained to insure the security of the policyholders, to pay claims, and to cover contingencies. It then, in its discretion, decides how much should be distributed to the policyholders. The exercise of this discretion is reviewable by courts, the usual referents being bad faith, fraud, or abuse of discretion. *See* 6 Couch on Insurance 2d 971-74, §§ 34:121-22 (rev ed 1985); *see also Gilmore v. State Compensation Insurance Fund*, 23 Cal App 2d 325, 328, 73 P2d 640, 642 (1937) (premium paid to California State Compensation Fund "in excess of compensation necessarily paid, and the cost of creating and maintaining the fund, is to be refunded in dividends or credited on the renewal * * *"; petition failed to allege facts showing a breach of duty by the fund).

I have no opinion and the record does not show whether the SAIF board would have declared a dividend but for the $81 million transfer. (As stated, we do know that SAIF declared a dividend in 1981 and 1982. Section 1(4) of the 1982 law states: "Dividends for calendar years 1981 and 1982 have already been declared and paid.") If the facts would warrant such a distribution, presumably SAIF's board would order it, for the general rule is that directors of a mutual insurance company cannot withhold a dividend that should be declared. *Rhine v. New York Life Ins. Co.*, 273 NY 1, 6 NE2d 74 (1936).

One inescapable conclusion is that the transfer of the $81 million entirely prevented SAIF's board from exercising its discretion in deciding whether to declare a dividend.[3]

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[3] Soon after the 1982 legislation was passed, SAIF filed a complaint against the State of Oregon asserting that both 1982 laws were unconstitutional. *SAIF Corporation v. State of Oregon*, Marion County Circuit Court No. 136437.

SAIF was sensitive to its responsibilities to its workers and policyholders. Paragraph I of its complaint forthrightly alleged:

> "This is an action for a declaratory judgment regarding the validity of two Oregon laws, HB 3324 and HB 3325, which were enacted as a package on September 3, 1982. Those measures require that $81 million be taken from the Industrial Accident Fund and placed in Oregon's General Fund. Plaintiffs are public trustees of the Industrial Accident Fund, and contend that the proposed transfer violates the Oregon Constitution and the Constitution of the United States. They seek a declaratory judgment to that effect, a permanent injunction prohibiting the transfer, and restitution of any moneys transferred prior to final judgment."

The complaint also alleged:

> "The operations of SAIF Corporation are similar to those of the private insurance companies with which it competes.
>
> "* * * * *
>
> "HB 3324 and HB 3325 impair the obligations of the State of Oregon under its statutory charter to SAIF Corporation, and the obligations of SAIF's corporation's contracts with its policyholders and covered employees, in violation of Article I, § 21 of the Oregon Constitution and Article I, § 10 , cl. 1 of the United States Constitution.
>
> "* * * * *
>
> "HB 3324 and HB 3325 interfere arbitrarily with the settled expectations of SAIF Corporation, its policyholders and covered employees. Those statutes constitute an impermissible deprivation of property rights in violation of the Due Process Clause of the Fourteenth Amendment to the United States Constitution."

Attorney General Dave Frohnmayer responded by filing a separate action for declaratory judgment in which he alleged that the Attorney General "has general control and supervision of all civil actions * * * in which the State of Oregon may be a party," that SAIF "is an institution of the State of Oregon" and that "SAIF may not employ or be represented by other counsel or attorney at law * * *."

This court upheld the assertion of the Attorney General in *Frohnmayer v. SAIF*, 294 Or 570, 660 P2d 1061 (1983). The records of the Marion County Circuit Court show that the *SAIF Corporation v. State of Oregon* action was dismissed in January 1985 for lack of prosecution.

Turning to the question whether the plaintiff has been damaged, it is appropriate to ask: "Who is the owner of the SAIF surplus?" Unquestionably, that answer is: "SAIF, free from any right of the State of Oregon." Nonetheless, the majority rejects the plaintiff's right to relief herein beyond a declaration of rights because he had not "produced any evidence that he had been damaged by the state's breach of contract." 306 Or at ___. In this the majority errs.

Although SAIF was the "owner" of the surplus funds, the plaintiff, as an employer who was insured, has two distinct, real, substantial and legally cognizable interests in the fund. One is his right to the payment of dividends to be declared by SAIF. Granted, this is an inchoate right, but it is a right that gives him standing in this case, for as the majority itself admits, he "alleged legally cognizable injuries that he allegedly suffers as an employer insured with SAIF and not simply as a member of the public * * *." 306 Or at ___. The position as an insured that gives him standing is the very

reason for his right to dividends as and when they are declared. The state's breach of contract has entirely taken this away, at least to the extent of his "share" of the $81 million. This damage is sufficiently substantial to accord relief to the plaintiff.

Second, although this damage is less substantial and less immediate, policyholders of SAIF, including plaintiff, before passage of the 1982 laws very likely would have, by contract, an interest in the surplus as beneficial owners. In mutual insurance companies the policyholders are said to be the owners of the surplus. Were the legislature to dissolve SAIF and get out of the workers' compensation business, the surplus likely would be distributable to the persons entitled to that surplus, and the plaintiff herein likely would be entitled to his *pro rata* share. In any event, as between the State of Oregon and SAIF's insureds, under the contract between the state and SAIF's insureds, the insureds have a greater right to the $81 million surplus than does the State of Oregon.

Without any evidence beyond the statutes themselves, the plaintiff has established a right to relief. In his complaint he asks for return of the moneys to the fund. That simple measure of relief would, in one stroke, return the concerned parties to the status existing before the 1982 laws were passed. That is what should be done. The only effective remedy is to order the State of Oregon to repay the $81 million to SAIF. SAIF's board of directors then, and only then, could exercise its discretion to decide whether a dividend should be declared.

The concurring opinion suggests that relief might be available if a suit resembling a shareholder's derivative suit is filed and SAIF is made a party. *See* ORCP 29. I would not require that. I do not view SAIF as an indispensable party, *see* ORCP 29, and would simply remand for entry of a decree requiring the return of the $81 million to SAIF.

The transfer of the $81 million from SAIF to the General Fund breached the contract with SAIF's pol-

icyholders and impaired, permanently and irrevocably, the ability of SAIF to perform its contractual obligation to its insureds -- to consider the $81 million for distribution to SAIF's insureds. We would not permit a private insurer to do that; we should not permit the state to do it.

I fear that the majority's remedy is illusory. It apparently holds that (1) there was a breach of contract, and (2) that section 4 is unconstitutional, but it leaves open the question of what should be done with the $81 million. I confess a measure of bewilderment with this ultimate result. On the one hand, the majority holds that the state must "compensate employers for the breach." 306 Or at ___. But it turns away the plaintiff here because he has shown no "taking" or "deprivation" of his property, and because he has shown no "harm to his contractual interests." 306 Or at ___. Yet it holds — a holding with which I agree — that "ORS 656.634 expressed a contractual agreement of the state to employers who insured with SAIF that the state would not transfer IAF funds to the General Fund." 306 Or at ___.

I doubt that an employer ever will be able to show the type of damage that the majority apparently finds wanting, for until SAIF is returned the $81 million, it can never exercise its discretion to "declare a dividend to be paid to, or credited to the accounts of, employers who were insured by [SAIF] during all or part of the period for which the dividend is declared." ORS 656.526(2). I believe that the plaintiff has gone about as far as he can go. He has an interest in the $81 million, an interest that may never be recognized unless the return of the $81 million is ordered.

I therefore dissent in part. I should add that I agree with the second and third paragraphs of Justice Gillette's separate opinion.

GILLETTE, J., concurring in part and specially concurring in part.

I join fully in the court's opinion as to the unconstitutionality of section 4 of the Act and the breach of contract created by section 2. I write separately only with respect to the question of remedy.

It is regrettable that the entire collection of issues raised by this litigation, including the appropriate remedies for the participating insured and SAIF, could not be resolved in this one case. Had the matter come to us in some form in

which SAIF had been made a party[1] perhaps they could have been. In that way, SAIF would have been a party and the obvious remedy — repayment of the $81 million to SAIF —

[1] ORCP 29A provides, in pertinent part:

"A person who is subject to service of process shall be joined as a party in the action if (1) in that person's absence complete relief cannot be accorded among those who are already parties * * *. If a person should join as a plaintiff but refuses to do so, such person shall be made a defendant, the reason being stated in the complaint."

might have been ordered. In the wake of our decision today, such a case very well may be brought now.

For myself, I do not assume as readily as does the majority that consideration of this or a similar kind of remedy is foreclosed in this case. Rather than simply declare that the individual employer has not made out his individual damage case, as the majority does, I should have preferred that we ask the parties for supplemental briefing on the question of remedy. If insurmountable procedural difficulties prohibit us from resolving the entire controversy, it would be time enough to say so after full briefing on the issue.

I also agree with much of what is said in the separate opinion of Peterson, C.J. However, I cannot join in that opinion for these reasons:

1. I am more troubled than is the separate opinion by the absence of SAIF as a party.

2. I believe that the analogy to a mutual insurance company suggested by the separate opinion, while attractive, is not necessarily as complete as that opinion would have it. For example, I would not foreclose the possibility that SAIF, once its funds are restored, legally could choose to lower future rates instead of rebating portions of past premiums.

3. I do not know the extent to which, after today's decision, the state yet may assert that section 1(1) of the separate Tax Act, the "franchise tax" provision, Or Laws 1982 (Special Session 3), ch 3, is valid. In light of footnote 3 of the majority opinion, 306 Or at ___, such an argument (if made) may turn out to be a slender reed. But neither the majority nor the separate opinion has answered the question of the validity of section 1(1) and, without an answer, directing repayment to SAIF is premature.

Linde, J., joins in this concurring and specially concurring opinion.

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 the Beneficiaries of Jong J. Ahn, Claimants.

AHN et al,
Petitioners,

v.

FRITO-LAY, INC.,
Respondent.

(WCB 85-00438; CA A44113)

Judicial Review from Workers' Compensation Board.

Argued and submitted February 1, 1988.

James L. Edmunson, Eugene, argued the cause for petitioners. With him on the brief were Karen M. Werner and Malagon & Moore, Eugene.

Kenneth L. Kleinsmith, Portland, argued the cause for respondent. With him on the brief was Meyers & Terrall, Portland.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

BUTTLER, P. J.

Reversed and remanded for determination of benefits due under ORS 656.218.

BUTTLER, P. J.

In this workers' compensation case, claimants are the children of the deceased worker. In *Frito-Lay, Inc. v. Ahn,* 84 Or App 427, 734 P2d 15 (1987), we affirmed without opinion the Board's determination that the worker was suffering from an injury-related emotional condition. While that decision was pending, the worker committed suicide. On this review, we decide what impact the suicide has on claimants' entitlement to benefits under ORS 656.204 and ORS 656.218.

ORS 656.156(1) 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."

A beneficiary is not entitled to benefits for injury or death which results from the deliberate intention of the worker. In two recent cases, we discussed the standard of proof required to establish the compensability of a suicide. In *McGill v. SAIF,* 81 Or App 210, 724 P2d 905, *rev den* 302 Or 461 (1986), we ostensibly rejected the "irresistible impulse" test, to the extent that it suggests an element of delerium, frenzy or abruptness. We adopted the "chain-of-causation" rule, essentially as framed by the Supreme Court of Texas in *Saunders v. Texas Employers' Ins. Ass'n,* 526 SW2d 515, 517 (Tex 1975).

We agreed with the Texas court's reasoning that the essence of the test is whether an uncontrollable impulse resulted from an impairment of the worker's reasoning facilities which would cause the suicidal act to be an involuntary one. We held that a suicide is compensable if it resulted from work-related stress which produced a mental derangement that impaired the worker's ability to resist the compulsion to take his own life. In such a case, the suicide cannot be said to have arisen from a "deliberate intention." *McGill v. SAIF, supra,* 81 Or App at 214, 214 n 1, 215. In *McGill,* there was no dispute but that the suicide arose from a compensable depressive disorder. We found that the decedent was suffering from a depressive disorder that caused a mental derangement which rendered him incapable of forming a deliberate intent to commit suicide and therefore held that the suicide was, therefore, compensable.

In *Sullivan v. Banister Pipeline AM,* 86 Or App 334, 739 P2d 597, *rev den* 304 Or 280 (1987), the claimant sought benefits for hospitalization and treatment resulting from a suicide attempt. We found that a compensable injury was the material cause of the claimant's depressive disorder and the suicide attempt. We stated, however, that, in order to prove that the suicide attempt was not the result of a deliberate intention, the claimant had to establish that the depression was a mental derangement that impaired his ability to resist the compulsion to take his own life. The evidence showed that the claimant's psychiatric condition impaired his ability to think rationally and that the suicide attempt was an "impulsive act" with very little thought given to it and was strongly influenced by emotional factors. On that evidence, we held that the suicide attempt was not the result of a deliberate intention.

The "chain-of-causation" test as we have framed it in *McGill* and *Sullivan* requires (1) that the worker suffer from a work-related psychological condition which (2) causes or is itself a mental derangement that (3) impairs the worker's ability to resist the compulsion to take his own life. The medical evidence here does not establish any relationship between the worker's compensable emotional disturbance and her inability to resist the compulsion to take her own life. Dr. Johnson, the worker's treating physician, believed that the worker decided to take her own life after concluding that it was the only means of dealing with her problems, many of which were unrelated to work. In his view, the worker "planned her suicide, with the expectation that those left behind would be better off because of the insurance money and that she would be better off because she would no longer have the problems she had."

Although Johnson's reports show that the worker's mental state was one of the problems that led her to the decision to commit suicide, Johnson did not venture to state, and there is no other evidence, that the worker's compensable emotional disturbance affected her ability to reason and thereby prevented her from resisting the compulsion to take her own life. Claimants have not sustained their burden, and we conclude that the worker's death was a result of a deliberate intention to commit suicide.

Employer asserts, and the Board held, that claimants are precluded by ORS 656.156(1) from recovering *any* benefits, even those related to compensable conditions, *i.e.*, those not attributable to the suicide. We understand the statute to apply only to benefits for injury or death resulting from the deliberate act. Although claimants are not entitled to benefits for the worker's deliberate suicide, they are still entitled to benefits related to the worker's compensable shoulder and psychiatric conditions, pursuant to ORS 656.218.[1] Because the Board determined otherwise, it did not decide what those benefits are.

Reversed and remanded for determination of benefits due under ORS 656.218.

[1] ORS 656.218(1) provides:

"In case of the death of a worker entitled to compensation, whether eligibility therefor or the amount thereof have been determined, payments shall be made for the period during which the worker, if surviving, would have been entitled thereto."

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of M. Rae Hanna, Claimant.

HANNA,
Petitioner,

v.

FAIRVIEW HOSPITAL et al,
Respondents.

(WCB 86-05727; CA A45886)

Judicial Review from Workers' Compensation Board.

Argued and submitted April 1, 1988.

Peter McSwain, Portland, argued the cause for petitioner. On the brief were James L. Francesconi and Francesconi & Associates, P.C., Portland.

Darrell E. Bewley, Assistant Attorney General, Salem, argued the cause for respondent. With him on the brief were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

BUTTLER, P. J.

Affirmed.

BUTTLER, P. J.

On claimant's petition for review in this workers' compensation case, we conclude that the Board's opinion is supported by substantial evidence on the whole record; therefore we affirm. *George v. Richard's Food Center,* 90 Or App 639, 752 P2d 1309 (1988).

In *Fromme v. Fred Meyer, Inc.*, 89 Or App 397, 749 P2d 590, *rev allowed* 305 Or 467 (1988), we held that the legislature's 1987 amendment of ORS 656.236(2), Or Laws 1987, ch 250, § 4, is not retroactive and does not apply to cases filed in the Court of Appeals before September 27, 1987. The petition in this case was filed on September 29, 1987. The question we now consider is the substantive import of the amendment and whether it has the effect of overruling the Supreme Court's holding in *Compton v. Weyerhaeuser Co.*, 302 Or 366, 730 P2d 540 (1986), that costs on judicial review may be assessed against a claimant in a workers' compensation case pursuant to ORS 20.120.[1]

The legislature amended ORS 656.236(2) by adding the emphasized language:

> "Except as provided in ORS 656.506 and 656.538, none of the cost of workers' compensation to employers under ORS 656.001 to 656.794, *or in the court review of any claim therefor,* shall be charged to a subject worker." (Emphasis supplied.)

In *Fromme* we posed, but did not answer, the question whether the word "cost" in ORS 656.236(2), as amended, means the same thing as "costs" as used in ORS 20.120. We now address that issue in deciding whether the amendment has the effect of superseding ORS 20.120 in workers' compensation cases, thereby overruling *Compton.*

ORS 656.236(2) excludes payments made under ORS 656.506 and ORS 656.538 from the rule that the cost of workers' compensation cannot be charged against the worker. Those sections deal with assessments against employers and

workers for the Retroactive Reserve, the Workers' Reemployment Reserve and the Handicapped Workers' Reserve. Contributions made under those provisions are considered to be part of the "cost of workers' compensation," which suggests that the "cost of workers' compensation" means the cost of funding workers' compensation benefits or of securing workers' compensation coverage for employes. An employer would be prohibited, for example, from charging to any worker the premiums paid for workers' compensation insurance.

The legislature's addition of the phrase "or in the court review of any claim therefor" in ORS 656.236(2) creates confusion. The employer incurs no cost of funding workers' compensation benefits or securing workers' compensation coverage in the court review of a workers' compensation claim. The only "cost" is the legal expense associated with defending against the claim. In the context of the added language, the statute makes sense only if, in addition to the meaning previously discussed, the "cost of workers' compensation to employers" is also read to mean the "legal costs on court review of a claim for workers' compensation." We should attempt to give the new language a reasonable meaning rather than no meaning at all. *See 1000 Friends of Oregon v. Wasco County Court,* 299 Or 344, 358, 703 P2d 207 (1985); *Burt v.*

[1] ORS 20.120 provides:

> "When the decision of an officer, tribunal, or court of inferior jurisdiction is brought before a court for review, such review shall, for all the purposes of costs or disbursements, be deemed an appeal to such court upon errors in law, and costs therein shall be allowed and recovered accordingly."

Blumenauer, 84 Or App 144, 147, 733 P2d 462, *rev den* 304 Or 405 (1987). Inserting the new language purporting to deal with costs in a judicial review in ORS 656.236 creates a patent ambiguity, requiring resort to the legislative history to determine what the legislature intended.

The legislative minutes leave no doubt that the amendment was intended to overrule *Compton v. Weyerhaeuser Co., supra,* by providing that no court costs shall be charged to a worker in the court review of any claim. Minutes, Senate Committee on Labor, May 13, 1987, p 7; Minutes, House Committee on Labor, April 3, 1987, p 2. Accordingly, we conclude that the word "cost" in ORS 656.236, as amended by Or Laws 1987, ch 250, § 4, has two meanings, depending on the context in which it is used in the statute, and that the amended statute requires that no costs be assessed against a claimant in judicial review of a workers' compensation case. Given that meaning, the amended statute supersedes ORS 20.120, just as the APA provision, ORS 183.497, supersedes it when judicial review is sought under the

APA. *See Shetterly, Irick & Shetterly v. Emp. Div.*, 302 Or 139, 727 P2d 117 (1986). Because the petition for review in this case was filed after the effective date of the amendment, no costs may be assessed against claimant.

Affirmed.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

PACIFIC HOSPITAL ASSOCIATION,
Appellant,
v.
MARCHBANKS,
Respondent.

(16-87-00018; CA A43926)

Appeal from Circuit Court, Lane County.

Jack L. Mattison, Judge.

Argued and submitted December 22, 1987.

R. Scott Taylor, Eugene, argued the cause and filed the brief for appellant.

Kevin L. Mannix, Salem, argued the cause and filed the brief for respondent.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

WARREN, J.

Affirmed.

WARREN, J.

Defendant was insured by plaintiff through a group health insurance policy. He filed a workers' compensation claim against his employer. The claim was denied and, pur-

suant to ORS 656.313(3), plaintiff was required to and did pay defendant's medical bills that were part of his workers' compensation claim.

Under the terms of the health insurance contract, plaintiff required that defendant execute a loan receipt agreement which provided that, if any money for medical expenses were received by defendant from his employer or its workers' compensation insurance company, whether by way of compromise, settlement or judgment, he would repay or cause the employer or its insurance company to repay plaintiff to the extent that plaintiff had made payments for covered medical expenses.

Defendant apparently entered into a disputed claim settlement with his employer and its workers' compensation insurer for his compensation claim.[1] Plaintiff brought this action, seeking reimbursement for medical bills paid pending the resolution of the denied claim.

ORS 656.313(3) provides:

> "If an insurer or self-insured employer denies the compensability of all or any portion of a claim submitted for medical services, the insurer or self-insured employer shall send notice of the denial to each provider of such medical services and to any provider of health insurance for the injured worker. After receiving notice of the denial, a medical service provider may submit medical reports and bills for the disputed medical services to the provider of health insurance for the injured worker. *The health insurance provider shall pay all such bills in accordance with the limits, terms and conditions of the policy.* If the injured worker has no health insurance, such bills may be submitted to the injured worker. *A provider of disputed medical services shall make no further effort to collect disputed medical service bills from the injured worker until the issue of compensability of the medical services has been finally determined.* When the compensability issue has

> been finally determined or *when disposition of the claim has been made pursuant to ORS 656.289(4) [disputed claim settlement], the insurer or self-insured employer shall notify each affected medical service provider and each affected health insurance provider of the results of the determination, including the results of proceedings under ORS 656.289(4) and the amount of any settlement.* If the services are determined to be compensable, the insurer or self-insured employer shall reimburse each health insurance provider for the amount of claims paid by the health insurance provider pursuant to this section. Such reimbursement shall be in addition to compensation or medical benefits the worker receives. Medical service reimbursement shall be paid directly to the health insurance provider. As used in this subsection, 'health insurance' has the meaning for that term provided in ORS 731.162." (Emphasis supplied.)

The trial court dismissed the case, reasoning that the matter could only be resolved through arbitration, pursuant to ORS 656.289(4), which provides:

> "Notwithstanding ORS 656.236, in any case where there is a bona fide dispute over compensability of a claim, the parties

[1] The settlement agreement is not part of the record and we do not know its terms. Neither do we know whether defendant received any money in the settlement. The complaint does not allege that he did.

> 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 [a disputed claim settlement] 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." (Emphasis supplied.)

We agree with the circuit court's disposition. When there is a disputed claim settlement and the amount in dispute is at least $2,000, ORS 656.289(4) requires arbitration. The statutory scheme assumes that, when the worker has health insurance, the ultimate dispute as to who is responsible for medical bills does not involve the worker, but is between the

health insurance and medical service providers and the workers' compensation insurer or the self-insured employer. If the claim is determined to be compensable, the workers' compensation insurer or self-insured employer pays the bills. If the claim is determined not to be compensable, the health insurance provider pays the bills. ORS 656.313(3). If there is a disputed claim settlement, the workers' compensation insurer or self-employer and the medical service and health insurance providers are to resolve, through arbitration, any dispute which they might have concerning responsibility for and payment of medical bills. Plaintiff seeks to avoid the application of ORS 656.289(4) by attempting to collect unreimbursed medical expenses from the worker directly. That would thwart the legislative plan to keep the worker out of the dispute and to protect him from being left responsible for those expenses.

When the provisions of an insurance contract are inconsistent with pertinent statutes, the provisions of the statutes control. *Garrow v. Pennsylvania Gen. Ins. Co.*, 288 Or 215, 603 P2d 1175 (1979); *see Peterson v. State Farm Ins. Co.*, 238 Or 106, 393 P2d 651 (1964). The legislature has provided an integrated system for the resolution of disputes between workers' compensation insurance carriers and medical service and health insurance providers when a workers' compensation claim is settled by disputed claim settlement. It has provided that disputes as to the payment of medical bills *shall* be settled by arbitration among those parties. The loan receipt agreement attempts to involve the worker in the process and to that extent is contrary to the legislative policy. The contract is unenforceable to the extent that it allows plaintiff to seek reimbursement for medical expenses from defendant directly. We conclude that arbitration is the exclusive method available to plaintiff for resolving the question of liability for medical expenses. The trial court's dismissal of this action was therefore proper.

Affirmed.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Feliz Enriquez, Claimant.
OREGON HUMAN DEVELOPMENT et al,
Petitioners,
v.
ENRIQUEZ,
Respondent.
(WCB 85-04350; CA A44220)

Judicial Review from Workers' Compensation Board.

Argued and submitted March 14, 1988.

Allan M. Muir, Portland, argued the cause for petitioners. With him on the brief were William H. Replogle and Schwabe, Williamson & Wyatt, Portland.

Kenneth D. Peterson, Hermiston, argued the cause and submitted the brief for respondent.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

WARREN, J.

Affirmed.

WARREN, J.

Claimant suffered a head injury when he was allegedly assaulted without provocation by Gentry, a co-worker, while attending a conference. EBI accepted the worker's compensation claim in August, 1984. In January, 1985, employer received information that, in fact, claimant had been struck while attempting to steal money won by Gentry in a card game. EBI issued a denial of the claim on March 8, 1985, on the ground that claimant had misrepresented the cause of the injury and that it was not compensable. The referee allowed the denial, but the Board reversed. On review, EBI contends that it has established that claimant misrepresented facts material to his claim or, in the alternative, that claimant was engaged in an illegal activity, both of which allegedly justify a "backup denial" under the rule set forth in *Bauman v. SAIF,* 295 Or 788, 794, 670 P2d 1027 (1983):

> "If * * * the insurer officially notifies the claimant that the claim has been accepted the insurer may not, after the sixty days have elapsed, deny the compensability of the claim unless there is a showing of fraud, misrepresentation or other illegal activity."

Neither claimant nor Gentry appeared at the hearing. EBI relied on the written statement of Gentry and the testimony of Willocks, a "witness." On *de novo* review, we agree with the Board that EBI has not established that claimant misrepresented material facts as to the cause of his injury, and we adopt the Board's findings:

> "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 witten 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 to 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."

For the same reasons, we agree with the Board that EBI has not established that claimant was engaged in illegal activity at the time of his injury, even assuming that the facts which EBI's evidence could prove could constitute the type of "illegal activity" for which the court in *Bauman* intended to create an exception to the rule against backup denials.

Affirmed.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Joanne C. Krause, Claimant.

VIP'S RESTAURANT et al,
Petitioners,

v.

KRAUSE,
Respondent.

(WCB 86-05815; CA A42526)

Judicial Review from Workers' Compensation Board.

On petitioners' petition for reconsideration filed March 16, 1988; on respondent's petition for reconsideration filed March 30, 1988. Former opinion filed January 13, 1988. 89 Or App 214, 748 P2d 164.

Craig A. Staples and Roberts, Reinisch & Klor, P.C., Portland, for petitioners Vip's Restaurant and EBI Companies.

Charles S. Tauman and Bennett, Hartman, Tauman & Reynolds, P.C., Portland, for petitioner Joanne C. Krause.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

WARREN, J.

Vip's and EBI's petition for reconsideration allowed; claimant's petition for reconsideration denied; former opinion adhered to.

WARREN, J.

Claimant has filed a petition for review of our decision, 89 Or App 214, 748 P2d 164 (1988), reversing the Board's award of attorney fees. Vip's Restaurant and EBI Companies seek review of our decision affirming the Board's determination that Vip's was required to pay temporary total disability after it was held to be responsible for the claim and until the Evaluation Division determined that claimant was medically stationary. We allow only Vip's and EBI's petition for reconsideration. ORAP 10.10. We adhere to our opinion and write only to address Vip's and EBI's contention that they could not have sought claim closure before EBI was determined to be the responsible insurer, because SAIF had been designated the paying agent.

First, there is no indication in the record that SAIF had been designated as the paying agent. Second, even assuming that it had been, nothing prevented EBI, as a potentionally responsible insurer, from seeking a determination order any time after claimant became medically stationary. ORS 656.268.

Vip's and EBI's petition for reconsideration allowed; claimant's petition for reconsideration denied; former opinion adhered to.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Sheila C. Owsley (Karbonski), Claimant.

SAFEWAY STORES,
Petitioner,
v.
OWSLEY (KARBONSKI),
Respondent.

(WCB 85-13054; CA A44758)

Judicial Review from Workers' Compensation Board.

Argued and submitted March 18, 1988.

Kenneth L. Kleinsmith, Portland, argued the cause for petitioner. With him on the brief was Robert J. Radler, Portland.

Larry Schucht, Portland, argued the cause for respondent. On the brief was Marianne Bottini, Portland.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

WARREN, J.

Reversed; denial reinstated.

WARREN, J.

Employer seeks review of an order of the Workers'

Compensation Board affirming and adopting the referee's determination that claimant is entitled to benefits for temporary total disability and to a penalty and attorney fees for employer's alleged unreasonable termination of benefits.

Claimant suffered a compensable injury to her little finger at a time when she was earning $3.67 per hour. After two surgeries, she returned to work part-time, and employer began paying temporary partial disability benefits. In January, 1985, and in June, 1985, claimant received increases in her hourly pay as a result of union contract requirements. On August 7, 1985, she was fired for reasons unrelated to her claim. At that time, she was still working part-time, at an hourly wage of $5.08. Her total weekly wages were more than before the injury. Employer paid temporary partial disability benefits through August 3, 1985.

On October 3, 1985, after having received a request from claimant for temporary partial disability benefits, employer issued a partial denial of benefits for time loss after August 3, 1985, on the ground that, if claimant had not been fired, her weekly wages after that date would have exceeded her weekly wages at the time of the injury and that, therefore, she was not entitled to benefits under the terms of OAR 436-60-030. On December 6, 1985, the claim was closed with an award of temporary total disability from November 29, 1984, through December 16, 1984, and temporary partial disability from December 17, 1984, through September 17, 1985. Employer did not pay any benefits for the period between August 3, and September 17, 1985.

The Board, in adopting the referee's opinion, determined that employer was not authorized to terminate benefits unilaterally when claimant was fired. It awarded benefits for temporary partial disability based on her wages at the time of the injury. It also assessed a penalty and attorney fees for employer's alleged unreasonable termination of benefits.

Claimant's attorney stated at the hearing that claimant was seeking benefits for time loss after August 7, 1985, the date when she was terminated, but was not challenging the amount of temporary partial disability paid before that date.

Despite that, the Board determined that employer owed claimant benefits for temporary partial disability for the week before she was terminated. Employer contends that the Board should not have reached that issue, because claimant waived it. We conclude that the Board was free to make any disposition of the case that it deemed appropriate. *Destael v. Nicolai,* 80 Or App 596, 600, 723 P2d 348 (1986); *Russell v. A & D Terminals,* 50 Or App 27, 31, 621 P2d 1221 (1981). It had before it the general issue of entitlement to temporary partial disability benefits and could properly consider whether benefits for the period before claimant's termination had been calculated correctly.

ORS 656.212 provides:

> "When the disability is or becomes partial only and is temporary in character, the worker shall receive for a period not exceeding two years that proportion of the payments provided for temporary total disability which the loss of earning power at any kind of work bears to the earning power existing at the time of the occurrence of the injury."

The formula for calculating benefits for temporary partial disability is in OAR 436-60-030, which, at the relevant time, provided, in part:

> "(1) The rate of temporary partial disability compensation due a worker shall be determined by:
>
> "(a) Subtracting the post-injury wage earnings available from any kind of work; from
>
> "(b) the wage earnings from the employment at the time of, and giving rise to the injuries; then
>
> "(c) dividing the difference by the wage earnings in subsection (b) to arrive at the percentage of loss of earning power; then
>
> "(d) multiplying the current temporary total disability compensation rate by the percentage of loss of earning power.
>
> "(2) *If the post-injury wage earnings are equal to or greater than the wage earnings at the time of injury, no temporary disability compensation is due.*" (Emphasis supplied.)

Employer contends that claimant was not entitled to benefits as they are calculated under the rule and that it could therefore properly stop paying benefits.

Assuming for the moment that claimant had not been

fired, we must first determine whether she would have been entitled to benefits for temporary partial disability. In our view, that issue has been resolved against claimant in *Fink v. Metropolitan Public Defender*, 67 Or App 79, 676 P2d 934, *rev den* 296 Or 829 (1984), where we upheld a previous version of OAR 436-60-030, then codified as OAR 436-54-225. We stated that the rule was consistent with ORS 656.212 and required the conclusion that a claimant whose weekly wage at the time of partial disability is greater than at the time of the injury could not recover benefits for temporary partial disability despite the fact that the claimant was not working as many hours as she had been working before the injury. We held that "earning power" as used in ORS 656.212 refers to a worker's pre-injury wages. We rejected the "hours of work" concept as relevant to the question of diminished "earning power." We stated that the relevant inquiry is not whether the claimant was able to work as many hours as before the injury, but whether the claimant's actual earnings had been diminished:

> "We construe ORS 656.212 to provide that compensation for temporary partial disability of a worker who is recovering from a compensable injury but is nonetheless capable of earning wages and is employed is to be proportionate to the decrease in the worker's actual earnings.
>
> "The formula established by *former* OAR 436-54-225 for computing loss of earning power comports with our construction of ORS 656.212. The rule provided for an adjustment of the compensation to be paid for the difference between the wages the worker would have received for temporary total disability under ORS 656.210 [which is computed on the basis of the claimant's actual wages at the time of the injury]. If a claimant's post-injury wages exceed the claimant's pre-injury wages, the claimant suffers no loss of earning power and is not entitled to temporary partial disability benefits."

Although *Fink* involved interim compensation, the same analysis is applicable here. Claimant's weekly wages were more during the period for which she seeks compensation

than at the time of the injury. Therefore, she is not entitled to benefits for temporary partial disability. The Board's order determining otherwise and assessing a penalty and related attorney fees is therefore reversed, and employer's denial is reinstated.

We reject claimant's contention that employer was

required to begin paying temporary partial disability benefits again after she was fired. *See Noffsinger v. Yoncalla Timber Products*, 88 Or App 118, 745 P2d 245 (1987), *rev den* 305 Or 102 (1988); *Nix v. SAIF*, 80 Or App 656, 723 P2d 366, *rev den* 302 Or 158 (1986). Even assuming that claimant's termination did not preclude recovery of benefits for temporary partial disability, she would have been entitled only to the amount that she could have received on account of her disability had she not been fired. In this case, that is nothing.

Reversed; denial reinstated.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Lawrence N. Sullivan, Claimant.

SULLIVAN,
Petitioner - Cross-Respondent,

v.

BANISTER PIPELINE AMERICAN et al,
Respondents - Cross-Petitioners.

(84-09511; CA A43658 (Control))

In the Matter of the Compensation of Lawrence N. Sullivan, Claimant.

SULLIVAN,
Petitioner,

v.

BANISTER PIPELINE et al,
Respondents.

(85-14645; A43949)

Judicial Review from Workers' Compensation Board.

Argued and submitted February 1, 1988.

James L. Edmunson, Eugene, argued the cause for petitioner - cross-respondent. With him on the briefs were Karen M. Werner and Malagon & Moore, Eugene.

Richard Wm. Davis, Portland, argued the cause for respondents - cross-petitioners. With him on the brief were Davis, Bostwick, Scheminske & Lyons, Portland.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

ROSSMAN, J.

On petitions, reversed as to determination that claimant's psychological condition is not compensable; otherwise

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Brookshire, Joy J., 86-0689M (1/88)
Brown, Charles E., 86-0637M (6/88)
Brown, Donald M., 87-0718M (1/88)
Brown, Patrick B., 88-0016M (1/88)
Bruner, Michael, 88-0020M (1/88)
Buckman, Danny, 88-0353M (6/88)
Burgess, Paul H., 87-0351M (1/88)
Burkett, Ralph, 88-0539M (9/88)
Burrington, Kyle, 87-0711M (6/88)
Burris, Joann, 86-0382M (2,4/88)
Burt, William A., 87-0609M (1/88)
Burton, Jack, 87-0674M (1/88)
Burton, James, 88-0522M (9/88)
Bush, Ernest M., 87-0333M (5/88)
Bush, Shirley, 88-0109M (4,7/88)
Butler-Reeves, Kathleen, 87-0432M (7/88)
Byrd, Curtis, 87-0555M (7/88)
Caccamise, Chris, 86-0680M (2/88)
Cambron, Connell R., 88-0034M (2/88)
Cambron, Connell R., 88-0337M (7/88)
Campbell, Jess P., 87-0700M (1/88)
Carlson, Rick, 88-0435M (7/88)
Carlston, Lois O., 88-0342M (6/88)
Carlton, Dennis L., 88-0212M (5/88)
Carmien, James, 88-0333M (7/88)
Carothers, Norman D., 88-0368M (7/88)
Carr, Iola P., 86-0706M (8/88)
Carter, Donald, 88-0251M (5,7/88)
Carter, Dorothy, 88-0476M (9/88)
Carter, Ronald, 87-0294M (8/88)
Castoe, Ezra E., 87-0745M (2/88)
Charlson, Lynn, 88-0278M (6/88)
Chastain, Ronald, 88-0235M (5/88)
Cheatham, Verla, 87-0534M (5,9/88)
Chew, Vernon, 88-0379M (7/88)
Chilson, Bonnie D., 88-0120M (3/88)
Chittick, Zedra P., 88-0358M (9/88)
Chrestensen, Robert, 88-0119M (4/88)
Christensen, Jesse D., 88-0081M (2/88)
Christmas, Dorothy, 88-0391M (7/88)
Christopher, Ohman E., 87-0746M (1/88)
Christopher, Terry, 87-0712M (4/88)
Christy, Patty D., 84-0254M (7/88)
Clark, Michael, 88-0414M (8/88)

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Clark, William, 87-0760M (1/88)
Clavette, Reno, 88-0438M (8/88)
Clements, Thomas, 88-0257M (5/88)
Clevenger, Shirley E., 88-0206M (5/88)
Cochran, Robert, 88-0313M (6/88)
Collins, Donna, 85-0154M (1/88)
Cook, Dalta, 88-0001M (1/88)
Cook, Steven, 88-0332M (9/88)
Cooper, Gilbert W., 88-0026M (1/88)
Cooper, Terry S., 88-0351M (9/88)
Copher, Edwin L., 88-0108M (4/88)
Copher, Edwin L., 88-0573M (9/88)
Corliss, Phillip, 87-0753M (1/88)
Corwin, Jack L., 85-0635M (8/88)
Cottam, Linda, 86-0697M (8/88)
Cox, Charley, 88-0185M (6/88)
Cox, Danny R., 88-0470M (9/88)
Craig, James, 88-0321M (6,9/88)
Crawford, Hoyt W., 86-0068M (8/88)
Cress, Stanley, 88-0228M (5,8/88)
Cripps, Donald R., 87-0755M (1/88)
Croghan, Olin, 88-0373M (7/88)
Crowder, Virgie Mae, 88-0250M (5/88)
Cuellar, Eloy, 88-0450M (8/88)
Cummins, Mary J., 88-0208M (5/88)
Curtiss, Betty, 88-0312M (6/88)
Dalton, Robert W., 88-0085M (3/88)
Dalton, Robert, 87-0501M (7/88)
Dalton, Robert, 88-0568M (9/88)
Danielson, James L., 87-0259M (5/88)
Darcy, James G., 86-0600M (2/88)
Davenport, John D., 88-0273M (6/88)
David Hernandez, Isabel, 88-0071M (3,3/88)
Davidson, Raymond, 88-0057M (3/88)
Davis, Benjamin K., 88-0413M (8/88)
Davis, Frances, 87-0689M (5/88)
Davis, Wallace J., 87-0744M (4,9/88)
Davis, Wanda L., 88-0004M (1,2/88)
Dearmond, Gayford, 87-0475M (7/88)
Deitz, Gary M., 88-0387M (7/88)
DeLaRosa, Simon, 88-0420M (8/88)
Delgado, Nicholas, 88-0039M (3/88)
Deoton, Orville, 85-0014M (1/88)
DeTour, Ronald L., 87-0604M (8/88)
Devaney, Mike, 88-0325M (7/88)
Diaz, Barbara Ann, 87-0154M (2,2/88)
Dilka, Richard, 88-0103M (3/88)
Discant, Gladys, 88-0501M (9/88)
Doggett, Kenneth M., 88-0038M (2/88)
Dolinar, Henry J., 88-0122M (4/88)
Douglass, Paul, 87-0285M (6/88)
Driggers, Roger, 86-0429M (1/88)
Driggers, Roger, 86-0429M (9/88)
Dubay, Kenneth L., 88-0245M (6/88)
Dugan, Timothy, 88-0411M (8/88)
Duncan, Robert L., 87-0670M (2,2/88)

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Dupont, Ruben F., 88-0064M (2/88)
Durlam, Eugene D., 88-0031M (2/88)
Duyck, Richard J., 88-0182M (5/88)
Dyson, Daniel J., 88-0053M (2/88)
Eaton, Eleanor A., 87-0728M (1/88)
Edwards, Jeffrey, 87-0672M (9/88)
Edwards, Michael, 88-0033M (2/88)
Elder, William H., 88-0339M (6/88)
Ellison, Darrell, 88-0310M (7/88)
Elston, David, 88-0045M (4,6/88)
English, James C., 87-0160M (4/88)
Ensign, Gary, 87-0354M (1,2,4/88)
Erwen, Ted, 87-0738M (1/88)
Evison, Marjorie, 87-0531M (2/88)
Eyman, Ronald L., 88-0114M (8/88)
Eytchison, Steve, 88-0279M (7/88)
Fain, Mary C., 87-0627M (1/88)
Faircloth, Cecil A., 88-0062M (7/88)
Fandrich, John J., 88-0390M (8/88)
Felton, Roxy Dean, 87-0071M (3/88)
Ferber, Gwynn, 86-0417M (4/88)
Ferebee, John, 87-0208M (3/88)
Ferguson, Bill E., 87-0752M (1/88)
Fields, Eddie, 84-0536M (1/88)
Finley, Linda, 88-0234M (7/88)
Flaherty, Lawrence M., 88-0327M (6,7/88)
Follett, Larry L., 88-0175M (6/88)
Fowler, Sharon L., 88-0028M (2/88)
Franzwa, Peter, 88-0248M (6/88)
Frazier, Delpha, 88-0374M (8/88)
Frear, James, 85-0675M (3/88)
Freeman, Carl A., 88-0560M (9/88)
Frey, Edward, 88-0167M (4/88)
Friend, Joseph, 88-0077M (2/88)
Fuller, Clarence, 88-0399M (7/88)
Gabilondo, David, 87-0717M (1/88)
Galego, Arthur C., 85-0451M (8/88)
Garcia, Jose A., 88-0449M (8/88)
Garner, James E., 88-0440M (8/88)
Garnett, Harold D., 88-0214M (5/88)
Garza, Anita, 88-0326M (6/88)
Gates, David, 87-0239M (7/88)
Gavett, Mark J., 87-0702M (1/88)
Gay, Walter A., 88-0460M (8/88)
Gearin, Fred, Jr., 87-0460M (8/88)
Geenty, Richard, 83-0313M (1/88)
Gettman, Wilbur R., 88-0294M (6/88)
Gilbert, Frank, 88-0318M (7/88)
Gill, Charles, 87-0489M (8/88)
Glenn, Lester, 88-0561M (9/88)
Goetz, Steven, 88-0304M (5/88)
Goetzelman, George, 88-0474M (8/88)
Golden, Susan L., 87-0269M (2/88)
Gorecki, Thaddeus G., 87-0356M (7/88)
Grant, Maxine, 87-0023M (1/88)
Greenwade, Alton W., 88-0170M (4/88)

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Gregg, Robert, 88-0176M (4/88)
Gregor, Andrew J., 88-0295M (6/88)
Gregor, Robert, 88-0558M (9/88)
Griffin, Terrance A., 87-0618M (5/88)
Grimm, Kenneth, 88-0329M (6/88)
Griswold, James C., 87-0756M (2/88)
Grove, Gerald, 85-0361M (3/88)
Guerra, Michael, 88-0048M (2/88)
Hafemann, Diana, 88-0178M (5/88)
Hagan, Debra C., 88-0429M (8/88)
Hager, Jim, 88-0287M (5/88)
Hagg, Mary J., 87-0607M (3/88)
Hagger, Danny G., 87-0639M (5/88)
Hagner, Leonard, 88-0541M (9/88)
Hale, Glenn, 87-0750M (1/88)
Hall, Marina E., 87-0626M (4/88)
Hamilton, Robert, 88-0194M (5/88)
Hamm, James E., 87-0277M (3/88)
Hammond, Robert, 87-0305M (1/88)
Hampton, Boyd A., 88-0281M (9/88)
Hansen, Edward, 88-0446M (8/88)
Hardy, Thomas C., 88-0180M (5/88)
Harlin, Betty, 87-0516M (6/88)
Harmes, Robert W., 88-0412M (8/88)
Haron, Louis, 83-0348M etc. (8/88)
Harper, Betty L., 87-0763M (1/88)
Harper, Betty L., 87-0763M (8/88)
Harris, Michael, 88-0135M (4/88)
Harris, Rex L., 88-0186M (5/88)
Harroun, Elden, 88-0215M (5/88)
Hartley, Joann G., 88-0345M (7/88)
Harvey, Herman C., Jr., 87-0521M (4,5/88)
Hayes, Larry L., 85-0393M (1/88)
Heald, Peggy L., 86-0121M (7/88)
Hegele, Charles, 87-0109M (7/88)
Helvie, John S., 88-0018M (1/88)
Hendricks, James, 86-0640M (6/88)
Hendrickson, Shirley, 86-0169M (1/88)
Hendrix, Melvin E., 88-0359M (7/88)
Henshaw, Johnny L., 84-0588M (5/88)
Herrera, Luciano B., 88-0518M (9/88)
Herron, James M., 86-0466M (2/88)
Hickman, Donald, 88-0072M (3/88)
Hicks, Kenneth B., 88-0238M (5,6/88)
Hiles, Charles E., 88-0227M (7/88)
Hill, David, 87-0001M (9/88)
Hinton, Larry L., 88-0323M (8/88)
Hintz, Raymond, 88-0456M (9/88)
Hissner-Graham, Shirley, 87-0166M (8/88)
Hoff, Harley, 84-0032M (4/88)
Hogan, Lester, 88-0405M (7/88)
Hoisington, Dolores, 88-0507M (9/88)
Hoke, Harold L., 84-0476M (2/88)
Hollingsworth, Nettie, 88-0199M (5/88)
Holst, Albert S., 87-0530M (1/88)
Holsti, Hugo L., 88-0365M (7//88)

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Holt, Danny, 88-0060M (5/88)
Holt, Danny, 88-0060M (8/88)
Homsley, Robert, 88-0547M (9/88)
Hornberger, Julia M., 85-0137M (2/88)
Houk, Loren, 88-0479M (8,9/88)
Howard, David, 88-0300M (5,8/88)
Howard, James E., 87-0747M (7/88)
Howell, Donald, 88-0357M (8/88)
Howell, James, 88-0441M (8/88)
Howlan, Larry E., 87-0221M (9/88)
Hoyle, Fred L., 88-0301M (8/88)
Hunter, Harry L., 88-0398M (7/88)
Hunter, John H., 88-0139M (4/88)
Hutcheson, Orvilla J., 88-0274M (7/88)
Hylton, Bobby G., 87-703M (2/88)
Imbler, George L., 88-0127M (4/88)
Imbler, George, 88-0553M (9/88)
Isaacs, Minnie, 88-0237M (5/88)
Jackson, Eugene, 83-0153M (1/88)
Jackson, Hilda, 88-0011M (1/88)
Jackson, Howard, 87-0656M (1/88)
Jacobs, Jim G., 88-0192M (5,5,6/88)
Janzen, Clarence, 87-0649M (2/88)
Jeffers, Donald W., 88-0355M (8/88)
Jennings, Jeffrey, 88-0530M (9/88)
Jensen, Leonard J., 86-0694M (3,5/88)
Jensen, Terry D., 88-0554M (9/88)
Jesperson, Diane, 88-0204M (5/88)
Johnson, Charles E., 86-0457M (9/88)
Johnson, Daryl, 88-0267M (5/88)
Johnson, Robert H., 87-0758M (2/88)
Johnson, Robert, 88-0177M (9/88)
Johnson, Susanne, 88-0112M (4/88)
Jones, Roy L., 88-0205M (5/88)
Jones, Steven R., 87-0726M (1/88)
Jones, Tim, 88-0179M (4/88)
Joseph, Elaine, 87-0740M (5/88)
Joy, Patricia, 88-0198M (5/88)
Jurgensmeier, Ada, 87-0020M (8/88)
Keen, Gwendolyn, 88-0498M (9/88)
Kellison, Dolores, 88-0024M (2/88)
Kellogg, Lawrence L., 86-0607M (6,7/88)
Kelly, David D., 88-0143M (4/88)
Kelly, John R., 87-0679M (5/88)
Kendall, Geraldine Y., 87-0375M (7/88)
Kendall, Ronald, 88-0347M (6/88)
Kennedy, Kenneth, 88-0240M (5/88)
Kent, Hazel, 87-0572M (3/88)
Ketchum, Harry, 88-0500M (8/88)
Ketchum, Myron H., 87-0757M (1/88)
Kibbey, Ralph, 88-0239M (5/88)
Kindred, Ethel L., 88-0348M (9/88)
Kleger, John P., 88-0063M (3/88)
Knapp, Barbara, 88-0362M (8/88)
Knowland, Laurey J., 87-0761M (2/88)
Knowlson, James C., 88-0271M (5/88)

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Knox, Carole J., 88-0461M (8/88)
Koopman, Kerry L., 88-0537M (9/88)
Korhonen, Robert, 87-0595M (2/88)
Kosanke, Lucille V., 88-0465M (8/88)
Kosel, Lucie Mae, 88-0532M (9/88)
Kretschmer, Patrick L., 88-0210M (5/88)
Lacey, David C., 88-0451M (9/88)
Lacy, Lois A., 88-0049M (2/88)
Lakey, John, 87-0399M (7/88)
Lamarra, Laura M., 88-0457M (9/88)
Lane, Cameron, 87-0748M (6/88)
Lang, Terry, 88-0211M (5/88)
Langston, Bradley, 88-0201M (5/88)
Larose, Betty, 88-0315M (6/88)
Larsen, Frank E., 86-0686M (6/88)
Lathrop, Daniel, 88-0050M (2/88)
Laurens, Larry, 88-0513M (9/88)
Laurila, Jeanette, 88-0352M (9/88)
Lauritsen, Kerry L., 86-0570M etc. (3/88)
Ledoux, Martin, 87-0731M (1,4/88)
Lee, Brian David, 88-0366M (8/88)
Lee, Patricia, 88-0075M (4/88)
Lee, Terry G., 87-0453M (7/88)
Lehrmann, James, 88-0259M (5/88)
Lemar, Ruby, 88-0253M (5/88)
Lenhart, Guy A., 88-0468M (8/88)
Lenocker, Paul, 87-0624M (7/88)
Leonetti, Gregg, 88-0232M (8/88)
LeValley, Richard, 88-0346M (9/88)
Lewis, Wilbur A., 87-0540M (1/88)
Libel, Stanley R., 88-0230M (7/88)
Linton, Gregg, 88-0196M (5/88)
Liverman, Jack, 88-0490M (8/88)
Lloyd, John, 87-0446M (7/88)
Lockwood, Betty C., 88-0021M (2/88)
Logsdon, E.V., Jr., 88-0131M (4/88)
Lomas, Michael H., 87-0319M (3,4/88)
Louvring, Gordon E., 87-0343M (1/88)
Lovan, Herman, 87-0546M (9/88)
Lovell, Robert P., 88-0124M (4/88)
Lovenburg, Floyd, 88-0354M (9/88)
Lowther, Jeff W., 88-0475M (8/88)
Lutes, Stephen G., 87-0201M (1/88)
Luyet, Michael, 86-0086M (2/88)
Lynch, Raymond D., 88-0203M (5/88)
Madsen, Melvin K., 88-0455M (9/88)
Malar, Shirley E., 88-0392M (9/88)
Mangun-Wolverton, Beverly, 88-0147M (5/88)
Mansker, Howard, 88-0266M (5/88)
Mansker, Melba S., 87-0612M (1/88)
Maplesden, Amos A., 88-0269M (5/88)
Marsh, Donald, 88-0538M (9/88)
Marsh, Michael L., 88-0015M (2/88)
Marsh, Michael L., 88-0384M (8/88)
Marshall, Raymond, 88-0047M (2/88)
Marston, Ron, 88-0074M (3/88)

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Martin, David, 84-0207M (7/88)
Martin, Jack W., 88-0148M (4/88)
Martinez, Donnie, 88-0307M (7/88)
Mason, Carl D., 88-0397M (7/88)
May, George R., 87-0136M (5/88)
May, James R., 88-0343M (7/88)
McAdams, Valdean, Jr., 88-0283M (5/88)
McAlister, J.D., 88-0218M (5/88)
McBride, Roxanne, 88-0385M (7/88)
McCann, Herbert I., 88-0010M (1/88)
McConnell, Roy G., 88-0444M (9/88)
McCord, Flint L., 88-0051M (2/88)
McDaniel, William J., 88-0299M (6/88)
McDarment, Dorotha L., 87-0741M (5/88)
McGuire, Marc W., 87-0759M (1/88)
McKenzie, George J., 88-0236M (5/88)
McKinstry, Karri, 88-0223M (5/88)
McMahan, Claude A., 88-0123M (4/88)
McMillan, James, 88-0524M (9/88)
McMillan, Patrick D., 88-0424M (7/88)
McMullen, John M., 88-0216M (6/88)
McQueen, Michael, 88-0431M (9/88)
Medlock, Jarlin, 88-0409M (9/88)
Mercier, Darrel L., 87-0179M (8/88)
Miller, Barbara, 88-0549M (9/88)
Miller, Bernard, 88-0032M (4/88)
Miller, David R., 87-0204M (3,6/88)
Miller, George Irving, 87-0217M (4/88)
Miller, Merle, 88-0022M (1/88)
Miller, Thomas, 88-0540M (9/88)
Montes, Antonio, 88-0242M (5/88)
Montgomery, Robert L., 88-0172M (5/88)
Moon, Jerry D., 88-0102M (4/88)
Moore, Alan, 88-0286M (7/88)
Moore, Judith A., 86-0332M (6/88)
Morehead, James, 88-0073M (3/88)
Morgan, Linda, 88-0030M (2/88)
Morrison, Michael, 88-0495M (9/88)
Morrow, Steven, 88-0434M (8/88)
Morton, William E., 85-0022M (9/88)
Mossman, Leslie W., 86-0326M (5/88)
Mudrow, Robert, 88-0555M (9/88)
Muir, Nelson, 88-0302M (9/88)
Mullen, Gary L., 87-0481M (5/88)
Mullen, Lois E., 88-0309M (8/88)
Munson, Karen, 88-0284M (6/88)
Myers, Carl, 88-0436M (8/88)
Nelson, Juanita R., 88-0322M (9/88)
Nelson, Michael L., 88-0508M (9/88)
Netherton, Margaret, 88-0570M (9/88)
Neuman, William, 88-0401M (7/88)
Newingham, Donald, 88-0291M (5/88)
Newton, Jack A., 86-0061M (1/88)
Nichols, Steven, 87-0734M (1/88)
Nicks, Edward J., 88-0364M (7/88)
Niemann, David, 87-0095M (5/88)

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Noah, Donald K., 88-0442M (7/88)
Noel, Carroll, 88-0437M (9/88)
Noggle, Richard, 87-0073M (2/88)
Norrander, Ralph, 88-0394M (7/88)
Northrup, Frank, 88-0079M (2/88)
Nugent, Carole, 88-0229M (7,8/88)
Nylen, Lyman M., 88-0542M (9/88)
Oakes, Reeford, 88-0069M (2/88)
Ochsner, Ronald E., 88-0224M (7/88)
Oland, Delmar G., 87-0037M (4/88)
Olson, Robert O., 85-0297M (1/88)
Oran, Sheila, 88-0277M (7/88)
Osborne, Leonard L., 88-0487M (9/88)
Owens, James, 88-0367M (9/88)
Parker, George W., 88-0514M (9/88)
Parks, Robert, 88-0191M (5/88)
Parr, Chester, 88-0292M (6/88)
Paulus, Steve M., 87-0583M (7/88)
Payne, Thelma, 88-0506M (9/88)
Pepper, Wanda, 88-0133M (6/88)
Pero, Dan L., 88-0469M (8/88)
Pershall, James, 88-0013M (1,2/88)
Peterson, Charles F., 88-0496M (8/88)
Petrie, Terry A., 86-0096M (2,5/88)
Phibbs, Rena E., 88-0076M (4/88)
Philippi, Wesley I., 87-0410M (6/88)
Pieri, John, 88-0275M (6/88)
Piper, Daniel, 88-0316M (7/88)
Pitzer, Diana J., 86-0665M (9/88)
Poague, Robert, 88-0129M (7,8/88)
Pola, Barry, 88-0404M (8/88)
Potts, Clarence, 87-0469M (1/88)
Powell, Edgar, 85-0656M etc. (2,3/88)
Powell, James H., 87-0045M (1/88)
Powers, Roland, 88-0247M (7//88)
Prince, Ashley, 88-0341M (6/88)
Pruitt, Willie, 88-0025M (1/88)
Quinlan, Karen M., 87-0492M (6/88)
Rapoza, Robert K., 88-0084M (3/88)
Rauschert, John L., 87-0357M (1,2/88)
Ray, Robert A., 88-0184M (5,8/88)
Reason, Lynett, 87-0765M (4/88)
Reese, Georgia L., 87-0646M (1,7/88)
Reynolds, Becky J., 87-0427M (1/88)
Rice, Richard L., 88-0255M (5/88)
Richards, Stanley L., 87-0210M (5,9/88)
Richardson, Phyllis, 88-0471M (8/88)
Rickard, Ruth A., 88-0126M (4/88)
Ricksgers, Gary H., 88-0454M (8/88)
Riggs, Wilbur, 88-0150M (4/88)
Riley, John B., Sr., 87-0751M (1,6/88)
Roberts, Donald L., 87-0621M (1/88)
Roberts, George E., 88-0006M (3/88)
Rodriguez, Jesus, 88-0535M (9/88)
Rogers, Brian, 87-0010M (3/88)
Rogers, Walter Earl, 88-0141M (5/88)

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Roppe, Arthur D., 85-0106M (8/88)
Rose, Richard P., 88-0505M (9/88)
Ross, Charles A., 88-0066M (3/88)
Ross, Patricia, 88-0118M (4,9/88)
Rowan, John T., 86-0413M (2/88)
Ruff, Jerry, 88-0492M (9/88)
Rundle, Bradford, 88-0296M (7/88)
Rutherford, James W., 88-0473M (8/88)
Samuelson, Glenda, 88-0092M (5/88)
Sanders, Rene, 88-0155M (7/88)
Sanford, Dolly A., 88-0169M (4/88)
Satterfield, Fred, 88-0447M (8/88)
Sausa, Olegorio, 88-0340M (8/88)
Schafer, Franklin M., 87-0523M (1/88)
Schauss, Robert L., 88-0421M (7/88)
Schiller, John, 87-0257M (1/88)
Schmitt, Wendell J., 88-0510M (9/88)
Schuster, Danny, 88-0350M (6/88)
Sears, Ardith DeJong, 87-0101M (8/88)
Self, Ira D., 86-0242M (5,8/88)
Sharp, Gordon, 88-0484M (9/88)
Shine, Donn, 88-0012M (6/88)
Shine, Patrick J., 88-0289M (5/88)
Shingledecker, Irma L., 86-0359M (1/88)
Shipman, Orville D., 87-0680M (3/88)
Shockley, Dorothy, 88-0375M (9/88)
Short, Kenneth, 86-0387M (1/88)
Shumaker, Glenn, 88-0128M (4/88)
Smith, Alice L., 88-0378M (8/88)
Smith, Betty J., 88-0290M (6/88)
Smith, Carole, 88-0151M (8/88)
Smith, David A., 88-0160M (4/88)
Smith, David R., 88-0002M (1/88)
Smith, Edward G., 88-0381M (7/88)
Smith, Julie A., 88-0433M (8/88)
Smith, Leland, Jr., 87-0418M (8/88)
Snyder, James F., 88-0162M (4/88)
Souza, Joseph, 88-0029M (2/88)
Spencer, Mary I., 88-0042M (4/88)
Springer, Terry, 87-0554M (8/88)
Steen, Donald R., 86-0537M (4/88)
Stephens, John R., 86-0019M (3/88)
Stevens, Mike, 88-0415M (8/88)
Stewart, Albert F., 88-0213M (5/88)
Stewart, Craig, 87-0421M (8/88)
Stockebrand, Keith, 88-0432M (7/88)
Stoltenburg, Roy R., 88-0154M (5/88)
Stone, Jim L., 88-0008M (2/88)
Storms, Lenora, 88-0331M (7/88)
Strauss, Steven J., 88-0219M (5/88)
Striefel, Richard, 88-0423M (7/88)
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Swartwout, Sara, 88-0426M (8,9/88)
Sweet, Gary, 88-0202M (5/88)
Swenson, Mildred, 88-0516M (9/88)
Swindler, James, 88-0156M (4,5/88)

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Tanner, Linda, 88-0136M (7/88)
Taskinen, Richard J., 88-0086M (3/88)
Taylor, Doris A., 88-0491M (8/88)
Taylor, Wesley, 88-0349M (7/88)
Taylor, Wesley, 88-0349M (9/88)
Terry, Judith A., 86-0634M (9/88)
Thayer, Alvin, 88-0009M (2/88)
Thissell, John O., 88-0035M (2/88)
Thomas, Candy V., 87-0203M (3/88)
Thompson, Donald R., 88-0482M (9/88)
Thompson, Mary E., 88-0515M (9/88)
Thompson, Sam, Jr., 85-0516M (4/88)
Thompson, Vivian, 88-0324M (7/88)
Tichenor, Dale L., 88-0183M (6/88)
Tindall, James, 88-0095M (4,6/88)
Tindle, Nina, 88-0389M (7/88)
Todd, Sam, 88-0356M (9/88)
Toman, Stella, 88-0068M (2/88)
Tompkins, Theodore, 87-0602M (1/88)
Towns, Jerry, 88-0157M (4/88)
Townsend, Randy L., 88-0217M (5/88)
Tribur, Harold, 85-0493M (5/88)
Trollope, Stephen, 88-0146M (7/88)
Tunnell, Marsha, 88-0305M (5/88)
Underhill, Thelma L., 88-0087M (6/88)
Underhill, Thelma, 88-0486M (8/88)
Valle, Isaias, 87-0477M (5/88)
Vandehey, Kim M., 88-0256M (5/88)
Vanderzanden, Eleanor, 88-0276M (9/88)
Vargas, Ricardo, 88-0268M (5/88)
Wade-Wilson, Teresa, 88-0254M (6/88)
Wagenius, Ann, 88-0244M (6/88)
Walker, Edward, 85-0397M (1/88)
Wall, Barbara, 88-0499M (9/88)
Warner, Jim N., 87-0002M (2/88)
Warner, Ronald L., 86-0255M (8/88)
Warren, Deroyn P., 88-0400M (7/88)
Weaver, Stephen L., 88-0443M (7/88)
Webb, Andy, 88-0144M (4,5/88)
Weiler, Fred, 88-0263M (8/88)
Wells, Earl, 88-0107M (3/88)
Wendling, Rodney, 88-0396M (7/88)
Werner, Diane, 88-0164M (4/88)
West, Wilbur, 88-0565M (9/88)
Wheatley, Roy T., 86-0349M (4,5/88)
Wheeler, Harriette, 88-0046M (2/88)
White, Frank R., 87-0698M (1/88)
Whitethorn, Rick, 88-0142M (4/88)
Wilburn, James, 88-0153M (4/88)
Wild, Karl, 87-0411M (1,2,2/88)
Williams, Gary E., 87-0749M (1/88)
Williams, Glenn M., 88-0090M (3/88)
Williams, Glenn, 88-0363M (7/88)
Williams, Robert H., 87-0730M (3/88)
Williamson, Walter, 88-0226M (5/88)

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Wilson, Vaughn, 88-0511M (9/88)
Wincer, Donald S., 86-0406M (7,8/88)
Winningham, Brett, 88-0467M (8/88)
Winter, Michael, 88-0040M (2/88)
Wolf, Paul, 88-0111M (4/88)
Woltersdorf, Guenter, 88-0509M (9/88)
Woodman, Donald E., 88-0110M (4/88)
Woodruff, Ellanora, 87-0307M (5/88)
Woods, Deborah, 88-0104M (7/88)
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Wright, Bill M., 88-0280M (6/88)
Wright, Donald C., 86-0572M (7/88)
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