VAN NATTA'S WORKERS' COMPENSATION REPORTER

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This volume is a compilation of Orders of the Oregon Workers' Compensation Board and decisions of the Oregon Supreme Court and Court of Appeals relating to workers' compensation law.

Owing to space considerations, this volume omits Orders issued by the Workers' Compensation Board that are judged to be of no precedental value.

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CITE AS

42 Van Natta ____ (1990)

In the Matter of the Compensation of
LYNN D. BENSON, Claimant
WCB Case No. 88-03982
ORDER ON REVIEW
Emmons, et al., Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Cushing and Myers.

Claimant requests review of Referee Baker's order which upheld the insurer's denial of claimant's occupational disease claim for a pulmonary condition. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

Claimant began working for the employer in 1966. His work consisted of working on furnaces, glove welding and alloy preparation. Claimant did alloy preparation for approximately 19 years. During the last eight to nine years, claimant worked in Building 38, working roughly one-third of his day in the building.

In September 1987, the employer discovered the presence of asbestos in its ceiling insulation in Building 38. After investigation, it was determined that the amount of asbestos exposure to its employees never exceeded federal and state asbestos exposure limits.

In September 1987, claimant sought medical treatment for a pulmonary condition. X-rays were taken, with findings consistent with asbestos pleural disease. Claimant's chest x-rays from 1981, 1982 and October 1984 were essentially identical to his 1987 chest x-rays.

Claimant filed a claim for asbestosis in September 1987. He was treated by Dr. Ostrow, M.D., but continued to work in building 38. In October 1987, Dr. Mulkey, M.D., noted his impression of possible "asbestosis," noting that other agents can cause pleural calcification.

In December 1987, Dr. Rudin, M.D., independent medical examiner, evaluated claimant.

In January 1988, the insurer denied claimant's claim for his pulmonary condition, indicating that it was not related to his employment with his employer. Claimant requested a hearing.

In February 1988, claimant was evaluated by Dr. Kloster, cardiologist. Kloster did not relate claimant's current pulmonary condition to his work exposure. In March 1988, claimant was evaluated by Dr. Barker, M.D. In April 1988, cliamant was again evaluated by Mulkey.

Claimant was exposed to asbestos while working for his employer. His work activities with his employer were not the major contributing cause of his pulmonary condition.

Claimant has not been exposed to asbestos prior to his employment with the employer.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant failed to meet his burden of proving that his pulmonary condition was caused or worsened, in major part, by his employment exposure. Claimant argues that he has met his burden of establishing

that work exposure with the employer was "capable" of causing his disease. (Reply Br. at 7). Claimant is not applying the appropriate legal test.

In his reply brief, claimant cites to FMC Corp. v. Liberty Mutual Ins. Co., 73 Or App 223 (1985), and argues that the claim is compensable because his work was capable of causing his asbestos condition. FMC Corp., however, is a case applying the "last injurious exposure rule." This case does not involve the last injurious exposure rule. Claimant has not shown that multiple employers incrementally caused his condition. He testified, and we have found, that his only exposure is with this employer. Thus, the cite to FMC Corp. is inapposite. Instead, claimant must prove actual causation against the employer to meet his burden of proof.

Claimant's burden is to prove that his employment exposure with this employer was the major contributing cause of either the onset or worsening of his condition. 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). "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, 296 Or 145, 166 (1983); Dethlefs v. Hyster Co., supra. at 309-10; Clark v. Erdman Meat Packing, 88 Or App 1, 5 (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). We find that the issue of whether claimant's work activities were the major contributing cause of his current pulmonary asbestos-related condition is a complex medical question, requiring expert medical evidence. See Uris v. Compensation Department, 247 Or 420, 424 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985).

After our de novo review of the record, we conclude that there is no medical evidence to establish that claimant's work activity with his employer, with its limited exposure to asbestos, was the major contributing cause of either the onset or worsening of his current pulmonary condition.

Ostrow reported in September that "since pleural calcification was clearly present as early as 1982, it is quite unlikely that all the [claimant's] current changes seen were related to asbestos dust exposures beginning in 1966." Ostrow concluded that claimant's chest "x-rays showed evidence of asbestos-related bilateral calcified pleural plaques, with little or no progression between 1982 and 1987, probably resulting from asbestos dust exposures occurring 30-40 years or more earlier."

Rudin, the independent medical examiner, reported that "it is virtually impossible for any exposures in building 38 to have caused the lung condition that we are now seeing on [claimant's] x-rays . . . " Further, Rudin concluded that "over the time that building 38 has been utilized, . . . there was insufficient asbestos exposure to cause a disease identical to [claimant's]." In making such a conclusion, Rudin noted that studies have shown that building 38 met all federal requirements for asbestos control.

Likewise, Barker reported that claimant's "exposure [to asbestos] was at least 15-20 years ago or earlier."

Finally, in April 1988, Mulkey reported that claimant had evidence of asbestos pleural plaques, but such evidence "does not mean that he has asbestosis or pulmonary fibrosis as a result of asbestos exposure." Mulkey concluded that claimant's chest pain "is unrelated to his exposure to asbestos or the

presence of asbestos related pleural disease. It is likely that [claimant's] chest discomfort is due to cardiac disease which is now being treated."

Therefore, under the circumstances, we conclude that claimant has failed to meet his burden of proving that his asbestos exposure with the employer was the major contributing cause of either the onset or worsening of his current pulmonary asbestos-related condition.

ORDER

The Referee's order dated July 11, 1988, is affirmed. A client-paid fee, not to exceed $1,605.50, payable by the insurer to its counsel, is approved.

April 2, 1990 Cite as 42 Van Natta 779 (1990)

In the Matter of the Compensation of
BARBARA J. BROWN, Claimant
WCB Case No. 85-15686
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
G. Howard Cliff, Defense Attorney

Reviewed by Board Members Myers and Gerner.

The insurer requests review of those portions of Referee St. Martin's order which: (1) set aside its partial denial of claimant's psychological condition; (2) set aside its medical services denial for claimant's current treatment as being unrelated to the accepted low back condition; and (3) granted an award of permanent total disability, whereas a Determination Order declined to increase claimant's award beyond the 20 percent (64 degrees) already awarded. On review, the issues are compensability, medical services and permanent total disability. We reverse.

FINDINGS OF FACT

Claimant injured her upper back and neck on August 28, 1979 while working in a cannery for the insured. A week later she had a second at work incident resulting in a low back strain. Both incidents were treated as one injury and were accepted by the insurer. Claimant has a preexisting psychological condition diagnosed as hysterical neurosis. As a result of her injury she also experienced depression and sought psychological care.

Claimant's claim was first closed by Determination Order dated October 28, 1980 with an award of 10 percent unscheduled permanent disability. Claimant continued to complain of low back pain and her claim was reopened. The claim was again closed by Determination Order in May 1981. The insurer denied claimant's psychological/psychiatric problems in September 1981. Claimant and the insurer entered into a Disputed Claim Settlement to resolve the denial and entered into a Stipulation to award claimant an additional 10 percent unscheduled permanent disability. The claim was again reopened in 1982. Claimant received vocational assistance to increase her clerical skills.

On February 13, 1983, claimant took a Zomax pill to help relieve her back pain. She had an adverse reaction to the medication, fainted and hit her head. Claimant had a recurrence of psychological problems related to the adverse reaction to Zomax, including anxiety attacks.

Claimant returned to work for the first time in October 1984 with an insurance agency as a clerical worker. Six weeks later her back symptoms worsened. Claimant developed emotional problems and sought more psychological care.

Her claim was closed again by Determination Order in October 1985 which awarded three and one half years of temporary disability and no additional permanent disability beyond the 20 percent previously awarded. Claimant appealed the award. She declined further vocational assistance in November 1985 because she desired to continue her volunteer services with the library.

By 1986, claimant had developed a paranoid personality, agoraphobia, severe depression and suffered from anxiety and panic attacks. Claimant's husband took a job outside the state and as a result of this action, family pressures, a loss of family support to meet her dependency needs and a fear that her husband would leave her, claimant was hospitalized for psychiatric care. The insurer issued a medical services denial of claimant's current treatment on June 29, 1987 and orally amended the denial at the November 6, 1987 hearing to include a partial denial of claimant's psychological condition.

Claimant has no objective abnormality with her low back. Her low back condition has not changed since the last arrangement of compensation on October 1, 1981. (Ex. 50; Tr. 59, 77). The medical treatment she received contemporaneous with the denial is not materially related to the accepted injury. Claimant's current psychological condition is not materially related to the accepted injury.

CONCLUSIONS OF LAW AND OPINION

Propriety of the Referee's Order

The Referee requested claimant to prepare a proposed Order including proposed findings of fact and conclusions of law. The Referee then used this document to prepare his order. The insurer objects to this practice.

The insurer is unable to cite any authority that casts any legal doubt upon the validity of the Referee's order. However, we do agree with the insurer that this practice is not desirable. The Board strongly discourages its Referees from requesting and then using party prepared findings of fact and conclusions of law. On review, the Board wishes to consider the Referee's findings and conclusions.

Medical Services and Psychological Condition Denial

The Referee set aside the insurer's partial denial of claimant's psychological condition and the denial of medical services by relying upon the opinions of two of claimant's treating doctors: Dr. Kester, a psychiatrist, and Dr. Kenyon, a surgeon. The Referee discounted the counter opinions of Drs. Parvaresh, psychiatrist, and Wilson, neurologist, because he found they had lost their objectivity and had become advocates for the insurer. We disagree with the Referee's evaluation of the medical opinions.

We evaluate three basic factors when assessing the persuasiveness of medical opinions: the source of the opinion, its factual basis and its logical force. Earl M. Brown, 41 Van Natta 287, 291 (1989). The source of the opinion includes the expertise and objectivity of the one giving it. The factual basis of the opinion includes completeness and correctness of the information upon which it is based. The logical force involves the depth, clarity and cogency of analysis.

Kester first evaluated and started to treat claimant in July 1986, late in the life of this claim. (Ex. 167). He has reviewed the complete medical file. Dr. Kester is the physician responsible for hospitalizing claimant in late 1986 for her psychiatric condition at a private hospital with which he is affiliated.

He explained the need for claimant's hospitalization to be the result of a "severe deterioration in her condition" with "the hope that she will be able to achieve a higher level of productive functioning than previously." (Ex. 168). He testified at hearing that the hospitalization was to help her "cope" with family problems and fears that her husband was leaving her. (Tr. 36). Despite the fact that claimant's back condition had not worsened, he was of the opinion that the hospitalization was related to the injury because "for her back to get better, she's got to feel she's in control in her life situation in other areas, in all areas of her life...." (Tr. 52).

We are not persuaded by Dr. Kester's opinion. His opinion lacks logical force. He does not explain why the psychiatric hospitalization is related to an industrial injury occurring over 10 year prior to admission where claimant's injury residuals have not worsened. While he acknowledges that one's psychological state can worsen after prolonged exposure to chronic pain, he does not state that such is the reason for this hospitalization. (Tr. 48). Dr. Kester seems to believe that the hospitalization is related because if it improves claimant's life, it has improved her injury, which is a part of her life. (Tr. 52). This reasoning does not address the question whether the injury is a material contributing cause of the need for hospitalization. In light of his reports that the hospitalization occurred because of family problems and because of claimant's fear that she may lose her husband, neither of which appear logically related to the injury, we do not find his opinion cogent or persuasive. Furthermore, he is not responsive to the criticism leveled by other professionals that this hospitalization was both unnecessary and excessive. (Tr. 53). Nor does he support his unique and uncorroborated diagnosis, also challenged, that claimant has "post-traumatic stress disorder." (Ex. 171A-12). For all the forgoing reasons, we do not defer to Kester's opinion.

Dr. Kenyon has been claimant's family doctor since before her industrial injury. At one time, he was even claimant's neighbor. (Tr. 17). He is not, however, a psychologist nor a psychiatrist. Dr. Kenyon is of the opinion that claimant's psychological condition and her need for treatment is related to her industrial injury. (Exs. 156, 166). He relates the current treatment and the psychological condition to the industrial injury by comparing claimant's pre and post Zomax incident psychological and physical states. He believes the Zomax incident worsened her back and worsened her psychological condition. However, at one point, Dr. Kenyon had the opposite opinion and had agreed that claimant's post-Zomax incident psychological condition had returned to its pre-Zomax incident state. (Ex. 146). We are not persuaded by his unexplained change of opinion. See Kelso v. City of Salem, 87 Or App 630 (1987). Furthermore, Dr. Goranson, an independent medical examiner, called into question Dr. Kenyon's own role in the development and perpetuation of claimant's psychological condition. He opined that the medical treatment given by Dr. Kenyon was excessive and was a means of meeting claimant's dependency needs. He stated that the treatment was neither related to nor necessary for the industrial injury. (Ex. 171A-11 through 13). Dr. Kenyon does not respond to this criticism. We are not persuaded by Dr. Kenyon's opinion.

Dr. Parvaresh is a consulting doctor who examined claimant on two occasions. (Tr. 105). He is a psychiatrist and he has reviewed the entire medical file in this case. He is of the opinion that claimant's current need for medical treatment and her psychological condition are not related to the industrial injury. He recognizes that the Zomax incident did result in an increase in psychological symptoms but that claimant's psychological condition returned to its preexisting premorbid level thereafter. (Ex. 144). However, when reaching the conclusion that claimant's current need for treatment and her current psychological state is not causally related to the industrial injury, Dr. Parvaresh interjects another analysis. He believes that claimant's worsened

condition that required psychiatric hospitalization is not related to the industrial injury because her physical back problems did not worsen. He is of the general opinion that without physical worsening, any worsening of a psychological condition is not related to the injury. (Ex. 172-3; Tr. 128). We are not persuaded by this assertion. On cross-examination Parvaresh was unable to clearly explain how his opinion was consistent with the existence of hysterical conversion reactions. (Tr. 128-129). Furthermore, Dr. Kester persuasively refuted this theory at hearing by explaining that constant and unchanged chronic conditions can themselves lead to increased psychological problems without any need for an intervening change in the physical problem. (Tr. 48). We are not persuaded by Dr. Parvaresh's opinion.

Dr. Goranson is a consulting doctor who examined claimant and reviewed all the medical records. Dr. Goranson is a psychiatrist. He is of the opinion that claimant's current need for treatment and her psychological condition are not materially related to her injury. We find Dr. Goranson's reports to be insightful. He speaks with conviction and presents a clear, cogent analysis of claimant's current condition as well as in-depth discussion of her condition since the claim's inception. (Exs. 171A, 171B). While acknowledging an interaction between the injury and her psychological condition, he finds the current condition and need for treatment are not materially related to the injury, but instead that they are "primarily due to the fact that her family was becoming impatient and pulling away from her, giving her less emotional nurturance and support; as a result she put increased demands on health care givers to provide substitutes." (Ex. 171A-13). Goranson's opinion is consistent with the two hundred and thirty two pages of contemporaneous hospital and treatment records. (Ex. 167A). It is consistent with the predictions of earlier doctors including former treating psychiatrist Dr. Maltby (Exs. 18, 35); psychologist Dr. Lowery (Ex. 17); and psychiatrist Dr. Wise (Ex. 75). We defer to the opinion of Goranson.

Accordingly, we conclude that claimant's current medical services are not compensable and that her current psychological condition is not compensable.

The insurer also argues that claimant's current psychological condition is barred by the terms of the September 21, 1981 Disputed Claim Settlement. Because of our resolution of the compensability of the condition on the merits, we decline to reach this argument.

Permanent Total Disability

The Referee found claimant permanently and totally disabled based in part upon her current psychological condition. Our reversal of the Referee as to the compensability of this condition results in a reversal of the permanent disability award as well.

Claimant's physical residuals from the compensable injury have not changed. Her psychological condition preexisted her injury. Because the injury has not permanently worsened her psychological condition we consider the condition to the extent that it was disabling at the time of injury. ORS 656.206(1)(a); Robert L. McMillan, 40 Van Natta 1241 (1988). We find that claimant was not disabled by her psychological condition at the time of injury. Her current psychological disability is significant, but the post-injury progression of a preexisting disability cannot be considered. John D. Kreutzer, 36 Van Natta 285, aff'd mem 60 Or App 78 (1984). Since the Determination Order on appeal is one closing an aggravation claim, claimant must establish a permanent worsening of her condition in order to prove entitlement to additional permanent disability. Stepp v. SAIF, 304 Or 375 (1987). Since claimant's physical condition is unchanged, and since the worsening is due to the progression

of a noncompensable preexisting condition, we conclude that claimant is not entitled to additional permanent disability.

ORDER

The Referee's order dated March 21, 1988 is reversed. The insurer's denial dated June 29, 1987 and its oral denial at hearing are reinstated and upheld. The award of a $2,000 insurer paid attorney fee to claimant's counsel is reversed. The award of permanent total disability is reversed. The Determination Order dated October 18, 1985 is reinstated in its entirety.

In the Matter of the Compensation of
BRIAN L. CARR, Claimant
WCB Case No. 88-12769
ORDER ON REVIEW (REMANDING)
Schwabe, et al., Attorneys

Reviewed by Board Members Cushing and Gerner.

Claimant requests review of Referee Galton's orders which dismissed claimant's request for hearing for failure to appear at hearing. We remand.

Claimant requested a hearing on July 26, 1988. The hearing convened on October 21, 1988. Claimant did not appear at the hearing; however, claimant's attorney did appear. Claimant provided no reason to his attorney for his failure to appear at the hearing. The Referee dismissed the request for hearing pursuant to his understanding of former OAR 438-06-071.

On October 24, 1988, the Referee issued an Opinion and Order dismissing claimant's request for hearing. On October 26, 1988, claimant's attorney wrote the Referee requesting reconsideration of the dismissal order. Claimant's request for reconsideration was based upon an affidavit dated October 25, 1988. The affidavit stated in material part:

> "That it was my belief that the proceeding for October 21, 1988 was what is known as an Informal Dispute Resolution Conference and my attendance was not required."

This was the sole reason that claimant gave for failing to appear at the hearing.

The Referee reviewed claimant's request, as well as the insurer's motion in opposition, and issued an Order on Motion on November 3, 1988. That order denied claimant's request to set aside the Order dismissing claimant's request for hearing.

The Court of Appeals has recently interpreted a regulation substantially the same as former OAR 438-06-071 as prohibiting dismissal of a request for hearing where claimant has failed to appear at hearing, but claimant's attorney has appeared at hearing. Williams v. SAIF, 99 Or App 367 (1989). Accordingly, we conclude that the Referee erred in dismissing the request for hearing. This case will be remanded to the Referee for a hearing.

Our second inquiry is whether claimant has waived his right to testify in the hearing before the Referee by failing to establish sufficient grounds which would have justified a postponement. Mark S. Lesowske, 41 Van Natta 2154 (1989).

Claimant's request for reconsideration is to be treated as a motion for postponement. Mark R. Luthy, 41 Van Natta 2132 (1989). Here, the Referee concluded that claimant had not established grounds to justify a postponement because he did not believe the allegations of the affidavit, nor that the allegations of the affidavit constituted sufficient grounds for failing to appear at the hearing. We agree.

The Referee in his Order on Motion explained his reasons for not believing the claimant's affidavit. We adopt those reasons as our own. Considering those findings and conclusions, claimant has not shown sufficient circumstances to justify a postponement under former OAR 438-06-081. Claimant has waived his appearance and his right to testify in his own behalf.

Therefore, the case will be remanded to the Referee to hold a hearing and decide the case on the merits. In holding the new hearing, no exhibit shall be received which was not submitted in connection with the prior hearing nor shall any witness, including claimant, be permitted to testify who was not available to and planning on testifying at the prior hearing or under subpoena to testify at that hearing. Mario Miranda, 42 Van Natta 405 (1990).

ORDER

The Referee's order, dated October 24, 1988, is reversed. This case is remanded to the Referee for proceedings consistent with this order. The Board approves a client-paid fee, not to exceed $1,532.25, payable from the employer to its counsel.

April 2, 1990 Cite as 42 Van Natta 784 (1990)

In the Matter of the Compensation of
LOYD W. DILL, Claimant
WCB Case No. 88-14865
ORDER ON REVIEW
W. Daniel Bates, Jr., Claimant Attorney
Cummins, et al., Defense Attorneys

Reviewed by Board Members Gerner and Cushing.

Claimant requests review of those portions of Referee Mirassou's order that: (1) awarded 5 percent (7.5 degrees) scheduled permanent disability for the loss of use or function of his right forearm; and (2) awarded 5 percent (7.5 degrees) scheduled permanent disability for the loss of use or function of his left forearm. The self-insured employer cross-requests review, arguing that the Referee's award of permanent disability should be reversed. On review, the issue is extent of scheduled permanent disability. We affirm.

FINDINGS OF FACT

The Board adopts the Referee's Findings of Fact and Findings of Ultimate Fact as our own.

CONCLUSIONS OF LAW AND OPINION

The Board adopts the Referee's Conclusions of Law, with the following supplementation.

In determining the extent of claimant's permanent disability, the Referee applied the standards for evaluating permanent disability as adopted by the

Director of the Department of Insurance & Finance pursuant to ORS 656.726(3)(f). See ORS 656.283(7). Specifically, the Referee applied former OAR 436-35-000 et seq, which was effective at the time of the December 29, 1988 Determination Order. See OAR 438-10-005; 438-10-010. These are the rules which we apply as well. ORS 656.295(5); OAR 438-10-005; 438-10-010.

The Referee, in making her disability determination, applied the clear and convincing evidence standard of review and concluded that claimant was restricted from performing certain activities because of disabling pain. Consequently, the Referee awarded claimant 5 percent scheduled disability for each forearm. We agree with the Referee's conclusions; however, the use of the clear and convincing standard was not appropriate.

All fact finding under the standards is made upon a preponderence of the evidence. Michelle Griffith, 40 Van Natta 2086, 2089 (1988).

The employer argues that the Referee misapplied the standards by rating claimant's disabling pain and factoring that pain into the final determination of the level of claimant's permanent disability. We disagree. Disabling pain may be considered in determining permanent disability under OAR 436-35-010(2)(a). See Daniel Alire, 41 Van Natta 752 (1989).

Here, after conducting our de novo review, we find that claimant has suffered a 5 percent loss of use or function in each forearm.

Claimant's counsel is statutorily entitled to a reasonable, insurer-paid attorney fee for services rendered on Board review concerning the employer's cross-request. Such a fee is defined as an "assessed fee." See OAR 438-15-005(2). However, we cannot award 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 cannot presently be awarded. See OAR 438-15-010(5).

ORDER

The Referee's order dated December 29, 1988, is affirmed. A client-paid fee, not to exceed $1,136, payable from the employer to its counsel, is approved.

April 2, 1990 Cite as 42 Van Natta 785 (1990)

In the Matter of the Compensation of
ABRAHAM HEAMISH, Claimant
WCB Case No. 86-17367
ORDER ON REVIEW
Schwabe, et al., Attorneys

Reviewed by Board Members Gerner and Cushing.

Claimant, pro se, requests review of those portions of Referee Schultz's order which: (1) affirmed a Director's Order terminating vocational assistance; (2) did not award additional temporary disability from October 1, 1985 through May 6, 1986; and (3) declined to assess penalties and attorney fees for the alleged outrageous conduct of the employer in the processing and administration of this claim from its beginning. Claimant also requests review of the interim discovery order, dated October 14, 1987, which did not allow claimant access to certain documents in the self-insured employer's claim file because of an attorney-client privilege. Claimant, lastly, requests the Board to admit certain additional documents into the record. Such a request is treated by us as a

motion for remand to the Referee for the taking of additional evidence. The employer cross-requests review of that portion of the order that found claimant had sustained a compensable aggravation claim. The issues on review are remand, discovery, vocational rehabilitation, aggravation, temporary disability, penalties and attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

Claimant, a bus driver, injured his back and left arm on June 25, 1981. This claim was accepted and processed. The claim was first closed by a Determination Order dated March 16, 1984, which awarded claimant 15 percent unscheduled permanent disability. This award was increased to 25 percent unscheduled and 20 percent scheduled permanent disability by Opinion and Order.

Thereafter claimant was found eligible for vocational assistance and he was referred to Cascade Rehabilitation Counseling on January 24, 1985. Following evaluation, an academic skills program was recommended in order to prepare claimant to become a legal assistant. The program began on March 11, 1985. This program included course work aiding claimant to receive his GED and to become a legal assistant. This course work was to be followed up by a professional skills program with an employer.

Claimant's professional skills training was performed at The Consumer Sounding Board. The program was to have run from June 17, 1985 to September 27, 1985. While participating in this program, claimant was also participating in typing and legal terminology courses.

In June of 1985, claimant's vocational counselor wrote him a letter advising him that claimant had mistakenly received a $40 check made out to the employer which was intended for another claimant to use to obtain a bus pass. Claimant used this check to obtain a bus pass for his daughter and failed to reimburse Cascade Rehabilitation despite several demands to do so. In the meantime, claimant failed a course in legal terminology and failed to send his counselor copies of his final grades. These actions by claimant resulted in the termination of his vocational rehabilitation assistance.

Following this termination, a new Determination Order was issued on October 16, 1985. The employer also denied a claim for aggravation on October 31, 1985. These issues were litigated in a hearing before Referee Neal on January 13, 1986.

At the time of the hearing, claimant was not working. He suffered disabling pain with almost any activity and was significantly restricted in sitting, standing, walking, lifting, bending, driving, and other bodily movements. Claimant also had numerous internal medicine problems and had psychological problems. Referee Neal affirmed the Determination Order as well as the denial of aggravation.

In May 1986, claimant started treating with Dr. McGovern, a psychologist. Claimant complained of problems of fatigue, tiredness, malaise, forgetfulness, excitability, easy irritation, and depression. These symptoms had been present at times prior to the compensable injury in 1981 and as well as prior to the last arrangement of compensation.

Claimant challenged the termination of his vocational assistance and, pursuant to that challenge, the Director held a review of the termination. The Director issued an order upholding the termination on November 5, 1986. In conducting his review, the Director's agents interviewed all the relevant parties as well as reviewed the record.

The Director found claimant to be not credible. The finding of lack of credibility supported the Director's finding that claimant failed to fully cooperate in his vocational assistance program. This finding was also supported by the fact that claimant had misused vocational assistance funds and had not promptly returned them in spite of several requests to do so. The Director also found claimant had failed to cooperate with the program because he violated the rule that required him to submit his grades to his counselor immediately. Based on these findings, the Director found that claimant had violated sufficient vocational rules to justify a termination of his vocational assistance.

Claimant filed an aggravation claim in May 1987 contending that he now had a psychological condition that had worsened. The claim for aggravation was denied on May 19, 1987.

Claimant's psychological and pain symptoms worsened at the time of his termination from the vocational rehabilitation program and have not materially worsened since that time. Claimant's symptoms have improved since the last arrangement of compensation. Claimant's limitations have not increased nor has his ability to obtain and hold a job in the broad field of general occupations lessened since the last arrangement of compensation.

After the request for hearing was filed herein, claimant requested discovery of Dr. Silver's file and the employer's claim file. In a discovery order dated May 14, 1987, Presiding Referee Daughtry ordered the discovery of Dr. Silver's file. Subsequent thereto, on June 15, 1987, a discovery conference was held with Assistant Presiding Referee Lipton. The purpose of the conference was to allow claimant to have discovery of the two files claimant had requested.

At the conference, the employer asserted an attorney-client privilege over several documents in its claims file. Lipton conducted an in-camera review of these documents and provided claimant, whose attorney was not present at the conference, with copies of only the non-privileged documents. Claimant protested Lipton's action and procedure. This procedure was affirmed by Daughtry in an Interim Order on discovery issued on October 1, 1987.

CONCLUSIONS OF LAW AND OPINION

Remand

Claimant has submitted documents with a motion to supplement the record on review. Such a motion is treated by us as a motion for remand to the Referee for the taking of additional evidence.

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 the 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); Bernard L. Osborne, 37 Van Natta 1054, 1055 (1985), aff'd mem 80 Or App 152 (1986).

We are not persuaded that the record concerning the multiple issues herein has been improperly, incompletely or otherwise insufficiently developed. We are similarly unpersuaded that most of the documents submitted by claimant were unobtainable with due diligence at the time of the hearing. Accordingly, we conclude that remand is not warranted.

Discovery Procedure

Claimant contends that the Interim Order on discovery, dated October 1, 1987, should be reversed because it did not allow claimant, or his representative, to view documents in the claim file that were claimed to be privileged by the employer. We disagree.

OAR 438-07-015 entitles a party to all documents pertaining to a claim except those documents that are for impeachment (OAR 438-07-017) or those documents that are subject to a privilege (see ORCP 36.B(1)). The attorney-client privilege exception to discovery is found in ORS 40.225 and is recognized in State v. Jancsek, 302 Or 270 (1986).

In this case, claimant was allowed by a discovery order to personally view the claims file. A discovery conference was held on June 15, 1987, to accomplish that end. Assistant Presiding Referee Lipton, who was not assigned to hear the case on the merits, conducted the conference. At the conference, the employer asserted that some of the documents in the claims file were privileged and thus were not discoverable to claimant. In order to insure that the asserted privilege was not abused to claimant's detriment, nor that the employer's asserted privilege was violated, Lipton held an in-camera review of the documents claimed to be privileged and decided which documents were discoverable. Claimant and his representative were not allowed to see the documents that Lipton found to be privileged. It is this action that claimant contends was error. We disagree.

The actions of Lipton were appropriate and correct under these circumstances to protect both the employer's privilege and claimant's discovery rights. The review of the documents by a neutral referee was the best way to achieve a fair result. To allow claimant or his representative to view the documents to see if they were privileged, would defeat the privilege itself.

The discovery process, as ordered in the Interim Order of October 1, 1987, was appropriate and correct.

Director's Order

The Referee found that the Director had not abused his discretion in finding that claimant's vocational rehabilitation assistance should be terminated. We agree.

Orders of the Director regarding vocational rehabilitation issues are reviewed pursuant to ORS 656.283(2). The scope of review is limited and a decision may only be modified if it:

> "(a) Violates a statute or rule;
> (b) Exceeds the statutory authority of the agency;
> (c) Was made upon an unlawful procedure; or
> (d) Was characterized by an abuse of discretion or clearly unwarranted exercise of discretion."
>
> ORS 656.283(2).

A review for an abuse of discretion is the only standard applicable in this case.

When dealing with an abuse of discretion by the Director, the legal issue is not whether the Director reached the only possible decision, or even the correct decision. The legal issue is whether the evidentiary record contains

sufficient evidence to support the decision as not being unreasonable or an abuse of discretion. See Schreindl v. SAIF, 48 Or App 127, 131 (1980).

In this case, the Director granted claimant the right to present his case and, having done so, made specific findings of violations of the vocational rules. There is ample evidence in the record to support the Director's conclusion. There being evidence to support the conclusion, the conclusion cannot be unreasonable or an abuse of discretion. The Director's order shall remain affirmed.

Aggravation

The Referee concluded that claimant had proven a compensable aggravation although no evidence explicitly addressed the issue of claimant's inability to work. We disagree.

To establish an aggravation, claimant must show a worsening of his compensable condition since the last arrangement of compensation. Smith v. SAIF, 302 Or 396 (1986). "Worsening" within this context means increased symptoms, or a worsened underlying condition, resulting in a diminishment of earning capacity. Id. If the last arrangement of compensation anticipated future exacerbations accompanied by a diminished earning capacity, claimant must also prove: (1) that his earning capacity was diminished longer or in greater degree than was anticipated; or (2) that his exacerbation resulted in 14 consecutive days of total disability or inpatient hospitalization. Gwynn v. SAIF, 304 Or 345 (1987), on rem 91 Or App 84 (1988); Edward D. Lucas, 41 Van Natta 2272 (1989).

The focus of this aggravation claim is a worsening of claimant's psychological condition. In this case, claimant has failed to prove that he has worsened since his last arrangement of compensation and that he is less able to work than he was at the time of the last arrangement of compensation.

The medical record establishes that claimant complained of psychological symptoms such as fatigue, tiredness, malaise, forgetfulness, excitability, easy irritation and depression. These symptoms were present prior to the compensable injury and the last arrangement of compensation, and were also present at the time of the aggravation claim. The question is whether these symptoms have worsened since the last arrangement of compensation in January 1986.

The testimonial evidence, as well as Dr. McGovern's testimony, points out that claimant's psychological symptoms worsened when he was terminated from his vocational rehabilitation program in July 1985. Since that time, claimant's symptoms have either remained essentially the same or improved. At one point, Dr. McGovern states that psychological treatment has failed to make any change in claimant's condition since the time he first saw him. But at the time of hearing claimant had sufficiently improved to be able to return to his regular work, unrestricted, for the first time since early in the claim. These facts are significant in that the vocational program terminated in July 1985, and the last arrangement of compensation was a hearing held on January 13, 1986.

Since claimant's psychological condition worsened prior to the last arrangement of compensation and has remained essentially the same or improved since that time, he has failed to show a compensable worsening of his psychological condition after his last arrangement of compensation. Likewise, any increased back pain is not shown to have happened after the last arrangement of compensation rather than before. The evidence presented by claimant again points out that the worsening, be it psychological or physical, started at the termination of the vocational program.

Even if there was a worsening of claimant's symptoms, psychological or physical, claimant has failed to prove that these worsened symptoms made him any less able to work than he was at the last arrangement of compensation. At the January 1986 hearing, claimant was not working. He suffered disabling pain with almost any activity and was significantly restricted in sitting, standing, walking, lifting, bending, driving and other bodily movements. Claimant also had a host of internal medicine problems and had psychological problems. This myriad of limitations and complaints establish that claimant was limited in his ability to obtain and hold jobs in the broad field of general occupations. Claimant must show limitations and complaints that restrict him from even a greater share of the broad field of general occupations than did the limitations and complaints he experienced at the January 1986 hearing.

Claimant presented no testimonial evidence that his limitations increased after the last hearing, nor did he present any evidence that he is less able to work since the last hearing. The evidence establishes that claimant's increased limitations occurred prior to, and were taken into consideration at, the last hearing. He has not shown a lessened ability to work after that time.

The medical evidence also does not meet claimant's burden of proving that he is less able to work than he was at the last arrangement of compensation. The only medical evidence that addresses inability to work is a letter by Dr. McGovern in February 1987. In that letter, McGovern opines that, when he first saw claimant in May 1986, claimant, due to depression, would not have been able to perform four types of jobs. There is no opinion rendered that claimant was able to perform these jobs prior to his last arrangement of compensation. Without that necessary addition, Dr. McGovern's opinion is not persuasive.

Claimant has failed to prove that he has a compensable aggravation claim.

Time Loss

Claimant contends that he is entitled to additional temporary disability benefits from October 1, 1985 through May 6, 1986. We disagree.

The entitlement to temporary disability from October 1, 1985 through January 13, 1986 was resolved by Referee Neal's order and cannot now be relitigated. As to entitlement to temporary disability since that time, that issue is resolved by our finding that claimant has not proven a compensable aggravation claim.

Penalties and Attorney Fess

Claimant contends that he is entitled to penalties because of the employer's outrageous conduct in processing and administering the claim. Most of claimant's contentions revolve around the vocational assistance given to him. Claimant alternately contends that the employer delayed placing him in a vocational program or put him in one too soon. In either case, the Board and Hearings Division are without jurisdiction to assess penalties in vocational matters. Joel I. Harris, 36 Van Natta 829 (1984), aff'd mem, 72 Or App 591 (1985).

Therefore, claimant is not entitled to a penalty in this matter for jurisdictional reasons, but even if there were jurisdiction to assess a penalty in this case, claimant has failed to prove that the carrier was doing anything unreasonable in processing the claim.

ORDER

The Referee's order dated April 20, 1988 is reversed in part and affirmed in part. That portion of the order that found claimant had sustained a compensable aggravation is reversed. The remainder of the order is affirmed.

In the Matter of the Compensation of
JEFF D. POWELL, Claimant
WCB Case No. 87-06294
ORDER ON REVIEW
Royce, et al., Claimant Attorneys
Cummins, et al., Defense Attorneys

Reviewed by Board Members Cushing and Gerner.

The self-insured employer requests review of Referee Mulder's order that granted claimant permanent total disability, whereas a Determination Order had awarded him 35 percent (112 degrees) unscheduled permanent disability for an upper back and neck condition, 5 percent (9.6 degrees) scheduled permanent disability for loss of use or function of the left arm, and 5 percent (9.6 degrees) scheduled permanent disability for loss of use or function of the right arm. On review, the issue is extent of permanent disability, including permanent total disability. We reverse the award of permanent total disability, but increase claimant's unscheduled permanent partial disability.

FINDINGS OF FACT

Claimant sustained a compensable injury to his low back in 1973. As a result of that injury, he underwent a laminectomy and spinal fusion in 1975 and a repeat fusion in 1977. By a 1979 referee's order, claimant was awarded 50 percent unscheduled permanent disability for his low back injury.

In 1984, claimant sustained a compensable injury to his neck and right arm, while working as a truck driver for the instant employer. A myelogram revealed cervical spondylosis with right C8 and possible C5 nerve root compression. As a result of his compensable injury, claimant underwent decompression surgery of the right C5 through C8 nerve roots. In June 1984, claimant was referred for vocational assistance.

In September 1984, claimant attempted to return to his regular work, but was not successful. Thereafter, with some vocational assistance, he became self-employed as a cook. In March 1985, claimant was released from work due to increasing symptoms. Vocational assistance was terminated in May 1985 as claimant indicated that once his medical problems were resolved, he would return to his restaurant business. In October 1985, claimant underwent an anterior discectomy and fusion surgery.

Vocational assistance was reinstated in July 1986. In late 1986, claimant's treating surgeon, Dr. Berkeley, approved work as a dump truck driver. Vocational assistance was terminated in September 1986 on the basis that claimant was not motivated nor cooperative in his job search program. An April 1987 Determination Order closed claimant's claim with an award of 35 percent unscheduled permanent disability for his neck condition as well as a 5 percent scheduled permanent disability award for both his left and right arms.

Thereafter, claimant sought vocational counseling from William Skilling. However, Mr. Skilling's services were terminated in early 1988, at the request of claimant's counsel.

Claimant is 54 years old and has a GED. His past work experience includes truck driving, cooking and restaurant supervision and ownership. He has owned a trucking company and a grocery store as well as managed apartment complexes. He has also worked as a janitor and a machinist. As a result of his compensable neck and arm injury he is permanently restricted to sedentary or light work. As

a result of his compensable neck injury, claimant has sustained permanent impairment in the moderate to severe range.

FINDINGS OF ULTIMATE FACT

Claimant is not permanently incapacitated from regularly performing work at a gainful and suitable occupation.

Claimant has not made reasonable efforts to seek or obtain gainful, suitable employment.

CONCLUSIONS OF LAW AND OPINION

Permanent Total Disability

The Referee concluded that claimant was permanently and totally disabled as a result of his 1984 compensable injury. We disagree.

To establish permanent total disability, claimant must prove that he his permanently incapacitated from regularly performing work at a gainful and suitable occupation. ORS 656.206(1). Claimant may prove permanent total disability by a combination of medical and nonmedical disabilities which effectively foreclose him from gainful employment. Welch v. Bannister Pipeline, 70 Or App 699 (1984). Unless claimant's physical incapacity in conjunction with his nonmedical disabilities renders work search futile, he must also establish that he is willing to seek regular gainful employment and has made reasonable efforts to obtain such employment. ORS 656.206(3); SAIF v. Scholl, 92 Or App 594 (1988).

The first step in determining whether claimant is permanently and totally disabled requires an evaluation of his physical condition. Subsequent to claimant's 1986 surgery, Dr. Berkeley limited claimant to lifting and carrying up to 20 pounds. He approved work as a dump truck driver as being within claimant's limitations. Dr. Mandiberg opined that claimant was not totally disabled and felt he could perform sedentary to light work. Dr. Mickel also opined that claimant could perform sedentary to light work. Finally, Dr. Mason opined that claimant may have difficulty performing work 40 hours per week, but felt that he might be able to do very sedentary work.

Dr. Thompson opined that claimant was unable to perform any work because his cervical condition made it difficult to perform activity that required use of the arms or any repetitive bending or lifting. Dr. Thompson's opinion, however, does not contain any explanation of his conclusion. Therefore, we are not persuaded by his opinion, particularly in light of the remaining medical opinions which indicate that claimant is capable of sedentary to light work. See Somers v. SAIF, 77 Or App 259 (1986). Accordingly, we conclude that claimant is physically capable of sedentary to light work.

We next turn to the nonmedical factors. Claimant was 54 years old at the time of hearing and has obtained his GED. He has also completed a year of community college and has taken courses in hotel and restaurant management. His prior work experience includes work as a janitor, machinist, truck driver, cook and apartment complex manager. He has also owned and supervised a restaurant, trucking company and grocery store.

Mr. Lageman, vocational expert, opined that claimant had above average intelligence and work skills, but felt that claimant would be unable to perform sedentary work due to his cervical condition. He further opined that it may be futile for claimant to search for work unless an employer made special adaptations with regard to claimant's cervical limitations. Mr. Lageman's opinion, however, is based on a medical conclusion that claimant cannot perform sedentary

work due to his cervical condition and we have herein found to the contrary. We give less weight to an expert's testimony regarding issues outside his field of expertise. See e.g. Jack Nealy, 41 Van Natta 1829 (1989). Therefore, to the extent that Mr. Lageman's conclusion is based upon his assessment of claimant's medical condition, we do not find his opinion persuasive.

By contrast, vocational expert William Skilling opined that claimant was employable. Skilling had performed a labor market survey and testified to numerous jobs that were within claimant's physical limitations and consistent with his vocational aptitudes. He testified however, that claimant was not motivated to find work at that time. Mr. Skilling's opinion is consistent with the medical opinion regarding claimant's physical capabilities and we find it to be persuasive. Accordingly, we conclude that claimant has not established that he is permanently restricted from performing suitable gainful work due to non-medical factors.

Finally, we conclude that claimant has not established that he is willing to seek work and has made reasonable efforts in this regard. Between 1986 and 1988, claimant made no efforts to locate employment. His vocational assistance was terminated in September 1986 due to lack of motivation and noncooperation. His latest vocational efforts were terminated in early 1988 at the request of his attorney. Under these circumstances, vocational efforts would not have been futile, and claimant's motivation and cooperation were not reasonable. ORS 656.206(3).

Extent of Permanent Disability

Unscheduled

Although we have concluded that claimant is not permanently and totally disabled, we do find that he has lost earning capacity, due to his compensable cervical condition, in excess of the 35 percent unscheduled permanent disability awarded by the Determination Order. Considering our findings regarding claimant's injury-related impairment and the nonmedical factors pertinent to the evaluation of loss of earning capacity, we conclude that an award of 70 percent unscheduled permanent disability more accurately compensates claimant for his loss of earning capacity due to his compensable cervical condition.

Scheduled

Extent of scheduled permanent partial disability is measured by the permanent loss of use or function of the injured member due to the compensable injury. ORS 656.214(2). In determining loss of use or function, we consider 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. See SAIF v. Baer, 61 Or App 335, rev den 294 Or 749 (1983). After considering the medical and lay evidence, in light of the aforementioned guidelines, we find no persuasive evidence to suggest that claimant has lost more than 5 percent of use or function of either arm. Accordingly, we conclude that a 5 percent award for both arms adequately compensates claimant for the loss of use or function due to the industrial injury.

ORDER

The Referee's order dated May 10, 1988, is reversed. That portion which awarded permanent total disability is reversed. In lieu of the Referee's order award of permanent total disability, and in addition to the 35 percent (112 degrees) unscheduled permanent disability awarded by Determination Order, claimant is granted an additional 35 percent (112 degrees) unscheduled permanent

disability for a total of 70 percent (224 degrees) unscheduled permanent disability for his cervical condition. Claimant's attorney is entitled to 25 percent of the increased compensation created by this order, not to exceed $3,800. The employer is permitted to credit the attorney fee paid pursuant to the Referee's award against the attorney fee awarded herein. A client-paid fee, not to exceed $2,502, is approved, payable by the self-insured employer to its counsel.

In the Matter of the Compensation of
ROBERT D. REBMANN, Claimant
WCB Case No. 88-10514
ORDER ON REVIEW
Mautz, Hallman,et al., Claimant Attorneys
Bottini, et al., Defense Attorneys

Reviewed by Board Members Cushing and Gerner.

The insurer requests review of Referee Galton's order which set aside its denial of claimant's occupational disease claim for a low back condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

Claimant was 35 years old at the time of the hearing. Claimant suffered two compensable back injuries while working for a prior employer in the early 1980's. (Tr. 5).

A June 22, 1982 Determination Order awarded claimant 15 percent unscheduled permanent disability for the low back. (Ex. 32). A February 15, 1984 Determination Order granted claimant no additional permanent disability. (Ex. 37).

Claimant became employed by the insured in 1985 as a service writer shop foreman. He was terminated by the insured on April 21, 1988 due to a poor attendance record. (Ex. 42).

On May 20, 1988, claimant filed an 801 form alleging that on April 1, 1988, there was excessive bending and lifting in the shop and that he had developed low back problems. (Ex. 38).

On June 7, 1988, the insurer denied claimant's claim, asserting that the medical condition did not arise out of or in the course of claimant's employment with the insured. (Ex. 48).

We do not find claimant to be a credible witness.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant suffered a compensable occupational disease. We disagree.

For an occupational disease claim, the date of "injury" is the date upon which the claimant was last exposed to the employment conditions which cause the disease. Johnson v. SAIF, 78 Or App 143, rev den 301 Or 240 (1986). Claimant alleged that his work exposure during his employment with the insured led to his

back condition. He filed his 801 form on May 20, 1988. Accordingly, the new occupational disease law which became effective January 1, 1988, is applicable.

To be compensable under the new law, claimant's occupational disease must fall within one of the three subsections of ORS 656.802(1). Here, claimant worked as a service writer shop foreman. It is a position which involved writing up service orders, meeting and conferring with customers, taking cars on test drives and, at times, looking under hoods and crawling under cars. We conclude that claimant's claim is for a condition resulting from a "series of traumatic events or occurrences" pursuant to ORS 656.802(1)(c).

To establish that his condition arose out of and in the course of his employment, claimant must prove that his work exposure was a material cause of his condition. ORS 656.802(1)(c); Donna E. Aschbacher, 41 Van Natta 1242 (1989); Carole J. Damm, 42 Van Natta 225 (1990).

When credibility findings have been based on claimant's demeanor, the court generally defers to the credibility findings of the Referee. See Coastal Farm v. Hultberg, 84 Or App 282 (1987). However, given the unsupported substance of claimant's testimony, we cannot do so in the present case. See Davis v. Hanel Lumber Co., 27 Or App 35, 38 (1984).

After reviewing his testimony, we find claimant not credible for several reasons. Claimant presented multiple explanations and descriptions regarding the onset of his back condition.

First, claimant testified that he initially sought medical treatment from Dr. Peterson, chiropractor, on April 11, 1988. (Tr. 14). He indicated that his work load coming out of the winter months increased, but that the insured had not increased the number of employees to meet the demand. Consequently, claimant was obliged to do work that was not suited for his back. (Tr. 9). He noted that the back pain began towards the end of January 1988, and that it started to affect his work in February 1988. However, claimant's supervisor testified that claimant did not complain of back pain prior to April 1988, and that claimant's position did not require him to clean cars, as he had a crew assigned to him to do such duties.

Claimant's version of events contradicts Dr. Peterson's chart notes relating to the back condition. An April 11, 1988 chart note reports that for the past six years claimant had done "fairly well." Moreover, Peterson notes that claimant had developed right buttocks posterior leg pain to the knee, subsequent to falling out of a new chair at home. (Ex. 45-1). Gradually his leg and back pain increased to the point where claimant was unable to work. (Ex. 50-1). By letter dated August 19, 1988, Dr. Peterson reported that claimant indicated that his date of injury was March 1, 1988. (Ex. 39-1).

Claimant was terminated by the insured on April 21, 1988, due to a poor attendance. Shortly thereafter, on May 20, 1988, he filed his 801 form.

Secondly, claimant's co-workers do not support his assertions of a work related occupational disease. On direct examination claimant denied telling any co-worker that he had sustained an off-the-job injury. (Tr. 13). Claimant's supervisor stated that on or about April 4, 1988 claimant told him that during an Easter egg hunt he had leaned against a fence which in turn collapsed causing him to fall into some bushes. Thereafter, claimant experienced back pain. (Ex. 42-2).

Moreover, two of claimant's co-workers'testified that he had told them that during Easter he had fallen into a bush. Subsequent to that event, claimant experienced back pain. (Tr. 49).

Finally, on direct examination claimant denied that he told Dr. Peterson that he fell out of the a new chair at home. (Tr. 17). However, Dr. Peterson's chart notes indicate that on March 1, 1988 claimant sat in the new chair, he then tipped backwards, dropping claimant to the ground. Claimant then developed right buttocks and leg pain to the knee. (Ex. 45-1).

After considering the aforementioned inconsistencies and contradictions, we find claimant's testimony as to the origins of his back condition, and his ensuing history of complaints to be unpersuasive. Because we are unable to rely upon claimant's testimony we are also unable to rely upon Dr. Peterson's opinion. A medical opinion formed exclusively or in significant part from a claimant's statement is valid only insofar as a claimant relates and the doctor receives an accurate picture of claimant's condition. Dr. Peterson did not have an accurate understanding of claimant's duties, nor was he aware of the Easter egg hunt episode.

In this case, there are many potential causes for claimant's back condition, some work, and some nonwork. There are a series of nonwork-related activities, such as falling out of a new chair at home, and falling into a bush which could have been the cause of claimant's back condition. Additionally, claimant has failed to establish the sequence of at work events which led to the development of his back condition. The 801 form indicated that claimant suffered the injury on April 1, 1988. On the other hand, claimant asserted on an insurance questionnaire, that the date of injury was March 1, 1988. He has been unable to satisfactorily explain the contradiction.

Accordingly, claimant has failed to persuade us that his back condition is due to a series of on-the-job traumatic episodes. Consequently, we conclude that claimant has failed to prove by a preponderance of the evidence that he sustained a compensable occupational disease during the course and scope of his employment.

ORDER

The Referee's order dated October 12, 1988 is reversed. The insurer's denial dated June 7, 1988 is reinstated and upheld. The award of a $2,250 insurer paid attorney fee is reversed. The Board approves a client-paid fee not to exceed $1,265, payable from the insurer to its counsel.

April 3, 1990 Cite as 42 Van Natta 796 (1990)

In the Matter of the Compensation of
WALTER G. BAILEY, Claimant
WCB Case No. 88-10986
ORDER ON REVIEW
Sharp & Durr, Claimant Attorneys
Bonnie V. Laux (Saif), Defense Attorney

Reviewed by Board Members Speer and Howell.

Claimant requests review of that portion of Referee Leahy's order which dismissed his request for hearing from the SAIF Corporation's denial of his decompressive disc surgery. On review, the issues are res judicata and medical services. We reverse the Referee's order and set aside SAIF's denial.

FINDINGS OF FACT

Claimant had a compensable injury on October 29, 1985. He treated with chiropractors but the pain in his upper back and neck and accompanying headaches persisted.

In late 1987 claimant first saw an orthopedic surgeon who diagnosed a degenerative condition of the spine. Claimant submitted medical bills at that time which were denied by SAIF as not being related to the industrial injury. Claimant, pro se at the time, requested a hearing, which was set for April 1, 1988. SAIF subsequently paid the medical bills.

In December 1987, claimant had an independent medical examination at which time one of the physicians told him to have a myelogram in order to get an accurate diagnosis of the cause of his persistent neck pain. An MRI and myelogram in early 1988 detected a bulging disc. Surgery was recommended.

Claimant then sent a handwritten letter to the Hearings Division requesting a postponement of the April 1, 1988 hearing until after the surgery. That letter apparently was interpreted as a withdrawal of claimant's request for hearing and the hearing was dismissed on April 25, 1988. Not knowing whether the hearing would be postponed, claimant had arrived at the time and place set for the hearing on April 1, but no one else was there. The April 25, 1988 dismissal order became final without a request for review having been filed.

Before his surgery, claimant requested authorization for the surgery which was denied by SAIF on June 17, 1988. Claimant timely requested a hearing on that denial. That hearing resulted in the order presently before us which dismissed claimant's request.

ULTIMATE FINDING OF FACT

Claimant's cervical disc bulge at C3-4 occurred as a result of his industrial injury.

CONCLUSIONS OF LAW AND OPINION

Res Judicata

The Referee held that the April 25, 1988 Order of Dismissal dismissing claimant's request for hearing on SAIF's December 23, 1987 denial of medical services disposed of all "neck issues." Thus, the Referee dismissed claimant's second request for hearing from the June 17, 1988 denial of cervical decompressive surgery, on the basis that the issue was barred by the doctrine of res judicata. We disagree.

We find that the first dismissal became final because the Order of Dismissal was not appealed within the allowable time. However, we further find that that dismissal does not have preclusive effect on claimant's subsequent request for hearing based on the subsequent denial.

The doctrine of res judicata precludes relitigation 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 for the preclusive effect of a prior adjudication on a claim and "issue preclusion" for the preclusive effect of a prior adjudication on an issue. Id.; Restatement (Second) of Judgments, Introduction at 1-5 (1982).

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 claim or any part thereof. Id. 17-19, 24; 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 claim or cause of action is an aggregate of operative facts which compose a single occasion for judicial relief. Restatement

(Second) of Judgments 24(2) (9182); see also Dean v. Exotic Veneers, Inc., 271 Or 188, 192-93 (1975); Carr v. Allied Plating Co., supra 81 Or App at 310.

The rule of issue preclusion is that if an issue 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 claim. North Clackamas School District v. White, supra, 305 Or at 53; Restatement (Second) of Judgments 27 (1982).

Here, the first order of dismissal constitutes a final judgment as to those claims for medical services which SAIF initially denied, but subsequently accepted. The present claim is for a distinct medical service, surgery, and could not have been made until after claimant's bulging disc was detected and surgery was recommended. Thus, the first dismissal order does not bar claimant's present claim for surgery.

Because no issues were actually litigated prior to the first dismissal order in this matter, issue preclusion cannot bar the litigation of any issues related to the present claim for surgery. Therefore, neither claim preclusion nor issue preclusion is applicable in the present case.

Accordingly, we review on the merits.

Compensability of Cervical Decompressive Surgery

Claimant had been treating conservatively with chiropractors for nearly two years after his injury. Over the course of those treatments, the pain in his neck and accompanying headaches persisted. X-rays taken of claimant's neck did not detect any reason to explain the continuing pain. In late 1987 claimant went to Dr. Spina, an orthopedic surgeon. Dr. Spina diagnosed cervical osteoarthritis, a degenerative condition.

An MRI in February 1988, more than two years after the injury, was the first indication that there was any problem with claimant's cervical spine. The radiologist noted a slight herniation of the C3-4 disc which was reported as possibly significant. A subsequent myelogram detected a right lateral indentation at the C3-4 level. (Ex. 14). It also showed significant narrowing of the cervical subarachnoid space at the C3-4 level.

Claimant then saw Dr. Mason, a neurosurgeon, who stated that claimant's October 29, 1985 neck injury had materially worsened claimant's pre-existing degenerative condition, resulting in the bulging disc. Dr. Spina also stated that claimant's neck condition was causally related to his work-related injury. Those opinions constitute a preponderance of the evidence.

We find that claimant's bulging disc at C3-4 was materially caused by his compensable injury. SAIF does not dispute that the requested surgery was reasonable and necessary treatment for that compensable condition. We, therefore, conclude that the requested surgery is compensable and that SAIF's denial must be set aside.

Claimant's counsel is statutorily entitled to a reasonable, insurer-paid attorney fee for services rendered at hearing and on Board review. Such a fee is defined as an "assessed fee." See OAR 438-15-005(2). However, we cannot award 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 awarded. See OAR 438-15-010(5).

ORDER

The Referee's order dated September 29, 1988 is reversed. SAIF's June 17, 1988 denial is set aside. This claim for medical services is remanded to SAIF for acceptance and processing in accordance with law.

In the Matter of the Compensation of
JOHN M. OLIVER, Claimant
WCB Case No. 88-14035
ORDER ON REVIEW
Gerald R. Hayes, Claimant Attorney
Constance Wold, Defense Attorney

Reviewed by Board Members Speer and Howell.

Claimant requests review of that portion of Referee Hoguet's order which declined to award temporary disability and interim compensation. On review, the issue is entitlement to temporary disability and/or interim compensation. We affirm.

FINDINGS OF FACT

The Board adopts the Referee's "Findings of Fact" with the following supplementation.

The insurer first received medical verification of claimant's inability to work after July 25, 1988 when it received a letter dated July 25 from Dr. Sirounian, to whom claimant was referred by Eastmoreland Hospital Emergency Room.

The insurer issued a denial of an aggravation of claimant's compensable injury on August 1, 1988.

Claimant has not returned to work since April 15, 1987, the date an Opinion and Order awarded him an additional 10 percent unscheduled permanent disability, for a total of 35 percent permanent disability resulting from a January 6, 1984 back injury.

After his injury, during 1985, claimant was receiving vocational assistance. His file was closed on January 2, 1986 because of non-cooperation in the development of a return-to-work plan.

CONCLUSIONS OF LAW AND OPINION

Interim Compensation

Entitlement to interim compensation in the form of temporary disability depends on whether, before the denial of an aggravation claim, there was a medical verification of a claimant's inability to work due to a worsening of the compensable injury. ORS 656.273 (6); Berkey v. Fairview Hospital, 94 Or App 28 (1988). If an employer has notice or knowledge of verification, temporary total disability payments must begin within 14 days. ORS 656.273(6). The duty to pay interim compensation does not mature until the insurer receives medical verification of an inability to work due to a worsening of the compensable injury. Silsby v. SAIF, 39 Or App 555, 563 (1979).

Here, claimant first went to the emergency room on July 4, 1988. There is no indication in the record that the employer received notice of the emergency room visit at that time. The first report in the record that indicates the insurer received medical verification of claimant's inability to work is dated July 25, 1988. However, the record does not establish when that verification was received. The insurer denied the aggravation claim on August 1, 1988. The 14-day period within which interim compensation must begin has not been shown to have run. Consequently, we find that claimant has failed to prove he is entitled to interim compensation.

Temporary Disability

A worker who withdraws from the labor force prior to an aggravation is not entitled to temporary total disability benefits. Cutright v. Weyerhaeuser Co., 299 Or 290 (1985). There may be times when a claimant is unable to work because of a prior compensable injury, yet may remain in the work force. Dawkins v. Pacific Motor Trucking, 308 Or 254 (1989). In order for claimant here to be entitled to temporary disability, he must show that, although he was not employed at the time of an aggravation of his compensable injury, he was willing to work and was making reasonable efforts to obtain employment (unless such efforts would have been futile because of the work-related injury). Dawkins, supra, citing Cutright, supra.

We are not convinced that claimant was willing to, and made reasonable efforts to, obtain employment. Although he stated several times at hearing that he wanted to work, he admitted that the jobs he had been seeking were of the type he was not capable of performing given his physical limitations. Moreover, even though claimant stated that he had put in applications all over the city, the Referee found that his testimony was not credible and must be viewed with caution.

Claimant's treating physician and independent examiners have stated that claimant must be retrained to do lighter work than he previously had done. Nevertheless, claimant did not cooperate with vocational counselors who were working with him. His vocational assistance file was closed on January 2, 1986 because of non-cooperation in the development of a return to work plan.

Because we find that claimant has not proven by a preponderance of the evidence that he is willing to work and is making reasonable efforts to obtain employment, we conclude that claimant had withdrawn from the work force at the time of the alleged aggravation of his compensable injury. Accordingly, claimant is not entitled to temporary total disability.

ORDER

The Referee's order dated November 29, 1988 is affirmed.

April 4, 1990 Cite as 42 Van Natta 800 (1990)

In the Matter of the Compensation of
JOHN C. HOLLAND, Claimant
WCB Case No. 88-10344
ORDER ON REVIEW
Emmons, et al., Claimant Attorneys
Cummins, et al., Defense Attorneys

Reviewed by Board Members Crider and Nichols.

The insurer requests review of that portion of Referee Seymour's order that increased claimant's unscheduled permanent disability award for a cervical and related upper extremity injury from 15 percent (48 degrees), as awarded by a Determination Order, to 50 percent (160 degrees). On review, the issues are extent of scheduled and unscheduled permanent disability. We modify.

FINDINGS OF FACT AND ULTIMATE FACT

We adopt the Referee's findings subject to the following exceptions and additions.

Claimant's correct age at the time of hearing was 46, not 39, and he completed 10 hours of community college credit in basic study skills. He has a herniated disc at C6-7, which results in impairment of each arm and his neck. At the time of hearing, claimant had not returned to work and was unable to perform his usual and customary medium work. He was capable of performing light work.

Claimant's triceps are mildly atrophied bilaterally, resulting in a slight weakness in both arms which is apparent in extending the elbows against resistance. He cannot hold his arms spread out while bending from the waist, and his arm weakness prevents him from waterskiing or getting in and out of a boat. He must rest after swimming 50 feet. His arms go to sleep at night and while driving. He has tingling of the right first, second and third fingers. Claimant's grip strength is less in the left arm than in the right. He has constant numbness of the left wrist and left second and third fingers. He is limited to repetitive lifting of no more than 20 pounds and no repetitive pushing and pulling with his arms.

Claimant has constant aching in both right and left paracervical areas, especially after repetitive movement of his head. He should not perform repetitive flexion/extension and lateral motions with his neck as required by his job at injury. Constant cervical pain limits his driving to one and a half hours and he is unable to perform overhead work.

Claimant has sustained a 10 percent loss of use or function of his right arm and a 15 percent loss of use or function of his left arm. He has sustained permanent cervical impairment resulting in a 25 percent loss of earning capacity.

CONCLUSIONS OF LAW AND OPINION

The Referee declined to award claimant scheduled disability for his arms. Instead, he awarded claimant 50 percent (160 degrees) unscheduled disability on the theory that the impairment of claimant's arms was based upon radiation from the neck, and that any disability resulting from the atrophy in his arms was included in the unscheduled award. We disagree with this analysis.

Separate awards are required when injury to an unscheduled portion of the body results in disability to both unscheduled and scheduled portions. Foster v. SAIF, 259 Or 86 (1971). When a claimant is suffering from "referred" pain in a scheduled body part, although the pain does not arise out of an injury to that body part per se, a separate award should be allocated for loss of function to the scheduled member. Olds v. Superior Fast Freight, 36 Or App 673 (1978); Victoria W. Fox, 37 Van Natta 10 (1985).

Generally the Board awards scheduled disability only when requested by a claimant. Michelle Griffith, 40 Van Natta 2086 (1988). But where, as here, both scheduled and unscheduled awards were raised at hearing, a party seeks a reduction (or increase) of the unscheduled award on review, and the award should be allocated to scheduled and unscheduled body parts, we will award scheduled disability on our own motion.

Extent of Scheduled Disability

Scheduled permanent disability is rated on the permanent loss of use or function of a body part due to the compensable injury. OAR 436-35-010. The extent of loss of use does not necessarily correlate with the extent of mechanical impairment, although the latter is usually a relevant consideration. Boyce v. Sambo's Restaurant, 44 Or App 305, 308 (1980).

Like the Referee, we rely on the opinion of consulting neurologist Tsai. Our findings of fact regarding claimant's bilateral arm condition are based on the opinions of Tsai and Bassinger and claimant's credible testimony. We do not rely, however, on that portion of Dr. Bassinger's September 14, 1988, report that indicates grip strength on August 19, 1988 of 55 on the left and 340 on the right. The report indicates a great discrepancy in right and left grip strength which is undercut by Dr. Tsai's measurements reported August 18, 1988. We rely on claimant's testimony that his grip is less strong on the left and Dr. Tsai's findings of 320 on the left and 380 on the right. In light of these findings, we conclude that claimant has demonstrated a 10 percent loss of function of his right arm and a 15 percent loss of function of his left arm.

Unscheduled Permanent 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 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).

Our findings of fact regarding claimant's cervical impairment are based on the opinions of Drs. Bassinger and Tsai and claimant's credible testimony. Based on claimant's age of 46, his high school diploma, his adaptability from medium to light work, the labor market, and his neck impairment, we rate his loss of earning capacity at 25 percent.

ORDER

The Referee's order dated October 11, 1988 is affirmed in part and modified in part. In lieu of the Referee's award of 50 percent (160 degrees) permanent unscheduled disability, and in addition to the Determination Order award of 15 percent (48 degrees) unscheduled permanent disability, claimant is awarded: 10 percent (32 degrees) unscheduled permanent disability for his cervical condition, for a total award of 25 percent (80 degrees) unscheduled disability; 10 percent (19.2 degrees) scheduled permanent disability for the right arm; and 15 percent (28.8 degrees) scheduled permanent disability for the left arm. The remainder of the order is affirmed. Claimant's attorney is allowed an approved fee in the amount of 25 percent of the increased scheduled disability compensation awarded by this order, payable by the insurer directly to claimant's attorney. The total of the approved fees awarded by the Referee and the Board shall not exceed $3,800. We authorize a client-paid fee, not exceeding $1,427, payable by the insurer to its counsel.

In the Matter of the Compensation of
EMILY A. MANLEY, Claimant
WCB Case No. 84-10900
ORDER ON REVIEW
Rick W. Roll, Claimant Attorney
Roberts, et al., Defense Attorneys

Reviewed by Board Members Nichols and Brittingham.

Claimant requests review of those portions of Referee McCullough's order which: (1) upheld the insurer's denial of claimant's aggravation claim for a low back injury; and (2) upheld the insurer's partial denial insofar as it

denied claimant's claim for chiropractic treatment in excess of two times per month. The insurer cross-requests review of that portion of the order which assessed penalties and related attorney fees for an unreasonable denial of all chiropractic treatment. On review, the issues are aggravation, reasonableness and necessity of treatment, penalties and related attorney fees. We affirm.

FINDINGS OF FACT AND ULTIMATE FACT

We adopt the Referee's findings of fact, as set forth in the "Findings and Opinion" section of his order, with the following supplementation.

Claimant has experienced a symptomatic worsening of her low back condition since the last arrangement of compensation by Determination Order, issued October 7, 1985.

Claimant's disability was no greater in February 1986 than at the time of the October 1985 Determination Order.

Chiropractic treatment in excess of two times per month is not reasonable and necessary treatment for claimant's compensable low back injury.

The insurer's denial of all chiropractic treatment was unreasonable.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that the symptomatic flareup which claimant experienced in February 1986 was of the type anticipated given claimant's prior award of permanent disability. Relying upon the Court of Appeals' initial decision in Gwynn v. SAIF, 84 Or App 67, remanded 304 Or 345 (1987), on rem 91 Or App 84 (1988), he found that claimant had not sustained an aggravation. We agree with the Referee's ultimate conclusion, but for different reasons.

To establish an aggravation, claimant must show a compensable worsening of her low back condition since the last arrangement of compensation. Smith v. SAIF, 302 Or 396 (1986). "Worsening" within this context means increased symptoms, or a worsened underlying condition, resulting in a diminishment of earning capacity. Id.

Here, the last award of compensation was the October 7, 1985 Determination Order awarding claimant 20 percent (64 degrees) unscheduled permanent partial disability. Claimant has experienced increased back symptoms since that award. However, she has not established that she was less able to work.

Claimant's employment status at the time of the alleged aggravation was the same as it had been in October 1985: she was unemployed. There is a paucity of evidence regarding whether claimant is less able to work as a result of the exacerbation of her back injury. Subsequent to claimant's exacerbation of February 1986, consulting physician Buza, neurologist, noted that a CT scan and mylogram were negative, and he opined that no surgery was needed and claimant should undergo only conservative treatment. He felt that claimant was stable and stationary. After examining claimant on March 24, 1987, Dr. Simpson, D.C., stated that, "[c]urrent physical findings show no significant progressive loss of mobility compared with findings documented by Dr. Poulson in August 1985." The only medical opinion supporting a loss of earning capacity is from Dr. Butler, the treating chiropractor. He opined that claimant was totally disabled as of February 21, 1986.

The Board defers to the opinion of the treating physician absent persuasive reasons to do otherwise. Somers v.SAIF, 77 Or App 259 (1986). Here, we

find persuasive reasons to do otherwise. Treating chiropractor Butler's opinion that claimant cannot work is not well reasoned as he failed to state any basis for his opinion. We therefore give it little weight.

On this record, we conclude that claimant has not demonstrated that her ability to work is less than at the time of the October 1985 Determination Order. Accordingly, we find that she has not established an aggravation of her low back condition.

Chiropractic Treatment

We adopt the Referee's conclusions regarding claimant's chiropractic treatments since January 24, 1985.

Penalties and Attorney Fees

In regard to the remaining issues of penalties and related attorney fees, we adopt the Referee's conclusions as set forth in the "Findings and Opinion" section of his order.

ORDER

The Referee's order dated September 3, 1987 is affirmed. A client-paid fee payable from the insurer to its counsel is approved, not to exceed $1,117.

April 4, 1990 Cite as 42 Van Natta 804 (1990)

In the Matter of the Compensation of
ROSE M. PAAVOLA, Claimant
WCB Case No. 87-12632
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Nichols and Crider.

The self-insured employer requests review of Referee Hoguet's order that set aside its denial of claimant's occupational disease claim for a stress-caused mental disorder. On review, the issues are collateral estoppel and compensability. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the exception of the last paragraph of his findings. We make the following additional findings:

When Mr. Opitz began as district supervisor in 1984, he verbally instructed claimant to complete the filing system. Claimant never intentionally disregarded those instructions regarding the organization of the filing system; but, due to repeated new instructions from Mr. Opitz, she was never able to keep the system current.

When claimant sought counselling the day of her suspension, she reported the suspension and indicated she felt that it would lead to discharge. She planned to contact a lawyer concerning the filing of a claim. She reported headaches, neck pain and numbness in the arm. Claimant had previously reported a late 1984 onset of similar physical symptoms.

When claimant saw her family physician the day following the suspension, she again reported headaches and arm numbness as well as job stress.

Over the following weeks, her counselling sessions focussed on financial concerns and anger and depression concerning her termination.

Claimant's working conditions were objectively capable of causing stress.

Claimant suffered an adjustment reaction following her suspension and termination.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that the factual issues regarding the implementation of the filing system had previously been decided at claimant's unemployment hearing and that the self-insured employer was therefore collaterally estopped from arguing that Mr. Opitz' instructions to claimant did not repeatedly change. He further concluded that claimant's work conditions, not her termination from employment, were the major contributing cause of her mental disorder.

We do not agree that the self-insured employer was collaterally estopped by the prior Employment Division findings from arguing that the "goal posts" did not change. We conclude, however, that the evidence supports claimant's contention that she was never able to complete the filing system due to the repeated instructional changes. We do not agree, however, with the Referee's ultimate finding that work conditions--other than the suspension and termination--were the major contributing cause of claimant's mental disorder. Therefore, we do not adopt his opinion.

Collateral Estoppel

The doctrine of issue preclusion--that is, collateral estoppel--precludes relitigation of issues of fact which were finally determined in a prior proceeding between the same parties, provided that the findings of fact were clear and were essential to the judgment. Chavez v. Boise Cascade, 307 Or 632 (1989); State Farm Fire & Casualty v. Reuter, 299 Or 155 (1985). Following claimant's suspension, claimant was administratively allowed unemployment insurance benefits. The employer requested a hearing. The ultimate question in that proceeding was whether claimant either voluntarily quit or was suspended or discharged for misconduct. The unemployment referee found, inter alia, that the Astoria office, in which claimant worked, did not successfully complete conversion of the old filing system to the new. She further found that the system that claimant tried to implement did not conform to the employer's guidelines. Nevertheless, she also found that, "Claimant did not refuse to perform as directed." Consequently, she found that claimant was not guilty of misconduct. The Appeals Board adopted the referee's findings and also found that the local office supervisor, apparently Mr. Opitz, interfered with claimant's ability to complete the file conversion by repeatedly changing instructions. It is this finding that claimant seeks to import into this case.

The key question in the unemployment case was whether or not claimant intentionally disregarded her employer's interests. The finding that Mr. Opitz "changed the goalposts" was not essential to that ultimate finding. Therefore, we conclude that the self-insured employer is free to attempt to persuade us, in this regard, that he did not.

Based on this record, however, we have reached the same conclusion as the Referee. In doing so, our determination of the parties' credibility is of primary importance.

Credibility

Claimant was employed with the employer for more than 20 years and had been doing filing under previous systems without difficulty. At the age of 46,

she had nothing to gain and much to lose by intentionally disregarding the instructions of her district supervisor. Claimant's testimony, particularly at her unemployment compensation hearing, was detailed, consistent and believable. Although written reprimands and disciplinary actions abound in the record, there is no indication that claimant ever received written instructions from Mr. Opitz outlining a set procedure for the organization of the filing system. In October 1986, claimant received a good annual progress report and performance evaluation from Mr. Opitz; she was not informed that her organization of the filing system was inadequate. Claimant rarely asked for guidance in this regard since she honestly believed that the job had been completed following each new set of instructions. It also seems improbable that the self-insured employer would wait two and a half years to discharge an insubordinate employee who was wreaking havoc on something as integral to the efficient operation of its business as the central filing system.

Although the Referee failed to make a credibility finding and we do not have the benefit of firsthand observation of the parties' demeanor, we find the substance of claimant's testimony credible and rely upon it.

Compensability

Claimant last worked for the employer in 1987. Consequently, her last potentially injurious exposure occurred prior to the effective date of the 1987 amendments to ORS 656.802(2). Therefore, the former law applies. Johnson v. SAIF, 78 Or App 143, rev den 301 Or 240 (1986); Donna E. Aschbacher, 41 Van Natta 1242 (1989).

In order to conclude that this claim is compensable, we must find that claimant was subjected to real events or conditions of employment that were objectively capable of causing stress; that claimant suffered from a mental disorder; and that employment exposures when compared to nonemployment exposures were the major contributing cause of the disorder. McGarrah v. SAIF, 296 Or 145 (1983). For our purposes, however, a disorder caused by stress resulting from the fact of termination or loss of employment is not compensable. Elwood v. SAIF, 298 Or 429 (1985).

There is no question that claimant's working conditions were objectively capable of causing stress or that claimant suffered from a mental disorder. The self-insured employer does not challenge the Referee's findings in these regards and we concur in those findings.

There is further no doubt that the adjustment disorder--which was diagnosed by both Dr. Turco, an independent medical examiner for the self-insured employer, and Dr. Goranson, who examined claimant at her attorney's behest--was caused either by claimant's work, her suspension and termination, or both. The question is whether the evidence establishes that the disorder was caused by working conditions, as opposed to the suspension and discharge. We are unable to find that it does.

The record includes no opinion on the causation issue from claimant's counselor. We must rely on the opinions of the two examiners, Dr. Turco and Dr. Goranson. Both physicians are psychiatrists. Each had an opportunity to review the records maintained by claimant's counsel, her family physician and the like. Each examined her.

Dr. Turco noted, based on claimant's statements in examination, that

claimant had sought medical help because she was "so angry" concerning the suspension. He wrote that,

> "[s]he appears to have experienced an adjustment reaction.... The only stressors I can identify are her perceived stressors that the company was essentially out to 'get rid of her.' Her current emotional distress as well as her need for psychological intervention in the past has been related to the termination. As far as I can determine losing her job was the stressful issue." (Ex. 12-4)

In deposition, Dr. Turco agreed that claimant had been exposed to objectively stressful working conditions. (Ex. E-10). He nonetheless adhered to the view that her disorder was caused by the termination, not to stress on-the-job. (E-21 and 22).

Dr. Goranson, unlike Dr. Turco, credited claimant's reports of her experience from the outset and did not base his opinion on the conviction that claimant suffered no real and objective on-the-job stressors. In that regard, his report is more consistent with our findings of fact than is Dr. Turco's. Nevertheless, Dr. Goranson made no effort to distinguish between stress due to the termination and other work-related stressors. He simply concluded that,

> "I believe there were predisposing conditions in her development in terms of her unresolved issues with her mother; however, it was the appearance of Mr. Optiz on the scene and his behavior towards her that triggered the mental disorder." (Ex. 13-5 and 6)

The focus of the report is on claimant's reaction to her termination and to its similarity to her reaction to the death of her mother. Although the report recites unpleasant workplace incidents, which are also reported in the testimony, it does not describe the relationship, if any, between those incidents and claimant's condition.

Assuming that Dr. Goranson's conclusion that "real stressful events and conditions were the major contributing cause for this claimant's mental disorder" should be read to attribute the disorder to conditions other than the termination, we do not find that view persuasive. It is inconsistent with the fact that claimant's conversations with her counselor dealt almost exclusively with the termination and its aftermath, rather than with events that occurred while claimant was employed. It is also inconsistent with Dr. Goranson's failure to note any onset of symptoms prior to the termination and with his comments concerning the extraordinary impact of the termination on claimant.

Its shortcomings notwithstanding, we are more persuaded by Dr. Turco's opinion, as amplified in his deposition, than by Dr. Goranson's opinion. Consequently, we are unable to find that stressful conditions on the job were the major contributing cause of claimant's mental disorder. The claim is not compensable.

ORDER

The Referee's order dated March 23, 1988, is reversed. The self-insured employer's denial of July 31, 1987, is reinstated and upheld. The Referee's $4,500 attorney fee award is reversed. The Board authorizes a client-paid fee, not to exceed $1,622, payable by the self-insured employer to its counsel.

In the Matter of the Compensation of
T. TIMOTHY SPREADBOROUGH, Claimant
WCB Case No. 88-11731
ORDER ON REVIEW
Peter O. Hansen, Claimant Attorney
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Myers and Cushing.

The insurer requests review of Referee St. Martin's order which: (1) found that claimant was entitled to a redetermination of his permanent disability following a vocational assistance program; and (2) granted claimant permanent total disability. On review, the issues are jurisdiction and extent of permanent disability, including permanent total disability. We affirm.

FINDINGS OF FACT

In April 1976, claimant sustained a compensable injury to his low back while employed as an embalmer and funeral director. The claim was initially closed by a September 1976 Determination Order which did not award permanent disability. Thereafter, claimant sustained an aggravation and his claim was reopened. The claim was again closed by a July 1979 Determination Order which granted claimant 5 percent unscheduled permanent disability. A September 1979 Stipulation increased claimant's unscheduled permanent disability award to 25 percent.

In late 1980, claimant began treating with Dr. Ruminson, psychiatrist, for depression, secondary to his compensable injury. Claimant was placed in vocational rehabilitation, however the services were suspended in March 1982 when claimant underwent an exploration and foraminotomy at the left L5-S1, left L4-5 medial foraminotomy and a bilateral discectomy at L3-4. Following the surgery, vocational assistance was reinstated. A May 1984 Determination Order closed claimant's claim with no further award of permanent disability. Thereafter claimant requested a hearing contending that he was permanently and totally disabled.

In December 1984, an earlier referee found claimant permanently and totally disabled. In August 1985, the Board reversed the award of permanent total disability and granted claimant an increase in unscheduled permanent disability to 75 percent for his compensable low back and psychological conditions. Timothy T. Spreadborough, 37 Van Natta 1055 (1985). The Board's decision was affirmed without opinion by the Court of Appeals. Spreadborough v. Holman Funeral Service, 80 Or App 593 (1986). Thereafter, the Supreme Court denied claimant's petition for review. Spreadborough v. Holman Funeral Service, 302 Or 571 (1987).

Vocational assistance was reinstated in December 1984. It was terminated in July 1985 as claimant wished to pursue a degree. In February 1986, vocational assistance was again instituted in order for claimant to complete a course in computer programming. The assistance was again terminated in January 1987 on the basis that claimant was not actively participating in his training. Thereafter, vocational assistance was reinstated when claimant returned to school. On May 18, 1987, vocational assistance was terminated on the basis that claimant had reduced his class load without prior authorization.

By agreement of September 10, 1987, the insurer agreed to provide further vocational assistance to claimant. These vocational services ended in July 1988 on the basis the claimant was not able to benefit from the services due to his psychological condition. A June 1988 Determination Order closed claimant's claim and awarded temporary disability benefits from March 31, 1986 through April 27, 1988. The temporary disability benefits were awarded pursuant to the time period claimant spent in vocational rehabilitation. No further permanent disability was awarded.

Claimant is 47 years old. He has a 12th grade education and one semester of junior college work. The majority of his work prior to the injury was as an embalmer and funeral director. He also worked one year as production control expeditor for an electronics firm. Following the industrial injury, claimant worked for a few months as a manager trainee for an insurance adjustment firm and a few months as a sales representative for a telephone service. Claimant also has some limited training in computer programming.

As a result of his compensable low back injury, claimant has sustained permanent impairment in the moderate to moderately severe range and can only perform sedentary work. As a result of his compensable psychological condition, claimant has sustained permanent impairment in the moderate range.

FINDINGS OF ULTIMATE FACT

Claimant is permanently incapacitated from regularly performing work at a gainful and suitable occupation.

Claimant's vocational efforts have been reasonable and further efforts to obtain work would be futile.

CONCLUSIONS OF LAW AND OPINION

Jurisdiction

The Referee found that he had jurisdiction to redetermine claimant's permanent disability following the June 1988 Determination Order. We agree.

The insurer contends that claimant's permanent disability cannot be redetermined as his aggravation rights have expired. However, the Determination Order challenged here issued not after a reopening pursuant to ORS 656.273 or 656.278, but rather pursuant to ORS 656.268(5). Therefore, claimant is entitled to a redetermination of his permanent disability independent of his aggravation or "own motion" rights. Wayne D. Cooper, 39 Van Natta 325 (1987). Accordingly, the Referee had jurisdiction to redetermine claimant's permanent disability.

Permanent Total Disability

The Referee concluded that claimant was permanently and totally disabled as a result of his compensable low back and psychological conditions. We agree.

At the outset, the insurer argues that claimant must prove a worsening in order to obtain additional permanent disability benefits. As noted above, however, the Determination Order challenged here issued not after reopening pursuant to ORS 656.273, but rather after reopening for vocational services. Accordingly, the insurer's argument is without merit. Hanna v. SAIF, 65 Or App 649, 652 (1983).

To establish permanent total disability, claimant must prove that he is unable to perform any work at a gainful, suitable occupation. Wilson v. Weyerhaeuser, 30 Or App 403 (1977). Claimant may prove permanent total disability by a combination of medical and nonmedical disabilities which effectively foreclose him from gainful employment. Welch v. Bannister Pipeline, 70 Or App 699 (1984). In addition, claimant has the burden to establish that he is willing to seek regular, gainful employment and has made reasonable efforts to obtain such employment. ORS 656.206(3).

Claimant is 47 years old and the majority of his work experience involves work as an embalmer and funeral director. He can no longer do such work.

Claimant has been through various vocational rehabilitation programs and the medical evidence indicates that he can perform sedentary work from a physical standpoint. Despite being able to perform work from a physical standpoint, claimant's compensable psychological condition has prevented him from performing such work. His last vocational efforts were terminated due to his psychological condition.

Dr. Gwinnell, claimant's treating psychiatrist, opined that claimant was unable to perform regular, gainful employment due to a combination of his physical and psychological disabilities. Her opinion is supported by the physicians at the Northwest Pain Center who opined that although claimant may be physically capable of performing some work, his psychological condition prevented him from doing so. Further, Dr. Labs, psychologist, concurred with Dr. Gwinnell's opinion that no further vocational assistance would be helpful due to claimant's psychological difficulties.

Claimant has actively participated in various vocational rehabilitation efforts. However, his participation in vocational assistance was terminated due to his compensable psychological disability. His treating psychiatrist has opined that further vocational assistance would be of no benefit. We find that claimant's participation in his vocational rehabilitation has been reasonable, and that further participation would be futile. Butcher v. SAIF, 45 Or App 313 (1980).

Claimant is no longer able to obtain and hold gainful employment in the broad field of occupations. His efforts to obtain employment have been reasonable in light of his compensable back and psychological conditions. Accordingly, we conclude that claimant has sustained his burden of establishing that he is permanently and totally disabled.

ORDER

The Referee's order dated November 1, 1988, is affirmed. For services on review, claimant's counsel is awarded a reasonable assessed fee of $800. A client-paid fee, not to exceed $2,404.75, is approved.

April 5, 1990 Cite as 42 Van Natta 810 (1990)

In the Matter of the Compensation of
WILLIAM C. FORD, Claimant
WCB Case No. 88-08083
ORDER ON REVIEW
Robert Goodwin, Claimant Attorney
Randolph Harris (Saif), Defense Attorney

Reviewed by Board Members Nichols and Brittingham.

The SAIF Corporation requests review of those portions of Referee Thye's order that: (1) required payment of temporary disability compensation for an ankle injury, from March 9, 1985 through at least April 5, 1985; (2) required payment of unpaid medical expenses related to the ankle injury and reimbursement to claimant of medical expenses for that injury paid by him or his employer; and (3) assessed penalties and attorney fees for alleged unreasonable claims processing. If the Board affirms the Referee's award of temporary disability compensation and medical benefits, SAIF requests an offset against future awards of permanent disability compensation. The issues on review are temporary disability compensation, medical services, offset and penalties and attorney fees. We affirm in part, reverse in part, and modify in part.

FINDINGS OF FACT

We adopt the Referee's Findings and Ultimate Findings.

CONCLUSIONS OF LAW AND OPINION

We adopt the Referee's conclusions except as follows.

Temporary Total Disability

The Referee found that claimant was entitled to temporary disability benefits due to the ankle claim because his doctor did authorize time loss. In this matter we disagree with the Referee because as a result of the March 1985 incident, claimant lost no time from work. His employer told him to drive or be fired, and claimant chose to drive. The action of the employer may have been outrageous; however, that fact alone does not entitle claimant to temporary disability benefits. Temporary disability benefits are to compensate workers for wages lost because of their inability to work due to the compensable injury. Cutright v. Weyerhaeuser Co., 299 Or 290 (1985). Claimant did not lose any time from work for this injury nor did he suffer a reduction in wages which would entitle him to temporary partial disability.

Medical Services

The Referee ordered SAIF to pay unpaid medical expenses and reimburse claimant for medical expenses paid by claimant or the employer. This issue was not raised at the hearing before the Referee. When an issue is not raised at hearing and the record is closed, that issue will not subsequently be considered. Mavis v. SAIF, 45 Or App 1059 (1980); Randy D. Johnson, 39 Van Natta 463, 465 (1987). It would be fundamentally unfair to address an issue that was not raised at hearing. Consequently, we reverse that portion of the Referee's order which addresses this issue.

Penalties and Attorney Fees

The Referee concluded that the employer acted unreasonably in failing to refer claimant's ankle claim to SAIF in a timely manner. Imputing the employer's action to SAIF, he assessed a penalty equal to 25 percent of the temporary disability due on the ankle claim and an associated $200 attorney fee. ORS 656.262(10) and 656.382(1).

We agree that the employer's processing of the ankle claim was unreasonable. However, in light of our disposition of the temporary disability and medical services issues, there are no amounts due on which to base a penalty. ORS 656.262(10); Wacker Siltronic Corporation v. Satcher, 91 Or App 654, 658 (1988). Accordingly, we reverse the Referee's assessment of a penalty.

Unlike a penalty, an attorney fee can be awarded even though there are no "amounts then due", provided that the carrier has otherwise unreasonably resisted the payment of compensation. ORS 656.382(1); Cindi A. Cadieux, 41 Van Natta 2259 (1989). Here, the employer pressured claimant not to file a workers' compensation claim and told claimant he would be fired if he did not continue working following his ankle injury. This clearly constitutes an unreasonable resistance to the payment of compensation within the meaning of ORS 656.382(1). Accordingly, we affirm the Referee's assessment of a penalty-related attorney fee.

ORDER

The Referee's order dated October 18, 1988 is affirmed in part and reversed in part. The Referee's awards of temporary disability compensation and

medical services related to the ankle injury are reversed. The Referee's assessment of a penalty for unreasonable processing of the ankle injury claim is reversed. The remainder of the order is affirmed.

In the Matter of the Compensation of
ROBERT D. GUDGE, Claimant
WCB Case No. 88-05247
ORDER ON REVIEW
Merrill Schneider, Claimant Attorney
Thomas E. Ewing (Saif), Defense Attorney

Reviewed by Board Members Crider and Brittingham.

Claimant requests review of those portions of Referee Galton's order that: (1) concluded that the SAIF Corporation was entitled to terminate temporary disability compensation on December 30, 1987; (2) declined to award additional temporary disability compensation; and (3) declined to assess penalties and attorney fees for unilateral termination of temporary disability compensation. SAIF cross-requests review of that portion of the order that assessed penalties and attorney fees for late payment of temporary disability for the period July 24 through August 17, 1987. On review, the issues are temporary disability compensation and penalties and attorney fees. We reverse.

FINDINGS OF FACT

Claimant suffered compensable injury to his neck and back on June 26, 1987, while working for the insured. At the time of the injury, he was employed as a choker setter at a wage of $9.00 per hour.

Claimant completed work on June 26 and also may have worked June 27, 1987. On July 2, 1987, he was examined at the Portland Adventist Hospital emergency room. He missed time from work with pay until he returned to work July 13, 1987. Claimant again did not work due to the injury on July 14, 15 and 16, 1987. Again, the employer paid him for this lost time. On July 16, 1987, he commenced treating with Dr. Hyland, chiropractor.

Dr. Hyland released claimant to return to modified work as a log production monitor on July 17, 1987.

On Monday, July 20, 1987, claimant reported for work at the regular time of 4:00 a.m. Claimant performed the light work duties that day, for which he was paid his standard $9.00 hourly wage.

The next morning, claimant did not report for work due to a non-injury-related illness. David Burt, claimant's supervisor, instructed the insured's bookkeeper to terminate claimant for being absent from work without notifying the employer, unless he presented a doctor's note authorizing the absence.

Claimant reported for work at about 3:45 a.m. Wednesday, July 22, 1987, at which time Burt advised him that he was terminated unless he had a physician's release. Claimant telephoned the bookkeeper. She told him that he was terminated because he did not contact the employer ahead of time regarding his absence from work the day before. Claimant was terminated for failure to call in.

Either on Thursday, July 23, 1987, or more likely on Friday, July 24, 1987, claimant reported for work with notes from Dr. Bauer, M.D., stating that

he had been seen in the Broadway Medical Clinic on July 22, 1987 with bronchitis and an ear infection; should be excused from work; but would be ready to return to work on July 24, 1987. The insured did not relent; claimant's termination stood.

Claimant continued to treat with Dr. Hyland. On August 17, 1987, Dr. Hyland released claimant to full work.

SAIF received the Form 801 on or just before September 28, 1987, at which time it accepted the claim as a disabling injury and paid claimant temporary total disability benefits from July 24 to August 17, 1987. On December 2, 1987, Dr. Hyland reported that claimant had suffered an exacerbation and reauthorized temporary total disability compensation effective that date. He referred claimant to Dr. Aversano, osteopath. SAIF recommenced payment of temporary total disability effective December 2, 1987.

Upon Dr. Hyland's referral, claimant was examined by Dr. Aversano on December 14, 1987. Dr. Aversano prescribed physical therapy and a work hardening program.

Sometime in January, 1988, Dr. Hyland had a conversation with a SAIF claims examiner in which he advised her that as of December 30, 1987, claimant had been physically capable of performing the insured's log production monitor job. Claimant was not advised that he was released to the job, however, because the job was not actually available to him inasmuch as he had been discharged. SAIF did not pay claimant temporary disability compensation for any time after December 30, 1987.

Claimant continued to treat with Dr. Aversano and to receive physical therapy.

By February 9, 1988, claimant was able to return to work with restrictions. It remained possible that the restrictions could be removed in the future.

FINDINGS OF ULTIMATE FACT

Claimant was discharged in July 1987 for reasons unrelated to the compensable injury.

Claimant's post-injury earnings at the time of his discharge were equal to his pre-injury earnings.

SAIF's conduct in paying temporary disability compensation for the period July 24 to August 17, 1987 on September 28, 1987, was not a delay in compensation; it was not unreasonable.

Claimant became temporarily, totally disabled on December 2, 1987. He had not become medically stationary nor had he been released to regular work by his attending physician on December 30, 1987.

SAIF's unilateral termination of temporary total disability payments on December 30, 1987, was unreasonable.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant was entitled to no temporary disability compensation after he was discharged for reasons unrelated to the compensable injury because, at the time of the discharge, claimant's wages equalled his pre-injury wages. He relied on Safeway Stores v. Owsley, 91 Or App 475 (1988).

Although we also believe that Owsley is relevant to the disposition of all of the issues before us on review, we reach a different result.

Penalties and attorney fees for late payment of TTD

The Referee assessed a penalty and attorney fee for SAIF's untimely payment of temporary disability for the period July 24 through August 17, 1987. SAIF did not pay that compensation until September 28, 1987. We disagree with the Referee's ruling.

When claimant returned to modified work, he was entitled to temporary partial rather than temporary total disability benefits. OAR 436-60-030(3).

However, because claimant was paid his regular wage for the modified work, his temporary partial disability benefit was equal to zero. OAR 436-60-030(2).

The court held, in Owsley, that if a worker is discharged for reasons unrelated to the compensable injury while still temporarily disabled, the worker does not thereby become entitled to resumption of temporary total disability. Rather, the worker is entitled to temporary partial benefits only. Where the benefits received prior to the discharge were zero, a worker is entitled to nothing.

We have concluded that claimant was discharged in July 1987 for reasons unrelated to the compensable injury. At that time he was receiving his regular wage for modified work. Thus, we disagree with the Referee's conclusion that temporary total disability benefits came due 14 days after claimant left work due to the discharge.

The Referee reasoned that an obligation to pay arose from SAIF's September 28, 1987, acceptance of the claim as disabling. The Referee held, citing Bauman v. SAIF, 295 Or 788 (1983), that when an insurer accepts a claim as disabling it commits to pay temporary disability compensation and, in this case, waives the defense that no further compensation is due. We disagree. This claim was disabling from the outset. Claimant was unable to work for more than three days following the injury. Thus, he was entitled to payment of temporary total disability (ORS 656.210(3)) and, therefore, the claim was disabling. ORS 656.005(7)(b). Although the employer continued to pay claimant his regular wages during the period of disability, as is permitted by statute, the payment of wages by the employer in lieu of payment of temporary disability compensation, does not render a disabling claim nondisabling. SAIF correctly designated the claim. It was nonetheless entitled not to resume temporary disability payments in view of the discharge.

We conclude that when SAIF paid temporary disability compensation for the period July 24 to August 17, 1987, it made payments it was not required to make. A voluntary payment cannot be late. Therefore, claimant is not entitled to a penalty and attorney fee for late payment of compensation.

December 30, 1987, termination of temporary total disability

We have held that claimant was not entitled to resumption of temporary disability compensation following the discharge. However, a discharge does not forever terminate entitlement to temporary disability compensation.

A worker whose temporary disability benefits have been properly terminated becomes entitled to resumption of temporary total disability payments if, prior to claim closure, the attending physician again authorizes time loss. OAR 436-60-0030(4)(a) and (6)(a). Rodgers v. Weyerhaeuser Company, 88 Or App 458 (1987).

Therefore, when Dr. Hyland, claimant's attending physician, authorized temporary total disability beginning December 2, 1987, claimant was entitled to a resumption of payments. Thereafter, SAIF was not entitled to terminate those payments until claimant is medically stationary and released to regular work or the claim is closed. Fazzolari v. United Beer Distributors, 91 Or App 592 (1988).

SAIF terminated benefits on December 30, 1987. SAIF does not contend that claimant was either medically stationary or released to regular work on December 30, 1987. Instead, it argues that claimant was released to modified work on December 30 and, therefore, that it was entitled to terminate temporary total disability and commence payment of temporary partial disability at a rate of zero even though the employer did not offer claimant an opportunity to return to the modified employment.

The argument is faulty because it is based on the erroneous factual premise that Dr. Hyland released claimant to modified work. While Dr. Hyland may have advised SAIF that claimant was capable of performing modified work, it does not appear the physician told claimant he could return to work. ORS 656.252(2)(b).

Moreover, once a worker is totally disabled, the insurer may not discontinue temporary total disability payments and begin paying temporary partial disability payments until the worker "accepts and commences...wage earning employment"--OAR 436-60-030(3)--or light duty work is offered in accordance with the procedures set out in the rules and such work is refused. OAR 436-60-030(5). Claimant neither recommenced employment nor refused an offer of employment prior to December 30, 1987. Therefore, SAIF's unilateral termination of temporary total disability was wrong. SAIF must continue paying temporary disability compensation in accordance with law.

Penalties and attorney fees for unilateral termination of temporary disability compensation

SAIF's unilateral termination of benefits was clearly contrary to the administrative rules. It was, therefore, unreasonable. A penalty of 25 percent of the unpaid temporary disability compensation shall be assessed. Claimant's attorney shall be awarded a reasonable fee.

ORDER

The Referee's order dated June 24, 1988, is reversed in part and affirmed in part. That portion of the order that assessed a 25 percent penalty and an attorney fee of $150 for late payment of temporary total disability benefits from July 24 to August 17, 1987, is reversed. Claimant is awarded additional temporary total disability compensation commencing December 31, 1987 until terminated in accordance with law. Claimant is awarded a penalty of 25 percent of the temporary total disability compensation awarded by this order and claimant's attorney is awarded an assessed fee of $2,300 for services at hearing and on review in connection with the unilateral termination of temporary disability compensation. The balance of the order is affirmed.

In the Matter of the Compensation of
RAYMOND E. MEREDITH, JR., Claimant
WCB Case No. 88-09326
ORDER ON REVIEW
Brian Whitehead, Claimant Attorney
Kate Waldo (Saif), Defense Attorney

Reviewed by Board Members Crider and Nichols.

Claimant requests review of Referee Foster's order that upheld the SAIF Corporation's denial of a claim for carpal tunnel. The issue on review is compensability. We reverse.

FINDINGS OF FACT

Claimant suffers from bilateral carpal tunnel syndrome. The syndrome became intermittently symptomatic in 1982, while claimant was working as a plumbing helper, and again in November 1984, while claimant was bundling Christmas trees.

The symptoms disappeared when claimant quit those jobs. Claimant was able to work as a janitor for a hospital and for Salem Pool where he was asymptomatic.

Symptoms of pain and numbness again became troublesome in 1985, while claimant was pulling green chain for Action Lumber, Inc., Liberty Northwest Insurance Corporation's insured. In September 1985, claimant filed a claim for injury to the wrists, "suspected tendonitis." He underwent testing, and bilateral carpal tunnel syndrome was diagnosed. Surgery was recommended. Liberty Northwest denied the claim. Claimant quit work at Action and returned to work for Salem Pool in March 1986. On May 6, 1986, he entered into a disputed claim settlement, disposing of the Action claim.

While working for Salem Pool, claimant's symptoms were much reduced and intermittent. The symptoms did not interfere with his ability to work. He did not undergo surgery.

In October 1987, the work at Salem Pool slowed. Claimant began working for Westar Building Systems, the SAIF Corporation's insured. His work involved the use of power tools such as a nail gun and drill. His wrist symptoms returned. Beginning February 18, 1988, the symptoms became increasingly acute. His hand numbness, rather than being intermittent, became constant. Pain increased with activity. Claimant again sought medical treatment. On March 4, 1988, Dr. Hubbard, neurosurgeon, recommended claimant undergo surgery to relieve his pain and numbness. The doctor released claimant from work until the surgery could be performed.

At the time of hearing, claimant's symptoms were constant although he was no longer working.

FINDINGS OF ULTIMATE FACT

While working for Westar, performing manual work which subjected his arms to repetitive trauma, claimant's symptoms of carpal tunnel worsened although the underlying disease process did not. Claimant's work activities for Westar are a material contributing cause of his worsened symptoms. As a result of the worsened condition, claimant suffered greater disability and need for treatment than at the time of the Disputed Claim Settlement.

CONCLUSIONS OF LAW AND OPINION

The Referee and the parties have presented this claim as an occupational disease claim. The Referee found that because there had been no worsening of

the underlying preexisting condition the claim could not be compensable under Weller v. Union Carbide, 288 Or 27 (1979). Weller is not controlling in this matter.

The legislature amended the occupational disease statute, ORS 656.802, effective January 1, 1988. Since claimant's last exposure to work activity that could have affected his condition occurred in 1988, we find that this case should be analyzed under the new statute. Donna E. Aschbacher, 41 Van Natta 1242 (1989).

Claimant's claim is for conditions resulting from repetitive use of the hands. Therefore, it must be assessed under ORS 656.802(1)(c). It defines as one type of occupational disease.

> "[a]ny series of traumatic events or occurrences arising out of and in the course of employment which requires medical services or results in physical disability or death."

The Board held in Aschbacher that a claimant who suffers a preexisting condition may establish a compensable occupational disease claim under ORS 656.802(1)(c) without proving a worsening of the preexisting condition itself. Rather, the claimant need only show an increase in symptoms of the preexisting condition -- provided that the increase in symptoms causes greater disability or need for medical services. Further, because the relevant portion of the statute no longer requires that the agent of the condition be one to which claimant "is not ordinarily subjected or exposed other than during a period of regular actual employment therein," claimant need only show that the work exposure was a material contributing cause of those increased symptoms. He need not establish that work exposure was the major contributing cause of them.

Claimant's testimony of repetitive hand use on the job is credible and has not been contradicted. Dr. Hubbard and Dr. Button both believe that the worsened symptoms of claimant's carpal tunnel condition are related to his work exposure at Westar. There is no contrary medical evidence. The treating physician, Dr. Hubbard, also believes that conservative measures to treat these symptoms have been exhausted and that claimant should not work until surgery is performed. We find that claimant has carried his burden to prove that a series of traumatic occurrences arising out of his employment has caused increased disability and requires medical services, and thus the has proven a compensable occupational disease.

Claimant had previously agreed through a disputed claim settlement that the preexisting carpal tunnel condition was not work related. The Referee felt that this barred the claim. However, a worker may establish a compensable claim, a disputed claim settlement notwithstanding, if he shows that the disputed claim has worsened or that a new condition has arisen. Proctor v. SAIF, 68 Or App 333 (1984); Hollister L. Starr, 39 Van Natta 79 (1987). We have found that claimant's condition, which was only mildly and intermittently symptomatic at the time of the settlement, has worsened such that he was constantly symptomatic in 1988. Therefore, claimant may and has established a compensable claim for the worsened condition. Nevertheless, because this claim is for a symptomatic worsening of that same condition, the insurer is responsible for the worsening only. See analogously, Barrett v. D & H Drywall, 300 Or 325 (1985), modified, 300 Or 553 (1986).

ORDER

The Referee's order dated September 23, 1988 is reversed. The denial issued by the SAIF Corporation April 21, 1988 is set aside, and the matter is remanded to SAIF for further processing consistent with this order. Claimant's attorney is awarded an assessed fee of $1,600 for services at hearing and on Board review to be paid by SAIF.

In the Matter of the Compensation of
ROGER J. DICKINSON, Claimant
WCB Case No. 88-09780
ORDER ON REVIEW
Tennyson & Winemiller, Claimant Attorneys
Norman Cole (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

The SAIF Corporation requests review of that portion of Referee Schultz's order which awarded 35 percent (112 degrees) unscheduled permanent disability for a kidney injury, whereas a Determination Order had awarded no permanent disability. On review, the issue is extent of permanent disability. We reverse.

FINDINGS OF FACT

Claimant suffered a compensable right renal artery aneurysm on July 6, 1987 as a result of minor flank trauma which occurred while he was operating heavy equipment. Surgery was performed on July 15, 1987. As a result of the surgery, claimant's kidney function stabilized.

In October 1987, claimant developed pain in the area of the left kidney. A subsequent arteriogram ruled out an infarct of the left kidney. Dr. Froom, the treating physician, attributed the pain on the left side to acute back strain, rather than recurrent renal arterial disease.

Claimant did not suffer any permanent impairment as a result of his compensable injury.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant was at a greater risk to further renal injury if he returns to employment as a heavy equipment operator. On review, SAIF argues that the medical evidence fails to establish that claimant is at increased risk due to his compensable injury. We agree.

Dr. Froom advised lighter work which would not involve potential trauma. He was concerned that claimant might suffer more vascular trauma if his work activity caused heavy movement or constant "bouncing" of the right kidney. He did not state that claimant was at risk of experiencing more vascular trauma due to his compensable injury. Similarly, Dr. Kratka agreed that claimant should avoid the jolting or bouncing of the thorax and abdomen that is associated with heavy equipment operation. He believed that because this sort of incident occurred once, claimant may continue to be at risk in the future. However, none of the physicians have stated that claimant's prior injury has placed him at increased risk that the artery problem will recur.

Before permanent disability may be awarded, claimant must prove that injury-related impairment of the whole person exists. See former OAR 436-30-380; Pamela J. Johnson, 37 Van Natta 1672, 1673 (1985). Because we are not persuaded that claimant has suffered any permanent impairment as a result of the injury, we reinstate the Determination Order.

ORDER

The Referee's order dated September 27, 1988 is reversed in part. The Referee's award of 35 percent (112 degrees) unscheduled permanent disability is reversed. The Determination Order of June 6, 1988 is reinstated and affirmed. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
ROBERT W. MANSFIELD, Claimant
WCB Case No. 88-10802
ORDER ON REVIEW
Brothers, et al., Claimant Attorneys
Debra Kronenberg (Saif), Defense Attorney

Reviewed by Board Members Speer and Howell.

Claimant requests review of Referee Nichols' order that: (1) upheld the SAIF Corporation's partial denial of his right shoulder condition; and (2) declined to assess penalties and related attorney fees for an alleged untimely denial. Additionally, claimant requests review of the Referee's admission into the record of evidence of inconsistent statements made by claimant. On review the issues are evidence, compensability, penalties and related attorney fees. We affirm.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact with the following supplementation.

On December 7, 1987, claimant's wife talked to a SAIF representative and informed SAIF that claimant had injured his shoulder when the original injury occurred and was receiving physical therapy. (Ex. 13A).

Dr. Karmy, orthopedic surgeon and claimant's treating physician since the injury in May 1987, first noted claimant's shoulder problems in his November 19, 1987 chart note, which was received by SAIF on December 17, 1987. (Ex. 1-4).

On January 15, 1988, Dr. Karmy wrote to SAIF indicating that claimant had a shoulder problem in addition to continued pain in both wrists. (Ex. 15)

On February 2, 1988, SAIF inquired of Dr. Karmy about claimant's shoulder condition. (Ex. 15-A).

On February 25, 1988, Western Medical Consultants examined claimant. At that time, claimant was complaining of right wrist pain, left hand pain, right shoulder pain, low back pain and had recently undergone ankle surgery by Dr. Karmy for a bone spur on his left ankle from an older injury. (Ex. 18).

On March 4, 1988, in response to another inquiry from SAIF, Dr. Karmy affirmed that the first time claimant ever mentioned the shoulder problem was on November 19, 1986. (Ex. 19).

On April 5, 1988, SAIF sent a check-the-box inquiry to Dr. Karmy which asked: "...if [claimant] had injured his right shoulder at the same time he injured his wrists back on May 25, 1987, that given the hypothetical mechanism of injury (which is twisting within the hands of a drill motor when the drill bit stuck), that his shoulder would have been symptomatic previous to November 16, 1987. Is this correct?" (Ex. 24). On April 18, 1988, Dr. Karmy responded by placing an X by the "yes." (Ex. 24).

On April 28, 1988, by partial denial, SAIF denied claimant's right shoulder claim. (Ex. 25).

CONCLUSIONS OF LAW AND OPINION

Evidence

Claimant first argues that the Referee erred in allowing into the record evidence of inconsistent statements made by claimant to an investigator for SAIF.

OAR 438-07-017 allows that documents reasonably believed relevant and material only for purposes of impeaching a witness need not be disclosed before the hearing and may be offered and admitted solely for purposes of impeachment, but may not be considered by the referee as substantive evidence. Common law or statutory rules of evidence do not apply to workers' compensation hearings and the Referee has discretion as to the admission of evidence provided "substantial justice" is afforded the parties. ORS 656.283(7). Furthermore, we do not find that the Referee used the evidence for its substantive content, nor do we look to the inconsistent statements as substantive evidence.

Accordingly, we find that the Referee was within her discretion to allow the evidence of claimant's inconsistent statements.

Compensability

The Referee found that claimant had not carried his burden to show that his right shoulder condition was causally related to his May 1987 compensable injury. We adopt the Referee's opinion and conclusions as to the compensability of claimant's right shoulder condition.

Penalty and Attorney Fees

The Referee failed to address the issue of penalties and related attorney fees for untimely denial.

An insurer must accept or deny a claim within 60 days. ORS 656.262(6). Penalties may be assessed when a carrier "unreasonably delays or unreasonably refuses to pay compensation." ORS 656.262(10). Attorney fees may be assessed when the insurer unreasonably resists the payment of compensation. ORS 656.262(10), 656.382(1); Ellis v. McCall Insulation, 308 Or 74 (1989); Lloyd L. Cripe, 41 Van Natta 1774 (1989).

SAIF concedes that its denial was untimely, but argues that its delay was due to its receipt of conflicting history and the need to clarify whether claimant's shoulder condition was compensable.

SAIF first had notice of claimant's claim for his shoulder condition when claimant's wife talked to a SAIF representative on December 7, 1987, and informed SAIF that claimant had injured his shoulder when the original injury occurred and was receiving physical therapy. Additionally, SAIF had more formal notice of claimant's shoulder claim when it received Dr. Karmy's November 19, 1987 chart note on December 17, 1987. (Ex. 1-4). And yet, SAIF did not begin its investigation of the shoulder claim until it wrote to Dr. Karmy on February 2, 1988, inquiring about claimant's shoulder condition and on February 25, 1988, when Western Medical Consultants examined claimant. These factors persuade us that SAIF's lack of timeliness issuing the denial was not reasonable.

To support a penalty, there must be an unpaid "amount then due" at the time of the denial. ORS 656.262(10); Wacker Siltronic Corporation v. Satcher, 91 Or App 654, 658 (1988). The record does not establish what, if any, amounts were "then due" as of the date of the insurer's denial. Accordingly, no penalty will be assessed. See ORS 656.262(6); Eastmoreland Hospital v. Reeves, 94 Or App 698, 702 (1989).

Unlike a penalty, an attorney fee can be awarded even though there are no "amounts then due," if the insurer has otherwise unreasonably resisted the payment of compensation. Ellis v. McCall Insulation, 308 Or 74 (1989). Because we have concluded that claimant's shoulder condition is not compensable and the medical services claims at issue do not result from a compensable condition, we

conclude that SAIF's untimely denial was not an unreasonable resistance to the payment of compensation. See Ellis, supra; Lloyd L. Cripe, supra.

ORDER

The Referee's order, dated October 21, 1988, is affirmed.

April 6, 1990 Cite as 42 Van Natta 821 (1990)

In the Matter of the Compensation of
J. D. McALISTER, Claimant
Own Motion No. 88-0218M
OWN MOTION ORDER ON RECONSIDERATION
Longo, Eder & Lovejoy, Claimant Attorneys
Saif Legal Department, Defense Attorney

Claimant has requested that the Board reconsider its March 9, 1990 Own Motion Order Reviewing Carrier Closure. The Board ruled that the request for review was filed untimely. Claimant apparently contends thathis request for hearing on the issue of premature closure and scheduled permanent disability constituted a timely request for review of the Notice of Closure.

The SAIF Corporation issued a Notice of Closure on June 28, 1989 and claimant requested a hearing on the notice to the Hearings Division on July 13, 1989. However, the appeal rights on the Notice of Closure state, " If you think this claim closure is wrong, you may ask the Workers' Compensation Board to review it and decide whether you are entitled to more compensation. You must ask for a review within 60 days of the date of this notice or your rights to contest this notice will be lost. You may ask for a review by writing to the Board at 480 Church St SE, Salem, OR 97310." A request for hearing submitted to the Hearings Division does not constitute a request for review of the insurer's Notice of Closure.

Accordingly, the request for reconsideration is denied. The parties' rights of reconsideration shall continue to run from the date of our prior order.

IT IS SO ORDERED.

April 6, 1990 Cite as 42 Van Natta 821 (1990)

In the Matter of the Compensation of
MICHAEL R. WARD, Claimant
WCB Case Nos. 87-19714, 87-15986 & 87-13863
ORDER ON REVIEW
Max Rae, Claimant Attorney
Davis & Bostwick, Defense Attorneys
J. Richard Scruggs, Defense Attorneys

Reviewed by Board Members Howell and Speer.

Argonaut Insurance Company (Argonaut) requests review of that portion of Referee Myzak's order which: (1) set aside its denial, on behalf of Chapin Livestock Supplements (CLS), of claimant's occupational disease claim for hypersensitivity pneumonitis; and (2) upheld the SAIF Corporation's denial, on behalf of Elliot Feed and Seed (Elliot), of the same condition. Argonaut has moved that we strike the brief submitted by Elliot. In the event the Board reverses

the Referee on the denial issue, claimant asserts entitlement to a penalty and associated attorney fee for alleged untimely claims processing on behalf of Elliot. On review, the issues are motion to strike, compensability and penalties and attorney fees. We deny the motion to strike and affirm the Referee on the merits.

FINDINGS OF FACT

The Board adopts the Referee's "Findings of Fact."

CONCLUSIONS OF LAW AND OPINION

Motion to Strike

Argonaut moved to have the brief submitted by Elliot stricken on the grounds that there is a question of timeliness of the brief and that it contains statements and references to matters not in the record. We reject Argonaut's timeliness argument and accept Elliot's brief but decline to consider any evidence that was not previously made a part of the record.

Compensability

Argonaut argues, relying on Newport Seafood v. Shine, 71 Or App 119 (1984), that claimant had to have actual knowledge of the owner/operator of the business by whom he was employed in order to have an employment relationship. We disagree.

Claimant's knowledge of the owner/operator of the business for whom he works is irrelevant. Here, it is sufficient that the businesses had completed the necessary paperwork making claimant an employee of CLS at the time he contracted the hypersensitivity pneumonitis. We conclude that claimant was an employee of CLS and that he was covered by Argonaut, their workers' compensation insurer.

ORDER

The Referee's order dated September 2, 1988, as corrected September 9, 1988, is affirmed. Claimant's attorney is awarded a reasonable assessed fee of $750 for services on Board review, payable by Argonaut Insurance Company.

April 9, 1990 Cite as 42 Van Natta 822 (1990)

In the Matter of the Compensation of
VIRGIL A. CHAPPELL, Claimant
WCB Case No. 87-12857
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Cummins, et al., Defense Attorneys

Reviewed by Board Members Gerner and Cushing.

The insurer requests review of those portions of Referee Myzak's order which: (1) set aside its partial denial of claimant's L5-S1 intervertebral disc syndrome; (2) affirmed a Determination Order award of 30 percent (96 degrees) unscheduled permanent disability for a low back injury; (3) set aside the insurer's medical services denial; and (4) assessed penalties and attorneys fees for improper claims processing. On review, the issues are compensability, medical services, permanent disability, penalties and attorney fees. We affirm in part, modify in part and reverse in part.

FINDINGS OF FACT

The Board adopts the Referee's "Finding of Fact".

CONCLUSIONS OF LAW AND OPINION

Compensability

The Referee found that claimant's L5-S1 intervertebral disc syndrome compensable because the insurer was precluded by Georgia Pacific v. Piwowar, 305 Or 494 (1988) from partially denying the condition after it had been ordered to accept the "low back condition." We agree that the condition is compensable but for different reasons.

The Referee reasoned that by having claimant's "low back injury" ordered accepted by a prior referee, that the insurer was required to accept the L5-S1 intervertebral disc condition. We disagree.

The earlier referee's order did not specifically order the insurer to accept claimant's L5-S1 intervertebral disc syndrome. He ordered that, "The denial issued by the employer on January 21, 1987 is hereby set aside. The matter is referred back to the employer for acceptance and payment of compensation as provided by law." (Ex. 20A-3). When a Referee orders a claim accepted, the insurer has the duty to process the claim in accordance with law. ORS 656.262(1). Because there is no evidence that L5-S1 condition was actually accepted by the insurer, or that the condition was ordered accepted by the earlier referee, Piwowar, supra is not applicable.

The Board adopts the Referee's opinion and conclusions in regard to the "factual basis" for setting aside the insurer's denial.

Unreasonable Denial

The Referee found the insurer's denial of claimant's L5-S1 condition to have been an unreasonable denial. We disagree.

The insurer based its denial on favorable medical reports it obtained prior to issuing the denial. The insurer had a reasonable basis for denying the claim. Moreover, the earlier referee never specifically ordered the insurer to accept the L5-S1 condition. We conclude that the insurer had a legitimate doubt concerning whether a causal relationship had been established between the November 18, 1986 incident and the L5-S1 intervertebral disc syndrome. See Brown v. Argonaut Insurance Company, 93 Or App 588 (1988). Therefore, the insurer's denial was not unreasonable.

Medical Services

The Referee found the medical services provided to diagnose and treat claimant's back condition to be compensable. Because the insurer concedes that these medical services are compensable if the partial denial is reversed. (App. Brief, p. 14), we adopt the Referee's conclusion.

Extent of Disability

The Board adopts the Referee's conclusions in regard to the extent of disability issue.

Late Time Loss

The Referee found the late payment of time loss to be unreasonable and assessed the maximum penalty and a $200 assessed fee because the insurer was notified at the prior hearing of claimant's new address, but sent the check to his old address. However, a change of address given to counsel at hearing is

unusual. Furthermore, there is no evidence to establish that the insurer intentionally sent claimant's check to the wrong address. Consequently, although we consider the conduct to be unreasonable, we conclude that a 15 percent penalty and $250 assessed attorney fee is proper.

Order

The Referee's order, dated September 26, 1988, is affirmed in part, modified in part, and reversed in part. That portion of the Referee's order that found the insurer's denial of claimant's L5-S1 condition to have been unreasonable is reversed. That portion which assessed a $1,000 attorney fee for an unreasonable denial is reversed. In lieu of the Referee's assessment of a penalty and attorney fee for its improper mailing of claimant's time loss benefits, the insurer shall pay claimant a penalty equal to 15 percent of $5,366.66 and a $250 assessed attorney fee. The remainder of the Referee's order is affirmed. For services on review, concerning the compensability and extent of permanent disability issues, claimant's attorney is awarded an assessed fee of $1,000 to be paid by the insurer. The Board approves a client-paid fee, not to exceed $2,120.50, payable from the insurer to its counsel.

In the Matter of the Compensation of
KENNETH DOGGETT, Claimant
Own Motion No. 90-0062M
OWN MOTION ORDER
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted to the Board claimant's claim for an alleged worsening of his June 4, 1971 industrial injury. Claimant's aggravation rights have expired. SAIF has accepted responsibility for the claimant's condition. However, it opposes reopening of his claim for payment of temporary total disability benefits, contending that claimant has removed himself from the work force.

We may exercise our own motion authority and reopen claimant's claim for additional temporary total disability compensation if he has sustained a worsening of his compensable injury requiring either inpatient or outpatient surgery, or other treatment requiring hospitalization. ORS 656.278(1)(a). We conclude that claimant has sustained such a worsening.

Claimant's compensable injury has worsened requiring surgery. Yet, claimant has not worked since September, 1985, well before the most recent worsening. Therefore, in order to prevail, claimant must prove that he is willing to work and that either: (1) he is making reasonable efforts to obtain work; or (2) reasonable efforts to obtain work would be futile due to the compensable injury. See Dawkins v. Pacific Motor Trucking, 308 Or 254, 258 (1989). We are persuaded that any effort to obtain work would be futile due to the compensable injury. Claimant has had seven surgical procedures since 1971; that most recent was in 1987. He began receiving disability benefits from Social Security sometime after the 1987 surgery.

Accordingly, claimant's claim is reopened with temporary disability benefits to commence December 10, 1989, the date he was hospitalized for surgery. SAIF shall continue paying temporary disability compensation until claimant is medically stationary and the claim is closed, or claimant returns to regular work at the regular wage, 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 under OAR 438-12-055.

IT IS SO ORDERED.

April 9, 1990 Cite as 42 Van Natta 825 (1990)

In the Matter of the Compensation of
RONALD V. STABEN, Claimant
WCB Case No. 87-04547
ORDER ON REVIEW
Jolles, et al., Claimant Attorneys
Roy Miller (Saif), Defense Attorney

Reviewed by Board Members Crider and Nichols.

The SAIF Corporation requests review of Referee St. Martin's order that set aside its partial denial of claimant's claim for a low back condition. On review, the sole issue is compensability. We reverse.

FINDINGS OF FACT

Claimant suffered a muscle pull-type injury to his abdomen and groin on July 2, 1986, when he slipped off a log. He treated conservatively with Dr. Vander Waal, his long-time treating physician, for mild abdominal discomfort. Vander Waal diagnosed a pulled abdominal rectus muscle. The injury claim was accepted by SAIF.

During subsequent visits to Vander Waal, claimant complained of an occasional "flushed warm feeling" in the abdomen and left thigh accompanied by anxiety and heart palpitations. When studies yielded no etiology, Vander Waal attributed those complaints to anxiety. In mid-August, 1986, claimant complained of mild achiness in the left leg. Vander Waal diagnosed a mild muscle strain and referred claimant to Dr. Borman, an osteopath. Claimant saw Borman with complaints of left thigh pain occasionally involving the left ankle. He also complained of some back pain. Borman diagnosed lumbar radiculitis (nerve root inflammation) and spinal stenosis (narrowing of spinal canal); however, a subsequent CT scan of the lumbar spine revealed no significant evidence of stenosis or disc derangement. On February 9, 1987, SAIF denied the low back condition, asserting that it is unrelated to the accepted injury.

In March, 1987, claimant returned to Vander Waal complaining of continued discomfort in the left lower abdomen. An MRI scan in April, 1987, revealed a small L4-5 disc herniation. In May, 1987, claimant underwent an independent medical examination (IME) by Drs. Snodgrass and Stewart. Claimant reported occasionally feeling numerous sensations in the abdomen, including aching, swelling, popping, "girgling" and vibrations. He also reported "spreading" pains in the low back and left thigh extending to the groin, "burning" sensations in the left thigh, aching of the left ankle, and vibrations in the left foot sometimes extending to the entire left leg. The results of the IME were normal and did not substantiate claimant's complaints. Snodgrass recommended a psychiatric or psychological evaluation but none was done.

Later in May, 1987, claimant saw Dr. Mason, the consulting neurosurgeon. Mason ordered a myelography and scanning of the lumbar spine, but the results were normal. Claimant was then referred for physical therapy which reduced his complaints, though he still had some back discomfort. Mason took claimant off work in July, 1987, due to continuing symptoms.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant's low back condition was the result of his compensable injury, relying on the medical opinion of Dr. Mason. We disagree with the Referee's finding and reasoning.

To establish the compensability of his low back condition, claimant must prove by a preponderance of the evidence that the July, 1986, industrial injury materially contributed to that condition resulting in disability or his need for medical services. Harris v. Albertson's, Inc., 65 Or App 254, 256-57 (1983). Dr. Borman opined that the compensable injury worsened the preexisting, asymptomatic spinal stenosis, apparently by making the stenosis symptomatic. (Ex. 23). However, there is persuasive evidence that claimant does not have spinal stenosis. Diagnostic studies of the lumbar spine, including a myelography and scans, have either specifically ruled out stenosis or made no mention of it. (Exs. 8, 23, 24). Indeed, Dr. Snodgrass opined that the diagnosis of spinal stenosis was erroneous and should be discarded. (Ex. 19). After reviewing the record, we are not persuaded that claimant has spinal stenosis. Inasmuch as Borman's opinion is based on a questionable diagnosis, we discount it accordingly. See, e.g., Barbara A. Jacobs, 41 Van Natta 1397, 1398 (1989).

Dr. Mason opined that claimant's "current clinical condition" resulted from the compensable injury. (Ex. 24). However, his opinion is conclusory because it fails to identify the "clinical condition" and fails to explain how it resulted from the compensable injury. Furthermore, the opinion is inconsistent with the normal results of the May 1987 myelography and scanning of the lumbar spine, which suggest that the lumbar spine is not involved in the "clinical condition." Given the nature of Mason's opinion, we decline to rely on it. See Moe v. Ceiling Systems, 44 Or App 429, 433 (1980).

We rely, instead, on the thorough and well-reasoned opinion of Dr. Snodgrass. See Somers v. SAIF, 77 Or App 259, 263 (1986). He described claimant's symptoms as "bizarre and wide-spread," and opined that they were not compatible with nerve root involvement or disc injury because there were no radicular-type symptoms. (Tr. 45, 48, 53, 55; see also Ex. 20). He related them, instead, to psychological factors. (Ex. 19; Tr. 60). Snodgrass conceded that, if claimant had experienced low back symptoms immediately after his industrial accident, then there probably is a causal connection. (Tr. 66). However, he added that the medical records show that claimant first complained of back pain in September, 1986, two months after the industrial accident. (Tr. 47). Our review of the records confirms that observation. (See Ex. 6). Although claimant testified at hearing that he had back pain immediately after the industrial accident (Tr. 31), we find that testimony unreliable in light of Vander Waal's chart notes which fail to mention back pain. (See Exs. 1-1, 1-2, 1-3). Accordingly, Snodgrass' opinion does not support claimant's claim. Dr. Vander Waal, the treating physician, concurred with Snodgrass' opinion that claimant's back condition, i.e., disc bulging, did not cause his symptoms and has no relationship to the compensable injury. (Ex. 20, 22).

This record does not persuade us that the compensable injury materially contributed to claimant's current low back condition, disability or need for medical services. We conclude, therefore, that claimant's claim for a low back condition is not compensable.

ORDER

The Referee's order dated June 7, 1988, is reversed. The SAIF Corporation's partial denial of February 9, 1987, is reinstated and upheld. The Referee's assessed fee award of $1,500 to claimant's attorney is reversed.

In the Matter of the Compensation of
JOHN VOSIKA, Claimant
Own Motion No. 90-0059M
OWN MOTION ORDER
Pozzi, et al, Claimant Attorneys

The insurer has submitted to the Board claimant's claim for an alleged worsening of his June 13, 1979 industrial injury. Claimant's aggravation rights have expired. The insurer has accepted responsibility for the proposed surgery, but opposes reopening of his claim for temporary disability benefits on the ground that claimant has withdrawn from the work force.

Under 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 claimant's compensable injury has worsened requiring surgery. However, the dispositive issue is whether claimant has withdrawn from the work force. If so, claimant is not a "worker" within the meaning of the Workers' Compensation Law and, hence, may not receive temporary disability benefits. See Cutright v. Weyerhaeuser Company, 299 Or 290 (1985).

Based on our review of this record, we find that claimant has not worked for at least the last five years. Therefore, in order to prevail, claimant must prove that he is willing to work and that either: (1) he is making reasonable efforts to obtain work; or (2) reasonable efforts to obtain work would be futile due to the compensable injury. See Dawkins v. Pacific Motor Trucking, 308 Or 254, 258 (1989).

Claimant's treating physician recommended vocational rehabilitation to return claimant to less strenuous work. Although claimant submitted to vocational evaluation, he declined to participate in the development of a return-to-work plan. For that reason, claimant's eligibility for further vocational rehabilitation was terminated as of December, 1985. Submitting an affidavit, claimant represents that he is willing to work but is not willing to work for substantially less pay than he had been earning at the time of injury.

Notwithstanding claimant's representations, we are not persuaded that, at the time of his worsening, claimant was willing to work and making reasonable efforts to obtain work. We base that finding on claimant's documented refusal to cooperate in the development of a return-to-work plan and his failure to make independent efforts to find work. Claimant's release for vocational assistance indicates that reasonable efforts to obtain work would not have been futile. We find, therefore, that claimant had withdrawn from the work force at the time of his worsening. See id. He is not entitled to temporary disability benefits. Accordingly, claimant's request for own motion relief is denied.

IT IS SO ORDERED.

In the Matter of the Compensation of
LINDA L. WALLACE, Claimant
WCB Case No. 88-05466
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Howell, Speer and Perry.

Claimant requests review of that portion of Referee Quillinan's order that upheld the self-insured employer's denial of claimant's medical care provided by a particular out-of-state chiropractor. The employer cross-requests review of that portion of the order that awarded claimant 5 percent (16 degrees) unscheduled permanent disability for a neck condition, whereas a Determination Order had awarded no permanent disability. On review, the issues are medical services and extent of unscheduled permanent disability. We reverse in part and affirm in part.

FACTS

The Board adopts the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Medical Services

The Referee upheld the employer's denial of claimant's medical care by Dr. Schillerstrom, her treating out-of-state chiropractor. The Referee found that the employer had complied with the administrative provisions pertaining to out-of-state medical care. OAR 438-60-050(5). The Referee found that the employer had properly notified claimant that it objected to her choice of physician and had designated an alternate physician. We do not agree with the Referee's conclusion that the employer here may deny claimant's choice of an out-of-state physician.

The employer contends that it may reject bills from claimant's out-of-state treating chiropractor because it chose another physician in the same location with the same specialty and claimant was notified that further treatment by her current chiropractor would not be authorized. In this regard, OAR 436-60-050(5) provides that:

> "When the worker chooses an attending physician outside the State of Oregon, the insurer may object to the worker's choice and select the attending physician. Payment for treatment or services rendered to the worker after the insurer has objected to the worker's choice of attending physician may be rejected by the insurer."

This rule would allow a carrier an unlimited veto power over an injured worker's choice of an out-of-state physician. ORS 656.245(1), however, requires employers and insurers to provide reasonable medical services without regard to the injured worker's geographic location. Reynaga v. Northwest Farm Bureau, 300 Or 255, 261 (1985). A carrier's power to veto claimant's choice of an out-of-state physician under ORS 656.245(3) is not unlimited. Day v. S & S Pizza Co., 77 Or App 711, 716 (1986).

We have found that an injured worker has the initial right to select an out-of-state attending physician and that this choice of an attending physician is subject to a carrier's right of veto. Monty R. Jones, 41 Van Natta 1288

(1988) citing Reynaga v. Northwest Farm Bureau, supra; Day v. S & S Pizza Co., supra. In a recent case, however, we construed Reynaga and Day to stand for the proposition that the employer has a limited right to veto out-of-state care and that a basis must therefore be demonstrated in the exercise of such veto. Phyllis I. Dupape, 41 Van Natta 2427 (1989). In Dupape, we concluded that under the Reynaga and Day holdings, the only adequate basis for a veto would appear to be circumstances where the out-of-state doctor is unlikely to comply with reporting requirements. Dupape, 41 Van Natta at 2427.

We conclude that, under the current law, we are required to find that claimant's medical service claim for treatment from her out-of-state chiropractor is compensable. The employer has failed to show that claimant's physician would be unlikely to comply with reporting requirements. Claimant should therefore be allowed to receive chiropractic treatment from Dr. Schillerstrom.

Permanent Partial Disability

The Board adopts the Referee's findings and conclusions in regard to the issue of permanent disability.

ORDER

The Referee's order, dated July 26, 1988, is reversed in part and affirmed in part. That portion of the Referee's order that upheld the self-insured employer's denial of care by Dr. Schillerstrom is reversed. The employer's denial is set aside and the claim is remanded to the employer for payment of Dr. Schillerstrom's billings. For services at hearing on the denial issue and for services on review regarding both the denial and extent issues, claimant's attorney is awarded an assessed fee of $1,800. A client-paid fee, payable by the self-insured employer to its counsel, not to exceed $1,444, is approved.

Board Chair Perry, specially concurring:

The majority concludes that resolution of the medical services issue is controlled by the prevailing case law. I agree. The court's decision in Day dictates the result reached by the majority. However, I believe that the court's holding in Day construes Reynaga too narrowly.

The issue decided by the court in Reynaga was whether the insurer could deny an entire category of otherwise reasonable out-of-state medical services. The Court concluded that an insurer could not do so. I would interpret the Reynaga Court's discussion regarding compliance with reporting requirements as support for the validity of an employer/insurer veto power generally, rather than as an exclusive definition of the scope of that veto power. In the absence of the Court of Appeals' opinion in Day, I would not interpret an insurer's veto power as limited to those presumably rare occasions where an insurer has shown that a particular physician is unlikely to comply with reporting requirements.

April 10, 1990 Cite as 42 Van Natta 829 (1990)

In the Matter of the Compensation of
MEE BUCHSBAUM, Claimant
WCB Case No. 88-12869
ORDER ON REVIEW
Vick & Gutzler, Claimant Attorneys
Tom Sheridan (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

Claimant requests review of Referee Podnar's order that dismissed claimant's request for a hearing challenging the SAIF Corporation's partial

denial of chiropractic treatment in excess of the Director's guidelines. The issues on review are entitlement to chiropractic treatment beyond the guidelines and penalties and attorney fees. We reinstate claimant's request for a hearing and, on the merits, uphold SAIF's denial and decline to award penalties and attorney fees for untimely denial.

FINDINGS OF FACT

We adopt the Referee's findings with the following supplementation.

Claimant received physical therapy at Northwest Physical Therapy Clinic, two times a week from May 1987, until mid December 1987. (Exs. 9 & 10).

Dr. Weintraub, orthopedic surgeon, a treating physician, last examined claimant in December 1987 and could not offer claimant anything more in the way of treatment. (Ex. 8-7).

On December 4, 1987, claimant began treatment with Dr. Cogut, D.C., two or three times a week and submitted bills to SAIF for this treatment. On March 14, 1988, SAIF requested a report from Dr. Cogut justifying the need for treatment in excess of the guidelines set forth in OAR 436-10-040(2)(a). SAIF explained that until it received a report from Dr. Cogut justifying the excess treatment, only two treatments a month (of the billings received) would be paid for by SAIF. (Ex. 28).

On March 25, 1988, Dr. Cogut responded to SAIF's inquiry:

> "Since Ms. Buchsbaum had not had any effective therapy prior to coming to my office, it was absolutely necessary to have her come in for therapy on a schedule of approximately three times per week. Anything less than this would not have been effective and two times per month would have been totally ineffective and a waste of time and money. Within ten days of commencing treatment, Ms. Buchsbaum began to improve and continued to do so until I last saw her on March 18, 1988. The effectiveness of treatment when there was no prior improvement is in itself evidence of the necessity for the treatment as well as to the inaccuracy of her prior proclaimed medically stationary status." (Ex. 29).

The Orthopaedic Consultants, who had examined claimant in 1987, reexamined claimant in September 1988. Claimant reported to them that her pain at the time of their reexamination was more in her left shoulder than in her right and that her condition was only a little better than it had been. (Ex. 31-2).

CONCLUSIONS OF LAW AND OPINION

There was no basis for dismissing claimant's hearing request, nor any request by the parties to do so. A hearing was held on the matter and we review on the merits.

Medical Services

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 at 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 due to the nature of the injury or to the process of recovery. James v. Kemper, supra at 82-84; West v. SAIF, supra at 320; Kemp v. Workers' Comp. Dept., 65 Or App 659, 669 (1983), modified 67 Or App 270, rev den 297 Or 227 (1984).

Generally the Board gives greater weight to the conclusions of a treating physician. However, it will not do so when there are persuasive reasons to do otherwise. Weiland v. SAIF, 64 Or App 810, 814 (1983); Nancy E. Cudaback, 37 Van Natta 1522, 1580, withdrawn on other grounds, 37 Van Natta 1596 (1985), republished 38 Van Natta 423 (1986).

Dr. Weintraub, who had been treating claimant for over a year, reported in December 1987, that there was nothing more he could offer her as treatment for her condition. Shortly thereafter, claimant began to receive treatment from Dr. Cogut. In response to SAIF's request for substantiation of claimant's need for treatment in excess of the guidelines, Dr. Cogut merely states that it is "absolutely necessary" that claimant be treated by him on a schedule of approximately three times per week. We do not find Dr. Cogut's reply to SAIF's inquiry persuasive substantiation of a need for chiropractic care in excess of the administrative guidelines.

On the other hand, the Orthopaedic Consultants report that at the time of their reexamination in September 1988, after Dr. Cogut had been treating her, claimant's condition,

> "has not changed in any way from a neurological or orthopaedic [sic] point of view since the last examination although the evidence of functional overlay has increased.
>
> "We do not feel that chiropractic treatments are reasonable or necessary. The patient does not confirm the report from the chiropractor that she was significantly improved by his treatments...." (Ex. 31-4).

Accordingly, we conclude that claimant has not proven that that the chiropractic treatment she received from Dr. Cogut in excess of the guidelines is necessary due to the nature of her injury or to the process of her recovery.

Penalties and Attorney Fees

Unreasonable failure to timely accept or deny claims may result in the assessment of a penalty and related attorney fee. ORS 656.262(10). However, a penalty is awardable only when there are amounts "then due" upon which to assess the penalty. Id. Here, pursuant to our decision denying the compensability of the chiropractic treatment in excess of the guidelines, there are no amounts "then due" upon which to base a penalty. Consequently, no penalty may be assessed. Similarly, a penalty-related attorney fee is awardable only where the insurer unreasonably resists the payment of compensation. ORS 656.382. We have

concluded that the chiropractic bills in excess of the guidelines were not compensable. Consequently, the delay in accepting or denying the billings did not delay any compensation and was, therefore, not an unreasonable resistance to the payment of compensation. Ellis v. McCall Insulation, 308 Or 74 (1989); Lloyd L. Cripe, 41 Van Natta 1774 (1989). No attorney fee may be assessed.

ORDER

The Referee's order, dated November 18, 1988, is modified. Claimant's hearing request is reinstated. The SAIF Corporation's denial of claimant's chiropractic treatment in excess of the administrative guideline is upheld.

April 10, 1990 Cite as 42 Van Natta 832 (1990)

In the Matter of the Compensation of
GEORGE W. CLARK, Claimant
WCB Case No. 88-10206
ORDER ON REVIEW
McNutt & Thrush, Claimant Attorneys
Dennis Ulsted (Saif), Defense Attorney

Reviewed by Board Members Nichols and Brittingham.

The SAIF Corporation requests review of that portion of Referee Holtan's order that increased a Determination Order award of 18 percent (57.6 degrees) unscheduled permanent disability to 36 percent (115.2 degrees). On review, the issue is extent of unscheduled permanent disability. We affirm.

FINDINGS OF FACT

Claimant is a 37-year-old log truck driver, who has completed school through the 10th grade, obtained his GED and completed one and one-half years of college. Claimant's past relevant work includes, log truck driver, long-haul trucker and logger.

Claimant suffered a compensable injury on September 16, 1987 while working as a log truck driver for SAIF's insured. Claimant was injured when he was struck on the right side, hip and thigh by a log that had slipped from the grapples of a loader, pinning him against the cab of his truck.

Following his compensable injury claimant received conservative medical treatment, primarily with Dr. Matteri, orthopedist. Physicians from Medical Operations Management, Inc. performed an independent medical examination April 30, 1988.

A Determination Order issued August 10, 1988 awarding claimant 18 percent (57.6 degrees) unscheduled permanent disability and no award of scheduled permanent disability for loss to his right leg. Claimant's condition became medically stationary on May 27, 1988.

Claimant has exogenous soft tissue calcification in the right groin area, objectively verified by x-rays.

Claimant experiences constant pain in the right hip, right groin and right low back areas. This pain radiates down the back of his right thigh to the knee. The hip and outside of the thigh become numb three to four times a day. The muscles of the right leg cramp with extended walking. There is no

evidence of right leg pathology separable from radiating symptoms from the unscheduled areas of the body.

Claimant's bending and stooping restrictions significantly limit his ability to lift objects from the ground level. His ability to lift is not limited above the waist level.

CONCLUSIONS OF LAW AND OPINION

In determining the extent of claimant's permanent disability, the Referee applied the standards for evaluating permanent disability as adopted by the Directory of the Department of Insurance and Finance pursuant to ORS 656.726(3)(f). See ORS 656.283(7). Specifically, the Referee applied former OAR 436-35-000 et seq, which was effective at the time of claimant's August 10, 1988 Determination Order. See OAR 438-10-005; 438-10-010. These are the rules which we apply as well. ORS 656.295(5); OAR 438-10-005; 438-10-010.

The Referee increased claimant's unscheduled permanent disability award for his low back condition from 18 percent (57.6 degrees) to 36 percent (115.2 degrees). We agree with the Referee's award; however we reach our conclusion in the following manner.

The hearing and Board review of the issue of permanent partial disability continues to be de novo on the hearing record. The underlying facts to which the "standards" are applied need only be established by a preponderance of the evidence. However, either party may establish that the record, as a whole, constitutes clear and convincing evidence that the degree of permanent partial disability suffered by the claimant is more or less than the entitlement indicated by the "standards". ORS 656.283(7) and 656.295(5).

The determination of permanent partial disability under the "standards" is made by determining the appropriate values assigned by the "standards" to the claimant's age, education, adaptability and impairment. Once established, the values for age and education are added and the sum is multiplied by the appropriate value for adaptability. The product of those two figures is then added to the appropriate value for impairment to yield the percentage of unscheduled permanent partial disability. Former OAR 436-35-280.

Age

The appropriate value for claimant's age of 37 years is 0. Former OAR 436-35-290.

Formal Education

The appropriate value for claimant's 12 years of formal education is 0. Former OAR 436-35-300(3).

Skills

Former OAR 436-35-300(4) adopts by reference the "SVP" (specific vocational preparation time) values assigned to various occupations by the Dictionary of Occupational Titles (DOT), published by the U.S. Department of Labor. The highest SVP level demonstrated by a claimant during the ten years prior to the date of injury is used to determine a value for skills. Former OAR 436-35-300(4). Claimant's highest SVP during the ten years prior to the date of injury was 4 as a log truck driver (DOT #904.683-010). Therefore, the appropriate value for skills is +3. Former OAR 436-35-300(4).

Training

Claimant has no documented training. Therefore, the appropriate value for training is +1. Former OAR 436-35-300(5). Claimant's total education value

is +4, the formal education value plus the skills value plus the value for training. Former OAR 436-35-300(6).

Adaptability

An adaptability value for a claimant who is unable to return to his or her usual and customary work [see former OAR 436-35-270(3)(a)] and who has not returned to modified work is determined by the claimant's residual physical capacity, without regard to that claimant's physical capacity prior to the injury. Former OAR 436-35-310(4).

Claimant is unable to return to his usual and customary work and has not returned to, or been offered, regular, modified work since he became medically stationary (when permanent disability is rated). Claimant's physical capacity falls within the light category. Thus, the appropriate adaptability value is +4. Former OAR 436-35-310(4)(c).

Impairment

The Referee awarded claimant 4 percent for his loss of flexion in his thoracolumbar spine. We agree. The medical evidence is sufficient to prove that claimant has lost 40 degrees of flexion and is therefore entitled to a 4 percent impairment value. Former OAR 436-35-360(6).

The Referee awarded claimant 1.5 percent for the loss of 15 degrees of extension in the thoracolumbar spine, which he averaged upward to 2 percent. We disagree. While claimant is entitled to 1.5 percent for the 15 degrees of loss of extension in his thoracolumbar spine, the percentage is not to be averaged upward to the next percent. Therefore, we find that claimant is entitled to 1.5 percent for loss of extension of the thoracolumbar spine. Former OAR 436-35-360(7).

The values for loss of range of motion in each area of the thoracolumbar spine are to be added (not combined) for a total impairment value that represents loss of range of motion of the spine. Former OAR 436-35-360(10). When these values are added, we find that claimant is entitled to a total 5.5 percent impairment value for his low back condition.

SAIF argues that claimant should have been awarded a value of 2 percent for a fractured pelvis which heals with displacement and deformity in the ilium, rather than the 15 percent the Referee awarded for disabling pain. Former OAR 436-35-270(2). We disagree. We find that there is insufficient evidence to support a finding that claimant's ilium healed improperly. Therefore, we do not award claimant 2 percent for his fractured pelvis.

Finally, the Referee awarded claimant 15 percent for pain which has resulted in a loss of use and function. We agree. Former OAR 436-35-320(1)(a) provides that pain can result in loss of use or function. When it does, it is rated based on the loss of use or function which results and no additional value is allowed for the pain alone. The Board in Daniel M. Alire, 41 Van Natta 752 (1989), held that, inasmuch as the standards do not provide for a value range for impairment attributable to disabling pain, the Board on de novo review can consider the evidence and award the claimant a value that adequately compensated him for his loss of use or function attributable to the disabling pain.

In this case, the record establishes that claimant has exogenous soft tissue calcification in the right groin area; that claimant has constant pain in the right hip, groin and low back that results in a loss of function; that claimant experiences pain radiating to the right knee and that claimant suffers from right thigh numbness. We find that the preponderance of the evidence

demonstrates that claimant has a loss of use and function attributable to his pain.

Inasmuch as the standards do not provide for a value range for impairment attributable to disabling pain, we consider a value of 15 percent in this particular case to be reasonable. Combining the aforementioned value with the 5.5 percent impairment value for loss of range of motion in the thoracolumbar spine results in a total of 19.6 percent. This value represents claimant's total impairment value.

Computation of Unscheduled Disability.

Having determined each value necessary to compute claimant's permanent disability under the "standards," we proceed to that calculation. When claimant's age value (0) is added to his education value (+4) the sum is +4. When that value is multiplied by claimant's adaptability value (+4) the product is +16. When that value is added to claimant's impairment value 19.6 percent the result is 35.6 percent unscheduled permanent partial disability. Former OAR 436-35-280(7). That disability figure is rounded to the next higher whole percentage. Id. Claimant's permanent disability under the "standards" is, therefore, 36 percent (115.2 degrees).

ORDER

The Referee's November 10, 1988 order is affirmed. Claimant's attorney is awarded a reasonable assessed fee of $760, to be paid by the SAIF Corporation.

April 10, 1990 Cite as 42 Van Natta 835 (1990)

In the Matter of the Compensation of
ROBERT P. DAVIS, Claimant
WCB Case No. 86-01331
ORDER ON REVIEW (REMANDING)
Roberts, et al., Attorneys
Art Stevens (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

Claimant requests review of Referee Higashi's order that dismissed his request for hearing. The issue on review is dismissal. We remand the case to the Hearings Division for further evidence taking and reconsideration.

FINDINGS OF FACT

Claimant was compensably injured on September 27, 1983 while employed by SAIF's insured. He was subsequently awarded 25 percent permanent disability on his claim.

On April 25, 1985, SAIF received chart notes from treating physicians Matthews and James indicating a need for treatment due to worsened symptoms from claimant's 1983 injury and scheduling testing for a suspected herniated disk. Claimant's former attorney subsequently requested a hearing, listing "Failure to reopen claim" as one of the issues to be heard. That request was dated May 16, 1985 and was filed with the Board on June 6, 1985.

On June 10, 1985, the Hearings Division acknowledged receipt of claimant's May 16, 1985 hearing request and assigned to it WCB Case No. 85-06788.

On June 24, 1985, SAIF issued a denial of claimant's aggravation claim.

On July 30, 1985, claimant's counsel sent a letter to SAIF, with a copy to the Hearings Division, stating as follows:

> "I am in receipt of your letter dated July [sic] 24, 1985 denying the above-captioned request to reopen his claim.
>
> "I am assuming this is in response to the Request for Hearing filed May 16, 1985.
>
> "If it is not in response to that Request for Hearing we would request a hearing, by copy of this letter to the Hearings Division, in regard to your letter of June 24, 1985."

Upon receipt by the Hearings Division, claimant's July 30, 1985 letter was treated as a supplemental request for hearing and was included in the file for WCB Case No. 85-06788.

On September 19, 1985, an Order to Show Cause why WCB Case No. 85-06788 should not be dismissed as abandoned was issued by the Presiding Referee. The order referred to the June 6, 1985 hearing request, but made no mention of the July 30, 1985 "supplemental" hearing request. Claimant did not respond to the show cause order. On November 4, 1985 an Order of Dismissal was entered in WCB Case No. 85-06788.

On January 28, 1986, claimant filed another Request for Hearing, listing SAIF's failure to reopen his claim as among the issues to be heard. This request was assigned WCB Case No. 86-01331.

Claimant obtained a new attorney, and on October 17, 1986, claimant's new attorney filed an Application to Schedule a Hearing in WCB Case No. 86-01331. The application indicated that claimant wished to contest SAIF's June 24, 1985 denial.

On December 12, 1986, claimant's new attorney filed a second Application to Schedule. The application again indicated that claimant intended to contest SAIF's June 24, 1985 denial. The cover letter accompanying the application stated, in part:

> "This is in regard to the Request for Hearing dated July 30, 1985, which was never acknowledged by you, a copy of which is enclosed herewith. I would ask that a WCB number be assigned."

One week later, the Hearings Division responded by letter to claimant's attorney indicating that claimant's July 30, 1985 "supplemental" request had been made a part of the case file in WCB Case No. 85-06788, and that all issues in that case file had been dismissed pursuant to the November 4, 1985 Dismissal Order. The letter further indicated that the issues listed in claimant's December 11, 1986 Application to Schedule would become a part of WCB Case No. 86-01331.

On March 17, 1986, SAIF filed a Motion to Dismiss WCB Case No. 86-01331 on the basis that claimant was precluded by <u>res judicata</u> from contesting its June 24, 1985 denial.

The Referee initially denied the dismissal motion. However, on reconsideration, the motion was granted and WCB Case No. 86-01331 was dismissed.

CONCLUSIONS OF LAW AND OPINION

The Referee's decision to grant SAIF's dismissal motion was based upon two factors. First, he found that it was "logical" for the Hearings Division to file claimant's July 30, 1985 hearing request in WCB Case No. 85-06788. Second, the Referee found that claimant was "charged with" notice of the merger of the two hearing requests. He concluded that claimant had been afforded "procedural due process."

Claimant contends on review that he cannot be charged with notice of the consolidation of the two hearing requests because no acknowledgment of the July 1985 hearing request was issued by the Hearings Division. Assuming arguendo that claimant's July 1985 hearing request was not acknowledged by the Hearings Division, we agree that he cannot be charged with notice of the merger of the hearing requests. This is particularly true because the Show Cause Order which was subsequently issued referred solely to the May 1985 hearing request. No mention was made of the July hearing request. And yet, a supplemental hearing request stands independent of the original hearing request. Leonard A. Chambers, 40 Van Natta 117, 969 (1988).

Under the assumed circumstances of no Board acknowledgment, we do not agree with the Referee's conclusion that claimant had constructive notice that his July 1985 hearing request was threatened with dismissal along with his May 1985 hearing request. Moreover, in the absence of actual or constructive notice, dismissal of claimant's current hearing request would not result in substantial justice. See OAR 438-05-035.

However, we are not able to reach a finding as to whether the Hearings Division did, in fact, acknowledge receipt of claimant's July 1985 hearing request. The only evidence on this question in the record is the representation of claimant's second attorney, who did not represent him at the time an acknowledgment would have been made, that no acknowledgment was issued. In this regard, the Board may remand a case to the referee for further evidence taking where the Board determines that a case has been improperly, incompletely or otherwise insufficiently developed or heard. ORS 656.295(5). We conclude that the record as to whether the Hearings Division acknowledged receipt of claimant's July 1985 hearing request is insufficiently developed.

Accordingly, we will remand this matter to the Presiding Referee, who shall assign a referee for further evidence taking on this issue. If the assigned referee determines that no acknowledgment of the July 1985 hearing request was provided to claimant, the Referee shall proceed to a hearing on the issues raised by claimant's July 1985 hearing request.

Claimant's attorney has requested the award of an assessed fee for his services on Board review. No assessed fee is payable under ORS 656.382(2) because SAIF did not request or cross-request review on any issues. No assessed fee is payable under ORS 656.386(1) because claimant has not prevailed finally on a denied claim. No other grounds exist for the award of an assessed fee. Therefore, claimant's attorney's request is denied. However, should claimant finally prevail after remand, his attorney fee award would include services rendered before this forum. See ORS 656.388(1).

ORDER

The Referee's order on reconsideration dated March 8, 1988 is vacated and the case is remanded to the Presiding Referee for further proceedings consistent with this order.

In the Matter of the Compensation of
LLOYD A. DOUGLASS, Claimant
WCB Case No. 86-12211
ORDER ON RECONSIDERATION
Emmons, et al., Claimant Attorneys
Kevin L. Mannix, Defense Attorney
Lester Huntsinger (Saif), Attorney
Carl M. Davis, Assistant Attorney General

The noncomplying employer and claimant have requested reconsideration of our March 12, 1990 order which found the SAIF Corporation, as insurer for Beehive Rental Company, rather than the noncomplying employer, responsible for claimant's low back and left leg condition.

The employer has enclosed a copy of his counsel's October 26, 1988 letter to the Board, which indicates that the employer was withdrawing his request for review in this case. Based on this submission, the employer seeks withdrawal of our order. We decline to withdraw our prior order.

There is no record that the employer's withdrawal was received by the Board prior to our review and the issuance of our order. Under such circumstances, we retain jurisdiction to consider the matters raised by the employer's request for review, as well as issue our order. See Vernon G. Sebastian, 38 Van Natta 1527 (1986).

Since we had jurisdiction to issue our order, we also have authority to award claimant an attorney fee for his counsel's services on review, provided that claimant's counsel is entitled to such a fee. Submitting a statement of services, claimant seeks an attorney fee pursuant to ORS 656.382(2). We decline to award such a fee. Here, claimant has not submitted a brief and the record does not otherwise document services on review. Under such circumstances, there is no entitlement to an attorney fee. Shirley M. Brown, 40 Van Natta 879 (1988).

Accordingly, our prior order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our prior order, effective this date. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
LLOYD A. DOUGLASS, Claimant, and
In the Matter of the Complying Status of
DAVID C. SCHULTZ, dba DAVE'S AUTOS AND dba SUTTLE LAKE RESORT, Employer
WCB Case No. 86-14252
ORDER ON RECONSIDERATION
Emmons, et al., Claimant Attorneys
Kevin L. Mannix, Attorney
Lester Huntsinger (Saif), Defense Attorney

The noncomplying employer and claimant have requested reconsideration of our March 12, 1990 order which affirmed a Referee's order that: (1) affirmed a Stipulation and Order which awarded claimant 10 percent (32 degrees) unscheduled permanent disability for a low back injury; and (2) denied the noncomplying employer's motion to set aside the Stipulation and Order.

The employer has enclosed a copy of his counsel's October 26, 1988 letter to the Board, which indicates that the employer was withdrawing his request for review in WCB Case No. 86-12211, another case which was pending before the Board. Based on this submission, the employer seeks withdrawal of our order. We decline to withdraw our prior order.

To begin, the employer's withdrawal of a request for review concerning another case which pertained to another referee's order has no impact on a pending request for review of this case and this Referee's order. Moreover, assuming that the withdrawal did concern this request for review, there is no record that the employer's withdrawal was received by the Board prior to our review and the issuance of our order. Under such circumstances, we retain jurisdiction to consider the matters raised by the employer's request for review, as well as issue our order. See Vernon G. Sebastian, 38 Van Natta 1527 (1986).

Since we had jurisdiction to issue our order, we also have authority to award claimant an attorney fee for his counsel's services on review. We previously declined to award such a fee because we had not received a statement of services. Submitting a statement of services, claimant seeks an attorney fee pursuant to ORS 656.382(2).

After review of the statement of services and considering the factors listed in OAR 438-15-010(6), we award $450 as a reasonable attorney fee for claimant's counsel's services on review. This fee shall be paid by the SAIF Corporation, as processing agent for the noncomplying employer.

Finally, the employer appears to question the authorization of his counsel's $1,660 client-paid fee in our prior order. For purposes of clarification, our order does not direct the employer to pay his counsel the aforementioned fee. Rather, our order authorizes the employer's counsel to charge the employer a fee not to exceed $1,660. Considering the length of time between the employer's request for review and the issuance of our order, in all likelihood the employer has already settled his bill with his counsel. In that case, no further payment from the employer to his counsel would be necessary.

Accordingly, our prior order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our prior order, effective this date. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

April 10, 1990 Cite as 42 Van Natta 839 (1990)

In the Matter of the Compensation of
CLIFTON L. FURGASON, Claimant
WCB Case No. 88-10803
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Brian L. Pocock, Defense Attorney

Reviewed by Board Members Gerner and Myers.

The self-insured employer requests review of those portions of Referee Mongrain's order which: (1) made the alternative finding that if claimant had not proven his aggravation claim, he would be permanently and totally disabled; and (2) awarded claimant's attorney a fee for prevailing on the aggravation issue. Claimant cross-requests review, arguing that he is permanently and totally disabled. On review, the issue is an alleged improper finding by the Referee concerning permanent total disability.

We affirm and adopt the Referee's order

Attorney fees are not "compensation" within the meaning of ORS 656.382(2). See Dotson v. Bohemia, Inc., 80 Or App 233 (1986). Consequently, claimant is not entitled to an attorney fee for defending such an award on review. Moreover, because the Referee's finding of permanent total disability was an alternative finding, it was of no force or effect. Thus, such a finding did not result in an award of compensation. Inasmuch as there was no award of compensation, claimant is also not entitled to an attorney fee for defending this alternative finding on review.

ORDER

The Referee's order dated December 19, 1988, as amended December 23, 1988, is affirmed. A client-paid fee, payable from the employer to its counsel, is approved, not to exceed $400.

In the Matter of the Compensation of
JERRY R. MILLER, Claimant
WCB Case Nos. 87-10549 & 87-06381
ORDER ON RECONSIDERATION
Patrick K. Mackin, Claimant Attorney
Stafford Hazelett, Defense Attorney
Carroll Smith (Saif), Defense Attorney

Claimant has requested reconsideration of our March 21, 1990 Order on Review that reversed a Referee's award of permanent total disability, but increased claimant's permanent disability award from 15 percent (48 degrees) to 35 percent (112 degrees). Specifically, claimant objects to our attorney fee award. In response to claimant's objections, we issue the following clarification.

As a result of the Referee's award of permanent total disability, claimant's attorney was allowed a fee equal to 25 percent of the award not to exceed $1,500. Liberty Northwest requested review, contending that claimant was not entitled to permanent total disability. In response, claimant defended the Referee's award and, alternatively, sought an increase in claimant's permanent disability award.

Following our review, we concluded that the permanent total disability award should be reversed, but that claimant's unscheduled permanent disability award should be increased by 20 percent. In so doing, we allowed claimant's attorney an approved fee, equal to 25 percent of the increased compensation created by our order, not to exceed $3,000. We further stated that Liberty Northwest was permitted to credit attorney fees paid pursuant to the Referee's order against our attorney fee.

Claimant objects to our authorization of an "offset", contending that out-of-compensation fees paid pending review cannot be offset against out-of-compensation fees awarded following review. We concede that the language used in our order may have been misleading. However, we continue to hold that our conclusion is appropriate.

Pursuant to claimant's retainer agreement, claimant agreed that his counsel would receive 25 percent of any increased permanent disability not to exceed "$3,000 after hearing up to and including review." Thus, the maximum out-of-compensation attorney fee to which claimant's counsel is entitled for services at hearing and on review is $3,000.

Our prior order accomplished the intention of claimant and his counsel as expressed in their retainer agreement. In effect, we allowed claimant's counsel an additional attorney fee, equal to 25 percent of the increased compensation created by our order, provided that the total attorney fees awarded by the Referee and Board order did not exceed $3,000. Thus, rather than permitting an "offset," we were allowing an additional out-of-compensation fee up to the maximum level provided in claimant's retainer agreement.

Accordingly, our prior order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our prior order. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

April 10, 1990 Cite as 42 Van Natta 841 (1990)

In the Matter of the Compensation of
WILLIAM J. THOMAS, Claimant
WCB Case No. 87-10347
ORDER ON REVIEW
Rasmussen & Henry, Claimant Attorneys
H. Thomas Andersen (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

Claimant requests review of those portions of Referee Gruber's order that: (1) affirmed a Determination Order award of 15 percent (48 degrees) unscheduled permanent disability for injury to his head; (2) affirmed a Determination Order award of 15 percent (28 degrees) scheduled permanent disability for loss of use of his right arm; and (3) affirmed a Determination Order award of 10 percent (15 degrees) scheduled permanent disability for loss of use of his right leg. On review, the issue is extent of permanent partial disability both scheduled and unscheduled. We affirm the Referee's order on other grounds.

STATEMENT OF FACTS

Claimant became medically stationary on or about May 13, 1987. The claim was closed by Determination Order on July 1, 1987, which awarded scheduled and unscheduled permanent disability. Claimant appealed the permanent disability awarded by this Determination Order. Before a hearing was scheduled for the matter, claimant underwent surgery in December 1987, and the claim was reopened. He became medically stationary on June 23, 1988. A July 25, 1988 Determination Order again closed the claim increasing claimant's unscheduled disability award under the standards as applicable under OAR 438-10-005. Claimant requested a hearing with regard to the July 25, 1988 Determination Order.

At the September 9, 1988 hearing, claimant withdrew his request for hearing related to the July 25, 1988 Determination Order but continued to assert his appeal of the July 1, 1987 Determination Order. The Referee heard and admitted evidence pertaining to claimant's condition as it existed prior to claim reopening in December 1987. By Opinion and Order, the Referee affirmed the July 1, 1987 Determination Order.

CONCLUSIONS OF LAW AND OPINION

Disability is to be rated at the time of hearing. See Gettman v. SAIF, 289 Or 609, 614 (1980); Emmons v. SAIF, 34 Or App 603 (1978). Here, the evidence in the record relates solely to claimant's condition prior to claim re-

opening in December 1987. Claimant has presented no evidence of his condition as it existed at the time of the September 9, 1988 hearing. Even though claimant's request for hearing was from an earlier Determination Order, we find no reason to evaluate claimant's permanent disability at any time other than at hearing. Furthermore, former OAR 438-10-005 (temporary) was in effect at the time of hearing. See also Former OAR 436-35-003. That rule required application of the "standards" for evaluation of permanent disability to claims closed and evaluated after July 1, 1988 where claimant last became medically stationary after January 1, 1988.

Here, claimant's claim was closed and evaluated on July 25, 1988. He last became medically stationary on June 23, 1988. The "standards" are applicable to the evaluation of claimant's permanent disability, but claimant has offered no evidence which would permit us to apply those standards. The underlying facts, such as age, education, adaptability and impairment, necessary to apply the "standards" are determined as they existed at the time of hearing. Tracey A. Fast, 41 Van Natta 835 (1989). Therefore, claimant has failed to prove by a preponderance of the evidence that he is entitled to a greater award of unscheduled or scheduled permanent disability than previously awarded.

ORDER

The Referee's order, dated November 18, 1988, is affirmed.

April 11, 1990 Cite as 42 Van Natta 842 (1990)

In the Matter of the Compensation of
TINA M. DAVIDSON, Claimant
WCB Case No. 88-13148
ORDER ON REVIEW
Wilbur C. Smith, Jr., Claimant Attorney
Yturri, Rose, et al., Defense Attorneys

Reviewed by Board Members Gerner and Cushing.

Claimant requests review of those portions of Referee Peterson's order which: (1) found that a Determination Order did not prematurely close claimant's right wrist injury claim; and (2) affirmed the same Determination Order award of no scheduled permanent disability. On review, the issues are premature closure and scheduled permanent disability. We affirm in part and modify in part.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact with the following supplementation. Claimant is restricted from repetitive grasping of the right hand. She has mild disabling pain. Claimant has not sustained nerve damage.

CONCLUSIONS OF LAW AND OPINION

Premature Closure

The Referee concluded that the Determination Order did not prematurely close claimant's claim. We agree.

It is claimant's burden to establish that she was not medically stationary when the claim was closed. Berliner v. Weyerhaeuser, 54 Or App 624, 628 (1981); Dale R. Bennett, 40 Van Natta 843 (1988). The resolution of the medically stationary date is primarily a medical question based on competent medical evidence. Harmon v. SAIF, 54 Or App 121, 125 (1985). We evaluate claimant's condition and the reasonable expectation of improvement as of the date of closure. Alvarez v. GAB Business Services, 72 Or App 524 (1985).

At the time of closure, four medical doctors, including claimant's then attending doctor, had opined that claimant was medically stationary. (Exs. 25, 28, 35 and 38). No doctor had opined that she was not medically stationary. Thereafter, claimant's new attending physicians, Dr. Donald A. Smith and Dr. Johnson, opined that claimant was not medically stationary. We do not rely upon the opinion of Dr. Donald A. Smith because he never addressed the legally relevant inquiry whether claimant was medically stationary at the time of closure, as opposed to the post closure time of his treatment. Alvarez, supra. Dr. Johnson, at deposition agreed that claimant was medically stationary at the time of closure. (Ex. 49-19). All the probative medical opinions agree that claimant was medically stationary at the time of closure. Therefore, we conclude that the Determination Order did not prematurely close claimant's claim.

EXTENT OF DISABILITY

If a claimant became medically stationary after January 1, 1988 and his or her claim was closed on or after July 1, 1988, a subsequent determination by a referee or the Board of the claimant's permanent partial disability must be made pursuant to ORS 656.283(7) and 656.295(5), respectively. OAR 438-10-005 and Michelle Griffith, 40 Van Natta 2086 (1988).

In this case, the "standards" adopted effective July 1, 1988, former OAR 436-35-001 et seq, apply to the rating of claimant's permanent partial disability. Former OAR 436-35-010 through 436-35-260 apply to the rating of scheduled permanent partial disabilities. Former OAR 436-35-010(1).

Former OAR 436-35-010(2)(a) allows an impairment value for loss of use or function due to pain. We find that claimant's pain limits her ability to use her injured forearm and allow 5 percent impairment.

Claimant argues that she is entitled to an additional 35 percent impairment for loss of grip strength. Former OAR 436-35-110(3)(a) allows for an award of impairment for loss of grip strength due to nerve damage. Claimant has not sustained nerve damage. No award of impairment is appropriate under this rule.

Former OAR 436-35-110(3)(d) allows impairment for loss of grip strength due to atrophy or other anatomical changes. Claimant has failed to establish that her loss of grip strength is due to atrophy or other anatomical changes. She was noted to have inconsistencies in examination of a psychological origin which is another potential cause of her loss of grip strength. (Ex. 35-3). Grip strength loss due to such causes is not ratable under the standards.

We conclude that claimant is entitled to a total award of 5 percent scheduled disability for loss of use or function of her right forearm.

ORDER

The Referee's order dated November 14, 1988 is modified in part. That portion of the Referee's order which declined to award scheduled permanent disability is modified. Claimant is awarded 5 percent (7.5 degrees) scheduled permanent disability for her right forearm. Claimant's attorney is awarded 25 percent of the additional compensation granted by this order, not to exceed $3,800, as a reasonable attorney's fee, payable directly to claimant's attorney. The remainder of the Referee's order is affirmed. The Board approves a client-paid fee, not to exceed $1,027.50, payable from the insurer to its counsel.

In the Matter of the Compensation of
JOHN R. GARVER, Claimant
WCB Case Nos. 88-08090 & 88-07209
ORDER ON REVIEW
Callahan & Gardner, Claimant Attorneys
Kevin L. Mannix, Defense Attorneys
Pamela A. Schultz, Defense Attorney

Reviewed by Board Members Myers and Cushing.

Claimant requests review of those portions of Referee Bennett's order that: (1) set aside American Fabricators' responsibility denial of claimant's aggravation claim for a low back condition; and (2) upheld Stevens Equipment Company's responsibility denials of claimant's "new injury" claim for the same condition. On review, the issue is responsibility. We reverse in part and affirm in part.

Preliminary Matter

Stevens Equipment asserts that the Board is without jurisdiction to review the respondent's brief submitted by American Fabricators arising out of WCB Case No. 88-08090 and 88-072029. Stevens contends that American Fabricators should be considered an Appellant because it is American's denial that was set aside by the Referee's order. Consequently, Stevens argues that American's "Respondent's Brief" should be deemed untimely and should be stricken. We disagree.

No party may, by the terms of its request for review, limit the Board's de novo review of all the issues before it. See William E. Wood, 40 Van Natta 999 (1988). Moreover, claimant requested review. Therefore, he is the Appellant and the remaining parties are Respondents. See OAR 438-11-020(2). Accordingly, the motion to strike American Fabricators' respondent's brief is denied.

FINDINGS OF FACT

Claimant first compensably injured his back on March 13, 1980 while working for Layton Manufacturing Company. He had been lifting some metal parts at work when he felt sudden back pain in the midline at the lumbosacral joint. For this injury, claimant received 5 percent unscheduled permanent disability.

On September 5, 1985, claimant again injured his back while working for American Fabricators. Claimant experienced low back pain, with occasional pain radiating down his left leg to his foot.

Dr. Atkinson, surgeon, and claimant's treating physician indicated that the 1985 incident constituted a new injury.
(Ex. 89).

By a February 9, 1988 Stipulation and Order, claimant received an additional 10 percent unscheduled permanent partial disability for the 1985 injury.

Thereafter, on February 23, 1988, claimant injured his back while working for Stevens Equipment Company. He carried a 25 pound hydraulic jack approximately 60 feet. He set it down and felt numbness and tingling from his rib cage to his feet. Claimant experienced an entirely new kind of pain in his right leg and mid-back. Claimant also felt a sudden onset of mid back pain and of low back pain, which extended equally into both legs. He reported feeling a rubbery feeling in both legs and "lightening bolts" of pain in the right leg. (Tr. 23).

On April 29, 1988, Stevens issued a denial of claimant's February 23, 1988 injury. Stevens asserted that there was insufficient evidence to show that this claim arose within the course and scope of claimant's employment.

On June 6, 1988, Stevens amended its April 29, 1988 denial by denying responsibility and indicating that claimant's back disability was a result of the September 1985 injury with American Fabricators. The denial noted that compensability was not being denied. (Ex. 142-1).

At the hearing, Stevens accepted the mid-back condition, but continued to deny responsibility for the low back condition.

CONCLUSIONS OF LAW AND OPINION

Responsibility

The Referee found that claimant's employment at Stevens did not contribute to a worsening of his underlying low back condition. Consequently, the first employer, American Fabricators, remained responsible. We disagree.

Because the discrete incident affecting the mid and low back occurred while claimant was employed at Stevens, Stevens carries the burden to prove that the injury did not "independently contribute" to the low back disability. See Linda L. Wise, 42 Van Natta 115 (1990). "Independent contribution" means a worsening of claimant's underlying condition. See Hensel Phelps Const. v. Mirich, 81 Or App 200, 294 (1986).

Here, three physicians discuss the the effects of the new injury upon claimant's low back condition. Dr. Atkinson, M.D., claimant's treating physician, opined there was an exacerbation of the low back condition, but he was unable to tell whether or not there was a pathological change in the condition. (Ex. 148-30). Dr. Paluska, M.D. opined that claimant's new injury only caused an aggravation of a preexisting condition. (Ex. 141A-3). In addition, Dr. Chester, M.D. indicated that claimant's low back discomfort at the lumbosacral junction was, "...probably related to minor osteoarthritis (facet syndrome)." (Ex. 141-1).

The correct legal test is whether or not the new incident independently contributed to a worsening of claimant's underlying condition. Hensel Phelps, supra. Because no doctor addresses the critical legal test, we are unable to determine whether or not there had been an independent contribution to a worsening of claimant's underlying low back condition. Since none of the physicians persuasively state that the incident at Stevens did or did not independently contribute to a worsening of claimant's underlying condition, Stevens has failed to carry its burden of proof and it must be found responsible for claimant's low back condition. Wise, supra.

ORDER

The Referee's order dated September 1, 1988 is reversed in part and affirmed in part. American Fabricators' denial of April 29, 1988 is reinstated and upheld. Stevens Equipment Company's denial dated April 9, 1988, as amended June 6, 1988 is set aside and the claim is remanded to its insurer for processing according to the law. The remainder of the order is affirmed. Claimant's attorney is awarded 25 percent of the increased compensation, if any, created by this order, not to exceed $1,050. A client-paid fee not to exceed $835.50 is approved, payable by Stevens to its counsel. A client-paid fee not to exceed $2,687 is approved, payable by American Fabricators to its counsel.

In the Matter of the Compensation of
HENRY M. GRANADO, Claimant
WCB Case No. 88-18475
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
David L. Jorling, Defense Attorney

Reviewed by Board Members Cushing and Myers.

The self-insured employer requests review of those portions of Referee Lipton's order which: (1) reinstated claimant's temporary total disability benefits; and (2) awarded claimant's attorney an assessed fee for the unreasonable delay in the payment of compensation. On review, the issues are temporary total disability and attorney fees. We affirm in part, modify in part, and reverse in part.

FINDINGS OF FACT

The Board adopts the Referee's Findings of Fact as our own.

CONCLUSIONS OF LAW AND OPINION

Preliminary Matters

ORS 656.283(1) provides that any party may request a hearing on any question concerning a claim. Here, claimant requested a hearing on the issues of entitlement to temporary disability compensation, penalties and associated attorney fees. The Referee, in addition to ordering the reinstatement of claimant's temporary disability benefits and awarding an attorney fee for the unreasonable termination of such benefits, ordered the following:

> "2. The employer shall provide, and claimant shall attend, an inpatient treatment program for substance abuse for such time as required to attain a condition which will permit him to be examined and tested in the manner contemplated by the physicians comprising the Objective Medical Assessment's panel.
>
> 3. Claimant shall not consume alcohol or other intoxicants until completion of an examination designated by the employer.
>
> 4. The employer shall be entitled to again suspend claimant's compensation in the event that claimant refuses treatment, fails to complete treatment or consumes alcohol or other intoxicants from the time he enters the treatment program through the completion of the examination designated by the employer."

We find that: (1) ordering the employer to provide for inpatient treatment program for substance abuse to claimant; (2) ordering claimant not to consume alcohol; and (3) the listing of conditions whereby claimant's compensation could again be terminated are not matters directly concerning the issues presented before the Referee.

Because we find that the Referee exceeded the scope of his authority in ordering the above actions, we conclude that those portions of the Referee's order should be reversed.

Temporary Total Disability

The Referee awarded the reinstatement of claimant's temporary total disability benefits. We agree.

ORS 656.325(1)(a) provides that:

> "[i]f the worker refuses to submit to any such [medical] examination, or obstructs the same, the rights of the worker to compensation shall be suspended with the consent of the director until the examination has taken place, and no compensation shall be payable during or for account of such period."

Here, when claimant presented himself for an independent medical examination, he was intoxicated. Because this was so, the independent medical examination could not adequately be performed.

As a result of claimant's August 8, 1988 independent medical examination, the physicians reported that:

> "[i]n summary, we feel that before [claimant] can be fully assessed for evaluation of permanent or temporary impairment from preexisting and unrelated conditions, he needs to be sober at the time of his evaluation. In addition, any progress in terms of evaluating and treating his 'temporary or permanent disabilities' should be pursued after the patient has gone through an alcohol treatment program and is in a full recovery mode." (Ex. 5-17).

Based on this information, the employer sought and obtained an Order from the Director suspending claimant's temporary disability compensation until such time as claimant could present himself for medical examination in a "state of sobriety."

After claimant agreed to the conditions of the suspension order, the employer determined that claimant's temporary disability benefits would not be reinstated until he "attained" a state of sobriety.

After our de novo review of the record, we find that the suspension order is subject to two reasonable yet opposing interpretations. The critical issue, then, is whether the Director, by requiring a "state of sobriety", intended that claimant "attain" a state of sobriety, or merely intended that claimant present himself for the requisite independent medical examination in a "sober" state.

The independent medical examiner's report indicated that claimant "needs to be sober at the time of his evaluation." The Director issued his suspension order based on this report. Based on a reading of the medical report and the specific language in the suspension order together, we conclude that the correct interpretation of the Director's suspension order is that claimant was required to present himself for the examination in a "sober" state, and that he was not required to "attain" a state of sobriety prior to such an examination.

Consequently, we conclude claimant is entitled to reinstatement of temporary disability compensation.

The Referee ordered the reinstatement of claimant's temporary total disability benefits as of December 1, 1988, the date of the Referee's order. While

we agree that claimant is entitled to reinstatement of his disability benefits, we disagree with the Referee's determination to reinstate the benefits on the date of his order.

The Director's suspension order provided that claimant would again be entitled to temporary disability when he presented himself, in a sober state, to an independent medical examination. Here, however, because the employer's interpretation of the Director's order was that claimant "attain" a state of sobriety, it refused to set up a subsequent independent medical examination, thereby preventing claimant from obtaining temporary disability benefits.

Claimant notified the employer on September 30, 1988 that he would cooperate with the suspension order. Further, he requested that a subsequent independent medical examination be scheduled so that he could cooperate with such order. There is no evidence in the record to establish whether claimant has undergone a subsequent independent medical examination since the date of the suspension order. Because we find that the employer's actions effectively prevented claimant from satisfying the requirements of the suspension order, thereby preventing the reinstatement of his temporary disability benefits, we conclude that claimant is entitled to reinstatement of temporary disability beginning on the date he notified the employer of his willingness to cooperate with the suspension order.

Penalties and Associated Attorney Fees - Unreasonable Delay in Payment of Temporary Disability Benefits

The Referee found that the employer's position "effectively delays, unreasonably, the resumption of claimant's compensation and operates to circumvent the procedures for claim termination." As a result, he awarded claimant's attorney a $500 fee for the employer's unreasonable termination of claimant's temporary disability benefits.

Because we have found that both interpretations of the suspension order were reasonable, we conclude that claimant's attorney is not entitled to an assessed fee based on the alleged unreasonable delay in payment of temporary disability benefits.

ORDER

The Referee's order dated December 1, 1988, is affirmed in part, modified in part, and reversed in part. That portion of the Referee's order which reinstated claimant's temporary total disability benefits is affirmed, except that the effective date of the reinstatement shall be September 30, 1989, rather than December 1, 1989. The Referee's award of a $500 employer assessed fee is reversed. Claimant's attorney is awarded 25 percent of the increased compensation as a result of this order, not to exceed $3,800. For services on Board review on the issue of temporary disability compensation, claimant's attorney is awarded a reasonable assessed fee of $750, payable by the employer. The remainder of the order is affirmed.

April 11, 1990 Cite as 42 Van Natta 848 (1990)

In the Matter of the Compensation of
ELIZABETH A. LAWRENCE, Claimant
WCB Case No. 87-06597
ORDER ON REVIEW
David J. Hollander & Associates, Claimant Attorneys
Stafford J. Hazelett, Defense Attorney

Reviewed by Board Members Gerner and Myers.

The insurer requests review of Referee Heitkemper's order which: (1) continued the hearing, over its objections, to permit claimant to seek and intro

duce additional medical evidence; and (2) set aside its denial of claimant's occupational disease claim for her stress-related psychological condition. On review, the issues are the Referee's procedural ruling and compensability. We reverse.

FINDINGS OF FACT

Claimant was employed at Portland State University, beginning in 1984, as a secretary. Her duties included typing, completing receptionist duties, ordering supplies, and providing information to interested persons.

Claimant's grandmother died in May 1984, several months before claimant began working at the university. Her daughter's father died in November 1985. Her daughter found it difficult to cope with her father's death, and claimant ultimately sought psychological treatment for her daughter. Claimant's sister-in-law died in 1986.

In January 1986, a theft of a large sum of money occurred at claimant's work. An investigation ensued, but was ultimately closed and no suspects were identified. In June 1986, claimant was promoted. In late 1986, claimant was informed that her son had been making obscene phone calls to one of her good friends.

Claimant left work in January 1987 because of depression. She returned to work on February 17, 1987.

She was first treated by Dr. Caldwell, M.D., on January 7, 1987, at which time she complained solely of family related problems. Caldwell referred claimant to Dr. DeBardelaben, clinical psychologist, who treated her from January 1987 through March 1987. Claimant first mentioned work-related stress to DeBardelaben in mid-February 1987.

On March 31, 1987 claimant filed a claim for "job stress" which she alleged occurred February 1, 1987. The insurer denied the claim in April 1987.

In late March, DeBardelaben referred claimant to Dr. Belleville, psychiatrist, for ongoing psychotherapy and continued medication. Dr. Belleville, M.D., had prescribed medication for claimant during her visits with DeBardelaben, and first treated her as a psychologist in April 1987.

In May 1987, Dr. Parvaresh, psychiatrist, completed an independent medical evaluation. In late September 1987, Parvaresh reevaluated claimant.

At the request of claimant, a hearing was scheduled and conducted on October 15, 1987. At hearing, evidence was submitted and both sides rested. Claimant's attorney then requested that the record be kept open to allow the submission of new medical reports which had yet to be completed. The insurer objected to this request, indicating that the reasons for the request were "not extraordinary circumstances that would require the postponement" of the hearing. Regardless, the record was kept open to consider a motion for continuance by claimant's attorney.

A second hearing convened the following day, at the conclusion of which the Referee again kept the record open. About one month later, the Referee declined to order either a continuance or a postponement, and instead, reset the hearing for the taking of additional evidence. During the subsequent January 1988 hearing, claimant submitted new medical evidence which had been prepared after the date of the initial hearing. The Referee closed the record on February 2, 1988.

Belleville reassessed claimant's condition in November 1987, after being provided with a correct psychological history by claimant.

Claimant's work conditions were not the major contributing cause of her current psychological condition.

CONCLUSIONS OF LAW

The insurer has requested review of the Referee's granting of a continuance for the purposes of allowing claimant to submit additional medical evidence. Therefore, we must address the procedural issue prior to an analysis of the merits of claimant's claim.

Procedural Ruling

The Referee granted a continuance in order to allow "any further documentary or live evidence by the claimant; the insurance company's case; followed by argument on both sides." He stated further that "one of the reasons for a continuance deals with the reasons for postponement, and postponement includes reasons that would result in extreme hardship or manifest injustice." Thus, we find that the Referee based the continuance on OAR 438-06-091(4), which provides that the Referee may continue a hearing, "for any reason that would justify postponement of a scheduled hearing under 438-06-081".

OAR 438-06-081 requires that in order to postpone a scheduled hearing, the Referee is required to make a finding of extraordinary circumstances beyond the control of the party or parties requesting the postponement. We find that the Referee failed to make such a finding. Moreover, on de novo review, we do not consider the circumstances surrounding the granting of the continuance to have been either extraordinary or beyond the control of the requesting party. Therefore, we conclude that the continuance was improper.

Because we hold that the continuance was improper, we continue our discussion of the merits of the case based on the record as presented and concluded on October 15, 1987.

Compensability

The Referee found claimant's stress condition compensable, finding that claimant's work conditions were the major contributing cause of her mental condition. We disagree.

Claims for benefits arising out of stress-caused mental disorders are compensable if they flow from objectively existing conditions of the worker's employment and those work conditions, when compared to non-employment conditions, are the major contributing cause of claimant's mental disorder. McGarrah v. SAIF, 296 Or 145, 166 (1983). Claimant's reaction to events need not have been reasonable or rational. If claimant reacted to real events, she has a basis for a stress claim. See Leary v. Pacific Northwest Bell, 67 Or App 766 (1984).

The Referee based his determination of compensability on the principle that "a worker's inability to keep up the pace of the job is real stress." He concluded that the combination of the employer's accusations against claimant for theft and the requirement of overtime to complete claimant's duties, resulted in real stress sufficient to establish that claimant's job related activities were the major contributing cause to her mental condition. We disagree.

The issue is whether claimant's work activities at the university were the major contributing cause of her mental condition. Such an issue represents a complex medical question. Thus, although claimant's testimony may be probative, resolution of the issue turns largely on an analysis of the medical evidence. Uris v. Compensation Dept., 247 Or 420, 426 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985).

The medical evidence, as presented on October 15, 1987, is insufficient to prove that claimant's working conditions at the university were the major contributing cause of her current stress-related psychological condition.

Claimant first sought medical treatment for depression in January 1987 from Dr. Caldwell. However, at that time, she did not complain of any work-related stress. Rather, her complaints centered on family problems associated with her son's obscene phone calls, the recent deaths of several family members, and the inability of her daughter to cope with the death of her father.

DeBardelaben treated claimant from January, following her leave of absence from work for depression, through March 1987. He noted that claimant did not complain of work-related stress conditions until mid-February. It was not until that time that she complained that her work was stressful, and related to DeBardelaben the history of the theft incident which had occurred in early 1986.

Belleville began treating claimant in April 1987. At that time, Belleville opined that "work most probably aggravated and accelerated [claimant's] condition. I believe that she certainly had stresses outside the work place which contributed to her problems and it is difficult for me to say which has the most burden on her."

While Belleville opined that claimant's work aggravated her stress-related condition, he did not indicate that such working conditions were the major contributing cause of her condition until September 1987, after he performed a subsequent reevaluation of claimant. At that time, he reported that "again, the work situation was felt to be the major contributing factor in the development of a condition serious enough to require medical treatment." However, after our review of the medical reports, we find that Belleville had not previously indicated that claimant's work related conditions were the major contributing factor to the development of her mental condition. Moreover, Belleville does not explain the potential impact of claimant's family problems to her current conditions. Therefore, we do not find the opinion of Belleville to be persuasive.

Finally, Parvaresh, who performed an independent medical examination of claimant in May 1987, did not indicate whether claimant's condition was related to work. However, he did report that, "in terms of significance of various stressors you find day-to-day pressure of work ranking far below losses in the immediate family which are by their very nature emotionally quite impacting."

Parvaresh reevaluated claimant in late September 1987. After reviewing claimant's personnel records, his own prior examination, and the prior chart notes of Drs. Caldwell, DeBardelaben and Belleville, he concluded that, "certainly one cannot assign the job per se as the major contributing cause of what psychological problems [claimant] was going through in January, February and March, 1987."

Where the medical evidence is divided, we give more weight to that opinion which is well-reasoned, complete and based on an accurate history. Somers v. SAIF, 77 Or App 259, 262 (1986). After our review of the medical evidence, we find the more well-reasoned opinion of Dr. Parvaresh, which was based on a review of claimant's personnel records, a personal examination and the chart notes of all previous treating physicians, to be more persuasive.

Consequently, we conclude that claimant has failed to meet her burden of proving that her work related activities were the major contributing cause to her mental condition.

ORDER

The Referee's order dated May 16, 1988, is reversed. The insurer's denial of claimant's stress claim is reinstated and upheld. The Referee's $2,000 attorney fee award with respect to the issue of compensability of claimant's stress claim is reversed.

April 13, 1990 Cite as 42 Van Natta 852 (1990)

In the Matter of the Compensation of
ANTHONY B. BEARDSLEE, Claimant
WCB Case No. 88-10474
ORDER ON REVIEW
Donald L. Dickerson, Claimant Attorney
Roberts, et al., Defense Attorneys

Reviewed by Board Members Speer and Howell.

The insurer requests review of Referee Michael Johnson's order that set aside its denial of claimant's claim for injuries sustained in a motor vehicle accident on his way to an independent medical examination (IME). On review the issue is compensability. We reverse.

FINDINGS OF FACT

Claimant filed two workers' compensation claims. One was for back pain in August 1987, and the other for right forearm pain in December 1987. (Ex. 11). The insurer placed the claims in deferred status pending an IME at 3:30 p.m., January 20, 1988, in Portland, Oregon. On January 20, 1988, at approximately 12:30-1:30 a.m., claimant, allegedly on his way to the IME, fell asleep at the wheel and his car went off the road into a ditch. (Tr. 9, 17, 22-24; Ex. 1, 3-1). Claimant did not go to the hospital for medical treatment of his injuries stemming from the car accident until 9:00 a.m., January 20, 1988. (Tr. 24-26). Claimant's mother drove him to Portland and the IME, on January 20, 1988.

On May 25, 1988, a hearing was held pursuant to the insurer's denial of claimant's back strain and forearm strain claims before Referee Nichols. Referee Nichols issued her Opinion and Order upholding the insurer's denials on August 22, 1988. (Ex. 11). No request for review was filed with respect to Referee Nichols' Opinion and Order and it became final by operation of law.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant's injuries from the car accident of January 20, 1988, were compensable because they were sustained while claimant was on his way to an IME for evaluation of injuries allegedly sustained in the course of and arising out of his employment, and that claimant would not have had the accident but for the appointment for the IME. The Referee relied upon the reasoning of Wood v. SAIF, 30 Or App 1103 (1977), and Fenton v. SAIF, 87 Or App 78 (1987). We disagree.

The Wood court held that the worker's injuries sustained while participating in a vocational rehabilitation program following a compensable back injury were compensable. The court referred to Professor Larson's "quasi-course of employment" concept, concluding that, although the worker was engaged in

activities outside the time and space limits of the employment, the activity (vocational training) was a direct and natural consequence of the primary compensable injury. See 1 Larson, The Law of Workmens' Compensation, 3-378, 13.11(d) (1985).

The Fenton court also looked to Larson's "quasi-course of employment" concept and held that when a worker is injured in an accident which occurs during a trip to see a physician for treatment of a compensable injury, the new injury is a compensable consequence of the primary compensable injury.

Larson's "quasi-course of employment" concept derived from problems in applying a "single unified formula" work connection/causation test to situations where consequential injuries are sustained outside of the normal course of employment, but are nevertheless substantially related to the employment because they are necessary or reasonable activities that would not have been undertaken but for a compensable injury. See 1 Larson, The Law of Workmens' Compensation, supra.

Here, there is no relationship between claimant's car accident injuries and any compensable injury or disease. Claimant sustained injuries in a car accident on his way to an IME for purposes of pursuing his workers' compensation claim for conditions subsequently found not to be compensable. We find that the "quasi-course of employment" concept of compensable consequences is inapplicable here because the underlying condition is not compensable. Because there is no proximate causal relationship between claimant's employment and his car accident injuries, claimant's injuries are not compensable.

ORDER

The Referee's order, dated October 14, 1988, is reversed. The insurer's June 15, 1988 denial is reinstated and upheld. The Referee's attorney fee award of $1,400 is reversed. The Board approves a client-paid fee not to exceed $1,368, payable from the insurer to its counsel.

April 13, 1990 Cite as 42 Van Natta 853 (1990)

In the Matter of the Compensation of
CONNIE A. MARTIN, Claimant
WCB Case Nos. 85-06954, 85-00847 & 84-13523
SECOND ORDER DENYING RECONSIDERATION
Donald L. Dickerson, Claimant Attorney
Roberts, et al., Defense Attorneys
Dennis Ulsted (Saif), Defense Attorney
Schwenn, et al., Defense Attorneys

Fire & Casualty Company (F & C) seeks "republication" of our April 6, 1990 Order Denying Reconsideration of our March 7, 1990 Order on Review that affirmed a Referee's order assigning F & C responsibility for claimant's low back condition. We deny the request for lack of jurisdiction.

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. ORS 656.295(8). 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, at the very least, the language of the second order must be specific. See Farmers Insurance Group v. SAIF, 301 Or 612, 619 (1986).

Here, F & C asks that we republish our April 6, 1990 Order Denying Reconsideration in a manner to extend its appeal rights from our March 7, 1990 Order on Review. We are without authority to take such an action.

The April 6, 1990 order expressly denied reconsideration of the March 7, 1990 order. In so doing, we stated that the parties' rights of appeal continued to run from the March 7, 1990 order. Inasmuch as the March 7, 1990 order has neither been appealed, abated, "stayed", nor republished within 30 days of its issuance, it has become final by operation of law. See ORS 656.295(8); International Paper Co. v. Wright, supra; Fischer v. SAIF, supra. Consequently, we lack authority to grant F & C's request.

IT IS SO ORDERED.

In the Matter of the Compensation of
JOSEPH P. MATHIAS, Claimant
WCB Case Nos. 88-03360 & 88-07242
ORDER ON REVIEW
Emmons, et al., Claimant Attorneys
Dennis Martin (Saif), Defense Attorney
Cummins, et al., Defense Attorneys

Reviewed by Board Members Brittingham and Nichols.

Claimant requests review of Referee Daron's order that: (1) upheld CNA Insurance Company's denial of claimant's medical services claim for his current chiropractic treatment for his back; (2) affirmed a Determination Order award of no permanent disability; and (3) dismissed, at claimant's request, his hearing request from a denial issued by the SAIF Corporation. Claimant contends that he is entitled to an attorney fee for evoking the rescission of CNA's "responsibility" denial by means of the withdrawal of his hearing request with SAIF. On review, the issues are medical services, extent of permanent disability, and attorney fees. We reverse in part and affirm in part.

FINDINGS OF FACT

Claimant is a 44-year-old high school graduate. His past work includes fiberglass laminator, construction painter and artist.

Claimant injured his low back on February 2, 1987, pulling a floor jack while employed for CNA's insured, as a light industrial worker. Two weeks later, claimant again injured his low back, while pushing a pallet jack. He filed an injury claim on February 26, 1987.

Claimant began treating with Dr. Burdell, chiropractor, on February 21, 1987. Dr. Burdell released claimant for light duty on March 13, 1987. After a series of exacerbations and resolution of symptoms, claimant's low back condition was medically stationary with no permanent partial disability on July 25, 1987.

In August of 1987 claimant went to work for a new employer, insured by the SAIF Corporation. While working on his own car, after hours, for which he was not being paid, claimant smashed his finger and fainted, injuring his finger, back and neck as he fell. The parties stipulated that this was not a compensable injury.

A Determination Order issued, closing claimant's low back claim with CNA, on September 28, 1987. Claimant was awarded temporary total disability for the period of February 18, 1987 through April 27, 1987 and temporary partial disability from April 28, 1987 through July 6, 1987. No permanent disability was awarded.

On December 3, 1987, Dr. Howell, osteopath, performed an independent medical examination. Dr. Howell found a history of low back muscle strain, which he concluded was medically stationary without permanent disability.

On January 18, 1988, CNA denied the reasonableness and necessity of claimant's current chiropractic treatment and the compensability of his chiropractic treatment during December 1987 on causation grounds. CNA also denied responsibility for claimant's treatment.

Dr. Duncan, chiropractor, examined claimant at the request of CNA, on April 26, 1988. Dr. Duncan concluded that claimant's low back condition was medically stationary; that no additional treatment was required and that claimant's condition has resolved with no loss of function or measurable impairment.

Claimant continued to treat with Dr. Burdell twice monthly from January 18, 1988 until the time of the hearing.

Claimant filed a request for hearing on CNA's January 18, 1988 denial and on the issue of responsibility on March 3, 1988. A supplemental request for hearing on the issue of extent of permanent disability was filed on March 18, 1988. The SAIF Corporation issued denials on April 25, 1988 and May 26, 1988 denying that claimant was a subject worker and the compensability of claimant's right fourth finger and right cheek injuries.

On the day set for hearing, claimant voluntarily withdrew his request for hearing, on the SAIF denials. CNA withdrew its denial of responsibility from its January 18, 1988 denial. Claimant did not raise as an issue an attorney fee for CNA's rescission of its responsibility denial. The Referee dismissed claimant's hearing request concerning SAIF.

CONCLUSIONS OF LAW AND OPINION

MEDICAL SERVICES

The Referee found that claimant had failed to present any persuasive evidence that his chiropractic care between January 18, 1988 (the point at which the denial issued) and August 25, 1988 (the date of the hearing) was causally related to his compensable injury, reasonable or necessary. We agree with that portion of the Referee's order that upholds CNA's January 18, 1988 denial on reasonable and necessary grounds; however, we reject the Referee's causation analysis.

CNA denied claimant's current chiropractic treatment as not being reasonable and necessary and his treatment in December 1987 as not being causally related to his compensable injury. The Referee, however, addressed the chiropractic treatment claimant received between January and August 1988. We disagree with that approach.

The record establishes that, at the time the denial issued, there were outstanding chiropractic bills that had not been paid. We understand CNA's denial not to be prospective, but to have denied medical bills that were outstanding at the time the denial issued. Therefore, we must determine causation

and reasonableness and necessity of claimant's medical services up to the time of the denial.

First we address CNA's denial to the extent that it denied claimant's December 1987 chiropractic treatment on causation grounds. We find that claimant has met his burden of proving the causal connection between his chiropractic treatment with Dr. Burdell in December 1987 and his February 1987 low back injury.

The treatment claimant received for his February 1987 low back injury was a material contributing factor to his need for treatment in December 1987. It is clear from the medical record that Dr. Burdell continued to treat claimant, for his low back condition, on a regular basis even after Dr. Burdell found claimant medically stationary in July 1987.

For claimant's chiropractic treatment to be compensable claimant must prove that his compensable low back condition, was a material contributing cause to his need for the chiropractic care. See Grable v. Weyerhaeuser Co., 291 Or 387 (1981). We find that claimant has met his burden; therefore, we find that claimant's chiropractic treatment during the month of December 1987 was causally related to his compensable injury and we set aside CNA's denial, to the extent it denies causation.

In addition however, claimant need prove the reasonableness and necessity of his chiropractic care. A claimant is entitled to all reasonable and necessary curative or palliative medical care required for a compensable injury. 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). Claimant has the burden of proving that the treatment is reasonable and necessary. McGarry v. SAIF, supra.

On our de novo review of the medical evidence, we are not persuaded that claimant's "current" chiropractic treatments, up to the time of the January 18, 1988 denial were reasonable and necessary. In so finding, we rely upon the well reasoned and persuasive opinions of Drs. Howell and Duncan. See Somers v. SAIF, 77 Or App 259 (1986). Dr. Howell examined claimant on December 3, 1987. He found that claimant's low back condition was medically stationary at that time and opined that further chiropractic treatment was neither reasonable nor necessary. Dr. Duncan examined claimant on April 26, 1988. His opinion supports that of Dr. Howell's in that he concluded claimant's low back condition was medically stationary and opined that further chiropractic care was not reasonable or necessary. We find Drs. Howell and Duncan's opinions persuasive and give them greater weight than claimant's treating physician Dr. Burdell. See Weiland v. SAIF, 64 Or App 810, 814 (1983).

EXTENT OF PERMANENT PARTIAL DISABILITY

The Referee found that claimant did not suffer any loss of earning capacity and therefore affirmed a Determination Order which awarded no permanent disability for a low back injury. We agree

First we address claimant's argument that his unscheduled permanent disability should be rated under the Disability Rating Standards. The Disability Rating Standards are applicable to rating permanent impairment and loss of earning capacity in those cases where the claimant was medically stationary after January 1, 1988 and the claimant's claim was closed after July 1, 1988. ORS 656.727(C). In the instant case, claimant's claim was closed by a Determination Order that issued September 27, 1987. Therefore, the Disability Rating Standards are not applicable to claimant's claim.

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 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 has failed to prove permanent impairment or the existence of any loss of earning capacity attributable to his compensable injury. Claimant's treating physician opined that claimant did not have any permanent impairment as a result of his February 1987 low back injury. In addition, both Drs. Duncan and Howell opined that claimant's low back condition was medically stationary with no permanent disability or loss of function. Moreover, claimant states that he sustained himself through heavy manual labor. Yet, the record does not support that contention. The record reflects that at the time of his February 1987 injury, claimant was working in a light industrial position. Moreover, the record indicates throughout that claimant considered himself primarily an artist and there is no evidence that claimant cannot continue in this capacity nor that he is unable to continue to supplement his income by doing the same type of work he had done prior to his February 1987 low back injury.

Based upon claimant's testimony and the medical evidence, we find claimant has failed to sustain his burden of proving permanent impairment and a loss of earning capacity. Therefore, we affirm the Referee and the Determination Order which awarded claimant no unscheduled permanent disability for his low back injury.

ATTORNEY FEES

Claimant argues that he is entitled to a fee for his services in the rescission of the denial of responsibility immediately prior to the hearing. Claimant did not however raise this issue at hearing. Therefore, the Board is precluded from addressing it at this late date. See Gunther J. Jacobi, 41 Van Natta 1031 (1989); Richard C. Centeno, 41 Van Natta 619, 620 (1989).

ORDER

The Referee's order dated September 23, 1988 is reversed in part and affirmed in part. That portion which upheld CNA's denial of claimant's December 1987 chiropractic treatment as not causally related to his compensable injury is reversed. That portion of the Referee's order that upheld CNA's denial on the basis that the chiropractic treatment was not reasonable and necessary is affirmed. The remainder of the order is affirmed. A client-paid fee, payable from CNA to its counsel, is approved, not to exceed $1,589.50.

In the Matter of the Compensation of
ROGER L. SNIDER, Claimant
WCB Case Nos. 86-16046 & 87-01404
ORDER ON REVIEW
Rasmussen & Henry, Claimant Attorneys
Garrett, et al., Defense Attorneys
Acker, et al., Defense Attorneys

Reviewed by Board Members Crider and Brittingham.

Claimant requests review of Referee Holtan's order which upheld Liberty Northwest Insurance Corporation's denial of claimant's low back injury claim. On review, the issue is responsibility. We reverse.

FINDINGS OF FACT

On May 21, 1985, claimant was working as an "image operator" for the employer, which was then insured by Safeco Insurance Company. On May 23, he filed a form 801 stating that he strained his lower back while moving panels. He sought treatment. When he reported increasing pain, his physician authorized a few days off work. On June 13, 1985, claimant began treating with Dr. McMahon, chiropractor, who again took him off work. The claim was accepted as a disabling injury by Safeco.

Safeco denied chiropractic treatments in excess of the Director's guidelines.

Claimant returned to work December 9, 1985, in a different position.

The claim was closed without permanent disability by Determination Order dated May 30, 1986.

Claimant requested a hearing on the medical services denial and the Determination Order. When the hearing convened, on June 27, 1986, the parties agreed to resolve their dispute on a disputed claim basis. Safeco alleged that claimant had obtained acceptance of the injury by fraud, misrepresentation, or other illegal activity. Claimant contended that the injury was compensable. The parties stipulated that Safeco would pay certain medical bills and pay claimant a lump sum in exchange for an agreement that claimant would lose all rights in the claim on a disputed claim basis. The request for hearing was dismissed pursuant to the stipulation.

Claimant continued working for the employer. The employer changed workers' compensation insurers from Safeco to Liberty Northwest.

On September 2, 1986, claimant reported that he had slipped on a wet rubber mat and fell on his back while carrying a load of panels. He again sought chiropractic treatment. A form 801 was filed.

Claimant advised Liberty Northwest's investigator, on November 20, 1986, that he had suffered a previous back injury in 1985 while at work.

On January 7, 1987, Liberty Northwest denied responsibility for claimant's back condition, saying:

> "At this time, we are unable to accept responsibility of your present back condition as there is insufficient medical evidence indicating that there has been a material worsening of her [sic] underlying condition. Therefore, we feel Safeco Insurance Company is

> the responsible carrier for your present back symptoms.
>
> This denial is for responsibility only. We are not denying the compensability of your present back condition. In the event that Safeco Insurance Company also denies responsibility, we will write to the Workers' Compensation Department requesting that they designate a paying agent under ORS 656.325 and OAR 436.60."

Liberty Northwest did request a paying agent. However, on January 20, 1987, Safeco denied the compensability of the claim on the basis of the June 1986 disputed claim settlement. Consequently, the Department declined to issue a .307 order. Claimant requested a hearing, specifying as issues both the Liberty Northwest and the Safeco denials. The cases were consolidated.

Safeco moved for an order dismissing the request for hearing concerning the Safeco denial on the basis of the disputed claim settlement. Apparently, neither claimant nor Liberty Northwest opposed the motion. The Referee dismissed the request for hearing, leaving Liberty Northwest the only insurer. (Tr. 1.)

At hearing, the Referee stated the issues as follows:

> "As I understand it, the sole issue today is the January 7, 1987, Denial of responsibility for a low-back condition or injury with a date of injury of September 2, 1986."

Counsel for Liberty Northwest agreed, stating that, "[w]e are not denying compensability, just responsibility.... True, there may be a new incident, but there has been no 'new injury', and that for that reason, the Denial should be affirmed and Liberty should not be held responsible." (Tr. 23-24.)

Throughout the hearing, claimant's attorney objected to questions eliciting testimony addressed to the question of compensability and Liberty Northwest continued to maintain that the issue was responsibility only. Liberty Northwest never sought to amend its denial or to raise the issue of compensability.

FINDINGS OF ULTIMATE FACT

Liberty Northwest has conceded the compensability of claimant's back condition. No other insurer has been joined in this proceeding.

CONCLUSIONS OF LAW AND OPINION

The Referee upheld Liberty Northwest's denial of responsibility on the ground that claimant had failed to prove a new injury. He held that Liberty Northwest's denial was a "de facto" denial of compensability by virtue of the dismissal of Safeco. Nevertheless, rather than requiring that claimant simply prove that the 1986 incident was a material contributing cause of claimant's condition, he placed the burden on claimant to prove that the 1986 incident independently contributed to a worsening of claimant's condition. He thus required claimant to establish not only a symptomatic worsening, but also a pathological worsening. In other words, while construing the denial as a compensability denial, he upheld the denial because claimant had failed to prove facts relevant only to assignment of responsibility.

On review, Liberty Northwest asserts that to establish a "new injury" claimant must prove that the 1986 incident materially contributed to a worsening of his preexisting back condition. We disagree.

This case is one of responsibility only. Liberty Northwest's written denial denied responsibility and expressly conceded compensability. Liberty Northwest never sought to amend the denial. Liberty Northwest never sought to raise the issue of compensability, even after it became aware that the 1985 injury was not compensable by virtue of the disputed claim settlement.

OAR 436-60-140(4) requires that when an insurer denies a claim, it must do so in a writing which states the factual and legal basis for the denial. We have held that the insurer's denial frames the issues for hearing, and that an insurer may not deny on one basis and then seek to raise another at hearing. Patricia N. Hall, 40 Van Natta 1873 (1988). See also, Runft v. SAIF, 303 Or 493, 496, n.1 (1987). And even more surely, an insurer may not deny on one basis, proceed at hearing on that basis and then, after hearing, raise a new basis of denial. See Edward A. Rankin, 41 Van Natta 1926, on recon, 41 Van Natta 2133 (1989). Thus, Liberty Northwest can defend this case solely on the basis of responsibility.

When the only issue is responsibility, a claimant is entitled to compensation. The only issue is which insurer will pay. The insurers may introduce evidence establishing that one or the other is responsible, but claimant has no burden whatever. Boise Cascade Corporation v. Starbuck, 296 Or 238 (1984); Bracke v. Baza'ar, 293 Or 239 (1982). Inasmuch as Liberty Northwest has joined no other insurer, it cannot avoid responsibility by proving that exposure while it was on the risk did not independently contribute to a worsening of claimant's back condition. See Runft v. SAIF, supra.

The Referee declined to apply this rule for policy reasons. He felt that to hold that Liberty Northwest is responsible as a matter of law might encourage an insurer to "dispute out" a claim while leaving another insurer "holding the bag." The Referee's concern is serious. However, the law does not permit this. If claims are filed against two insurers, both have conceded compensability but denied responsibility, and a .307 order has issued, no settlement can be entered between claimant and an insurer unless the other insurer is a party as well. J. C. Compton Company v. DeGraff, 52 Or App 317 (1981).

Nor is an insurer necessarily "left holding the bag" in the somewhat different situation presented here, where the 1985 injury was noncompensable by virtue of a prior disputed claim settlement to which it was not a party. Liberty Northwest could have contended with that fact by denying compensability. It failed to do so. We are not free to hold it harmless for that error by requiring claimant to prove that a concededly compensable claim is work-related or to prove that the 1986 injury, which occurred when Liberty Northwest was on the risk, did not independently contribute to disability that occurred at some previous time and for which no other insurer is responsible.

For these reasons, we must set aside the denial.

ORDER

The Referee's order dated April 28, 1988, is reversed. Liberty Northwest Insurance Corporation's denial is set aside and the claim is remanded to Liberty Northwest for processing according to law. For services at hearing and on review, claimant's attorney is awarded $2,500, to be paid by Liberty Northwest. The Board authorizes a client-paid fee, not to exceed $825, payable by Liberty Northwest to its counsel.

In the Matter of the Compensation of
JEROME S. ANDRE, Claimant
WCB Case No. 88-15523
ORDER ON REVIEW
David R. Nepom, Claimant Attorney
Davis & Bostwick, Defense Attorneys

Reviewed by Board Members Cushing and Gerner.

The insurer requests review of Referee Podnar's order which increased claimant's unscheduled permanent disability by 18 percent (57.6 degrees) for a left shoulder condition, whereas a Determination Order had awarded no additional unscheduled permanent disability beyond the 40 percent (128 degrees) previously awarded. On review, the issue is extent of unscheduled permanent disability. We reverse.

FINDINGS OF FACT

Claimant compensably injured his right shoulder, right ankle and cervical spine in a dump truck accident on July 27, 1982. He underwent bilateral thoracic outlet rib resection surgery and right rotator cuff repair surgery. His claim was closed by Determination Order on November 5, 1985 which awarded 20 percent unscheduled disability and 10 percent scheduled disability for loss of use or function of his right foot (ankle). An August 22, 1986 stipulation awarded claimant an additional 20 percent unscheduled disability, for a total of 40 percent unscheduled permanent disability, and an additional 10 percent scheduled disability for a total of 20 percent scheduled permanent disability.

Claimant's claim was reopened for aggravation in 1986 for a left shoulder condition. Claimant underwent a left shoulder surgery, distal clavicle resection, in January of 1987. (Ex. 9A). His claim was again closed by Determination Order dated June 23, 1987 which awarded no additional permanent disability. Claimant appealed this order and resolved all but the extent of permanent disability issue and mileage reimbursement by stipulation dated May 18, 1988, and "reserved" the extent of disability issue because claimant's claim was again open due to aggravation. (Ex. 11). Claimant did not re-request a hearing on the June 23, 1987 Determination Order before the one year period in which to appeal had expired.

Claimant's claim was again reopened effective July 1987 for additional diagnostic studies including arthrography. Claimant's later aggravation claim was closed by Determination Order dated August 30, 1988 which awarded additional scheduled permanent disability but did not award any additional unscheduled permanent disability. Claimant timely appealed the August 30, 1988 Determination Order.

FINDINGS OF ULTIMATE FACT

Claimant's injury conditions, including the left shoulder condition, have not worsened since the May 18, 1988 stipulation.

CONCLUSIONS OF LAW AND OPINION

Both the parties and the Referee operated under the mistaken notion that the issue of extent of permanent disability arising from the appeal of the June 23, 1987 Determination Order was a justiciable issue at hearing. It was not. That issue had become final by operation of law when the parties failed to reappeal the Determination Order within the time limits prescribed by former ORS 656.319(4). The parties' attempt to "reserve" the issue was not effective to preserve the issue for later adjudication without a timely appeal of the

Determination Order. Claudia I. Hamilton, 42 Van Natta 600 (1990); David L. Mallette, 38 Van Natta 843 (1986).

Since the May 18, 1988 stipulation resolved temporary disability issues arising from the June 23, 1987 Determination Order, it is the last arrangement of compensation for the purposes of determining a worsening of disability. ORS 656.273.

The Referee, in awarding additional unscheduled permanent disability to claimant, resorted to the Director's standards to determine the increased impairment from the distal clavicle resection surgery to claimant's left shoulder. Reasoning that this surgery had not happened by the time of the last arrangement of compensation as both he and the parties understood it (i.e. the August 22, 1986 stipulation), the Referee awarded claimant the additional impairment for the surgery and loss of ranges of motion. However, since we have found that the last arrangement of compensation was the May 18, 1988 stipulation, and since the surgery occurred before this time, claimant is entitled to additional compensation only for a worsening since that time. Stepp v. SAIF, 304 Or 375 (1987). We conclude claimant has failed to meet his burden of proof.

Claimant testified to increased pain since August 1986. (Tr. 23-25). This testimony is not probative to establish a worsening since April 1988. The latest claim reopening was to allow additional diagnostic studies, including an arthrogram. This test was performed on April 21, 1988. There is no indication that claimant's impairment increased during the open period and no indication that it permanently worsened. Therefore, we conclude that claimant's condition has not worsened and that he is not entitled to have his claim reevaluated under the standards to determine entitlement to additional compensation. Stepp, supra.

ORDER

The Referee's order dated January 5, 1989 is reversed. The August 30, 1988 Determination Order is reinstated and affirmed in its entirety. The appeal from the June 23, 1987 Determination Order is dismissed as untimely. The Board approves a client-paid fee, not to exceed $845.50, payable from the the insurer to its counsel.

April 16, 1990 Cite as 42 Van Natta 862 (1990)

In the Matter of the Compensation of
ROBERT R. BROWN, Claimant
WCB Case No. 88-15039
ORDER ON REVIEW
Cynthia L. Barrett, Claimant Attorney
Schuyler T. Wallace, Jr., Defense Attorney

Reviewed by Board Members Gerner and Myers.

Claimant requests review of Referee Podnar's order which upheld the insurer's denial of his claim for a left knee injury. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

Claimant is a 47 year old retail sales representative at a lumber yard. On June 23, 1988, he took a call from a customer who wanted to know where his load of lumber was. In order to assist the customer, claimant went out into the lumber yard and asked two drivers about the load. About that time a work glove

flew through the air and struck claimant. Claimant picked up the glove, threw it back, and exchanged words with the thrower of the glove.

Moments after throwing the glove, claimant began to run towards a pile of lumber. A co-worker, Warren "Butch" Hansen ran after claimant. Thereafter, both claimant and Hansen became entangled while jumping the pile of lumber and ended up on the ground. Following the incident, claimant's supervisor had a conversation with claimant and Warren and both admitted to "horsing around."

Claimant continued to work the balance of his shift, but his left knee began to swell. He did not work for several days and then returned to light duty. He was unable to continue on light duty and was again taken off work. The injury to his left knee ultimately resulted in surgery.

Claimant's supervisor had been transferred to the lumberyard in order to slow down horseplay among other duties. He had reprimanded claimant in the past for verbal indiscretions.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant's left knee injury did not arise out of nor was in the course and scope of his employment. We agree.

In Rogers v. SAIF, 289 Or 633 (1980), the Supreme Court adopted a unitary "work-connection" approach which poses that following question: "Is the relationship between the injury and the employment sufficient that the injury should be compensable?" Id. at 642. In applying this approach, it is first necessary to determine whether the injury occurred while claimant was at work or engaged in a work-related activity, taking into consideration time, place, and circumstances surrounding the injury. Phil A. Livesley Co. v. Russ, 296 Or 25, 29 (1983). There must also be a showing that a causal link exists between the occurrence of the injury and a risk connected with the particular employment. Id. at 29.

In the instant case, when claimant threw back the glove and started speaking to Warren, he was engaged in horseplay. Thereafter, Warren chased claimant and both attempted to jump a pile of lumber which resulted in claimant's left knee injury. This activity did not benefit the employer. Further, it was not an activity that was contemplated as part of claimant's job duties at the time he was hired. Claimant, however, was paid his normal salary on the day he was injured.

While the injury did occur at work, it cannot be said that claimant was engaged in a work-related activity. Further, the employer, rather than acquiescing to this type of behavior was actively engaged in a program to keep this type of activity under control. The employer did not condone this type of behavior and in fact both claimant and Warren admitted that they were "horsing around." As such, there is no causal relationship between claimant's injury and a risk connected with his employment.

The only connection between claimant's injury and his employment is the fact that the injury occurred while he was at work and was paid his normal salary on the day in question. These factors are not sufficient to make the injury compensable. Rogers, supra. Accordingly, claimant's injury did not arise out of nor was in the course and scope of his employment.

ORDER

The Referee's order dated December 19, 1988, is affirmed. A client-paid fee, not to exceed $991.50, is approved, payable by the insurer to its counsel.

In the Matter of the Compensation of
DUANE FRESH, Claimant
WCB Case Nos. 88-12216 & 88-12217
ORDER DISMISSING REQUEST FOR REVIEW
Westmoreland & Shebley, Claimant Attorneys
Williams, Zografos & Peck, Defense Attorneys
Julia Philbrook (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

Claimant requests review of Referee Peterson's order that upheld the SAIF Corporation and the self-insured employer's denials of his occupational disease claim for a bilateral carpal tunnel syndrome condition. We conclude that the Referee lacked jurisdiction to hear claimant's hearing requests. Accordingly, we vacate the Referee's order and dismiss claimant's requests for hearing.

FINDINGS OF FACT

The self-insured employer (GAB) denied claimant's carpal tunnel syndrome condition claim on October 6, 1987, on the basis that the claim was not timely filed. Claimant challenged the denial by filing a request for hearing dated October 23, 1987. On February 1, 1988, GAB amended its denial by denying compensability and responsibility. Claimant filed a new request for hearing on February 2, 1988.

Upon motion of GAB, SAIF was ordered joined in the proceedings pursuant to the October 23, 1987, and February 2, 1988, requests for hearing. On April 7, 1988, SAIF denied compensability and responsibility for claimant's condition. Claimant challenged SAIF's denial by filing a request for hearing dated April 15, 1988.

The parties appeared for a hearing on May 5, 1988, before Referee Leahy. Because the Referee was related to a principal of one of the parties, claimant did not wish to proceed and, on May 13, 1988, Referee Leahy entered an order directing that the pending requests for hearing be reset. Rather than being reset for hearing, the hearing requests filed October 23, 1987, February 2, 1988 and April 15, 1988, were dismissed without prejudice by a June 2, 1988 order. That order became final without a request for review having been filed.

On July 14, 1988, claimant filed another request for hearing contesting the GAB denial letters issued October 6, 1987 and February 1, 1988. On that same date, claimant filed another request for hearing contesting SAIF's April 7, 1988 denial. GAB and SAIF subsequently moved for dismissal of claimant's hearing requests on the grounds of untimeliness. On September 26, 1988, Referee Peterson issued an Order Denying Dismissal, reasoning that claimant had filed his requests for hearing within the 180-day good cause period.

At hearing, the SAIF attorney agreed that the issue of untimely request for hearing was being waived. SAIF agreed to proceed on the merits of the case.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant's condition was not compensable; he therefore concluded that he was not required to decide the issues of responsibility or timeliness of the requests for hearing. SAIF and GAB contend that the Referee had no authority to hear claimant's case if the requests for hearing were not timely. We agree.

It is our duty to raise a want of jurisdiction on our own motion. See Southwest Forest Industries v. Anders, 299 Or 205 (1985).

ORS 656.319 provides that:

> "(1) With respect to objection by a claimant to denial of a claim for compensation under ORS 656.262, a hearing thereon shall not be granted and the claim shall not be enforceable unless:
>
> (a) A request for hearing is filed not later than the 60th day after the claimant was notified of the denial; or
>
> (b) The request is filed not later than the 180th day after notification of denial and the claimant establishes at a hearing that there was good cause for failure to file the request by the 60th day after notification of denial."

At the outset, we find that, although SAIF's attorney attempted to waive the issue of untimely request, the provisions for timely request for hearing are statutory and cannot be waived.

Claimant's July 14, 1988 request for hearing was filed over 180 days after GAB's first denial of October 23, 1988. Claimant's hearing request is also over 60 days past GAB's amended denial of February 2, 1988, and SAIF's denial of April 7, 1988.

On de novo review, we find that claimant has not provided any evidence of good cause for failure to file his request by the 60th day after notification of denial. Therefore the requests for hearing were untimely. The Referee did not have authority to address the merits of the claims. Sweeden v. City of Eugene, 95 Or App 577 (1989). Accordingly, claimant's requests for hearing and request for review must be dismissed.

ORDER

The Referee's order dated November 2, 1988 is vacated and claimant's July 14, 1988 requests for hearing are dismissed. Claimant's request for review is dismissed. A client-paid fee paid by the self-insured employer to its attorney, not to exceed $1,559.75, is approved.

April 16, 1990 Cite as 42 Van Natta 865 (1990)

In the Matter of the Compensation of
DAVID F. GRANT, Claimant
WCB Case No. 86-13821
ORDER ON REVIEW
James B. Griswold, Claimant Attorney
Stafford J. Hazelett, Defense Attorney

Reviewed by Board Members Cushing and Gerner.

Claimant requests review of Referee Mulder's order which upheld the insurer's denial of claimant's injury claim for a back condition. Claimant also challenges the Referee's evidentiary ruling concerning the admissibility of claimant's wife's testimony and seeks remand to the Referee for the taking of

additional evidence. The insurer moves to strike that portion of claimant's reply brief which addresses claimant's request for remand. On review, the issues are remand, evidence and compensability. We deny the motion to remand and affirm.

FINDINGS OF FACT

Claimant injured his knees, back and right shoulder in a noncompensable motorcycle accident in May 1983. In May 1985, claimant suffered a work-related eye injury. Sometime in June or July 1986, claimant was involved in another noncompensable motorcycle accident.

Claimant contends that on Monday, July 14, 1986, he strained his back while baling and lifting bundles of bags. He did not report the injury to the employer. He did complete his shift. The next day, claimant phoned his treating physician, Dr. Reynolds, and reported "severe back and leg pain - started yesterday. Unable to stand or sit for very long. Hasn't injured himself that he knows of." Reynolds saw claimant that day, diagnosed lumbosacral sprain and released him from work. Claimant then saw Dr. Burgermeister, M.D., who noted "no sign of acute injury or degenerative changes." Later that week, Reynolds referred claimant to Dr. Schmidt, neurologist.

On July 21, 1986, claimant reported to Schmidt that "approximately 10 days ago he was standing in the yard when he developed low back pain which caused him to quit working." Claimant continued by reporting that one week later, "after shopping," he suffered "severe pain from the buttock down to the foot" while getting into his car.

The following day, claimant submitted a claim form indicating that he had strained his back "baling and lifting bundles of bags." In late July 1986, the employer, in completing its portion of the claim form, indicated that it was "unknown" whether claimant's injury occurred in the "course of employment."

In August 1986, Reynolds completed a form 827, by checking the box indicating that claimant's injury was "work related." Schmidt also reported that claimant "strained [his] back while baling and lifting bundles of bags." That same month, Dr. Wade, M.D., evaluated claimant and diagnosed a herniated disc.

On September 2, 1986, the insurer denied claimant's claim for his back strain injury. Claimant requested a hearing.

At hearing, claimant requested that the record be left open to allow his wife to testify. Over objection, the Referee kept the record open, limited the scope of such testimony, and sustained the insurer's objection regarding the scope of such testimony.

In September 1986, claimant was evaluated by a referral physician, Dr. Franks, M.D.. Claimant indicated to Franks that he had injured his back on July 11, 1986, while "lifting and twisting pallets." Franks recommended disc surgery. Schmidt performed disc surgery on claimant in late September 1986.

FINDINGS OF ULTIMATE FACT

Claimant is not credible based on inconsistencies in the record.

The Referee did not abuse his discretion by denying claimant's request to allow the entirety of the wife's testimony into the record.

Claimant has failed to show that material evidence was not obtainable with due diligence at the time of the hearing.

Claimant failed to meet his burden of proving that his work activity was a material contributing cause of his disability or need for medical services.

CONCLUSIONS OF LAW AND OPINION

Evidentiary Issue

A Referee "may continue a hearing * * * [u]pon a showing of due diligence if necessary to afford reasonable opportunity for the party bearing the burden to obtain and present final rebuttal evidence * * *." OAR 438-06-091(3). Here, the Referee allowed a continuance due to the unavailability of a witness.

Claimant's wife was unable to appear at hearing due to a recent surgery. Consequently, claimant requested that the record be left open for the specific purpose of allowing her testimony concerning claim forms. Over objection, the Referee allowed the record to be left open, limited the testimony he would consider, and sustained the insurer's objection to any evidence beyond questions regarding claim forms. As a result, the Referee rejected testimony as to the date and circumstances regarding a prior motorcycle accident. Claimant argues that the Referee abused his discretion by refusing to permit this evidence to be entered into the record. We disagree.

OAR 438-06-091(3) is couched in permissive language and contemplates that the exercise of authority to continue a hearing rests within a Referee's discretion. Sue Bellucci, 41 Van Natta 1890 (1989); see Randy L. Kling, 38 Van Natta 1046 (1986). Further, ORS 656.283(7) provides that ". . . the referee is not bound by common law or statutory rules of evidence . . . ."

Here, at the end of the hearing, claimant requested a continuance so that his wife could testify as to the date and other matters concerning the relevant claim forms. Because the Referee found claimant's wife unavailable to appear at hearing, the Referee granted a continuance for the sole purpose of testimony regarding the claim forms. At the subsequent hearing, claimant's attorney sought not only rebuttal testimony regarding the claim forms, but also testimony as to other issues in the case.

Under the circumstances, we conclude that the Referee did not abuse his discretion by denying claimant's request to allow the entirety of the wife's testimony into the record. "Substantial justice" was served. See ORS 656.283(7).

Remand

In his brief, claimant also requests remand to the Referee "to allow claimant to present all his evidence." The insurer subsequently moved to strike the remand portion of claimant's brief. While we do take notice of the motion to strike, we do not address the motion specifically because of our decision concerning the remand request. We do, however, address the request for remand.

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). Claimant attempted to present evidence which was beyond the scope allowed by the Referee. However, the Referee, as we have found, reasonably limited the scope of claimant's wife's testimony. There is no other evidence which claimant seeks to introduce. Likewise, we find that the evidence which claimant seeks to introduce into the record upon remand is not "material evidence" as to the compensability of claimant's back condition. Therefore, under the circumstances, we conclude that remand is not appropriate in this instance. Consequently, the request for remand is denied.

Compensability

The Referee found that claimant's "credibility/reliability [was] sufficiently eroded so that he has not proven his claim." The Referee indicated that there were "too many inconsistencies and omissions to overlook." The Referee further indicated that "[t]o the extent the medical evidence concludes that claimant suffered a compensable injury or condition, the above findings and conclusions attenuate that medical opinion." As a result, the Referee upheld the insurer's denial of claimant's back injury claim. We agree.

To establish the compensability of an injury claim for a back condition, claimant has the burden of proving that his work activity was a material contributing cause of his disability or need for medical services. See Harris v. Albertson's, Inc., 65 Or App 254, 256-57 (1983). "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).

When credibility findings have been based on claimant's demeanor, the court defers to the credibility findings of the Referee. Coastal Farm Supply v. Hultberg, 84 Or App 282 (1987); Humphrey v. SAIF, 58 Or App 360, 363 (1982). However, when the Referee's credibility finding is based on the substance of the witness' testimony, rather than the witness' demeanor, we are equally capable of assessing credibility. Hultberg, at 285.

Here, the Referee found that there were enough inconsistencies in the record to conclude that claimant is not credible. We agree.

Claimant has given inconsistent dates of injury (See Exs. 5, 6, 10, 14 and 23); inconsistent places/mechanics of injury (See Exs. 10, 15, 17 and 23); and inconsistent reports of time of injury (See Exs. 14, 15, Tr. 18, Tr. 35-36). Further, there is conflicting evidence concerning a motorcycle accident which claimant was involved in prior to his current injury (See Tr. 17 and 30). These inconsistencies and variances are material. We conclude that claimant is not credible because of the above inconsistencies and because his testimony is contradicted by the credible testimony of other witnesses. Therefore, we conclude that claimant has failed to establish an injurious event occurred within the course and scope of his employment on July 14, 1987.

Assuming, arguendo, that an incident did occur on July 14, 1987, we do not believe claimant has established a compensable injury because there is no persuasive evidence to establish that his disability and need for medical treatment is causally related to such an incident.

The Referee concluded that "to the extent the medical evidence concludes that claimant suffered a compensable injury or condition, the above findings and conclusions attenuate that medical opinion." While we agree that claimant is not credible, we do not find, after our de novo review of the record, that there is any medical evidence which establishes that claimant suffered a compensable injury or condition.

Claimant's back condition was treated by two physicians, Drs. Reynolds and Schmidt, neither of which persuasively opine that claimant's work activities were a material cause of his current back condition.

Reynolds, claimant's family practitioner, after being asked whether claimant's work was a material contributing cause of the herniated disc, reported that, "the history is not completely clear as to whether [claimant's condition] was immediately and directly related to [his] work activities."

Reynolds concluded that claimant's type of work "could . . . be a major contributing cause to the herniation of his disc . . ." (Ex. 28). We find Reynold's opinion to be of little weight, given his use of the term "could," which connotes possibility not probability. Gormley v. SAIF, 52 Or App 1055, 1060 (1981).

Further, while Schmidt treated and performed surgery on claimant, at no time did he make a determination as to whether claimant's current condition was work related. Even if he had, we would question the persuasiveness of such an opinion given Schmidt's inconsistent reports of the mechanics of claimant's injury.

Schmidt's first report noted that, "approximately 10 days ago [claimant] was standing in the yard when he developed low back pain which caused him to quit working . . . ." Several weeks later, Schmidt reported that claimant had injured his back while "lifting." However, in the surgical report in late September 1986, Schmidt again reported that claimant had injured himself while working in the yard. Because of Schmidt's inconsistent reporting of the mechanics of claimant's alleged injury, we do not find his opinion to be persuasive.

Consequently, there is no persuasive medical evidence to establish that claimant's work activities on the date in question were a material contributing cause of his current back condition.

ORDER

The Referee's order dated January 26, 1988, is affirmed.

April 16, 1990 Cite as 42 Van Natta 869 (1990)

In the Matter of the Compensation of
BLAINE M. JONES, Claimant
WCB Case No. 88-08226
ORDER ON REVIEW
Peter O. Hansen, Claimant Attorney
Joseph McNaught (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

Claimant requests review of Referee Knapp's order which: (1) declined to grant permanent total disability; (2) increased claimant's unscheduled permanent disability for a back injury from 15 percent (48 degrees), as awarded by a Determination Order, to 60 percent (192 degrees); (3) adjusted claimant's temporary total disability rate; and (4) granted the SAIF Corporation's request for an offset for overpaid temporary disability benefits. On review, the issues are temporary total disability rate, extent of permanent disability, including permanent total disability and offset. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following supplementation.

Vocational assistance began in June 1988. (Ex. 32). Claimant indicated to the vocational counselor that he was willing to seek employment in the Pendleton, Walla Walla and Milton-Freewater areas. (Ex. 32; Tr. 61, 62). The vocational counselor arranged for one job interview for claimant for a job opening as a motel clerk that had physical requirements that claimant could not meet

and which had already been filled. (Tr. 42 & 43). The counselor anticipated other job opportunities could become available. (Tr. 102, 123, 124, 126, 128, 129).

CONCLUSIONS OF LAW AND OPINION

Extent of Disability

To establish permanent total disability, claimant must prove that he is unable to regularly perform work at a gainful and suitable occupation. ORS 656.206(1)(a); Harris v. SAIF, 292 Or 683, 695 (1982); Wilson v. Weyerhaeuser, 30 Or App 403 (1977). Permanent total disability may be established through medical evidence of physical incapacity or through the "odd-lot" doctrine under which a disabled person may be permanently disabled due to a combination of medical and nonmedical disabilities, which effectively foreclose him from gainful employment. Welch v. Banister Pipeline, 70 Or App 699, 701 (1984).

Claimant is not entitled to a permanent total disability award if he is capable of regularly performing at least part-time work. Georgia-Pacific Corp. v. Perry, 92 Or App 56, 58 (1988); Hill v. SAIF, 25 Or App 697, 701 (1976). Claimant's attitude toward returning to work may be relevant in determining whether claimant "is excluded from employment by his own will rather than by that of employers." Wilson v. Weyerhaeuser, supra.

The Western Medical Consultants report that claimant's "total impairment is in the upper range of moderate. He appears capable of working only in a relatively sedentary capacity with ability to sit or get up and stand as necessary for comfort." (Ex. 33-3).

The Referee found claimant and his witnesses credible. Claimant and his witnesses describe claimant's condition/disabling pain as preventing him from regularly performing even part-time work. Claimant spends 6-8 hours a day in a reclining chair in order to relieve himself of constant pain. On good days with assistance he can perform minimal activity for short periods of time. Claimant's treating physician, Dr. Smith, M.D., orthopedic surgeon, concurs with claimant's perception of his physical limitations/capacity. (Ex. 29 c-2). Dr. Smith stated that claimant could not "sit for (an 8-10 hour day) even if it were broken up into short stretches." (Ex. 31). Further, Dr. Smith reported that he did not feel that claimant could perform the job duties of regular employment. (Ex. 29, c-2).

Vocational assistance has been unsuccessful in finding suitable and gainful employment for claimant. The vocational counselor only speculates as to job availability. Job availability cannot be based on speculation. The only job the vocational counselor found, for which claimant interviewed, was inappropriate considering claimant's physical limitations. We find that claimant demonstrates a motivation to work, has made reasonable efforts to find work, but that his physical limitations are such as to substantially minimize his labor market.

We find that claimant's physical impairment, in combination with nonmedical factors, such as his age, education, work experience, adaptability to nonphysical labor, mental capacity and emotional conditions effectively foreclose him from gainful employment and that he is permanently totally disabled. See Clark v. Boise Cascade Corp., 72 Or App 397, 399 (1985).

Temporary Total Disability and Offset

The Referee found that because claimant was "regularly employed" the statute controlled the calculation of claimant's temporary total disability rather than the director's rules. We disagree.

ORS 656.210(2)(a) provides the method by which a disabled worker's "weekly wage" and resulting temporary total disability compensation rate are computed unless the worker is not "regularly employed" or the worker is paid on a basis other than a daily or weekly wage. ORS 656.210(2)(c). In cases such as this, where the worker is regularly employed but paid an hourly wage, computation of a weekly wage and temporary total disability rate is controlled by rules adopted by the director. ORS 656.210(2)(c); Lowry v. Dulog Inc., 99 Or App 459 (1989).

Because claimant was paid by the hour, rather than by the day or week, and worked on an on-call basis, his benefits are properly computed pursuant to OAR 436-60-020(7)(a), based upon the average of his earnings in the 26 weeks prior to his date of injury. That is apparently the method SAIF used when it recalculated claimant's temporary total disability rate. If so, it is not entitled to adjust that rate and is not entitled to an offset for overpaid temporary total disability.

Claimant contends that he should be paid temporary total disability based upon availability for work. As noted above, the rule controls and provides to the contrary.

ORDER

The Referee's order, dated October 27, 1988, is reversed. Claimant is awarded permanent total disability, effective August 9, 1988. The SAIF Corporation is entitled to offset permanent partial disability benefits paid after that date against permanent total disability benefits granted by this order. Claimant is entitled to temporary total disability based upon a weekly wage computed by averaging his earnings over the 26 weeks prior to the date of injury. SAIF's request for an offset for overpaid temporary total disability is denied. 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 $6,000.

April 16, 1990 Cite as 42 Van Natta 871 (1990)

In the Matter of the Compensation of
JULIE MAYFIELD, Claimant
WCB Case No. 88-15545
ORDER ON REVIEW
Black, Chapman & Webber, Claimant Attorneys
Beers, Zimmerman & Rice, Defense Attorneys

Reviewed by Board Members Gerner and Myers.

The insurer requests review of Referee Mongrain's order which dismissed claimant's request for hearing without prejudice. On review, the insurer contends that the request for hearing should have been dismissed with prejudice. We affirm.

FINDINGS OF FACT

Claimant requested a hearing on September 7, 1988. In her specification of issues, she checked spaces next to "MEDICAL SERVICES ORS 656.245" and "PENALTIES AND ATTORNEY FEES." In the space for explanations, claimant indicated that the medical services claim related to a surgery request and that the penalty and fee claim related to unreasonable "de facto" denial of surgery.

Hearing was scheduled for December 5, 1988. On December 2, 1988 claimant's attorney wrote to the Referee requesting dismissal of the request for hearing without prejudice. The Hearings Division received the motion on December 5.

The hearing convened on December 5, 1988. Claimant's attorney, the insurer's attorney and the Referee were present. Claimant was not. Claimant's attorney reiterated his motion to dismiss without prejudice. The insurer's attorney opposed the motion, arguing that the dismissal should be with prejudice.

The parties agreed that the insurer had never formally denied the surgery request.

The insurer also contended that the request for hearing should be dismissed because claimant had failed to appear at hearing. Claimant's attorney represented that claimant did not appear due to illness.

The Referee stated on the record that he would dismiss the request for hearing as to the penalty and attorney fee issue with prejudice, but would dismiss the request for hearing as to the medical services issue without prejudice. On December 15, 1988, the Referee issued an order dismissing the request for hearing without prejudice as to all issues. The Referee made the alternative finding that claimant had established sufficient justification for a postponement because she was ill at the time scheduled for the hearing.

CONCLUSIONS OF LAW AND OPINION

Neither the Workers' Compensation Act nor our rules of practice and procedure specifically address the authority of a Referee to dismiss a request for hearing upon motion of the party originally requesting the hearing. Furthermore, we have found no case law addressing this question. We conclude, however, that authority to dismiss a request for hearing upon motion of the party requesting the hearing is inherent within the general statutory grant of authority in ORS 656.724 which gives the Referee authority to hold hearings according to law.

Because we have no specific guidance from the statute, our rules or case law, we look to the Oregon Rules of Civil Procedure for guidance. ORCP 54A(1) allows a plaintiff to dismiss any action without permission of the court if the withdrawal is not less than five days before trial and there is no counterclaim. ORCP 54A(2) requires an order of the court to voluntarily dismiss within 5 days of trial. It states in relevant part:

> "Except as provided in subsection (1) of this section, an action shall not be dismissed at the plaintiff's instance save upon judgment of dismissal ordered by the court and upon such terms and conditions as the court deems proper....Unless otherwise specified in the judgement of dismissal, a dismissal under this subsection is without prejudice."

We have previously held, consistent with ORCP 54A(2) that unless an order of dismissal specifically states that the dismissal is with prejudice, then the dismissal is without prejudice. Robert L. Murphy, 40 Van Natta 442 (1988). We now hold that when the party requesting a hearing moves for dismissal and there is no cross-request for hearing, the Referee has discretion to set the terms and conditions of an order of dismissal as he or she deems proper. We will not disturb the terms and conditions imposed by the Referee except upon a showing of abuse of discretion. We find no abuse of discretion here.

We are in receipt of a statement of services from claimant's attorney for services rendered on Board review. Since this case was brought upon the insurer's appeal, an assessed fee is governed by ORS 656.382(2). That statute

limits such fees to cases where the insurer seeks a reduction in compensation and we find that compensation should not be disallowed or reduced. Since the insurer in this case does not seek a reduction in compensation and since we have made no finding that it should not be disallowed or reduced, no assessed fee can be awarded. See MacDonald v. Safeway, 87 Or App 86 (1987); Saxton v. SAIF, 80 Or App 631 rev den 302 Or 159 (1986).

ORDER

The Referee's order dated December 15, 1988 is affirmed.

April 16, 1990 Cite as 42 Van Natta 873 (1990)

In the Matter of the Compensation of
DENNIS D. REED, Claimant
WCB Case No. 88-16423
ORDER ON REVIEW
W. Daniel Bates, Jr., Claimant Attorney
Employers Defense Counsel, Defense Attorneys

Reviewed by Board Members Cushing and Myers.

The insurer requests review of Referee Livesley's order that increased claimant's scheduled permanent disability award for the loss of use or function of his right hand from 5 percent (7.5 degrees), as awarded by Determination Order, to 50 percent (75 degrees). On review, the issue is extent of scheduled permanent disability. We modify.

FINDINGS OF FACT

Claimant compensably injured his right hand on July 29, 1987 when the cable he was pulling backlashed causing a hook to strike his right palm. The accident acutely thrombosed his right ulnar artery.

Claimant filed a claim in August 1987 for Renaud Syndrome. The insurer denied the claim in September 1987. Claimant requested a hearing.

Claimant underwent an endarterectomy and decompression of the right ulnar artery and nerve in late September 1987.

In January 1988, the parties entered into a stipulation whereby the insurer's denial of claimant's Renaud Syndrome condition was set aside.

Claimant's surgeon, Dr. Teal, recommended permanent modified duty status. Teal also restricted claimant from performing activities causing trauma to the palms of the hand. Teal restricted claimant's lifting/carrying capacity to 25 pounds for 1-15 repetitions during an 8-hour period and restricted his use of vibrating tools.

On March 1, 1988, claimant returned to work with restrictions. Claimant was declared medically stationary in September 1988.

In September 1988, a Determination Order awarded claimant 5 percent scheduled permanent disability for the loss of use or function of claimant's right hand. Claimant requested a hearing.

Claimant's range of motion in his right hand is normal and symmetrical. He suffers occasional numbness of his right hand due to cold intolerance.

Claimant suffers significant disabling pain in his right hand. He has suffered a scheduled loss of use or function of his right hand of 35 percent.

CONCLUSIONS OF LAW AND OPINION

The Referee increased claimant's scheduled permanent disability award for the loss of use or function of his right hand from 5 percent, as awarded by Determination Order, to 50 percent. In making his determination, the Referee concluded that claimant had proven "by clear and convincing evidence" that he suffered a "substantial" loss of use and function "which is not compensated by the Standards." He based this conclusion upon disabling pain.

After our de novo review of the record and analysis of claimant's impairment based on the standards, we find that claimant has met his burden of proving that he has suffered a loss of use or function of his right hand which is greater than that awarded by the September 1988 Determination Order. However, we find that claimant's loss of use or function is not as great as that found by the Referee. Further, we note that the Referee's use of the clear and convincing standard of review was inappropriate in this case, because disabling pain may be considered under those Standards applicable to this case.

To establish the extent of claimant's permanent disability, we apply the standards for evaluating permanent disability as adopted by the Director of the Department of Insurance & Finance pursuant to ORS 656.726(3)(f). See ORS 656.283(7). Specifically, we apply former OAR 436-35-000 et seq, which was effective at the time of the September 9, 1988 Determination Order. See OAR 438-10-005; 438-10-010.

Scheduled disability is rated on the permanent loss of use or function of a body part due to an injury connected with the job. Disabling pain can result in loss of use or function. Such pain is rated based on the loss of use or function which results. Former OAR 436-35-010(2). Daniel Alire, 41 Van Natta 752, 757 (1989).

The only medical evidence in the record evaluating the extent of injury to claimant's right hand is a wrist/hand evaluation which was performed by Dr. Saunders in July 1988. That report indicated that claimant's injured hand ranges of motion and flexion were normal and symmetrical. Although, the report did indicate a reduced grip strength, the extent of such decrease is unclear. Moreover, while claimant credibly testified to reduced grip strength, his testimony is insufficient to clarify the degree of reduction in grip strength. Thus, the Board has insufficient information to rate claimant's loss of grip strength. Under such circumstances, we conclude that claimant has failed to establish a ratable loss of grip strength.

Claimant also suffers from numbness in several of his fingers and in his right thumb. However, because we have no evidence of the degree of numbness, no impairment value may be assessed for that condition.

Claimant does suffer from disabling pain, for which an impairment value may be assessed. Former OAR 436-35-010(2). Claimant credibly testified that he is unable to grip without debilitating pain and that he can no longer drill, use screw drivers, rototillers, hammers, split wood, saw, sand or drive a car without extreme discomfort and associated pain in his hand and fingers. Finally, claimant can no longer do his long time hobby of wood working.

Further, because of the degree of claimant's pain, physical restrictions have been placed on his work performance. Claimant's treating physician, Dr. Teal, placed claimant on permanent modified work status, and restricted claimant to lifting and carrying up to 25 pounds no more often than 1-15 repetitions per 8 hour shift. Teal also restricted claimant from working with vibratory tools,

and reported that claimant was unable to return to his at-injury work. We find that claimant's impairment resulting from disabling pain totals 35 percent.

After considering claimant's disabling pain, we conclude that claimant suffers a loss of use or function of his right hand of 35 percent.

ORDER

The Referee's order dated January 1, 1989, is modified. In lieu of the Referee's award and in addition to the 5 percent (7.5 degrees) scheduled permanent disability awarded by Determination Order, claimant is awarded 30 percent (45 degrees) scheduled permanent disability, for a total award of 35 percent (52.5) scheduled permanent disability. A client-paid fee, not to exceed $750, payable by the insurer to its counsel, is approved.

In the Matter of the Compensation of
DUANE L. JONES, Claimant
WCB Case No. 88-10417
ORDER ON REVIEW
Merrill Schneider, Claimant Attorney
Tom Ewing, Assistant Attorney General

Reviewed by Board Members Cushing, Brittingham and Crider.

Claimant requests review of Referee Foster's order that declined to award claimant's counsel an attorney fee for efforts regarding the Inmate Injury Fund's rescission of its denial of claimant's claim. On review, the sole issue is attorney fees.

FINDINGS OF FACT

In January 1988, claimant filed a claim for a head, back, and leg injury with the Inmate Injury Fund. In May 1988, the Inmate Injury Fund denied claimant's claim. On June 20, 1988, claimant requested a hearing on the denial. In July 1988, before the hearing commenced, the Inmate Injury Fund retracted its denial and accepted claimant's claim. No hearing on the merits of the denial was held before a referee.

CONCLUSIONS OF LAW

The Referee concluded that there was no authority under ORS chapter 655 for awarding attorney fees to claimant's counsel for his efforts in getting the Inmate Injury Fund's denial rescinded. We affirm the Referee, however, we do so on a different basis.

Subsequent to the Referee's decision, the Supreme Court issued its opinion in Dept. of Justice v. Spears, 308 Or 594 (1989). In Spears, the Court held that attorney fees were available under ORS Chapter 655 because that chapter incorporates the attorney fee provisions of ORS Chapter 656. ORS 655.520. Accordingly, claimant's entitlement to attorney's fees in this matter depends upon whether they are authorized pursuant to ORS chapter 656. We hold they are not.

This case presents a question challenging a long-standing Board practice of allowing attorney fees where a denial is rescinded before hearing. Clarence A. Hooper, 1 Van Natta 160 (1968); see also Edward M. Anheluk, 34 Van Natta 205 (1982). This agency is mindful that the holding of this case reverses this long-standing policy. We will endeavor to explain our reasoning behind this reversal. ORS 183.482(8)(b)(B); ORS 656.298(6).

Until this time, this agency has not had to articulate why claimant is entitled to attorney fees when an employer rescinds a denial. After review of the language of the controlling statutes, we conclude that claimants are not entitled to assessed fees when the employer reasonably issues and then reasonably rescinds a denial before hearing.

Entitlement to attorney fees in workers' compensation cases is governed by statute. Unless specifically authorized by statute, attorney fees cannot be awarded. Forney v. Western States Plywood, 297 Or 628 (1984). ORS Chapter 656 has six statutory provisions relating to attorney fees: 656.307(5); 656.382(1), (2) and (4); 656.386(1) and (2). The relevant provisions in the instant case are ORS 656.386(1) and (2) which provide:

> "(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. In the event that a dispute arises as to the amount allowed by the referee or board or appellate court, that amount shall be settled as provided for in ORS 656.388(2). 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 claimant's award of compensation except as otherwise provided in ORS 656.382."

The plain language of ORS 656.386(1) indicates that to be entitled to a carrier-paid attorney fee for services rendered at the hearing level, claimant must finally prevail in a rejected case in a hearing before a Referee. We conclude that this statutory term is one of precise meaning which does not allow this agency any interpretation to derive its meaning. Springfield Education Assn. v. School Dist., 290 Or 217, 223 (1980). A review of ORS Chapter 656, indicates that "hearing" means an actual administrative proceeding. Use of the term "hearing" is consistent throughout Workers' Compensation Law. For example:

> (1) ORS 656.265(5): ". . . failure to give notice must be raised at the first hearing ..."
>
> (2) ORS 656.283(4): ". . . The hearing shall be scheduled for a date . . ."
>
> (3) ORS 656.283(5): "At least 10 days prior to notice of the time and place of hearing . . . Hearing shall be held in the county . . ."
>
> (4) ORS 656.283(6): "A record of all proceedings at the hearing shall be kept but need not be transcribed . . ."
>
> (5) ORS 656.283(9): "After a party requests a hearing and before the hearing commences . . ."

(6) ORS 656.289(1): "Upon the conclusion of any hearing, . . . the referee shall promptly and not later than 30 days after the hearing . . ."

(7) ORS 656.291(3)(c): "No hearing shall be held in cases assigned to . . ."

(8) ORS 656.295(3): "When review has been requested, the record of such oral proceedings at the hearings before the referee . . ." (Emphasis supplied.)

We conclude that the word "hearing" and the phrase "in a hearing before a Referee," mean an administrative proceeding (trial) before a Referee where a record is opened, testimony, evidence and/or stipulations are taken, and the merits are litigated. We draw support for this conclusion from the language of the companion fee statute, ORS 656.382(2), which provides that upon an employer's appeal, the reviewing body shall award an attorney fee to claimant "for legal representation by an attorney for the claimant at and prior to hearing....". We construe statutes to effect some meaning to the legislature's choice of wording. Therefore, we conclude that the legislature intended what it meant; that, under ORS 656.382(2), fees are awardable for services at and prior to hearing, but that fees are only allowed under ORS 656.386(1) if the claimant prevails in a hearing. If the legislature had intended to allow fees under ORS 656.386(1) for prevailing prior to hearing, we presume they would have incorporated language similar to that found in ORS 656.382(2).

Furthermore, to conclude that "in a hearing" before a Referee in ORS 656.386(1) has a meaning other than the one we have concluded it must have, would require us to either redefine the phrase throughout the chapter, or to create an exception and thus subject each use of the phrase to ad hoc redefinition in the future.

Assuming that the words "in a hearing" before a referee, as used in ORS 656.386(1), do not mean "in a hearing" but, instead, mean at the hearing level, there is another reason why a carrier paid attorney fee may not be allowed under the circumstances of this case. Clearly, one prerequisite to the award by a forum of an attorney fee under ORS 656.386(1) is that claimant prevail finally before that forum on the claim for compensation. It is not enough, as is the case with some other statutes, that claimant simply prevail. Under the circumstances of this case he or she must prevail finally in a hearing before a referee (or, for the sake of argument, at the hearing level before a referee). ORS 656.386(1); Greenslitt v. City of Lake Oswego, 305 Or 530, 533 (1988); and Shoulders v. SAIF Corporation, 300 Or 606, 611 (1986).

While a claimant may "prevail" at a particular administrative or judicial level without action by the forum, a claimant does not "finally" prevail before a forum, as is required by ORS 656.386(1), without some action by the forum which resolves the claim for compensation. As the court noted in Greenslitt v. City of Lake Oswego, 305 Or at 534:

> "A claimant 'prevails finally' before a forum if that forum holds in the claimant's favor on the issue of the claimant's right to workers' compensation and that determination is not appealed within the time allowed by statute. For example, '[u]nder ORS 656.289(3) the matters determined by [a referee's order becomes] 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 review by the board under ORS 656.295'." Farmers Ins. Group v. SAIF, 301 Or 612, 619, 724 P2d 799 (1986).

> Had the claimant in this case 'prevailed finally' before the referee on the merits of his workers' compensation claim, leaving only attorney fees in dispute, the circuit court would have been the proper forum to review the referee's award of attorney fees. However, in the present case, SAIF, the employer's insurer, timely sought review of the referee's order. Because the claimant did not 'prevail finally' before the referee, ORS 656.386(1) is not applicable." (emphasis supplied.)

A claimant does not "finally prevail" before the Board when an employer or insurer withdraws its request for review before the Board has considered an issue of compensation. Liberty Northwest Ins. Corp. v. McKellips, 100 Or App 549, 550 (1990). This is true even though the result will be that claimant will have finally prevailed before another forum - the referee. The result is that claimant is not entitled to a carrier paid attorney fee under ORS 656.386(1) for efforts on Board review. (There are reasons other than that claimant did not "prevail finally before the Board" that a carrier paid attorney fee is not due under such circumstances. See Liberty Northwest Ins. Corp. v. McKellips, supra.) The same reasoning leads to the conclusion that a claimant does not "finally prevail" in a hearing before a referee until the referee has entered an order which "...holds in claimant's favor on the issue of claimant's right to workers' compensation and that (order) is not appealed within the time allowed by statute". Greenslitt v. City of Lake Oswego, 305 Or at 534. Again, this is true even though claimant may eventually prevail for other reasons; that is, the employer's or insurer's withdrawal of its denial before hearing in conjunction with its limited ability to subsequently deny the same claim for compensation. See Bauman v. SAIF, 295 Or 788 (1983).

As a result of our holding, we are forced to evaluate the propriety of one of our administrative rules. OAR 438-15-030(1) provides:

> "If an attorney is instrumental in obtaining compensation for a claimant without a hearing before a referee, a reasonable attorney fee may be approved or assessed. The amount of the fee shall be determined in a summary proceeding by a referee." (Emphasis added.)

OAR 438-15-005(2) defines an "assessed fee" as "... an attorney fee paid to a claimant's attorney by an insurer or self-insured employer in addition to compensation paid to claimant".

Since the scope of section (1) of OAR 438-15-030 exceeds the scope of the governing statute, ORS 656.386(1), in providing for a carrier paid attorney fee without a hearing and without the necessity of claimant prevailing finally before a referee, that section of the rule is invalid. See Miller v. Employment Division, 290 Or 285 (1986) (an agency need not persist in error when its rules are found to be invalid, but it may correct the matter on its own initiative without the need for a formal rules challenge). We note parenthetically, that the portion of OAR 438-15-030(1) which allows for an approved, or out-of-compensation fee, is authorized under ORS 656.386(2). Therefore, an approved fee, for services rendered short of a hearing, has a statutory basis. Although an approved fee is available, we do not award one in the instant case, as there is no compensation out of which to grant the attorney fee.

In making this decision we are mindful of the Supreme Court's admonition that:

> "Since claimant is restricted to a statutory remedy and none is available, the ... denial of the

> worker's petition for attorney fees was legally correct. If this has resulted in an inequity to the worker in this case and is likely to affect many similar claims, that inequity must be corrected by the legislature and not by this court [board]." Forney, supra. at 634.

ORDER

The Referee's order dated September 28, 1988, is affirmed.

Board Member Brittingham, specially concurring.

I agree that the plain meaning of ORS 656.386(1) mandates the result reached in the majority opinion. I write to express my concern that this decision may foment abuses.

Before this decision, claimants' attorneys have always borne the risk that they would not get paid if their clients did not prevail against denials; now, as a result of this decision, there will be cases in which claimants prevail against denials, but their attorneys still do not get a carrier paid fee. Thus, attorneys who generally represent injured workers may think twice about even taking cases in which the risk of going uncompensated is even greater.

Additionally, an insurer could choose to put claimant's attorney in an ethical and monetary bind by offering a disputed claim settlement at a certain amount for the claimant and the claimant's attorney (which may not be in the claimant's interest) with the express or implied threat that if the attorney refuses the settlement offer the insurer will accept the claim before hearing and leave the attorney without compensation. That would leave the claimant with an accepted claim to the benefit of the claimant, but would create a lasting chilling effect on the attorney. Attorneys placed in such a bind might be reluctant to take such a case the next time around, thus leaving a claimant without representation which has a negative impact overall on the ability of claimants to get adequate representation.

This decision might also be seen as a green light for insurers to deny claims that should be accepted. I note that there are protections for the claimant from abuses by the insurer. Insurers are under the duty to reasonably process claims. The denial, when issued, must be reasonable. However, under this decision the only risk the insurer bears is penalties and fees for unreasonable denial; it does not bear the risk of attorney fees for claimant's prevailing against the denial, so long as it accepts before hearing.

If claimants go unrepresented as a result of this decision, then insurers will be able to issue denials on compensable claims with the knowledge that those denials have a good chance of standing. Unrepresented claimants, as a practical matter, have little chance of prevailing against the resources of insurers and self-insured employers.

As the majority points out by quoting the Supreme Court in Forney "an inequity to the worker" may have been wrought by today's decision. If this inequity is to be corrected, then the legislature must construct a mechanism to allow an attorney who actively participates in pre-hearing negotiations to be adequately compensated from resources other than those of claimant.

Board Member Crider, dissenting.

The majority today declares that a worker is entitled to an insurer-paid attorney fee for services in overcoming a denial of a claim only if the worker finally prevails in a hearing; a worker does not finally prevail in a hearing unless the referee holds in claimant's favor on the issue of claimant's right to compensation. Thus, the worker is entitled to no fee if the insurer, having denied the claim, rescinds that denial on the eve of hearing or, indeed, after hearing but before an order issues. In so doing, the Board jettisons 22 years of precedent and declares invalid its own longstanding rule of procedure in order to adopt an interpretation of ORS 656.386(1) which is neither required by the language of the statute (or judicial construction of it) nor consistent with the purposes of the attorney fee provisions of the Workers' Compensation Law.

ORS 656.386(1) states that when a worker "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 from compensation...[or] in a hearing before the referee or in a review by the board itself", the referee, board or court shall award an attorney fee.

It, therefore, entitles the worker to an insurer-paid fee if a claim for compensation, once denied, is ultimately accepted at any stage of the proceedings and if the services of the worker's attorney are instrumental in establishing the right to compensation. It is not necessary that claimant establish the right to compensation "in" a hearing. OAR 438-15-030(1) correctly implements the statute. Claimant's attorney is entitled to a fee in this case. Therefore, I dissent.

The majority states that its interpretation of this statute is compelled by the plain meaning of the words "in a hearing." If this term has a precise meaning, then our task is merely one of factfinding. Springfield Education Association v. School District, 290 Or 217 (1980). We must find, based on the record, whether claimant, having obviously finally prevailed, did so "in a hearing."

Indeed, the majority asserts that its decision is based upon its view that the term "in a hearing before the referee" is a term of precise meaning, in the taxonomy of Springfield Education Association. Let us, then, examine the majority's premise.

A hearing is an opportunity to present evidence to a decision-maker in an adversarial setting. It is rare for either party to prevail during this event. Ordinarily, a worker prevails in a denied case in one of two circumstances. He prevails when, prior to the commencement of an evidentiary hearing, the insurer unilaterally or by way of settlement agrees to accept a denied claim. Or he prevails when, after an evidentiary hearing is conducted and the record is closed, the referee issues an opinion and order. In neither of these two most common scenarios has the worker prevailed "in" the hearing.

Indeed, it is difficult to imagine how a worker would literally prevail during the evidentiary hearing itself: A literal reading of the statute would require us to find that the worker prevails in a hearing if the insurer makes a surprise announcement that it will rescind its denial when the parties go on the record, but that the worker does not prevail in a hearing if the announcement is made during preliminary discussions before the referee goes on the record. It will require us to find that the worker prevails in a hearing if the insurer interrupts the taking of evidence to announce that it has changed its position but not if, during a recess, the insurer notifies the worker that it will accept a claim. It might require us to find that the worker prevails in a hearing if

the referee makes a bench decision at the close of hearing, but it would certainly require us to find that the worker does not prevail in a hearing if the decision is announced in the form of a written order.

What, after all, is the plain, literal meaning of the term "in a hearing"? Are the parties "in" a hearing only when the referee is on the record? Are they "in" a hearing when they are assembled with the referee in the hearing room whether or not on the record? Indeed, are they "in" a hearing from the date and time the referee goes on the record until the date and time the record is closed? Each of these interpretations would produce a different result. Whichever were adopted for purposes of subsection 386(1), it would be rare indeed that a worker would be entitled to a fee.

The majority is not troubled by the wearisome questions that inevitably arise from a literal reading of the statute. The majority simply asserts that the meaning of the language "finally prevails...in a hearing before a referee" is "plain" and blithely announces that a worker does not do so unless a referee issues an order holding in claimant's favor. Therefore, although the majority concedes that claimant prevails when an insurer withdraws its denial and accepts a claim, the lead opinion holds that claimant is not entitled to an insurer-paid attorney fee.

I submit that the majority is not interpreting the phrase "finally prevails...in a hearing" literally. Indeed, we have seen that no precise meaning of the term obtains.

Therefore, it is the Board's function to determine,

> "whether a particular interpretation or application is consistent with or tends to advance a more generally expressed legislative policy."

Springfield Education Association v. School District, supra, 290 Or at 226. We should seek to understand and carry out the purpose that informs the statutory scheme.

Fortunately, considerable guidance is available to assist us in ascertaining legislative intent. The Supreme Court has examined the purpose of ORS 656.386(1) and declared:

> "The legislature clearly intended that a workman whose claim is erroneously rejected and who is thereby forced to appeal should not be forced to bear the additional expense of employing an attorney to represent him."

Cavins v. SAIF, 272 Or 162, 164 (1975). To be entitled to a fee award, the worker must establish "the right to compensation after an original rejection of the claim." Peterson v. Compensation Department, 257 Or 369, 375 (1971). To read into the statute additional requirements only interferes with the realization of its fundamental purpose, which is to make certain that a worker need not expend his or her own resources to establish entitlement to compensation.

There can be little doubt that a claimant establishes the right to compensation if a claim is accepted by an insurer; for once a claim is accepted, it cannot be denied. Bauman v. SAIF, 295 Or 788 (1983). Thus, when, after an insurer has rejected a claim, the worker requests a hearing and the denial is rescinded, the worker has finally prevailed in a rejected case. The worker has overcome the denial, and litigation of the compensability issue is over. It is not necessary, in order to "prevail," that the worker obtain relief in the form of a settlement

or judicial or quasi-judicial order. See e.g., Maher v. Gagne, 448 U.S. 122 (1980)(interpreting the term "prevailing party" in 42 U.S.C. sec. 1988). Moreover, the worker's victory is not subject to appeal when a denial is rescinded and an acceptance issues. The victory is thus final--even though not achieved by a final order addressing the issue of compensability.

Inasmuch as no judicial or quasi-judicial action is necessary in order that a worker "prevail," the question is whether the phrase, finally prevails "in a hearing", requires as a condition of a fee, that the right to compensation is established by a referee's order which has issued after an evidentiary hearing. The answer is no.

The statutory references to hearing before a referee, review to the board, appeal to the Court of Appeals and petition for review to the Supreme Court signal an intent to be inclusive with regard to the time when the prevailing worker is entitled to a fee. The string of references simply clarifies that a worker is entitled to an insurer-paid fee at whatever level of review he prevails.

The statute's litany of tribunals is primarily a function of history. Prior to 1957, former ORS 656.588 entitled the worker to an insurer-paid fee only when prevailing over a commission order in the circuit court. In 1957, the statute was amended to allow a fee when the worker prevailed before the State Industrial Accident Commission also. And, in 1965, when the Board replaced SIAC, the statute was amended to allow fee at the hearing level as well as before the Board. Peterson v. Compensation Department, supra, 257 Or at 374. Given this history, the majority errs in reading more into the term "in a hearing before a referee."

The Supreme Court, interpreting a similarly worded statute, held that one who prevails via a nonsuit on the eve of trial has prevailed "at trial" for purposes of entitlement to a fee award. Dean Vincent, Inc. v. Krishnell Lab, 271 Or 356 (1975). The statute in issue provided that,

> "In any action or suit on a contract...the prevailing party...at trial or on appeal, shall be entitled to reasonable attorney fees in addition to costs and necessary disbursements."

ORS 20.096(1). A contract action was brought. Defendant answered. Two days before trial, the plaintiff voluntarily dismissed the action. The plaintiff contended defendant was not entitled to fees as prevailing party. The plaintiff argued that "ORS 20.096 provides for such fees 'at trial or on appeal' and that 'at trial' means a trial or a hearing upon an issue of fact." The Court rejected this contention, saying:

> "In the cases upon which plaintiff relies, the word 'trial' was interpreted to mean a hearing upon issues of fact. It is our conclusion that in enacting the statute here under consideration, the legislature intended the use of the words 'at trial' to distinguish between proceeding at the trial court level as compared with those on appeal and that it did not intend the use of the term to categorize judicial proceeding upon a determination of whether or not a hearing on the merits of a claim had begun."

Dean Vincent, Inc. v. Krishnell Lab, supra, 271 Or at 359.

The majority here employs precisely the reasoning rejected in Dean Vincent. Yet to read ORS 656.386(1) differently than ORS 20.096(1) would serve no conceivable purpose. While there are certainly attorney fee statutes that allow for a fee award payable to the prevailing party only where the court or administrative tribunal makes findings on the merits of the dispute, they are explicit in that regard. For example, the statutes provide that the Employment Relations Board shall award a fee when, "as a result of a hearing...the board finds" that an unfair labor practice has been committed. ORS 243.676. The legislature took a similar approach in ORS 656.382(2), providing for award of a fee when the adjudicator presiding in an appeal from a prior award "finds that the compensation awarded to a claimant should not be disallowed or reduced":

> "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 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."

ORS 656.386(1), in contrast, uses no language expressly requiring that the adjudicator make findings on the merits of the dispute as a predicate to award of a fee. Nevertheless, the majority creates such a predicate in reliance on decisional law which is inapposite. The majority relies on decisions in cases in which claimant initially prevailed over a denial via a referee's order but that order was appealed; the problem addressed by the court in those decisions was not want of a referee's order but rather the lack of finality of that order. The majority also relies on a decision that interpreted, not ORS 656.386(1), but ORS 656.382(2) which, as we have seen, does include express language requiring an adjudicator's finding. The decisions thus offer no guidance in this case.

The majority states that "a claimant may not 'finally' prevail before a forum, as is required by ORS 656.386(1), without some action by the forum which resolves the claim for compensation." For this proposition, the majority relies on a quotation from Greenslitt v. City of Lake Oswego, 305 Or 530 (1988), an opinion which simply holds that a claimant does not finally prevail before a forum if the forum issues a decision but the decision does not become final because it is appealed. The principle proposed by the majority, which I believe to be in error, does not logically follow from Greenslitt.

The facts before the court in Greenslitt were these: An insurer denied a claim; a referee set it aside by order and awarded an attorney fee; the insurer requested review of the order; the board affirmed the referee's decision on the compensability issue but reduced his fee award. The question addressed by the court was whether, in these circumstances, the insurer was required to challenge the referee's fee award in the circuit court, pursuant to ORS 656.388(2), or whether it properly did so by request for review to the board. The court held that only fees awarded under ORS 656.386(1) may be challenged in circuit court. Although the referee's fee award was made under color of ORS 656.386(1), the court held that the fee award was contingent: It was effective only if the order became final because no party appealed it timely. When the City appealed the referee's order, the fee award vanished. And when the board affirmed that portion of the referee's order setting aside the denial, the board awarded a fee under ORS 656.382(2) covering both services at hearing and services on review. The court held that because claimant did not "finally" prevail before the referee, no fee

had been awarded pursuant to ORS 656.386(1) and none could be challenged in the circuit court.

The problem addressed by the Court in Greenslitt simply has nothing to do with the question of whether claimant may "finally prevail...in a hearing before a referee" if the worker finally prevails at the hearing level because there is no appeal, but claimant prevails when the insurer accepts his claim rather than via final referee order. The Board's decisions holding that a worker is entitled to an insurer-paid fee under these circumstances, are entirely consistent with the holding and the reasoning in Greenslitt.

The majority also relies, for its view that no fee may be awarded unless a referee decides the compensability issue in the worker's favor, on Liberty Northwest Ins. Corp. v. McKellips, 100 Or App 549 (1990). In McKellips, the court affirmed our decision denying a request for fees on review: The referee had set aside a denial of compensation, the insurer requested review, and the insurer withdrew its request before the board considered the case. The court held that claimant was not entitled to a fee for services on review under ORS 656.382(2) because the board had not made any finding that claimant's compensation should not be disallowed or reduced. See Agripac, Inc. v. Kitchel, 73 Or App 132 (1985). By virtue of the withdrawal of the request for review, the referee's order, including any contingent fee he may have awarded under ORS 656.386(1), became final. The court's holding with respect to the breadth of our power, under ORS 656.382(2), to award a fee on board review of a referee's order setting aside a denial does not suggest, much less require, a similarly narrow view of a referee's power, under an entirely different statute, to award a fee on a worker's request for hearing on a denial of compensability.

On the contrary, because ORS 656.382(2) includes express language requiring an adjudicator to make findings on a worker's entitlement as a condition of a fee and ORS 656.386(1) does not, the contrast between the two tends to suggest that the legislature may have intended to authorize award of a fee under subsection 386(1) in the absence of a finding by the adjudicator.

The McKellips court also observed that claimant was entitled to no fee for services on review under ORS 656.386(1). The court denied a fee for services on review not because the board had rendered no decision on the merits, but rather because claimant was not the appealing party. See also, Shoulders v. SAIF, 300 Or 606 (1986)(holding that claimant is entitled to a fee under ORS 656.382(2) rather than ORS 656.386(1) when the board affirms a referee's order setting aside a denial of compensation). Again, the court's reasoning does not bear on the question presented by this case.

Finally, the majority suggests that if the legislature had intended to direct us to award fees for services performed to achieve rescission of a denial, the legislature should have used the phrase "at and prior to hearing," a phrase which it later used in ORS 656.382(2) to achieve an entirely different purpose. In ORS 656.382(2) the language addresses the amount of, not the entitlement to, a fee. It simply provides that, when a fee is due, it shall include all services reasonably provided relative to the issue. Nevertheless, the majority apparently suggests that the legislature should have directed the referee to award a fee whenever a worker finally prevails "at and prior to hearing" rather than "in a hearing before a referee." Assuming that the meaning of such language would be plain, the legislature did not use it. Indeed, none of the many statutes calling for fees "at trial or on appeal" use such cumbersome phraseology to say that a party is entitled to a fee if the party prevails without an evidentiary hearing or a judicial order. The absence of the language in ORS 656.386(1) is of no value in ascertaining the intent of the legislature.

The majority's reading of the statute would doubtless discourage attorneys from the representation of injured workers as it will greatly increase the risk that, in any given case, their services will go uncompensated. It would eliminate an important incentive for insurers to promptly and carefully investigate and accept meritorious claims. It may also discourage claimants' attorneys, against their clients' interests, from working, in cooperation with counsel for the insurer, to obtain pre-hearing rescission of denials because, by obtaining relief for their clients, they will eliminate their own opportunity to collect a fee.

OAR 438-15-030(1) and the Board's decisions in Clarence A. Hooper, 1 Van Natta 160 (1968) and Edward M. Anheluk, 34 Van Natta 205 (1982) tend to advance the legislative intent that the insurer, not the worker, bear the cost of legal representation for workers whose claims are erroneously rejected. That assignment of costs, in turn, furthers the legislative interest in timely delivery of benefits to all who are entitled to them under the law. The majority today betrays that legislative policy by repudiating our rule, disavowing our prior decisions, and denying claimant a fee award in this case.

April 17, 1990 Cite as 42 Van Natta 885 (1990)

In the Matter of the Compensation of
JOE O. REID, Claimant
WCB Case No. 88-08768
ORDER ON RECONSIDERATION
Peter O. Hansen, Claimant Attorney
Scheminske & Lyons, Defense Attorneys

The self-insured employer requests reconsideration of our Order on Review dated March 20, 1990.

The employer contends that we erred in the following respects:

(1.) The employer contends that it was entitled to discontinue payment of compensation on April 4, 1988, based on an IME report that claimant was medically stationary and able to work. It is argued that it is claimant's burden to establish a substantive entitlement to compensation after April 4, 1988, by proving that he was in fact unable to work.

(2.) The employer further contends that claimant was working and thus was entitled to temporary partial disability only; that temporary partial disability need not be paid pending review of a referee order finding a claim compensable; and, therefore, that the employer was not required to pay compensation pursuant to Referee Mulder's order finding the claim compensable.

(3.) The employer finally contends that its failure to respond to claimant's efforts to cooperate with its claims adjuster's request for information was not unreasonable. The employer contends that the adjuster could not speak with claimant because she was represented by counsel.

As to the employer's first contention, the statute plainly requires, as a condition to pre-closure termination of temporary total disability compensation, that claimant be both medically stationary and released to work by the attending physician. In this case, the employer never commenced payment of compensation and, if any compensation had been paid, the factors justifying termination of compensation did not obtain. Consequently, claimant is entitled to an order requiring the employer to pay until the claim is properly closed. Claimant was not required to prove that he was substantively entitled to compensation. Substantive entitlement was not in issue. Substantive entitlement is only in

issue if a claimant seeks additional compensation after compensation has been properly terminated, if a claim has been closed and a claimant seeks more compensation than was allowed by determination order or notice of closure, or if an insurer seeks an offset of an alleged overpayment. Compare Fazzolari v. United Beer Distributors, 91 Or App 592 (1988); Carmen Salinas, 42 Van Natta 518 (1990). Consequently, the Board properly addressed only the procedural entitlement issue in this case.

As to the second contention, we observe that the employer has failed to establish that claimant was entitled to temporary partial, rather than temporary total, disability compensation. Nevertheless, assuming for the purposes of argument, that claimant was entitled to temporary partial disability compensation only, such compensation must be paid pending review of a referee's order finding the claim compensable. We rejected the employer's argument to the contrary in Theodore W. Lincicum, 40 Van Natta 1953, 1955 (1988), aff'd mem, 100 Or App 100 (1990).

ORS 656.313(1) establishes the general rule that compensation must be paid pending appeal of an order. Although the general rule provides that compensation payable under certain sections of the statute must be paid pending appeal, for purposes of the general rule medical services are not compensation. ORS 656.313(4). In Lincicum we held that although ORS 656.212, dealing with temporary partial disability compensation, was not specifically listed in ORS 656.313(4), it must be paid pending appeal. We held that absent a specific exclusion in subsection (4), the general rule applies to temporary partial disability compensation just as it does to temporary total disability compensation. In so holding, we noted that the Supreme Court has rejected an argument that interim compensation need not be paid pending appeal because it is not specifically listed in subsection (4) and, after review of the legislative history of the provision, has declared that medical services are the only form of compensation that need not be paid pending appeal. Georgia-Pacific v. Hughes, 305 Or 286, 292-3 (1988). We adhere to our holding in Lincicum.

Finally, we adhere to our decision that the employer's failure to pay temporary disability benefits because claimant did not provide "tax statements" was unreasonable for two independent reasons. First, an employer may not unilaterally suspend compensation for failure to cooperate in calculation of benefits. And second, this employer rebuffed claimant's efforts to cooperate.

Claimant's attorney has requested reconsideration of that portion of our March 20, 1990 Order on Review that declined to award an assessed fee for services at hearing and on review on the issue of the employer's unreasonable failure to pay compensation. Claimant is entitled to such a fee. We declined to award the fee because claimant's counsel had not submitted a statement of services as required by OAR 438-15-010(5). Claimant's attorney has now submitted a statement of services for his efforts concerning this issue, and he seeks an attorney fee pursuant to ORS 656.382(1). After reviewing the statement of services and considering the factors set forth in OAR 438-15-010(6), we award a reasonable assessed fee of $800.

Accordingly, our prior order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our March 20, 1990 order in its entirety. The parties' right of appeal shall run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
THOMAS L. SWANGER, Claimant
WCB Case No. 88-13157
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Nancy Marque (Saif), Defense Attorney

Review by Board Members Speer, Howell, and Perry.

The SAIF Corporation requests review of Referee Brown's order which increased claimant's scheduled permanent disability for loss of use or function of the left leg from 5 percent (7.5 degrees), as awarded by Determination Order, to 20 percent (30 degrees). On review the issue is extent of scheduled permanent disability. We affirm.

FINDINGS OF FACTS

Claimant, a 26-year-old male, compensably injured his left knee on June 9, 1987. As a result of that injury, claimant experienced a tear of the anterior cruciate ligament of the left knee. Dr. Larson, an orthopedic surgeon, surgically repaired the ligament on June 15, 1987.

Dr. Larson followed claimant after surgery and claimant became medically stationary on June 6, 1988. At that time claimant had tenderness over a lateral portion of the left knee. He had left knee crepitation and pain when doing a deep knee bend. Claimant had a full range of motion of both knees. No instability was present and muscle strength in the left leg was slightly reduced but good, with some left thigh atrophy. Dr. Larson recommended that claimant avoid working on steep terrain, jumping or carrying heavy loads. Dr. Larson estimated claimant's permanent left leg impairment at 20 percent.

A July 8, 1988 Determination Order closed claimant's claim and awarded 5 percent scheduled permanent disability for loss of the left leg.

At the time of hearing claimant experienced occasional giveway of the left knee, resulting in his falling. He had difficulty walking on rough terrain and up stairs. He could not kneel on his left knee. He limped most of the time and he had not regained full strength in the left leg. His ability to stand, carry heavy loads, and squat was materially limited by his injured left knee. Based upon a demonstration by claimant during the hearing, the Referee estimated that claimant then had a 5 degree loss of left knee extension and a 10 degree loss of left knee flexion.

CONCLUSIONS OF LAW

The only issue in this case is the extent of claimant's scheduled permanent partial disability.

If a claimant became medically stationary after January 1, 1988 and his or her claim was closed on or after July 1, 1988, a subsequent determination by a referee or the Board of the claimant's permanent partial disability must be made pursuant to ORS 656.283(7) and 656.295(5) respectively. OAR 438-10-005 and Michelle Griffith, 40 Van Natta 2086 (1988).

For purposes of determining injury-related permanent partial disability, ORS 656.283(7) and 656.295(5) require application of the standards for the evaluation of disabilities adopted by the director pursuant to ORS 656.726(3)(f)(A). Those "standards" in effect on the date of the Determination Order from which the hearing was requested control the evaluation of permanent partial disability. OAR 438-10-010.

The hearing and Board review of the issue of permanent partial disability continues to be de novo on the hearing record. The facts to which the "standards" are applied need only be established by a preponderance of the evidence. However, either party may establish that the record, as a whole, constitutes clear and convincing evidence that the degree of permanent partial disability suffered by the claimant is more or less than the entitlement indicated by the "standards." ORS 656.283(7) and 656.295(5).

In this case, the "standards" adopted effective July 1, 1988, former OAR 436-35-001 et seq, apply to the rating of claimant's permanent partial disability. Former OAR 436-35-010 through 436-35-260 apply to the rating of scheduled permanent partial disabilities. Former OAR 436-35-010(1).

The Referee found that claimant was entitled to an impairment value for lost left knee motion under former OAR 436-35-220(1)&(2). We disagree.

Assuming for the sake of argument that a referee can determine lost range of motion and that the Referee's determination of lost motion in this case is persuasive despite Dr. Larson's findings of full motion a few months earlier, there is no evidence in this record which would establish that such limitations represent permanent impairment. Claimant has failed to prove a permanent loss of left knee motion as a result of his compensable injury.

The only permanent residual that claimant has proven which is valued for purposes of permanent disability under the "standards" is slight left thigh weakness/atrophy. Such an impairment is valued, according to its severity, from 0 to 10 percent of the leg. Former OAR 436-35-230(5)(b). Given the rather mild degree of weakness and atrophy in claimant's left leg, we find that that impairment represents a 3 percent loss of use under the "standards."

Claimant argues that the record as a whole constitutes clear and convincing evidence that his left leg disability is greater than indicated by application of the "standards." We agree.

Dr. Larson, claimant's treating orthopedic surgeon, estimated claimant's permanent left leg impairment to be 20 percent. That opinion is unrebutted. Dr. Larson's assessment is supported, moreover, by claimant's credible testimony. Claimant cannot kneel on his left knee. He now has weakness, atrophy, a limp and occasional giveway in the left leg. He has difficulty walking on rough terrain or up stairs. Additional injury-related limitations include a reduced ability to stand, carry heavy loads and to squat.

Viewed as a whole, we find the record to constitute clear and convincing evidence that claimant's loss of left leg use exceeds 3 percent, the value assigned by application of the "standards." We find the evidence clear and convincing -- that is, highly persuasive, free from confusion and distinct -- that claimant suffers at least a 20 percent loss of use or function of his left knee due to his compensable injury. ORS 656.295(5).
See Riley Hill General Contractor Inc. v. Tandy Corp., 303 Or 390, 407 (1987).

Claimant's attorney is entitled to a fee on review. However, we cannot presently award such a fee because a statement of services has not been received. OAR 438-15-010(5).

ORDER

The Referee's order dated November 5, 1988 is affirmed.

In the Matter of the Compensation of
ANNA M. MONSON, Claimant
WCB Case Nos. 88-09685 & 88-05604
ORDER ON REVIEW
Rasmussen & Henry, Claimant Attorneys
Schwenn, et al., Defense Attorneys
Arthur W. Stevens III (Saif), Defense Attorney

Reviewed by Board Members Crider and Nichols.

Claimant requests review of those portions of Referee Thye's order that: (1) set aside the SAIF Corporation's denial of claimant's aggravation claim for a low back condition, on behalf of Thunderbird Inn; (2) upheld SAIF's denial of claimant's "new injury" claim for the same condition, on behalf of Sunbrite Janitorial Service; and (3) awarded claimant an attorney fee of $1,000, rather than a larger sum, payable by SAIF, on behalf of Sunbrite, on the compensability issue. In its brief, SAIF, on behalf of Sunbrite, contends that no assessed fee should have been awarded, payable by Sunbrite. On review, the issues are responsibility and attorney fees. We affirm.

We adopt the Referee's "Findings" and his "Conclusions and Opinion" with the following discussion.

On review, SAIF/Sunbrite contends that the Referee's order should be affirmed with the exception of that portion of the order that purported to disapprove and set aside Sunbrite's denial insofar as it denied compensability and awarded claimant an attorney fee for services related to overcoming the denial of compensability. We conclude that the Referee should not have set aside Sunbrite's denial in any respect simply because claimant was victorious with respect to one ground of the denial, when responsibility was assigned to SAIF/Thunderbird and not to SAIF/Sunbrite. Nevertheless, claimant was nonetheless entitled to an insurer-paid fee, payable by Sunbrite.

Thunderbird Inn denied responsibility only whereas Sunbrite Janitorial Service denied both compensability and responsibility. No .307 order issued. Therefore, compensability was at issue at hearing. Claimant's right to compensation was not secure. She was required to litigate the compensability of her claim. Under such circumstances, claimant is entitled to an insurer-paid fee. See e.g., Stovall v. Sally Salmon Seafood, 84 Or App 612 (1987); Ronald J. Broussard, 38 Van Natta 59, 61 (1986), aff'd mem. Western Employers Insurance v. Broussard, 82 Or App 550 (1986). If both potentially responsible employers deny compensability, the fee is paid by the insurer found responsible for the claim. If, however, only one denies compensability, that employer must pay the fee because its denial forced claimant to litigate the issue. Karen J. Bates, 39 Van Natta 42 (1987). The Referee's award of a fee is consistent with these principles.

Claimant argues that the Referee's fee award was inadequate. We decline to alter the award. Claimant's attorney filed a Statement of Services indicating that 18.5 attorney hours had been spent on the case at hearing. The issues at hearing included not only compensability and responsibility (the evidence concerning which is often inseparable) but also interim compensation and penalties and attorney fees for delay in accepting or denying the claim and delay in commencing payment of interim compensation. Claimant's attorney was awarded $250 on the penalty issues. She did not prevail on the interim compensation issue. Under all these circumstances, the Referee did not abuse his discretion to set a reasonable fee for services in light of the factors enumerated in OAR 438-15-010(6). The award will be affirmed.

ORDER

The Referee's order dated November 17, 1988, as modified and republished by order dated November 25, 1988, is affirmed. The Board authorizes a client-paid fee, not to exceed $792, payable by the SAIF Corporation, on behalf of Sunbrite Janitorial Service, to its counsel.

April 19, 1990 Cite as 42 Van Natta 890 (1990)

In the Matter of the Compensation of
DON G. CYSEWSKI, Claimant
WCB Case No. 88-15120
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Peter Preston (Saif), Defense Attorney

Reviewed by Board Members Crider and Nichols.

The SAIF Corporation requests review of Referee Podnar's order that increased a Determination Order award of 15 percent (22.5 degrees) scheduled disability for loss of use or function of the right leg to 30 percent (45 degrees). On review, the issue is the extent of scheduled permanent disability. We modify.

FINDINGS OF FACT

Claimant is a 50 year old truck driver who compensably injured his right knee when he slipped and fell while using a pry bar on May 31, 1986. Claimant was seen by Dr. Puziss, orthopedic surgeon. He diagnosed a probable torn right medial meniscus.

On June 6, 1986, a right knee arthrogram was performed. The arthrogram showed no definite abnormality.

Claimant began treating with Dr. Baldwin, orthopedist, on July 10, 1986. Dr. Baldwin's diagnosis was a tear in the anterior cruciate ligament, along with a tear in the lateral meniscus of the right knee. On December 2, 1986, arthroscopic examination revealed a complex tear of the posterior horn of the medial meniscus but no damage to the lateral meniscus. Dr. Baldwin performed an arthroscopic medial meniscectomy and an arthroscopically-aided anterior cruciate reconstruction.

Dr. Baldwin released claimant to return to his former work with no restrictions as of August 4, 1987. Claimant's condition was medically stationary as of July 29, 1988.

A Determination Order issued August 26, 1988, awarding claimant 15 percent (22.5 degrees) scheduled disability for loss of claimant's right leg.

Claimant's range of motion in the right knee is from -2 to 136 degrees. Claimant's medial collateral ligament is stable, his lateral collateral ligament is stable, his anterior drawer is negative, and his pivot shift is negative. Claimant experiences swelling and pain while walking, going down stairs and sitting for prolonged periods of time. In addition, claimant has difficulty operating the foot pedals on heavy equipment as a result of the pain in his right knee. Claimant's pain has resulted in a loss of use or function.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant was entitled to an additional 15 percent (22.5 degrees) scheduled disability for loss of use or function that has resulted from the pain in claimant's right knee. The Referee did not apply the disability rating standards.

If a claimant became medically stationary after January 1, 1988 and his or her claim was closed on or after July 1, 1988, a subsequent determination by a referee or the Board of the claimant's permanent partial disability must be made pursuant to ORS 656.283(7) and 656.295(5), respectively. OAR 438-10-005 and Michelle Griffith, 40 Van Natta 2086 (1988).

The hearing and Board review of the issue of permanent partial disability continues to be de novo on the hearing record. The underlying facts to which the "standards" are applied need only be established by a preponderance of the evidence. ORS 656.283(7) and 656.295(5).

In this case, the "standards" adopted effective July 1, 1988, (former OAR 436-35-001 et seq), as amended by temporary rules effective August 19, 1988, apply to the rating of claimant's permanent partial disability. Former OAR 436-35-010 through 436-35-260 apply to the rating of scheduled permanent partial disabilities. Former OAR 436-35-010(1).

Claimant is entitled to a value based upon his permanent loss of use or function in his right knee. The value given for claimant's lost range of motion in his right knee is based upon active degrees of motion. See former OAR 436-35-010(3). To calculate a loss of motion one of two methods is provided for by the "standards". Former OAR 436-35-010(3). The "standards" rate loss of motion either by comparing the active degrees of motion of the injured body member to the degrees of motion possible in the contralateral normal joint or by comparing the active degrees of motion of the injured member to the ranges of motion established, as normal, by the American Medical Association. Id. In the instant case, there is no evidence of the degrees of motion in the normal contralateral joint (i.e. claimant's left knee). Therefore, we compare the range of motion in claimant's right knee to the ranges of motion established by the American Medical Association as normal.

Claimant's range of motion in his right knee, as measured by Dr. Baldwin, is -2 to 136 degrees. Claimant has retained 136 degrees flexion in his right knee. Pursuant to former OAR 436-35-220(1) claimant is entitled to a value of 5.2 percent for loss of flexion. Claimant has -2 degrees of extension and is, therefore, entitled to no value for loss of extension. See former OAR 436-35-220(2). Claimant's total rating for loss of motion in his right knee is 5.2 percent. Former OAR 436-35-220(4); 436-35-240(2).

Claimant is entitled to a value pursuant to the "standards" of 10 percent for a complete medial meniscectomy. Former OAR 436-35-230(4)(c).

To arrive at a total rating for impairment to claimant's right knee, the value for claimant's right knee lost range of motion (5.2 percent) and the value for his surgery (10 percent) are combined (not added). See former OAR 436-35-220(4). The result is 14.2 percent.

In addition, the Referee awarded claimant an additional 15 percent (22.5 degrees) scheduled disability based upon claimant's disabling pain. Former OAR 436-35-010(2)(a) provides that pain can result in loss of use or function. When it does, it is rated based on the loss of use of function which results and no additional value is allowed for pain alone. The Board in Daniel M. Alire, 41 Van Natta 752 (1989) held that, inasmuch as the standards do not provide for a value range for impairment attributable to disabling pain, the Board on de novo review can consider the evidence and award the claimant a value that adequately compensates him for his loss of use or function attributable to disabling pain.

In this case, the record establishes that claimant has a loss of use or function, attributable to disabling pain. Dr. Baldwin opined that claimant has

"significant residual and experiences pain and disability as a result of his right knee injury." Claimant credibly testified that he experiences pain when walking on flat and uneven surfaces, going down stairs and sitting for prolonged periods of time. Claimant has difficulty operating the foot pedals on heavy equipment as a result of the pain in his right knee. He has swelling and he limps. Claimant has given up hunting, and riding his motorcycle as a result of the pain he experiences in his right knee. Dr. Baldwin, applying the A.M.A. Guides for Rating Disability suggested that claimant was entitled to 10 percent for loss -- in addition to loss of range of motion -- due to disabling pain. Under these circumstances, claimant is entitled to a value, based upon his disabling pain which has resulted in a loss of use or function, of 10 percent.

Having determined each value necessary to compute claimant's permanent disability under the "standards", we proceed to that calculation. When the total value for range of motion and surgery (14.2 percent) is combined with the value for disabling pain (10 percent) the result is 23.2 percent scheduled permanent disability. That disability figure is rounded to the next higher whole percentage. Former OAR 436-35-010(6). Claimant's permanent disability under the "standards" is, therefore, 24 percent.

ORDER

The Referee's order dated December 16, 1988 is modified. In lieu of the Referee's award and in addition to the Determination Order award of 15 percent (22.5 degrees) scheduled permanent disability for loss of use or function of the right leg, claimant is awarded 9 percent (13.5 degrees), for a total award to date of 24 percent (36 degrees).

In the Matter of the Compensation of
RONALD C. EARL, Claimant
WCB Case No. 87-19461
ORDER ON RECONSIDERATION
Peter O. Hansen, Claimant Attorney
Kevin L. Mannix, Defense Attorneys

The insurer has requested reconsideration of the Board's Order on Review dated January 4, 1990. On January 19, 1990, we withdrew our order for reconsideration and granted the parties an opportunity to respond to the motion for reconsideration. The time within which to respond having now elapsed, we proceed with our reconsideration. In place of our January 4, 1990 order, we issue the following order.

The insurer requests review of that portion of Referee Bennett's order which set aside its June 1987 aggravation denial of claimant's psychological condition. Claimant cross-requests review and seeks remand alleging that the Referee should have set aside a December 1987 aggravation denial in addition to the June 1987 denial. Claimant also seeks additional temporary disability benefits. On review, the issues are remand, aggravation and temporary disability. We modify the Referee's order.

Remand

Claimant seeks remand because the Referee did not set aside a December 16, 1987 denial, but only set aside a June 30, 1987 denial. We may remand when a case has been improperly, incompletely or otherwise insufficiently developed or heard by the Referee. ORS 656.295(5). Both denials concerned the same issue:

aggravation. We conclude that the record has been adequately developed to allow the Board to review both denials. The motion for remand is denied.

FINDINGS OF FACT

Claimant has sustained injuries before the current injury of 1981. In 1976 claimant compensably injured his low back. Shortly after this injury he manifested psychological difficulties, emotional problems and a high preoccupation with pain. Claimant sought psychological treatment from Dr. Hickman, psychologist, to assist in vocational readjustment. After a period of time, claimant's continued need for psychological treatment ceased to be related to the 1976 injury and, instead, became related to his chronic personality disorder. Claimant sustained two more industrial injuries, one to his left leg on March 16, 1978 and another to his low back in October 1980.

On July 22, 1981 claimant sustained a low back injury with the insured. A later August 28, 1981 injury, also with the insured, was combined with the July injury to form the current injury claim at issue. By October 1981, claimant had become disabled by emotional problems and pain related to this claim. The insurer was ordered to accept the psychological condition and treatment. The claim was first closed by Determination Order without an award of permanent disability. Thereafter, claimant continued to experience emotional problems and to seek psychological care through 1983. In 1985, claimant began to treat with Dr. Beavers for his psychological condition. The insurer was ordered to pay for the resulting medical services. Claimant applied for and was granted Social Security Disability.

In April 1987, claimant was hospitalized for psychiatric care and he filed an aggravation claim. The insurer denied this claim on June 30, 1987. Claimant appealed this denial. In August 1987, claimant's psychological state changed when he learned that his girl friend was seeing and sleeping with another man. Claimant filed another aggravation claim. To allow the insurer time to process the new aggravation claim, claimant voluntarily withdrew his appeal of the June 1987 aggravation denial. We take administrative notice that this case, WCB# 87-10303, was dismissed. On December 16, 1987 the insurer denied claimant's second aggravation claim. Claimant was again hospitalized for psychological care in December 1987 for eight days and once more in April 1988. Claimant has not returned to gainful and suitable employment since his injury.

CONCLUSIONS OF LAW AND OPINION

Aggravation

The Referee set aside the insurer's June 30, 1987 aggravation denial, but did not set aside the December 16, 1987 aggravation denial. The insurer argues that the Referee could not address the merits of the June 1987 denial because that denial had become final by operation of law and because it was not at issue in the hearing. Claimant agrees that the June 1987 denial was not at issue, but he argues that temporary disability should be ordered retroactive to April 1987, before the June denial, as a matter of correct processing for prevailing on the December aggravation denial. We agree that the June denial was not at issue at hearing and should not have been set aside by the Referee.

The current aggravation claim is actually two claims. The first claim surrounds the insurer's June 30, 1987 denial. While ordinarily an aggravation denial will address new aggravation claims subsequent to its issuance that occur before hearing, see Rater v. Pacific Motor Trucking, 77 Or App 418 (1986) and Vandehey v. Pumilite Glass & Building Co., 35 Or App 187 (1978), the parties in this case opted to process claimant's post denial worsening occurring in August

1987 as a separate claim when claimant voluntarily dismissed his hearing request on the June denial in exchange for the insurer processing the August worsening as a second claim. The June denial, therefore, only operates to deny the alleged worsening occurring prior to its issuance. In this case, the April 1987 worsening and hospitalization are covered by that denial.

Claimant nonetheless asserts he is entitled to temporary disability retroactive to April 1987. We disagree. The parties' choice of processing of this matter affects the scope of claimant's relief even if he prevails on his aggravation claim. The June 1987 denial has become final by operation of law and has the effect of precluding relief for temporary disability and precluding reopening the claim before its issuance. See Liberty Northwest Ins. Co. v. Bird, 99 Or App 560 (1989). However, claimant can nonetheless establish entitlement to additional compensation for a worsened condition resulting from his injury after the June denial by showing both a changed condition since the denial and a worsening since the last arrangement of compensation resulting from the injury. Id. We evaluate the record to determine whether this occurred at any time before hearing.

To establish an aggravation, claimant must show both a worsening of his condition since the last arrangement of compensation, Smith v. SAIF, 302 Or 396 (1986), and a causal connection between the worsening and the industrial injury. Brewer v. SAIF, 59 Or App 87 (1982). "Worsening" within this context means increased symptoms, or a worsened underlying condition, resulting in a diminishment of earning capacity. Id. There is no per se test for worsening, it is determined on a case by case basis as a matter of fact, not law. Perry v. SAIF, 307 Or 654 (1989). If claimant's condition has worsened, he may nonetheless not be entitled to a reopening of his claim if the last arrangement of compensation anticipated future worsenings (e.g. "waxing and waning" or "exacerbations") and the particular worsening at issue did not: (1) diminish his earning capacity longer or in greater degree than was anticipated; nor (2) result in 14 consecutive days of total disability or inpatient hospitalization. Gwynn v. SAIF, 304 Or 345 (1987), on rem 91 Or App 84 (1988); see generally Edward D. Lucas, 41 Van Natta 2272 (1989).

The first evidence of a worsening subsequent to the June denial is an alleged August 1987 worsening that formed the basis of the second aggravation claim. At that time claimant learned that his girl friend was sexually involved with another man. We are not persuaded that claimant's condition worsened at this time. Dr. Maletzky opined that claimant's condition had worsened since April 1987 "because he has lost his girl friend," and that during his visits in August 1987 he would have been psychologically unable to work. (Ex. 64). Maletzky does not explain his rationale for this observation and we find it highly conclusory and unpersuasive. See Marshall v. Boise Cascade, 82 Or App 130, 133 (1986). This is especially true since claimant sought no further treatment from Maletzky until December 1987. (Ex. 64; 65). Since claimant had not been working prior to the alleged August 1987 worsening, we are unable to draw the inference that he was less able to work after this time simply by the fact that he was not working. Maletzky's own chart notes indicate that claimant was experiencing "a normal grief reaction." (Ex. 61-1). Without some explanation, we cannot conclude that "a normal grief reaction" materially reduced claimant's earning capacity below its previous level.

Moreover, we are not persuaded that if claimant's condition did worsen during this time, that such worsening was causally related to the industrial injury. Claimant must prove a causal connection between the worsening and the industrial injury. Brewer v. SAIF, supra. A causal connection is established if the industrial injury is a material contributing cause of the worsened condition or need for treatment. Grable v. Weyerhaeuser, 291 Or 387, (1981).

Dr. Maletzky is of the opinion that claimant's August worsening is related to claimant's injury. We are not persuaded by his opinion in this regard either. He acknowledges that the precipitating trauma for claimant's worsened psychological condition was the loss of claimant's girl friend but attempts to tie this ordinarily purely personal problem to a work related injury by declaring that "had [claimant] not had [his 1981 work injury], the loss of a girl friend would not have produced severe psychiatric impairment." (Ex. 69). Indeed, Maletzky states that "[h]ad the injury not occurred, [claimant] would not have needed psychiatric care whatsoever." Id. This conclusory statement by Maletzky does not acknowledge claimant's long standing preexisting chronic psychological condition noted by multiple early doctors, a condition that necessitated treatment long before the current injury. Moreover, Maletzky's own chart notes undercut his opinion that claimant's worsening in August 1987 is materially causally related to the injury. He notes that, when claimant first discovered that his girl friend was "seeing and sleeping with another man", claimant's back pain stopped bothering him. (Ex. 59-2). Without the residuals of the injury being a material contributing cause of claimant's worsening, the worsening is not compensable. Grable, supra. We are unable to conclude that the injury materially contributed to any alleged worsening in August 1987 and find instead that the worsening was due to noncompensable intervening psychological trauma from claimant's personal life. Grable at 400.

The next alleged worsening occurred in December 1987 when claimant was psychiatrically hospitalized. The Referee concluded that claimant had established a compensable aggravation because he was hospitalized. We disagree with the Referee's reasoning, but concur with his result.

Being hospitalized does not automatically entitle claimant to reopening under ORS 656.273. Some hospitalizations do not evidence a lessened ability to work. See e.g. Perry v. SAIF, on remand 99 Or App 64 (1989). The Referee's implied reasoning that claimant had established an aggravation because he was hospitalized is not correct. Hospitalization is evidence of worsening but it is not dispositive evidence, in the same way a doctor's authorization for temporary disability is evidence of disability, but is not determinative of it. See Botefur v. City of Creswell, 84 Or App 627 (1987). The fact that claimant was hospitalized does not end our inquiry of whether claimant has worsened and we proceed to apply our analysis advanced in Edward Lucas, supra.

1. Did claimant's psychological condition change?

The day before claimant was hospitalized he called his attending doctor on the phone. At that time Maletzky noted his distraught affect and that claimant had started drinking again. Maletzky advised admission, to which claimant agreed. (Ex. 66). Upon hospitalization claimant was acutely agitated and presented suicidal ideation. (Ex. 65-4). After discharge another physician, Dr. Collisto, continued to authorize total disability. We find that claimant's psychological condition changed in December 1987.

2. Did the change result in diminished earning capacity below the prior fixed level?

Claimant argues that a comparison of claimant's current condition with his condition at the time of the last arrangement of compensation is inappropriate because claimant's last award of compensation did not award any compensation and claimant has no permanent disability for this claim. He argues that with no award of permanent disability, any worsening entitles claimant to a reopening as a matter of law. We disagree.

The absence of an award of permanent disability effects only steps 3 and 4 of the Edward Lucas analysis. Without an award of some permanent disability,

the defense of "waxing and waning" is not available, but a comparison of claimant's allegedly worsened condition with his condition at the time of a prior award granting no permanent disability is still required. Claimant's argument is another way of asserting that claimant has proven worsening as a matter of law. But worsening is a matter of fact, not law. Perry, 307 Or 654.

In this case, the last arrangement of compensation is the June 17, 1983 hearing where claimant was awarded additional temporary disability, but no permanent disability. (Ex. 33). At that time, claimant was in need of psychiatric care on an outpatient basis only. He had not been hospitalized for his psychological condition. At the time of the prior award, claimant was not experiencing suicidal ideation and was not noted to be in acute emotional distress. There is no indication that claimant then required psychiatric hospitalization for either his preexisting chronic psychological difficulties, his psychological residuals from the injury or a combination of them both.

We conclude that the need for inpatient hospitalization, the acute deterioration of his psychological condition and claimant's suicidal ideation adversely affected claimant's earning capacity and rendered him totally disabled, at least for the duration of his hospitalization. This level of incapacity exceeded the level of psychological incapacity claimant experienced at the time of the June 1983 hearing, therefore, claimant has established a "worsening" since the last arrangement of compensation.

3. Waxing and waning defense.

Claimant's worsening in December 1987 may nonetheless not entitle claimant to reopening of his claim if the last arrangement of compensation contemplated future worsening and the current episode of worsening did not: (1) exceed the expected level of future worsening, (2) result in 14 days of total disability; nor (3) result in inpatient hospitalization. Lucas, supra.

The last arrangement of compensation in this case did not contemplate any future waxing and waning because there was no award of permanent disability. Therefore, because the current worsening resulted in inpatient hospitalization, claimant has established a compensable aggravation.

The insurer argues that claimant's worsening is not causally related to the original industrial injury. We disagree. Unlike the alleged August 1987 worsening which was due to a personal crisis with claimant's girl friend, the December 1987 worsening is materially due to the industrial injury. Shortly before his admission, claimant had been allowed to view his medical records, including the reports of the psychologists and psychiatrists. He perceived these to be replete with error and to be an invasion of his privacy. (Ex. 65-2). The resulting emotional upset necessitated hospitalization. Dr. Maletzky is of the opinion that the need for hospitalization is related to the industrial injury. (Ex. 69). Dr. Turco did not comment upon the work relatedness of the hospitalization per se, and in regards to claimant's general psychological condition, was not able to make any opinion on causation. (Ex. 72-4). We perceive no reason not to defer to the opinion of the attending doctor on this issue. See Weiland v. SAIF, 64 Or App 810 (1983). His opinion of causation is essentially uncontroverted. Therefore, we conclude that claimant's December 1987 hospitalization is materially related to the industrial injury.

Temporary Disability

Claimant argues that he is entitled to temporary disability beginning July 1, 1987, the day after the June 30, 1987 denial, for prevailing upon the aggravation issue because his attending doctor has authorized temporary disability retroactive to April 1987. (Ex. 64). We disagree.

Because this case presents more than one potential aggravation claim, we will address the temporary disability aspect of the insurer's processing duties. C.f. R. D. Robbins, 39 Van Natta 1112 (1987) (where the issue is compensability, instructions as to processing is dicta). Claimant has established that his condition worsened in December 1987, not before. Accordingly, claimant is only entitled to temporary disability benefits beginning in December 1987. We leave the choice of starting dates to the insurer and the Evaluation Section to determine, each according to their processing powers under statute. ORS 656.262(1); 656.268.

ORDER

The Referee's order dated April 20, 1988 is modified in part and affirmed in part. That portion of the Referee's order which set aside the insurer's June 30, 1987 aggravation denial is modified to set aside the December 16, 1987 aggravation denial. The aggravation claim is remanded to the insurer for processing according to law. The June 30, 1987 denial is reinstated and upheld. The Referee's attorney fee award is affirmed. Claimant's attorney is awarded $500 for services on Board review concerning the aggravation issue, to be paid by the insurer. The Board approves a client-paid fee, not to exceed $2,071, payable from the the insurer to its counsel.

April 19, 1990 Cite as 42 Van Natta 897 (1990)

In the Matter of the Compensation of
JOHN C. HOLLAND, Claimant
WCB Case No. 88-10344
ORDER ON RECONSIDERATION
Emmons, et al., Claimant Attorneys
Cummins, et al., Defense Attorneys

The insurer has requested reconsideration of that portion of our April 4, 1990 Order on Review that reclassified the Referee's unscheduled disability award into separate scheduled and unscheduled awards. The insurer claims that an offset of overpaid unscheduled disability should be permitted against the scheduled award.

By statute, the insurer cannot offset an overpayment of compensation paid pursuant to a Referee's order pending Board review. ORS 656.313(2); Sullivan v. Banister Pipeline American, 91 Or App 493, 497 (1988). Thus, it cannot recoup any of the monies paid to claimant for the Referee's award of an additional 35 percent (112 degrees) unscheduled disability for his cervical and related upper extremity injury.

Here, the Referee erred analytically in failing to separate out the loss of function of the arms; that loss of function was included in his award for unscheduled disability. As a result, our reclassification into separate scheduled and unscheduled awards does not require the insurer to make additional payment for claimant's scheduled disabilities, for it has not ultimately resulted in an increase in the amount of compensation. See Olds v. Superior Fast Freight, 36 Or App 673 (1978). As the Court of Appeals in Olds, we see no reason why claimant should be twice compensated for the same functional difficulties.

We adhere to our order awarding claimant an additional 10 percent (32 degrees) unscheduled permanent disability for his cervical condition, for a total award of 25 percent (80 degrees) unscheduled disability; 10 percent (19.2 degrees) scheduled permanent disability for the right arm; and 15 percent

(28.8 degrees) scheduled permanent disability for the left arm. However, because there there was no increase in the amount of compensation, claimant's attorney is not entitled to an approved fee equal to 25 percent of the scheduled disability compensation.

Accordingly, our April 4, 1990 order is withdrawn. On reconsideration, as amended herein, we adhere to and republish our April 4, 1990 order in its entirety. The parties' right of appeal shall run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
GARY D. POOLE, Claimant
WCB Case No. 88-07827
ORDER ON REVIEW
Dennis O'Malley, Claimant Attorney
Norman Cole (Saif), Defense Attorney
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Howell and Speer.

The SAIF Corporation requests review of Referee Podnar's order that: (1) set aside its aggravation denial of claimant's back condition; and (2) upheld CIGNA's denial of a "new injury" claim for the same condition. In its reply brief, CIGNA argues that our review should be limited to questions of law pursuant to ORS 656.307(2). On review, the issues are the standard of review and responsibility. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings with the exclusion of the first paragraph on page 2 of his Opinion and Order and with the following supplementation.

From May 1979 until October 1982, claimant required no medical treatment for his back condition. In October 1982, claimant sought treatment from Dr. Harvey for "gradually increasing back pain." (Exs. 5 & 6). Claimant did not seek medical treatment again until August 2, 1986. (Ex. 9). Claimant reported to Dr. Harvey in August 1986 that his back condition "never got all better since 1979." (Ex. 9-1).

At hearing the issues included both compensability and responsibility. (Tr. 14). An arbitrator was not appointed by the Board to determine the responsible party pursuant to ORS 656.307(2). (Tr. 14).

CONCLUSIONS OF LAW AND OPINION

Standard of Review

In its brief on review CIGNA argues that our review should be limited to questions of law pursuant to ORS 656.307(2) and not de novo. CIGNA is correct that on review the only issue is responsibility, but this is not the determinative factor for a "question of law" standard of review. The determinative factors are whether a ".307" order was issued prior to the hearing, and whether the Board appointed an arbitrator to make the determination. See ORS 656.307(2). A ".307" order was not issued. The Board did

not appoint an arbitrator. Our review is of the Referee's Opinion and Order (not of an arbitrator's application of the law). Accordingly, our review is de novo.

Responsibility

This case involves an accepted compensable injury followed by an increase in disability during employment with a later employer/insurer. In such a case, responsibility is fixed with the employer/insurer which accepted the claim. In order to shift responsibility, the original employer/insurer must prove affirmatively that a later employment independently contributed to a pathological worsening of the accepted condition. Spurlock v. International Paper Co., 89 Or App 461 (1988); Crowe v. Jeld-Wen, 77 Or App 81 (1985); Fred Meyer v. Benjamin Franklin Savings & Loan, 73 Or App 795 (1985); see Hensel Phelps v. Mirich, 81 Or App 290 (1986).

SAIF accepted claimant's back condition as a compensable condition in 1977. We are not persuaded by the evidence SAIF relies on in support of its contention that claimant's work for CIGNA's insured, independently contributed to a worsening of claimant's condition. At the most, we view the evidence as demonstrating that claimant's work activities with CIGNA's insured caused an "exacerbation" of his symptoms and not of the underlying condition. SAIF has not carried its burden.

ORDER

The Referee's order, dated November 14, 1988, is affirmed. The Board approves a client-paid fee, not to exceed $1,438.75, payable from CIGNA to its counsel.

April 19, 1990 Cite as 42 Van Natta 899 (1990)

In the Matter of the Compensation of
ROBERT C. SMITH, Claimant
WCB Case No. 88-19105
ORDER ON REVIEW
Charles D. Maier, Claimant Attorney
Saif Legal Department, Defense Attorney

Reviewed by Board Members Crider and Nichols.

Claimant requests review of Referee Garaventa's order that: (1) declined to assess penalties and attorney fees for the SAIF Corporation's alleged unreasonable failure to accept or deny claimant's injury claim timely; and (2) declined to assess penalties and attorney fees for SAIF's alleged failure to disclose documents timely. On review, the issues are penalties and related attorney fees. We affirm.

FINDINGS OF FACT

The Board adopts the Referee's findings of fact.

FINDINGS OF ULTIMATE FACT

SAIF's failure to accept or deny the compensability of claimant's left hand injury claim within 60 days was unreasonable.

SAIF's delay in providing discovery was unreasonable.

CONCLUSIONS OF LAW AND OPINION

FAILURE TO ACCEPT OR DENY WITHIN 60 DAYS

The Referee denied claimant's request for penalty and related attorney fees based upon SAIF's failure to accept or deny the claim within 60 days. The Referee concluded that SAIF did not act unreasonably and therefore that claimant was not entitled to an award of penalties or attorney fees. We find SAIF's conduct unreasonable. However, we decline to assess a penalty or related attorney fee for the reasons stated below.

SAIF failed to accept or deny claimant's left hand injury claim within 60 days. The employer had notice of the injury on June 21, 1988; but at the time of the hearing, November 29, 1988, the claim had not been accepted or denied by SAIF. We note that SAIF argues that the failure of claimant's treating physician to promptly provide a diagnosis may have hampered its acceptance. However, once SAIF had notice of claimant's diagnosis, it failed to act promptly in scheduling IME examinations. Due to SAIF's processing, at the time of the hearing SAIF had not accepted or denied claimant's claim. Therefore, we find that SAIF's failure to accept or deny the claim within 60 days was unreasonable.

However, SAIF paid interim compensation, during the period the claim was in deferred status. Therefore, there are no "amounts then due" upon which to base a penalty. Claimant is not entitled to a penalty for SAIF's unreasonable failure to accept or deny the claim within 60 days.

Unlike a penalty, an award of attorney fees is assessed under ORS 656.382, for unreasonably resisting the payment of compensation. While we find that SAIF acted unreasonably in the processing of this claim, we are unable to determine whether SAIF unreasonably resisted the payment of compensation because the record fails to establish the compensability of claimant's claim. Therefore, we are unable to award claimant an attorney fee. Ellis v. McCall Insulation, 308 Or 74 (1989).

FAILURE TO PROVIDE DISCOVERY TIMELY

The Referee found that OAR 438-07-015(2) applies only to "cases pending before the Hearings Division" and therefore did not rely upon the Board's rule. Instead the Referee relied upon the Director's rule, OAR 436-10-030(10). The Referee concluded that under the Director's rule SAIF did not act unreasonably in providing claimant with discovery documents and therefore declined to assess a penalty or attorney fee. We disagree with the Referee that SAIF's failure to provide discovery timely was reasonable.

Claimant is entitled to a penalty and related attorney fee if SAIF acted unreasonably in failing to provide discovery timely. In order to decide whether SAIF acted unreasonably, we must first determine whether the production of documents was regulated under the Board's discovery rule, the Director's rule or both. Under the Board's rule, OAR 438-07-015(2), the carrier must furnish requested materials to claimant within 15 days of the mailing date of the request. The Director's rule, OAR 436-10-030(10), does not identify any time period within which the materials must be produced.

Under OAR 438-05-010, the rules in Chapter 438 "shall apply to all cases pending before the Hearings Division. . . . " Thus, the discovery rule at OAR 438-07-015(2) is not applicable until a hearing request is filed. The Director's rule, on the other hand, applies to all requests including those made prior to the filing of a hearing request. At the time that claimant filed his request for discovery no hearing request was pending. Therefore, the Director's discovery rule rather than the Board's rule governs the facts of this case. Lawrence A. Durette, 42 Van Natta 413 (1990).

We must, therefore, determine whether SAIF's production of documents was reasonable under the Director's rule. Although the Referee concluded that SAIF acted reasonably under the Director's rule, we disagree.

The Director's rule does not establish a specific time within which a carrier must comply with a request for documents. In Durette, we concluded that the rule requires that documents be produced in a reasonable time given the circumstances surrounding the request. Whether the insurer's conduct is reasonable in a particular case depends not only on how quickly documents are produced but also on the claimant's need for the documents. Here SAIF originally sent claimant discovery material that related to a different claimant. When notified of the mistake, SAIF corrected the error and claimant received the requested discovery material within 30 days of his request. However, under the facts of this case, we conclude that clerical error is not a sufficient basis upon which to find the carrier acted reasonably. See Michael R. Redden, 40 Van Natta 1852 (1988). Moreover, at the time claimant requested the discovery material his claim had not as yet been accepted or denied, although the 60-day time for accepting or denying the claim had elapsed, thereby increasing the need for claimant's attorney to have the proper discovery material. We find that SAIF's failure to provide discovery timely was unreasonable.

Claimant is entitled to a penalty if we find that there were "amounts then due" upon which to base the penalty. Although the circumstances may support a penalty, we find nonetheless "no amounts due" upon which to base a penalty. Therefore, we find that claimant is not entitled to a penalty for SAIF's unreasonable failure to provide discovery documents to claimant.

In addition, claimant is entitled to an attorney fee if SAIF's delay in producing the requested documents is found to have been an unreasonable resistance to the payment of compensation within the meaning of ORS 656.382(1). While the circumstances may warrant an attorney fee we are unable to determine whether SAIF unreasonably resisted compensation because the record does not establish the compensability of claimant's claim. Therefore, we decline to award claimant an attorney fee for SAIF's unreasonable failure to provide discovery timely under the circumstances.

ORDER

The Referee's order dated December 8, 1988 is affirmed

April 19, 1990 Cite as 42 Van Natta 901 (1990)

In the Matter of the Compensation of
RICHARD P. VAUGHN, Claimant
WCB Case No. 88-14609
ORDER ON REVIEW
Robert E. Nelson, Claimant Attorney
Stafford J. Hazelett, Defense Attorney

Reviewed by Board Members Speer and Howell.

Claimant requests review of Referee Schultz's order which upheld the insurer's denial of his occupational disease claim for carpal tunnel syndrome. In his appellant's brief, claimant alleges entitlement to carrier-paid attorney fees pursuant to ORS 656.382. On review, the issues are compensability and attorney fees. We affirm.

FINDINGS OF FACT

The Board adopts the Referee's "Findings of Fact."

CONCLUSIONS OF LAW AND OPINION

Compensability

The Referee found claimant's occupational disease claim not to be compensable. We agree.

For an occupational disease claim, the date of "injury" is the date upon which the claimant was last exposed to the employment conditions which cause the disease. Johnson v. SAIF, 78 Or App 143, rev den 301 Or 240 (1986). Claimant alleged that his work exposure during March 1988, led to the carpal tunnel condition. He filed his workers' compensation claim after March 1988. Accordingly, the new occupational disease law which became effective January 1, 1988, is applicable. ORS 656.802.

In his order, the Referee stated that claimant's work activities must be the major contributing cause of the occupational disease. That was the standard before the statute was changed by the 1987 legislature. See Weller v. Union Carbide, 288 Or 27 (1979). Under current law, a claimant must prove, by a preponderance of the evidence, that work activities are a material contributing cause of the disease leading to disability and/or the need for medical care. ORS 656.802(1)(c); See Donna E. Aschbacher, 41 Van Natta 1242 (1989).

Claimant relies on his treating physician, Dr. Balkovich, who stated that the carpal tunnel condition "appeared" to be related to his work. Because we find that Dr. Balkovich's opinion is conclusory and does not offer an explanation of the pathology of the condition, we conclude that his opinion lacks persuasiveness. Somers v. SAIF, 77 Or App 259 (1986). Moreover, we conclude that the question of the causation of claimant's condition requires expert analysis rather than expert external observation. Thus, we do not give special credit to the evidence from claimant's treating physician in this case. Allie v. SAIF, 79 Or App 284, 287 (1986); see also Somers v. SAIF, supra.

On the other hand, we find the opinion of Dr. Button, a hand surgery specialist, to be thorough and well-reasoned. He examined claimant and had EMG and nerve conduction studies performed. Dr. Button did not believe that claimant's bilateral carpal tunnel conditions "directly relate to his relatively brief period of employment" with the insured.

A third physician, Dr. Weintraub, who examined claimant on referral from Dr. Balkovich, was unable to come to any strong conclusion as to whether claimant's carpal tunnel complaints were work related or not.

After de novo review, we conclude that claimant has failed to sustain his burden of proving that his work activities were a material cause of his carpal tunnel syndrome.

Attorney Fee

In the conclusion of his brief, claimant asserts entitlement to an attorney fee pursuant to ORS 656.382. Because claimant, rather than the insurer, requested review, claimant must be alleging entitlement to a penalty-related attorney fee pursuant to ORS 656.382(1). See ORS 656.382(1) and (2). However, penalty-related attorney fees were not an issue at hearing. (Tr. 1). Thus, claimant has waived his right to assert the issue on Board review. See Mavis v. SAIF, 45 Or App 1059 (1980).

ORDER

The Referee's order dated November 18, 1988, is affirmed.

In the Matter of the Compensation of
JIMMY M. CAMPOZ, Claimant
WCB Case No. 88-14232
ORDER ON REVIEW
Brian R. Whitehead, Claimant Attorney
Kevin L. Mannix, PC, Defense Attorneys

Reviewed by Board Members Myers and Cushing.

Claimant requests review of those portions of Referee Nichols' order which dismissed his request for hearing on the issue of extent of disability. On review the issues are: (1) whether claimant is precluded from raising the issue of extent of disability as a result of a stipulation; and (2) if claimant is not precluded, extent of disability. We modify.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following supplementation. The insurer requested a Determination Order on April 27, 1988. A copy of the form requesting the Determination Order was sent to claimant's attorney. On May 4, 1988, the insurer's representative signed a stipulation which fixed claimant's medically stationary date as March 7, 1988, resolved an issue of temporary disability and awarded claimant's attorney an attorney fee. The stipulation recited:

> "Claimant's request for hearing and all issues raised or raisable at the time of this stipulation is approved shall be dismissed with prejudice."

Claimant and his attorney signed the stipulation on May 5, 1988. The Determination Order, at issue, was published on May 12, 1988. Claimant requested a hearing to protest the Determination Order on May 17, 1988. A Referee approved the stipulation on May 20, 1988.

CONCLUSIONS AND OPINION

The Referee concluded that claimant was barred from litigating the issue of extent of disability based on the doctrine of res judicata. She reasoned that the issue of extent of disability was raisable at the time the earlier Referee approved the stipulation and that the language of the stipulation disposed of all issues raisable at that time. We disagree.

It is important to distinguish two different aspects or rules of res judicata. The first rule, formerly referred to as res judicata, is now termed "claim preclusion". The second aspect is "issue preclusion"; formerly referred to as the rules of direct estoppel or collateral estoppel. Restatement, (Second) of Judgments, Introduction at 1-5 (1980); North Clackamas School Dist. v. White, 305 Or 48, on recon 305 Or 468 (1988).

"Claim (cause of action) preclusion" is the rule that a party may not assert a claim arising from a transaction with respect to which he has already prosecuted such a claim to a valid and final judgment. See Restatement, (Second) of Judgments, Introduction 1 and 18 & 19 (1980); Dean v. Exotic Veneers, Inc., 81 Or 188 (1975); Carr v. Allied Plating Co., 81 Or App 306 (1986); and Tana Wilson, 40 Van Natta 476 (1988). Three key elements of "claim preclusion" are: 1) the same parties (or those in privity); 2) the same claim (or a second claim arising from the same transaction or series of connected transactions out of which the first claim arose); and 3) a valid and final judgment on the first claim.

This case does not involve claim preclusion. Although there is an identity of parties in this case and the stipulation and a final judgment in the stipulation, the question of extent of permanent disability is not the same claim as the

questions of when claimant became medically stationary or the dates when claimant was entitled to temporary disability benefits. Neither does it involve the same transaction out of which the settlement arose.

"Issue preclusion" may involve the same claim (direct estoppel) or entirely different claims (collateral estoppel). The Oregon Supreme Court in State Farm Fire & Cas. v. Reuter, 299 Or 155, 158 (1985) explained those rules:

> "If a person has had a full and fair opportunity to litigate a claim to final judgment, most courts (including this one) hold that the decision on a particular issue or determinative fact is determinative in a subsequent action between the parties on the same claim (direct estoppel). See, e.g., Waxwing Cedar Products v. Koennecke, 278 Or 603, 610, 564, P2d 1061, 1064-65 (1977); Bahler v. Fletcher, 257 Or 1, 4, 474 P2d 329, 331 (1970). The judgment generally is conclusive as well in a different action between parties as to issues actually litigated and determined in the prior action if their determination was essential to the judgment (collateral estoppel)."

The Restatement, (Second) of Judgments, 27 (1980); states the general "issue preclusion" rule as follows:

> "When an issue of fact or law 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 claim."

Key elements of issue preclusion include: 1) the same parties; 2) a valid and final judgment; 3) actual litigation of an issue of fact or law; and 4) a determination of such issue which is essential to the judgment.

We conclude that this case does not involve issue preclusion. There was no actual litigation of the issue of extent of disability in the settlement.

The only way that we might conclude that claimant is barred from raising the issue of extent of disability is if we were to conclude that by the stipulation claimant had waived his right to raise the issue of extent of permanent disability. See, Leola Judson, 42 Van Natta 321 (1990); but see, ORS 656.236(1). However, in this case, we conclude that claimant could not have waived his right to raise the issue of extent of disability because at the time he agreed to the stipulation, the Determination Order had not issued and, therefore, the issue of extent of disability was not ripe. See, John Schiller, 39 Van Natta 368 (1987). We arrive at this conclusion notwithstanding the fact that the stipulation purports to resolve all issues raisable at the time the stipulation was approved. Accordingly, we reverse that portion of the Referee's order which concluded that claimant was barred from raising the issue of extent of disability.

On the issue of extent of disability, we adopt that portion of the Referee's "Opinion and Conclusions" entitled "Extent." On the merits, claimant has not proven entitlement to any award for permanent disability.

Even though claimant has prevailed on the issue of the dismissal, he has not prevailed on the issue of entitlement to increased compensation. Accordingly, he is not entitled to an attorney fee. ORS 656.386(2).

ORDER

The Referee's order dated December 13, 1988 is modified. That portion of the Referee's order which dismissed claimant's request for hearing is reversed.

That portion of the Referee's order which held that claimant is not entitled to an award for permanent disability is affirmed. The Board approves a client-paid fee, not to exceed $749, to be paid by the insurer to its attorney.

April 20, 1990 Cite as 42 Van Natta 905 (1990)

In the Matter of the Compensation of
LYNDA R. PACE, Claimant
WCB Case Nos. 87-12731 & 87-12730
ORDER ON REVIEW
Charles D. Maier, Claimant Attorney
Meyers & Radler, Defense Attorneys

Reviewed by Board Members Brittingham and Nichols.

Claimant requests review of those portions of Referee Borchers' order that: (1) upheld the self-insured employer's denial of a claim for thermographic evaluation of claimant's low back and right arm conditions; (2) upheld the employer's denial of current chiropractic treatment for her low back and right arm; and (3) declined to assess penalties and attorney fees in connection with the above denials. On review, the issues are medical services, penalties and attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

The Board affirms and adopts the Referee's findings of fact as set forth in the FACTS section of her order with the following supplementation.

Claimant filed a claim for her low back condition on December 30, 1986, which was accepted by her employer as a "new injury" on May 8, 1987.

Claimant's right elbow condition was found medically stationary on July 15, 1987.

On August 11, 1987, the employer denied a claim for thermographic evaluation of the right elbow and low back as not being reasonable and necessary. In addition, the denial denied chiropractic care of the right elbow and low back as not being related to claimant's compensable injuries or reasonable and necessary.

At the time the denial issued, claimant's low back condition, for which he was being treated, was inseparable from her accepted low back condition, the claim for which remained in open status.

An August 20, 1987 Determination Order, closing the right elbow claim, issued awarding claimant temporary total disability from March 19, 1987 through July 15, 1987.

CONCLUSIONS OF LAW AND OPINION

A carrier can deny medical services on the basis that they are not causally related to the compensable injury, or because the requested service is not reasonable and necessary. In the present case, the Referee found that claimant's need for medical services for his right elbow was causally related to her compensable injuries, but found that chiropractic treatment and thermographic evaluation were not reasonable and necessary, as they were not effective toward the process of recovery. The Referee did not address whether the need for low back treatment was causally related to claimant's compensable injury. We affirm in part and reverse in part.

Thermographic Evaluation

We adopt the Referee's opinion concerning this issue.

Chiropractic Treatment

The employer's August 11, 1987 denial denied chiropractic care for claimant's right elbow and low back conditions as not being related to her compensable injuries and as not being reasonable and necessary.

At the time the employer's denial issued, August 11, 1987, claimant's right elbow claim was not yet closed. Closure for the right elbow condition did not occur until the August 20, 1987 Determination Order issued and, as such, the employer's denial was premature. See Guerrero v. Stayton Canning Company, 92 Or App 209, 212 (1988). However, we find that the employer was not attempting to short-circuit claims processing and, therefore, the denial could become valid with the first closure. Guerrero at 212. As such, we address the merits.

First, we address the employer's denial on the basis that it denied claimant's chiropractic care as not being causally related to her right elbow injury. Based upon the well-reasoned and complete opinions of Dr. Button and the Western Medical Consultants, we conclude that there continues to be a causal relationship between claimant's chiropractic care and her compensable right elbow.

However, we find that claimant has failed to meet her burden of proving that the requested chiropractic care for her right elbow injury was reasonable and necessary for her compensable injury. To prove the reasonableness and necessity of rendered medical services, a claimant must show that at the time the services were rendered they were likely to be of curative, palliative, preventative or restorative benefit. West v. SAIF, supra; Michael D. Barlow, 38 Van Natta 196, 197-98 (1986).

Claimant's treating physician, Dr. Warner, concluded that chiropractic care for her right elbow was reasonable and necessary, although he admitted that other types of care might be reasonable as well. Dr. Button, who examined claimant at the requests of the employer, found no objective abnormalities of the right elbow and opined that the chiropractic care for her upper extremities condition was not reasonable and necessary. The Western Medical Consultants on two occasions found that the chiropractic care claimant was receiving for her right elbow condition was not reasonable and necessary.

We are not persuaded by the opinion of claimant's treating physician; instead, we defer to the well-reasoned and complete opinions of Dr. Button and the Western Medical Consultants. Somers v. SAIF, 77 Or App 215 (1986). Therefore, we find that claimant has failed to prove the reasonableness and necessity of her current chiropractic care for her right elbow injury of February 1987.

In addition, the employer's August 11, 1987 denial denied chiropractic care for claimant's low back condition. The claimant's low back injury claim had not been closed at the time of the hearing. Under such circumstances, the employer is prohibited from issuing a partial denial for medical services for the same accepted condition. Guerrero, supra, at 212, 213; Roller v. Weyerhaeuser Co., 67 Or App 583, on reconsideration 68 Or App 743, Rev den 297 Or 601 (1984); Safstrom v. Riedel International, Inc., 65 Or App 728, rev den 297 Or 124 (1983). Therefore, we conclude the employer's denial of claimant's low back condition is void.

Penalties and Attorney Fees

Finally, we disagree with the Referee that penalties and attorney fees are not warranted. ORS 656.262(10) provides for a penalty based upon a percentage of "amounts then due." In the instant case, the employer's denial of chiropractic treatment for claimant's low back is void. Claimant is entitled to a 25

percent penalty based upon all the outstanding chiropractic bills for treatment relating to her low back.

Claimant's counsel is statutorily entitled to a reasonable, insurer-paid attorney fee for services rendered in setting aside the denial of claimant's chiropractic treatment for her low back condition and because that denial was unreasonable. Such a fee is defined as an "assessed fee." See OAR 438-15-005(2). However, we cannot award 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 cannot presently be awarded. See OAR 438-15-010(5).

ORDER

The Referee's order dated January 7, 1988 is affirmed in part and reversed in part. That portion of the order that upheld the denial for chiropractic care for claimant's low back is reversed. The claim is remanded to the self-insured employer for further processing in accordance with law. That portion of the order that upheld the remaining contentions of the denial of August 11, 1987 is affirmed. The employer shall pay to claimant a penalty of 25 percent of the overdue chiropractic bills for treatment to her low back. A client-paid fee, payable from the employer to its counsel, not to exceed $1,249.50, is approved.

April 20, 1990 Cite as 42 Van Natta 907 (1990)

In the Matter of the Compensation of
KIMBERLY A. SANTANGELO, Claimant
WCB Case No. 88-13465
ORDER ON REVIEW
Gastineau & Smith, Claimant Attorneys
Cowling & Heysell, Defense Attorneys

Reviewed by Board Members Cushing and Myers.

The self-insured employer requests review of that portion of Referee Brown's order which found that claimant was entitled to a temporary disability compensation rate based on a 40-hour work week. On review, the issue is the rate of temporary disability. We modify.

FINDINGS OF FACT

The Board adopts the Referee's Findings of Fact, as set forth in the "Findings" portion of the order, with the exception of the following: "(6) At the time of her injury, Ms. Santangelo had a reasonable expectation that she would be regularly employed 40 hours per week."

The Board adopts the Referee's "Ultimate Findings of Fact" with the exception of the following: "(3) At the time of her injury, Ms. Santangelo was a regularly employed on-call employee with a reasonable expectation she would be provided 40 hours per week employment."

In place of the aforementioned exceptions, we find that claimant was not regularly employed with the employer. Rather, claimant was employed on a "part-time" status.

CONCLUSIONS OF LAW AND OPINION

The Board adopts the Referee's Conclusions of Law, as set forth in the "Opinion" portion of the order, with the following exception:

> "Here, Ms. Santangelo was actually employed 40 hours per week for 1 1/2 to 2 months prior to injury, and has been ever since her release back to work. She satisfied the statutory [regularly employed] definition; there is no need to resort to the Director's rules. Saville v. EBI, 81 Or App 469 (1986); cf. Ovenby v. Kaiser Health Plan, 93 Or App 175 (1988)."

The Referee concluded that because claimant had been working full-time both prior to and after her compensable injury, and because she had a "reasonable expectation" of full-time work, she was "regularly employed." As a result, the Referee ordered the employer to recompute claimant's temporary disability compensation based on an average work week of 40 hours. We disagree.

Claimant argues that she is a regular employee and her benefits should be calculated under ORS 656.210 rather than former OAR 436-60-020. ORS 656.210 regulates the computation of time loss benefits for temporary total disability, determining such disability based on the number of days a week a claimant is "regularly employed."

Claimant first became employed with the employer in November 1987, working full-time during the Christmas season, followed by decreasing hours both in January and February, 1988. Near the end of February 1988, claimant was transferred from one department to another, where she worked full-time for approximately two months. Thereafter, claimant returned to the previous department on an on-call basis. (Tr. 17-19). She worked 3 days, then was on-call for the following 2 days. Claimant suffered her compensable injury while working in this department. Therefore, we find that, at the time of her injury, claimant was on an "on-call" work status and working varying hours.

Although claimant may well have had an expectation of working a regular full-time work week, considering the variety of work assignments and hours detailed above, we conclude that claimant was not "regularly employed." Even if claimant was considered to be a regular employee, she worked varying hours and her benefits would still be calculated under the Director's rules. Lowry v. Du Log, Inc., 99 Or App 459 (1989). Therefore, we conclude that claimant's temporary disability rate should be calculated according to former OAR 436-60-020(4)(a).

ORDER

The Referee's order dated December 6, 1988, is modified in part. The self-insured employer shall recalculate claimant's temporary disability rate pursuant to OAR 436-60-020(4)(a) by averaging her actual hours worked over 26 weeks prior to injury. The remainder of the order is affirmed. A client-paid fee, payable from the employer to its counsel, not to exceed $373, is approved.

April 20, 1990 Cite as 42 Van Natta 908 (1990)

In the Matter of the Compensation of
HAMID A. SARHADI, aka ABDUL H. SARHADI, Claimant
WCB Case No. 88-16316
ORDER ON REVIEW
Andrew H. Josephson, Claimant Attorney
Davis & Bostwick, Defense Attorneys

Reviewed by Board Members Cushing and Gerner.

The insurer requests review of Referee Galton's order which: (1) set aside its denial of claimant's injury claim for an ulcer condition; and (2) assessed penalties and attorney fees for an unreasonable denial. On review, the issues are compensability, penalties and attorney fees. We reverse.

FINDINGS OF FACT

Claimant has been employed as a power sewing machine operator with the insured since June 17, 1985. On April 29, 1988, claimant consumed some sour milk from a vending machine in the insured's lunchroom and became ill. On May 4, 1988, he sought medical attention for an upset stomach, constipation and fever.

Claimant submitted an unsigned and undated 801 form. The insured had notice of claimant's claim on May 4, 1988. On September 16, 1988, the insurer denied claimant's claim for a stomach condition. It alleged that claimant's condition did not arise out of the course and scope of his employment. (Ex. 17). Claimant had experienced heartburn and epigastric pain prior to the alleged industrial injury and had sought medical prescriptions for these conditions.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant had suffered a compensable injury based on claimant's credible testimony that drinking sour milk caused his stomach problems. We disagree.

Claimant has the burden to show that the April 29, 1988 incident was a material contributing cause of his stomach condition. Hutchenson v. Weyerhaeuser, 288 Or 51, 56 (1979); James v. Kemper Ins. Co., 81 Or App 80, 81 (1986). We conclude that the causal connection between claimant's drinking sour milk and his ulcer is a complicated medical question that requires expert medical evidence to establish causation. Uris v. Compensation Department, 247 Or 420, 426 (1967); Kassahn v. Publishers Paper Co., 76 Or 105, 109 (1985).

In Uris, supra, the Court held that the distinguishing features of a medically uncomplicated situation are, "...the immediate appearance of symptoms, the prompt reporting of the occurrence by the workman to his superior and consultation with a physician and the fact that plaintiff was theretofore in good health and free from any disability of the kind involved." Id. at 426. Here, claimant was not free of stomach symptoms before the alleged injury date. He had experienced stomach pain and sought medical attention prior to drinking sour milk on April 29, 1988. Accordingly, we do not find causation in this case to be an "uncomplicated" situation such as in Uris, supra. See Paul R. Cheek, 40 Van Natta 1868 (1988). Indeed, the causation of claimant's stomach condition is a medically complex question. We find claimant has not met his burden of proof.

No physician opines that claimant's drinking of sour milk caused his stomach condition. Claimant's own belief that it did, while probative, is not persuasive. Accordingly, we conclude that claimant has failed to establish a causal connection between his employment and his stomach condition.

Considering this conclusion, we further hold that the insurer's denial was not unreasonable. Consequently, we also reverse the Referee's assessment of a penalty and associated attorney fee.

ORDER

The Referee's order, dated January 4, 1989 is reversed. The insurer's denial is reinstated and upheld. The Referee's attorney fee award of $1,800 to claimant's counsel is reversed. The Referee's penalty assessment and associated $150 attorney fee award is reversed.

In the Matter of the Compensation of
LINDA R. SCOTT, Claimant
WCB Case No. 88-13640
ORDER ON REVIEW
Swaim & Betterton, Claimant Attorneys
Cummins, et al., Defense Attorneys

Reviewed by Board Members Myers and Gerner.

Claimant requests review of those portions of Referee Foster's order which: (1) upheld the insurer's "de facto" denial of her claim for a left knee condition; (2) found that the insurer had accurately calculated her temporary disability benefits; (3) declined to assess a penalty or related attorney fee for alleged unreasonable termination of temporary disability benefits; and (4) awarded her counsel a $1,350 attorney fee for services rendered at hearing. The insurer cross-requests review of that portion of the Referee's order which set aside its partial denial of claimant's medical services claim for a low back condition. On review, the issues are compensability, calculations of temporary disability benefits, penalties, attorney fees and amount of attorney fees. We affirm in part and modify in part.

FINDINGS OF FACT

In September 1987, claimant sustained a compensable low back injury. At the time of injury, she had worked for approximately three weeks for Oregon Freeze Dry Company as a part of Kelly Services, the instant employer. She sought treatment at an emergency room for a lumbar sprain. Several days later, she was referred to Dr. Fitchett, orthopedist. He recommended physical therapy consisting of hot and cold packs and ultrasound massage. Claimant participated in physical therapy three times per week for the next several months.

In late October 1987, claimant was grocery shopping with her mother on the way home from physical therapy. She went around her car and in attempting to step over a concrete bump, caught her left foot and fell on her left hip and knee. She sought treatment for this injury at the emergency room. As a result of the falling incident, claimant underwent arthroscopic surgery on her left knee in January 1988.

Claimant continued to experience low back pain and, in mid-1988, a lumbar CT scan revealed a herniated disc at L5-S1. In June 1988, claimant was seen by Dr. Poulson, orthopedist. Dr. Poulson reported that claimant experienced persistent back pain and requested authorization for low back surgery. In July 1988, the insurer denied claimant's request for low back surgery.

At hearing, the parties stipulated that claimant's left knee condition was "de facto" denied.

During her three week employment with Oregon Freeze Dry Company, claimant worked on an "as needed" basis. She worked five days per week, between 7 1/2 and 10 1/2 hours per day and was paid $4.50 per hour.

CONCLUSIONS OF LAW AND OPINION

Compensability

Left Knee Condition

The Referee concluded that claimant's left knee condition was not materially related to her compensable low back condition. We agree.

Claimant bears the burden of proving by a preponderance of the evidence that an industrial injury materially contributed to her disability or need for medical treatment. Milburn v. Weyerhaeuser Co., 88 Or App 375, 378 (1987).

Accordingly, claimant must establish that the industrial injury of September 1987 materially contributed to her left knee condition and need for treatment.

Drs. Fitchett and Poulson, both of whom have treated claimant, opine that there is no causal relationship between her compensable back injury and her left knee condition. This conclusion is also supported by the opinions of Dr. Rosenbaum and the Orthopaedic Consultants. Further, Dr. Rosenbaum opined that claimant's compensable back condition did not cause claimant to trip over the concrete bump. There is no contrary medical evidence. Accordingly, we conclude that claimant has failed to establish that her compensable back injury is a material contributing cause of her left knee condition.

Low Back Surgery

The Referee concluded that claimant's compensable low back injury was a material contributing cause of her need for back surgery. We agree.

For every 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). Claimant bears the burden of proving by a preponderance of the evidence that an industrial injury materially contributed to the need for medical treatment. Hutcheson v. Weyerhaeuser, 288 Or 51, 56 (1979).

Dr. Poulson reported that claimant had a herniated disc at L5-S1 which was causing her current back symptoms. He opined that her condition was causally related to the compensable injury. Dr. Tsai also opined that claimant's current condition was causally related to her current low back condition. Dr. Fitchett opined that the October 1987 falling incident was the most significant contributor to claimant's low back condition, but noted that there may have been some "blending" of that incident and the September 1987 compensable incident. The Orthopaedic Consultants opined that claimant's September 1987 compensable injury was resolved, but offered no further explanation in regard to causation. Finally, Dr. Rosenbaum did not offer an opinion regarding causation.

We conclude that claimant has established that her compensable injury is a material contributing cause to her current need for surgery. In reaching this conclusion, we rely on the opinions of Drs. Poulson and Tsai. Further, although Dr. Fitchett felt that the October 1987 incident was the most significant contributor to claimant's current condition, we interpret his opinion to support the conclusion that the compensable injury was at least a material contributing cause. See Van Blokland v. Oregon Health Sciences University, 87 Or App 694 (1987); McClendon v. Nabisco Brands, Inc., 77 Or App 412 (1986). Accordingly, the requested surgery is compensable.

Calculation of Temporary Disability

The Referee found that claimant's rate of temporary disability rate should be calculated on the basis of five days per week, 7 1/2 hours per day, at $4.50 per hour. We modify.

Former OAR 436-60-020(4)(a) provides that in the case of on-call employees who have worked less than four weeks, temporary disability benefits are computed based on the intent of the worker and employer at the time of hire.

In the instant case, claimant was hired to work "as needed." Although the 801 form listed claimant's hours as 7 1/2 per day, during claimant's short duration, she occasionally worked 10 1/2 hours per day. The insurer originally calculated claimant's rate of temporary disability on the basis of 7 1/2 hours per day. Later, however, it recalculated to take into account claimant's actual hours, including that days in which she worked up to 10 1/2 hours per day.

Under these circumstances, we conclude that claimant's rate of temporary disability, based on her actual hours, more accurately reflects the intent of the parties at the time of hire. Accordingly, we modify the Referee's order to reflect this change.

Penalties and Attorney Fees

Claimant seeks penalties and attorney fees for an alleged unreasonable termination of temporary disability benefits. The Referee did not address this issue. Although claimant's hearing request contains an "x" beside the issue line of Penalties & Attorney Fees, that issue was not raised as an issue by claimant's counsel at the hearing. The only discussion between the parties concerned entitlement to temporary disability benefits.

Under these circumstances, we conclude that the issue of penalties and attorney fees is being raised for the first time on Board review. See Linda A. Stevenson, 42 Van Natta 86, 262 (1990). As this issue was not raised at hearing, we decline to address it on review. Mavis v. SAIF, 45 Or App 1059, 1062-63 (1980); Richard C. Centeno, 41 Van Natta 619, 620 (1989).

Attorney Fees

The Referee granted claimant's counsel an attorney fee of $1,350 for services rendered in overcoming the insurer's denial of the low back surgery. Claimant contends this award is inadequate. After review of claimant's counsel's statement of services and retainer agreement, and considering the factors set forth in OAR 438-15-010(6), we conclude that the Referee's award of attorney fees adequately compensates claimant's counsel for his efforts at hearing concerning the surgery denial.

ORDER

The Referee's order dated November 25, 1988, is modified in part and affirmed in part. That portion which found that claimant's temporary disability benefits should be calculated on the basis of a 7 1/2 hour work day is modified. Claimant's temporary disability benefits are to be calculated based on an average of her actual hours worked. Claimant's attorney is awarded 25 percent of the increased compensation, if any, created by this order, not to exceed $3,800. The remainder of the order is affirmed. For services on review concerning the back surgery denial, claimant's counsel is awarded a reasonable assessed fee of $500, payable by the insurer. A client-paid fee, not to exceed $2,866.50, is approved, payable by the insurer to its counsel.

In the Matter of the Compensation of
JULIE A. SIMONEAU, Claimant
WCB Case No. 88-14038
ORDER ON REVIEW
Andrew H. Josephson, Claimant Attorney
Roberts, et al., Defense Attorneys

Reviewed by Board Members Myers and Cushing.

Claimant requests review of those portions of Referee Mills' order which: (1) upheld the insurer's denial of her aggravation claim for a low back injury; (2) upheld the insurer's partial denial of her medical services claim for current chiropractic treatment; and (3) affirmed a Determination Order which awarded 10 percent (32 degrees) unscheduled permanent disability for a low back

injury. On review, the issues are aggravation, compensability and extent of permanent disability. We affirm.

FINDINGS OF FACT

In June 1986, claimant sustained a compensable injury to her right low back. The injury occurred while she was lifting a case of merchandise. Her injury was a lumbar sprain and she was treated by Dr. Villnave, chiropractor. In August 1986, claimant began treating with Dr. Kennedy, chiropractor. Dr. Kennedy treated claimant approximately three times per week for the next several months.

Dr. Kennedy released claimant to modified work on October 5, 1986. On October 17, 1986, claimant was again released from work. Thereafter, in January 1987, claimant was released to modified work. Claimant continued light duty work, although missing occasional days due to back pain, until June 25, 1987 at which time Dr. Kennedy released her from work. An August 1987 Determination Order closed claimant's claim without awarding any permanent disability. On August 14, 1987, the insurer denied claimant's chiropractic treatment as well as her psychological condition. Claimant returned to modified work in September 1987. A September 1987 Determination Order rescinded that prior Determination Order and reopened claimant's claim.

In October 1987, the insurer rescinded its denial of chiropractic treatment and reiterated that the psychological condition remained in denied status. In February 1988, the parties entered into a Disputed Claim Settlement which resulted in denial of claimant's psychological condition remaining in force. Claimant continued to work until June 1988 when Dr. Kennedy again released her from work. Dr. Kennedy resumed treating claimant approximately three times per week. Claimant had not treated with Dr. Kennedy from approximately January 1988 through May 1988.

In June 1988, a Determination Order closed claimant's claim and awarded 10 percent unscheduled permanent disability. On August 10, 1988, the insurer denied claimant's aggravation claim as well as chiropractic treatment. Following the denial, claimant continued to treat with Dr. Kennedy.

Claimant is 28 years old and has a GED. Claimant's work experience includes work as a supervisor/cashier in a retail store, pantry food preparer, rental car driver, sales clerk and restaurant food preparer. As a result of her compensable injury, claimant has sustained permanent impairment in the minimal range.

CONCLUSIONS OF LAW AND OPINION

At the outset, we note that various medical providers have reported that psychosomatic factors play a large role in claimant's subjective complaints. However, the psychological aspect of claimant's condition is noncompensable by virtue of the February 1988 Disputed Claim Settlement and therefore cannot be considered. Further, the Referee found that claimant's testimony, regarding disabling pain, was not consistent with the medical documentation of her condition and therefore found it unreliable. We agree and give claimant's testimony little weight.

Aggravation

The Referee concluded that claimant had not sustained a compensable aggravation in June 1988. We agree.

To establish a compensable aggravation, claimant must prove a worsened condition resulting from the industrial injury. ORS 656.273(1); Perry v. SAIF, 307 Or 654 (1989). To prove a worsening, claimant must show that she is more disabled; i.e., less able to work, since the last arrangement of compensation.

Dr. Kennedy, claimant's treating chiropractor, opined that claimant's condition worsened in June 1988, which resulted in claimant's being released from work. Dr. Milanovich, consulting chiropractor, concurred with Dr. Kennedy. Dr. Kennedy's opinion, as well as Dr. Milanovich's concurrence, however, are based upon claimant's subjective complaints which we have found not reliable. Accordingly, we are not persuaded by Dr. Kennedy's or Dr. Milanovich's opinion. See Miller v. Granite Construction Co., 28 Or App 473, 476 (1977).

By contrast, Dr. Tilden opined that claimant did not have any objective findings to indicate a worsening of her compensable condition in June 1988. Dr. Tilden, in conjunction with Western Medical Consultants, examined claimant in July 1987 and August 1988. He reported no change in her condition and opined that psychosomatic factors were playing a significant role in her subjective complaints. We find Dr. Tilden's opinion persuasive.

We conclude that claimant has not established that her condition worsened in June 1988. In reaching this conclusion, we are aware that an MRI scan did show a slight herniation and transitional disc, however, both Dr. Tilden and Butler reported that there was no nerve root compression or irritation as a result. Further, in concluding that claimant's condition had not worsened, Dr. Tilden persuasively explained that claimant's subjective symptoms did not correlate with the MRI findings.

Chiropractic Treatment

The Referee concluded that claimant's current chiropractic treatment was not reasonable and necessary as a result of her compensable injury. We agree.

For her compensable injury, claimant is entitled to medical services "for such period as the nature of the injury or the process or 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. McGarry v. SAIF, 24 Or App 883, 888 (1976). Claimant bears the burden of establishing that the treatment is reasonable and necessary.

Dr. Kennedy reported that his treatment is reasonable and necessary due to claimant's chronic back pain. Drs. Bussanich and Milanovich concur in this opinion. As noted above, however, Dr. Kennedy's assessment is based on claimant's subjective complaints which are not reliable. Accordingly, we do not find his opinion or the supporting opinions persuasive.

Dr. Tilden opined that chiropractic care was neither reasonable nor necessary. His opinion is based on the fact that claimant has no objective findings to support her subjective complaints. He reported that claimant's subjective complaints stem from psychosomatic factors. Finally, he opined that chiropractic care, particularly manipulation, would in fact harm claimant due to the presence of the transitional disc. Dr. Duncan concurred with Dr. Tilden's assessment. We find the well reasoned opinions of Drs. Tilden and Duncan persuasive. Accordingly, we conclude that claimant has not established that her current chiropractic treatment is reasonable and necessary as a result of her compensable injury.

Extent of Permanent Disability

We adopt the conclusions and reasoning concerning extent of permanent unscheduled disability as set forth in the Referee's order.

ORDER

The Referee's order, dated December 5, 1988, is affirmed. A client-paid fee, not to exceed $1,688, is approved.

In the Matter of the Compensation of
BURTON A. ROCHEFORT, Claimant
WCB Case No. 88-14395
ORDER ON REVIEW
Callahan, et al., Claimant Attorneys
John Motley (Saif), Defense Attorney

Reviewed by Board Members Nichols and Brittingham.

Claimant requests review of Referee Seifert's order that upheld the SAIF Corporation's denial of claimant's right foot condition. On review, the issue is compensability. We affirm.

FINDINGS OF FACT AND ULTIMATE FACT

We adopt the Referee's findings with the following supplementation:

Claimant received no treatment from either Dr. Miller or Dr. Fitchett. Neither doctor authorized time loss for claimant's arthritic condition nor did they place any limitations on claimant's activities. Claimant quit his job with the school district for reasons unrelated to this arthritic foot condition.

CONCLUSIONS OF LAW AND OPINION

The Referee upheld SAIF's denial because claimant had failed to prove that his work activities were the major contributing cause of a worsening of his pre-existing arthritic condition. We agree with the result and find that the denial should be upheld but for other reasons.

This is an occupational disease claim in which claimant's last work exposure occurred in May 1988. Therefore this claim would be governed by the current occupational disease law that became effective January 1, 1988. The applicable section of that law is ORS 656.802(1)(c) dealing with repetitive trauma. That statute defines an occupational disease as: "Any series of traumatic events or occurrences arising out of and in the course of employment which requires medical services or results in physical disability or death."

With the change in the law, claimant need only prove that his work activity was a material contributing cause of an increase in symptoms of his pre-existing arthritic condition. Donna E. Aschbacher, 41 Van Natta 1242 (1989). Claimant, however, must also show that these increased symptoms required medical services or resulted in disability. The medical evidence in this record, from both Dr. Miller and Dr. Fitchett, indicates no treatment was given and none was necessary. Their services were diagnostic only. Further, the medical reports do not indicate that these symptoms were disabling. Lay evidence could be sufficient to show disability; however, in this case claimant testified that he left work for reasons unrelated to his foot problem and he did not indicate the problem prevented him from doing any activity. We find claimant has failed to prove that the symptoms from his arthritic foot are compensable as an occupational disease.

ORDER

The Referee's order dated December 20, 1988 is affirmed.

In the Matter of the Compensation of
JOSEPH A. AZAR, Claimant
WCB Case No. 87-02374
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Lester Huntsinger (Saif), Defense Attorney

Reviewed by Board Members Brittingham and Nichols.

The SAIF Corporation requests review of Referee Shebley's order that granted permanent total disability, whereas a Determination Order awarded 60 percent (192 degrees) unscheduled permanent disability for a low back injury. On review, the issue is permanent total disability. We reverse the Referee's order and reinstate the Determination Order.

FINDINGS OF FACT

We adopt the Referee's findings of fact as set forth in the Referee's order, except we do not adopt the Referee's finding that SAIF has not proven by a preponderance of the evidence that claimant actually works in and manages a delicatessen and is employed. We also make the following additional findings.

Claimant was performing work activities for a bakery and delicatessen. Claimant's compensable injury and relevant social/vocational factors did not render him permanently incapacitated from regularly performing work at a gainful and suitable occupation.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that SAIF had failed to establish that claimant was actually employed. Therefore, the Referee reinstated claimant's permanent total disability award. We disagree.

When an injured worker has received an award for permanent total disability, the award may be revoked or diminished only upon a showing by a preponderance of the evidence by the employer or insurer that the worker is capable of performing work at a gainful and suitable occupation. Harris v. SAIF, 290 Or 683, 696-697 (1982). The employer or insurer may do so by proving "that a claimant is presently capable of performing some work and that * * * capacity may be indicated either by proof of improvement in the claimant's medical condition or by circumstantial evidence of his employability." Kytola v. Boise Cascade Corp., 78 Or App 108, 111, rev den 301 Or 765 (1986) (emphasis in original).

To begin, claimant's compensable condition is for the low back. We do not rely on the opinion of Dr. Fagan, an orthopedic surgeon, who performed the last medical examination of claimant prior to the hearing and found claimant to be worse than he had been prior to the last surgery, and unemployable. In finding claimant to be permanently and totally disabled, Dr. Fagan considered claimant's cervical impairment at the time of the examination. There is no contention that claimant's degenerative cervical condition was either caused or worsened by his compensable injury, or that it was disabling at the time of his compensable injury in 1978. Therefore, it will not be considered in determining whether claimant's permanent total disability should be revoked.

At the hearing SAIF called several investigators who had conducted surveillance of claimant. They indicated that claimant was working as the manager of a bakery and delicatessen of which he was part owner. The Referee discounted the testimony of the investigators, finding that they actually saw

claimant perform very little in the way of work. Relying on other testimony that claimant did not work in the deli and did little in the way of work activities, the Referee found that SAIF had not proven by a preponderance of the evidence, that claimant actually works in and manages the deli and bakery. He therefore could not conclude that claimant is actually employed.

Claimant denied that he was the manager of the deli, but conceded that he did often go down to the business to drink coffee with friends. He also acknowledged that he sometimes rode along in the delivery truck while employees of the business made deliveries. The employee of another bakery that does business with claimant's bakery testified to seeing claimant two or three times a week when bread was being delivered by claimant's bakery and claimant dropped off the invoice. Films submitted by the investigators show claimant walking in and out of the deli, drinking coffee at a table inside the business, talking on the telephone and performing a few chores.

Although we do not doubt that claimant sustained significant permanent impairment as a result of his 1978 low back injury, the evidence that claimant spends considerable time at the deli and performs various work activities, including operating a cash register, clearing off and waiting on tables, repairing equipment in the bakery, pouring coffee, and going along on deliveries, convinces us that claimant is currently employed and working at the delicatessen and bakery.

Based upon our de novo review of the evidence, we conclude that SAIF has carried its burden of proving that claimant is actually employable. Thus, we hold that claimant is not currently entitled to an award of permanent total disability.

ORDER

The Referee's order dated January 20, 1988, is reversed. The Determination Order award of 60 percent (192 degrees) unscheduled permanent disability is reinstated and affirmed.

April 24, 1990 Cite as 42 Van Natta 917 (1990)

In the Matter of the Compensation of
EDWARD J. CONNOR, Claimant
WCB Case No. 87-14925
ORDER ON RECONSIDERATION
Pozzi, et al., Claimant Attorneys
John B. Motley (Saif), Defense Attorney

The SAIF Corporation requested reconsideration of our February 28, 1990 Order on Review that disapproved SAIF's method of calculating claimant's temporary disability rate and directed SAIF to recalculate claimant's temporary disability benefits based upon a weekly wage of $971.02 plus any statutory increases. In order to allow the parties an opportunity to present written argument on SAIF's request, we abated our order. Having received the parties' submissions, we now address SAIF's request.

Claimant was employed as a truck driver by SAIF's insured. He was paid pursuant to a contract. Under that contract, SAIF's insured took 10 percent off the top of his gross receipts. Out of the remaining 90 percent, it paid claimant's fuel costs, road taxes and workers' compensation insurance. Claimant received the balance remaining, by way of check.

We concluded that claimant's rate of temporary total disability benefits should be based upon the weekly average of his earnings during the 26 weeks prior to the date of injury. ORS 656.210; OAR 436-60-020(4). During the 26

weeks prior to his injury, claimant received remuneration from SAIF's insured totalling $25,246.48. Accordingly, we found that claimant's average weekly wage during this period was $971.02.

On reconsideration, SAIF does not contest our determination that claimant's temporary total disability rate should be based upon his average weekly wage rate. However, citing Gerald W. Barrow, 41 Van Natta 1370 (1989), William P. Maloney, 38 Van Natta 213 (1986), and Everett L. McDonald, 41 Van Natta 510 (1989), SAIF argues that when a claimant receives payment for both his labor and his expenses, temporary total disability is not based upon that portion of the payment that was for expenses. SAIF therefore contends that, in the process of arriving at claimant's "weekly wage rate," claimant's average weekly expenses must first be deducted from his earnings. Based upon claimant's 1986 federal income tax return, SAIF computes claimant's average weekly expenses at $585.46. Subtracting this figure from our figure of $971.02, SAIF arrives at an average weekly wage of $385.56.

Claimant argues that the cases relied upon by SAIF are distinguishable on their facts. In addition, claimant contends that his remuneration did not include any expenses that SAIF's insured paid for claimant. Moreover, claimant argues that SAIF's approach allowing insurers to deduct any business deductions provided for under the federal tax code would result in unsupported reductions in the temporary disability benefits payable to injured workers. We agree.

In Gerald W. Barrow, supra, claimant, a shake bolt cutter, was paid a certain amount for rental of his saw in addition to an amount per cord. We concluded that the payments made by the employer for saw rental were not "wages" and must be excluded from the computation of claimant's average weekly wage. Here, by contrast, claimant's contract with SAIF's insured neither expressly nor impliedly provided for payment of any of the expenses which SAIF argues should be deducted from claimant's remuneration in arriving at his average weekly wage rate.

Similarly, the issue in William P. Maloney, supra, was the correct wage rate for computing claimant's temporary disability compensation. Both parties agreed that claimant's total remuneration amounted to $10 per hour. Claimant argued that his wage rate should be based upon that $10 per hour figure. The employer argued that claimant, a tree thinner, was paid at a rate of $8 per hour for his labor, and $2 per hour for saw rental. The employer contended that claimant's wage rate should be based only upon the $8 per hour figure. We agreed with the employer. We noted in this regard that claimant received two separate checks: one for his labor and one for saw rental. We also noted that the employer's standard wage rate for tree thinners who did not provide their own chainsaws was $8 per hour. Here, claimant received a single check. Moreover, there is no evidence in the record that any specific amount of claimant's remuneration was designated as reimbursement of claimant's expenses.

In Everett L. McDonald, supra, claimant and his wife were paid jointly under one contract for the performance of janitorial work. We found as fact that claimant performed 80 percent of the labor under that contract. Accordingly, we excluded from claimant's temporary total disability rate the 20 percent portion of the contract which was performed by claimant's wife. No issue was raised as to deduction of expenses for such things as janitorial supplies. We conclude that McDonald is inapplicable here.

In sum, SAIF has failed to establish the existence of an agreement, express or implied, whereby a specific portion of claimant's remuneration is intended for reimbursement of the expenses that SAIF requests be deducted from claimant's remuneration. We note in this regard that claimant and SAIF did

agree that certain expenses would be deducted from claimant's gross revenues in order to arrive at his remuneration. While claimant no doubt incurred additional expenses in the operation of his truck, as evidenced by his federal tax return, we are unwilling to extend our holdings in Barrow, Maloney and McDonald in the absence of evidence of an agreement between the parties concerning such expenses.

Accordingly, the request for reconsideration is granted and our prior order withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our February 28, 1990 order. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

April 24, 1990 Cite as 42 Van Natta 919 (1990)

In the Matter of the Compensation of
DARRELL K. FALLINE, Claimant
WCB Case Nos. 87-14474 & 84-12198
ORDER ON REVIEW
Wade P. Bettis, Jr., Claimant Attorney
Richard Barber (Saif), Defense Attorney

Reviewed by Board Members Crider, Nichols and Brittingham.

The SAIF Corporation requests review of that portion of Referee Peterson's order that set aside its denial of claimant's aggravation claim for a shoulder injury. The sole issue on review is whether claimant filed his aggravation claim within the statutory aggravation period. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact and make the following additional findings.

SAIF misclassified claimant's injury as nondisabling.

SAIF's January 8, 1981 acceptance did not notify claimant of his right to reclassify the claim as disabling under former ORS 656.262(10). Claimant did not otherwise receive actual or constructive notice of that right.

The November 12, 1982 Determination Order was the first closure of claimant's 1980 injury claim.

Claimant's aggravation claim was filed no later than October 30, 1987.

FINDINGS OF ULTIMATE FACT

The five-year aggravation period on claimant's 1980 injury claim ran from the date of the November 12, 1982 Determination Order. Claimant filed his aggravation claim within the statutory aggravation period.

CONCLUSIONS OF LAW AND OPINION

SAIF denied claimant's claim on the ground that his aggravation rights had expired. The Referee set aside the denial after concluding that claimant's aggravation claim was filed within the five-year aggravation period.

Claimant was injured on November 14, 1980; the first closure issued November 12, 1982; and his aggravation claim was filed no later than October 30, 1987. Thus, his claim was not timely filed if aggravation rights run from the date of injury, but was timely filed if aggravation rights run from the date of the November 1982 Determination Order.

If a claim that a nondisabling injury has become disabling is not made within one year of the injury, the claim is treated as one for aggravation under ORS 656.273. Former ORS 656.262(10), now 656.262(12). The version of ORS 656.273 effective at the time of claimant's injury computed aggravation rights from the date of injury where "the injury was nondisabling and no determination was made . . . ." Former ORS 656.273(4)(b). Otherwise, aggravation rights run from the date of the first determination issued under former ORS 656.268. Former ORS 656.273(4)(a).

SAIF contends that claimant's aggravation rights ran from the date of injury under former ORS 656.273(4)(b) because the claim was not reclassified as disabling within one year after the injury.

The Referee apparently concluded that a claimant's aggravation rights extend for five years after the first determination order even if the injury was not disabling at the outset and did not become disabling until more than one year after the injury. Therefore, he declined to apply former ORS 656.278(4)(b) and held that claimant's aggravation rights do not expire until five years after the November 12, 1982 Determination Order. We disagree with the Referee's analysis, but we agree with his ultimate conclusion.

We conclude that aggravation rights run from the date of injury under former ORS 656.273(4)(b), rather than from the date of the first determination order, whenever a properly processed claim which is nondisabling does not become disabling within one year after the injury. The aggravation rights of a worker whose injury is initially nondisabling and whose claim is properly processed run from the date of injury provided that the claim does not become disabling within the year after the injury. This is so even if, as in this case, the claim becomes disabling more than a year after the injury, the claim is reopened as an aggravation claim under former ORS 656.262(10) and ORS 656.273, and a determination order subsequently issues. See Margarett I. Schaffer-Wright, 39 Van Natta 1113 (1987). In other words, only a determination order which closes an original claim, as opposed to a claim for aggravation, is a baseline for determining aggravation rights. We disavow the contrary rationale articulated in Edward Reuter, 42 Van Natta 19 (1990).

Nevertheless, the record in this case indicates that claimant was not able to return to his regular work following the 1980 injury, but was only able to perform light work. Accordingly, we conclude that claimant's injury was initially disabling, and that the insurer misclassified the injury as nondisabling. Therefore, former ORS 656.262(10), now ORS 656.262(12), which provided that a nondisabling claim may be reclassified more than one year after the date of injury only pursuant to a claim for aggravation, is not applicable to this case. Davison v. SAIF, 80 Or App 541 (1986). Since the claim was disabling from the outset and was first closed by determination order, aggravation rights must be calculated as for a disabling claim under former ORS 656.273(4)(a)--that is, the aggravation period extends for five years after the first determination order.

Moreover, assuming the claim had been properly classified as nondisabling, SAIF's January 8, 1981 acceptance of the claim did not notify claimant of his right to reclassify the claim as disabling under former ORS 656.262(10). Claimant did not otherwise receive actual or constructive notice of that right. Under this circumstance, claimant's aggravation rights run from the date of the first closure in the claim, i.e., the November 1982 Determination Order. Richard M. Egli, 41 Van Natta 149 (1989). Cf. Davison v. SAIF, supra.; Dewey Davis, 41 Van Natta 349 (1988).

Accordingly, we conclude that claimant's aggravation claim was filed within the statutory aggravation period, and we affirm the Referee's order.

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).

ORDER

The Referee's order, dated January 19, 1988, is affirmed. For services on review, claimant's attorney is awarded $550, to be paid by the SAIF Corporation.

April 24, 1990 Cite as 42 Van Natta 921 (1990)

In the Matter of the Compensation of
CAROL A. FISHER, Claimant
WCB Case Nos. 87-15218 & 87-12543
ORDER ON RECONSIDERATION
Pozzi, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys
James E. Griffin, Assistant Attorney General

On July 20, 1988, we withdrew our June 17, 1988 order which had abated our May 18, 1988 Order on Review. See Carol A. Fisher, 40 Van Natta 458, 610, 847 (1988). Since SAIF had requested judicial review of our May 18, 1988 order before we had abated the order, we concluded that our abatement order had been a nullity. We also declined to withdraw our appealed May 18, 1988 order for reconsideration.

The court has concluded that, SAIF's appeal notwithstanding, we had authority to withdraw our May 18, 1988 order for the purpose of reconsideration. SAIF v. Fisher, 100 Or App 288, 291-92 (1990). The court reasoned that no provision in either ORS chapter 656 or ORS chapter 183 limits the Board's authority to reconsider an order before it becomes final, regardless of whether a petition for judicial review has been filed. Id. Finally, because we did not redecide the case after granting reconsideration, the court held that the case remains pending before us. Id.

In light of the court's holding, we proceed to SAIF's request for reconsideration of our May 18, 1988 order which set aside SAIF's denial of claimant's injury claim for her low back. SAIF contends that the Board erred in: (1) deciding the case on an industrial injury theory because the case was litigated by the parties on an occupational disease theory; (2) characterizing claimant's claim as one for industrial injury; and (3) finding that the medical evidence established compensability of the claim. On reconsideration, we disagree with each of SAIF's contentions.

First, the applications to schedule a hearing associated with claimant's hearing requests raised industrial injury as well as occupational disease theories of compensability. Moreover, both theories were raised in claimant's opening statement and evidence on both theories was introduced and presented at the hearing. Although the insurers noted that they had not anticipated claimant proceeding on an industrial injury theory only, claimant did not waive the issue and the insurers had the opportunity to fully litigate it. Under such circumstances, we conclude that compensability under an industrial injury theory was raised as an issue and can be considered.

Alternatively, SAIF asserts that claimant's claim should be analyzed as an occupational disease claim. SAIF argues that: (1) claimant's work activity during the week of May 25, 1987 was of a kind, rate and duration which was likely to result in the condition for which claimant now seeks benefits; and (2) a period of two days of work activity is too long to satisfy the "sudden in

onset" element of an industrial injury. In connection with this latter point, SAIF accurately notes that claimant worked two days, rather than three days, during the week of May 25, 1987, as found in our prior order.

Despite this correction of our prior finding concerning the duration of claimant's work activities during the week of May 25, 1987, we continue to conclude that the claim should be considered under an industrial injury theory. To begin, we are not persuaded that a worsening of claimant's spondylolysis condition was a risk inherent in her work. See Morrow v. Pacific University, 100 Or App 198 (1990); O'Neal v. Sisters of Providence, 22 Or App 9 (1975). Consequently, we conclude that the onset of her worsened condition was unexpected.

Furthermore, we hold that the worsening of claimant's condition was "sudden in onset." Valtinson v. SAIF, 56 Or App 184, 187-88 (1982). In reaching this conclusion, we disagree with SAIF's assertion that this claim should be analyzed as an occupational disease under the rule espoused in Hall v. Home Insurance Co., 59 Or App 526, 528-29 (1987). We find Hall to be distinguishable.

In Hall, the claimant worked for an extended period of time and experienced gradually increasing low back pain. The claimant then began a new position, which involved more twisting and lifting than she had previously been doing and after two days her back deteriorated suddenly. The Hall court applied an occupational disease analysis.

Here, claimant sustained an off-the-job low back injury and then returned to work, where she experienced periodic low back pain at approximately a constant level. After engaging in two days of more strenuous activity than usual, she experienced a sudden increase in low back pain. Unlike the claimant in Hall, claimant's back pain was not gradually worsening with work activity only to be suddenly worsened by more work activity. Rather, her back pain was caused primarily by an off-the-job accident and then remained relatively constant until it was worsened suddenly by two days of work activity. Under such circumstances, we conclude that the worsening of claimant's condition was "sudden in onset."

Finally, subject to the modification herein, we continue to adhere to our prior conclusion that claimant's two days of work activity during the week of May 25, 1987 were a material contributing cause of her subsequent disability and need for medical services. Consequently, we reiterate our holding that claimant has established the compensability of her injury claim.

Accordingly, our prior orders are withdrawn. On reconsideration, as supplemented and modified herein, we adhere to and republish our May 18, 1988 Order on Review, effective this date. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
JEAN F. JOHNSON, Claimant
And, In the Matter of the Complying Status of
JOSEPH W. ZOCHERT and NOVEMBER C. ZOCHERT, dba
Entertainment Management Specialists, Inc., dba E.M.S., Employer
WCB Case No. 88-01827
ORDER OF DISMISSAL
Coons & Cole, Claimant Attorneys
Norman Cole (Saif), Defense Attorney

The noncomplying employer, Joseph W. Zochert, doing business as 8-Ball Inn, requested review of Referee Neal's June 27, 1988 order. We have reviewed

the request to determine whether we have jurisdiction to consider the matter. Because we conclude that the request is untimely, the request for review is dismissed.

FINDINGS OF FACT

The Referee's order issued June 27, 1988. The order included notice of when (within 30 days) and where (with the Workers' Compensation Board) a request for review of the order should be filed. On March 29, 1990, the Board received a copy of the noncomplying employer's request for review. The request was filed by the SAIF Corporation, as claims processor for the noncomplying employer. SAIF's date stamp indicates that it received the noncomplying employer's request on July 15, 1988. The request indicates that copies of the request were mailed to the other parties to the proceeding on July 13, 1988. The request does not indicate that it was mailed to the Workers' Compensation Board.

SAIF and the other parties received the request for Board review within 30 days of the Referee's June 27, 1988 order. However, the noncomplying employer's request for review was not provided to the Board within 30 days of the Referee's order.

CONCLUSIONS OF LAW

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 noncomplying employer's request for Board review was received by SAIF and the other parties to the proceeding within 30 days of the Referee's order. However, the record fails to establish that the request was mailed to, or received by, the Board within the statutory 30-day period. Consequently, we lack jurisdiction to review the order, which has become final by operation of law. See ORS 656.289(3); 656.295(2); Argonaut Insurance v. King, supra; Robert G. Ebbert, 40 Van Natta 67 (1988).

We are mindful that the noncomplying employer 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. However, instructions for requesting review were clearly recited in the Referee's order. Moreover, 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.

In the Matter of the Compensation of
ALLAN E. ORTON, Claimant
Own Motion No. 90-0046M
OWN MOTION ORDER
Christopher Moore, Claimant Attorney
SAIF Legal Department, Defense Attorney

The SAIF Corporation has voluntarily reopened claimant's 1983 back injury claim pursuant to ORS 656.278. It now asks the Board to authorize reimbursement from the Reopened Claims Reserve. We decline to grant such an authorization.

Claimant has required an October 24, 1989 surgery to remove his teeth and a January 11, 1990 surgery for a bilateral temporomandibular joint syndrome condition. SAIF has voluntarily reopened claimant's 1983 back injury claim for these surgeries and provided temporary disability compensation. This action was apparently prompted by the parties' June 1989 stipulation, which set aside SAIF's February 1, 1989 partial denial of claimant's "tooth treatment."

SAIF may voluntarily reopen any claim to provide benefits or grant additional medical or hospital care to claimant. ORS 656.278(3). However, we may exercise our "Own Motion" authority to award temporary disability only if we find that 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).

Here, as previously noted, claimant has undergone surgeries to remove his teeth and repair a jaw condition. SAIF has accepted responsibility for the medical services claims and provided temporary disability compensation, apparently concluding that the surgeries are causally related to claimant's 1983 back injury claim. This decision to voluntarily reopen the claim is certainly within SAIF's discretion. See ORS 656.278(3). Yet, such an action does not automatically result in our authorizing the reimbursement of such funds from the Reopened Claims Reserve.

As previously noted, our authority to award temporary disability is subject to a series of strict limitations. One of those limitations is that we must find that claimant's compensable condition has worsened. Here, the record does not establish that claimant's teeth extraction and jaw surgeries are causally related to his 1983 compensable back injury.

In reaching this conclusion, we are persuaded by the opinion of Dr. Higdon, craniomandibular specialist, who found no "probability whatever of a direct causal relationship" between claimant's back injury and his oral condition. We further note that claimant's dentist, Dr. Boni, concurred with Higdon's opinion. Considering the expertise of these specialists, we find their opinions more persuasive than that of Dr. McCleery, claimant's treating chiropractor, who suggested that it was "possible that by stabilizing [claimant's] cranium, his neck and lower back will follow."

As previously discussed, SAIF rescinded its February 1989 denial of claimant's dental problems pursuant to a June 1989 stipulation. Yet, this stipulation and SAIF's acceptance of responsibility for claimant's oral surgeries does not require us to authorize reimbursement for these benefits from the Reopened Claim Reserve, particularly where the evidence overwhelming establishes that claimant's oral problems are not causally related to his compensable back injury. Moreover, our authority is discretionary, not mandatory. See ORS 656.278(1)(a); OAR 438-12-052. Considering the circumstances described herein, we do not choose to exercise our discretion to authorize reimbursement.

As a reasonable fee for his counsel's efforts in prompting the voluntary reopening of this claim, claimant's attorney is awarded 25 percent of this additional compensation, not to exceed $250. See OAR 438-15-080.

IT IS SO ORDERED.

In the Matter of the Compensation of
LELAND M. POLLOCK, Claimant
WCB Case No. 88-12908
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Nancy Marque (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

The SAIF Corporation requests review of Referee Brown's order which increased claimant's unscheduled permanent disability award for a neck and back injury from 21 percent (67.2 degrees) as awarded by Determination Order, to 35 percent (112 degrees). On review the issue is extent of unscheduled permanent disability. We modify.

FACTS

Claimant was 30 years old on the date of hearing. He has nine years of formal education. He has no documented competence in a specific vocational pursuit. During the period September 1977 to September 1987 claimant worked as a warehouse worker for one and one-half years, as a lumberyard worker for one year and as a surveyor helper and later surveyor assistant for seven years. He worked in self employment cutting firewood and, in September 1987, he worked as a firefighter in the woods.

On September 3, 1987, while working for the employer, claimant was compensably injured. He received chiropractic and medical treatment for neck and shoulder stiffness and pain. Later he received treatment for low back pain and left leg numbness. He was found to have a herniated intervertebral disc at L4-5 and a bulging disc at L5-S1. Surgery was recommended but claimant declined.

Claimant became medically stationary on May 3, 1988. At that time he had cervical extension limited to 25 degrees. Cervical lateral flexion was 15 degrees to both the left and right. Thoracolumbar flexion was 80 degrees, extension was 20 degrees, left and right lateral flexion was 15 degrees and left and right rotation were 20 degrees. A July 19, 1988 Determination Order closed his claim and awarded 21 percent unscheduled permanent partial disability.

Claimant is unable to return to his usual and customary work, which involved heavy physical exertion. As a result of his compensable injury, he is now limited to light to medium work. Claimant had not returned to modified work at the time of hearing, although he had worked some part-time, light duty work for the employer before he became medically stationary.

CONCLUSION

The only issue in this case is the extent of claimant's unscheduled permanent partial disability.

If a claimant became medically stationary after January 1, 1988 and his or her claim was closed on or after July 1, 1988, a subsequent determination by a referee or the Board of the claimant's permanent partial disability must be made pursuant to ORS 656.283(7) and 656.295(5) respectively. OAR 438-10-005 and Michelle Griffith, 40 Van Natta 2086 (1988).

For purposes of determining injury-related permanent partial disability, ORS 656.283(7) and 656.295(5) require application of the standards for the evaluation of disabilities adopted by the director pursuant to ORS 656.726(3)(f)(A). Those "standards", which were in effect on the date of the

Determination Order from which the hearing was requested, control the evaluation of permanent partial disability. OAR 438-10-010.

The hearing and Board review of the issue of permanent partial disability continues to be de novo on the hearing record. The facts to which the "standards" are applied need only be established by a preponderance of the evidence. However, either party may establish that the record, as a whole, constitutes clear and convincing evidence that the degree of permanent partial disability suffered by the claimant is more or less than the entitlement indicated by the "standards". ORS 656.283(7) and 656.295(5).

In this case, the "standards" adopted effective July 1, 1988, former OAR 436-35-001 et seq, apply to the rating of claimant's permanent partial disability. Former OAR 436-35-270 through 436-35-440 apply to the rating of unscheduled permanent partial disabilities. Former OAR 436-35-270(1).

The determination of permanent partial disability under the "standards" is made by determining the appropriate values assigned by the "standards" to the claimant's age, education, adaptability and impairment. Once established, the values for age and education are added and the sum is multiplied by the appropriate value for adaptability. The product of those two figures is then added to the appropriate value for impairment to yield the percentage of unscheduled permanent partial disability. Former OAR 436-35-280.

The appropriate value for claimant's age of 30 years is 0. Former OAR 436-35-290(3).

The appropriate value for claimant's nine years of formal education is 1. Former OAR 436-35-300(3)(b).

Former OAR 436-35-300(4) adopts by reference the "SVP" (specific vocational preparation time) values assigned to various occupations by the Dictionary of Occupational Titles (DOT), published by the U.S. Department of Labor. The highest SVP level demonstrated by a claimant during the ten years prior to the date of injury is used to determine a value for skills. Former OAR 436-35-300(4). Claimant's highest SVP during the ten years prior to the date of injury was 7 as a surveyor helper (DOT 018.167-034). Therefore, the appropriate value for skills is 1. Former OAR 436-35-300(4).

Claimant has no documented training. The appropriate value for training is 1. Former OAR 436-35-300(5)(a). Claimant's total education value is 3, the formal education value plus the skills value plus the value for training. Former OAR 436-35-300(6).

An adaptability value for a claimant who is unable to return to his or her usual and customary work [See former OAR 436-35-270(3)(a)] and who has not returned to modified work is determined by the claimant's residual physical capacity, without regard to that claimant's physical capacity prior to the injury. Former OAR 436-35-310(4).

Claimant is unable to return to his usual and customary work and has not returned to, or been offered, regular, modified work since he became medically stationary (when permanent disability is rated). His physical capacity falls between the light and medium categories as defined in former OAR 436-35-310(4)(a)&(b). In such cases the values for the two categories are averaged to obtain the appropriate adaptability value. Former OAR 436-35-310(4). The average of 1, the value for medium physical capacity, and 4, the value for light physical capacity, is 2.5.

The final element necessary to determine disability under the "standards" is the impairment value. For lost cervical extension (from 30 degrees to 25 degrees) claimant is entitled to an impairment value of 0.5 percent. Former OAR 436-35-360(3). For lost left and right lateral cervical flexion (from 40 degrees each to 15 degrees each) claimant is entitled to 1.5 percent each, or 3 percent. Former OAR 436-35-360(4). For reduced thoracolumbar flexion (from 90 degrees to 80 degrees) claimant is entitled to an impairment value of 1 percent. Former OAR 436-35-360(6). For reduced thoracolumbar extension (from 30 degrees to 20 degrees) claimant is entitled to an impairment value of 1 percent. Former OAR 436-35-360(7). Claimant's reduced thoracolumbar lateral flexion, both left and right (from 20 degrees to 15 degrees), entitles him to an impairment value of 1 percent each, or 2 percent. Former OAR 436-35-360(8). For reduced thoracolumbar rotation to both the left and right (from 30 degrees to 20 degrees) claimant is entitled to an impairment value of 2 percent each, or 4 percent. Former OAR 436-35-360(9). The values for lost range of motion in claimant's spine are added (not combined) to obtain a single value. Former OAR 436-35-360(10). In this case the sum of the impairment values for lost spinal motion is 11.5 percent.

In addition to reduced spinal motion, claimant has unoperated disc derangement at two levels of the spine. SAIF concedes that those findings are injury related. Claimant is entitled to an impairment value of 4 percent each for those disc derangements, or 8 percent. (The "standards" do not indicate, but we presume that such values are added.) Former OAR 436-35-350(2).

The impairment values for claimant's disc derangement and for lost spinal motion are combined (not added) to obtain a single impairment value for the spine. Former OAR 436-35-360(11). However, former OAR 436-35-001 et seq, does not define the term "combine". We note then that current OAR 436-30-005(2) (effective January 1, 1988) and current OAR 436-35-005(4) (effective January 1, 1989) do define that term. Current OAR 436-35-005(2) defines "combine" as a means of putting two percentages together by use of the formula A% + B% (100% - A%) where A and B are written as decimals. (100% is presumably written as 1.00) We utilize that formula to combine percentages where required by former OAR 436-35-001 et seq. Here, 11.5 percent and 8 percent combine to a value of 18.6 percent (to the nearest 1/10th of one percent).

Having determined each value necessary to compute claimant's permanent disability under the "standards", we proceed to that calculation. When claimant's age value (0) is added to his education value (3) the sum is 3. When that value is multiplied by claimant's adaptability value (2.5) the product is 7.5. When that value is added to claimant's impairment value (18.6) the result is 26.1 percent unscheduled permanent partial disability. Former OAR 436-35-280(7). That disability figure is rounded to the next higher whole percentage. Former OAR 436-35-280(7). Claimant's permanent disability under the "standards" is, therefore, 27 percent.

Claimant argues that he has established by clear and convincing evidence that his disability is more than is indicated by application of the "standards" and that the Referee's award of a total of 35 percent unscheduled permanent disability is justified. The Referee, in his order, found various "underlying facts" [see ORS 183.470(2)] to have been established by a preponderance of the evidence. He found other "underlying facts" to have been established by clear and convincing evidence. He then made an "ultimate finding" [see ORS 183.470(2)] that claimant had sustained 35 percent loss of earning capacity. The Referee did not indicate by what degree of proof that "ultimate finding" had been established.

We believe the Referee may have misconstrued ORS 656.283(7). That section allows either party to establish by clear and convincing evidence that a

claimant's permanent disability is more or less than the entitlement indicated by the "standards". We do not read that provision to require that any underlying fact be established by clear and convincing evidence. Instead, the statute requires that the Referee determine whether the hearing record, when viewed as a whole, constitutes clear and convincing evidence of permanent disability which is less than or more than the disability value obtained by application of the "standards". That is, is the record as a whole highly persuasive, free from confusion, fully intelligible and distinct in indicating more or less disability than would be awarded under the "standards"? See Riley Hill General Contractor Inc. v. Tandy Corp., 303 Or 390, 407 (1987).

On this record we do not find clear and convincing evidence that claimant's disability is more or less than 27 percent. Claimant is entitled to an award of 27 percent unscheduled permanent partial disability.

ORDER

The Referee's order dated November 22, 1988 is modified. In lieu of the Referee's increased award of unscheduled permanent disability claimant is awarded 6 percent (19.2 degrees) unscheduled permanent partial disability in addition to the 21 percent (67.2 degrees) awarded by Determination Order, for a total award of 27 percent (86.4 degrees).

April 24, 1990 Cite as 42 Van Natta 928 (1990)

In the Matter of the Compensation of
RAMONA J. SCHNEPP, Claimant
WCB Case No. 88-11913
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Tom Sheridan (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

The SAIF Corporation requests review of Referee Fink's order that: (1) denied SAIF's request for a continuance pending an independent medical examination (IME); and (2) granted claimant permanent total disability, whereas a Determination Order had awarded no additional permanent disability beyond the 55 percent (176 degrees) unscheduled permanent disability for claimant's back condition and 5 percent (6.75 degrees) scheduled permanent disability for loss use of her right foot she had previously received. In her brief, claimant cross-requests review to determine the effective date of permanent total disability. SAIF requests that the Board remand the matter for further taking of evidence. On review, the issues are remand, extent of disability, including permanent total disability and the effective date of permanent total disability. We deny the motion to remand and affirm the permanent total disability award, effective as of February 4, 1988.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" with the following supplementation.

SAIF had scheduled an IME for September 22, 1988. The hearing was scheduled for October 6, 1988. Claimant filed a Motion To Quash on September 19, 1988, stating that she had been examined by more than three independent medical examiners and should not be required to be examined by more than that allowed by law. Claimant, upon advice of her attorney, did not attend the IME. An Interim Order issued on October 11, 1988, denying SAIF's motion for a continuance stating that the information sought by SAIF could have been obtained with due diligence.

CONCLUSIONS OF LAW AND OPINION

Remand

SAIF requests remand for the taking of additional evidence; i.e., another IME. We deny the request.

We may remand a case to the Referee for further evidence taking if we determine that the case has been improperly, incompletely or insufficiently developed. ORS 656.295(5). Remand, however, is generally appropriate only upon a showing of good cause or other compelling basis. Kienow's Food Stores v. Lyster, 79 Or App 416 (1986). If evidence was obtainable prior to the hearing with due diligence, remand is generally not appropriate. Bernard L. Osborn, 37 Van Natta 1054, 1055, aff'd mem 80 Or App 152 (1986); See Compton v. Weyerhaeuser Co., 301 Or 641 (1986).

Here, claimant has been examined by the Orthopaedic Consultants on five different occasions. Additionally, the record shows that claimant had been subjected to a total of 19 independent medical examinations by the time of hearing.

We conclude that this case has not been improperly, incompletely or otherwise insufficiently developed pursuant to ORS 656.295(5). Accordingly, we deny SAIF's request for remand.

Permanent Total Disability Award

We adopt the Referee's Conclusion and Opinion on this issue.

Effective Date of Disability:

It is implicit in every case involving permanent total disability that the award, if granted, should be made effective as of the date the evidence establishes the disability status. Adams v. Edwards Heavy Equipment, Inc., 90 Or App 365, 370-71 (1988); Robert D. Hanks, 40 Van Natta 2067 (1988).

Here, the April 19, 1988, Determination Order found claimant to be medically stationary as of February 4, 1988. Following our de novo review, we are persuaded that all medical, social and vocational factors relevant to claimant's permanent total disability existed at the time his condition was considered to be medically stationary. Consequently, we conclude that claimant's permanent total disability benefits should begin as of February 4, 1988.

In reaching this conclusion, we note that a subsequent hearing has been held between the parties which concerned the effective date for claimant's permanent total disability award. The Referee's order arising from that hearing also determined that the effective date for claimant's permanent total disability award was February 4, 1988. However, as previously discussed, the effective date is implicit in every case concerning the issue of permanent total disability. Inasmuch as the present case pertains to the issue of permanent total disability, which necessarily includes the effective date for such an award, the subsequent referee was without authority to rule on the effective date for the award granted by this Referee's order. Consequently, the subsequent Referee's order was a nullity.

ORDER

The Referee's order, dated October 26, 1988, is affirmed. The effective date for claimant's permanent total disability award is February 4, 1988. Claimant's attorney is awarded an assessed fee of $1,965 to be paid by SAIF.

In the Matter of the Compensation of
GLENNA J. SHEPHERD, Claimant
WCB Case No. 88-13213
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Barbara Brainard (Saif), Defense Attorney

Review by Board Members Speer and Howell.

Claimant requests review of Referee Fink's order which affirmed a Determination Order which awarded no permanent unscheduled disability compensation for claimant's bilateral temporomandibular joint condition. On review the issue is the extent of unscheduled permanent disability. We affirm.

FINDINGS OF FACT

We adopt the Referee's FINDINGS OF FACT with the following correction and supplementation: Claimant will be required to wear braces on her teeth for about four years. The record does not indicate how long she may have to wear an orthotic (Herbst device). (Tr. 14 & 15). Claimant last became medically stationary on June 13, 1988. (Exs. 125 & 126).

CONCLUSIONS OF LAW AND OPINION

If a claimant became medically stationary after January 1, 1988, and his or her claim was closed on or after July 1, 1988, a subsequent determination by a Referee or the Board of the claimant's permanent partial disability must be made pursuant to ORS 656.283(7) and 656.295(5), respectively. OAR 438-10-005 and Michelle Griffith, 40 Van Natta 2086 (1988).

For purposes of determining injury-related permanent partial disability, ORS 656.283(7) and 656.295(5) require application of the standards for the evaluation of disabilities adopted by the director pursuant to ORS 656.726(3)(f)(A). Those "standards" in effect on the date of the Determination Order from which the hearing was requested control the evaluation of permanent partial disability. OAR 438-10-010.

In this case, the "standards" adopted effective July 1, 1988, former OAR 436-35-001 et seq, apply to the rating of claimant's permanent partial disability. Former OAR 436-35-270 through 436-35-440 apply to the rating of unscheduled permanent partial disabilities. Former OAR 436-35-270(1).

Those "standards" provide that "(T)here shall be no unscheduled disability if the injury did not result in impairment." Former OAR 436-35-280(1). In this case, claimant asserts entitlement to unscheduled permanent disability compensation for the cosmetic effects of her orthotic and for alleged speech impairment. Former OAR 436-35-320 through 436-35-440 provide no valuation for impairment from either cosmetic effects of an injury or speech impairment. Claimant is, therefore, entitled to no impairment value under the "standards" and no permanent disability may be awarded under the "standards." Former OAR 436-35-280(1).

Although no permanent disability is awardable under the "standards," either party may establish that the record, as a whole, constitutes clear and convincing evidence that the degree of permanent partial disability suffered by the claimant is more or less than the entitlement indicated by the "standards." ORS 656.283(7) and 656.295(5).

Claimant testified credibly that her braces and/or orthotic affected her speech. However, the Referee, who saw and heard claimant testify, had no

difficulty comprehending her when she spoke. We give great weight to that first-hand observation. There is no other evidence concerning the effects of claimant's temporomandibular joint injury on her earning capacity.

We do not find this record to be highly persuasive, free from confusion and distinct in indicating that claimant has suffered a loss of earning capacity as a result of the injuries in question. We, therefore, conclude that claimant has failed to prove by clear and convincing evidence that she suffers unscheduled permanent disability. See Riley Hill General Contractor, Inc. v. Tandy Corp., 303 Or 390, 407 (1987).

ORDER

The Referee's order, as amended November 22, 1988, is affirmed.

April 24, 1990 Cite as 42 Van Natta 931 (1990)

In the Matter of the Compensation of
RONALD D. WYTCHERLEY, Claimant
WCB Case No. 88-13310
ORDER ON REVIEW
Dobbins & McCurdy, Claimant Attorneys
David Fowler (Saif), Defense Attorney

Reviewed by Board Members Crider and Nichols.

Claimant requests review of Referee Mulder's order which dismissed claimant's request for hearing. On review, the issue is dismissal. We affirm.

FINDINGS OF FACT AND ULTIMATE FACT

Claimant injured his upper back while employed by a noncomplying employer in March 1988. On April 21, 1988 Dr. Swan filed a Form 827. On June 21, 1988 the Compliance Section, Workers' Compensation Division, referred the claim to the SAIF Corporation for processing. On June 23, 1988 the Department issued a proposed and final order finding the employer to be noncomplying and claimant to be a subject worker.

On August 4, 1988, claimant requested a hearing on the issues of compensability, temporary disability, noncompliance, and penalties and attorney fees. On August 3, 1988, SAIF accepted claimant's claim. A Notice of Hearing set October 24, 1988 as the date of hearing on claimant's request.

On August 18, 1988, the employer requested a hearing contesting the compensability of claimant's claim. A Notice of Hearing set the employer-requested hearing for November 3, 1988.

Neither claimant nor his counsel appeared at the October 24, 1988 hearing. Claimant's attorney admits he mistakenly assumed the October 24, 1988 hearing was consolidated with the November 3, 1988 hearing, which is why he and claimant did not appear at the October hearing. The Referee dismissed the October hearing under OAR 438-06-071. Claimant made no request for reconsideration of the dismissal.

CONCLUSIONS OF LAW AND OPINION

Claimant argues that ORCP 71(B)(1), which applies to relief from an order for "mistake, inadvertence, surprise, or excusable neglect," should apply to the

Referee's October 1988 order of dismissal. He maintains that his counsel's mistake was reasonable and not negligent.

ORCP 71(B)(1) does not apply in this situation. Under the applicable rules, failure of both claimant and his counsel to appear was a waiver of appearance. Former OAR 438-06-071. The Referee was required to dismiss unless a postponement was granted under OAR 438-06-081. Claimant never gave the Referee a reason to postpone. Even after the hearing and the dismissal order, he did not request reconsideration under OAR 438-07-025(1). Thus, the Referee had no information on which to grant a postponement, had one been requested, and his only option was to dismiss the request for hearing.

ORDER

The Referee's order dated October 31, 1988 is affirmed.

April 25, 1990 Cite as 42 Van Natta 932 (1990)

In the Matter of the Compensation of
LOU D. BALES, Claimant
WCB Case No. 88-05665
ORDER ON REVIEW
Burt, et al., Claimant Attorneys
Gail Gage (Saif), Defense Attorney

Reviewed by Board Members Crider and Nichols.

The SAIF Corporation requests review of Referee Borchers' order that set aside its denial of claimant's occupational disease claim for chronic obstructive pulmonary disease (COPD). On review, the issue is compensability. We affirm.

FINDINGS OF FACT AND ULTIMATE FACT

We adopt the findings of fact on the first two pages of the Referee's order, with the following supplementation.

On-the-job smoke exposure has materially contributed to claimant's current impairment of health and need for treatment of his chronic obstructive pulmonary disease.

CONCLUSIONS OF LAW AND OPINION

At issue here is the "fireman's presumption" of former ORS 656.802(2) (now renumbered ORS 656.802(3)). To establish the presumption, claimant must prove: (1) he has a disability or impairment of health; (2) he was employed as a fireman of a political subdivision; (3) he has completed more than five years of employment in that capacity; (4) a disease of the lungs or respiratory tract caused his disability or impairment of health; and (5) he had a physical examination at the time of or subsequent to his becoming a fire fighter which failed to reveal any evidence of such condition or impairment of health which preexisted his employment.

The insurer argues that the fireman's presumption is inapplicable because a satisfactory physical examination was not performed pursuant to the statute. The Referee found that claimant was examined by his treating physician in 1983 and several times subsequently, that claimant's lungs were clear, and that there was no evidence of COPD. We agree with the Referee that this examination satisfied the statutory requirement and that therefore the presumption applies.

The impairment of health arising under former ORS 656.802(2) which is presumed to result from a fireman's employment includes a worsening of symptoms as well as a worsening of the underlying disease. Wright v. SAIF, 289 Or 323, 335 (1980). In order for SAIF to sustain its denial, it has the burden of producing clear and convincing medical evidence that claimant's current symptoms and need for treatment are unrelated to his employment. SAIF argues that it has sustained its burden. We disagree.

The Referee found Dr. Foster's conclusion that claimant's COPD was related to his work as a fire fighter to be persuasive because it was thorough, well reasoned, and based on his findings that claimant suffered no symptoms prior to 1987 and that COPD symptoms developed rapidly thereafter. We agree.

SAIF relies on the opinions of Drs. Montanaro and Parosa to support its argument that claimant's exposure to smoke at work is neither a cause nor a worsening factor in his COPD. However, both opinions support compensability.

Although Dr. Montanaro opined that cigarette smoking was the major causative factor in claimant's disease, he testified that smoke inhalation caused claimant to have irritant exposure. Thus, since symptoms causing disability or impairment of health are compensable under former ORS 656.802(2), we conclude that Montanaro's opinion does not serve to rebut the presumption.

Dr. Parosa, in his first opinion, opined that both claimant's cigarette smoking and his various smoke exposures caused claimant's COPD, although Parosa was unable to attribute specific percentages of causation to either. In his second opinion, after reviewing Dr. Montanaro's report, Parosa stated that he did not think that claimant's work had a major role in the development of the COPD, but that claimant's work exposure, particularly that unprotected by a mask, may have caused a worsening by exposure to smoke. He further stated that the kinds of smoke claimant inhaled should be considered exacerbaters of the underlying condition caused by cigarette smoking. Both opinions, therefore, suggest some causal relation between claimant's exposure to smoke at work and his impairment of health.

Given the above medical evidence, we find that SAIF has not established by clear and convincing medical evidence that claimant's COPD is unrelated to his employment as a fire fighter. Therefore, claimant's COPD is compensable.

Claimant is entitled to an attorney fee for services on Board review. ORS 656.382(2). However, because no statement of services has been submitted, no fee can presently be awarded. See OAR 438-15-010(5).

ORDER

The Referee's order dated August 12, 1988 is affirmed.

April 25, 1990 Cite as 42 Van Natta 933 (1990)

In the Matter of the Compensation of
ARTHUR A. HARDING, Claimant
WCB Case No. 88-16153
ORDER ON REVIEW
Andrew H. Josephson, Claimant Attorney
Thomas Ewing (Saif), Defense Attorney

Reviewed by Board Members Nichols and Brittingham.

The SAIF Corporation requests review of Referee Hoguet's order that increased claimant's unscheduled permanent disability award for a low back injury from 15 percent (48 degrees) as awarded by a Determination Order to 40 percent (128 degrees). The issue on review is extent of unscheduled permanent disability. We modify.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact."

CONCLUSIONS OF LAW AND OPINION

SAIF, in its brief, contends that the Referee's award of permanent disability is excessive and should be reduced. SAIF cites two specific rules that it contends were improperly interpreted by the Referee in rating unscheduled permanent disability. OAR 436-35-300(5) allows a value of plus 1 if there is no documentation demonstrating competence in some specific vocational pursuit; and no value if there is such documentation. In this matter, claimant has been certified as a welder; however, at the time of the hearing, his certification had lapsed.

The Referee gave claimant a value of plus 1 because the certificate had lapsed and because it was for a job that claimant could no longer perform. The rule does not require anything more than documentation demonstrating competence.

Alternatively, claimant argues that there was no certificate produced at the hearing and thus the requirement of the rule has not been met and claimant should receive a value of plus 1 for training. The vocational reports verify that claimant is a certified welder. Claimant testified at hearing that he is a certified welder but since the injury he has let his certification lapse. All he has to do to reinstate that certificate is pay a renewal fee. Claimant's testimony is a concession that he has attained a certificate. We find there is adequate evidence in this record that claimant is a certified welder and the Referee erred in giving him a value for training.

OAR 436-35-300(4) relates to job skills. Reference is made in that rule to specific vocational preparation (SVP) time as found in the Dictionary of Occupational Titles (DOT) produced by the U.S. Department of Labor. SAIF argues that because claimant testified that it took him longer to learn the skills of his vocation than indicated on the DOT, his SVP classification should be higher than what is stated in the DOT. We disagree. The rules state that the SVP rating shall be as found in the DOT. We decline to change the value given by the Referee for skills.

After adjusting clainant's disability rating consistent with the above discussion, we arrive at a total rating of 36 percent (115.2 degrees) unscheduled permanent disability. In our de novo review of this record we notice there are other errors in the computation of claimant's disability rating. However, because SAIF limited its request for review to these two specific areas in rating disability, we decline to address other factors that are considered in arriving at a rating of permanent disability.

ORDER

The Referee's order dated January 6, 1989 is modified. In lieu of the Referee's award and in addition to the 15 percent (48 degrees) unscheduled permanent disability awarded by the Determination Order, claimant is awarded 21 percent (67.2 degrees) unscheduled permanent disability, giving him a total award to date of 36 percent (115.2 degrees) unscheduled permanent disability for a low back injury.

In the Matter of the Compensation of
ARLISS C. HUGHES, Claimant
WCB Case Nos. 87-03398, 88-11189, 87-19163, 88-07600 & 88-07601
ORDER ON REVIEW
Stebbins & Coffey, Claimant Attorneys
Mitchell, Lang, et al., Defense Attorneys
Vicki Silbernagel, Assistant Attorney General
Beers, et al., Defense Attorneys

Reviewed by Board Members Nichols, Brittingham and Crider.

The SAIF Corporation requests review of that portion of Referee Holtan's order that granted claimant's attorney an assessed fee payable by SAIF for the attorney's efforts in obtaining acceptance of claimant's right ulnar nerve condition. Claimant has filed a motion to dismiss SAIF's request for review, contending this is the wrong forum to challenge attorney fees. The issues on review are jurisdiction and attorney fees. We reverse.

Claimant contends the Board does not have jurisdiction to review the issue raised by SAIF. We disagree. The Board does have jurisdiction to address the issue of entitlement to attorney fees, which is the issue being raised here. Ronald L. Warner, 40 Van Natta 1082, 1194 (1988).

FINDINGS OF FACT

We adopt the Referee's findings with the following supplementation. SAIF's insured, Mo's, became a party to these proceedings through an Order of Joinder issued by a Referee. Mo's/SAIF did not issue a denial and prior to the hearing accepted the claim.

CONCLUSIONS OF LAW AND OPINION

The Board has recently held in Duane L. Jones, 42 Van Natta 875 (1990) that it is improper to award an assessed fee in a matter where the insurer accepts the claim prior to hearing. We find that case to be controlling in this matter. The order of an assessed fee is reversed.

ORDER

The Referee's order dated October 18, 1988 is affirmed in part and reversed in part. That portion of the order that required SAIF to pay an assessed attorney fee of $1,200 is reversed. The remainder of the order is affirmed.

Board Member Crider, dissenting:

The Referee correctly awarded a carrier-paid attorney fee to claimant's attorney for services which were instrumental in obtaining acceptance of the claim.

ORS 656.386(1) entitles a worker to an attorney fee award whenever the attorney is instrumental in establishing the worker's right to compensation. That right was established after SAIF, as insurer of Mo's Restaurant, failed to timely accept or deny the claim for compensation filed on behalf of claimant by EBI Companies pursuant to OAR 436-60-180. Claimant, therefore, has prevailed in a rejected case and is entitled to a fee. Edward M. Anheluk, 34 Van Natta 205 (1982); Clarence A. Hooper, 1 Van Natta 160 (1968).

The majority reverses the fee award in reliance on the Board's recent decision in Duane L. Jones, 42 Van Natta 875 (1990). I dissent for the reasons stated in my dissenting opinion in that case.

In the Matter of the Compensation of
WCB Case No. 88-05299
ERNEST J. JOHNSON, Claimant
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
Kevin L. Mannix, Defense Attorney

Reviewed by Board Members Cushing and Gerner.

Claimant requests review of those portions of Referee Leahy's order which: (1) upheld the insurer's denial of claimant's aggravation claim for a low back injury; (2) upheld the insurer's denial of claimant's medical services claim for the same injury; and (3) declined to assess penalties or a related attorney fee for an alleged untimely denial. On review, the issue are compensability, aggravation, penalties and attorney fees. We affirm.

FINDINGS OF FACT

In August 1977, claimant sustained a compensable injury to his left arm and shoulder while working for a prior employer. The claim was closed by a November 1977 Determination Order which awarded temporary disability benefits. While with the same employer, claimant sustained a compensable injury to his low back in July 1978. This claim was closed by a December 1978 Determination Order which awarded temporary disability benefits only.

In December 1983, claimant sustained a compensable injury to his low back while working as a timber faller for the instant employer. This injury was a lumbar strain with left sciatica. He was treated with physical therapy. He was given a home traction unit and a lumbosacral belt and released to work in May 1984. The claim was closed by a December 1984 Determination Order which did not award any permanent disability benefits.

On December 13, 1984, claimant was involved in a automobile accident in which his car was rear-ended. He was treated by Dr. Srch, chiropractor, for acute cervical and thoracic strains as well as an acute lumbo-pelvic strain at L5-S1. Dr. Srch treated claimant through December 1985 pursuant to an automobile accident claim with Farmers Insurance.

In September 1987, claimant sought treatment from Dr. Hurd, chiropractor, for complaints of low back pain. On February 10, 1988, the insurer denied reopening of claimant's claim on the basis that his current condition was not related to the compensable 1983 injury.

CONCLUSIONS OF LAW AND OPINION

Compensability

The Referee concluded that claimant's current low back condition was not materially related to his 1983 industrial injury. 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). Accordingly, claimant must prove that the December 1983 industrial injury materially contributed to his current low back condition and need for treatment.

Given the length of time between the industrial injury and the treatment at issue, as well as the intervening incident, we find that the question of whether claimant's industrial injury is materially related to his current low back condition is a complex medical issue. Thus, although claimant's testimony

is probative, the resolution of this issue largely turns on an analysis of the medical evidence. See Kassahn v. Publishers Paper Co., 76 Or App 105 (1985).

Dr. Hurd, who first started treating claimant in late 1987, opined that claimant's 1983 industrial injury was a material contributing cause to his current low back condition. Dr. Hurd's opinion, however, is based on a history of continuous symptoms with no intervening injuries. This history, however, is inaccurate. In December 1984, claimant sought treatment for an acute lumbo-pelvic strain from Dr. Srch related to an automobile accident. At that time, Dr. Srch recorded a history of no low back symptoms for the previous six months. Dr. Srch treated claimant for approximately one year and declared claimant stationary with no residuals. Thereafter, claimant did not seek treatment for low back pain until approximately 21 months later. In light of these facts, Dr. Hurd's opinion is based on an inaccurate history and therefore, we do not find it persuasive. See Moe v. Ceiling Systems, 44 Or App 429 (1980).

We are likewise not persuaded by the opinion of Dr. Srch to the extent that it can be interpreted to find a material relationship between the 1983 industrial injury and claimant's current low back condition. Dr. Srch's opinion was in response to a hypothetical history given by claimant's counsel which is not consistent with the contemporaneous medical reports, including those authored by Dr. Srch. Further, Dr. Srch did not see claimant either after the 1983 injury or in regard to his current condition.

Accordingly, claimant has not established that the 1983 industrial injury is materially related to his current low back condition. As we have concluded that claimant's current condition is not related to the 1983 industrial injury, we do not reach the issue of whether the compensable condition has worsened.

Penalties and Attorney Fees

The Referee declined to assess a penalty or related attorney fee for an alleged untimely denial. We agree with the Referee, but do so on a different basis.

Here, the insurer received Dr. Hurd's report on November 23, 1987. It did not issue its denial until February 10, 1988, approximately 17 days past the statutory 60-day time limit. ORS 656.262(6). The insurer contends that it was unable to complete its investigation within the statutory time limit. Although this might have some bearing on the amount of a penalty, it does not constitute a reasonable explanation for failure to issue it denial in a timely fashion. Accordingly, we find that the insurer's late denial was unreasonable.

Although we have found the insurer's late denial unreasonable, there are no amounts "then due" upon which we might base a penalty for the insurer's delay. ORS 656.262(10). Consequently, the Referee was correct in declining to assess a penalty. Further, we have herein concluded that claimant's low back condition is not compensable, therefore, we cannot award a penalty related attorney fee as there as not been an unreasonable resistance to the payment of compensation. Ellis v. McCall Insulation, 308 Or 74 (1989); Lloyd L. Cripe, 41 Van Natta 1774 (1989).

Under these circumstances, we conclude that claimant is not entitled to a penalty or related attorney fee for the insurer's late denial.

ORDER

The Referee's order dated January 10, 1989, is affirmed. A client-paid fee, not to exceed $400, is approved, payable by the insurer to its counsel.

In the Matter of the Compensation of
WCB Case No. 88-14443
JEAN D. STIERNS, Claimant
ORDER ON REVIEW
Drakulich & Carlson, Claimant Attorneys
Acker, et al., Defense Attorneys

Reviewed by Board Members Myers and Gerner.

The insurer requests review of that portion of Referee Menashe's order which set aside its denial of claimant's left leg condition. Claimant cross-requests review of that portion of the Referee's order which required her to pay for the deposition of Dr. Bachhuber. On review, the issues are compensability and the cost of the deposition. We affirm.

FINDINGS OF FACT

We adopt the Findings of Fact in the Referee's Opinion and Order with the following supplementation. The insurer submitted the exhibits 7, 10, 12, 15, and 24 into evidence. These are chart notes and reports authored by Dr. Bachhuber. Claimant submitted exhibit 26 into evidence. This is a report from Dr. Bachhuber. Dr. Bachhuber's deposition is not cross-examination based on the reports submitted by the insurer; rather, it was taken to expand on the position taken by Dr. Bachhuber in support of the compensability of the claim.

CONCLUSIONS OF LAW AND OPINION

We adopt the conclusions in the Referee's Opinion and Order with the following supplementation on the issue of the cost of the deposition. OAR 438-07-005(3) requires an insurer to pay for the cost of a deposition in which claimant cross-examines a physician whose reports the insurer relies upon. We have found that in this case the deposition of Dr. Bachhuber was not cross-examination, but direct examination in support of claimant's case. Accordingly, the deposition is a cost of claimant's case for which the insurer need not pay.

Claimant's counsel is statutorily entitled to a reasonable, insurer-paid attorney fee for services rendered on Board review concerning the compensability issue. Such a fee is defined as an "assessed fee." See OAR 438-15-005(2). However, we cannot award 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 cannot presently be awarded. See OAR 438-15-010(5).

ORDER

The Referee's order dated December 15, 1988, as republished January 19, 1989, is affirmed. The Board approves a client-paid fee, not to exceed $1,575, to be paid by the insurer to its attorney.

In the Matter of the Compensation of
JOHN A. TALLANT, Claimant
WCB Case Nos. 86-08967 & 86-02121
ORDER ON REVIEW
Black, Chapman & Webber, Claimant Attorneys
David Horne, Defense Attorney
Cowling & Heysell, Defense Attorneys
Les Huntsinger (Saif), Defense Attorney

Reviewed by Board Members Crider and Brittingham.

The Workers' Compensation Division of the Department of Insurance and Finance (Department) and the SAIF Corporation request review of that portion of Referee Melum's order on remand that: (1) refused to set aside disputed claim settlements entered into by Wausau Insurance and its insured, Green Holdings, Inc., and claimant and by Trojan Concrete and Excavation Co. and claimant; and (2) declined to address the issues of compensability and responsibility. On review, claimant contends that the Referee erred when he concluded that the Department and SAIF have standing to challenge the validity of the disputed claim settlements or that the Department and SAIF waived the right to do so by failing to attend the initial hearing in this case. On review, the issues are standing, validity of settlements, compensability and responsibility. We reverse.

FINDINGS OF FACT

Claimant was employed by Trojan Concrete as a cement finisher. [Record II-T. 160]. On November 18, 1985, while working for Trojan, claimant suffered an onset of low back pain. The pain increased the following day. [Record II-T. 162, Ex. 3 and 8 (Huntsinger list 7/15/87), Ex. 18 (Chapman list 8/6/87)]. The pain was much more severe than any prior general soreness or tiredness he had experienced. [Record II-T. 195-200]. On that date, Trojan was engaged as a subcontractor on a job for which Green Holdings, Wausau's insured, was the prime contractor. On the date work commenced on the contract between Green Holdings and Trojan, Trojan was covered by workers' compensation insurance. Coverage lapsed on September 20, 1985. [Record II-Ex. 6A (Chapman list 7/17/86)]. On the date of injury, Trojan was not insured. [Record II-T. 27-29].

Claimant's pain reflected an acute strain superimposed on preexisting degenerative disc disease. He was treated by both a doctor of medicine and a chiropractor.

Claimant prepared a Form 801 contending that he had injured his lower back on November 18, 1985. He listed as his employer, Trojan. [Record II-Exhibit 7A].

On February 12, 1986, claimant filed a Request for Hearing, listing Trojan as the employer. He raised the issues of compensability of the November 18, 1985 injury and penalties and attorney fees for failure to timely accept or deny the claim. [Record I] The Board assigned a case number, WCB 86-02121 and sent acknowledgments of the request to claimant, his attorney, Trojan and the SAIF Corporation. [Record I]. SAIF requested its dismissal as a party on the ground that SAIF neither insured Trojan nor had Trojan been declared a noncomplying employer and the claim been forwarded to SAIF for processing. [Record II-Exhibit 10A].

On March 31, 1986, however, the Workers' Compensation Department (now the Workers' Compensation Division of the Department of Insurance and Finance) issued a Notice of Proposed and Final Order declaring Trojan a noncomplying employer from September 21 to November 19, 1985. [Record II-Exhibit 12A-3 (Chapman list 8/20/87)]. Claimant's claim was referred to SAIF for processing. [Record II-Exhibit 12A-1 (Chapman list 8/20/87)].

The Referee never ruled on SAIF's motion to dismiss.

By Notice dated April 2, 1986, and mailed to the parties, including SAIF, a hearing was scheduled for April 21, 1986 on claimant's Request for Hearing. [Record II-Exhibit 14B (Chapman list 8/20/87)].

SAIF accepted the claim for a strain on May 30, 1986 and notified Trojan of the acceptance. [Record II-Exhibits 16 and 17 (Huntsinger list 7/15/87)]. SAIF, as processing agent, has expended more than $10,000 in disability and medical benefits in this claim. [Record II-Tr. 44-45]. The Department of Insurance and Finance, formerly the Workers' Compensation Department, reimburses SAIF its costs as well as an administrative fee in processing claims on referral. The Department is entitled to recover the costs of a compensable claim from the noncomplying employer. [Record II-T. 147-148, 155, 157].

Trojan requested a hearing on June 27, 1986, contesting SAIF's acceptance of claimant's claim and asked that its request be consolidated for hearing with WCB 86-02121. [Record I]. The request for hearing was assigned a new number, WCB 86-08967. [Record I]. Trojan also moved for joinder of its general contractor, "Green Builders, Inc." (actually Green Holdings, Inc.), on the ground that, if the claim was compensable, the general contractor would be liable for the claim under ORS 656.029. The motion was granted. [Record I]. Hearing was scheduled in the consolidated cases for August 1, 1986. Notice of the hearing was mailed to SAIF and the Department.

Counsel for claimant, Wausau, the insurer for Green Holdings, and Trojan were in attendance at the time and place scheduled for the August 1, 1986 hearing. A representative of neither SAIF nor the Department was in attendance. No hearing was convened. [Record II, T. 185-191]. Trojan and claimant entered into an agreement captioned "Stipulation and Order of Settlement Pursuant to ORS 656.289(4)." The settlement provided that claimant released his claim against Trojan in exchange for $625.00. In addition, Green Holdings and Wausau entered into an agreement with claimant captioned "Disputed Claim Settlement" by which claimant released his claim against Green Holdings in exchange for $2,000. Neither SAIF nor the Department was a party to either agreement. Neither consented to it. Referee Brown approved the stipulations and dismissed the requests for hearing. [Record II-Exhibits 17G and 17H (Chapman list 8/20/87)].

The Workers' Compensation Department timely requested review of Referee Brown's orders. SAIF also requested review. Trojan and Green Holdings moved to dismiss the requests for review on the ground that neither the Department nor SAIF had standing to request review. [Record I]. We concluded that the record had been insufficiently developed to allow us to address the merits of petitioners' contentions on review. We, therefore, remanded the cases to the Referee to determine whether petitioners had standing to challenge the legal sufficiency of the settlement agreements and dismissal orders pursuant thereto; whether the settlement agreements should be set aside; and, if so, whether the claim was compensable and which employer was responsible. [Record I].

On remand, the cases were assigned for hearing before Referee Melum. The following persons appeared through counsel at the April, 1988 hearing: Claimant; the Workers' Compensation Division of the Department of Insurance and Finance; Green Holdings, Inc. and Wausau; and Trojan Concrete. Each sought to participate and was permitted, by the Referee, to participate in the proceeding.

FINDINGS OF ULTIMATE FACT

SAIF and the Department were parties to WCB Case Nos. 86-02121 and 88-08967.

The Department had an interest in the outcome of WCB Case Nos. 86-02121 and 88-08967. On remand, the Department appeared through the Department of Justice.

Trojan was an employer of subject employees on the date of claimant's injury. Trojan was not covered by workers' compensation insurance on that date.

Green Holdings, Inc. awarded a contract to Trojan for the performance of construction work. Construction work was a normal and customary part of Green Holdings, Inc.'s business. At the time work commenced under the contract, Trojan was covered by workers' compensation insurance.

Claimant's injury while employed by Trojan was a material contributing cause of his back strain.

CONCLUSIONS OF LAW AND OPINION

Order on Remand

On remand, Referee Melum concluded that SAIF and the Workers' Compensation Department had standing to question the validity of the settlement agreements between Trojan and claimant and Green Holdings/Wausau and claimant. He rejected a contention that the agreements should be set aside on the grounds that there was no bona fide dispute concerning the compensability of the claim: He found that there was evidence to support both the position that the claim was compensable and that it was not. In addition, he held that the agreements were procedurally valid because they did not require the approval of SAIF or the Department. Having so ruled, the Referee did not address the issues of compensability and responsibility. The record, however, is sufficient to allow us to address those issues on de novo review.

Standing

On review, no party seriously contends that SAIF and the Department do not, in the ordinary case, have standing to object to a disputed claim settlement between claimant and a noncomplying employer or a contractor which may be liable under ORS 656.029. Nevertheless, claimant argues that SAIF and the Department waived that right by failing to appear, through counsel, at the time set for hearing before Referee Brown on the compensability of the claim. We conclude that SAIF and the Department do have standing to contest the validity of the settlements and did not waive the right to do so in this case.

SAIF Corporation

Trojan was declared a noncomplying employer by order of the Department. That order became final twenty days after its issuance, when Trojan did not challenge it. SAIF, therefore, as processing agent on the claim, was solely responsible for the processing of the claim. It, not Trojan, was required to accept or deny the claim. When SAIF accepted the claim, Trojan was entitled to challenge that acceptance by request for hearing. Clark v. Linn, 98 Or App 393 (1989).

The Workers' Compensation Law recognizes that an insurer for an employer is a party to a workers' compensation proceeding. ORS 656.005(19). Although SAIF, when acting as a processing agent for a noncomplying employer, is not technically an insurer for an employer, we conclude that it is a party to any proceeding involving the compensability of a claim which has been referred to it for processing under ORS 656.054. Moreover, SAIF had an interest in the proceeding: It was SAIF's decision that was being challenged; and SAIF had expended its funds to pay benefits in the claim. Finally, the agency had recognized SAIF's party status by mailing to SAIF a notice of hearing and by not acting on SAIF's early motion to dismiss it as a party. Therefore, also, SAIF was a party to the proceeding. See ORS 183.310(6). As a party to the proceeding at

hearing, SAIF was entitled to request review of the order approving the settlement agreements and dismissing the request for hearing. ORS 656.289(3).

Claimant's contention that SAIF waived it right to challenge the settlement agreements by failure to attend the hearing in this case is without merit. Nothing in the statute or the rules required any party, other than the party that requested the hearing, to appear personally or through counsel at the hearing. See former OAR 438-06-070. Therefore, SAIF retained its right to request review of the Referee's order approving the stipulations, its failure to appear notwithstanding.

The Department

The Department, like SAIF, had standing to challenge Referee Brown's order because it was a party to the proceeding and did not waive its right to request review by not sending a representative to the hearing.

In addition, the Board has held that the Department may seek review of a referee's order in any case provided that it has a stake in the outcome of the proceeding. Therefore, in Todd A. Aucune, 37 Van Natta 552 (1985), the Board, at the request of the Department, reviewed an order concerning the compensability of a claim that had been denied by SAIF, as processing agent for a noncomplying employer. We entertain some doubt as to the viability of this doctrine as applied to cases in which the Department has not chosen to participate in a case at hearing. [1] But where the Department was a party at hearing, as in this case, it clearly has standing to request Board review under ORS 656.289(3).

The Department also has standing to challenge the disputed claim settlements for another reason. A settlement may be collaterally attacked as invalid by request for hearing. See e.g., Greenwade v. SAIF, 41 Or App 697 (1979). The Director of the Department may, at any time, request a hearing on a matter concerning a claim. ORS 656.283. The validity of the settlement agreements are matters concerning a claim. Consequently, the Director is entitled to challenge any settlement agreement in any case as protector of the public interest. The Director would have standing to challenge the settlement agreements at issue in this case even if the Department had not been a party at hearing and even if it had no other stake in the proceedings.

We conclude that, assuming the Department was not entitled to challenge Referee Brown's decision to approve the agreements via direct review, the Department was entitled to challenge them at the hearing that we ordered be conducted on remand. Although the Department did not formally request a hearing, we treat the Department's participation on remand as the functional equivalent of such a request.

For all of these reasons, the Department has standing to challenge the settlement agreements.

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[1] The Administrative Procedures Act permits any person adversely affected by a contested case order to request review. The petitioner need not have been a party in the proceeding before the agency. ORS 183.480. The right to request review to the Board, however, is not controlled by the Administrative Procedures Act. ORS 183.315(1). The right to request review of a referee's order is controlled by chapter 656. ORS 656.289(3) provides that a referee's order must be mailed to the parties; the order becomes final unless one of the parties requests review within 30 days.

The Validity of the Settlement Agreements

The Agreement between Trojan and Claimant

The statute provides that, "in any case where there is a bona fide dispute over compensability of a claim, the parties may, with the approval of a referee, the board or the court, by agreement make such disposition of the claim as is considered reasonable." ORS 656.289(4). There is a bona fide dispute if a claim has been filed, the insurer or self-insured employer has denied the claim, and there is evidence to support the divergent positions. SAIF and the Department contended at hearing that there was no evidence to support the contention that claimant's claim was not compensable and thus that the dispute was not bona fide. We do not reach that issue.

A stipulation may be set aside not only if there is no colorable basis for the claim or the denial of it but also if necessary parties have not agreed to it. J.C. Compton v. DeGraff, 52 Or App 317 (1981). That is the case here. The court's opinion in the case of Clark v. Linn, supra, establishes that the agent for processing of a claim made for injury while employed by a noncomplying employer is SAIF. Because Trojan was a noncomplying employer when claimant's injury occurred, Trojan could not accept or deny his claim. Therefore, while a bona fide dispute might exist between claimant and SAIF, as processing agent, no bona fide dispute could exist between Trojan and the noncomplying employer. By failing to purchase insurance, Trojan gave up any right it might have had to enter into a settlement agreement of any kind with claimant concerning his workers' compensation claim.

The settlement agreement between claimant and Trojan must be set aside because Trojan was legally foreclosed from entering into such an agreement and because SAIF, which did have the authority to enter into such an agreement, was not a party to the agreement.

The Agreement between Green Holdings/Wausau and Claimant

The issue scheduled for hearing before Referee Brown was the compensability of claimant's claim against Trojan. Trojan joined Green Holdings, its general contractor, apparently in order to argue that Green Holdings was liable under ORS 656.029. Thereupon, Green Holdings entered into a disputed claims settlement with claimant. The question is the validity of that settlement.

Ordinarily, when compensability as well as responsibility is in issue, a claimant and one of the potentially responsible employers may enter into a disputed claims settlement. Compare J.C. Compton v. DeGraff, supra. By entering into such a settlement against one employer, the claimant takes a risk that although his claim is ultimately found compensable, he will be unable to establish that one of the remaining employers is responsible. Thus, although he has a compensable claim, no employer will be required to pay benefits in the claim.

The question is whether this case varies from the ordinary compensability/responsibility case because the responsibility question arises under ORS 656.029. We hold that it does not. The Department and SAIF, of course, would have an interest in assignment of responsibility to Green Holdings rather than Trojan because Green Holdings is insured and Trojan is not. However, if the Department had wished to contend that the claim was the responsibility of Green Holdings, it would not have found Trojan noncomplying and referred the claim to SAIF for processing; instead, the Department would have directed the claim to Green Holdings. Inasmuch as the Department did refer the claim to SAIF and SAIF accepted the claim, rather than denying responsibility

for it and seeking a .307 order, claimant and Green Holdings were free to enter into any unilateral settlement that pleased them.

The settlement is valid. There was a bona fide dispute between claimant and Green Holdings. Trojan had filed a claim on claimant's behalf by joining the general contractor. Green Holdings had ample reason to doubt its responsibility in the claim.

At the time of injury, ORS 656.029 provided as follows:

> "If a person awards a contract involving the performance of labor where such labor is a normal and customary part or process of the person's trade or business, the person awarding the contract is responsible for providing workers' compensation insurance coverage for all individuals, other than those exempt under ORS 656.027, who perform labor under the contract unless the person to whom the contract is awarded provides such coverage for those individuals before labor under the contract commences."

OAR 436-50-040(2) provided that the critical date under the statute was the date work commences under the contract. If the person to whom the contract was let had coverage at that time but the coverage lapsed at a later time, the person to whom the contract was let is noncomplying. The person letting the contract is not responsible.

Given that Trojan had coverage when work commenced, Green Holdings had a strong basis for its contention that it was not responsible.

Therefore, the disputed claims settlement between Green Holdings/Wausau and claimant was both procedurally and substantively valid.

Compensability

Claimant suffered an onset of back pain on November 18, 1985. The onset occurred during a discrete period of work activity. The claim, therefore, must be analyzed as one for an industrial injury. Valtinson v. SAIF, 56 Or App 184 (1982). To be compensable, the workplace injury must be a material contributing cause of claimant's need for medical treatment. Summit v. Weyerhaeuser Co., 25 Or App 851, 156 (1976). Because the claim was accepted by SAIF, it is the noncomplying employer's burden to establish, by a preponderance of the evidence, that the injury did not occur or was not a material contributing cause of claimant's pain and need for treatment.

We have found, based on claimant's credible testimony, that he did suffer an onset of pain at work. We have further found that the claimant's pain was caused by a strain due to his work activities. In so doing, we rely on the opinions of Dr. Matthew, claimant's treating orthopedist, and Dr. Hearns, D.C., to whom claimant transferred his care. The strain, together with preexisting, asymptomatic degenerative disc disease, caused disability and need for treatment.

The report of the Orthopaedic Consultants is not to the contrary. The Consultants examined claimant more than a year after the injury. They diagnosed a lumbar strain, by history, and concluded that the November 1985 injury exacerbated the preexisting degenerative condition. Although the Consultants opined that the injury left no residuals, they did not contend that claimant was not injured at work.

We, therefore, conclude, based on the claimant's credible testimony and the uncontradicted medical evidence, that claimant suffered a work-related injury while working for the noncomplying employer. The claim is compensable.

Responsibility

SAIF accepted the claim. We have found that it is compensable. Therefore, the question arises whether the noncomplying employer or the general contractor is responsible. As we noted above, in our discussion of the bona fides of the dispute between claimant and Green Holdings, Trojan, rather than Green Holdings, was responsible to provide workers' compensation coverage for its employees, if it provided coverage for them at the time work on the contract commenced. The parties stipulated that Trojan did provide such coverage at the time work commenced but allowed it to lapse prior to the compensable injury. Therefore, the injury was the responsibility of Trojan. OAR 436-50-040(2)(a).

SAIF's acceptance, as processing agent of the claim for Trojan as noncomplying employer, was proper.

ORDER

The Referee's order dated May 25, 1988, as modified by order on reconsideration dated July 5, 1988, is reversed in part and affirmed in part. The disputed claim settlement between Trojan Concrete and Excavation Co. and claimant is set aside. The SAIF Corporation's acceptance of claimant's claim, as processing agent, is upheld. The remainder of the order is affirmed. The Board authorizes a client-paid fee, not to exceed $1,351, payable by Trojan to its counsel.

April 25, 1990 Cite as 42 Van Natta 945 (1990)

In the Matter of the Compensation of
STEPHANIE L. VOLLENDROFF, Claimant
WCB Case Nos. 86-05226 & 84-09021
ORDER ON REVIEW
Vick & Gutzler, Claimant Attorneys
Rankin, et al., Defense Attorneys
Beers, et al., Defense Attorneys

Reviewed by Board Members Crider and Nichols.

Stayton Canning Company (SCC), a self-insured employer, requests review of the portions of Referee Howell's order that: (1) set aside its denial of claimant's claim for medical and temporary disability benefits relating to a cervical condition; (2) directed it to pay claimant medical and temporary disability benefits up to the date of the Referee's order; and (3) declined to order EBI Companies to reimburse SCC for benefits to be paid up to the date of the Referee's order. EBI Companies cross-requests review of the portions of the order that: (1) set aside its denials of claimant's aggravation claim for the cervical condition; and (2) found it responsible for the same condition. We reverse.

ISSUE

Preclosure Denials of Claims. Did SCC's denial of claimant's claim for medical and temporary disability benefits constitute a preclosure denial of future responsibility for a previously accepted condition? If not, compensability of and responsibility for claimant's cervical condition.

FINDINGS OF FACT

Claimant, a certified nurse aide, suffered a compensable injury on September 13, 1983, when she received an electrical shock through the left hand and was "jerked" away from the outlet by a coworker. She initially sought treatment with Dr. Young for symptoms in the left shoulder, arm and hand, but later also complained of headaches, neck pain and muscle spasms. She was ultimately diagnosed with a cervical strain and taken off work. Her disabling injury claim was accepted by EBI and closed by Determination Order on August 1, 1984, with no permanent disability award.

On September 25, 1984, claimant began working as a corn cutter for SCC. At that time, she had daily headaches and occasional muscle spasms. After a week of repetitive reaching on the corn cutter belt, however, she developed increased pain and muscle spasms in the left neck and shoulder area. She saw Dr. Young and filed a new injury claim for a cervical strain on October 4, 1984. Young released her for modified work, which she performed until being laid off two weeks later. SCC accepted claimant's claim as nondisabling, but the claim has never been closed.

Claimant continued to have pain and numbness in the neck and left shoulder for which Young prescribed medication. In November 1984, she began working as a grocery clerk; however, she left that job in March, 1985, with increased neck and left shoulder symptoms. She then worked as a live-in nurse aide for the elderly. In July 1985, she was referred to Dr. Knox, a neurologist, with continuing neck and left shoulder symptoms. Claimant also began experiencing numbness in her left hand and arm. Knox interpreted an EMG study as compatible with an apparent C8-T1 radiculopathy and/or brachial plexopathy, and attributed claimant's need for treatment to the 1983 industrial injury.

Viewing Knox's reports as a claim for aggravation, EBI issued letters dated March 4, 1986, and September 16, 1986, denying the claim on the bases that claimant's cervical condition is not related to the 1983 injury and, alternatively, that her condition is due to the 1984 injury accepted by SCC. Knox subsequently opined that the 1984 injury had independently worsened claimant's cervical condition. Despite never closing the 1984 claim, SCC viewed Knox's report as an aggravation claim and, by letter dated September 24, 1986, denied the claim as unrelated to the 1984 injury.

Knox took claimant off work in July, 1986, due to increased symptoms and limitations in the left upper extremity. As of the date of hearing, claimant remained off work and was treating with Knox. Both the compensability of and the responsibility for claimant's disability and treatment in 1985 and 1986 remained at issue at hearing.

FINDING OF ULTIMATE FACT

SCC's denial of claimant's claim for medical and temporary disability benefits issued before claim closure and denied future responsibility for a previously accepted condition.

CONCLUSIONS OF LAW AND OPINION

The Referee set aside SCC's denial as procedurally improper and ordered it to pay claimant's compensation through the date of his order. However, the Referee then proceeded to the merits of each denial and found EBI responsible for claimant's aggravation claim as of the date of his order. We agree that SCC's denial must be set aside; however, we find the Referee's subsequent analysis to be unnecessary and, instead, assign responsibility to SCC.

The law in effect at the time of injury governs whether an initial injury claim must be closed. See Webb v. SAIF, 83 Or App 386, 390 (1987). At the time of claimant's 1984 injury with SCC, ORS 656.268 required closure of nondisabling injury claims. See Or Laws 1981, ch 854, 7a. We reject SCC's contention that the 1985 amendments, eliminating the duty to close nondisabling claims, retroactively absolved insurers/employers of the duty to close claims for injuries occurring prior to the effective date of the amendments. See Or Laws 1985, ch. 600, 8, 19.

Because SCC failed to close claimant's claim for the 1984 nondisabling injury, it was precluded from denying further responsibility for any inseparable part of that claim before the extent of the accepted condition(s) had been determined pursuant to the statutory procedures for claim closure. See Roller v. Weyerhaeuser Co., 67 Or App 583, amplified 68 Or App 743, rev den 297 Or 601 (1984); Safstrom v. Riedel International, Inc., 65 Or App 728 (1983); Arthur E. Matthews, 39 Van Natta 361 (1987).

The medical reports and lay testimony establish that, since her 1984 cervical injury with SCC, claimant has had continuing symptoms of pain and numbness in the left neck and shoulder area. We are persuaded, therefore, that the cervical symptoms resulting in claimant's disability and need for treatment in 1985 and 1986 are a continuation of symptoms arising from the accepted 1984 injury with SCC. Accordingly, we find that SCC's denial constituted a preclosure denial of future responsibility for a previously accepted condition. Hence, the denial is procedurally improper and must be set aside. See Roller v. Weyerhaeuser Co., supra; Safstrom v. Riedel International, Inc., supra.

SCC argues that preclosure denials of responsibility are permissible under Jimmy C. Lay, 37 Van Natta 583 (1985), and Stephen K. Napier, 37 Van Natta 1031 (1985). In each of those cases, the claimant had an accepted injury claim with the first employer/insurer. Before closure of that claim, the claimant returned to work while a second employer/insurer was on the risk and reinjured the same body part. Claims were filed against both employers/insurers; both claims were denied on responsibility grounds. The second employer/insurer argued that, because the first injury claim remained in open status, the first employer/insurer's denial of responsibility was procedurally invalid for the reasons stated in Roller v. Weyerhaeuser Co., 67 Or App 583, amplified 68 Or App 743, rev den 297 Or 601 (1984), and Safstrom v. Riedel International, Inc., 65 Or App 728 (1983), rev den 297 Or 124 (1984). The Board rejected that argument, however, reasoning that "it is the better policy to allow an employer/insurer to issue a preclosing denial of continued responsibility for an accepted condition where it appears that injuries or conditions attributable to a subsequent employment aggravate or exacerbate the condition such as to make a shift of employer/insurer responsibility appropriate." Jimmy C. Lay, supra, 37 Van Natta at 584. See also Harry A. Joers, 40 Van Natta 110, 111, recon 41 Van Natta 849 (1989).

Without commenting on the continued validity of the decisions in Lay and Napier, we hold that those cases are inapposite here. In both cases, the first employer/insurer sought to shift responsibility to a later employer/insurer by issuing a preclosure denial of responsibility. Here, the second employer issued the preclosure denial, seeking to shift responsibility back to the earlier employer. This case bears a greater similarity to Mason L. Asbury, 38 Van Natta 961 (1986), where the second of two successive insurers issued a preclosure denial of responsibility for a previously accepted condition in an apparent attempt to shift responsibility to the earlier insurer. The Board set aside that denial as procedurally improper, because the evidence failed to establish that work conditions subsequent to the second employment had worsened the previously accepted condition so as to shift responsibility to a later (e.g., third)

employer/insurer. Id. at 964. Though not expressly stated, the Board impliedly reasoned that a later employer/insurer may not issue a preclosure denial of responsibility for a previously accepted condition in order to shift responsibility back to an earlier employer/insurer.

The underlying rationale in Asbury is this: If a later employer/insurer believes that the injury it accepted has resolved and that future responsibility for claimant's disability and/or treatment should revert to an earlier employer/insurer, it should close the accepted claim before issuing a denial of responsibility for the current condition. The responsibility issue can then be litigated between the respective employers/insurers. That procedure prevents the effective termination of claimant's compensation for an accepted condition before he/she has had an opportunity to seek a determination of the extent of his/her disability, if any, by the Evaluation Section pursuant to ORS 656.268. See Roller v. Weyerhaeuser Co., supra; Safstrom v. Riedel International, Inc., supra.

Although we have permitted an insurer of the first injury to raise the responsibility issue by issuing a denial when an intervening work-related injury occurs before the first injury has become medically stationary and thus ripe for closure, we nevertheless do not allow the insurer to cease paying benefits pursuant to the denial. For practical purposes, therefore, the denial may be used to force a hearing on the responsibility issue and no more. The use of this procedural oddity may be appropriate if no other procedure is available. Where, however, an insurer of the second injury wishes to argue that the injury has resolved, that it no longer bears any relationship to a worker's condition, and, therefore, that responsibility for the ongoing condition should revert to the insurer of the first injury, there is no need for any aberrant procedure. If the worker is medically stationary, then the claim may be closed. Litigation of the responsibility issue need not occur until the worker claims additional compensation. At that time, the insurers may contest the compensability of and responsibility for claimant's then-current condition. In short, when an insurer of a second work injury seeks to shift responsibility backward, there is no justification for forcing the insurer of the first injury and the worker to litigate the effect of the second injury in the context of a responsibility hearing. Instead, the question of the permanent effect of the second injury should first be decided via the claim closure process. For this reason, we are persuaded that the rule implicit in Mason L. Asbury, supra, is appropriate.

SCC argues that the policy underlying Roller and Safstrom does not apply here because its preclosure denial did not terminate claimant's compensation. We disagree. Although SCC may not have received any claims for medical expenses prior to the issuance of its denial, it clearly sought to deny future responsibility for any medical expenses that may be incurred for the cervical condition. Furthermore, absent claim closure, claimant was entitled to temporary disability benefits when his doctor declared him to be physically unable to work due to the compensable condition. See Hallmark Fisheries v. Harvey, 100 Or App 657 (1990). Dr. Knox declared claimant temporarily and totally disabled as of July 7, 1986, due to the compensable cervical condition (Ex. 49). Yet, SCC attempted to prevent claimant from receiving additional compensation. Accordingly, its denial had precisely the effect which is prohibited by Roller and Safstrom.

SCC's denial must be set aside; therefore, we need not address the remaining issues raised by the parties.

ORDER

The Referee's order dated February 6, 1987, as reconsidered March 10, 1987, is reversed in part, modified in part, and affirmed in part. The portions

of the Referee's order that set aside the EBI Companies' aggravation denials and found it responsible for claimant's medical services and disability relating to the cervical condition are reversed. The EBI Companies' denials of March 4, 1986, and September 16, 1986, are reinstated and upheld. Claimant's claim for temporary disability and medical benefits relating to her cervical condition is remanded to Stayton Canning Company for further processing according to law. The portion of the Referee's order that directed each carrier to pay half of claimant's assessed fee award is modified. Stayton Canning Company shall pay the entire assessed fee of $1,400. The remainder of the order is affirmed. Claimant's attorney is awarded an assessed fee of $1,000, payable by Stayton Canning Company, for services rendered on Board review of the preclosure denial issue.

April 26, 1990 Cite as 42 Van Natta 949 (1990)

In the Matter of the Compensation of
DANIEL J. BERGMANN, Claimant
WCB Case Nos. 88-03592, 88-06021, 88-06022 & 87-19384
ORDER ON REVIEW (REMANDING)
Malagon, et al., Claimant Attorneys
Lester R. Huntsinger (Saif), Defense Attorney
Jaqua, Wheatley, et al., Defense Attorneys

Reviewed by Board Members Nichols, Brittingham and Crider.

Claimant requests review of Referee Howell's order declining to award an insurer-paid attorney fee for services culminating in settlement of a dispute concerning responsibility. On review, the issue is attorney fees. We reverse and remand.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact and make the following additional findings:

The first determination order issued in the 1980 claim on September 3, 1981, more than five years prior to the 1987 worsening.

Claimant's October 3, 1987, worsening did not require surgery or hospitalization.

FINDINGS OF ULTIMATE FACT

Claimant appeared in the .307 proceeding through counsel and actively and meaningfully participated in the proceeding, culminating in settlement of the responsibility dispute.

CONCLUSIONS OF LAW AND OPINION

Claimant had an accepted claim for a 1980 injury; the SAIF Corporation was the insurer. In 1987, claimant was reinjured while working for SAFECO's insured. SAIF and SAFECO both issued denials of responsibility only. Claimant's attorney filed requests for hearing challenging the denials. A .307 order issued; and the order was sent to the Board to assign an arbitrator to hear the case. Thereafter, SAIF, SAFECO and claimant entered into a stipulation, resolving the dispute over responsibility for claimant's condition. They were unable to agree concerning claimant's entitlement to an insurer-paid attorney fee and, if entitled, the amount of the fee.

The Referee declined to award a fee. He reasoned that because neither insurer denied compensability, claimant's compensation was not at risk and thus that he was not entitled to a fee under ORS 656.386(1).

Claimant contends that although neither insurer denied the compensability of his claim, his right to compensation was nonetheless at risk because his aggravation rights have expired in the 1980 claim. The Board's authority under its own motion jurisdiction does not extend to awards of temporary disability except when a worker undergoes surgery or is hospitalized for treatment of a compensable condition and does not extend to awards of permanent disability in any case. ORS 656.278. Therefore, claimant had significant stake in the outcome of the responsibility dispute. If claimant's condition was an aggravation of the 1980 injury, he would be entitled to no temporary or permanent disability compensation. If, however, claimant's condition was a new injury, he would be entitled to temporary disability compensation and to a rating of permanent disability. Thus, the claimant contends, claimant's stake in the responsibility dispute was not speculative [Anfora v. Liberty Communications, 88 Or App 30 (1987)] but just as immediate as in SAIF v. Phipps, 85 Or App 436 (1987). Therefore, claimant contends he is entitled to an assessed fee under ORS 656.386(1).

Claimant's contention is one of the first impression. We do not reach it because we conclude that the arbitrator may award a fee under ORS 656.307(5).

The Referee declined to award a fee under ORS 656.307(5). In so doing he construed ORS 656.307(5) to permit award of an insurer-paid fee only when claimant actively and meaningfully participated in a hearing. Because the parties settled this case before an evidentiary hearing was convened, he held that claimant was not entitled to a fee.

The Referee's reasoning is similar to the reasoning we adopted in Duane L. Jones, 42 Van Natta 875 (1990). In Duane L. Jones, supra, we interpreted ORS 656.386(1) to preclude award of an assessed fee when an insurer rescinds a denial prior to hearing. We did so in reliance on the language of that statute. The language of ORS 656.307(5) is different. Whereas ORS 656.386(1) provides for an insurer-paid fee when a claimant finally prevails "in a hearing before a referee," an insurer-paid fee may be awarded under ORS 656.307(5) under less limited circumstances.

ORS 656.307(5) reads:

> "The claimant shall be joined in any proceeding under [section 307] as a necessary party, but may elect to be treated as a nominal party. If the claimant appears at any such proceeding and actively and meaningfully participates through an attorney, the arbitrator may require that a reasonable fee for the claimant's attorney be paid by the employer or insurer determined by the arbitrator to be the party responsible for paying the claim."

Thus, if claimant participates actively and meaningfully through an attorney in a .307 "proceeding," he may be awarded a fee.

The legislature also used the term "proceeding" in ORS 656.307(2), and therein authorized the board to prescribe rules for the conduct of arbitration proceedings. This rule making authority parallels that conferred by ORS 656.726(4) with respect to hearing and review "proceedings". Pursuant to the authority granted by these two statutes, the board has promulgated rules for the conduct not only of the evidentiary hearing itself but for the processing of the case from its commencement until the order becomes final or the case falls

within the jurisdiction of another tribunal. In short, we have construed an arbitration proceeding to begin when we receive the .307 order. See Timothy R. Schroeder, 41 Van Natta 568 (1989).

Consequently, the arbitrator may award an insurer-paid attorney fee whenever a claimant actively and meaningfully participates in a responsibility matter after the board receives the .307 order. It is apparent here that claimant's attorney actively prosecuted this case both before and after the board received the .307 order. Before the receipt of the .307 order, claimant's attorney assisted claimant in filing the new injury claim; requested a hearing on each of the insurers' denials of responsibility; and prepared for hearing on the consolidated cases by, inter alia, submitting exhibits. After the receipt of the .307 order, counsel was further involved in the preparation of the case and in achieving settlement. We conclude, therefore, that claimant actively and meaningfully participated in the proceeding. The Referee, acting as arbitrator, therefore erred in denying a fee on the ground that claimant did not actively and meaningfully participate in the arbitration proceeding.

Neither ORS 656.307(5), nor OAR 438-15-090, requires an arbitrator to award a fee in any particular case. The law simply authorizes the arbitrator to award a fee in his discretion. Nevertheless, the legislature has chosen to allow a fee under circumstances in which none could previously be granted. See Petshow v. Farm Bureau Insurance, 76 Or App 563 (1985). That being the case, we conclude that when a claimant actively and meaningfully participates in an arbitration proceeding, an insurer-paid fee should be awarded absent unusual circumstances.

Nevertheless, because an award under ORS 656.307(5) is within the discretion of the arbitrator, we remand. On remand, the Referee shall determine whether or not claimant should be awarded a fee in this case under ORS 656.307(5) and, if so, shall award a fee, payable by SAFECO.

ORDER

The Referee's order dated September 1, 1988, is reversed. The case is remanded for further proceedings consistent with this order.

April 26, 1990 Cite as 42 Van Natta 951 (1990)

In the Matter of the Compensation of
HAZEL P. FLORY, Claimant
WCB Case Nos. 85-15107 & 85-15106
ORDER ON REVIEW
Sharp & Durr, Claimant Attorneys
Thomas Sheridan (Saif), Defense Attorney
Stafford Hazelett, Defense Attorney
Beers, et al., Defense Attorneys

Reviewed by Board Members Nichols and Brittingham

Liberty Northwest Insurance Corporation requests review of that portion of Referee Fink's order that: (1) set aside its denial of responsibility for claimant's "new injury" claim for her neck, left shoulder, and upper back condition; and (2) upheld the SAIF Corporation's denial of responsibility for claimant's aggravation claim for that condition. EBI Insurance Companies cross-requests review of that portion of the order that: (1) set aside its denial of responsibility for claimant's carpal tunnel condition; and (2) upheld Liberty Northwest Insurance Corporation's denial of responsibility for that condition.

Claimant cross-requests review of that portion of the order that declined to award an assessed fee for prevailing against the denial of the carpal tunnel condition.

On review, the issues are responsibility for the carpal tunnel condition; responsibility for the upper back, neck, and left shoulder condition; and attorney fees for services at hearing. We reverse in part and modify in part.

FINDINGS OF FACT

In October 1979 claimant suffered a compensable injury to her thoracic and cervical musculature. The claim was accepted by SAIF. She returned to work after a few days and treated from time to time with Dr. Corrado, chiropractor. In December 1979, her claim was closed by a Determination Order, which awarded time loss only.

Claimant continued to suffer symptoms periodically and sought chiropractic treatment for a variety of complaints. Hand numbness and tingling were noted, but not diagnosed. No treatment was offered. No loss of function was noted.

On June 28, 1985, Dr. Corrado diagnosed right carpal tunnel syndrome (CTS). (Ex. 39). Dr. Wilson, neurologist, confirmed this diagnosis. (Ex. 40). On October 8, 1985, Dr. Schwartz, orthopedist, performed a right carpal release.

SAIF was on the risk through June 1980. EBI was on the risk from July 1, 1980 through June 1985. Liberty Northwest secured the coverage July 1, 1985.

On October 24, 1985, Liberty denied responsibility for claimant's right CTS. (Ex. 46). On February 24, 1986, EBI denied responsibility for bilateral CTS. (Ex. 61). (No claim was made for left CTS.) Claimant requested a hearing on the denials, and a .307 order issued in March 1986.

Claimant was released for work in March 1986. (Ex. 76). Her work involved repetitive picking up and reaching, which she now performed with her left hand only. In mid March 1986, she began having pain in her back and neck (Ex. 72), which she described as more severe than that associated with the 1979 industrial injury.

A June 2, 1986 Determination Order awarded 5 percent permanent disability for loss of use of the right forearm (wrist).

In March 1987, x-rays revealed a protruding disc in claimant's cervical spine.

On July 23, 1986, Liberty Northwest issued a compensability and responsibility denial of claimant's upper back, neck, and shoulder condition. (Ex. 81). On December 19, 1986, EBI also denied compensability and responsibility for that condition. Claimant requested a hearing on Liberty Northwest's denial. EBI's denial became final as a matter of law.

Claimant's hearing requests were consolidated. The parties agreed that SAIF should be joined as a necessary party to determine the compensability of and responsibility for claimant's carpal tunnel, neck, back, and shoulder conditions. SAIF was then joined in this proceeding by the Board under its own motion authority and the Referee was instructed to take evidence on whether claimant's current condition was related to her 1979 injury, and whether the condition had materially worsened so as to justify reopening.

FINDINGS OF ULTIMATE FACT

Claimant's carpal tunnel condition became disabling when she underwent a carpal tunnel release on October 8, 1985, when Liberty Northwest was on the risk. Work activity with Liberty Northwest's insured was of the type that could have caused the carpal tunnel condition; it was not impossible for that work activity to have caused the condition; and prior work activity was not the sole cause of the condition.

Claimant's compensation was at risk at hearing as a result of the contention that SAIF was responsible for claimant's neck, back, shoulder and carpal tunnel condition.

CONCLUSIONS OF LAW AND OPINION

The Referee found claimant entirely credible, based on her demeanor at hearing. He also found her testimony corroborated by doctor's reports and test results. We agree.

Responsibility for Carpal Tunnel Condition

The Referee found that claimant's wrist condition became disabling when she sought treatment for it. This occurred on June 28, 1985, when Dr. Corrado first diagnosed right carpal tunnel syndrome. The Referee held that EBI was responsible because it remained on the risk until July 1, 1985. We disagree.

Claimant's condition is properly analyzed as an occupational disease. Responsibility rests, in the first instance, with the last "potentially causal" employment prior to the onset of disability. Bracke v. Baza'r, 293 Or 239 (1982). Contrary to the Referee's finding, claimant's carpal tunnel condition became disabling when she underwent surgery in October 1985. Inez Horsey, 42 Van Natta 331 (1990).

Therefore, claimant's last employment prior to the onset of disability was with Liberty Northwest's insured. Her work activities primarily involved repetitive picking up and reaching. We conclude that this work was of the type that could have caused claimant's carpal tunnel condition. Moreover, Liberty Northwest has not demonstrated that it was impossible for work activity while it was on the risk to have caused the condition, or that prior work activity was the sole cause of the condition. FMC Corp. v. Liberty Mutual Ins. Co., 70 Or App 370, modified 73 Or App 223 (1984). Consequently, Liberty Northwest remains responsible.

Responsibility for Upper Back, Neck, and Shoulder Condition

The Referee found that claimant's back, neck and shoulder condition worsened dramatically after March 1986. He held that the condition was compensable and that Liberty Northwest was responsible for her current condition, apparently because it was on the risk at the time of the worsening. On review, Liberty Northwest challenges the Referee's responsibility ruling. We reverse.

After reviewing the evidence we are unable to determine whether claimant's underlying neck and upper back condition was worsened by her work activities while at Liberty Northwest's insured, or whether she suffered a mere symptomatic worsening. Accordingly, we find the evidence to be in equipoise. Thus, to resolve this case we must determine which party has the burden of proof. See Linda L. Wise, 42 Van Natta 115 (1990).

The dispute on this issue involves only SAIF and Liberty Northwest. SAIF accepted claimant's upper back and neck condition in 1979. Claimant then suffered an increase in symptoms--and perhaps a pathologic worsening--during employment with Liberty Northwest's insured. Responsibility is initially fixed with SAIF as insurer on the accepted claim. In order to shift responsibility, SAIF must prove affirmatively that the later employment with Liberty Northwest independently contributed to a pathological worsening of the accepted condition. See Spurlock v. International Paper Co., 89 Or App 461 (1988); Crowe v. Jeld-Wen, 77 Or App 81, 86 (1985); Linda Wise, supra. Because we have concluded that the evidence in this case is in equipoise as to whether the later employment independently contributed to a pathological worsening of claimant's accepted condition, responsibility remains with SAIF.

Attorney Fees

The Referee found that claimant's attorney "remained neutral as to which carrier was responsible" for claimant's carpal tunnel claims. Consequently, no assessed fee was awarded. We disagree.

Following an initial hearing, SAIF was joined as a necessary party to the proceeding. Thus, despite the issuance of the ".307" order concerning EBI and Liberty Northwest, claimant's compensation was at risk by virtue of the joinder of SAIF. Where claimant's right to compensation remains at risk, we have held that claimant's attorney is entitled to an assessed fee from the responsible carrier, even if that carrier did not contest compensability. See Ronald L. Warner, 40 Van Natta 1082, 1194 (1988); Thomas S. Williamson, 39 Van Natta 1147 (1987).

Admittedly, SAIF did not seek the issuance of a ".307" order. However, under these circumstances, particularly considering its late entrance into the proceedings, we do not consider SAIF's failure to seek a ".307" order renders it responsible for claimant's attorney fee. See Dorothy A. Amstutz, 42 Van Natta 339 (1990).

Accordingly, we hold that claimant's attorney is entitled to an assessed fee for services at hearing and on review concerning the carpal tunnel issue. This fee should be paid by Liberty Northwest, the carrier responsible for the claim. However, such a fee cannot be awarded unless a statement of services is received. See OAR 438-15-010(5). Because no statement of services has been received, an assessed fee cannot presently be awarded.

ORDER

The Referee's order, dated July 24, 1987, is reversed in part and modified in part. Liberty Northwest Insurance Corporation's denial of claimant's neck, upper back, and left shoulder condition is reinstated and upheld. The SAIF Corporation's denial of that condition is set aside, and the claim is remanded to SAIF for further processing. The assessed fee awarded by the Referee regarding the upper back, neck and left shoulder claim shall be paid by SAIF rather than Liberty Northwest. EBI Insurance Companies' denial of claimant's carpal tunnel condition is reinstated and upheld. Liberty Northwest's denial of that condition is set aside, and the claim is remanded to Liberty Northwest for further processing.

In the Matter of the Compensation of
ERNEST C. RICHTER, Claimant
WCB Case Nos. 88-04556, 86-13711 & 85-12160
ORDER ON REVIEW
Emmons, et al., Claimant Attorneys
John Motley (Saif), Defense Attorney
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Nichols, Brittingham and Crider.

Claimant requests review of that portion of Referee Brazeau's order that awarded an attorney fee payable out of claimant's compensation rather than payable by the insurer for services performed in obtaining a .307 order. Argonaut Insurance Company cross-requests review of those portions of the order that: (1) declined to dismiss claimant's request for hearing on the issue of extent of permanent disability; (2) set aside Argonaut's denial of claimant's claim for chiropractic care; and (3) upheld the SAIF Corporation's denial of claimant's "new injury claim" for the same services. On review, the issues are attorney fees, procedure and responsibility. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the Findings of Fact in the Referee's Second Corrected Opinion and Order dated February 17, 1988. We make the following additional findings:

On September 13, 1985, Argonaut denied payment of Dr. Saboe's billings for treatment from July 11 through August 9, 1985 on compensability grounds, stating that claimant's "current symptoms and need for treatment are not attributable to your industrial injury of 2/12/82." On October 7, 1985, claimant, through his attorney, filed a request for hearing specifying, as the issue, the compensability of Dr. Saboe's services. In preparation for a hearing on that issue, claimant's attorney undertook a number of things. He requested medical records from Argonaut; not receiving them, he requested summary action by the Hearings Division on the request; and he represented claimant's interests in a deposition of Dr. Saboe taken by Argonaut.

More than a year later, on September 18, 1986, claimant submitted a new injury claim to his employer on a form provided by SAIF, seeking payment for treatment from SAIF, the employer's insurer at that time. SAIF denied responsibility for payment of Dr. Saboe's bills by letter of October 2, 1986. Claimant's attorney promptly requested a hearing on this denial.

Meantime, claimant had also requested a hearing on the December 3, 1984 Determination Order and requested that a hearing be scheduled on the permanent disability and medical services issues.

The cases involving Argonaut and SAIF were consolidated and a hearing scheduled for January 15, 1987; it was reset for February 2, 1987 before Referee Wilson. Claimant and his attorney were notified of the setting. Neither claimant nor his attorney attended the February 2, 1987 hearing. Argonaut and SAIF did appear. The insurers moved to dismiss the case for failure to appear. Counsel for Argonaut contended that claimant's testimony was necessary to the resolution of the responsibility issue; he also noted that claimant was an essential party as regards the extent of disability issue. Referee Wilson declined to dismiss. He postponed the case because claimant was not present. The hearing was reset for October 19, 1987.

At the time and place for hearing, claimant again failed to appear personally or by counsel. The insurers renewed their motions to dismiss the requests

for hearing. Referee Brazeau took the motions under advisement. He sought a response from claimant's attorney. After counsel responded, Argonaut and SAIF advised the Referee that if the Referee declined to dismiss the requests for hearing, the insurers had agreed to submit the responsibility issue on the documentary record.

The Referee denied the motion to dismiss; decided the responsibility issue on the documentary record; and directed that the extent of disability issue be set for hearing at a later time.

FINDINGS OF ULTIMATE FACT

Each time these consolidated cases were set for hearing, claimant should have known that all issues specified in the pending requests for hearing and applications to schedule would be heard. At no time was there any agreement that the extent of disability issue would be litigated separately from the responsibility issue. Claimant failed to appear at the October 19, 1987 hearing without good cause.

Claimant's work activities since SAIF came on the risk have not independently contributed to the causation of claimant's need for medical services.

Claimant's attorney was instrumental in achieving the insurers' concessions of the compensability of Dr. Saboe's treatment and the issuance of the .307 order.

CONCLUSIONS OF LAW AND OPINION

Motion to Dismiss

The Referee denied the insurers' motions to dismiss although claimant conceded and the Referee found that there had been no specific understanding among the parties that the issues of extent and responsibility would be bifurcated. The insurers contend that claimant's repeated failure to appear personally or by counsel at hearing warrants dismissal of his request for hearing on the extent of disability issue. We agree.

When claimant first failed to appear, the hearing was postponed so that he could attend. Referee Wilson's order would appear to assume that the hearing would concern both the extent and the responsibility issues. Claimant's counsel does not contend, either in his correspondence with Referee Brazeau or in his brief on review, that there was any basis for any unilateral understanding he may have had that the issues would be bifurcated. There is no basis in the rules, in past practice before this agency or in the record of this case for such an understanding. We conclude, therefore, that claimant's failure to appear was without good cause and consequently constituted an abandonment of the extent of disability issue. Former OAR 438-06-070.

Responsibility

We adopt the Referee's Opinion and Conclusions in his Second Corrected Opinion and Order dated February 17, 1988.

Attorney Fees

We adopt the Referee's Opinion and Conclusion in his Order on Reconsideration dated September 23, 1988. See Duane L. Jones, 42 Van Natta 875 (1990).

ORDER

The Referee's order dated February 8, 1988, as amended on February 9 and February 17, 1988, and supplemented by an order dated Febrary 24, 1988 and two orders dated September 23, 1988, is affirmed in part and reversed in part. Claimant's request for hearing on the extent of disability issue is dismissed. The balance of the Referee's order is affirmed. The Board authorizes a client-

paid fee, not to exceed $1,774.50, payable by Argonaut Insurance Company to its counsel.

Board Member Crider, concurring in part and dissenting in part:

I concur in those portions of the order that reverse the Referee's order insofar as it denied the Motion to Dismiss claimant's request for hearing relating to extent of permanent disability and affirmed the order insofar as it set aside Argonaut Insurance Company's denial of claimant's claim for medical services. I dissent from that portion of the order that denied claimant an attorney fee for services in overcoming Argonaut's denial of compensability.

The Referee, in his Second Corrected Opinion and Order, denied claimant's attorney an insurer-paid fee on the ground that counsel did not appear and take a position at hearing on the responsibility issue. In his Order on Reconsideration dated September 23, 1988, he allowed claimant's attorney a fee, payable out of claimant's compensation, but continued to deny an insurer-paid fee. In so doing, the Referee relied on Queener v. SAIF, 89 Or App 84 (1987). The majority adopted that reasoning. The reliance on Queener v. SAIF, supra, is misplaced.

While I agree that claimant is not entitled to a fee on the responsibility issue inasmuch as he performed no services in that regard, claimant in fact seeks a fee under ORS 656.386(1) for services on the compensability issue. He is entitled to such a fee. Argonaut's denial was one of compensability. Claimant's attorney performed extensive services over a period of one year which culminated in Argonaut's decision to concede that the disputed medical services were compensable and to accede to a .307 order. In this case, in contrast to Queener, claimant's compensation was not secure from the outset. Under such circumstances, we have concluded that an insurer-paid fee is assessable against the insurer that denied compensability. Gregory A. McClellan, unpublished order issued December 11, 1989.

April 26, 1990 Cite as 42 Van Natta 957 (1990)

In the Matter of the Compensation of
DARIO RODRIGUEZ, Claimant
Own Motion No. 89-0710M
OWN MOTION ORDER ON RECONSIDERATION
Michael Dye, Claimant Attorney
SAIF Legal Department, Defense Attorney

Claimant requests reconsideration of our January 9, 1990, Own Motion Order that denied own motion reopening of the above-captioned claim on the ground that claimant had withdrawn from the work force. Claimant contends he was self-employed in Mexico as he owned and rented-out a truck. Further, he has not voluntarily withdrawn from the work force but rather, his compensable injury makes it impossible for him to work. In order to allow sufficient time to consider claimant's motion, we abated and withdrew our Own Motion Order on January 30, 1990.

New evidence submitted with a request for reconsideration will be considered only if the Board finds that: (1) the record, without the additional evidence, has been improperly, incompletely or otherwise insufficiently developed; and (2) the additional evidence was unobtainable with due diligence prior to this submission. OAR 438-12-065(3). The new evidence before us consists of two affidavits from Mexico that support claimant's claim that he owned a truck he rented to other people to earn a living in Mexico. We find that the additional evidence submitted was unobtainable at the time of review. However, claimant has not worked since March 3, 1983 and there is no evidence that

claimant was working or making reasonable efforts to find work immediately prior to the worsening. Moreover, the use of a capitol investment for living expenses is not wages. Therefore, the additional evidence does not convince us that claimant was in the work force at the time of his worsening.

Accordingly, we adhere to and republish our order dated January 9, 1990, in its entirety. The parties' rights of reconsideration and appeal shall run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
CISSIE L. ST. CLAIR, Claimant,
WCB Case No. 88-05465
And, In the Matter of the Complying Status of
NUGGET REALTY, INC. dba Century 21 Nugget Realty,
John P. Reaksecker,Individually, and Linda Williamson, Individually, Employer
WCB Case Nos. 88-03193 & 88-03192
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Employers Defense Counsel, Defense Attorney
Lombard, et al., Attorneys
David Ray Fowler (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

Liberty Northwest Insurance Corporation, as insurer for Citizens Savings & Loan (Citizens), requests review of Referee Livesley's order which: (1) held it, rather than Century 21, Nugget Realty (Nugget), a noncomplying employer, responsible for claimant's compensable injury; and (2) assessed a penalty and attorney fee against Liberty Northwest for unreasonable refusal to pay compensation by way of its March 29, 1988 denial. On review the issues are responsibility, penalties and attorney fees. We affirm.

FINDINGS OF FACT

Citizens, a savings and loan, contracted with Nugget, a property management firm, to manage the Cottage Grove Hotel for $300 per month. Citizens had acquired the hotel by foreclosure or a deed back.

Citizens directed Nugget to hire a resident manager for the hotel. Nugget advertised for a manager and, with Citizens approval, hired claimant and her husband for the manager's position. Claimant and her husband were provided an apartment rent free and $5.00 per hour for cleaning and maintenance work. Nugget directed claimant's activities.

Nugget had to submit proposals for any repairs on the hotel to Citizens for approval. At Citizens' direction, Nugget established a bank account for the hotel. Rental receipts were deposited in the account and expenses, including claimant's pay, were paid by Nugget from the account. Nugget was required to provide Citizens with a monthly accounting of receipts and expenses.

On November 11, 1988, claimant was injured while carrying a sofa up a flight of stairs at the Cottage Grove Hotel. A claim was filed for that injury with Nugget and with Citizens.

The Workers Compensation Division investigated the claim against Nugget. Nugget was found to be a subject employer of claimant, a subject worker. Nugget did not provide workers' compensation coverage for claimant during a period including the date on which claimant was injured. On January 19, 1988, the Workers' Compensation Division issued a "Proposed and Final Order; Notice" declaring Nugget to be a noncomplying employer. Nugget requested a hearing from that order.

The Workers' Compensation Division referred the claim against Nugget to the SAIF Corporation for processing pursuant to ORS 656.054(1). By "Notice of Claim Acceptance" dated February 29, 1988, SAIF accepted claimant's claim as a compensable, disabling injury. No request for hearing was filed from SAIF's acceptance of the claim.

Liberty Northwest, on behalf of Citizens, had also accepted claimant's claim on December 24, 1987. However, by letter dated March 29, 1988, it rescinded its acceptance, alleging misrepresentation by claimant. Claimant filed a request for hearing from that denial. That request for hearing was consolidated for hearing with Nugget's request for hearing and heard on September 17, 1988.

CONCLUSION OF LAW AND OPINION

The Referee concluded that Nugget was a subject employer, that claimant was a subject worker of Nugget and that Nugget failed to provide workers' compensation coverage as required by ORS 656.017. The Proposed and Final Order; Notice was affirmed and that holding is not challenged on review.

The Referee set aside Liberty Northwest's denial and found it responsible for claimant's injury under ORS 656.029(1). Also, although no request for hearing has been filed with respect to it, the Referee set aside SAIF's acceptance of claimant's claim. Finally, the Referee found Liberty Northwest's "back-up" denial to have been unreasonable, but not invalid, under Bauman v. SAIF, 295 Or 788 (1983).

In the absence of fraud, misrepresentation or other illegal activity an insurer may not accept a claim and then, more than 60 days after notice of the claim, deny the compensability of the claim. Bauman v. SAIF, supra. Here, Liberty Northwest conceded that it had accepted claimant's claim on December 24, 1987. More than 60 days thereafter it denied the claim. Liberty Northwest had the burden to prove fraud, misrepresentation or other illegal activity in order for its denial of compensability to have been valid. Parker v. North Pacific Insurance, 73 Or App 790 (1985) and Parker v. D. R. Johnson Lumber Co., 70 Or App 683 (1984).

Liberty Northwest offered no evidence of fraud, misrepresentation or other illegal activity by claimant. We conclude, therefore, that Liberty Northwest's March 28, 1988 denial is invalid to the extent that it denies the compensability of claimant's claim.

This matter is, therefore, before us in the posture of a responsibility case. Both Liberty Northwest and SAIF have accepted claimant's injury claim. Liberty Northwest has not validly denied the claim and SAIF's acceptance of the claim has not been challenged. Responsibility for the claim must, however, be determined. It is that issue which the parties apparently litigated at hearing and all potentially interested parties were given an opportunity to participate in that hearing.

The Referee found that claimant was Nugget's employee but that Citizens was responsible for the claim under ORS 656.029(1). We agree that

Citizens is responsible but for different reasons.

ORS 656.029(1) provides that,

> "If a person awards a contract involving the performance of labor where such labor is a normal and customary part or process of the person's trade or business, the person awarding the contract is responsible for providing workers' compensation insurance coverage for all individuals, other than those exempt under ORS 656.027, who perform labor under the contract unless the person to whom the contract is awarded provides such coverage for those individuals before labor under the contract commences . . . ."

The Referee concluded that Citizens had awarded a contract to Nugget, a noncomplying employer, for the performance of labor which was a normal and customary part or process of Citizens' business. That conclusion was based upon the "facts" that; "(I)t is axiomatic that a large percentage of mortgages are foreclosed by the lenders and purchased by said lenders at foreclosure sale in order to extinguish the debt and satisfy the judgment. Management of properties purchased at foreclosure sale is an integral normal and customary part of the mortgage banking business." Nugget argues that, while there is no evidence in the record to support such findings, it was proper for the Referee to take official notice of such facts pursuant to ORS 183.450(4). Citizens argues that, not only are those findings unsupported by evidence in the record, but they are not appropriately the subject of official notice and that, even if they were, they do not support the conclusion that Citizens' business normally and customarily included property management. We agree with Citizens.

There is no evidence in the hearing record to support the Referee's findings of fact with regard to the common practice of mortgage foreclosures or property management being integral to the mortgage banking business. Review by the Board is statutorily limited to evidence found in the hearing record. ORS 656.295(5). Our resort to official notice is extremely limited. We may not take official notice of pivotal facts that an opposing party was given no opportunity to contest, cross-examine or refute but which may be subject to dispute. Groshong v. Montgomery Ward Co., 73 Or App 403 (1985). ORS 183.450(4) does not apply to the Department of Insurance and Finance (including the Workers' Compensation Board) with respect to its functions under ORS Chapter 656. ORS 183.315. We decline to take official notice of those facts found by the Referee which are not supported by evidence in the record. We conclude that the evidence does not establish facts necessary for the applicability of ORS 656.029(1).

Although ORS 656.029(1) is not applicable, we, nevertheless, find that claimant was Citizens' employee. Nugget, acting as Citizens' agent and at its direction, hired claimant. While Nugget directed claimant's day to day activities, we are persuaded that Citizens had the right to direct and control claimant's activities and to terminate her employment had it chosen to do so. Claimant was paid from Citizens' assets. That is, the apartment provided her was Citizens'. The monies she was paid were Citizens, although the money was issued by its agent, Nugget, from an account maintained by Nugget for Citizens. We conclude that Citizens hired claimant, that it had the right to direct and control claimant's activities either directly or through its agent, that it paid claimant's wages and that it could terminate claimant. Claimant was an employee of Citizens and Citizens is responsible for her compensable injury.

The Referee found Liberty Northwest's denial to have been unreasonable. We agree. Liberty Northwest's March 29, 1988 denial was prohibited in the absence of fraud, misrepresentation or other illegal activity. Bauman v. SAIF, supra.

While the denial alleged misrepresentation, there is no indication in this record that claimant engaged in any misrepresentation or that Liberty Northwest had any evidence of such misrepresentation. Under such circumstances we conclude that Liberty Northwest's denial was unreasonable.

ORDER

The Referee's order dated October 26, 1988, is affirmed. For services on review concerning the responsibility issue, claimant's attorney is awarded a $1,000 assessed fee payable by Liberty Northwest. A client-paid fee of $1,771 is approved for Liberty Northwest's attorney.

April 27, 1990 Cite as 42 Van Natta 961 (1990)

In the Matter of the Compensation
HUBERT W. BARKER, Claimant
WCB Case No. 87-00261
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Ronald Pomeroy (Saif), Defense Attorney

Reviewed by Board Members Nichols and Brittingham.

The SAIF Corporation requests review of Referee Mongrain's order that granted claimant an award of permanent total disability, whereas prior Determination Orders had awarded a total of 65 percent (208 degrees) unscheduled permanent disability for a neck and back injury, and 10 percent (15 degrees) scheduled permanent disability for the loss of use or function of the left leg. On review, the issue is extent of disability, including permanent total disability. We reverse.

FINDINGS OF FACT

We adopt the Referee's "Findings" with the following supplementation.

The sanitor job offered by the employer requires light-duty work.

FINDINGS OF ULTIMATE FACT

Claimant is not physically incapacitated to the extent that he cannot regularly perform gainful and suitable employment.

Claimant is capable of performing light employment.

Claimant is not foreclosed from gainful employment due to a combination of medical and nonmedical factors.

Claimant did not make reasonable efforts to find work and a work search would not have been futile.

As a result of his compensable injury, claimant has sustained a 65 percent loss of earning capacity and a 10 percent loss of use of function of the left leg.

CONCLUSIONS OF LAW AND OPINION

To establish permanent total disability, claimant must prove that he is unable to perform any work at a gainful and suitable occupation. Wilson v. Weyerhaeuser, 30 Or App 403 (1977). Permanent total disability may be established through medical evidence of physical incapacity, or through the "odd-lot" doctrine, under which a disabled person may remain capable of performing work of some kind, but still be permanently disabled due to a combination of medical and

nonmedical disabilities which effectively foreclose him from gainful employment. Welch v. Banister Pipeline, 70 Or App 699, 701 (1984).

The nonmedical factors to be considered in an "odd-lot" analysis include age, education, adaptability to nonphysical labor, mental capacity and emotional condition, as well as the conditions of the labor market. Welch, supra, 70 Or App at 701; Livesay v. SAIF, 55 Or App 390, 394 (1981). Because application of an "odd-lot" analysis presupposes some capacity for employment, an injured worker is statutorily required to make reasonable efforts to find work, although he need not engage in job seeking activities that, in all practicality, would be futile. ORS 656.206; SAIF v. Simpson, 88 Or Ap 638, 641 (1987); Welch, supra, 70 Or App at 701.

Extent of Impairment

SAIF argues that the record establishes that claimant is physically capable of performing gainful and suitable work. We agree.

Claimant's former treating orthopedist, Dr. Peterson, opined in February 1987 that claimant could frequently lift, carry and push up to 20 pounds and continuously carry 10 pounds, occasionally twist, climb stairs, bend, stoop, crouch, squat, crawl, kneel, or walk on uneven surfaces, and frequently use arms, wrists and hands in repetitive motions.

Neurologist Maukonen, claimant's treating physician at the time of hearing, indicated that claimant has no capacities whatsoever as of January 1987.

Dr. Thompson, claimant's treating psychiatrist, opined on March 5, 1987 that claimant is permanently and totally disabled.

Dr. Yamodis, neurological surgeon, who also treated claimant, stated on October 9, 1984 that claimant was totally disabled.

This record persuades us that claimant is not permanently and totally disabled from a medical standpoint alone; rather we find that he is able to perform light work. We rely on the opinion of Dr. Peterson, who as claimant's treating surgeon was familiar with claimant's problems and possessed the expertise to accurately analyze those problems.

The Referee relied on the opinions of Drs. Thompson and Maukonen in reaching his conclusion that claimant is permanently and totally disabled. We disagree.

Dr. Maukonen stated that claimant was permanently and totally disabled in January 1987 and drew a vertical line through the physical limitations chart in the "never" column. Although the Board generally gives greater weight to the conclusions of a treating physician, it will not do so 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). Here, we find persuasive reasons not to defer to Dr. Maukonen's opinion. His conclusions conflict with claimant's testimony that he can twist, lift 20 to 30 pounds, drive for more than an hour at a time, do yard work, and sometimes put in an eight hour day as a volunteer. Further, Maukonen's rating was based on claimant's condition following a cervical flare-up in December 1986. There is no indication that the flare-up was permanent. Moreover, Maukonen told rehabilitation counselor Davis in April 1987 that claimant should attempt a trial return to modified work; this indicates that the restriction from all work was only temporary. Accordingly, we do not give Dr. Maukonen's opinion great weight in rating permanent disability.

We are also not persuaded by the opinions of Drs. Thompson and Yamodis; they failed to state the basis of their conclusion that claimant is totally disabled. Finally, we do not rely on claimant's subjective limitations, given the documented history of functional overlay. Also, the fact that claimant performs volunteer youth counseling indicates that he is capable of at least sedentary work.

Odd-Lot Doctrine

The Referee found claimant was permanently and totally disabled based on a combination of medical and nonmedical factors. The Referee alluded to motivational problems but did not make an express ruling on whether claimant had complied with the work search requirement or whether a work search would be futile. We disagree with the Referee's ruling.

At the time of the hearing, claimant was 63 and had his GED. He had worked part time for 11 years as a youth counselor supervisor and has been actively involved in the Jackson County Fair Board. The Referee noted that claimant has general skills in the use of common sense, applying technical knowledge, instructing and planning, directing the work of others, enforcement and application of government regulations, basing decisions on information gathered relative to rules and regulations, speaking clearly, and using tools for the performance of manual and uncomplicated repetitious work. Claimant has been a meat cutter, financial secretary, meat inspector, and a butcher.

Treating orthopedist Peterson evaluated the physical demands of a sanitor job which claimant was offered by the employer at injury. In January 1987 he determined that the job demands were within claimant's physical capabilities. Dr. Maukonen also approved this job on a trial basis for claimant. The employer stated that this job has been done by a 60 year-old grandmother, by a 72 year-old man, by a school-aged child, and by herself despite arthritis in her neck. The employer also knew of and agreed to accommodate claimant's limitations. Despite these facts, the Referee found that this job was specially adapted for claimant, implying that claimant would be unable to get this job in a normal labor market. However, the testimony of the employer indicated that that this was a union created job which has existed for many years and had been adapted for the people who did it over the years.

Claimant's rehabilitation counselor, Davis, opined that claimant could perform a job as counselor at at youth center based upon general skills, education, age, and more than ten years of supervisory volunteer experience with juvenile probationers. This position fit within Dr. Peterson's physical limitations. The endurance required for full time work at this job was sit, stand, and walk for up to two hours at a time and from seven to eight hours per day; drive zero to one hours at a time and up to two hours per day. However, as this would be a part time job, the endurance required of claimant would be less than the stated requirements for full time work. In addition, claimant has been a volunteer worker in this position since 1976 and stated that he regularly drives for over an hour twice a day. Moreover, he demonstrated in April 1982 at Callahan Center that he could put in a six-hour workday.

In addition to the medical record, the Referee relied on the opinion of Byron McNaught, a rehabilitation counselor to whom claimant was referred by his attorney. McNaught, relying in part on the opinions of doctors Maukonen and Thompson, together with claimant's subjective history, concluded that claimant was not employable. He also relied on the DOT description of a Sanitor as a heavy-work job and opined that the job, as described, was beyond Dr. Peterson's and Dr. Maukonen's restrictions. This was contradicted by the testimony of the employer as described above. Further, claimant's rehabilitation counselor Davis

went to this job site to view the work environment. His testimony indicated that this would be a light duty, part time job.

In light of these facts, we find that claimant has not established permanent total disability status under the "odd lot" doctrine. We further find that a work search in this case would not have been futile; therefore claimant is not excused from the seek work requirement. Claimant did not make a reasonable attempt to find work. Although he was offered the position of sanitor, claimant refused to cooperate.

In sum, claimant has not shown that he is foreclosed from gainful employment due to his physical incapacity or under the "odd lot" doctrine. Therefore, we hold that claimant is not permanently and totally disabled.

Unscheduled Permanent Partial Disability

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 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. See Harwell v. Argonaut Insurance, 296 Or 505, 510 (1984); Fraijo v. Fred N. Bay News Co., 59 Or App 260, 269 (1982).

Claimant has undergone six spinal surgeries and he suffers from lost range of lumbar motion and moderate disabling pain in the cervical and lumbar spine. Due to his compensable injury claimant is precluded from performing his at-injury duties. However, he has not demonstrated that he is unable to perform light work, including the job of sanitor which was offered by the employer at injury. He is capable of working as a youth counselor, at least on a part-time basis, a job at which he has volunteered for 11 years. At the time of hearing, claimant was 63 years old. He has his GED. After taking into consideration these factors, we conclude that the 65 percent unscheduled permanent disability claimant has previously been awarded adequately compensates claimant for his lost earning capacity.

Scheduled Permanent Partial Disability

The criterion for rating scheduled permanent disability is the permanent loss of use or function of the affected member due to the compensable condition. ORS 656.214(2). Here, the December 4, 1986 Determination Order awarded claimant 10 percent permanent disability for his left leg.

At hearing, claimant testified that his left leg gets weak and has, on occasion, given way. However, the record contains no evidence of lost range of motion or sensory loss; only disabling pain is indicated. We find no evidence to justify an increase beyond the 10 percent permanent disability awarded for this condition.

ORDER

The Referee's order dated November 19, 1987, as amended and supplemented by his order dated December 3, 1987, is reversed. The December 4, 1986 Determination Order is affirmed.

In the Matter of the Compensation of
HARRY J. BATTILEGA, Claimant
WCB Case No. 88-05011
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
Saif Corp Legal, Defense Attorney

Reviewed by Board Members Howell and Speer.

The SAIF Corporation requests review of that portion of Referee Mirassou's order which granted claimant permanent total disability, whereas prior awards totalled 45 percent (144 degrees) unscheduled permanent disability for a low back injury. In his respondent's brief, claimant seeks clarification of the effective date of the permanent total disability award. On review, the issues are extent of permanent disability, including permanent total disability, and effective date of disability. We affirm the permanent total disability award and make it effective as of the medically stationary date.

FINDINGS OF FACT

The Board adopts the Referee's "Findings of Fact."

CONCLUSIONS OF LAW AND OPINION

The Board adopts the Referee's "Conclusions and Reasons" with the following supplementation.

Effective Date of Permanent Total Disability

An award of permanent total disability under the "odd lot" doctrine is effective the earliest date all relevant medical, vocational and social elements exist to support the award. Adams v. Edwards, 90 Or App 365 (1988); Morris v. Denny's, 53 Or App 863 (1981). Here, all relevant medical and social elements existed by the October 26, 1987 medically stationary date. An employability assessment conducted on June 8, 1988, concluded that vocational services were not recommended. Because we find that there had been no change in claimant's potential employability between the October 26, 1987 medically stationary date and the June 8, 1988 employability assessment, we conclude that claimant's permanent total disability award should be effective as of October 26, 1987.

ORDER

The Referee's order dated September 30, 1988 is affirmed. Claimant's permanent total disability award is made effective as of October 26, 1987. Claimant's attorney is awarded a reasonable assessed attorney fee of $1,500, payable by the SAIF Corporation.

In the Matter of the Compensation of
ANTHONY B. BEARDSLEE, Claimant
WCB Case No. 89-03300
ORDER ON REVIEW (REMANDING)
Malagon, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Speer and Howell.

Claimant requests review of Referee Gruber's order that dismissed claimant's request for hearing because claimant failed to appear at hearing. On

review, claimant contends that the dismissal order should be vacated and the matter remanded to the Referee for hearing on the merits. We remand.

FINDINGS OF FACTS

On February 24, 1989, the parties were notified that this case was scheduled for hearing on May 16, 1989 at 2:00 p.m. On the appointed date, claimant's attorney appeared. Claimant did not appear. (Tr. 1). Claimant had contacted his attorney the morning of the hearing and explained to his attorney that he had moved to California and had not received notice of the hearing until the day before when his mother informed him. (Tr. 2). By order dated May 18, 1989, the Referee dismissed claimant's request for a hearing for failure to appear. By letter of June 5, 1989, claimant explained that he had not known of the hearing nor known of his need to be present at hearing and moved for a postponement. By Order on Reconsideration, dated July 11, 1989, the Referee found that claimant had not met his burden to prove good cause for his failure to appear for the May 16, 1989 hearing.

We take administrative notice that we recently concluded that claimant's injuries sustained in a car accident on his way to an IME for purposes of pursuing his workers' compensation claim were not compensable because the underlying condition was not compensable. Anthony B. Beardslee, 42 Van Natta 852 (1990).

CONCLUSIONS OF LAW AND OPINION

The Referee apparently relied on OAR 438-06-071 which authorizes the Referee to dismiss a request for hearing for "failure of a party or the party's representative to appear at the time and place scheduled for a hearing...." Claimant did not fail to appear. He appeared through counsel. OAR 438-06-071 does not provide authority for dismissal for failure of a claimant to appear at hearing if claimant's attorney does appear at hearing. See Williams v. SAIF, 99 Or App 367 (1989); Mark A. Wiitala, 42 Van Natta 196 (1990); Denette D. Dale, 41 Van Natta 2179 (1989). Accordingly, the Referee was without authority to dismiss.

The Referee considered claimant's motion to postpone and found that claimant had failed to establish circumstances which would justify a postponement. Under OAR 438-06-081 claimant must demonstrate that extraordinary circumstances existed that prevented his appearance at hearing. Claimant contends that he did not know of the hearing nor of his need to be present at the hearing. Claimant did not know of the hearing because claimant had moved to Florida, and then California, without leaving an address with his lawyer or maintaining contact with the Hearings Division. Claimant's attorney left messages on claimant's mother's answering machine prior to the hearing, but claimant did not contact his attorney until the morning of the hearing. (Tr. 3). We agree with the Referee that claimant has failed to establish extraordinary circumstances which would justify a postponement.

The effect of the Referee's ruling on the postponement motion is a decision that claimant has waived his right to appear at hearing. Dale, supra at 2181. We agree that claimant has waived his right to appear.

Consequently, we remand this matter to the Referee for appropriate action, including a determination of what issues remain viable in light of our recent decision in Beardslee. If a hearing is held on the merits, no exhibit shall be received which was not submitted in connection with the prior hearing nor shall any witness, including claimant, be permitted to testify who was not available to and planning on testifying at the prior hearing or under subpoena to testify at that hearing.

ORDER

The Referee's order, dated May 18, 1989, as reconsidered on July 11, 1989, is vacated and the case is remanded to the Referee for further proceedings consistent with our opinion. A client-paid fee, not to exceed $1,345, payable by the insurer to its counsel, is authorized.

April 27, 1990 Cite as 42 Van Natta 967 (1990)

In the Matter of the Compensation of
JAMES A. COOPER, Claimant
WCB Case No. TP-87022
THIRD PARTY ORDER ON REMAND
Hayner, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys
Rankin, et al., Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. The court has affirmed the Board's decision that allowed claimant to rescind his election to assign his third party action to the paying agency and directed that the proceeds of a subsequent third party settlement be redistributed in accordance with the statutory scheme established in ORS 656.593. EBI Companies v. Cooper, 100 Or App 246 (1990). Following the court's decision, claimant submitted a petition for an attorney fee payable from the proceeds. The court has remanded the petition for our consideration. Pursuant to the court's April 13, 1990 order, we have been instructed to determine claimant's entitlement to attorney fees payable out of the proceeds of the third party settlement.

Claimant's counsel requests a fee equal to 25 percent of the first $8,000 recovered by claimant out of the settlement proceeds plus 10 percent of all amounts above $8,000 recovered by claimant. In accordance with ORS 656.593(1)(a), the attorney fees from a third party recovery shall in no event exceed the advisory schedule of fees established by the Board. The Board's advisory schedule of fees is set forth in OAR 438-15-095, which provides that, absent a finding of extraordinary circumstances, an attorney fee not to exceed 33-1/3 percent of the gross recovery obtained by the plaintiff in a third party action is authorized. Here, the amount of the settlement was $60,000. Thus, absent extraordinary circumstances, the maximum attorney fee which may be authorized under our rules is $20,000.

The record does not establish the amount of the paying agency's costs and attorney fees incurred in litigating the third party action. Nor does the record establish the paying agency's current and future claim costs. Therefore, we are unable to determine the amount of claimant's share of the settlement proceeds. ORS 656.593(1). However, we note that even if claimant were to receive the entire proceeds of the settlement, the fee requested by his attorney would not begin to approach the maximum fee allowed by our rules. Therefore, after considering claimant's attorney fee petition, we conclude that the fee requested by claimant's attorney is reasonable. Consequently, claimant's counsel is entitled to receive 25 percent of the first $8,000 recovered by claimant out of the settlement proceeds plus 10 percent of all amounts above $8,000 recovered by claimant.

IT IS SO ORDERED.

In the Matter of the Compensation of
PABLO G. CORTES, Claimant
WCB Case No. TP-90011
THIRD PARTY ORDER
Welch, et al., Claimant Attorneys
Saif Corp Legal, Defense Attorney

Claimant has petitioned the Board for resolution of a dispute concerning a purported third party settlement. Claimant contends that the SAIF Corporation, as a potential paying agency, is not entitled to a share of the proceeds because his claim is in denied status. We agree.

FINDINGS OF FACT

In July 1988, claimant sustained injuries in a motor vehicle accident with another vehicle. He filed a workers' compensation claim with his alleged employer, who did not have workers' compensation insurance.

SAIF, as claims processor for the alleged noncomplying employer, denied the claim. SAIF contended that claimant was not a subject worker and that the employer was not a subject employer.

Claimant requested a hearing concerning SAIF's denial. In January 1989 a Referee upheld SAIF's denial. Claimant's request for review of the Referee's order remains pending.

Claimant retained legal counsel to explore the possibility of bringing suit against the driver of the other vehicle. In February 1990 claimant and the insurer for the other vehicle agreed to settle claimant's cause of action.

Since his claim has neither been accepted nor found compensable, claimant has not sought SAIF's approval of the settlement. Instead, he seeks the Board's acknowledgment that SAIF is not entitled to a share of the settlement proceeds.

CONCLUSIONS OF LAW

We have previously held that where a claim has not been accepted, voluntarily or otherwise, at the time of the settlement, a workers' compensation carrier is not a paying agency as defined in ORS 656.576. Rachid Kaady, 41 Van Natta 1388, 1534 (1989); Marvin C. Wright, 41 Van Natta 36 (1989). Under such circumstances, the carrier is not entitled to a share of the settlement proceeds. Id.

Here, SAIF has neither accepted claimant's injury claim nor has the claim been found compensable. In accordance with the Kaady and Wright rationale, we hold that SAIF is not entitled to a portion of the settlement because it is not a paying agency.

Accordingly, claimant's counsel is directed to distribute the settlement proceeds in accordance with claimant's executed retainer agreement.

IT IS SO ORDERED.

In the Matter of the Compensation of
TERESA A. LAWHON, Claimant
WCB Case No. 88-10562
ORDER ON REVIEW
Gordon L. Osaka, Claimant Attorney
David B. Smith (Saif), Defense Attorney

Reviewed by Board Members Nichols and Brittingham.

Claimant requests review of those portions of Referee Bennett's order that: (1) upheld the SAIF Corporation's denial of claimant's aggravation claim

for a low back and right leg condition; and (2) declined to assess penalties and attorney fees for an unreasonable denial. Alternatively, claimant has also moved for remand for the introduction of a post-hearing medical report. On review, the issues are aggravation, remand, penalties and attorney fees for SAIF's alleged unreasonable denial and remand. We reverse.

FINDINGS OF FACT

Claimant was compensably injured on August 29, 1984 when she slipped and fell. A CT scan showed a left-sided disc protrusion at L4-5 and a right-sided protrusion that slightly elevated the right S1 nerve root. A myelogram was normal. Subsequently a L4-5 disc protrusion was diagnosed, as well as diffuse disc bulging at L5-S1 on the right.

Claimant had a discectomy at L4-5 on the left, on July 10, 1985 and had an additional surgery two days later.

A Determination Order issued, May 17, 1985 awarding claimant 10 percent (32 degrees) unscheduled permanent disability for her low back condition. This was increased by a subsequent Determination Order that issued April 8, 1986 which awarded claimant an additional 15 percent (48 degrees) unscheduled permanent disability for a total award of 25 percent. By Stipulation of May 14, 1986 claimant was awarded an additional 15 percent (48 degrees) unscheduled permanent disability for a total award of 40 percent (128 degrees). This stipulation was claimant's last arrangement of compensation.

Claimant was treated by Dr. Brett on July 24, 1986 for hip pain. A CT scan of June 29, 1987 showed a loss of disc space at L4-5, which was a change as compared with the CT scan of June 19, 1986. On January 25, 1988 Dr. Mack diagnosed chronic low back pain and noted that the CT scan was essentially negative.

On February 11, 1988, claimant was admitted to Portland Adventist Medical Center for severe back pain and nausea. Dr. Mack diagnosed post-surgery back pain syndrome.

On February 15, 1988, an MRI was performed, which revealed a bulging disc at L5-S1 which significantly affected and displaced the S1 nerve root. Dr. Mack related claimant's hospitalization to her previous back injury and surgeries and an infection she had had in her disc space.

The Orthopaedic Consultants examined claimant on April 12, 1988. They found severe interference in the examination. Their diagnosis was contusion, low back, resolved; chronic low back pain; and status post operative laminectomy, discectomy. The Consultants concluded that neither claimant's symptoms nor conditions had worsened since May 1986.

Dr. Mack initially concurred with the Consultants' opinion. Thereafter, Dr. Mack found claimant's condition had worsened. On April 25, 1988 SAIF denied claimant's aggravation claim. It bases its denial solely on the Consultants' opinion.

Claimant's legs were totally numb when she was admitted to the hospital in February 1988. At the time, she was having sharp pains in her hips and from the middle of her back down her legs. She has numbness in her legs now which comes and goes.

FINDINGS OF ULTIMATE FACT

Since the May 1986 stipulation, claimant has experienced a symptomatic exacerbation rendering her less able to work. That exacerbation resulted in more than 14 days of total disability and inpatient hospitalization.

SAIF's aggravation denial was not unreasonable.

CONCLUSIONS OF LAW AND OPINION

AGGRAVATION

The Referee upheld SAIF's denial of claimant's aggravation claim, stating that he was unable to determine if claimant was less able to work. We disagree.

For every claim of aggravation of an unscheduled condition, the claimant must show increased symptoms or a worsened underlying condition and a resultant diminishment of earning capacity. In those cases in which the last award or arrangement of unscheduled permanent partial disability compensation anticipated future exacerbation, accompanied by a diminished earning capacity, the claimant must also prove that his earning capacity was diminished longer or in greater degree than was anticipated, or that his exacerbation resulted in 14 consecutive days of total disability or inpatient hospitalization. Edward D. Lucas, 41 Van Natta 2272 (1989).

The medical evidence supports a finding that claimant suffered a symptomatic exacerbation of his compensable injury. We further find that, as a result of this exacerbation, claimant was less able to work than at the time of the last arrangement of compensation in May 1986. Dr. Mack found that claimant was unable to work on November 2, 1987, due to acute pain in her back. On January 25, 1988, Dr. Mack opined that claimant was definitely disabled and recommended an additional myelogram. On February 26, 1988, Dr. Mack concluded that claimant was totally disabled at the time she was hospitalized on February 9, 1988. Considering these circumstances, we find that claimant had an increase in symptoms which renders him less able to work.

Having met the first part of the analysis, i.e. was there an exacerbation of claimant's condition resulting in lost earning capacity, the next issue becomes whether or not the symptomatic exacerbation resulted in a greater degree of disability than was anticipated or resulted in 14 consecutive days of total disability or inpatient hospitalization.

Based upon the medical evidence, we find that the record establishes that: (1) claimant's compensable injury is a material cause of her increased symptoms; and (2) as a result of the increased symptoms, claimant became totally disabled for more than 14 days and required inpatient hospitalization. Thus, regardless of whether the last arrangement of compensation contemplated future exacerbations, we find that claimant has established an aggravation claim under Lucas.

REMAND

As a result of our decision concerning the aggravation issue, claimant's conditional remand request becomes moot.

PENALTIES AND ATTORNEY FEES

Penalty and attorney fees may be assessed when a carrier "unreasonably delays or unreasonably refuse to pay compensation." ORS 656.262(10); 656.382(1). The reasonableness of a carrier's denial of compensation must be gauged based upon the information available to the carrier at the time of its denial. Brown v. Argonaut Insurance Company, 93 Or App 588 (1988). Here, SAIF based its denial on the opinion of the Orthopaedic Consultants that neither claimant's symptoms nor his condition worsened. Under such circumstances we find that SAIF did not act unreasonably when it denied claimant's aggravation claim. Therefore, we conclude that claimant is not entitled to penalties or attorney fees for an unreasonable denial.

Claimant's counsel is statutorily entitled to a reasonable, insurer-paid attorney fee for services rendered at hearing and on Board review regarding the

aggravation claim. Such a fee is defined as an "assessed fee." See OAR 438-15-005(2). However, we cannot award 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 cannot presently be awarded. See OAR 438-15-010(5).

ORDER

The Referee's order dated October 4, 1988 is reversed in part and affirmed in part. The SAIF Corporation's denial is set aside and the claim is remanded to SAIF for processing according to law. The remainder of the Referee's order is affirmed.

April 27, 1990 Cite as 42 Van Natta 971 (1990)

In the Matter of the Compensation of
SANDRA L. MARKS-FIPPS, Claimant
WCB Case Nos. 87-18123, 87-18124 & 88-06238
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
H. Thomas Andersen (Saif), Defense Attorney
Phillip Nyberg, Defense Attorney
Rankin, et al., Defense Attorneys

Reviewed by Board Members Brittingham and Nichols.

Liberty Northwest Insurance Corporation (Liberty Northwest), on behalf of Plug Away Wood Products, Inc. (Plug Away), requests review of those portions of Referee Mirassou's order that: (1) set aside its denial of claimant's carpal tunnel syndrome; (2) assessed a penalty-related attorney fee for unreasonable denial; and (3) upheld the denials of Liberty Northwest, on behalf of Plug It Wood Products (Plug It), and the SAIF Corporation for the same condition. Liberty Northwest, on behalf of Plug It, contends that claimant's condition is not compensable. On review, the issues are compensability, responsibility, and attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT AND ULTIMATE FACT

We adopt the findings of fact and ultimate fact on pages two through four of the Referee's order, with the following correction and supplementation.

Dr. Ianora, not Dr. Feldman, was claimant's family physician.

Plug Away's initial denial of December 10, 1987 was a denial of responsibility only. Plug Away first raised the issue of compensability at hearing.

Claimant became disabled when taken off work for the first time in October 1987.

Work at all three employments contributed to claimant's carpal tunnel disease.

Dr. Nathan, orthopedist, performed an independent medical examination of claimant on March 7, 1988.

CONCLUSIONS OF LAW AND OPINION

Under the current statute, Board review of an arbitrator's responsibility determination is limited to questions of law. ORS 656.307(2). However, because no ".307 order" issued in this case, this is not a .307 arbitration case. As a result, the standard of review is de novo.

Compensability and Responsibility

We affirm and adopt the Referee's order on compensability and responsibility, with the following supplementation.

We first address the issue of whether this case is governed by the occupational disease law in effect in 1987 or the law that became operative January 1, 1988. Claimant was last exposed to conditions that could have caused the disability in October 1987, when she last worked for Plug Away. Thus, the old occupational disease law applies. Donna E. Aschbacher, 41 Van Natta 1242, recon denied 41 Van Natta 1334 (1989). The Referee correctly applied the appropriate test when she found that claimant's occupational disease arose out of and in the scope of employment, and that claimant's work conditions were the major contributing cause of the disability.

Attorney Fee

The Referee assessed a penalty-related attorney fee against Plug Away for an unreasonable denial of compensation. She found that the medical reports at the time of the December 10, 1987 denial supported causation and therefore that Plug Away had no basis to question the compensability of claimant's condition. However, Plug Away initially denied only responsibility. It did not raise the issue of compensability until hearing, at which time its denial was based on a March 7, 1988 medical report from Dr. Nathan and a May 23, 1988 report from Dr. Feldman. Nathan opined that claimant's carpal tunnel condition was not causally related to her employment and Feldman related claimant's symptoms to a shoulder condition. These opinions provided a reasonable basis for the denial of compensability. As a result, Plug Away's denial was not unreasonable.

ORDER

The Referee's order dated September 9, 1988 is reversed in part and affirmed in part. The Referee's assessment of a penalty-related attorney fee against Liberty Northwest Insurance Corporation, on behalf of Plug Away Wood Products, Inc., is reversed. The remainder of the Referee's order is affirmed. For services on review regarding the compensability issue, claimant's attorney is awarded an assessed fee of $1,000, payable by Liberty Northwest/Plug Away. A client-paid fee, not to exceed $1,480, payable by Liberty Northwest/Plug Away to its counsel, is approved. A client-paid fee, not to exceed $969, payable by Liberty Northwest/Plug It Wood Products to its counsel, is approved.

In the Matter of the Compensation of
JOYCE E. MITTS, Claimant
WCB Case No. 87-11662
ORDER DENYING RECONSIDERATION
Kenneth Peterson, Jr., Claimant Attorney
Hollis Ransom, Attorney
Yturri, et al., Defense Attorneys

Claimant has requested reconsideration of our February 14, 1990 Order on Review. Contending that neither she nor her counsel received a copy of the Board's order, claimant seeks "reissuance" of our order. We deny the request.

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. ORS 656.295(8). 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).

The Board may republish an order if it finds that it failed to mail a copy of its prior order to a party. Berliner v. Weyerhaeuser Company, 92 Or App 264, 266-67 (1988). An attorney is not a party. ORS 656.005(19); Berliner, supra, page 266, n. 1; Frank F. Pucher, Jr., 41 Van Natta 794, 795 (1989).

Here, claimant asserts that neither she nor her current counsel received a copy of the Board's February 14, 1990 order. She concedes that at the time of this appeal she resided in Umatilla, Oregon and was represented by a different counsel. She further acknowledges that her current address in Baker, Oregon and the name of her current attorney were provided to the Hearings Division concerning another WCB case number in December 1988 and May 1989. However, she makes no assertion that this updated information was provided to the Board concerning this case. Rather, she asks the Board to take "judicial notice" of the fact that the U.S. Post Office will not forward mail after an individual has left the address for more than one year.

These circumstances do not justify the reissuance of our order. To begin, the fact that claimant's current counsel apparently did not receive a copy of the Board's order does not invalidate the order. See Berliner, supra; Pucher, supra. Thus, to prompt the reissuance of our order, claimant must establish that a copy of the order was not mailed to her. The record does not support such a finding.

There has been no contention from either the employer, its insurer, or the attorneys of record (which includes claimant's former counsel) that they did not receive a copy of the Board's order. Moreover, the record does not contain a copy of the order marked undeliverable by the Post Office. Such circumstances persuade us that copies of the Board's February 14, 1990 order were mailed to all parties to the proceedings, as well as their respective attorneys of record.

It is unfortunate that claimant failed to apprise the Board of her change of residence. Yet, based on her counsel's recent request, it would appear that she had more than one year to provide the Board with such information in this case. In any event, her failure to receive a copy of the Board's order is not determinative. Instead, the issue is whether the order was mailed. See Berliner, supra.

Based on the foregoing reasoning, we are persuaded that a copy of our February 14, 1990 order was mailed to claimant and all other parties to the proceeding. Inasmuch as our order has neither been stayed, withdrawn, modified, nor appealed within 30 days of its mailing to the parties, it has become final. ORS 656.295(8). Consequently, we are without authority to "reissue" our order as claimant requests.

IT IS SO ORDERED.

April 27, 1990 Cite as 42 Van Natta 973 (1990)

In the Matter of the Compensation of
DANIEL E. NORTHWAY, Claimant
WCB Case No. 88-17097
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Employers Defense Counsel, Defense Attorneys

Reviewed by Board Members Gerner and Myers.

Claimant requests review of Referee Gruber's order which awarded 3 percent (4.5 degrees) scheduled permanent disability for loss of use or function of the left forearm in addition to the 33 percent (49.5 degrees) scheduled permanent

disability awarded by Determination Order. On review, the issue is extent of scheduled permanent disability. We modify.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant sustained a 45 percent grip strength loss due to his injury. The Referee then applied OAR 436-35-110(3)(d) and concluded that the 45 percent loss was equivalent to a 23 percent impairment rating. We disagree.

The standards applicable to this determination are the standards that were in effect at the time of the issuance of the Determination Order. OAR 438-10-010. Former OAR 436-35-110(3)(d) is applicable in this case.

Former OAR 436-35-110(3)(d) states:

> "Decreased grip strength due to atrophy or other anatomical changes (except amputations) is rated as follows:
>
> | | Forearm |
> |---|---|
> | up to 80% retained | 10% |
> | up to 60% retained | 20% |
> | up to 40% retained | 40% |
> | up to 20% retained | 40% |
> | complete loss | 50%" |

The insurer argues that the Referee, in calculating 23 percent impairment, properly applied former OAR 436-35-110(3)(d) and properly took into account a typographical error in the Evaluation Section's rule. The contended typographical error was that the rule awarded 40 percent impairment for up to a 60 percent loss of grip strength instead of the logical progression amount of 30 percent impairment. Claimant contends that the rule must be applied as written and that the Referee cannot correct any alleged errors in the Department's rules.

In cases such as this, the plain and unambiguous language of the rule controls. The rule plainly states that the impairment rating for that loss is 40 percent. Further, there is no evidence in this record of the Evaluation Section's intent when it promulgated this rule nor that the 40 percent impairment value for a 60 percent grip strength loss was a typographical error. Until the time that it was changed, the rule as specifically written had to be applied.

On review, we apply former OAR 436-35-110(3)(d) as written. Claimant's diminished grip strength is entitled to an impairment rating of 25 percent instead of 23 percent.

We adopt all the other calculations and conclusions of the Referee as our own.

ORDER

The Referee's order dated February 9, 1989 is modified. In addition to claimant's prior awards for his left forearm, claimant is awarded 2 percent (3 degrees) for a total of 38 percent (57 degrees) scheduled permanent disability. Claimant's attorney is awarded 25 percent of the additional compensation granted by this order, provided that the total fees awarded by the Referee and Board order does not exceed $3,000, to be paid directly to claimant's attorney. The Board approves a client-paid fee, not to exceed $401, payable from the insurer to its counsel.

In the Matter of the Compensation of
DEBORAH A. MacDONALD, Claimant
WCB Case No. 88-14462
ORDER ON REVIEW
Scott M. McNutt, Claimant Attorney
Dennis Ulsted (Saif), Defense Attorney

Reviewed by Board Members Nichols and Crider.

The SAIF Corporation requests review of Referee Quillinan's order that awarded 3 percent (9.6 degrees) unscheduled permanent disability for a low back injury, whereas a Determination Order had awarded no permanent disability. On review, the issue is extent of unscheduled permanent partial disability. We affirm.

FINDINGS OF FACT

Claimant, a 29 year-old motel maid, strained her low back in May 1988. She was treated by Dr. Garcia, M.D. X-rays of her low back were normal. Claimant experienced continuing low back pain. She reinjured her back on July 11, 1988. A July 27, 1988 Determination Order awarded her no permanent disability.

Claimant returned to Dr. Garcia in August 1988 because of a recurrence of back pain.

Claimant experiences numbness in the upper back of her right thigh, and low back pain on lifting, bending, standing, sitting, riding in a car, running, and pushing.

Claimant quit her job about two months after her injury because she needed to take muscle-relaxant medication in order to perform her work.

Claimant is permanently limited to lifting a maximum of 40 pounds and cannot do repetitive lifting, bending or stooping because of disabling pain resulting from her industrial injury.

Claimant has a ninth grade education. She has no training or employment experience other than as a motel maid.

FINDINGS OF ULTIMATE FACT

Claimant has sustained no less than 3 percent loss in earning capacity as a result of her low back injury.

CONCLUSIONS OF LAW AND OPINION

Claimant became medically stationary after January 1, 1988; her claim was closed by a July 27, 1988 Determination Order. Thus, the standards effective from July 1, 1988 through August 18, 1988 apply to this claim. OAR 438-10-010; Michelle Griffith, 40 Van Natta 2086 (1988).

The Referee based the award of 3 percent permanent disability on claimant's lifting, bending and stooping restrictions, and her decreased ability to sit and stand, all of which resulted from disabling back pain.

SAIF first argues that former OAR 436-35-320(1)(a) does not permit assigning a value for loss of use or function due to disabling pain if the particular loss is not assigned a value elsewhere in the disability standards. This argument was rejected in Daniel M. Alire, 41 Van Natta 752 (1989).

Secondly, SAIF contends that claimant did not prove she had any permanent impairment because she was not a credible witness. Although the Referee made no credibility finding, we infer that she found claimant's testimony to be credible because she made the ultimate finding, inter alia, that claimant had decreased ability to lift, bend, sit, and stand, to which claimant testified at hearing. On de novo review of the hearing record, we find that claimant was reliable as to her complaints and limitations.

In treating physician Garcia's last report, in September 1988, he limited claimant's lifting to 40 pounds and restricted her from repetitive lifting, bending or stooping. SAIF offers no medical evidence to rebut Dr. Garcia's reports and claimant's testimony in regard to her physical limitations. Instead, SAIF argues that claimant's testimony at hearing regarding her low back and her leg numbness contradicted her previous assertions to Dr. Garcia as well as his own findings. SAIF also argues that there was no evidence of claimant's problems with bending, standing and sitting in Garcia's chart notes and reports.

On review, we find the medical reports that SAIF contends are inconsistent with claimant's testimony regarding low back pain were made prior to claimant's July 1988 exacerbation to her back. Although SAIF was correct in noting that claimant's complaint of thigh numbness was not consistent with Garcia's post-July 1988 report, this inconsistency does not undercut the Referee's award, which was based on low back pain, not right leg numbness. Furthermore, even though Garcia did not address standing and sitting after the July 1988 reinjury, he restricted claimant from repetitive lifting, bending or stooping in his September 1988 report. His restrictions serve to substantiate claimant's testimony.

In addition, we find claimant's testimony regarding her performance or nonperformance of duties more reliable than that of her employer, Mr. Duvall, who relied on hearsay when he testified on this issue. Furthermore, claimant stated she was able to perform only because of medication, so the fact that she continued to work did not mean she had no impairment. Any other inconsistencies between claimant's and Duvall's testimony are too minor to persuade us that claimant was not telling the truth about her back pain.

Thirdly, SAIF argues that the Referee erred in going outside the standards to award claimant 3 percent unscheduled disability by considering bending and stooping restrictions, repetitive lifting restrictions, and decreased ability to sit and stand. However, this argument is not persuasive because the 3 percent award is supportable under the standards based on the 40 pound lifting restriction alone.

Accordingly, we find claimant has at least a 3 percent impairment due to loss of function based on disabling pain. The physical impairment alone justifies the Referee's award. We note that the Referee failed to take into account claimant's work status, age, education, and adaptability in rating claimant's disability under the standards. See OAR 436-35-270(2). However, as claimant does not request an increase in her award, we decline to consider these nonmedical factors and affirm the Referee's award of 3 percent. Daniel M. Alire, supra.

ORDER

The Referee's order dated December 5, 1988 is affirmed. For services on Board review, claimant's attorney is awarded an assessed fee of $300, payable by the SAIF Corporation.

In the Matter of the Compensation of
DEBRA M. BURNS, Claimant
WCB Case No. 88-13371
ORDER ON REVIEW
Ralph M. Yenne, Claimant Attorney
Gail Gage (Saif), Defense Attorney

Reviewed by Board Members Speer and Howell.

Claimant requests review of Referee Foster's order that: (1) declined to direct the SAIF Corporation to reimburse claimant for her travel expenses to her treating physician pending its appeal of an opinion and order that found claimant's condition compensable; and (2) declined to assess penalties and related attorney fees for an alleged unreasonable refusal to pay such benefits. On review the issue is reimbursement for travel expenses pending appeal, and penalties and attorney fees. We affirm.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact.

CONCLUSION OF LAW AND OPINION

The Referee's order that set aside SAIF's denial of claimant's back condition claim was on Board review at the time of hearing regarding reimbursement for the travel expenses to the treating physician. The issue here is whether SAIF is obligated to pay for medical benefits in the form of travel expenses reimbursement, on a claim in which compensability is still under appellate review. Travel expenses to the treating physician are considered medical services expenses. OAR 436-60-050(4); Pyle v. SAIF, 55 Or App 965 (1982); Stritt v. SAIF, 37 Or App 893 (1978). Medical services need not be paid pending review of the issue of compensability of the injury for which the medical services are sought. ORS 656.313(4). Moreover, SAIF's refusal to pay such benefits was not unreasonable.

Order

The Referee's order, dated November 21, 1988, is affirmed.

In the Matter of the Compensation of
JOHN A. CALDER, Claimant
WCB Case No. 86-16214
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
Ann Kelley, Assistant Attorney General

Reviewed by Board Members Crider and Nichols.

The Department of Justice, on behalf of the Inmate Injury Fund ("the Fund"), requests review of those portions of Referee Quillinan's order that: (1) set aside its denial of claimant's aggravation claim for a low back condition; (2) awarded claimant 10 percent (32 degrees) unscheduled permanent disability for the same condition; (3) assessed a penalty and related attorney fee against the Fund for its refusal to pay interim compensation; and (4) awarded claimant's attorney an assessed fee for prevailing at hearing from the Fund's aggravation denial. We affirm with some modifications.

ISSUES

1. Aggravation. Did claimant sustain a worsened condition after the last award or arrangement of compensation? Did the compensable injury materially contribute to that worsening?

2. Extent of Unscheduled Permanent Disability. How much permanent loss of earning capacity did claimant sustain due to the compensable low back injury?

3. Penalties and Attorney Fees. Did the Fund's refusal to pay interim (temporary total disability) compensation amount to an unreasonable resistance to the payment of compensation?

4. Attorney Fees for Services at Hearing.

FINDINGS OF FACT

The Board adopts the "FINDINGS OF FACT" portion of the Referee's opinion and order with the following supplement.

The last award or arrangement of compensation prior to claimant's filing of his aggravation claim was the Fund's Initial Determination of Award, which issued on February 12, 1987.

FINDINGS OF ULTIMATE FACT

1. Claimant's low back condition worsened after the last award of compensation on February 12, 1987. The compensable injury materially contributed to that worsening.

2. Claimant sustained 10 percent permanent loss of earning capacity due to the compensable low back injury.

3. The Fund's refusal to pay interim compensation amounted to an unreasonable resistance to the payment of compensation.

CONCLUSIONS OF LAW AND OPINION

Aggravation

1. Aggravation Rights for Injured Inmates

The Fund contends that injured inmates have no aggravation rights under ORS Chapter 655. The Referee disagreed, finding that the aggravation rights granted to injured workers were also incorporated into the Inmate Injury Law. We affirm.

The Inmate Injury Law (ORS 655.505 to 655.550) does not expressly provide for aggravation rights. However, ORS 655.515 reads that "[i]f an inmate sustains an injury ***, benefits shall be paid in the same manner as provided for injured workers under the workers' compensation laws of this state ***." The Fund argues that that provision merely incorporates the procedures for paying benefits under the workers' compensation laws, not the substantive rights to those benefits. That argument contradicts the Supreme Court's declaration in Johnson v. SAIF, 267 Or 299 (1973), that former ORS 655.515, which is substantially the same as the current version, provides an injured inmate with the same measure of benefits as an injured worker to the extent not inconsistent with other provisions of the Inmate Injury Law. Id. at 302-03. That declaration has recently been quoted approvingly by the Court of Appeals. Dept. of Justice v. Spear, 94 Or App 677, 681-82 (1989). The incorporation of aggravation rights

into the Inmate Injury Law would not conflict with any other provision of that law. Accordingly, we conclude that ORS 655.515 incorporates the aggravation rights granted injured workers under ORS 656.273.

2. Compensability of Aggravation Claim

To establish a compensable aggravation under ORS 656.273, claimant must prove: (1) his condition has worsened rendering him more disabled, either temporarily or permanently, since the last award or arrangement of compensation; and (2) a causal connection between the worsened condition and the compensable injury. See Smith v. SAIF, 302 Or 396, 399 (1986); Grable v. Weyerhaeuser Company, 291 Or 387, 400-01 (1981); Stepp v. SAIF, 78 Or App 438 (1986). Because an unscheduled body part is involved, "more disabled" means increased loss of earning capacity. See Smith v. SAIF, supra.

The Referee found that claimant's low back condition had worsened to the point where he was temporarily disabled. She concluded, therefore, that claimant had proven a compensable aggravation of his accepted injury. We agree.

At the time that claimant filed his aggravation claim in October, 1987 (Ex. 31), the last award of compensation was the "Initial Determination of Award" dated February 12, 1987. Because claimant was not awarded any permanent disability, we find that the last award of compensation did not contemplate any future exacerbations resulting in loss of earning capacity. See, e.g., Louis A. Duchene, 41 Van Natta 2399, 2400 (1989); Lorna G. Baker, 41 Van Natta 1844, 1846 (1989). Consequently, any subsequent change in claimant's condition resulting in temporary or permanent loss of earning capacity would be sufficient to prove a worsening.

By letter dated October 22, 1987, Dr. Van Hee, the treating chiropractor, advised that claimant had suffered a material worsening of his low back condition which rendered him temporarily disabled for more than three weeks in October, 1987 (Ex. 31A). Van Hee later added that the 1986 compensable injury materially contributed to the worsening (Ex. 39). Dr. Poulson, the consulting physician, described claimant's condition as static on November 3, 1987; however, his examination apparently took place after the period of claimant's temporary disability (Ex. 32). Poulson acknowledged that claimant would suffer remissions and exacerbations of pain depending on activity, and he did not question the causal relationship between the condition and the 1986 compensable injury. The Orthopaedic Consultants examined claimant at the Fund's request on November 6, 1987 (Ex. 35). They declared claimant medically stationary and capable of returning to regular work without restrictions. Like Poulson, they also saw claimant after he was no longer temporarily disabled. They did not find objective evidence to confirm his subjective complaints and thus concluded that "[t]here is no evidence that his condition objectively has recently worsened." However, claimant need not objectively prove a worsening in order to establish a compensable aggravation.

After reviewing the above reports, we are most persuaded by Van Hee's opinion on the aggravation issue. Unlike Poulson and the Orthopaedic Consultants, Van Hee saw claimant at the time of the alleged worsening and temporary disability. Additionally, as treating physician, Van Hee had the best opportunity to evaluate claimant's subjective complaints and relate them to his clinical condition, whereas the other examiners saw claimant only once. See Weiland v. SAIF, 64 Or App 810, 814 (1983). Finally, claimant's testimony regarding his worsening symptoms in October, 1987, is consistent with Van Hee's reports (Tr. 13). The Referee found claimant's testimony to be credible (O&O p. 4). Based on Van Hee's reports and claimant's credible testimony, we find that claimant suffered an exacerbation of his 1986 injury resulting in at least temporary loss

of earning capacity. We conclude that claimant's aggravation claim is compensable.

Extent of Unscheduled Disability

Based on the Orthopaedic Consultants' report (Ex. 35), we are persuaded that claimant became medically stationary on November 6, 1987. Because claimant's aggravation claim was found compensable and he was medically stationary at the time of hearing, we conclude that the Referee could properly rate the extent of his permanent disability. See ORS 655.525; OAR 438-08-020.

We adopt the portion of the Referee's opinion that awarded claimant 10 percent (32 degrees) unscheduled permanent disability for his low back condition.

Penalties and Attorney Fees

We adopt that portion of the Referee's order that assessed the Fund with penalties and attorney fees with the following modification and comment.

The Referee refers to the SAIF Corporation as the processing agent for the Fund. However, the Department of Justice, not SAIF, is the adjusting agent for the Fund. ORS 655.535. Accordingly, the portions of the Referee's opinion that refer to SAIF are replaced by references to the Fund and its adjusting agent, the Department of Justice.

The Referee found that the Fund had unreasonably delayed the payment of interim compensation. In so finding, she cited to former OAR 436-60-150(4) and stated that that rule "allows a grace period of one week in making the first TTD [temporary total disability] payment." Although we agree with the result reached by the Referee, i.e., the assessment of a penalty and fee, we note that since the Referee's order issued we have reinterpreted former OAR 436-60-150(4) to not allow for a seven-day grace period. Arlene Marshall, 40 Van Natta 1828 (1988).

Attorney Fees for Services at Hearing

The Referee found that claimant's attorney was entitled to both approved fees, which are payable out of claimant's increased temporary disability and permanent disability compensation, and an assessed fee for prevailing at hearing from the aggravation denial. On review, the Fund argues that ORS chapter 655 does not authorize attorney fees and suggests that Johnson v. SAIF, supra, which held that such fees are authorized, may no longer be valid under the current statutory scheme. However, the Court of Appeals recently held that attorney fees are authorized under ORS chapter 655. Dept. of Justice v. Spear, supra (citing and quoting Johnson v. SAIF, supra); see also Robert S. Waterston, 41 Van Natta 2025, 2028 (1989). Accordingly, the Referee properly approved and assessed fees. Finally, we conclude that the amount of the assessed fee awarded by the Referee is reasonable.

ORDER

The Referee's order dated January 20, 1988, is modified in part and affirmed in part. The portions of the Referee's order that remand claimant's aggravation claim for further processing and payment of temporary total and permanent partial disability compensation are modified. Instead, the Final Determination of Award dated November 19, 1987, is modified to award claimant temporary total disability compensation from October 5, 1987, through November 6, 1987, and 10 percent (32 degrees) unscheduled permanent disability compensation. The remaining portions of the order that refer to the SAIF

Corporation are substituted with references to the Inmate Injury Fund and its adjusting agent, the Department of Justice, in their stead. The Referee's order is otherwise affirmed. For services on Board review of the aggravation and extent of disability issues, claimant's attorney is awarded a reasonable assessed fee of $300, to be paid by the Inmate Injury Fund.

April 30, 1990 Cite as 42 Van Natta 981 (1990)

In the Matter of the Compensation of
JOHN A. CALDER, Claimant
WCB Case No. 88-14307
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
David R. Fowler, Assistant Attorney General

Reviewed by Board Members Crider and Nichols.

The Department of Justice ("the Department"), on behalf of the Inmate Injury Fund ("the Fund"), requests review of the portion of Referee Foster's order that assessed a penalty and related attorney fee for its allegedly unreasonable refusal to pay compensation pursuant to a prior Referee's order. We affirm.

ISSUE

Penalties and Attorney Fees. Did the Department's refusal to pay compensation pursuant to a prior Referee's order constitute an unreasonable resistance to the payment of compensation?

FINDINGS OF FACT

By order dated January 20, 1988, a prior Referee set aside the Fund's aggravation denial and, based on the mistaken belief that the SAIF Corporation is the Fund's adjusting agent, went on to order SAIF to pay claimant temporary and permanent disability compensation. However, SAIF was not a party to the prior proceeding. The Department, which was a party to the proceeding, recognized the Referee's error and, on February 4, 1988, requested abatement and reconsideration of the order, advising that it is the exclusive processor of inmate injury claims for the Fund. See ORS 655.535. Before the Referee could publish a corrected order, however, the Department removed her jurisdiction by requesting Board review of the order. The Department failed to pay the compensation awarded under the prior Referee's January 20, 1988 order. On review, we affirmed the order with minor modifications. John Calder, 42 Van Natta 977 (1990)

FINDING OF ULTIMATE FACT

The Department's refusal to pay compensation pursuant to the prior Referee's order constituted an unreasonable resistance to the payment of compensation.

CONCLUSIONS OF LAW AND OPINION

We adopt the Referee's opinion with the following supplement.

The Department contends that it was not obligated to pay any compensation pursuant to the prior Referee's order because the order directed SAIF, not the Department, to pay the compensation on the Fund's behalf. We disagree.

A public administrative body is generally not bound by technical rules regarding the form of its orders or final determinations. For that reason, its

orders are liberally construed to effectuate the intent of the body issuing them. State ex rel. Smith v. Smith, 197 Or 96, 105 (1953).

A fair reading of the prior Referee's order leaves no reasonable doubt that she intended to set aside the Fund's aggravation denial and award claimant compensation payable out of the Fund. Moreover, it is clear from the prior Referee's opinion that she ordered SAIF to pay the compensation only because she believed that SAIF, rather than the Department, was the Fund's processing agent.

Temporary disability compensation is required to be paid within 14 days after the date of the litigation order which orders temporary disability, while permanent disability compensation must be paid within 30 days after the date of a litigation order which orders permanent disability. OAR 436-60-150(3)(e), 436-60-150(5)(b). Moreover, payment of compensation pursuant to a litigation order is not stayed pending appeal of that order. ORS 656.313. Those provisions, among others, effectuate one of the primary purposes of the Workers' Compensation Act, which is to assure the prompt payment of compensation. See ORS 656.262(2). With that purpose in mind, we are persuaded that technical errors of form in litigation orders should not absolve the Department of its obligation to pay compensation where that obligation is otherwise clearly intended.

Here, the prior Referee's error should have been obvious to the Department, which was a party to the proceeding in its capacity as the Fund's processing agent. Upon receiving its copy of the order, the Department should have assumed its statutory duty to process the aggravation claim on the Fund's behalf and pay the temporary and permanent disability compensation awarded by the Referee on that claim. At the very least, the Department should have sought clarification of the order sooner than it did. By refusing to pay compensation pursuant to the order, the Department sought to elevate form over substance. We conclude that its conduct was unreasonable.

The Department further argues that, even if its conduct was unreasonable, ORS chapter 655 (Inmate Injury Law) does not allow for the imposition of penalties and attorney fees. In so arguing, the Department contends that Johnson v. SAIF, 267 Or 299 (1973), which authorized the assessment of attorney fees in inmate injury cases, is no longer valid. That is wrong.

The Court of Appeals recently cited and quoted from Johnson in holding that attorney fees are authorized under ORS chapter 655. Dept. of Justice v. Spear, 94 Or App 677, 681-82 (1989). Quoting from Johnson, the court stated in Spear that "the legislature intended to incorporate into the statutes dealing with inmates *** all of the procedural and remedial rights extended to injured workmen, with certain reservations necessitated by the unique position of the inmate." Id at 681. ORS 656.262(10) and 656.382(1) allow injured workers a penalty and attorney for an insurer's unreasonable resistance to the payment of compensation. Those provisions are not expressly excluded from ORS chapter 655, see generally ORS 656.515, 656.525, and, when read in the light of that chapter, provide the statutory authorization for the assessment of penalties and attorney fees in inmate injury cases. Inasmuch as we have already found the Department's conduct to be unreasonable here, we conclude that a penalty and attorney fee is appropriate. See Robert S. Waterston, 41 Van Natta 2025 (1989).

ORDER

The Referee's order dated December 5, 1988, is affirmed.

In the Matter of the Compensation of
DONNA L. CUMMINGS, Claimant
WCB Case Nos. 88-01483 & 88-02867
ORDER ON REVIEW
Emmons, et al., Claimant Attorneys
John Motley (Saif), Defense Attorney

Reviewed by Board Members Nichols, Brittingham and Crider.

The SAIF Corporation requests review and claimant cross-requests review, of that portion of Arbitrator Borchers' order that: 1) set aside its denial of claimant's aggravation claim for a worsened low back condition; and 2) upheld Wausau Insurance Companies' denial of claimant's "new injury" claim for the same condition. Claimant also raised entitlement to attorney fees in her brief as the Referee had denied her request for fees in his order. On review, the issues are responsibility and attorney fees.

Under the applicable law, the Board is bound by the findings of the Arbitrator and can only review the record for errors of law. ORS 656.307(2); Timothy R. Schroeder, 41 Van Natta 568 (1989).

The Board affirms and adopts the order of the Arbitrator.

ORDER

The Arbitrator's order dated October 25, 1988, is affirmed.

Board Member Crider, concurring:

I agree with the majority's decision to affirm the Arbitrator's conclusion that claimant has suffered an aggravation rather than a new injury and, therefore, that the Arbitrator correctly assigned responsibility to the SAIF Corporation. I disagree, however, with the majority's statement that we review only for errors of law. In this case, I believe, we are required to review de novo.

The rule governing the standard of review is stated in ORS 656.307(2), which reads, in relevant part, as follows:

> "The determination of the arbitrator may be reviewed by the board, and then by the Court of Appeals within the same period of time as provided for review of an order after hearing. Review of the determination of the arbitrator by the board and by the Court of Appeals is limited to questions of law and is not thereafter subject to review by any other court or administrative body. However, if the claimant can establish, on the arbitration record, that the determination resolves a matter concerning a claim as defined in ORS 656.704(3), review of the determination of the arbitrator by the board and the Court of Appeals shall be as provided for matters concerning a claim."

A matter concerning a claim is defined as one in which a worker's right to receive compensation, or the amount thereof, is directly in issue. ORS 656.704(3). We held, in Jon E. Robinson, 42 Van Natta 512 (1990), that when a claimant has established in the record that his or her rate of temporary disability compensation will be affected by the assignment of responsibility, she is entitled to de novo review of the Referee's order.

In this case, claimant participated as more than a nominal party at hearing. She seeks review of the order. The record establishes that the date of first injury, for which SAIF is responsible, was October 26, 1983. The claim was first closed, without permanent disability, on December 30, 1983. Therefore, claimant's aggravation rights in that claim expired on December 30, 1988. ORS 656.273(4)(c). If we find that claimant's condition is an aggravation of that injury, rather than a new injury, then claimant's aggravation rights have expired. The date of the claim for injury which is at issue in the responsibility case is February 23, 1988. Thus, if responsibility for claimant's condition is assigned to Wausau, as insurer of the new injury employer, the aggravation period for the disabling condition has not yet commenced. Claimant has great stake in the duration of the aggravation period, for she is entitled to additional temporary disability compensation if her condition worsens during the aggravation period whereas she may receive additional temporary disability compensation only under very limited circumstances if her condition worsens after the aggravation period expires. ORS 656.278(1).

The legislative history suggests an intent to allow a worker to invoke the Board's de novo review authority whenever the worker's interests are substantially affected by the resolution of the responsibility dispute. The Senate Committee on Labor, which crafted the exception, specifically noted that both a difference in the rate of temporary disability compensation and in the duration of the aggravation rights were such interests.

The limited appeal rights provision of ORS 656.307(2) had its origins in a bill introduced in the House of Representatives during the 1987 legislative session. HB 2271A, the bill as it passed the House, included language limiting review of arbitrator decisions in .307 cases to questions of law. In the Senate, however, Committee Chairman Hill proposed to add the additional language that appears in the current statute, allowing workers a right to review as in matters concerning a claim in certain cases. Minutes, Senate Committee on Labor, June 8, 1987, page 2. Exhibit A. Chairman Hill explained that his proposed amendment would allow the worker review as in ordinary workers' compensation matters when "the worker's rights are directly involved in the decision". Senate Committee on Labor, June 8, 1987, Tape 201, Side A.

During discussion the following day, the Chairman reiterated his point, saying,

> "[The] benefits the worker may receive and because they're based on the wage earning would be substantially altered depending upon what decision was made....Those cases where the worker's--worker's being severely affected, those would be appealable as a normal case."

Senate Committee on Labor, June 9, 1987, Tape 202, Side A.

Another member of the Committee, Senator Cub Houck, noted that workers also have substantial interest in the responsibility assignment's affect on the aggravation period. A colloquy occurred which establishes that the Committee understood the amendment to provide that review is not limited to questions of law when the duration of the aggravation period is in issue:

> "Senator Houck: One other question, Mr. Chairman, on the issue of whether the determination resolves a matter concerning a claim. It would appear then in most .307 disputes that the date of injury would be a subject question and some cases just aggravation or new injury and if the claimant's aggravation rights are affected by

> the decision, then I think that the claimant would have a--be a matter concerning a claim that would affect the claimant. It would follow in addition to the difference in wage.
>
> Chairman Hill: Okay."

Senate Committee on Labor, June 9, 1987, Tape 202, Side B.

The legislature clearly intended that if workers have a substantial interest in the responsibility issue, they should be entitled to de novo review. Claimant has established such an interest here. Therefore, he is entitled to de novo review.

On de novo review, we must not only determine whether or not the Arbitrator applied the correct legal principles but must also independently weigh the evidence, make findings of fact and articulate reasons for them. On de novo review, I would have reached the result reached by the Arbitrator for somewhat different reasons.

April 30, 1990 Cite as 42 Van Natta 985 (1990)

In the Matter of the Compensation of
MARTIN J. FOWLER, Claimant
WCB Case No. 88-12350
ORDER ON REVIEW
Charles D. Maier, Claimant Attorney
Merrily McCabe (Saif), Defense Attorney

Reviewed by Board Members Brittingham and Nichols.

Claimant requests review of that portion of Referee Garaventa's order that awarded scheduled permanent disability for loss of use or function of his right leg (knee) of 2 percent (3 degrees), whereas a Determination Order had awarded claimant temporary disability only. On review, the issue is extent of scheduled permanent partial disability. We modify.

FINDINGS OF FACT

On July 26, 1987, claimant sustained a compensable right knee injury as a result of pivoting while swinging a sledge hammer during a demolition project. Claimant was treated by Dr. Shaw, orthopaedic surgeon.

A right knee strain was accepted by the SAIF Corporation on August 28, 1987.

On October 15, 1987, Dr. Shaw performed an arthroscopic debridement of the right knee, a patellar and medial condylar shaving, and a lateral retinacular release.

Claimant has preexisting bilateral patellar subluxations. A denial of compensability of the left knee condition and symptoms was upheld by an Opinion and Order following a hearing.

Claimant was medically stationary on May 13, 1988.

A Determination Order issued July 14, 1988, awarding claimant temporary total disability from July 27, 1987 through May 8, 1988. No permanent disability was awarded.

FINDINGS OF ULTIMATE FACT

Claimant's range of motion in his right knee is 0 to 130 degrees. He has no measurable joint instability. His disabling pain does not result in any addition loss of use or function.

CONCLUSIONS OF LAW AND OPINION

The only issue on review is the extent of claimant's scheduled permanent disability.

The Referee found that claimant was entitled to a 2 percent scheduled permanent disability award for loss of use or function of his right leg. The Referee arrived at this award by comparing claimant's loss of motion in his injured right knee to his active degrees of motion in his contralateral joint. We disagree.

If a claimant became medically stationary after January 1, 1988 and his or her claim was closed on or after July 1, 1988, a subsequent determination by a referee or the Board of the claimant's permanent partial disability must be made pursuant to ORS 656.283(7) and 656.295(5), respectively. OAR 438-10-005 and Michelle Griffith, 40 Van Natta 2086 (1988).

The hearing and Board review of the issue of permanent partial disability continues to be de novo on the hearing record. The underlying facts to which the "standards" are applied need only be established by a preponderance of the evidence. However, either party may establish that the record, as a whole, constitutes clear and convincing evidence that the degree of permanent partial disability suffered by the claimant is more or less than the entitlement indicated by the "standards". ORS 656.283(7) and 656.295(5).

In this case, the "standards" adopted effective July 1, 1988, former OAR 436-35-001 et seq, apply to the rating of claimant's permanent partial disability. Former OAR 436-35-010 through 436-35-260 apply to the rating of scheduled permanent partial disabilities. Former OAR 436-35-010(1).

Claimant is entitled to a value based upon his permanent loss of use or function in his right knee. The value given for claimant's lost range of motion in his right knee is based upon active degrees of motion. See former OAR 436-35-010(3). To calculate a loss of motion one of two methods is provided for by the "standards". Id. The "standards" rate loss of motion by comparing the active degrees of motion of the injured body member to the degrees of motion possible in the contralateral normal joint or by comparing the active degrees of motion of the injured member to the ranges of motion established, as normal, by the American Medical Association. Id. The range of motion in claimant's uninjured left knee was measured at 12 to 135 degrees. The Referee found that claimant had a preexisting disease in his contralateral joint. Therefore, claimant does not have a normal contralateral joint to which we can compare his lost range of motion. Consequently, we rate claimant's lost range of motion by comparing claimant's active degrees of motion in his injured right knee to the ranges of motion established by the American Medical Association as normal.

Claimant's range of motion in his right knee, as measured by Dr. Shaw, is 0 to 130 degrees. Claimant has retained 130 degrees flexion in his right knee. Pursuant to former OAR 436-35-220(1) claimant is entitled to a value of 7 percent. Claimant can extend to 0 degrees and is therefore, entitled to no value for loss of extension. Former OAR 436-35-220(2). Claimant's total rating for loss of motion in his right knee is 7 percent. Former OAR 436-35-220(4); 436-35-240(2).

Claimant argues that he is entitled to an award for joint instability. See former OAR 436-35-230(3). However, former OAR 436-35-230(3) allows for a rating for instability only where the instability is measured. We find that claimant has failed to prove a measurable degree of instability. Therefore, claimant is entitled to no value for instability under the standards.

In addition, claimant argues that he is entitled to an increase in his scheduled permanent disability based upon disabling pain. We agree with the Referee's conclusion that claimant's pain does not result in any additional loss of use or function. See Daniel M. Alire, 41 Van Natta 752 (1989). Therefore, we do not award claimant a value based upon disabling pain.

Having determined each value necessary to compute claimant's permanent disability under the "standards", we proceed with that calculation. Claimant's permanent disability is 7 percent scheduled permanent disability for loss of use or function of claimant's right leg (knee).

ORDER

The Referee's order dated October 31, 1988 is modified. In addition to the Referee's award, claimant is awarded 5 percent (7.5 degrees) scheduled permanent disability, which gives him a total award to date of 7 percent (10.5 degrees) scheduled permanent disability for loss of use or function of his right leg (knee). Claimant's attorney is awarded 25 percent of the additional compensation granted by this order, provided that the total fee from the Referee and Board order does not to exceed $3,800, payable by the SAIF Corporation directly to claimant's attorney.

April 30, 1990 Cite as 42 Van Natta 987 (1990)

In the Matter of the Compensation of
RICHARD L. GELLINGS, Claimant
WCB Case No. 87-07419
ORDER ON REVIEW
Darrell L. Cornelius, Claimant Attorney
Roberts, et al., Defense Attorneys

Reviewed by Board Members Crider and Brittingham.

Claimant requests review of those portions of Referee Lipton's order that: (1) upheld the insurer's denial of claimant's aggravation and medical services claims for a low back condition; (2) held that a May 6, 1987 Determination Order was not prematurely closed; and (3) declined to assess a penalty and attorney fee for the alleged unreasonable denial and unreasonable claims processing. Claimant also challenges evidentiary rulings made by Referee's Galloway and Lipton. On review the issues are evidence, medical services, premature claim closure, aggravation, penalties and attorney fees. We reverse in part and affirm in part.

FINDINGS OF FACT

The Board adopts the Referee's "Findings" with the following addition.

The low back/hip/wrist claim was accepted on May 26, 1986.

Referee Galloway held the record open so that treating physician Keizer could perform a discogram and Dr. Langston, an independent medical examiner, could be deposed. Claimant subsequently offered Keizer's December 7, 1987 report and the insurer offered independent medical examiner Zivin's January 6,

1988 report and treating physician Satyanarayan's September 23, 1987 handwritten note. In a telephone conference Referee Galloway ruled that these exhibits would be admitted and that Keizer could submit a response to Zivin's report, Satyanarayan's note and Langston's deposition. Claimant submitted two reports from Keizer dated May 20, 1988 and June 10, 1988; attached to one of them was a report from consulting neurologist Smith dated November 30, 1987. Referee Lipton (who replaced Referee Galloway) refused to admit Keizer's June 10, 1988 report and Dr. Smith's November 30, 1987 report.

The discogram performed on December 7, 1987 indicated that claimant has a small defect present in the area of L5-S1.

FINDINGS OF ULTIMATE FACT

Claimant does not suffer from a herniated disc.

Claimant has no need for exploratory surgery.

At the time of claim closure, further improvement of claimant's condition could not be expected with further treatment or the passage of time.

As of March 12, 1986, when he sought reopening of his claim, claimant had not suffered a symptomatic or pathological exacerbation of his back condition, nor had he suffered additional loss of earning capacity since claim closure.

The insurer's September 22, 1987 denial of medical services and aggravation was not unreasonable.

Claimant did not seek penalties and attorney fees at hearing for the insurer's failure to supply him with a copy of Dr. Smith's November 30, 1987 report.

CONCLUSIONS OF LAW AND OPINION

Evidence

Claimant argues that Referee Galloway, in his telephone ruling, erred in admitting Dr. Zivin's January 6, 1988 report and Dr. Satyanarayan's hand written note. Claimant asserts that the record was initially left open to receive only a report from Dr. Keizer regarding discogram results and a transcript of Dr. Langston's deposition.

Claimant also argues in this regard that since Referee Galloway admitted the above mentioned exhibits, Referee Lipton should have admitted Dr. Smith's report of November 30, 1987 and Dr. Keizer's report of June 10, 1988.

Regarding the admission of Zivin's report and Satyanarayan's note, Referee Galloway acted within his discretion. Although Referee Galloway initially kept the record open only for Langston's deposition and the results of the discogram, it was within his discretion to also admit the response from Zivin and Satyanarayan.

With regard to Referee Lipton's refusal to admit Dr. Keizer's and Dr. Smith's reports, we find that Referee Lipton erred. Referee Galloway allowed the insurer, through Zivin's and Satyanarayan's reports, to respond to Keizer's report on the discogram results; in a telephone ruling, Referee Galloway expressly left the record open for Keizer's response. Referee Lipton then did not allow claimant to respond, through Keizer's June 10, 1988 report, to Zivin's and Satyanarayan's reports. Keizer's June 10, 1988 report should have been admitted.

Dr. Smith's report should also have been admitted because Dr. Keizer relied on Smith's report, and claimant could not have offered it earlier, with due diligence, because the insurer had not provided claimant with a copy of the report. For that reason, Referee Lipton erred in refusing to admit it.

Accordingly, on de novo review, we consider Dr. Keizer's June 10, 1988 report and Dr. Smith's November 30, 1987 report.

Denial of Medical Services

The Referee, finding that no objective findings existed to establish that claimant suffers from a herniated disc or requires surgery for it, held that no surgery was warranted. Claimant argues that the Referee erred in finding his proposed surgery noncompensable.

We agree with the Referee that claimant has no need for the proposed surgery.

An injured worker is entitled to all reasonable and necessary curative or palliative medical care required for a compensable injury. 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). Claimant has the burden of proving that the treatment is reasonable and necessary. McGarry v. SAIF, supra.

Dr. Keizer, treating orthopedist, first examined claimant in June 1987. Dr. Keizer stated that the MRI showed a suspected protrusion at the L5-S1 level and that a discogram showed a small defect in the area of L5-S1. He recommended exploratory surgery because of claimant's long period of pain in the lower back. Consulting neurologist Smith concurred in Dr. Keizer's opinion that claimant suffered from a herniated disc that required surgical repair.

The Orthopaedic Consultants, after examining claimant twice, opined that claimant's impairment was minimal and he had no need for surgery. Dr. Langston, orthopedist, gave a detailed explanation of his opinion that claimant has no need for surgery. Dr. Satyanarayan, a former treating physician, opined that further treatment would be of a palliative nature only. Dr. Benz, consulting physician, initially opined that surgery might be necessary; however, he subsequently diagnosed degenerative changes only and recommended that claimant wear a back brace. Neurologist Zivin, an independent medical examiner, stated that objective findings were minimal. Dr. Frank, a former treating physician, found claimant's problem confusing and referred him for electrical testing.

Dr. Smith's and Dr. Keizer's opinions are not sufficient to show a need for exploratory surgery. While Keizer's opinion may be supported by a neurologist, Keizer himself stated that there were no specific neurological findings to indicate that claimant has severe impingement on the nerve root; he conceded testing simply showed a slight bulge with "some" involvement of the nerve root.

Dr. Keizer stated that the "real point" justifying the proposed exploratory surgery was claimant's continued pain. Several of the examiners have stated that the pain itself is an insufficient basis to operate, and that such an operation can produce poor results.

The invasive studies performed in this case have revealed only borderline findings. Zivin stated that the findings were, at worst, minimal and that they are probably related to minor osteophytic encroachment rather than disc rupture.

The proposed surgery is of an exploratory nature. Dr. Langston testified that such surgery carries with it a significant risk of further injury, largely in the form of scar tissue, which could render claimant more disabled than he is now.

Keizer also relied on the discogram finding. Both Zivin and Langston agreed that discograms are of questionable value in determining whether a herniated disc exists.

We are persuaded by Dr. Langston's view that surgery is unlikely to provide relief and, indeed, is likely to increase claimant's disability. Therefore, claimant has not established his need for surgery. Accordingly, the Referee's order is affirmed regarding this issue.

Premature Closure

The Referee found no evidence to suggest that claimant's condition was not medically stationary at the time of closure. We agree.

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). The resolution of the medically stationary date is primarily a medical question based on competent medical evidence. Harmon v. SAIF, 54 Or App 121, 125 (1985).

Here, the claim was closed by Determination Order of May 6, 1987. At that point claimant had been declared medically stationary by the Orthopaedic Consultants, Dr. Langston and Dr. Satyanarayan. Only Dr. Keizer's reports suggest that this claim was prematurely closed, based on his surgery recommendation.

Since the proposed surgery is not reasonable or necessary, we conclude the claim was not prematurely closed. The Referee's order is affirmed regarding premature closure.

Aggravation

Claimant argues that the claim should be reopened for aggravation.

To establish an aggravation, claimant must show a worsening of his compensable condition since the last arrangement of compensation. Smith v. SAIF, 302 Or 296 (1986). "Worsening" within this context means increased symptoms, or a worsened underlying condition, resulting in a diminishment of earning capacity. Id.

There is no evidence of greater symptoms, pathological worsening or decreased ability to work since the May 20, 1987 Determination Order. We agree with the Referee that claimant's condition is not worse than at the time of closure.

Penalties and Attorney Fees

The Referee held that since claimant's condition did not warrant surgery and he had not shown an aggravation, the issue of penalties and attorney fees for unreasonable denial is moot. We disagree and decide this issue on the merits.

Claimant argues that the insurer's September 22, 1987 medical services/aggravation denial was unreasonable. We do not agree. The denial was supported by reports from the Orthopaedic Consultants and Dr. Langston of which the insurer was aware at the time of the denial. No penalty should be assessed.

Claimant also argues that the insurer should be assessed a penalty for not providing a copy of Dr. Smith's November 30, 1987 report to him. However, since claimant failed to raise this issue at hearing, it may not be considered on review.

ORDER

The Referee's order dated September 9, 1988 is affirmed in part and reversed in part. Dr. Keizer's June 10, 1988 report and Dr. Smith's November 30, 1987 report are admitted into evidence. The remainder of the order is affirmed. The Board authorizes a client-paid fee, not to exceed $1,349, payable by the insurer to its counsel.

April 30, 1990 Cite as 42 Van Natta 991 (1990)

In the Matter of the Compensation of
CHARLES L. GRUELLE, Claimant
WCB Case No. 87-14668
ORDER ON REVIEW
Richard Sly, Claimant Attorney
Roberts, et al., Defense Attorneys

Reviewed by Board Members Howell and Speer.

The insurer requests review of Referee Zucker's order which set aside its denial of claimant's aggravation claim for a low back injury. The issue is aggravation.

On review, claimant contends that, because the insurer's request for review specifically requested review of the Order Denying Reconsideration, the Board is limited only to discussing the issue mentioned on reconsideration, i.e., the allocation of the burden of proof. We disagree.

The Board is not confined to those issues alone which are expressly appealed to it. Instead, the Board may address any issue considered by the referee. Destael v. Nicolai Co., 80 Or App 596 (1986). Additionally, the Referee's Opinion and Order and the Order Denying Reconsideration both contained the same WCB case number. See William E. Wood, 40 Van Natta 999 (1988). We conclude that we are not limited in our review to the issue discussed in the Order Denying Reconsideration.

Subject to the above, the Board affirms and adopts the Referee's order.

ORDER

The Referee's order dated May 17, 1988 is affirmed. Claimant's attorney is awarded a reasonable assessed fee of $1,650 for services on Board review, payable by the insurer. A client-paid fee, not to exceed $945, is approved.

April 30, 1990 Cite as 42 Van Natta 991 (1990)

In the Matter of the Compensation of
DONALD A. HANSON, Claimant
WCB Case Nos. 88-13657, 88-10249, 88-13658 & 88-10248
ORDER ON REVIEW (REMANDING)
Cook & Seims, Claimant Attorneys
Thomas Sheridan (Saif), Defense Attorney
Davis & Bostwick, Defense Attorneys

Reviewed by Board Members Brittingham and Nichols.

The SAIF Corporation requests review of Referee/Arbitrator St. Martin's order/decision that: (1) upheld SAIF's denial, on behalf of Northwest Woodland

Services, of claimant's claim for his current low back condition; and (2) set aside SAIF's denial, on behalf of Triple T, of claimant's aggravation claim for the same condition. On review, the issue is responsibility. We remand.

The sole dispute before the Arbitrator concerned the assignment of responsibility either to Northwest Woodland Services or to Triple T. Neither employer accepted claimant's claim, but each conceded compensability. The Arbitrator issued his order pursuant to a .307 order issued on August 9, 1988. Therefore, ORS 656.307(2), which became effective January 1, 1988, applies in this case. Timothy R. Schroeder, 41 Van Natta 568 (1989).

Under the amended statute, Board review is limited to questions of law unless the claimant establishes on the hearing record that the responsibility determination will resolve a matter concerning a claim. ORS 656.307(2). Although claimant was a party to this proceeding, he chose to act as a nominal party, appearing at hearing solely as a witness. He offered no evidence. He took no position on the responsibility issue. He did not participate on review. As a result, claimant has not established facts that would allow us to find that the responsibility determination will also decide a matter concerning a claim. Therefore, our review is confined to questions of law and we are bound by the Arbitrator's findings of fact.

The findings of fact do not support the Arbitrator's conclusion.

In the context of an occupational disease, the last employment providing potentially causal conditions is initially deemed responsible for the condition. Boise Cascade Corp. v. Starbuck, 296 Or 238 (1984); Meyer v. SAIF, 71 Or App 371, 373 (1984). The date of onset of disability is the triggering date for the determination of the last potentially causal employment. Bracke v. Baza'r, 293 Or 239, 248 (1982). The date of onset of disability is the date on which a claimant first becomes disabled as a result of the compensable condition or, if the claimant does not become disabled, the date he or she first seeks medical treatment for the condition. Progress Quarries v. Vaandering, 80 Or App 160 (1986); SAIF v. Carey, 63 Or App 68 (1983); Inez Horsey, 42 Van Natta 331 (1990).

In order to shift responsibility to an earlier carrier or employer, the carrier or employer on the risk when claimant became disabled or sought medical treatment must establish that the work conditions while the other carrier or employer was on the risk were the sole cause of the disease, or that it was impossible for work conditions during the period when it was on the risk to have caused the disease. FMC Corp. v. Liberty Mutual Ins. Co., 70 Or App 370 (1984), clarified 73 Or App 223 (1985). In order to shift responsibility to a later carrier or employer, the initially responsible carrier or employer must show that a later employment independently contributed to a pathological worsening of the condition.

The Arbitrator concluded that claimant suffered a new injury, not an aggravation, at Triple T. First, the Arbitrator failed to state the legal principles on which he relied to reach his result. In addition, he did not make the findings that would permit him to apply the last injurious exposure rule as it should have been applied under the law. Moreover, he failed to discuss the relevant medical evidence. Lastly, he made no findings that would support the award of an attorney fee to claimant's attorney under ORS 656.307(5). For these reasons, we cannot review for errors of law. See, e.g., Inez Horsey, supra.

Should we determine that a case has been improperly, incompletely, or otherwise insufficiently developed, we may remand for further evidence taking, correction, or other necessary action. See ORS 656.295(5).

We conclude that this case has been insufficiently developed and that remand is appropriate.

ORDER

The Arbitrator's order dated December 23, 1988 is vacated. This matter is remanded to the Hearings Division for assignment to an arbitrator for a determination of the responsible employer.

In the Matter of the Compensation of
BRENDA M. HINKLE, Claimant
WCB Case No. 88-05331
ORDER ON REVIEW
Patrick K. Mackin, Claimant Attorney
Carrol J. Smith (Saif), Defense Attorney

Reviewed by Board Members Crider and Nichols.

Claimant requests review of Referee Leahy's order that: (1) upheld the SAIF Corporation's denial of claimant's aggravation and medical services claims for her current low back, hip and leg condition; and (2) declined to assess penalties and attorney fees for its alleged unreasonable denial and unreasonable processing of those claims, and its alleged failure to timely provide discovery documents. On review, the issues are aggravation, medical services, and penalties and attorney fees. We affirm.

FINDINGS OF FACT

Claimant, 27 at time of hearing, compensably strained her mid and low back in December, 1985, for which she was awarded 15 percent (48 degrees) unscheduled permanent disability in a June 13, 1986 Determination Order.

Claimant was treated by Dr. Strasser, chiropractor, until July 1986, when she began treating with Dr. Scott, chiropractor.

Claimant filed an aggravation claim in July 1986 which SAIF denied. An April 1987 Opinion and Order upheld the denial of the aggravation claim. Claimant's symptoms at the time of hearing included mid and low back pain, bilateral hip pain and leg numbness. In January 1989, after the Referee in the present case rendered his opinion, the Board issued an order affirming the April 1987 Opinion and Order on the grounds that claimant's increased back, hip and leg symptoms were unrelated to the compensable back injury.

In June 1987 claimant went to work for a new employer as a clerk-typist. In late December 1987 claimant stepped off a curb, which increased her low back pain. On January 13, 1988 Dr. Mulnick, Dr. Scott's partner, reported claimant's condition worsened. On January 15, 1988, she was treated at an emergency room for left low back pain and pain radiating down the right thigh and calf.

On January 18, 1988, she was seen by Dr. Duff, M.D., for back and left leg pain. He ordered a CT scan of her lower spine, which was normal. She received physical therapy from January 25 through January 29, 1988 for pain to the left L4-5 area, radiating into the buttock and down the back of her leg into the sole of her left foot.

Claimant left work on January 14, 1988 and returned to work on January 29, 1988.

Claimant filed an aggravation claim which SAIF received on January 21, 1988. The claim notice was incorrectly dated November 20, 1988 instead of January 20, 1988. SAIF denied the claim on March 28, 1988, contending that claimant's condition was not related to her compensable injury.

SAIF paid claimant interim compensation from January 21, 1988 through January 28, 1988.

Claimant treated with Dr. Scott for adjustments and physical therapy from July 1986 through January 1988.

In March 1988 claimant was examined by Dr. Strasser. She complained inter alia of lower back pain, bilateral leg pain, and numbness in her feet and legs.

Claimant was being treated for endometriosis by Dr. Dyson.

Claimant submitted to SAIF medical billings from Dr. Duff, Mr. Simmons, Drs. Scott and Mulnick, and Providence Hospital. It is not clear from the file when SAIF received these billings. SAIF issued denials on March 31, 1988 and April 1, 1988.

On April 5, 1988 claimant made a request for hearing under claim number D-767344. On April 5, 1988 she made a request for copies of her payment ledger and of her time loss check for the January 1988 aggravation under claim number D-764448.

On April 14, 1988, under claim number D-764448, claimant wrote to SAIF stating that she received discovery documents on April 13, 1988 which included Duff's January 25, 1988 report, Simmons' January 25, 1988 report, Morgan's January 22, 1988 report, and Strasser's March 8, 1988 report. She again requested copies of the payment ledger and time loss check in this letter.

On May 2, 1988, claimant wrote to SAIF stating she had not yet received copies of the payment ledger and time loss check she requested on April 5, 1988. She requested these materials under claim number D-767344 at this time.

FINDINGS OF ULTIMATE FACT

Claimant's current condition, manifested by lower back, hip and leg symptoms, is not different from her condition as of the April 1987 Opinion and Order. Claimant's current condition is not materially related to her compensable back injury in 1985.

SAIF's denial of claimant's aggravation and medical services claims was reasonable.

SAIF's untimely denial of claimant's aggravation claim was unreasonable.

SAIF's denial of medical services was not untimely.

SAIF's failure to disclose medical documents prior to claimant's hearing request was not unreasonable. SAIF's provision of claim-related documents under former OAR 438-07-015(2) was timely.

CONCLUSIONS OF LAW AND OPINION

Aggravation

Claimant filed an aggravation claim in 1986, complaining of lower back, hip and leg symptoms. The Board affirmed an April 1987 Opinion and Order upholding SAIF's denial of that aggravation claim. In its order, the Board concluded that claimant's symptoms were unrelated to her compensable back injury. Thus, in order to prevail in her present aggravation claim, claimant must show that her current condition is different from her condition as of the April 1987

order. If her current condition is not different, claimant would be barred by res judicata from reasserting that claim. Liberty Northwest Ins. Corp. v. Bird, 99 Or App 560 (1989).

Aside from the spread of numbness to the thighs and buttocks, claimant's current subjective symptoms and objective findings are the same as they were in April 1987.

In 1988, as in 1986, treating chiropractor Strasser diagnosed claimant with chronic musculoligamentous strain and functional overlay, based on inconsistencies. In 1986, as in 1988, Strasser found that claimant's subjective sensory complaints fit no known dermal patterns and that there were no objective findings to explain her low back, hip and leg pain and sensory loss. Furthermore, in June 1988, Dr. Mulnick opined that claimant has had continued lower back and leg symptomatology from the time of the original accident up to the January 1988 incident. (Ex. 26b). In light of this record, we conclude that claimant has not carried her burden to show that her current condition is different from her condition as of the April 1987 order. She is thus barred by res judicata from reasserting that claim.

Moreover, even if claimant's condition had changed, we would still conclude that her current condition is not compensable. We rely on the well-reasoned and fully documented opinion of Dr. Strasser, who opined in 1988, as he did in 1986, that claimant's compensable low back injury was not a contributing factor to her present condition.

Penalty and Attorney Fees for Unreasonable Aggravation Denial

Claimant argues that she is entitled to a penalty and attorney fee for SAIF's alleged unreasonable denial of her aggravation claim on causation grounds. At the time of denial, SAIF had received Dr. Strasser's March 4, 1988 report in which he opined that claimant's aggravation claim was unrelated to her compensable low back injury. The other reports in SAIF's possession from the emergency room, Dr. Duff, and the physical therapist do not address causation aside from claimant's own history. The note dated January 13, 1988 from Dr. Mulnick taking claimant off work merely stated that she was under his care for a low back injury that aggravated in December, with no explanation of etiology. (See Ex. 18f). His opinion that her lower back injury of December 6, 1985 materially contributed to her January aggravation was not received by SAIF until June 10, 1988. SAIF denied claimant's aggravation claim based on the medical evidence in its possession on March 28, 1988. On this record its denial was not unreasonable, and no penalty or related attorney fees are due.

Penalties and Attorney Fees for Untimely Processing of Aggravation Claim

An insurer must accept or deny a claim within 60 days or risk the imposition of penalties and attorney fees. ORS 656.262(6) & (10); ORS 656.382(1). The Referee declined to assess a penalty or attorney fees for untimely denial because he was unable to determine the date SAIF received notice of the aggravation claim. However, SAIF conceded at hearing that it received claimant's aggravation claim on January 21, 1988 and issued its denial on March 28, 1988, seven days late. SAIF offered no explanation for its delay. Accordingly, we conclude that SAIF's untimeliness was unreasonable.

However, there are no "amounts due" on which to base a penalty. SAIF received notice of the claim on January 21, 1988, and claimant returned to work January 29, 1988. Claimant is only entitled to interim compensation from the date of notice. Kosanke v. SAIF, 41 Or App 17 (1979). SAIF paid claimant interim compensation from the date of notice through January 28, 1988.

Moreover, as claimant's aggravation claim is not compensable, there is no resistance to the payment of compensation. Claimant is not entitled to any attorney fee for SAIF's unreasonable claims processing. Lloyd L. Cripe, 41 Van Natta 1774 (1989).

Entitlement to Medical Services and Related Penalties and Attorney Fees for Unreasonable Denial

SAIF denied claims for medical services for claimant's current condition. Claimant challenges SAIF's denial, arguing that she has a lifetime right to reasonable and necessary medical services related to her compensable injury under ORS 656.245. She further argues that she is entitled to a penalty and attorney fee for SAIF's alleged unreasonable denial of these medical services.

The Referee stated that because claimant did not raise these issues at a January 1988 hearing she waived consideration of the issues at the June 1988 hearing. We disagree. Claimant correctly noted that the January 1988 hearing related to a different claim for the wrist, and that medical services for claimant's low back, hip and leg condition were not under consideration. Thus, claimant was under no duty to raise the issues at that hearing.

Notwithstanding the Referee's error, we find that SAIF was under no duty to pay medical services, but for a different reason. We have previously concluded that claimant's current condition and need for treatment is not related to her compensable injury. Therefore, SAIF had no obligation to pay for medical services for claimant's current condition. As a result, claimant is not entitled to penalties and attorney fees for unreasonable denial. ORS 656.262(10) and 656.382(1).

Penalties and Attorney Fees for Failure to Timely Process Medical Services Claims

In addition to her contention that SAIF's medical services denial was not reasonable on the merits, claimant also contends that SAIF failed to issue a timely acceptance or denial of medical services billings. An insurer is required to accept or deny medical services claims within 60 days of receipt.

Claimant argues that bills for Dr. Duff, Mr. Simmons, Drs. Scott and Mulnick, and Providence Hospital for services rendered prior to the March 28, 1988 denial were not timely processed. Claimant has the burden to prove that SAIF received the bills more than 60 days prior to denial. None of the bills from these medical providers shows the date it was received by SAIF. On March 31, 1988, SAIF denied payment for Dr. Scott's services between January 6 and January 18, 1988 because the services were for treatment of a denied condition. The denial did not address the status of Scott's bills between November, 1987 and January 6, 1988; nor did the denial letter reveal the date on which SAIF received Scott's bills. Likewise, Providence Hospital had billed SAIF, as per SAIF's denial of payment for the same reason on April 1, 1988. Again, the denial letter did not reveal when these bills were received. Claimant has not otherwise established that SAIF received medical service billings more than 60 days prior to the March 28, 1988 denial. Thus, claimant has not carried her burden of proof to show that SAIF failed to deny medical services in a timely manner. No penalty or attorney fees may be assessed.

Penalties and Attorney Fees for Untimely Discovery

Claimant maintains that because her attorney has been representing her for several years, his January 20, 1988 claim notice was sufficient under OAR 438-

07-015(2) as a demand for discovery documents. The Referee failed to address this issue, and we disagree with claimant's analysis.

An insurer is subject to penalties and related attorney fees for untimely discovery if it fails to provide documents pertaining to claims within 15 days of a Request for Hearing under the Board's rule, former OAR 438-07-015(2). ORS 656.262(10). Disclosure is also required under the Director's rule, former OAR 436-10-030(10), which applies to requests for medical information made prior to the filing of a hearing request. Because the Director's rule prescribes no specific time for responding to a request for medical documents, we have concluded that the rule requires production of documents within a reasonable time. See Lawrence A. Durrette, 42 Van Natta 413 (1990).

Claimant did not file a Request for Hearing until April 5, 1988. Thus, SAIF was under no duty to disclose under the Board rule until that time, although it was under a duty to disclose under the Director's rule. However, claimant's counsel made no specific demand for medical documents in his January 20, 1988 claim notice. (See Ex. 27). Therefore, SAIF's failure to disclose prior to the hearing request was not unreasonable under the Director's rule because the January 1988 claim was not a request for medical documents within the meaning of that rule.

Moreover, disclosure following the April 5, 1988 hearing request did not violate the Board's rule. Claimant did not make a demand for documents under the correct claim number until May 2, 1988. (See Exs. 26a and d). There is nothing in the file to establish when these documents were received. As a result, claimant has not established that SAIF failed to comply with her demand for documents within 15 days. Thus, we find no reason to assess a penalty or attorney fees for untimely disclosure.

ORDER

The Referee's order dated July 6, 1988 is affirmed.

April 30, 1990 Cite as 42 Van Natta 997 (1990)

In the Matter of the Compensation of
KENNETH D. JOHNSON, Claimant
WCB Case Nos. 88-04629 & 88-04464
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Employers Defense Counsel, Defense Attorney
Dennis Ulsted (Saif), Defense Attorney

Reviewed by Board Members Nichols and Brittingham.

The SAIF Corporation requests review of Referee Mirassou's order that: (1) set aside SAIF's denial of claimant's claim for a low back condition; (2) upheld Liberty Northwest Insurance Corporation's denial of claimant's claim for the same condition; and (3) ordered SAIF to pay claimant's attorney an assessed fee. SAIF has raised as issues on review the jurisdiction of the Hearings Division to consider the claim against SAIF; the validity of a disputed claim settlement (DCS) between claimant and Aetna; and, in the alternative, compensability/responsibility of the claim against SAIF. We reverse in part and affirm in part.

FINDINGS OF FACT AND ULTIMATE FACT

We accept the Referee's findings of fact with the following additional comments: We do not accept as findings the second sentence of the first paragraph and the second paragraph of the findings of ultimate fact, nor general findings that would support those ultimate findings.

We make the following additional findings of fact.

Aetna accepted responsibility for the February 1987 surgery and the claim with Aetna was reopened.

Aetna denied claimant's October 1987 aggravation claim on the grounds that claimant's condition was permanently worsened by his work activities with SAIF's and Liberty Northwest's insureds, and that the condition was solely attributable to those activities.

No ".307 order" issued in this case.

We make the following additional findings of ultimate fact.

Requests for hearing on claims with SAIF and Liberty Northwest were pending at the time of the DCS between claimant and Aetna.

Claimant's work activity with SAIF's and Liberty Northwest's insureds did not independently contribute to claimant's condition.

CONCLUSIONS OF LAW AND OPINION

Jurisdiction

Claimant has an accepted claim with Aetna for a 1983 low back injury. An aggravation claim was made with Aetna and denied on November 19, 1987; claimant requested a hearing. Sometime thereafter, Aetna filed a motion to join SAIF and Liberty Northwest. A hearing was set for June 16, 1988. Claimant and Aetna entered into a DCS which was approved by the Hearings Division on June 13, 1988.

SAIF argues that the Hearings Division had no jurisdiction over SAIF or Liberty Northwest once claimant and Aetna had settled their claim. The thrust of SAIF's argument is that claimant had never made a claim against SAIF or Liberty Northwest; and since the two insurers had been brought into this matter through a motion and order of joinder, there was nothing left when the DCS was signed.

In this case when Aetna filed the motion to join and tendered the claim to SAIF and Liberty Northwest, a claim was made. Both SAIF and Liberty Northwest issued denials and claimant requested hearings on those denials. Those requests for hearing, which were matters concerning a claim, were consolidated with the claim against Aetna for the hearing process. We find that the Hearings Division has jurisdiction over these claims.

Disputed Claim Settlement

SAIF contends that the DCS should be held invalid because it is prejudicial to its claim. There was no ".307 order" issued in this matter. The court has held in J.C. Compton Co. v. Degraff, 52 Or App 317 (1981), that once a ".307 order" has been issued, there can be no DCS between claimant and an employer/insurer without the approval of other employers/insurers who are parties to the ".307 order". That case would not apply in this situation, where no ".307 order" issued. In a similar matter in which there was a question of responsibility, and no ".307 order" issued, the court approved a DCS. SAIF v. Matthews, 66 Or App 175 (1983).

If the facts, in this matter, would support a finding on the merits that responsibility remains with Aetna, SAIF v. Matthews, supra, would seem to allow claimant to enter into a DCS and risk losing those benefits related to the aggravation. Of course, claimant's continuing rights to benefits for conditions related to the 1983 accepted low back injury would remain. The prejudice, if there be any because of the DCS, would appear to be against claimant. We find that SAIF has no standing to contest the DCS entered into by Aetna and claimant.

Compensability

The denials issued by Liberty Northwest and SAIF were denials of responsibility only. At hearing those insurers raised the issue of compensability because Aetna was no longer a party at the hearing. The Referee allowed the insurers to orally amend their denials.

The Referee analyzed this as an occupational disease claim. We disagree. This claim began as an aggravation of an accepted claim with Aetna. The DCS between claimant and Aetna does not change the underlying basis of this claim and it should be analyzed as an industrial injury. As long as claimant's condition is materially related to the original injury claim with Aetna, compensability has been established.

Responsibility

There is an accepted low back injury claim with Aetna. Responsibility remains with the Aetna claim unless it can be shown that either Liberty Northwest's or SAIF's insured independently contributed to a worsening of that condition. Hensel Phelps Const. v. Mirich, 81 Or App 290 (1986).

The question of independent contribution is a complex medical question that requires expert medical evidence. The medical evidence in this matter is limited. Claimant's treating surgeon, Dr. Smith, last saw claimant in June 1987, prior to claim closure. He was unable to give an opinion on whether the claimant's back condition had worsened subsequent to June 1987. Dr. Hebert, D.C., filed a Form 828 on November 4, 1987 for a "flare-up" of claimant's industrial injury site. He gave no opinion on worsening.

The primary medical evidence in this matter is from Dr. Bert, who only saw claimant once. He did not have claimant's previous medical reports to review. In his February 1988 deposition, he admitted he had no way to compare his exam with previous exams, and as a result he could not say whether there had been any change in claimant's condition. In a report issued in May 1988, Dr. Bert did indicate that it was probable that the driving and motor vehicle accident which claimant had while he was working for SAIF's insured aggravated his back condition. There is no indication in that report what the doctor means by an aggravation; nor is there any reason given for his change of position regarding worsening from what he stated in his deposition.

We do not find the later report from Dr. Bert to be persuasive considering the testimony he gave in his deposition. As a consequence, there is no persuasive medical evidence that claimant's work activity at either Liberty Northwest's or SAIF's insured independently contributed to a worsening of claimant's condition. Responsibility for this aggravation claim remains with Aetna; however, since Aetna and the claimant entered into a DCS regarding this aggravation claim, claimant is not entitled to receive those benefits which would normally flow from this aggravation claim.

ORDER

The Referee's order dated October 24, 1988 is reversed in part and affirmed in part. That portion of the order that set aside the SAIF Corporation's denial of March 15, 1988 is reversed and the denial is reinstated and upheld. That portion that awarded claimant's attorney an assessed fee payable by SAIF is likewise reversed. The remainder of the order is affirmed.

In the Matter of the Compensation of
KENNETH KJELLAND, Claimant
WCB Case No. 88-14691
ORDER ON REVIEW
Jolles, et al., Claimant Attorneys
Arthur Stevens (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

The SAIF Corporation requests review of Referee Peterson's order that increased claimant's unscheduled permanent disability award for a low back injury from 3 percent (9.6 degrees), as awarded by Determination Order, to 10 percent (32 degrees). On review, the issue is extent of unscheduled permanent disability. We modify.

FINDINGS OF FACT

The Board adopts the Referee's Findings of Fact with the following supplementation.

Claimant became medically stationary on March 8, 1988. On June 17, 1988, an evaluation was conducted by Dr. Duncan, D.C. Range of motion findings from Dr. Duncan's evaluation revealed that claimant's lumbar flexion is limited to 65 degrees, extension to 35 degrees, right and left side bending to 35 degrees each way and right and left horizontal rotation to 45 degrees each way. Examination of the cervical spine showed flexion to 65 degrees, right and left lateral bending to 40 degrees each way and right and left horizontal rotation to 80 degrees each way. The maneuvers to establish these findings produced no reports of pain or difficulty.

CONCLUSIONS OF LAW AND OPINION

The Referee found that under the standards pursuant to OAR 436-35-280, claimant has a permanent unscheduled disability equal to 7 percent. Specifically, the Referee applied former OAR 436-35-000 et seq, which was effective at the time of claimant's August 10, 1988 Determination Order. See OAR 438-10-005; 438-10-010. These are the rules which we apply as well. ORS 656.295(5); OAR 438-10-010. In addition, the Referee awarded claimant another 3 percent permanent disability for loss of earning capacity because claimant had previously earned $135 per day but now earns $104 per day.

If a claimant became medically stationary after January 1, 1988, and his claim was closed on or after July 1, 1988, a subsequent determination by a referee or the Board of the claimant's permanent partial disability must be made pursuant to ORS 656.283(7) and 656.295(5), respectively. OAR 438-10-005 and Michelle Griffith, 40 Van Natta 2086 (1988).

For purposes of determining injury-related permanent partial disability, ORS 656.283(7) and 656.295(5) require application of the standards for the evaluation of disabilities adopted by the director pursuant to ORS 656.726(3)(f)(A). Those "standards" in effect on the date of the Determination Order from which the hearing was requested control the evaluation of permanent partial disability. OAR 438-10-010.

The hearing and Board review of the issue of permanent partial disability continues to be de novo on the hearing record. The underlying facts to which the standards are applied need only be established by a preponderance of the evidence. However, either party may establish that the record, as a whole, constitutes clear and convincing evidence that the degree of permanent partial disability suffered by the claimant is more or less than the entitlement indicated by the standards. ORS 656.283(7) and 656.295(5).

In this case, the standards adopted effective July 1, 1988, former OAR 436-35-001 et seq, apply to the rating of claimant's permanent partial disability. Former OAR 436-35-270 through 436-35-440 apply to the rating of unscheduled permanent partial disabilities. Former OAR 436-35-270(1).

The determination of permanent partial disability under the standards is made by determining the appropriate values assigned by the standards to the claimant's age, education, adaptability and impairment. Once established, the values for age and education are added and the sum is multiplied by the appropriate value for adaptability. The product of those two figures is then added to the appropriate value for impairment to yield the percentage of unscheduled permanent partial disability. Former OAR 436-35-280.

Age.

The appropriate value for claimant's age of 31 years is 0. Former OAR 436-35-290.

Formal education.

The appropriate value for claimant's 12 years of formal education is 0. Former OAR 436-35-300(3).

Skills.

Former OAR 436-35-300(4) adopts by reference the "SVP" (specific vocational preparation time) values assigned to various occupations by the Dictionary of Occupational Titles (DOT), published by the U.S. Department of Labor. The highest SVP level demonstrated by a claimant during the ten years prior to the date of injury is used to determine a value for skills. Former OAR 436-35-300(4). Claimant's highest SVP during the ten years prior to the date of injury was 3 as a timber faller (DOT #454.684-014). Therefore, the appropriate value for skills is 3. Former OAR 436-35-300(4).

Training.

Claimant has no documented training. Therefore, the appropriate value for training is 1. Former OAR 436-35-300(5). Claimant's total education value is 4, the formal education value plus the skills value plus the value for training. Former OAR 436-35-300(6).

Adaptability.

An adaptability value for a claimant who is unable to return to his or her usual and customary work [See former OAR 436-35-270(3)(a)] but who has returned to modified work is determined from a matrix of values at former OAR 436-35-310(3)(a). That matrix compares the physical capacity of the claimant's usual and customary work with the physical capacity required by the modified work. This is true even though claimant may have the physical capacity to do heavier work than is required by the modified employment. Physical capacities are not defined by the standards generally. We utilize those definitions contained in former OAR 436-35-310(4)(a)-(d).

In this case, claimant's usual and customary work required the physical capacity to do heavy work. Claimant's modified work requires medium to heavy physical capacity. Therefore, the appropriate adaptability value is 1.5. Former OAR 436-35-310(3)(a).

Impairment.

The Referee awarded claimant 7 percent for his loss of range of motion in his cervical region and his spine. We disagree. Claimant suffers no loss of

motion in the cervical region. Former OAR 436-35-360. For reduced thoracolumbar flexion (from 90 degrees to 65 degrees) claimant is entitled to an impairment value of 2.5 percent. Former OAR 436-35-360(6). Claimant is entitled to no other impairment values under the "standards."

Having determined each value necessary to compute claimant's permanent disability under the standards, we proceed to that calculation. When claimant's age value (0) is added to his education value (4), the sum is 4. When that value is multiplied by claimant's adaptability value (1.5), the product is 6. When that value is added to claimant's impairment value (2.5), the result is 8.5 percent unscheduled permanent partial disability. Former OAR 436-35-280(7). That disability figure is rounded to the next higher percentage. Former OAR 436-35-280(7). Claimant's permanent disability under the standards is, therefore, 9 percent.

The Referee awarded claimant 3 percent permanent partial disability, based upon claimant's loss of earning capacity. The Referee concluded that because claimant had earned $135 per day before his injury, as compared to $104 per day after his injury, claimant was entitled to an additional 3 percent permanent disability. We disagree. The Referee did not make a finding that claimant's disability is more or less than the 9 percent awarded under the standards. On review, we are unable to conclude that, upon this record, claimant has established by clear and convincing evidence that his permanent disability exceeds an award of 9 percent.

ORDER

The Referee's order, dated November 28, 1988, is modified. Claimant is awarded 6 percent (19.2 degrees) unscheduled permanent partial disability in addition to the 3 percent (9.6 degrees) awarded by Determination Order, for a total award of 9 percent (28.8 degrees).

April 30, 1990 Cite as 42 Van Natta 1002 (1990)

In the Matter of the Compensation of
SHARON MADRIGAL (ESPINOZA), Claimant
WCB Case No. 88-04880
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
Rankin, et al., Defense Attorneys

Reviewed by Board Members Howell and Speer.

The insurer requests review of those portions of Referee Peterson's order that: (1) set aside its partial denial of claimant's fibrositis condition; and (2) set aside its partial denial of claimant's psychological condition. On review, the issue is compensability of the two conditions.

We adopt the Referee's findings and conclusions, with the following supplementation.

The insurer conceded that it had accepted claimant's shoulder symptoms in both of its partial denials. The March 10, 1988 denial of claimant's psychological condition described claimant's accepted conditions as "neck, shoulder and arm pain and left carpal tunnel syndrome." (Ex. 108-1). The June 15, 1988 denial of claimant's fibrositis condition acknowledged that "the original claim for injury was accepted for left carpal tunnel syndrome, arm and shoulder pain, and neck pain due to overuse syndrome." (Ex. 120-1). Inasmuch as we are persuaded that claimant's diagnosed fibrositis condition is merely another term for the accepted left arm, shoulder and neck pain, we agree with the Referee that

the insurer is prohibited from denying responsibility for those complaints. In any event, we further conclude that claimant's April 1983 compensable injury is a material contributing cause of her fibrositis and psychological conditions.

ORDER

The Referee's order dated August 2, 1988 is affirmed. For services on review, claimant's attorney is awarded a reasonable attorney fee of $1,000, to be paid by the insurer. A client-paid fee, payable from the insurer to its counsel, is approved, not to exceed $1,776.50.

April 30, 1990 Cite as 42 Van Natta 1003 (1990)

In the Matter of the Compensation of
VIRGIL E. MOON, Claimant
WCB Case No. 88-14914
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Cummins, et al., Defense Attorneys

Reviewed by Board Members Myers, Cushing and Gerner.

The self-insured employer requests review of Referee Higashi's order which assessed penalties and attorney fees for the employer's delay in seeking claim closure of claimant's accepted claim. On review, the issues are penalties and attorney fees. We modify.

FINDINGS OF FACT

Claimant has an accepted knee injury claim that includes the neck, low back, right knee, left knee and left wrist. On May 18, 1988, claimant's attending physician, Dr. Holbert, opined in a letter to the employer that claimant's left wrist condition could proceed to closure. He did not mention the medical status of the other conditions. The employer received Holbert's report on May 28, 1988.

Claimant's attorney wrote a letter to the employer on June 24, 1988 inquiring about the closure of the claim. On July 20, 1988, the employer's claims examiner informed counsel that because of the unknown status of the other of claimant's conditions, that an independent medical examination was scheduled for August 31, 1988. On September 9, 1988, the employer received a copy of the examination report declaring all of claimant's conditions medically stationary. On October 31, 1988, the employer sent a letter to Holbert to see if he concurred with the independent medical examination's findings and recommendations.

A hearing occurred on November 22, 1988. By that time no reply had been received from Holbert nor had the employer submitted the claim for closure to the Evaluation Section. Claimant's claim remained open and the employer continued to pay temporary disability.

CONCLUSIONS OF LAW AND OPINION

The Referee found that the employer acted unreasonably when it failed to submit the claim for closure after receipt of Holbert's May 18, 1988 report and the attorney's June 24, 1988 letter. We disagree.

The employer is charged by the Director of the Department of Insurance and Finance to promptly submit claims for evaluation and closure:

> "(3) Unless the worker is actively engaged in training, the insurer shall request determination for those claims it elects not to close:

> (a) Within 14 calendar days after the worker becomes medically stationary and sufficient medical information is available to determine the extent of disability." OAR 436-30-030. (Emphasis added.)

Because more than one condition was in accepted status, Holbert's report declaring only one condition medically stationary was not "sufficient medical information" to determine the extent of claimant's disability. The employer properly scheduled an independent medical examination to determine the medically stationary status of the remaining conditions. Its actions were not unreasonable.

Claimant contends that the employer unreasonably delayed closure when it nonetheless failed to submit the claim for closure after it received its August 31, 1988 independent medical examination report. We agree. At that time the employer had all the necessary medical evidence for a determination of the extent of claimant's disability. The employer did not seek closure within 14 days as is required under the administrative rule. Therefore, the employer acted unreasonably unless it presents an excuse for its conduct. See Lester v. Weyerhaeuser, 70 Or App 307 (1984) rev den 298 Or 427 (1984).

The insurer presented no excuse for its conduct. While it is true that the insurer did request a concurrence from the attending doctor after it received the independent medical exam report, there is no evidence that the concurrence was necessary to present "sufficient medical evidence" to the Department. Nor does the employer explain the near two month delay in sending the concurrence letter in the first place. Since there is no indication that the employer has ever submitted this claim for closure and since the employer has presented no excuse for that failure, we conclude the employer acted unreasonably.

The employer argues that claimant is not entitled to a penalty because there are no amounts "then due." See ORS 656.262(12). We have already concluded that where an employer delays seeking closure but continues to pay temporary disability, that any unpaid temporary disability and any permanent disability awarded by a later Determination Order constitutes amounts "then due" for the assessment of a penalty. Brenda Hinkle, 40 Van Natta 1655, 1661 (1988). We adhere to that holding.

The employer also argues that claimant is not entitled to an attorney fee because there was no resistance to the payment of compensation. See ORS 656.382(1). We find that there is an unreasonable resistance to the payment of compensation if there are any amounts to be paid from the Determination Order when it issues. These payments were necessarily delayed by the employer's delay in requesting closure.

We note that claimant's attorney has submitted a statement of services for effort expended defending against the employer's request for review. Because the Referee's award of penalties and fees does not involve "compensation", claimant's attorney is not entitled to an assessed fee for services on Board review. ORS 656.382(2); McDonald v. Safeway, 87 Or App 86 (1987); Saxton v. SAIF, 80 Or App 631, rev den 302 Or 159 (1986); Bahler v. Mail-Well Envelope Co., 60 Or App 90 (1982).

ORDER

The Referee's order dated January 11, 1989 is modified. That portion of the Referee's order which awarded a penalty and an assessed attorney fee is modified to make the award contingent upon the award of any unpaid temporary disability and/or upon the award of permanent disability from the Notice of Closure or

Determination Order. The remainder of the order is affirmed. The Board approves a client-paid fee, not to exceed $1,540.50, payable from the self-insured employer to its counsel.

Board Member Gerner, concurring in part and dissenting in part.

The majority finds that there was an unreasonable delay from the date the insurer received the Independent Medical Examination report until the insurer's request for closure. Based upon OAR 436-30-030, I agree. The majority then assesses a penalty based upon the amounts to be awarded on a not-yet-issued Determination Order. As authority for this holding the majority cites ORS 656.262(10) and Brenda Hinkle, 40 Van Natta 1655, 1661 (1988). The notion that amounts to be awarded by a not-yet-issued Determination Order are "amounts then due" is erroneous. I, therefore, respectfully dissent.

Plainly, ORS 656.262(10) allows a penalty to be assessed only on "amounts then due." To support its penalty award, the majority adheres to the holding in Brenda Hinkle that finds (prospective) permanent and temporary disability awarded by not-yet-issued (prospective) Determination Orders are "amounts then due" under ORS 656.262(10). The genesis of this holding in Hinkle deserves some consideration.

Hinkle did not make this statement of the law for the first time. In its holding it "see" cited to Chester R. Rhodes, 38 Van Natta 1396 (1986), where the Board held that "should claimant be determined to have permanent partial disability after his claim has been processed . . . a penalty may be calculated therefrom." Id. at 1398 (emphasis added). Rhodes also "see" cited to another case, Harold A. Lester, 37 Van Natta 745 (1985). Harold Lester, in turn, was the case on remand to the Board from the Court of Appeals' case Lester v. Weyerhaeuser, 70 Or App 307, rev den 298 Or 427 (1984). It is this case, and its predecessor, Georgia-Pacific v. Awmiller, 64 Or App 56 (1983), that anchors the Board's long chain of "see" cites. These cases, however, are distinguishable.

In Lester the court and the Board found an unreasonable delay in processing a claim to closure. They also assessed a penalty on the amounts awarded on the Determination Order issued in that claim. However, unlike the present case, in both Lester and Awmiller a penalty was assessed because the Determination Orders had already been issued by the time of the hearing and permanent disability had been awarded. Awmiller, 64 Or App at 59; Lester, 70 Or App at 309. In neither case did the court assess penalties on prospective amounts, instead the amounts the penalties were assessed upon were amounts then due and in existence.

To the extent that Hinkle and Rhodes rely upon Lester and Awmiller as the authority for their holdings, they are wrong. The courts have gone to great lengths to state that the phrase "amounts then due" means exactly what it says, that the sums upon which the penalty is based have to be in existence at the time the penalty is assessed. Most recently, the Court of Appeals in Weyerhaeuser Company v. Knapp, 100 Or App 615 (1990), citing Wacker Siltronic Corporation v. Satcher, 91 Or App 654 (1988), stated that "amounts then due" in unreasonable denial cases are only those sums due when the denial is set aside. In short, the sums must be due no later than the time of the hearing on that issue. There is no meaningful distinction between Knapp and the circumstances of this case. The amounts due upon which to base a penalty must be amounts that are due by the date of the hearing and not upon some uncertain amounts that may be due at some prospective time. The majority holding in this case, as well as the holdings in Hinkle and Rhodes, violates this principle.

It may well be argued that there will then be no way to force a "rogue" carrier to ever close a claim. That is not true. The issue of not closing a

claim (apart from penalties for unreasonable resistance and delay) is a matter concerning a claim upon which a hearing may be held and relief granted. As for the fact that there may be no penalty assessable at that time because there may be no amounts then due if the Determination Order had not yet issued, it appears that the legislature has recognized this problem and dealt with it by enacting ORS 656.268(3)(f). This new statute, effective January 1, 1988, provides for a minimum penalty of $1,000, even if there are no "amounts then due."

In this case, it appears that the carrier may have unreasonably delayed closure, but there are no amounts then due upon which to assess a penalty. The Board therefore, is without authority to assess a penalty and I dissent from that portion of this case.

In the Matter of the Compensation of
MICHAEL C. MOORE, Claimant
WCB Case No. 88-15740
ORDER ON REVIEW
Brian R. Whitehead, Claimant Attorney
David O. Horne, Defense Attorney

Reviewed by Board Members Myers and Gerner.

The insurer requests review of Referee Seymour's order which set aside its denial of claimant's occupational disease claim for a low back condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

Claimant became employed with the employer, a temporary employment service, on May 4, 1988. Claimant's jobs included maintenance, cannery and fiberglass work.

On May 23, 1988, claimant sought medical treatment from Dr. Nickila, chiropractor, complaining of a stiff neck. That same day, claimant also noted low back pain. Nickila released claimant from work from May 23, 1988 through May 27, 1988. Claimant returned to work on May 31, 1988.

On June 18, 1988, claimant began working at a cannery sorting fruit. That same day, claimant returned to Nickila complaining of low back pain. Nickila diagnosed lumbar strain/sprain and released claimant from work beginning on June 22, 1988. Claimant did not return to work.

On June 27, 1988, claimant filed an occupational disease claim for a slipped disc, indicating that his injury occurred after standing stationary for an eight hour shift. On the claim form, claimant denied prior injuries to his back. (Ex. 5).

On August 16, 1988, the insurer denied claimant's claim for a low back strain/sprain. (Ex. 9-1). Claimant requested a hearing.

Claimant's work activities while employed with the temporary service were not a material cause of his current low back condition.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that "claimant's work activities while employed for Oregon Temporary Services caused the need for medical services to the claimant's low back." We disagree.

At hearing, claimant conceded that his claim was for an occupational disease. (Tr. 4). Therefore, we proceed under an occupational disease theory.

Because claimant's last exposure to working conditions, which he alleges caused his low back problem, was in June 1988, the occupational disease law, which became effective January 1, 1988, is applicable. To be compensable under the new law, claimant's occupational disease must fall within one of the subsections of ORS 656.802(1). Here, claimant contends that his work, since May 4, 1988, with the employer caused his low back problem. Further, claimant reported that he was doing heavy lifting. Therefore, we conclude that claimant's claim is for a condition resulting from a series of traumatic events or occurrences pursuant to ORS 656.802(1)(c).

Therefore, to establish that his low back condition arose out of and in the course of employment, claimant must prove that his work exposure was a material cause of his need for medical services or physical disability or death. ORS 656.802(1)(c); Donna E. Aschbacher, 41 Van Natta 1242 (1989); Carole J. Damm, 42 Van Natta 225 (1990).

After our de novo review of the record, medical and otherwise, we conclude that claimant has failed to meet his burden of proving that his need for medical treatment for his current low back condition arose out of and in the course of his employment with the employer. First, we note that even though claimant contends that his claim is for an occupational disease, which is gradual in onset, claimant, on his claim form, indicated that his low back condition began "while sorting product," on June 18, 1988, his last day of work. (Ex. 3).

Second, claimant contends that he did heavy lifting during May 4, 1988 and June 18, 1988 which caused his low back condition. However, after our review, we find no evidence to establish that any of claimant's jobs, while working for the temporary service, involved heavy lifting. Claimant worked for the employer approximately six weeks. During those six weeks, he worked approximately 3/4 of the available work days (Tr. 22). His first job was working with fiberglass. That job lasted only 2 days. He was then off a day or two. He was then sent to a second job working for Kerr Concentrate. That job lasted about 2 weeks and required claimant to dump 50-gallon barrels of fruit into a stir bin and cook them. He also did cleanup work. Claimant did not indicate that heavy lifting was required. Rather, he specifically noted that the job entailed pushing the 50-gallon barrels, rather than lifting. (Tr. 5). Claimant's third job lasted about one week. (Tr. 18-19). We find no evidence of lifting requirements during this third job.

On June 18, 1988, claimant began working at the fruit cannery sorting fruit. He worked approximately four hours, at which time his low back pain began. (Ex. 3). Again, no lifting was required. Claimant left work that day and did not return.

Claimant also testified that he jogged regularly and lifted weights daily. Under the circumstances, we conclude that the issue of whether claimant's work activities were a material contributing cause of his need for medical services for his low back condition is a complex medical question, requiring expert medical opinion. Uris v. Compensation Department, 247 Or 420, 424-26 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985).

The only medical evidence in the record is that of claimant's treating chiropractor, Dr. Nickila, and that of the Medical Consultants Northwest.

We generally assign greater weight to the opinion of claimant's treating physician, unless there are persuasive reasons to do otherwise. Weiland v. SAIF, 64 Or App 810 (1983). Here, we do not find the opinion of Nickila to be persuasive. In October 1988, Nickila opined that claimant's work with the employer "was a major contributing cause to the development of his conditions and

a worsening of the underlying conditions. I feel that the work [claimant] was doing, which was lifting, added to this underlying condition and these spinal symptoms were demonstrated by positive disc findings upon examination." (Ex. 14).

First, we note that there is no evidence to establish whether Nickila was aware of claimant's non-work related activities which could have caused the onset of his current back condition, i.e., jogging and daily weight lifting. Second, and more important, Nickila's opinion was based on the assumption that claimant's work entailed lifting. However, as we have already found, claimant's job requirements did not include much lifting. Consequently, we do not find the opinion of Nickila to be persuasive as it is based on an inaccurate history. Weiland, supra.

The only remaining medical evidence in the record is the opinion rendered by the Consultants. Drs. Kiest, orthopedist, and Gatterman, chiropractor, performed an evaluation of claimant in November 1988. During that examination, claimant reported that on "June 18, 1988, he started working for Oregon Temporary Services. . . . He was standing upright. He was not lifting. He worked less than one full day. He states that his back did not bother him immediately but started bothering him in a 'couple of days.'" (Ex. 15-1). The Consultants concluded that claimant's employment with the temporary service was not the cause of his current low back condition. They noted that, "he was working less than one day. The work was not strenuous. He was not doing specific bending, twisting, or lifting. . . . [Claimant] appears to have a degenerative disc condition involving his lower lumbar spine." (Ex. 15-4).

We find the more well-reasoned opinion of Drs. Keist and Gatterman to be persuasive. Miller v. Granite Construction Co., 28 Or App 473, 476 (1977). As a result, we conclude that claimant has failed to meet his burden of proving that his work exposure during May 4, 1988 and June 18, 1988 was a material cause of his need for medical treatment for his current low back condition.

ORDER

The Referee's order dated January 23, 1989, is reversed. The insurer's August 16, 1988 denial is reinstated and upheld. The Referee's $1,400 attorney fee award is reversed.

April 30, 1990 Cite as 42 Van Natta 1008 (1990)

In the Matter of the Compensation of
CAROL A. RAY, Claimant
WCB Case No. 88-17871
ORDER ON REVIEW
W. Daniel Bates, Jr., Claimant Attorney
Employers Defense Counsel, Defense Attorney

Reviewed by Board Members Crider and Nichols.

Claimant requests, and the insurer cross-requests review of Referee Myers' order that increased a Determination Order award of 5 percent (7.5 degrees) scheduled permanent disability for a bilateral loss of use or function of her forearms to 15 percent (22.5 degrees). On review, the issue is extent of scheduled permanent disability. We affirm.

FINDINGS OF FACT

Claimant has an accepted occupational disease claim to both forearms for carpal tunnel syndrome. Claimant has had carpal tunnel releases performed on each forearm.

Claimant has full active ranges of motion. Her neurological examination is normal. Her pinch and grip strength is stable. She is unable to regain extreme durability of her hands; consequently, she is required to avoid heavy repetitive use of her hands.

Claimant is restricted to lifting or carrying no more than twenty pounds.

A Determination Order issued September 9, 1988, awarding claimant 5 percent scheduled disability for loss of use or function to each forearm.

Claimant has been released for modified work. She returned to modified work in November 1988. She gradually increased the number of hours she worked from three to four hours per day up to six or seven hours per day. By January 1989 she was working six to seven hours per day. Claimant began to experience increased pain in her wrists, and began to treat again with Dr. Davis, orthopedist. He diagnosed bilateral hand sprain due to overuse.

The pain claimant experienced in her wrist, prior to her development of an overuse syndrome, resulted in a loss of use or function.

FINDINGS OF ULTIMATE FACT

Claimant has suffered a 15 percent loss of use or function in each forearm due to her compensable condition.

CONCLUSIONS OF LAW AND OPINION

The Referee increased a Determination Order award of 5 percent scheduled permanent disability to 15 percent scheduled disability for loss of use or function of each forearm. The Referee did not consider claimant's recent hand strain in rating the extent of her scheduled disability. See ORS 656.214(2). We also do not consider claimant's recent unrelated hand strain when rating the extent of her scheduled permanent disability. However, we do not agree with the Referee's application of the "standards." Therefore, while we affirm the Referee's award of 15 percent (22.5 degrees) scheduled permanent disability, we reach our conclusion on a different basis.

If a claimant became medically stationary after January 1, 1988 and his or her claim was closed on or after July 1, 1988, a subsequent determination by a referee or the Board of the claimant's permanent partial disability must be made pursuant to ORS 656.283(7) and 656.295(5), respectively. OAR 438-10-005 and Michelle Griffith, 40 Van Natta 2086 (1988).

The hearing and Board review of the issue of permanent partial disability continues to be de novo on the hearing record. The underlying facts to which the "standards" are applied need only be established by a preponderance of the evidence. However, either party may establish that the record, as a whole, constitutes clear and convincing evidence that the degree of permanent partial disability suffered by the claimant is more or less than the entitlement indicated by the "standards". ORS 656.283(7) and 656.295(5).

In this case, the "standards" adopted effective July 1, 1988, (former OAR 436-35-001 et seq), as amended by temporary rules effective August 19, 1988,

apply to the rating of claimant's permanent partial disability. Former OAR 436-35-010 through 436-35-260 apply to the rating of scheduled permanent partial disabilities. Former OAR 436-35-010(1).

The Referee concluded that claimant was entitled to no value, pursuant to the "standards", for loss range of motion. We agree. Claimant's active degrees of motion, as measured by her treating physician, Dr. Davis are: 70 degrees dorsiflexion; 80 degrees palmar flexion; 30 degrees radial deviation and ulnar deviation; and 80 degrees pronation and supination. Therefore, pursuant to the "standards" claimant is entitled to no impairment value for loss range of motion. See former OAR 438-35-080(1)-(9).

The Referee found that claimant was entitled to a 5 percent value for each forearm based upon her bilateral carpal tunnel releases. We disagree.

Former OAR 436-35-110(4)(f) provides for a 5 percent value for a carpal bone resection. In this case there is no evidence that a carpal bone resection was performed. Rather, carpal tunnel releases were performed; no value for carpal tunnel releases is provided for by the "standards".

The Referee found that claimant was not entitled to a value for pain as he did not believe claimant's pain resulted in a "measurable impairment." We disagree; the applicable standards do not define loss of use or function as a "measurable impairment". Former OAR 436-35-010(2)(a) provides that pain can result in loss of use or function. When it does, it is rated based on the loss of use or function which results and no additional value is allowed for pain alone. The Board in Daniel M. Alire, 41 Van Natta 752 (1989), held that, inasmuch as the standards do not provide for a value range for impairment attributable to disabling pain, the Board on de novo review can consider the evidence and award claimant a value that adequately compensates her for loss of use or function attributable to disabling pain.

In this case, the record establishes that claimant has a loss of use or function attributable to disabling pain. Dr. Davis, claimant's treating physician, found that any attempts at heavy, continuous work exacerbated claimant's pain and stiffness in her hands. Under these circumstances, claimant is entitled to a value, based upon her disabling pain which has resulted in a loss of use or function, of 5 percent for each forearm.

Having determined each value necessary to compute claimant's permanent disability under the "standards", we proceed to that calculation. We find, that pursuant to the "standards" claimant is entitled to a value of 5 percent for loss of use or function, to each forearm, attributable to disabling pain.

Having calculated claimant's permanent disability pursuant to the "standards", we then review the record to determine if claimant has proven, by clear and convincing evidence, that her disability exceeds that awarded under the "standards."

The Referee found that claimant had proven by clear and convincing evidence that her disability was greater than that awarded by the "standards." Therefore, the Referee increased claimant's disability award to 15 percent (22.5 degrees) scheduled permanent disability for a bilateral loss of use to her forearms. We agree.

ORS 656.283(7) provides:

> ". . . The referee shall apply to the hearing of the claim such standards for evaluation of disability as may be adopted by the director pursuant to

> ORS 656.726. Nothing 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."

Dr. Davis' findings are uncontradicted. He found that claimant never recovered strength and endurance in her hands. He found that claimant was unable to return to her previous employment which required heavy repetitious use of her hands. Dr. Davis concluded that claimant's inability to regain extreme durability in her hands permanently restricted her to moderate work. In addition, claimant's ability to lift and carry repetitively has been limited. These limitations are due to both loss of strength and endurance and to pain.

Viewed as a whole, we find the record to constitute clear and convincing evidence that claimant's loss of forearm use exceeds 5 percent, the value assigned by application of the "standards." We find the evidence clear and convincing -- that is highly persuasive, free from confusion, distinct and fully intelligible -- that claimant suffers a 15 percent loss of use or function of each forearm due to her compensable occupational disease claim. ORS 656.295(5). See Riley Hill General Contractor Inc. v. Tandy Corp., 303 Or 390, 407 (1987).

Claimant's counsel is statutorily entitled to a reasonable, insurer-paid attorney fee for services rendered on Board review concerning the insurer's cross-request. Such a fee is defined as an "assessed fee." See OAR 438-15-005(2). However, we cannot award 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 cannot presently be awarded. See OAR 438-15-010(5).

ORDER

The Referee's order dated January 24, 1989 is affirmed. A client-paid fee, payable from the insurer to its counsel, is approved, not to exceed $567.

April 30, 1990 Cite as 42 Van Natta 1011 (1990)

In the Matter of the Compensation of
KIRK A. SHIRA, Claimant
WCB Case No. 88-18208
ORDER ON REVIEW
Wilbur C. Smith, Claimant Attorney
Yturri, Rose, et al., Defense Attorneys

Reviewed by Board Members Myers and Cushing.

The insurer requests review of Referee Fink's order which awarded claimant 25 percent (33.75 degrees) scheduled permanent disability to the left foot in lieu of a Determination Order award of 14 percent (18.9 degrees) scheduled permanent disability to the left foot. On review, the sole issue is extent of scheduled permanent disability. We reverse.

FINDINGS OF FACT

Claimant compensably injured his left ankle on July 14, 1987. He fell from a debarker machine and fractured his tibia and his fibula. As a result of

the injury, claimant has the following ranges of motion: 5 degrees of extension; 30 degrees of flexion; 20 degrees of inversion; and 10 degrees of eversion. He has good neurovascular function and good strength pushing off. He can walk on his toes. He has good strength on manual testing.

Claimant wears a protective brace. He has difficulty running, jumping and maneuvering quickly to the left side. However, with the brace on, he is able to do his regular work and is able to play basketball.

Claimant became medically stationary on July 14, 1988. A Determination Order of August 2, 1988 awarded him 14 percent (18.9 degrees) scheduled disability to the left foot.

CONCLUSIONS OF LAW AND OPINION

Claimant's disability must first be rated using the standards in effect at the time of the Determination Order. The rule applicable to rating claimant's foot is former OAR 436-35-190. Claimant's 5 degrees of retained extension (dorsiflexion) entitles him to 6 percent. Claimant's 30 degrees of retained flexion entitles him to 4 percent. Claimant's 20 degrees of retained inversion entitles him to 2 percent. Claimant's 10 degrees of retained eversion entitles him to 2 percent. His total impairment due to loss of range of motion is 14 percent.

The Referee concluded that the fact that claimant wears a brace provides clear and convincing evidence that claimant's disability is greater than the 14 percent to which claimant is entitled under the standards. We disagree. The mere fact that claimant wears a brace is not sufficient to convince us that there is a high probability that claimant is more disabled than 14 percent. According to claimant's own testimony, the brace actually allows him to function better than he can without it.

ORDER

The Referee's order dated January 26, 1989 is reversed. The Determination award of 14 percent (18.9 degrees) for scheduled permanent disability to the left foot is reinstated and affirmed. The Board approves a client-paid fee, not to exceed $834, to be paid by the insurer to its attorney.

April 30, 1990 Cite as 42 Van Natta 1012 (1990)

In the Matter of the Compensation of
DONNA M. STEECE, Claimant
WCB Case No. 88-18096
ORDER ON REVIEW
Black, et al., Claimant Attorneys
Kate Donnelly (Saif), Defense Attorney

Reviewed by Board Members Crider and Nichols.

Claimant requests review of Referee Brazeau's order that affirmed a Determination Order that awarded 12 percent (18 degrees) scheduled permanent disability for injury to the left leg. On review, the issue is extent of scheduled permanent partial disability.

We affirm and adopt the Referee's order with the following comment.

On review of a referee's order applying the disability rating standards, we normally address each relevant component of the process for rating under the

standards and compute the worker's entitlement under the standards. Then, if the issue is raised by either party, we consider whether clear and convincing evidence establishes that claimant is entitled to more or less disability than indicated by the rating process established by the standards. Michelle Griffith, 40 Van Natta 2086 (1988).

In this case, however, on review, neither party challenges the Referee's rating under the standards. Therefore, although we are not persuaded that the Referee correctly applied the standards, we allow his rating under the standards to stand.

Claimant's sole contention on review is this: Claimant is more disabled than indicated by the standards because, in addition to the compensable injury to the leg, claimant also has a preexisting right arm disability (an amputation). She contends that she must use a cane because of the left leg injury. As she has no right arm, she must wield the cane with her sole remaining arm. The combination of the two disabilities means that she cannot lift or carry while standing. Thus, the combination of the disabilities limits her ability to engage in such activities as housecleaning and meal preparation. Therefore, she argues that she is entitled to a greater scheduled disability award.

We disagree. Scheduled permanent disability is defined as "loss of use or function of the injured member due to the industrial injury." ORS 656.214(2). The injured member in this case is the left leg. Therefore, our award must compensate her solely for the loss of use of the leg; it may not compensate her for the loss of use of the arm. It also may not compensate her for what is undoubtedly a very substantial loss of earning capacity due to the combination of her compensable leg injury and her preexisting disability. For these reasons, claimant's argument is not persuasive. She has failed to prove that she has suffered a greater loss of function of the left leg than indicated by the standards.

ORDER

The Referee's order dated January 25, 1989, is affirmed.

April 30, 1990 Cite as 42 Van Natta 1013 (1990)

In the Matter of the Compensation of
MARTY WINN, Claimant
WCB Case No. 88-05138
ORDER ON REVIEW
Woodward & McLaughlin, Claimant Attorneys
Mitchell, Lang & Smith, Defense Attorneys

Reviewed by Board Members Howell and Speer.

Claimant requests review of Referee Myers' order that: (1) upheld the self-insured employer's denial of his back condition on alternative theories of accidental injury, aggravation, and occupational disease; (2) declined to assess a penalty for an alleged unreasonable delay; and (3) did not address the issue of timely filing. In his brief, claimant submits two documents which were not in evidence at the time of hearing. We treat such submissions as a request for remand. In its brief, the employer requests clarification of the Referee's Order On Reconsideration which did not address the issue of attorney fees. On review, the issues are remand, timeliness, compensability, aggravation and penalties and attorney fees. We modify in part and affirm in part.

FINDINGS OF FACT

The Board adopts the Referee's Findings of Fact with the following supplementation.

On August 13, 1986, claimant reported to his supervisor that he had woken up with a sore back. Claimant told his supervisor that he was not certain whether his sore back was due to kidney problems or a back strain. First aid was administered by claimant's supervisor in case claimant had sustained a back strain. Claimant's supervisor knew there was a possibility that claimant had injured his back at work.

CONCLUSIONS OF LAW AND OPINION

Remand

Claimant submits two documents, a letter from Referee Holtan and the employer's reply. Claimant contends that the two documents narrow the issues that were before Referee Myers. Claimant argues that the issue of timeliness was before Referee Myers but was not decided at hearing.

We may remand when the record is incompletely, improperly, or otherwise insufficiently developed. ORS 656.295(5). Here, the documents offered by claimant were available at the time of hearing and claimant has not shown that, with due diligence, he was unable to procure them before the date of hearing. Moreover, the documents do not provide any additional evidence as the parties do not dispute that the issue of timeliness was before the Referee. We find that the record was not incompletely or improperly developed and we therefore deny claimant's request for remand.

Timeliness

At hearing, the employer asserted that claimant's original claim was not timely. In his Opinion and Order, however, the Referee did not address the issue of timeliness. On review, we address the issue of timeliness before we proceed to the merits of claimant's injury and occupational disease claims.

The employer argues that claimant's occupational disease and injury claims are not timely. It is claimant's burden of proof to establish that his claims were timely filed. Occupational disease claims must be filed within 180 days from the date a worker becomes disabled or is informed by a physician that he is suffering from an occupational disease, whichever date is later. Former ORS 656.807(1). Written notice of an injury must be provided within 30 days of the injury. ORS 656.265. Failure to give notice may bar a claim unless the employer otherwise had knowledge of the injury. OAR 656.265(4)(a); Inkley v. Forest Fiber Products, 288 Or 337, 348 (1980).

In the present case, claimant did not submit a written claim form for either an injury or an occupational disease occurring in 1986. Claimant instead argues that the employer had knowledge of the injury or occupational disease in August 1986. We agree. Knowledge of an injury should include sufficient facts to lead a reasonable employer to conclude that workers' compensation liability is a possibility and that further investigation is appropriate. Argonaut Ins. Co. v. Mock, 95 Or App 1 (1989).

The Referee found that the employer's representative was credible. The representative, who was also claimant's supervisor, testified that he applied first aid in case claimant had strained his back. The representative also testified that, at the time, he believed it was possible that claimant

could have injured himself at work. We find that, under the circumstances, a reasonable employer would have concluded that workers' compensation liability was a possibility. Because the employer had knowledge of a possible work-related injury, claimant's failure to give notice did not bar his 1986 claim.

Compensability

The Board adopts the Referee's opinions and conclusions on the issue of compensability, with the following supplementation.

On review, claimant asserts that the employer's denial letters denied the claims only on the grounds of untimely filing. Therefore, claimant argues, the Referee did not have the authority to address compensability of his claim. We disagree. When an insurer denies a claim, it must do so in a writing which states the factual and legal basis for the denial. OAR 436-60-140(4). An insurer's denial frames the issues for hearing. See Patricia N. Hall, 40 Van Natta 1873 (1988).

Here, the employer's denial letter stated that the claim was denied as being untimely. The letter also stated that:

> "We are also unable to ascertain that this condition arose out of or in the course and scope of your employment, or that your work activity materially contributed to a worsening of this condition. Therefore and without waiving any other questions of compensability, this matter is hereby denied."

We conclude that the employer denied claimant's claim both on the grounds of timeliness and compensability. Compensability was fully litigated at hearing and we therefore find that the Referee properly addressed compensability in his opinion and order.

Aggravation

Because we agree with the Referee that none of claimant's claims are compensable, we need not address the issue of aggravation.

Penalties and attorney fees

The Referee initially assessed a penalty and attorney fee against the employer for an unreasonable delay in processing the claim. On reconsideration, the Referee corrected his order and concluded that, because no amounts were due upon which a penalty could be based, no penalty could be assessed.

On review, the employer requests clarification of the Referee's Order on Reconsideration which did not address the issue of attorney fees. We find that, under the circumstances, neither a penalty nor an attorney fee may be awarded because there is no compensation due, nor any resistance to the payment of compensation. See Lloyd L. Cripe, 41 Van Natta 1774 (1989).

ORDER

The Referee's order dated October 5, 1988, as reconsidered November 15, 1988, is modified in part. Claimant is not entitled to a penalty-related attorney fee. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
MABLE A. FERRICK, Claimant
WCB Case No. 88-15868
ORDER ON REVIEW
Jeffrey A. Crook, Claimant Attorney
Thomas E. Ewing (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

The SAIF Corporation requests review of Referee Menashe's order which awarded 13 percent (41.60 degrees) unscheduled permanent disability for a low back injury, whereas a Determination Order had awarded no permanent disability. We affirm.

FINDINGS OF FACT

The Board adopts the Referee's "Findings of Fact" with the following supplementation.

Claimant has documentation of CNA training.

CONCLUSIONS OF LAW AND OPINION

The Board adopts the Referee's "Opinion and Conclusion" with the following comment.

We note that there is nothing in the Standards that requires a finding of impairment other than pain in order to assign an impairment value to disabling pain under former OAR 436-35-320(1)(a). See Dennis D. Reed, 42 Van Natta 873 (1990); Deborah A. MacDonald, 42 Van Natta 975 (1990).

ORDER

The Referee's order dated January 9, 1989, is affirmed. Claimant's attorney is awarded a reasonable assessed fee of $440, payable by the SAIF Corporation.

In the Matter of the Compensation of
NEIL J. HAUSER, Claimant
WCB Case Nos. 88-15793 & 88-15792
ORDER ON REVIEW
Brothers, et al., Claimant Attorneys
Bonnie Laux (Saif), Defense Attorney
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Howell and Speer.

The self-insured employer requests review of that portion of Referee Nichols' order that: (1) set aside its denial of claimant's "new injury" claim for his current left shoulder condition; and (2) upheld the SAIF Corporation's denial of claimant's aggravation claim for the same condition. In its brief, the employer contends that claimant's counsel is not entitled to an attorney fee for services on Board review. On review, the issues are responsibility and attorney fees. We affirm.

FINDINGS OF FACT

The Board adopts the Referee's Findings of Fact with the following supplementation.

Claimant worked for Express Temporary Services for approximately three to four weeks. Claimant earned $3.92 per hour while working for Mt. Bachelor and $5.00 per hour while working for Express. Claimant was employed in a temporary capacity with Express.

CONCLUSIONS OF LAW AND OPINION

The Board adopts the Referee's Conclusions of Law and Opinion with the following supplementation.

Claimant argues that, although the case involves only the issue of responsibility, his counsel is entitled to an attorney fee. A claimant's attorney is entitled to a carrier-paid fee for services rendered on Board review when a carrier initiates Board review of an issue which threatens the claimant's entitlement to receive compensation or the amount of that compensation, and the Board determines that "the compensation awarded to the claimant should not be disallowed or reduced." ORS 656.382(2); Bahler v. Mail-Well Envelope Co., 60 Or App 90, 93-94 (1982).

Here, claimant argues that the amount of compensation was at risk because his temporary disability rate at the second employer was higher. Claimant received $3.92 per hour while working for Mt. Bachelor and $5.00 per hour while employed with Express.

The employer argues that claimant was only a temporary worker with Express, therefore, his temporary total disability rate should be based upon his average weekly earnings for the weeks he worked prior to the July 1988 lifting episode. OAR 436-60-020(7)(c) provides that, for workers employed varying hours, shifts or wages, temporary total disability rates are calculated based upon average weekly earnings for the past 4 to 26 weeks, prior to injury. OAR 436-60-020(7)(a).

Because no evidence was submitted at the time of hearing to establish claimant's average weekly wage for the weeks prior to his injury, the employer contends that claimant has not proven that he would be entitled to a greater temporary disability benefit from Express. We agree.

We find that claimant has not shown that his temporary disability rate with Express would be greater than that of the first employer, Mt. Bachelor. We therefore conclude that claimant has not proven that his compensation was at risk. Accordingly, claimant's attorney is not entitled to a fee for services on review.

ORDER

The Referee's order, dated January 26, 1989, is affirmed. A client-paid fee, not to exceed $2,265, is approved, payable by the self-insured employer to its counsel.

In the Matter of the Compensation of
EDWIN D. BUZBEE, Claimant
WCB Case No. 88-13666
ORDER ON REVIEW
Francesconi & Associates, Claimant Attorneys
Thomas Ewing (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

Claimant requests review of Referee Podnar's order which affirmed a Determination Order that did not award unscheduled permanent disability for a back injury. On review, claimant contends that he has suffered permanent impairment as a result of his compensable back injury and is entitled to an award of unscheduled permanent disability.

We affirm and adopt the Referee's order with the following supplementation.

Claimant testified that he experiences pain which limits his ability to perform a variety of physical activities. Based on these complaints, his treating chiropractor, Dr. Mulnick, limited claimant's frequent lifting and carrying to 25 pounds, and occasionally 50 pounds. In addition, Mulnick recommended that claimant only occasionally bend, squat, crawl, climb, or reach and alternate his sitting, standing, and walking activities.

Despite these suggested limitations, claimant conceded that, after leaving the employer, he participated in a three and one-half week "white-water" rafting trip down the Colorado river. During the trip, he also hiked on trails "up the side canyons." Claimant has continued to engage in these rafting excursions, the most recent occurring on the Deschutes River some five weeks before the hearing.

If a claimant became medically stationary after January 1, 1988, and his or her claim was closed on or after July 1, 1988, a subsequent determination by a Referee or the Board of the claimant's permanent partial disability must be made pursuant to ORS 656.283(7) and 656.295(5), respectively. OAR 438-10-005; Michelle Griffith, 40 Van Natta 2086 (1988).

For purposes of determining injury-related permanent partial disability, ORS 656.283(7) and 656.295(5) require application of the standards for the evaluation of disabilities adopted by the director pursuant to ORS 656.726(3)(f)(A). Those "standards" in effect on the date of the Determination Order from which the hearing was requested control the evaluation of permanent partial disability. OAR 438-10-010.

The hearing and Board review of the issue of permanent partial disability continues to be de novo on the hearing record. The facts to which the "standards" are applied need only be established by a preponderance of the evidence. However, either party may establish that the record, as a whole, constitutes clear and convincing evidence that the degree of permanent partial disability suffered by the claimant is more or less than the entitlement indicated by the "standards." ORS 656.283(7); 656.295(5).

In this case, the "standards" adopted effective July 1, 1988, former OAR 436-35-001 et seq, apply to the rating of claimant's permanent partial disability. Former OAR 436-35-270 through 436-35-440 apply to the rating of unscheduled permanent partial disabilities. Former OAR 436-35-270(1). Those standards provide that "[T]here shall be no unscheduled permanent disability if the injury did not result in impairment." Former OAR 436-35-280(1).

Pain can result in loss of use or function. Former OAR 436-35-320(1)(a). When it does, it is rated based on the loss of use or function which results and no additional value is allowed for the pain alone. Id. Inasmuch as the standards do not provide for a value range for impairment attributable to disabling pain, the Board on de novo review can consider the evidence and award a claimant a value that adequately compensates him for his loss of use or function attributable to disabling pain. Daniel M. Alire, 41 Van Natta 752 (1989).

Here, we find the opinions authored by the Western Medical Consultants and the Medical Consultants Northwest to be persuasive. Each of these independent medical examining panels provided a detailed description of their findings and reasons for their conclusions. Each panel found no objective findings and concluded that there was no permanent impairment attributable to the compensable injury.

The aforementioned medical opinions, in conjunction with claimant's admitted physically active life-style, do not persuade us that any pain claimant experiences has resulted in a loss of use or function of his back. Consequently, we conclude that the pain is not disabling. Former OAR 436-35-320(1)(a).

Although no permanent disability is awardable under the "standards," either party may establish that the record, as a whole, constitutes clear and convincing evidence that the degree of permanent partial disability suffered by the claimant is more or less than the entitlement indicated by the "standards." ORS 656.283(7); 656.295(5).

Here, we do not find this record to be highly persuasive, free from confusion and distinct in indicating that claimant has suffered a loss of earning capacity as a result of his compensable back injury. See Riley Hill General Contractor, Inc. v. Tandy Corp., 303 Or 390, 407 (1987). Accordingly, we conclude that claimant has failed to prove by clear and convincing evidence that he suffers unscheduled permanent disability.

ORDER

The Referee's order dated October 13, 1988 is affirmed.

May 3, 1990 Cite as 42 Van Natta 1019 (1990)

In the Matter of the Compensation of
STEVEN D. HOLT, Claimant
WCB Case No. 88-17844
ORDER ON REVIEW
Popick & Merkel, Claimant Attorneys
Cooney, et al., Defense Attorneys

Reviewed by Board Members Myers and Gerner.

The insurer requests review of Referee Mulder's order which increased claimant's unscheduled permanent disability to 26 percent (83.20 degrees), whereas a Determination Order had awarded 14 percent (44.80 degrees) unscheduled permanent disability for a low back condition. Claimant cross-requests review of the Referee's order and seeks an increase in unscheduled permanent disability. On review the issue is extent of unscheduled permanent disability. We modify.

FINDINGS OF FACT

We adopt the Referee's findings of fact as our own, with the following supplementation.

Claimant has the following ranges of motion: 80 degrees flexion, 25 degrees extension, 30 degrees right lateral flexion, 40 degrees left lateral flexion and 50 degrees right and left rotation. Claimant has two discs with some radicular pain into the right leg. (Ex. 33-3). Claimant has mild disabling pain. There is no documentation demonstrating competence in some specific vocational pursuit. Claimant can lift 30 pounds frequently and 40 pounds occasionally. (Exs. 27-2, 32-2). Claimant successfully achieved his highest level of "SVP" proficiency of 3. Claimant was not working and no work had been offered by the time of hearing.

CONCLUSIONS OF LAW AND OPINION

The Referee increased claimant's unscheduled permanent disability by changing the adaptability factor from +1 to +1.5, and by increasing claimant's impairment from 10 to 20 percent. We disagree.

Impairment:

Claimant's two discs have clinically related residual symptoms. He is entitled to an impairment of 4 percent for each disc. These values are added for a total of 8 percent. Leland M. Pollock, 42 Van Natta 925 (1990). Claimant's range of motion findings entitle him to 2 percent impairment. See generally former OAR 436-35-360(6) thru (9).

Claimant argues that he is entitled to additional impairment for the disabling effects of pain. We agree. Daniel Alire, 41 Van Natta 752 (1989). We value his mild disabling pain as 5 percent impairment. Combining claimant's impairments of 8 and 5 and 2 yields the value of 14.3 percent.

Adaptability:

The insurer contends that claimant's adaptability factor should be +1 because claimant is capable of medium level work. Claimant contends that his adaptability factor should be +8 because he is restricted to sedentary work. An adaptability value for a claimant who is unable to return to his or her usual and customary work, see former OAR 436-35-270(3)(a), and who has not returned to modified work is determined by the claimant's residual physical capacity, without regard to that claimant's physical capacity prior to the injury. Former OAR 436-35-310(4).

Claimant is unable to return to his usual and customary work and has not returned to, or been offered, regular or modified work since he became medically stationary. Claimant's physical capacity of lifting 30 pounds frequently and 40 pounds occasionally places him within the medium category. Thus, the appropriate adaptability value is +1. Former OAR 436-35-310(4)(b).

Other Factors:

Neither party contests the accuracy of the other factors found by the Referee. Claimant is entitled to a factor of zero for Age and a value of +4 for Education. The Age and Education sum is +4. This value is multiplied by the Adaptability factor of +1 to yield the product +4. To this product is added the

Impairment value of 14.3 percent to yield the total sum of 18.3 percent disability. See generally former OAR 436-35-280. This value is rounded up for a total disability under the standards of 19 percent. Former OAR 436-35-280(7).

ORDER

The Referee's order dated February 10, 1989 is modified in part and affirmed in part. That portion of the Referee's order which increased claimant's unscheduled permanent disability to 26 percent is modified to increase claimant's award to 19 percent (60.80 degrees) unscheduled permanent disability. The remainder of the order is affirmed. The Board approves a client-paid fee, not to exceed $822, payable from the insurer to its counsel.

May 3, 1990 Cite as 42 Van Natta 1021 (1990)

In the Matter of the Compensation of
JOANNE C. KRAUSE, Claimant
WCB Case No. 88-09894
ORDER ON REVIEW
Bennett & Durham, Claimant Attorneys
Sharon Schooley (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

Claimant requests review of Referee Leahy's order which: (1) held that a physician's report of October 20, 1987 was not an aggravation claim; (2) upheld the SAIF Corporation's denial of claimant's July 1988 aggravation claim for her cervical condition; (3) declined to assess penalties and associated attorney fees for failure to timely deny the alleged October 1987 aggravation claim; (4) declined to award interim compensation with regard to the July 1988 aggravation claim; and (5) declined to assess penalties and attorney fees for SAIF's alleged unreasonable failure to pay such interim compensation. On review, the issues are aggravation, interim compensation and penalties and attorney fees. We affirm.

FINDINGS OF FACT

The Board adopts the Referee's "Findings of Fact" with the following supplementation.

SAIF received notice of a medically verified inability to work due to an alleged worsening of claimant's compensable condition on August 22, 1988. SAIF denied claimant's aggravation claim on September 2, 1988.

CONCLUSIONS OF LAW AND OPINION

October 1987 Aggravation Claim

Claimant's first visit to Dr. Bhasin, chiropractor, was October 16, 1987. The only information Bhasin received was by way of claimant's subjective history which included an extensive description of her pain. Claimant was placed on a physical rehabilitation program. She was not taken off work. Dr. Bhasin indicated that claimant was very sensitive and had a low pain threshold.

Dr. Bhasin sent a report dated October 20, 1987 to SAIF. The report documented claimant's physical examination, diagnosis and treatment program. Because this was claimant's first visit to Dr. Bhasin, the physician did not indicate that there was any worsening of claimant's condition.

Claimant argues that Dr. Bhasin's October 20, 1987 report presents a claim for aggravation and that SAIF neither accepted the claim nor denied it within 60 days. The Referee held that Dr. Bhasin's report was insufficient to constitute a claim for aggravation requiring processing by SAIF. We agree.

After the last award or arrangement of compensation, the claimant is entitled to additional compensation, including medical services, for worsened conditions resulting from the original injury. ORS 656.273(1). A physician's report is an aggravation claim, so long as it, at a minimum, requests additional medical services or additional compensation for something more than a continuation of conditions resulting from the compensable injury. The report must indicate a change in claimant's condition. ORS 656.273(3); Krajacic v. Blazing Orchards, 84 Or App 127 (1987).

Here, Dr. Bhasin's report need not have proved that claimant's condition worsened, but it must have put SAIF on notice that treatment for more than continuing conditions was indicated. See Avalos v. Bowyer, 89 Or App 546, 549 (1988); Krajacic v. Blazing Orchards, 84 Or App 127, 130, modified 85 Or App 477, remanded for reconsideration on other grounds 304 Or 436 (1987), on remand 90 Or App 593 (1988).

Dr. Bhasin's October 20, 1987 report does not establish that the treatment he was recommending for claimant was for anything other than continuing problems, and there is no indication in that report that there was a change in claimant's condition since the last award of compensation. Accordingly, we agree with the Referee that the letter of October 20, 1987 did not present a claim for aggravation. Moreover, because there was no claim for aggravation the Referee was correct in not assessing a penalty and associated attorney fee for SAIF's failure to accept or denying an aggravation claim.

July 1988 Aggravation Claim

Between the end of 1987 and July 29, 1988, claimant did not receive treatment for either her upper back or her lower back conditions. On July 29, 1988, claimant saw an associate of Dr. Bhasin, Dr. Morrow, for the first time. Based upon claimant's subjective complaints, Dr. Morrow submitted a form on August 8, 1988 releasing claimant from work between July 29 and August 22, 1988. He prescribed a work-hardening program and physical therapy. SAIF issued an aggravation denial on September 2, 1988.

The Referee found that claimant had not met her burden of proving a worsened condition to support an aggravation claim. We agree. Claimant had not seen Dr. Morrow before July 29, 1988, and there is no evidence that he based his opinion of an aggravation on anything but claimant's own history of her condition. Dr. Morrow's report did not document a worsened condition.

Claimant was examined by the Orthopaedic Consultants in October 1988. The Consultants had also examined her two times previously, in July 1985 and May 1986. Based on their 1988 examination, the Orthopaedic Consultants found "no objective abnormality to support claimant's subjective complaints." Comparing claimant's condition in 1988 to their previous examinations, they concluded that there was no worsening of claimant's condition either in October 1987 or July 1988.

Because the Orthopaedic Consultants had seen claimant on two occasions prior to her alleged July 1988 aggravation, whereas claimant had not previously seen Dr. Morrow, we are more persuaded by their report than that of Dr. Morrow.

See Kienow's Food Stores v. Lyster, 79 Or App 416 (1986). Accordingly, we conclude that claimant did not suffer an aggravation of either of her conditions in July 1988.

Interim Compensation

Claimant contends that Dr. Morrow's Disability Certificate, dated August 8, 1988, constituted notice to SAIF of a medically verified inability to work. Thus, she argues that SAIF was obliged to pay interim compensation within 14 days of that notice. ORS 656.273(6); Silsby v. SAIF, 39 Or App 555 (1979). We disagree.

An insurer/employer must make the first interim payment of compensation no later than 14 days after the insurer/employer has notice or knowledge of a medically verified inability to work. Berkey v. Fairview Hospital, 94 Or App 28 (1988). Claimant has the burden of proving the date on which the insurer received the notice. Here, August 8 is the date on which Dr. Morrow signed the Disability Certificate, but not necessarily the date that SAIF received the notice. In fact, because the date stamp on the copy in the record is not legible and claimant did not offer evidence as to what that date was, the only other report which gives the insurer notice of a medically verified inability to work is that of Dr. Morrow dated August 18 and received by SAIF on August 22, 1988.

Because we conclude that claimant failed to show that SAIF received notice of a medically verified inability to work before August 22, 1988, and because SAIF denied the claim on September 2, 1988, 11 days after it is first shown to have received notice, we conclude that claimant has failed to prove that SAIF's obligation to begin paying interim compensation ever arose. For that reason, the Referee was correct in denying interim compensation. Moreover, no grounds exist for the award of a penalty or associated attorney fee for failure to pay interim compensation.

ORDER

The Referee's order, dated December 8, 1988, is affirmed.

May 3, 1990 Cite as 42 Van Natta 1023 (1990)

In the Matter of the Compensation of
DEBORAH L. PEARSON, Claimant
WCB Case No. 87-06095
ORDER ON RECONSIDERATION
Malagon, et al., Claimant Attorneys
Acker, et al., Defense Attorneys

The self-insured employer has requested reconsideration of that portion of our December 18, 1989 Order on Review which declined to apply the doctrine of res judicata to procedurally bar claimant from litigating the merits of its medical services denial. On January 4, 1990, we abated our December 18, 1989 order to further consider the matter in light of Liberty Northwest Ins. Corp. v. Bird, 99 Or App 560 (1989), and to allow claimant to respond to the employer's request. Having received claimant's response, we proceed to reconsider the case.

FINDINGS OF FACT

Claimant sustained a compensable injury to her neck, right shoulder and back in March 1983. She treated with Dr. Hebert, a chiropractor. In August

1983 she was released to work. Two months later claimant was involved in an automobile accident while traveling to Hebert's office for treatment of her March 1983 injury. The automobile accident traumatized the same body parts injured in the March 1983 injury. Following the automobile accident, Hebert continued to treat claimant's neck, right shoulder and back.

Claimant submitted her medical bills from Hebert to the employer in October 1985. By way of a February 1986 denial, the employer denied compensability stating: "[A]ll of the bills submitted * * * were the direct result of the motor vehicle accident of October 26, 1983, and that [the employer] is not responsible for payment thereof." Claimant requested a hearing. On July 16, 1986, the parties entered into a disputed claim settlement of "all issues raised or raisable by the Request for Hearing and Supplemental Request for Hearing" for $500. Claimant stipulated that none of the bills she submitted in October 1985 were compensable. She further stipulated that such billings "were solely occasioned by the motor vehicle accident of October 26, 1983."

Thereafter, claimant submitted additional billings from Hebert to the employer. In June 1987, the employer denied the compensability of the bills on the basis that they were "for conditions for which we are not responsible", "that all the billings submitted by Dr. Hebert are the direct result of the motor vehicle accident" and that the billings are for services which are not "substantially dissimilar" to the services previously denied and compromised by stipulation.

CONCLUSIONS OF LAW AND OPINION

In our order of December 18, 1989 we declined to apply the doctrine of res judicata to procedurally bar claimant's instant medical services claim because there had been no previous adjudication.

Res judicata or "claim preclusion" is the rule that a party may not assert a claim arising from a transaction with respect to which the party has already prosecuted such a claim to a valid and final judgment. See Restatement, (Second) of Judgments, Introduction 1 and 18 & 19 (1980); Dean v. Exotic Veneers, Inc., 81 Or 188 (1975); Carr v. Allied Plating Co., 81 Or App 306 (1986); and Tana Wilson, 40 Van Natta 476 (1988). Three key elements of "claim preclusion" are: 1) the same parties (or those in privity); 2) the same claim (or a second claim arising from the same transaction or series of connected transactions out of which the first claim arose); and 3) a valid and final judgment on the first claim.

Contrary to our December 18, 1989 order, we conclude that the disputed claim settlement is a valid and final judgment. Tana Wilson, supra. However, we continue to hold that res judicata does not apply to this case because the claims are not the same.

The employer argues that the claims are the same because claimant's conditions are the same. The employer argues that Bird controls this case. We disagree. Bird involved two claims for the same medical service; a surgical procedure. This case involves different medical services for different dates of treatment. Neither the prior denial nor the disputed claim settlement denied or resolved the compensability of claimant's then-current condition. The employer only denied the compensability of claimant's medical services. Such a denial has no prospective effect on future medical services; see Evanite Fiber Corp. v. Striplin, 99 Or App 353 (1989), unless the future medical services are the same services already at issue. Bird, supra. Accordingly, we conclude that claimant's current medical services claims are not barred by res judicata.

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our prior order, effective this date. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
DEBORAH L. SHERFIELD, Claimant
WCB Case No. 88-14154
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Davis & Bostwick, Defense Attorneys

Reviewed by Board Members Myers and Gerner.

The insurer requests review of Referee Scavera's order which awarded unscheduled permanent disability of 25 percent (80 degrees), whereas a Determination Order had awarded no permanent disability for a low back condition. On review, the issue is extent of unscheduled permanent disability. We modify.

FINDINGS OF FACT

We adopt the Referee's findings of fact as our own, except for his finding that claimant's highest SVP value is 2. Claimant's highest SVP value is 5.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant has a 1 percent impairment rating for loss of extension. We agree.

The insurer argues that Dr. Holbert's report of May 7, 1987, where he found that claimant had full ranges of motion, is persuasive. We note that claimant was not medically stationary when Dr. Holbert made this observation, and that claimant did not become medically stationary until over a year later. The Referee properly relied upon the ranges of motion found by the independent medical examiners who examined claimant when she was medically stationary.

The insurer argues that claimant is not entitled to a value for her lost extension because her ranges of motion are not corroborated by objective neurological findings and she has functional overlay. However, the independent medical examiners who measured claimant's loss of extension did not comment that their measurements were due to functional disturbances nor that the measurements were not accurate. Therefore, we decline to discount the measurements of loss of extension.

The Referee found that claimant's highest SVP value was 2, and that she was entitled to a value of +4. The insurer contends that claimant's highest SVP should be a 5, for a value of +2. We agree with the insurer.

Former OAR 436-35-300(4) adopts by reference the "SVP" (specific vocational preparation time) values assigned to various occupations by the Dictionary of Occupational Titles (DOT), published by the U.S. Department of Labor. The highest SVP level demonstrated by a claimant during the ten years prior to the date of injury is used to determine a value for skills. Former OAR 436-35-300(4).

Claimant has worked as a "salad maker." This occupation's DOT code is 317.384-010 and it has an SVP of 5. (Ex. 39-9). Since claimant has worked in this job for one year, she qualifies for this SVP and it, rather than the 2 found by the Referee, is claimant's highest SVP.

Changing the SVP value, changes the value of the Education Factor from +6, to +4. Taking the other undisputed values as found by the Referee, the Age and Education sum becomes +4. This value is multiplied by the Adaptability factor of +4 to yield the product +16. To this product is added the Impairment value of 1 percent to yield the total sum of 17 percent disability. See generally former OAR 436-35-280.

ORDER

The Referee's order dated January 17, 1989 is modified. That portion of the Referee's order which awarded 25 percent (80 degrees) unscheduled permanent disability is modified to increase her award to 17 percent (54.4 degrees) unscheduled permanent disability. The remainder of the order is affirmed.

In the Matter of the Compensation of
DONNA J. WILSON, Claimant
WCB Case No. 88-13422
ORDER ON REVIEW
Cynthia L. Barrett, Claimant Attorney
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Myers and Cushing.

The insurer requests review of those portions of Referee Galton's order which: (1) set aside the insurer's medical services denial of all chiropractic care; and (2) refused to admit any exhibits offered by the parties except the denial letter. On review, the issues are medical services and admission of evidence. We reverse in part and affirm in part.

Admission of Evidence

The Referee refused to admit any documentary evidence except the denial because he believed the denial itself was per se illegal. The insurer objects to this action. We agree. The refusal to admit any documentary evidence was an abuse of discretion. Since the excluded documents are contained in the record as certified by the Referee, we may admit and consider these documents. ORS 656.295(5). Accordingly, we admit exhibits 1 through 36, including exhibit 25A, into the record.

FINDINGS OF FACT

Claimant compensably injured her neck and low back on March 15, 1986. She originally sought care from Dr. Hardiman, orthopedic surgeon, until May 1987, when claimant changed attending physicians to Dr. Urban, chiropractor.

Dr. Urban treated claimant five days a week for six months with massage, vibration, ultrasound and adjustments. The palliative effects of the treatments would last one-half hour to forty-five minutes. In November of 1987, claimant's frequency of treatment with Dr. Urban dropped to three times per week. (Ex. 26). Claimant's claim was closed by a March 28, 1988 Determination Order which awarded temporary disability only. Three days later, Dr. Urban filed an

aggravation claim alleging that claimant's condition had worsened. The insurer denied this claim and that denial was subsequently upheld by a referee.

By May 1988 claimant had received approximately 180 chiropractic treatments from Dr. Urban. (Ex. 33). On July 20, 1988, the insurer denied continued chiropractic care because it was "contraindicated" and refused to make "further" payment. We take administrative notice of the Opinion and Order issued in WCB 88-19353 between the same parties and of the fact that claimant continued to receive chiropractic care from Dr. Urban after the insurer's denial and until hearing on October 28, 1988.

ULTIMATE FINDING OF FACT

Claimant's chiropractic treatment between the date of denial and hearing was not reasonable and necessary.

CONCLUSIONS OF LAW AND OPINION

The Referee set aside the insurer's denial reasoning that a denial of an entire class of care was impermissible. The Referee relied upon Reynaga v. Northwest Farm Bureau, 300 Or 255 (1985). We disagree.

Reynaga stands for the proposition that an insurer or self-insured employer cannot deny an entire class of care where that care is otherwise reasonable and necessary. Id. at 262. Where such care is not reasonable and necessary the insurer or self-insured employer may deny it, as the insurer did in this case.

Claimant argues that the denial should be set aside for procedural deficiencies. She argues that this denial does not contain the factual or legal grounds for denial as required under OAR 438-05-055. We disagree.

The denial states both that continued chiropractic care is "contraindicated" and that "[t]here is no objective evidence that [claimant is] receiving any material benefit of either a palliative or curative nature from this modality of treatment." These are factual and legal bases for denial in compliance with the rule. Moreover, even if there were no such bases in the denial, the denial could not be set aside for this failure. The remedy for an insufficient denial is penalties and fees for an unreasonable denial, not the reversal of the denial itself. OAR 438-05-037.

Claimant asserts that without the factual and legal basis contained in the denial, case preparation is not possible and that it is unfair to claimant to have to litigate such a denial. We agree. However, our rules provide the remedy of continuance should claimant be surprised by the bases of denial orally asserted at hearing; our rules do not provide that the denial is set aside. OAR 438-06-031. Since claimant did not move for continuance on the basis of surprise at hearing and elected to proceed instead, any such objections are waived. See Jeffery K. Stafford, 42 Van Natta 251 (1990). We proceed to address the merits of the denial.

Four doctors are of the opinion that claimant's chiropractic care is not reasonable and necessary. (Exs. 20, 21, 33, 34, 35, 36). Dr. Urban opines that claimant's condition has worsened and that "it is undetermined at this time as to what further medical or chiropractic treatment will be required to satisfactorily stabilize her condition." (Ex. 14-3). We find Urban's opinion nonresponsive and unpersuasive. He gives no opinion whatsoever why his treatments

are reasonable and necessary. Furthermore, his opinion that claimant's condition has worsened contradicts the law of the case that her condition has not worsened. Therefore, we discount his opinion entirely. See Kuhn v. SAIF, 73 Or App 768, 772 (1985). Because the uncontroverted opinions of the consulting doctors and claimant's former treating physician are that claimant's current chiropractic treatments are not reasonable and necessary, we reinstate and uphold the insurer's denial.

We note that the denial states it is denying payment for "further" chiropractic care. However, our reinstatement of the denial does not include a finding of noncompensability for any treatments rendered after the date of hearing. Hollie J. Rahim, 42 Van Natta 415 (1990). Denials of medical services cannot operate prospectively and to the extent that this denial attempts to do so, it is set aside as ineffective and void. Evanite Fiber Corp. v. Striplin, 99 Or App 353 (1989).

The insurer argues that such a holding creates a "nightmare of denying each medical bill for such treatment separately" and that such a system is "unworkable and administratively burdensome." Despite the burdens, the insurers and self-insured employers are charged to deny claims within 60 days of receipt. ORS 656.262(6); Billy J. Eubanks, 35 Van Natta 131 (1983). Medical services performed after a denial or, if it is appealed, after a hearing on the denial, are new claims that must be processed accordingly. Striplin, supra.

ORDER

The Referee's order dated November 4, 1988 is reversed in part and affirmed in part. To the extent that the insurer's denial relates to medical services given to claimant before hearing, the insurer's denial is reinstated and upheld. To the extent that the denial relates to future medical services after the date of hearing, the denial is set aside. The Referee's award of a $1,400 insurer-paid attorney fee to claimant's attorney is reversed. In lieu thereof, claimant's attorney is awarded an assessed fee of $300, to be paid by the insurer for services in setting aside the prospective portion of the denial. The Board approves a client-paid fee, not to exceed $2,338.75, payable from the insurer to its counsel.

In the Matter of the Compensation of
DARLENE J. BYRD, Claimant
WCB Case No. 88-13317
ORDER ON REVIEW
Hollander & Associates, Claimant Attorneys
Thomas A. Andersen, Defense Attorney

Reviewed by Board Members Gerner and Myers.

The insurer requests review of Referee Galton's order that increased claimant's unscheduled permanent disability award for a low back injury from 12 percent (38.4 degrees), as awarded by Determination Order, to 25 percent (80 degrees). On review, the issue is extent of unscheduled permanent disability. We modify.

FINDINGS OF FACT

In April 1987, claimant, a nurse's aide, compensably injured her low back while helping to lift a patient at the insured's nursing home. Claimant was treated by Dr. Freistat, who diagnosed lumbosacral strain, treated claimant conservatively and released her to return to work. She returned to work until July 1987, at which time her pain symptoms increased.

In August 1987, claimant began treating with Dr. Day, M.D. In September 1987, Day referred claimant to Dr. Harris, M.D. Harris took x-rays and noted no abnormalities.

In November 1987, claimant was evaluated by the Orthopaedic Consultants. Claimant complained of pain symptoms in her entire back, in her right knee cap, in her neck and between her shoulders. The Consultants noted that she could return to regular work with lifting limitations, and found her medically stationary in May 1988.

Claimant began a work hardening program, which she completed in January 1988. She then worked full-time as a computer operator, at a higher wage than she earned at her at-injury employment. She later became employed in July 1988 as a full-time secretary.

In July 1988, claimant was awarded 12 percent unscheduled permanent disability for her low back condition. Claimant requested a hearing.

Claimant, 25 years of age at hearing, is a high school graduate who attended two years of college. Her prior work experience includes working as a nurse's aide, cashier, bank teller, and cosmetologist. She also worked for a "professional dance group," doing African dancing.

Claimant has many transferable skills, a broad work history and is motivated to work. Her physical restrictions include the following: she can stand 30 minutes, sit 35 minutes, walk six blocks, lift 20 pounds, and drive short distances without pain.

Claimant suffers minimal asymmetry in the lateral recesses posterior to L4. This condition is classified, for impairment purposes, as an unoperated disc derangement without clinically related residual symptoms.

Claimant's pain symptoms in her right knee, right leg, neck and between her shoulders are not causally related to her compensable April 1987 injury.

Claimant has restricted thoracolumbar ranges of motion due to the compensable injury of 70 degrees flexion, 25 degrees extension, and normal degrees right and left flexion and rotation.

There is no documentary evidence in the form of certificates, diplomas, et cetera establishing that claimant has competence in the specific vocational pursuit as a cosmetologist. Claimant has successfully achieved her highest level of "SVP" proficiency of "6" for her work as a cosmetologist. Claimant is capable of performing light to moderate work with no heavy lifting.

Claimant suffers minimal disabling pain.

CONCLUSIONS OF LAW AND OPINION

In determining the extent of claimant's permanent disability, the Referee applied the standards for evaluating permanent disability as adopted by the Director of the Department of Insurance & Finance pursuant to ORS 656.726(3)(f). See ORS 656.283(7). Specifically, the Referee applied former OAR 436-35-000 et seq, which was effective at the time of the July 25, 1988 Determination Order. See OAR 438-10-005; 438-10-010. These are the rules which we apply as well. ORS 656.295(5); OAR 438-10-005; 438-10-010.

The Referee increased claimant's unscheduled permanent disability award from 12 percent, as awarded by Determination Order, to 25 percent for her low back condition. We modify.

After our de novo review of the record and analysis of claimant's impairment based on the standards, we find that claimant has met her burden of proving that she has suffered a permanent loss of earning capacity greater than that awarded by the July 1988 Determination Order. However, we find that claimant's loss of earning capacity is not as great as that found by the Referee.

Impairment

In rating the total impairment of claimant's low back condition, consideration is given to an analysis of restrictions on claimant's ranges of motion. In addition, percentages of impairment may be allotted for fractured vertebra and intervertebral disc lesions. Finally, percentages of impairment may be allotted for disabling pain. Former OAR 536-35-001 et seq.

Here, there is a disparity in the evidence with respect to claimant's range of motion findings. See exhibits 20 and 31-1. We defer to the measurements contained in exhibit 31-1, the more current medical report of the Consultants, which measurements were made nearest to claimant's medically stationary date. Claimant's total impairment based on her loss of range of motion is 2.5 percent.

Because claimant does not suffer from a fractured vertebrae condition, she is not allotted any percentage of impairment from this category. Former OAR 436-35-350(1). However, claimant does suffer some disc lesion.

In determining claimant's total impairment, the Evaluation Section added 4 percent impairment for claimant's "disc derangement." However, we find that the inclusion of the 4 percent was inappropriate. In October 1987, Dr. Harris specifically reported no abnormalities and noted "minimal asymmetry in the later recesses posterior to L4 . . . finding is of uncertain and probably dubeus [sic] clinical significance." There is no other medical opinion in the record to establish a relationship between claimant's compensable low back condition and the "disc bulge." Therefore, we do not allot 4 percent for claimant's disc condition as it is not medically significant and has no clinically-related residual symptoms. Former 436-35-350(2).

Finally, we agree with the Referee that claimant suffers disabling pain. We find that claimant suffers a five percent loss of use or function of her low back due to her low back condition. Former OAR 436-35-320(1)(a); Daniel Alire, 41 Van Natta 752 (1989).

Total impairment is calculated by application of former OAR 436-35-320. Where impairment results from injury to more than one body part or system, the values are combined. Finally, where impairment results from disabling pain, the pain impairment value is then combined with the body part impairment value, to determine total impairment. Former OAR 436-35-320(1)(a).

Here, claimant's low back impairment is 2.5 percent. Her pain impairment is 5 percent. These two percentages are then combined, to yield a total impairment of 7.4 percent.

Therefore, we find that claimant's total impairment, the combination of her body part impairment and her pain impairment, is 7.4 percent. Former OAR 436-35-320.

Age

The appropriate value for claimant's age of 25 years is 0. Former OAR 436-35-290(3).

Education

The appropriate value for claimant's two years of formal education is 0. Former OAR 436-35-300(3)(a).

Former OAR 436-35-300(4) adopts by reference the "SVP" (specific vocational preparation time) values assigned to various occupations by the Dictionary of Occupational Titles (DOT), published by the U. S. Department of Labor. The highest SVP level demonstrated by claimant during the ten years prior to the date of injury is 6, as specified in the DOT for the occupation of a cosmetologist. Therefore, the appropriate value for claimant's skills is +2.

Claimant has no documented training. Therefore, the appropriate value for training is +1. Former OAR 436-35-300(5)(a).

Claimant's total education value is +3. Former OAR 436-35-300(6).

Adaptability

In this case, claimant's usual and customary work required the physical capacity to do heavy work. Claimant's modified work requires light to medium physical capacity. Therefore, the appropriate adaptability value is +2.5. Former OAR 436-35-310(3)(a).

Computation of Unscheduled Disability

Claimant's Age and Education sum is +3. This value is multiplied by the Adaptability factor of +2.5 to equal +7.5. To this value is added the Impairment of 7.4 percent, for a total disability rating of 14.9 percent. See generally former OAR 436-35-280. This figure is rounded up to the nearest whole number. Former OAR 436-35-280(7). Claimant's disability under the standards is 15 percent.

Disability Outside the Standards

The Referee found clear and convincing evidence that claimant had lost more earning capacity than that allowed under the standards because of her permanent inability to dance professionally. While we agree that claimant has

suffered a loss of earning capacity with respect to her previous job as a nurse's aide, we are not persuaded that claimant has proven by clear and convincing evidence that she has a loss of earning capacity relative to her ability to "dance professionally."

Claimant contends that dancing is an occupation which was affected by her back condition, thereby affecting her wage earning capacity from this "occupation." However, we find no evidence in the record to establish that claimant treated her dancing as an "occupation." Claimant testified that she was paid for her dancing, yet there is no evidence that she was paid on a regular basis, the amount of such income or how often she danced. Moreover, claimant reported to her physicians that she danced "for enjoyment." Therefore, claimant's inability to dance due to the her April 1987 injury does not present clear and convincing evidence that her disability exceeds that found under the standards.

Additionally, the Referee determined that claimant suffered disabling pain, as addressed above, and, therefore, went outside the standards and considered such disabling pain. We have already held that disabling pain is considered in determining the extent of permanent disability under the standards in effect for this case. Consequently, such pain is not evaluated separately by going outside the standards, and by establishing by clear and convincing evidence that claimant's disability because of the pain is greater than the standards allow. See Daniel Alire, supra at 757. Disabling pain, when found, is factored into the disability equation under the impairment category. Id.

Accordingly, because claimant has not proven by clear and convincing evidence that her disability exceeds that under the standards, we conclude that claimant is entitled to 15 percent unscheduled permanent disability for her low back condition as allowed by the standards.

ORDER

The Referee's order dated November 21, 1988, is modified. In lieu of the Referee's increased award and in addition to the Determination Order award of 12 percent (38.4 degrees), claimant is awarded 3 percent (9.6 degrees), giving her a total award to date of 15 percent (48 degrees) unscheduled permanent disability for her low back injury.

May 7, 1990 Cite as 42 Van Natta 1032 (1990)

In the Matter of the Compensation of
ELLEN D. HOPE-SMITH, Claimant
WCB Case No. 88-15874
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Meyers & Radler, Defense Attorneys

Reviewed by Board Members Gerner and Myers.

Claimant requests review of those portions of Referee Thye's order which: (1) affirmed a Determination Order award of 15 percent (48 degrees) unscheduled permanent disability for a right shoulder injury; and (2) awarded claimant 5 percent (7.5 degrees) scheduled permanent disability for a right forearm condition, whereas a Determination Order had awarded no scheduled permanent disability. The self-insured employer cross-requests review of that portion of the Referee's order which awarded claimant permanent disability for her right forearm. On review, the issues are extent of scheduled and unscheduled permanent disability. We affirm in part, reverse in part and modify in part.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Extent of Unscheduled Permanent Disability

The Referee affirmed the three Determination Orders and awarded no additional permanent disability for claimant's disabling pain. We disagree.

At the outset, claimant asserts that the standards are inapplicable to this case because claimant's first two Determination Orders on appeal were issued before the standards took effect. We have previously held that where claimant was last medically stationary after January 1, 1988 and the claim is closed after July 1, 1988, that the standards are applicable notwithstanding prior Determination Orders. William J. Thomas, 42 Van Natta 841 (1990). However, notwithstanding Thomas, the standards would still be applicable to this case. The first two Determination Orders have become final by law. The parties' attempt to "preserve" the issue of extent after dismissal of the WCB case associated with the original appeal of these Determination Orders was ineffective. (Ex. 26AA); Claudia I. Hamilton, 42 Van Natta 600 (1990); David L. Mallette, 38 Van Natta 843 (1986). We dismiss the appeal of these two orders.

Impairment:

Claimant asserts that the Referee failed to make a finding of impairment for disabling pain. Daniel M. Alire, 41 Van Natta 752 (1989). We agree. The Referee found, and we have adopted his finding, that claimant has mild disabling pain which has restricted her to light duty work. We find claimant entitled to 10 percent impairment for this disabling pain. The Referee's range of motion findings correspond to 1 percent for loss of external rotation and .5 percent for loss of internal rotation. Former OAR 436-35-330(9) and (10). Claimant is entitled to 5 percent for her Neer acromioplasty. Former OAR 436-35-330(14). The shoulder values are added to arrive at an impairment of 6.5 percent. Former OAR 436-35-320(2). The impairment due to disabling pain is combined with this impairment to yield a total impairment of 14.85 percent.

Age:

The appropriate value for claimant's age of 50 years is +1. Former OAR 436-35-290.

Education:

Former OAR 436-35-300(4) adopts by reference the "SVP" (specific vocational preparation time) values assigned to various occupations by the Dictionary of Occupational Titles (DOT), published by the U.S. Department of Labor. The highest SVP level demonstrated by a claimant during the ten years prior to the date of injury is used to determine a value for skills. Former OAR 436-35-300(4). Claimant's highest SVP during the ten years prior to the date of injury was 5 as a bank teller. Therefore, the appropriate value for skills is +2. Former OAR 436-35-300(4). The appropriate value for claimant's GED degree is zero. Former OAR 436-35-300(3). Claimant has no documented training. Therefore, the appropriate value for training is +1. Former OAR 436-35-300(5). Claimant's total education value is +3, the formal education value plus the skills value plus the value for training. Former OAR 436-35-300(6).

Adaptability:

An adaptability value for a claimant who is unable to return to his or her usual and customary work [See former OAR 436-35-270(3)(a)] but who has returned to modified work is determined from a matrix of values at former OAR 436-35-310(3)(a). That matrix compares the physical capacity of the claimant's usual and customary work with the physical capacity required by the modified work. This is true even though claimant may have the physical capacity to do heavier work than is required by the modified employment. Physical capacities are not defined by the "standards" generally. We utilize those definitions contained in former OAR 436-35-310(4)(a)-(d).

In this case, claimant's usual and customary work required the physical capacity to do medium work. Claimant's modified work required a light physical capacity. Therefore, the appropriate adaptability value is +2. Former OAR 436-35-310(3)(a).

Standards Disability Computation:

The Age and Education sum is +4. This value is multiplied by the Adaptability factor of +2 to yield the product +8. To this product is added the Impairment value of 14.85 percent to yield the total sum of 22.85 percent disability. This result is rounded to the next higher whole percentage. Former OAR 436-35-280(7). Claimant's permanent disability under the standards is, therefore, 23 percent.

Claimant argues that she has proven by clear and convincing evidence that she has lost more earning capacity than that allowed under the standards. However, the evidence contained in this record as a whole is not highly persuasive, free from confusion, fully intelligible and distinct that claimant's loss of earning capacity is greater than that contemplated under the standards. See Riley Hill General Contractor Inc. v. Tandy Corp., 303 Or 390, 407 (1987). Accordingly, claimant is entitled to 23 percent unscheduled disability.

Extent of Scheduled Disability

The Referee awarded claimant 5 percent scheduled disability for her right carpal tunnel release by applying former OAR 436-35-110(4)(f). The employer argues that this rule is applicable only to carpal bone resection, not carpal tunnel releases and that the award of impairment was inappropriate. We agree with the employer.

Claimant argues that she is entitled to impairment for the loss of use or function of her right forearm due to disabling pain. See Alire supra. However, there is no evidence that the pain claimant experiences has resulted in loss of use or function of her wrist or forearm. Claimant's attending physician is of the opinion that claimant has no permanent impairment in the forearm. (Ex. 27). And while claimant asserts that her wrist condition has limited her to light duty work, her testimony fails to detail loss of use or function due to pain, rather than loss of earning capacity due to other circumstances. To the extent that claimant is limited to light duty work, that restriction is as likely to come from her compensable shoulder injury as it is from her wrist condition. On this record, claimant has failed to prove a loss of use or function due to pain.

ORDER

The Referee's order dated February 8, 1989 is affirmed in part, modified in part and reversed in part. That portion of the Referee's order which affirmed the Determination Orders of August 5, 1986 and August 10, 1987 is reversed. The appeal of these orders is dismissed as untimely. That portion of

the order which declined to award claimant additional unscheduled permanent disability is modified to award an additional 8 percent (25.60 degrees) unscheduled permanent disability for a total award of 23 percent (73.6 degrees) unscheduled permanent disability for her shoulder injury. That portion of the order which awarded claimant 5 percent (7.5 degrees) scheduled permanent disability is reversed. The remainder of the order is affirmed. Claimant's attorney is awarded 25 percent of the additional compensation granted by this order, not to exceed $3,800 as a reasonable attorney's fee, payable directly to claimant's attorney. The Board approves a client-paid fee, not to exceed $1,078.50, payable from the self-insured employer to its counsel.

May 7, 1990 Cite as 42 Van Natta 1035 (1990)

In the Matter of the Compensation of
PRIMROSE T. MORGAN, Claimant
WCB Case No. 89-21433
ORDER DENYING MOTION TO DISMISS
Ronald K. Pomeroy (Saif), Defense Attorney

The SAIF Corporation has moved the Board for an order dismissing claimant's request for review on the ground that copies were not timely mailed to the parties. The motion is denied.

FINDINGS OF FACT

The Referee's Order of Dismissal issued March 2, 1990. Claimant, pro se, mailed her undated request for review to the Board's Medford office, indicating copies had been provided to the employer and SAIF. The Board received the request in its Medford office on April 2, 1990, a Monday, the last day for filing a request for review. SAIF represents that neither it nor the employer received claimant's request for Board review until April 6, 1990. The Board's computer-generated letter acknowledging the request was mailed on April 16, 1990.

CONCLUSIONS OF LAW

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 March 2, 1990 order was April 1, 1990, a Sunday. Therefore, the last day to timely file a request for Board review was Monday, April 2, 1990. See ORS 174.120. Since claimant's request was received by the Board on April 2, 1990, it is timely.

Furthermore, included with claimant's request was her representation that copies had been sent to the other parties. Counsel for SAIF acknowledges its and the employer's receipt of a copy of the request April 6, 1990. SAIF also concedes that they did not retain the envelopes in which claimant mailed copies of her request for review. Under these circumstances, we find that claimant timely mailed a copy of her request for Board review to all parties to the proceeding. See ORS 656.295(2); Argonaut Insurance Co. v. King, supra;

Danny R. Akers, 39 Van Natta 732, 813 (1987). Consequently, we conclude that we have jurisdiction to consider her request for review.

Accordingly, SAIF's motion to dismiss is denied. As a result of this motion, the briefing schedule shall be revised as follows. Claimant's appellant's brief shall be due 14 days from the date of this order. SAIF's respondent's brief shall be due 14 days from the date of mailing of claimant's brief. Claimant's reply shall be due 7 days from the date of mailing of SAIF's brief. Thereafter, this case shall be docketed for review.

IT IS SO ORDERED.

May 7, 1990 Cite as 42 Van Natta 1036 (1990)

In the Matter of the Compensation of
WILLIAM J. THOMAS, Claimant
WCB Case No. 87-10347
ORDER OF ABATEMENT
Rasmussen & Henry, Claimant Attorneys
H. Thomas Anderson (Saif), Defense Attorney

The Board has received claimant's motion for reconsideration of our Order on Review dated April 10, 1990.

In order to allow sufficient time to consider the motion, the above-noted Board order is abated and withdrawn. The SAIF Corporation is requested to file a response to the motion within ten days. Thereafter, this matter shall be taken under advisement.

IT IS SO ORDERED.

May 8, 1990 Cite as 42 Van Natta 1036 (1990)

In the Matter of the Compensation of
WILLIAM O. ESSELSTROM, Claimant
WCB Case No. 88-12978
ORDER ON REVIEW
Flaxel, Todd, et al., Claimant Attorneys
Dennis Ulsted (Saif), Defense Attorney

Reviewed by Board Members Brittingham and Crider.

Claimant requests review of Referee Bennett's order that affirmed a Determination Order which awarded 5 percent (7.5 degrees) scheduled permanent disability for loss of use or function of the right leg (knee) and no scheduled permanent disability for the left leg (knee). On review the issue is extent of scheduled permanent partial disability. We affirm in part and modify in part.

FINDINGS OF FACT

The Board adopts the Referee's "Findings," with the following addition. The diagnosed rupture of the anterior cruciate ligament pertains to the left knee; no left knee surgery was performed.

ULTIMATE FINDING OF FACT

Claimant has sustained a 5 percent loss of use or function of each knee as a result of his compensable injury.

CONCLUSIONS OF LAW AND OPINION

The Referee held that since there were no objective medical findings on which to base an application of the standards, claimant's award of 5 percent permanent partial disability for the right knee should not be increased and he should not receive any award for the left knee. We disagree.

The Referee erred in two respects. First, he did not give value for disabling pain. Daniel Alire, 41 Van Natta 752 (1989). Second, he required objective medical findings to prove impairment. Linda Young, 41 Van Natta 1070 (1989).

We find that claimant's credible testimony has shown that he suffers disabling pain in each knee which has limited his ability to sit, stand and walk. The standards do not provide a value range for impairment attributable to disabling pain. We find a value of 5 percent for each knee to be reasonable in this case.

Dr. Meyers, claimant's treating surgeon, opined in April 1988 that claimant has full range of motion and has regained the strength in his knee. This is controverted by claimant's testimony. He testified to loss of strength and range of motion, and atrophy. Based on demeanor, the Referee found claimant to be a credible witness.

While the Referee found claimant credible, Dr. Meyers consistently reported that claimant's range of motion was full and that claimant had regained his strength. The record does not indicate that his condition worsened after Dr. Meyers' last reported examination. Under these circumstances, we give greater weight to the expert opinion of Dr. Meyers than claimant's lay opinion and find no loss of motion, loss of strength or atrophy.

In Linda Young, supra, the Board relied on a claimant's testimony to establish that the range of motion findings of one expert were more persuasive than the findings of another expert. Claimant's testimony supported the opinion of her chiropractor. In the instant case, however, the only medical opinion is inconsistent with claimant's assertion that he has lost range of motion, lost strength and atrophy. We give greater weight to the expert opinion, than to the lay opinion.

ORDER

The Referee's order dated September 27, 1988 is affirmed in part and modified in part. In addition to the 5 percent (7.5 degrees) scheduled permanent disability for loss of use or function of the right leg (knee) awarded by Determination Order, claimant is awarded 5 percent (7.5 degrees) scheduled permanent disability for loss of use or function of the left leg (knee). Claimant's attorney is allowed an approved fee in the amount of 25 percent of the increased compensation awarded by this order, not exceeding $3,800, payable by the SAIF Corporation directly to claimant's attorney out of that compensation.

In the Matter of the Compensation of
JERRY F. FOSTER, Claimant
WCB Case Nos. 88-00972 & 88-06209
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Cummins, et al., Defense Attorneys
David Horne, Defense Attorney

Reviewed by Board Members Gerner and Myers.

Wausau Insurance Company (Wausau) requests review of that portion of Referee Mirassou's order which set aside its denial of claimant's aggravation claim and of claimant's current condition as a nullity. Alexsis Risk Management (Alexsis) cross-requests review of that portion of the Referee's order that set aside its denial of claimant's aggravation claim as a nullity. On review, the issue is compensability. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact and ultimate finding of fact, except for the finding that Wausau's denial was without legal consequence, as our own. We further supplement the findings of fact as follows: The denial issued by Wausau was a denial of responsibility for claimant's current condition, not just a denial of aggravation.

CONCLUSIONS OF LAW AND OPINION

Wausau's Denial

The Referee found that claimant had an open claim based on a 1984 injury covered by Alexsis. Since claimant had an open claim with Alexsis, the Referee held that Wausau could not deny an aggravation to its 1973 injury claim for the same problems that were covered by the open claim with Alexsis. We disagree.

Wausau's denial, though using the word aggravation, was couched in terms of denying responsibility for claimant's currently claimed conditions. Wausau may issue such a denial even if the claim with Alexsis was open.

In this case, since the claim against Alexsis was open, and Alexsis had been previously determined to be the responsible party for these currently claimed conditions, Wausau's denial of responsibility for these currently claimed conditions should be upheld.

Alexsis' Denial

We adopt the Referee's conclusions and opinion on this issue as our own.

ORDER

The Referee's order dated January 27, 1989 is reversed in part and affirmed in part. That portion of the order that set aside Wausau's denial as a nullity is reversed and the denial is reinstated and upheld. The remainder of the order is affirmed. Claimant's attorney is awarded an assessed fee of $1,000, to be paid by Alexsis. The Board approves a client-paid fee, not to exceed $1,895, to be paid by Alexsis to its attorney.

In the Matter of the Compensation of
WILLIAM L. GUTHRIDGE, Claimant
WCB Case No. 88-13824
ORDER ON REVIEW
Quintin B. Estell, Claimant Attorney
Williams, et al., Defense Attorneys

Reviewed by Board Members Cushing and Gerner.

Claimant requests review of that portion of Referee Daron's order which upheld the insurer's denial of his occupational disease claim for a respiratory condition. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the "Findings of Fact" as set forth in the Referee's order.

CONCLUSIONS OF LAW AND OPINION

We adopt the "Opinions and Conclusions", concerning the compensability issue, as set forth in the Referee's order with the following supplementation.

We are not persuaded that Dr. Clohessy's opinion establishes that claimant's work activities were the major contributing cause of his respiratory condition. Dr. Clohessy opined that it was likely that claimant's work exposure was the most reasonable explanation for his respiratory condition. This opinion is insufficient to infer that claimant's work exposure is the major contributing cause of claimant's respiratory condition, particularly in light of Dr. Montanaro's well-reasoned opinion to the contrary. See Blakely v. SAIF, 89 Or App 653, 656, rev den 305 Or 672 (1988). Further, claimant cannot carry his burden of proof merely by disproving other possible explanations for his condition. ORS 656.266. Accordingly, we agree with the Referee that claimant has not established that his work exposure was the major contributing cause of his respiratory condition.

ORDER

The Referee's order dated February 8, 1989, is affirmed. A client-paid fee, not to exceed $1,098, is approved, payable by the insurer to its counsel.

In the Matter of the Compensation of
SHERI V. HILTNER, Claimant
WCB Case No. 88-21276
ORDER ON REVIEW
Philip F. Schuster II, Claimant Attorney
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Gerner and Cushing.

The insurer requests review of Referee Podnar's order which set aside its denial of claimant's injury claim. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

The insured leases the 15th floor of a multistory multipurpose commercial office building. On September 30, 1988, claimant slipped and fell on the polished tile floor of the ground floor lobby while returning from lunch. This fall occurred near one of the two general access doors to the building used by

employees and the general public. In addition to the insured, other businesses including a restaurant, bank, optometrist's office, store and travel agency are accessible through this public entrance.

Claimant's lunch break was for 30 minutes and was unpaid. She ate lunch outside the building while sitting on a bench in the sun. The insured required all employees to take a lunch break. The insured assumed no control over claimant during lunch periods and claimant was free to engage in any activity she pleased. The insured did not own the lobby, had no control over the lobby and did not create any special hazards in the lobby. Claimant's injury required her to seek medical care and to have X-rays taken. (Tr. 19).

CONCLUSIONS OF LAW AND OPINION

The Referee set aside the insurer's denial reasoning that claimant was injured on her employer's premises and that the insured exercised control over the lobby area because it paid rent. We disagree.

Claimant has the burden to prove that her injury arose out of and in the scope of her employment. ORS 656.005(7)(a). If the injury has a sufficient relationship to work, it is compensable. Rogers v. SAIF, 289 Or 633 (1980). Seven factors are evaluated to determine whether or not a particular injury has such a sufficient relationship to work. They are:

> "a. Whether the activity was for the benefit of the employer...;
>
> "b. Whether the activity was contemplated by the employer and employee either at the time of hiring or later...;
>
> "c. Whether the activity was an ordinary risk of, and incidental to, the employment...;
>
> "d. Whether the employee was paid for the activity...;
>
> "e. Whether the activity was on the employer's premises...;
>
> "f. Whether the activity was directed by or acquiesced in by the employer...;
>
> "g. Whether the employee was on a personal mission of his own...."

Jordan v. Western Electric, 1 Or App 441, 443-4 (1970); quoted with approval, Mellis v. McEwen, Hanna, Gisvold, 74 Or App 571, 574 (1985). We proceed to evaluate these factors. Timberline Lodge v. Kyle, 97 Or App 239 (1989).

Benefit to the Employer

Claimant argues that her lunch activity was of some benefit to her employer in that uniform lunch periods away from the work stations helped the employer to maintain certain production figures for payroll calculations and that claimant returned from lunch more refreshed and efficient than before. We agree.

Many off-work activities benefit an employer. However, some benefits are very incidental, others more direct. In Haugen v. SAIF, 37 Or App 601 (1978) the

Court of Appeals acknowledged that a police officer's injury at home while exercising with weights to maintain good physical conditioning was of benefit to the employer:

> "The employer is benefited. Arguably, of course, any employer is benefited if employees engage in activities which contribute to good physical and mental health." Id. at 604.

Here, claimant's employer secured a more relaxed employee because of the lunch breaks. (Tr. 32). We conclude that a more relaxed claimant is of benefit to her employer, but that such benefits are very incidental. Likewise, the requirement that all employees take a lunch break so that each employee's production could be easily compared with another employee's production is also of very incidental benefit to the employer. We conclude claimant's activity was of very slight benefit to her employer.

Activity Contemplated by the Parties

Claimant argues that since she was required to take lunch breaks that her activity was contemplated by her employer. We agree.

While it is true that claimant's employer allows employees to engage in any activity they desire at lunch, claimant engaged in an ordinary and foreseeable activity that her employer was aware could and did commonly occur. We conclude claimant's actions of leaving the building to eat lunch on a bench outside in the sun is an activity known and contemplated by both parties.

Ordinary Risk Incidental to Employment

Claimant argues that because she was injured while on a required lunch break that her injury is due to an ordinary risk incidental to her employment. We disagree.

Claimant cites to several Board and court cases holding that injuries incurred off premises because the employee is seeking refreshments are considered injuries incidental to risks of employment. Mellis v. McEwen, Hannah, Gisvold, supra; Halfman v. SAIF, 49 Or App 26 (1980); Jordan v. Western Electric, supra; Fred L. McComber, 35 Van Natta 383 (1983). The insurer distinguishes these cases on their facts and argues that in each the refreshments were sought during break times, not during lunch times. We agree with the insurer. Where, as here, claimant was on a half hour lunch break and was free to engage in any activity she desired, we conclude that she was not engaged in an activity incidental to employment when she used this time to go outside and eat lunch.

Payment for the Activity

Claimant was not paid for her lunch breaks.

Activity on the Employer's Premises

Claimant argues that the lobby of a multistory, multipurpose commercial complex in which her employer is located is the functional equivalent of the employer's premises because she had to enter into the building via the lobby in order to reach her employer's premises. We disagree.

Claimant's argument is another way of asserting that injuries sustained while trying to get to the work site are ordinary risks of employment. However, the presumption is just the opposite. Injuries occurring while coming to and

going from work are ordinarily not work related, unless the employer exercises some control over the place where the injury is sustained. Cope v. West American Ins. Co., 309 Or 232, 239 (1990). Control is manifested either by employer ownership; see Kowcun v. Bybee, 182 Or 271 (1947); employer actions; see Montgomery v. SIAC, 224 Or 380 (1960); or the presence of employer created special hazards. c.f. Adamson v. The Dalles Cherry Growers, Inc., 54 Or App 52, 58 (1981).

Here, claimant's employer does not own the lobby, does not exercise any control over the lobby and has not created any special hazards in the lobby. We conclude that claimant was not injured while engaged in an activity on her employer's premises.

Employer Direction or Acquiescence

Claimant's employer did not direct her to take her lunch time outside the building. However, her employer was aware that claimant and other employees did do so. This awareness means that her employer acquiesced in the activity when it made no attempt to forbid the activity. We conclude her employer acquiesced to claimant eating lunch outside the building.

Personal Mission

There is no allegation nor proof that claimant was engaged in any employment related activity. We conclude she was on a personal mission when she was injured.

In combination, the factors preponderate against a finding of a sufficient work connection to establish the compensability of the claim. Claimant was neither on her employer's premises, was not being paid and was not engaged in a task incidental to work, she was on a personal mission. While the activity was contemplated by and acquiesced to by her employer and was also of slight benefit to her employer, we consider these lessor considerations insufficient to establish the work connectedness of claimant's injury.

ORDER

The Referee's order dated January 26, 1989 is reversed. The insurer's denial is reinstated and upheld. That portion which awarded claimant a $1,200 assessed attorney fee is reversed. The Board approves a client-paid fee, not to exceed $1,632, payable from the insurer to its counsel.

May 8, 1990 Cite as 42 Van Natta 1042 (1990)

In the Matter of the Compensation of
RACHID KAADY, Claimant
WCB Case No. TP-89004
ORDER ON RECONSIDERATION
Pozzi, et al., Claimant Attorneys
Paul Rask, Attorney
Cooney, Moscato & Crew, Defense Attorneys
Schwabe, et al., Defense Attorneys
Acker, Underwood, et al., Defense Attorneys

EBI Companies has requested reconsideration of our August 17, 1989 Third Party Distribution Order which found that it was not entitled to a share of the settlement proceeds of a legal malpractice action arising out of a third party claim. On September 14, 1989, we issued an order of abatement to allow sufficient time to consider EBI's motion for reconsideration. On the same day we

abated and withdrew our order, the Professional Liability Fund ("Fund"), on behalf of claimant, filed with the Court of Appeals a petition for judicial review of that order.

By order dated April 6, 1990, the court dismissed the Fund's petition for judicial review for lack of jurisdiction. Citing SAIF v. Fisher, 100 Or App 288 (1990), the court found that our order of abatement rendered our August 17, 1989 order nonfinal and not subject to judicial review. In Fisher, the court reasoned that no provision in either ORS chapter 656 or ORS chapter 183 limits the Board's authority to reconsider an order before it becomes final, regardless of whether a petition for judicial review has been filed. Because in Fisher we did not redecide the case after granting reconsideration, the court held that the case remained pending before us. In light of the court's April 6, 1990 order and the court's decision in Fisher, we proceed to address EBI's motion for reconsideration.

Briefly stated, the facts are as follows. On April 15, 1983, claimant suffered a low back injury which was accepted by EBI as a compensable claim. Approximately two months later, on June 23, 1983, claimant was involved in an on-the-job motor vehicle accident. This accident also involved the low back. At the time of this accident, Fireman's Fund had replaced EBI as the employer's workers' compensation carrier. Two years later, claimant's attorney commenced a third party action arising out of the motor vehicle accident. That action was subsequently dismissed by the trial court. Claimant then asserted a legal malpractice claim against his attorney. The malpractice claim was settled. The dispute before us involves the question of EBI's entitlement as a "paying agency" to a share of the settlement proceeds. See ORS 656.576.

In our August 17, 1989 order, we found that EBI had not established payment of any compensation benefits as a result of the motor vehicle accident which eventually resulted in the third party settlement. Rather, we concluded that whatever benefits EBI had provided claimant were made pursuant to the accepted April 15, 1983 injury. In addition, we found that as of the date of the settlement, EBI had denied claimant's continued low back condition on the basis that claimant had injured his low back in the motor vehicle accident. We noted that the denial had become final by operation of law. For these reasons, we concluded that EBI had failed to establish its status as a paying agency as defined by ORS 656.576. See Marvin C. Wright, 41 Van Natta 36 (1989). Moreover, we found no enforceable lien existed because the third party recovery at issue was not attributable to a "compensable injury" due to the fact that EBI never accepted claimant's injury claim arising from the June 1983 motor vehicle accident. See ORS 656.578.

On reconsideration, EBI argues that it did provide benefits resulting from the motor vehicle accident until issuance of its denial of claimant's low back condition. In this regard, EBI notes our finding that the motor vehicle accident resulted in increased low back symptoms. Therefore, EBI argues, claimant's low back symptoms resulting from both the accepted April injury and the June motor vehicle accident are inseparable for purposes of payment. EBI would have us find that all payments made by EBI after the date of the motor vehicle accident were made pursuant to the accident and provide a proper basis for the assertion of a third party lien. We decline to do so.

It is the paying agency's burden to establish which expenses, if any, were incurred due to the third party injury rather than the prior accepted claim. See Timothy E. Dooley, 41 Van Natta 2322 (1989) (paying agency not entitled to share of third party settlement proceeds which stem from an accident which was neither compensable in its own right nor as a consequence of a compensable injury); see also John Galanopoulos, 34 Van Natta 615 (1982) (burden on

paying agency to segregate payments on account of original, pre-malpractice portion of injury from those portions attributable to an "aggravation" occasioned by malpractice); Leroy Millage, 38 Van Natta 626 (1986). We are unwilling to find that benefits were provided as a result of the motor vehicle accident simply because those payments were made after the date of the accident. To reach such a conclusion would require us to conclude that post-June 23, 1983 costs would not have been incurred absent the effects of the motor vehicle accident. In the absence of evidence to this effect, we refuse to so speculate.

Moreover, even if EBI had provided benefits which could be directly attributed to the motor vehicle accident, we would nevertheless conclude that EBI was not a paying agency because, as of the date of the settlement, EBI had denied continued responsibility for claimant's low back condition and was not providing benefits. See Marvin C. Wright, supra (date of settlement is key date for determining status as "paying agency"). EBI argues that Wright is not controlling because, here, EBI had continued to provide benefits for two years following the motor vehicle accident, whereas in Wright the purported paying agency had provided no benefits prior to issuing its denial. However, payment of compensation shall not be considered acceptance of a claim. ORS 656.262(9). Accordingly, EBI's decision to continue paying benefits for two years after the motor vehicle accident and prior to issuing a denial reflects a claims processing decision which, we conclude, does not elevate EBI's status during the two-year period to that of a paying agency.

Accordingly, the request for reconsideration is granted. On reconsideration, as supplemented herein, we adhere to and republish our August 17, 1989 order. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
NIKOLAI AFONIN, Claimant
WCB Case No. 86-02478
ORDER ON RECONSIDERATION
Francesconi & Associates, Claimant Attorneys
Dennis Martin (Saif), Defense Attorney

The SAIF Corporation requests reconsideration of that portion of our April 19, 1990 Order on Review that awarded claimant's attorney an assessed fee for prevailing against SAIF's cross-request for reduction of claimant's permanent partial disability award. SAIF accurately notes that it did not file a formal cross-request for review. However, contrary to SAIF's assertion, it did seek the reduction of claimant's permanent disability award as granted by the Referee. Since we affirmed the Referee's order, claimant is entitled to a reasonable attorney fee pursuant to ORS 656.382(2). See Kordon v. Mercer Industries, 308 Or 290, 295-96 (1989).

Accordingly, our April 19, 1990 order is withdrawn. On reconsideration, we adhere to and republish our April 19, 1990 order. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
JIMMY D. BASHAM, Claimant
WCB Case No. 88-13439
ORDER ON REVIEW
Myrick, et al., Claimant Attorneys
Employers Defense Counsel, Defense Attorney

Reviewed by Board Members Gerner and Myers.

The insurer requests review of that portion of Referee Mongrain's order which increased claimant's unscheduled permanent disability to 41 percent (131.2 degrees), whereas a Determination Order had awarded 30 percent (96 degrees) for a low back condition. On review, the issue is extent of unscheduled permanent disability. We modify.

FINDINGS OF FACT

Claimant compensably injured his low back and right knee on October 10, 1986. His claim was closed by a July 19, 1988 Determination Order which found claimant medically stationary on June 13, 1988.

Claimant has restricted thoracolumbar ranges of motion due to the compensable injury of: 30 degrees flexion, 10 degrees extension, 20 degrees right flexion and 20 degrees left flexion. There is no evidence of claimant's residual ability to perform right and left rotation. Claimant has undergone two surgical procedures due to the injury for diskectomy L5 right and for recurrent diskectomy L5 right.

Claimant was 38 at the time of hearing. He did not have a high school education nor a GED and had only completed the eighth grade. There is no documentary evidence in the form of formal certificates, diplomas etc. establishing that claimant has competence in some specific vocational pursuit. Claimant has successfully achieved his highest level of "SVP" proficiency of 7 for his work as a diesel mechanic. Claimant's job-at-injury was classified as heavy work. (Ex. 72-2). He received a job offer from an employer but did not accept the work. There is no evidence whether or not claimant's attending physician, Dr. Potter, released claimant to this job. Claimant is capable of performing sedentary level work.

CONCLUSIONS OF LAW AND OPINION

Impairment. The Referee calculated claimant's impairment and arrived at a value of 21 percent impairment. However, after noting the Evaluation Section's value of 25 percent, and the absence of a cross-appeal by the insurer, the Referee adopted the 25 percent value as the correct value. The insurer contends this is in error. We agree. The Referee must, when evaluating any factor under the standards, conduct a review of the record and determine each factor de novo. The absence of a cross-appeal does not relieve the Referee of this duty. Michelle Griffith, 40 Van Natta 2086 (1988).

There is a disparity in the evidence as to claimant's range of motion findings. See exhibits 57, 62 and 68. We defer to the measurements contained in exhibit 57, Dr. Grant's report, because it contains the most complete evaluation. Nonetheless, no evidence of loss of right or left rotation was introduced. Claimant argues that we should "infer" lost rotation proportional to the other range of motion losses. Such a loss would be speculative and impermissible. See Gettman v. SAIF, 289 Or 609 (1980). We decline to infer evidence into the record to relieve a party of its prima facia burden of proof. See Gormley v. SAIF, 52 Or App 1055 (1981). Claimant has a range of motion impairment of 8 percent. Former OAR 436-35-360(6), (7) and (8).

Claimant has additional impairment from the two surgical procedures at the same spinal level. Former OAR 436-35-350(2) allows 5 percent impairment for single discectomy. The rule, however, is ambiguous whether claimant is to receive a single 5 percent rating for each surgical level, or a 5 percent rating for each surgical procedure. Absent any evidence of any additional impairment resulting from the second surgery, we conclude that claimant is entitled to be given the value only once. Therefore, we conclude claimant is entitled to a total of 5 percent for both procedures. The combined total impairment is 12 percent.

Age. Claimant is entitled to no value for age. Former OAR 436-35-290(3).

Education. Claimant is entitled to a value of +1 for his formal education factor, a value of +1 for his training factor and a value of +1 for his "SVP" factor of 7. See generally former OAR 436-35-300. The sum of the education factors is, therefore, +3.

Adaptability. Claimant has not returned to work. He has received a job offer, but his doctor did not release him to that job. The Director's adaptability rule does not describe the adaptability value for this claimant's situation. Former OAR 436-35-310(3)(b) governs claimants who have been offered work at a modified job and have been released to that job by the attending physician. Former OAR 436-35-310(4) governs claimants who have neither returned to work nor been offered a job. The situation of a claimant who has been offered a job, but not released to it, is not addressed elsewhere in the rules. We construe the rule in favor of the injured worker and apply the more generous adaptability factor in former OAR 436-35-310(4). Claimant's adaptability factor is +8.

Assembling the Factors. The Age and Education sum is +3. This value is multiplied by the Adaptability factor of +8 to yield the product +24. To this product is added the Impairment value of 12 percent to yield the total sum of 36 percent disability. See generally former OAR 436-35-280.

Neither party argues that we should step outside the standards because claimant's disability is more or less than the standards. See ORS 656.295(5). Therefore, we conclude that claimant has lost 36 percent of his earning capacity.

ORDER

The Referee's order dated December 2, 1988 is modified in part and affirmed in part. The Referee's total award of 41 percent (131.2 degrees) unscheduled permanent disability is modified. In lieu of the Referee's award and in addition to the Determination Order award of 30 percent (96 degrees), we award 6 percent (19.2 degrees) unscheduled permanent disability, for a total award for his low back injury of 36 percent (115.2 degrees). The remainder of the order is affirmed. The Board approves a client-paid fee, not to exceed $402, payable from the insurer to its counsel.

In the Matter of the Compensation of
DONALD A. HANSON, Claimant
WCB Case Nos. 88-13657, 88-10249, 88-13658 & 88-10248
ORDER OF ABATEMENT
Cook & Seims, Claimant Attorneys
Davis & Bostwick, Defense Attorneys
Thomas Sheridan (Saif), Defense Attorney

The SAIF Corporation, on behalf of Northwest Woodland Services, requests reconsideration of our April 30, 1990 order which remanded this case to the

Referee with instructions to determine the responsible employer. Contending that SAIF, on behalf of Triple T, withdrew its request for review prior to our decision, SAIF (Northwest Woodland Services) seeks withdrawal of our order and reinstatement of the Referee's order.

Before addressing the motion, we request a response from SAIF (Triple T) within 10 days from the date of this order. Consequently, our April 30, 1990 order is withdrawn. Upon receipt of the aforementioned response, we shall take this matter under advisement.

IT IS SO ORDERED.

May 9, 1990 Cite as 42 Van Natta 1047 (1990)

In the Matter of the Compensation of
ROBERT J. HUNT, Claimant
WCB Case Nos. 87-00747 & 87-00748
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Lester R. Huntsinger (Saif), Defense Attorney
Cummins, et al., Defense Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Howell and Speer.

Yamhill County Job Training and Placement Center, Inc. (Yamhill), a noncomplying employer, requests review of Referee Hettle's order which: (1) set aside the SAIF Corporation's denial, on Yamhill's behalf, of claimant's hip injury claim; (2) upheld the denial of Wettereau Bakery, a self-insured employer, of the same injury claim; and (3) assessed a penalty and associated attorney fee for an alleged unreasonable denial. On review, the issues are responsibility, penalties and attorney fees. We reverse in part and affirm in part.

FINDINGS OF FACT

The Board adopts the Referee's "Findings" with the following supplementation.

Claimant was under an express contract of hire with Yamhill and an implied contract of hire with Wettereau.

Both Yamhill and Wettereau had the right to simultaneously control claimant's employment activities.

Claimant simultaneously performed services for both Yamhill and Wettereau.

The services claimant performed for Yamhill and Wettereau were the same.

CONCLUSIONS OF LAW AND OPINION

Responsibility

The Referee concluded that claimant was a subject employee of Yamhill but not of Wettereau. On review, Yamhill contends that claimant was a "dual employee" of both Yamhill and Wettereau. In addition, Yamhill argues that, pursuant to ORS 656.029, Wettereau was responsible for providing workers' compensation insurance coverage for claimant.

For purposes of workers' compensation, an employee can have more than one employer. ORS 656.005(13) and (27); Blacknall v. Westwood Corp., 89 Or App 145, 147-48 (1987); Robinson v. Omark Industries, 46 Or App 263 (1980), rev dismissed 291 Or 5 (1981). In order for that to be the case, the worker must have a contract of hire, either express or implied, with each employer and must be under the direction and control of each.

Here, it is undisputed that claimant was a subject employee of Yamhill, a corporation providing temporary employees to other employers, including Wettereau. Yamhill instructed claimant where to report to work. Yamhill hired claimant and had the ability to fire him. Wettereau did not directly pay Yamhill employees, rather it paid Yamhill based on a billing statement. Yamhill, in turn, paid claimant.

When claimant was at the work site, however, he was directly supervised and controlled by Wettereau and he worked only for Wettereau. Because claimant was compensated by Wettereau through Yamhill, was subject to Wettereau's control and worked at Wettereau subject to its approval, we conclude that an implied contract of hire existed between claimant and Wettereau. We conclude that claimant was a subject employee of Wettereau. See Blacknall, supra.

Both Yamhill and Wettereau employed claimant. In resolving responsibility disputes in such cases, the concepts of "dual employment" and "joint employment" are useful.

> "Joint employment occurs when a single employee, under contract with two employers, and under the simultaneous control of both, simultaneously performs services for both employers, and when the service for each employer is the same as, or is closely related to, that for the other. In such a case, both employers are liable for workmen's compensation." Mission Insurance Co. v. Miller, 73 Or App 159 (1985); citing 1C Larson, Workmen's Compensation Law, 48.40 (1982).

Here claimant, a single employee, was under contract of hire with both Yamhill and Wettereau. Yamhill and Wettereau had simultaneous control of claimant's employment. Yamhill hired claimant to work for Wettereau. While claimant worked at Wettereau he was simultaneously performing the services for which both Yamhill and Wettereau employed him. We, therefore, conclude that: (1) claimant was a joint employee subject to simultaneous control of Yamhill and Wettereau; and (2) he performed the same services simultaneously for each. Both Yamhill and Wettereau are fully responsible for claimant's injury. Mission Insurance Co. v. Miller, 73 Or App at 163.

Yamhill argues that, in the event we should conclude that claimant was an employee of both employers, the Board should find that Wettereau is responsible for providing workers' compensation insurance coverage pursuant to ORS 656.029. That statute provides that a person who awards a contract involving the performance of labor where such labor is a normal and customary part of the person's trade or business, the person awarding the contract is responsible for providing workers' compensation insurance coverage for all individuals who perform labor under the contract.

Yamhill's reliance on that statute is misplaced. The purpose of the statute is to provide coverage to subcontractors who are hired by the general contractor to do its work. That is not the case here. Yamhill runs an employment service which provides temporary help to a variety of employers. Neither

it nor claimant were subcontractors to Wettereau. Wettereau did not award a contract to Yamhill for the performance of labor by Yamhill. Instead, it contracted with Yamhill to supply it with a temporary employee. Accordingly, as stated above, both Yamhill and Wettereau are jointly responsibility for claimant's injury.

Penalty and Attorney Fee

The Referee found Yamhill's assertion that claimant was not its subject employee to be unreasonable. He imposed a penalty and associated attorney fee. See ORS 656.262(10) and 656.382(1).

We do not agree that Yamhill's action was unreasonable because, under the circumstances of claimant's employment, Yamhill had a legitimate doubt as to its responsibility to provide claimant's workers' compensation coverage. See Norgard v. Rawlinsons, 30 Or App 999, 1003 (1977). The fact that claimant was injured on Wettereau's premises, while directly under its control, was sufficient basis to raise a doubt as to Yamhill's responsibility. Accordingly, we find that Yamhill's denial was not unreasonable.

ORDER

The Referee's order dated November 12, 1987, as reconsidered February 23, 1988, is reversed in part and affirmed in part. That portion of the Referee's order that upheld Wettereau Bakery Products' denial is reversed. The claim is remanded to Wettereau and the SAIF Corporation to be jointly processed. Wettereau and SAIF are jointly responsible for Referee's $1,200 attorney fee award. The Referee's assessment of a penalty and the $300 associated attorney fee, payable by SAIF, on behalf of Yamhill, is reversed. A client-paid fee not to exceed $1,009.50, payable by Wettereau to its counsel, is approved. A client-paid fee not to exceed $1,163.50, payable by SAIF to its outside counsel, is approved. Claimant's attorney is awarded an assessed fee of $750 for services on Board review, payable equally by SAIF (on behalf of Yamhill) and Wettereau.

In the Matter of the Compensation of
CHRISTOS KEKRIDES, Claimant
WCB Case No. 88-03645
ORDER ON REVIEW
Pozzi, Wilson, et al., Claimant Attorneys
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Crider and Brittingham.

Claimant requests review of Referee Tenenbaum's order that increased claimant's unscheduled permanent disability award for a low back injury from 50 percent (160 degrees), as awarded by prior orders, to 60 percent (192 degrees). On review, the issues are extent of unscheduled permanent disability, including permanent total disability. We reverse.

FINDINGS OF FACT AND ULTIMATE FACT

We adopt the Referee's "Stipulations" and "Findings" with the following clarifications, corrections, and additions:

On January 12, 1982, claimant fell on his left hip and thigh, compensably injuring his low back.

The Referee found that claimant owned a shoe manufacturing company and had management, manufacturing and sales responsibilities in Greece prior to 1962. Instead, we find that claimant and his brother-in-law made and sold sandals for about seven months in Greece after they got out of the Greek army in the late 1950s.

Claimant was examined by the Orthopaedic Consultants in August 1985.

Claimant was examined by Dr. Smith, neurologist, in April 1988 and by Dr. Glass, psychiatrist, in May 1988.

In addition to his history of hard physical labor, claimant continued to work for nine months after his injury, until such work was precluded by his pain.

Claimant sleeps only 2-3 hours at a time because of his pain. When he feels better, he tries to work around the house, but as a result his condition deteriorates and he must sit or lie down in order to relieve his discomfort. Since the injury, he no longer keeps up his large yard of flowers and roses. He was unable to sit long enough to fly to Greece to see his mother after she had a second stroke. He is depressed about his situation, and his home life has deteriorated.

Claimant at the time of hearing suffered from high blood pressure, for which he was prescribed Inderol. This condition arose after the injury, and is not materially related to the injury.

FINDINGS OF ULTIMATE FACT

Claimant's psychological condition is materially related to the injury.

Claimant's condition has worsened since the September 1985 hearing.

Claimant is unable to regularly perform any type of work because of the combined effect of his low back condition, psychological factors, including an hysterical component, and other nonmedical factors.

Work search would be futile.

CONCLUSIONS OF LAW AND OPINION

Permanent Total Disability

Permanent total disability is the only issue presented by claimant on review. When a worker who has not previously been awarded permanent total disability asserts a claim for such benefits following an aggravation claim, the worker must first prove a permanent injury-related worsening of the condition since the last arrangement of compensation. Stepp v. SAIF, 304 Or 375 (1987).

Here, the last arrangement of compensation was the Board's August 1986 order awarding a total of 50 percent unscheduled disability. Claimant's condition was rated as of the September 1985 hearing.

Neither the November 1985 referee's order nor the August 1986 Board order specifically addressed the extent of claimant's physical impairment beyond stating that he was "substantially disabled." In its August 1986 order, the Board stated that there was no persuasive evidence that claimant's functional overlay was a permanent impairment or the cause of permanent loss of earning capacity.

In 1988, claimant's right lateral range of motion (ROM) was 5 degrees, as compared with 10 degrees in 1985. Claimant reported greater pain with lumbar ROM manipulations in 1988 than in 1985. In 1988, claimant had bilateral hypesthesia and hypalgesia along the distal thigh and leg, which extended to the left ankle and foot, as compared to diminished sensitivity extending only to the hip.

Claimant testified to greater pain in his low back and legs in 1988 than in 1985. Furthermore, while the Board found no permanent functional overlay in 1985, Dr. Glass, psychiatrist, opined that claimant is now unable to work because of his psychological condition.

We find Dr. Glass' uncontradicted opinion to be persuasive on the issue of claimant's psychological condition. Glass opined that claimant's hysterical behavior resulted from his age and ethnicity, his inability to cope with pain, and his anxiety about returning to work. Dr. Glass related claimant's pain and anxiety to his compensable injury and the lengthy period of unemployment following that injury. He also opined that the psychological factors involved in claimant's disability were fixed and unresponsive to psychological treatment.

Psychological conditions which are due to the compensable injury are considered in determining whether claimant's condition has worsened. Taking into account claimant's psychological problems, decreased ROM, and increased pain and loss of sensitivity, we find claimant's condition has worsened since the last arrangement of compensation.

Accordingly, claimant is entitled to a reevaluation of his permanent disability. To establish permanent total disability, claimant must prove that he is unable to perform any work at a gainful, suitable occupation. Wilson v. Weyerhaeuser, 30 Or App 403 (1977). Claimant may prove permanent total disability under the "odd lot" doctrine by a combination of medical and nonmedical disabilities which effectively foreclose him from gainful employment. Welch v. Bannister Pipeline, 70 Or App 699 (1984). In addition, claimant has the burden to establish that he is willing to seek regular, gainful employment and has made reasonable efforts to obtain such employment, unless it is shown that efforts would be futile. ORS 656.206(3); Butcher v. SAIF, 45 Or App 318 (1983).

Dr. Glass opined that because of psychological factors superimposed on claimant's physical injury, claimant would not be able to return to work. Vocational rehabilitation counselor Nelson stated that claimant was not employable. Vocational rehabilitation counselor Shivell stated that there were jobs that claimant was physically capable of performing. We find Nelson's opinion to be more persuasive than that of Shivell because, although Shivell knew claimant was illiterate and had an IQ of 78, she did not take these factors into account in performing her hypothetical job analysis. Furthermore, she did not take into account claimant's psychological condition. In contrast, Nelson, who had 15 years experience in placing people with severe disabilities in employment, persuasively opined that there was no work to which claimant could transfer his skills, and that jobs in this geographical area either exceeded claimant's physical capabilities or required reading and writing.

In light of the opinions of Dr. Glass and vocational counselor Nelson, claimant's physical and psychological disability, his advanced age of 57, his heavy accent, his illiteracy, his lack of transferable skills, his inability to adapt to nonphysical labor, and his IQ of 78, we conclude that he falls in the odd-lot category of permanent total disability. See Ferguson v. Industrial Indemnity Co., 70 Or App 46 (1984).

We further conclude that work search would be futile. Just as physical incapacity may render efforts to obtain employment futile, nonmedical factors considered for purposes of the odd-lot doctrine may also make efforts to obtain work futile. SAIF v. Scholl, 92 Or App 594 (1987). We are aware that the Board in 1986 found that claimant had not conducted a reasonable search for work and thus found him not entitled to permanent total disability. However, the Board did not consider claimant's functional overlay to be a permanent psychological impairment, and, as a result, found the social and vocational factors alone insufficient to

support a finding that work search would not be futile. In 1988, claimant's physical and psychological condition combined with the factors noted above that place him in the "odd lot" category, convince us it would be futile for him to make efforts to obtain work.

Based on the above, we find claimant to be permanently and totally disabled.

ORDER

The Referee's order dated July 8, 1988 is reversed. In lieu of the Referee's increased award of unscheduled permanent disability, claimant is granted permanent total disability effective June 8, 1988, the date the hearing record closed. The employer is permitted to offset permanent disability payments paid subsequent to that date against claimant's permanent total disability benefits. Claimant's attorney is awarded a fee equal to 25 percent of the increased disability compensation created by this order, payable by the self-insured employer directly to claimant's attorney, except that total out-of-compensation fees awarded by the Referee and the Board shall not exceed $6,000.

May 9, 1990 Cite as 42 Van Natta 1052 (1990)

In the Matter of the Compensation of
REBECCA A. KUHLMAN, Claimant
WCB Case No. 89-21478
ORDER OF DISMISSAL
Roger D. Wallingford, Claimant Attorney
Roberts, et al., Defense Attorneys

Claimant requests review of Referee Shebley's March 13, 1990 order. We have reviewed the request to determine whether we have jurisdiction to consider the matter. Because we conclude that the request is untimely, the request for review is dismissed.

FINDINGS OF FACT

The Referee's order issued March 13, 1990. The order included notice of when (within 30 days) and where (with the Workers' Compensation Board) a request for review of the order should be filed. On April 26, 1990, the Board received a letter from claimant. The letter was not mailed by registered or certified mail.

Included with claimant's letter was a copy of a request for Board review of the Referee's order. The request for review, which was dated March 25, 1990, indicated that copies had been provided to the other parties to the proceeding and their counsel. Although the request for review is addressed to the Board, there is no indication that the request was mailed to the Board on or before its inclusion in the letter received on April 26, 1990. Moreover, in her April 26, 1990 letter, claimant explained that her former attorney had not instructed her "to send [the Board] a letter."

Claimant's request for review was neither mailed to nor received by the Board within 30 days of the Referee's order.

CONCLUSIONS OF LAW

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 order was neither mailed by registered nor certified mail. Since the request was actually received by the Board on April 26, 1990, after the date for filing, it is presumed to be untimely. This presumption of untimeliness is further supported by claimant's acknowledgment that her former attorney did not advise her "to send [the Board] a letter."

Under these circumstances, the record fails to establish that claimant's request was received by the Board within the statutory 30-day period. Consequently, we lack jurisdiction to review the order, which has become final by operation of law. See ORS 656.289(3); 656.295(2); Argonaut Insurance v. King, supra; Robert G. Ebbert, 40 Van Natta 67 (1988).

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. However, instructions for requesting review were clearly recited in the Referee's order. Moreover, 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.

May 9, 1990 Cite as 42 Van Natta 1053 (1990)

In the Matter of the Compensation of
MARTIN J. McKEOWN, Claimant
WCB Case No. 88-13531
ORDER ON REVIEW
Robert J. Guarrasi, Claimant Attorney
Nancy Marque (Saif), Defense Attorney

Reviewed by Board Members Perry and Speer.

The SAIF Corporation requests review of Referee Livesley's order that: (1) set aside its denial of claimant's medical services claim for eye glasses; and (2) awarded a penalty-related attorney fee for an untimely denial. On review, the issues are compensability and attorney fees. We reverse.

FINDINGS OF FACT

Claimant wears glasses, but only for reading. During his normal working hours, while claimant was bending over to pick up a case file, his glasses fell out of his pocket. The right lens broke.

Claimant had been wearing the glasses in the course of performing his work immediately prior to the accident. However, he was not using them when he bent over to get the file and the glasses dropped out of his pocket.

CONCLUSIONS OF LAW AND OPINION

The Referee held that claimant's eyeglass claim was compensable. We disagree.

A compensable injury is an accidental injury, or accidental injury to prosthetic appliances, arising out of and in the course of employment requiring medical services or resulting in disability or death. ORS 656.005(7)(a).

Eyeglasses are included in the definition of prosthetic appliances under OAR 436-60-050(2). That rule provides, however, that the prosthetic appliance must be in use at the time of a compensable injury in order for the damage to be compensable.

The rule states in pertinent part: "If such a prosthetic appliance is damaged when in use at the time of a compensable injury the cost is a compensable medical expense, regardless of whether the worker actually received a physical injury at the time of the compensable injury." Here, the eyeglasses were in claimant's shirt pocket when they fell to the floor as claimant stooped to pick up a file. Under such circumstances, we conclude that the eyeglasses were not in use at the time of the incident. Inasmuch as we find that the eyeglasses were not in use, the damage to them cannot be compensable under OAR 436-60-050(2).

Moreover, we note with approval Larson's comment in 1B Workmen's Compensation Law (1987), 42.12:

> "A familiar and understandable condition of many of these provisions [of various state statutes in which the concept of injury has been extended to cover injury to prosthetic devices] is that the damage to the eye glasses or other device must have coincided with an otherwise compensable accident. The obvious intent is that the wheels of compensation liability should not be set in motion every time a workman drops his glasses and cracks the lenses."

Since claimant did not require medical treatment or suffer disability to his person, the accident was not otherwise compensable as described in Larson.

Finally, because we do not find the claim compensable, the attorney fee issue has become moot because there has been no unreasonable resistance to the payment of compensation. See Lloyd L. Cripe, 41 Van Natta 1774 (1989).

ORDER

The Referee's order dated October 5, 1988 is reversed. The SAIF Corporation's denial is reinstated and upheld. The Referee's attorney fee awards of $400 are reversed.

In the Matter of the Compensation of
AUDREY L. YAKES, Claimant
Own Motion No. 89-0503M
THIRD OWN MOTION ORDER ON RECONSIDERATION
Doblie & Associates, Claimant Attorneys
Roberts, et al., Defense Attorneys

Claimant requests reconsideration of our April 10, 1990, Second Own Motion Order on Reconsideration which denied her request for reconsideration. We deny claimant's current request as untimely.

A motion for reconsideration shall be denied if not timely submitted to the Board. OAR 438-12-065(2). To be timely, the motion must be filed within 30 days of the date of mailing of the final order, or within 60 days of that mailing date if the party requesting reconsideration establishes to the Board's satisfaction that there was good cause for the failure to file the request within 30 days of that date. Id.

Here, the order was mailed March 27, 1990. Claimant, through her attorney, filed the motion for reconsideration on May 2, 1990, more then 30 days after the date of mailing of the order but within 60 days of that mailing date. Claimant contends that she had good cause for failing to file sooner because she suffers "profound psychological disability" due to an organic mental disorder. She relies on a previously-submitted psychological evaluation report dated October 24, 1988. However, there is no persuasive medical evidence that claimant currently suffers mental or psychological impairment so severe that it prevented her from timely requesting reconsideration of our order. Moreover, claimant is represented by an attorney capable of timely requesting reconsideration on his client's behalf. For these reasons, we do not find that claimant has established good cause for the untimely filing of her motion.

Claimant's request for reconsideration is denied as untimely.

IT IS SO ORDERED.

In the Matter of the Compensation of
HAZEL P. FLORY, Claimant
WCB Case Nos. 85-15107 & 85-15106
ORDER OF ABATEMENT
Sharp & Durr, Claimant Attorneys
Thomas Sheridan (Saif), Defense Attorney
Stafford Hazelett, Defense Attorney
Beers, et al., Defense Attorneys

Claimant requests reconsideration of our April 26, 1990 Order on Review. Before considering the request, we grant the other parties an opportunity to respond.

Accordingly, our April 26, 1990 order is withdrawn. The other parties are requested to submit their respective responses within 14 days from the date of this order. Thereafter, we shall proceed with our reconsideration.

IT IS SO ORDERED.

In the Matter of the Compensation of
RONALD R. ROBINETT, Claimant
WCB Case No. 88-16807
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Garrett, et al., Defense Attorneys

Reviewed by Board Members Brittingham and Crider.

The self-insured employer requests review of Referee Livesley's order that increased a Determination Order award of 21 percent (31.5 degrees) scheduled permanent disability for loss of use or function of the the left leg (knee) to 40 percent (60 degrees). On review, the issue is extent of scheduled permanent disability. We modify.

FINDINGS OF FACT

We adopt the Referee's "findings of fact" with the following supplementation. Claimant became medically stationary on August 15, 1988. Claimant's meniscus remained intact following surgery. Claimant has atrophy of his left thigh.

FINDING OF ULTIMATE FACT

Claimant has suffered a 35 percent loss of use or function of the left leg due to the compensable injury.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant had proven by clear and convincing evidence that claimant had sustained a 40 percent (60 degrees) loss of use or function of his left knee. He did so without first calculating claimant's total disability under the "standards." This approach is incorrect.

If a claimant became medically stationary after January 1, 1988 and his or her claim was closed on or after July 1, 1988, a subsequent determination by a referee or the Board of the claimant's permanent partial disability must be made pursuant to ORS 656.283(7) and 656.295(5), respectively. OAR 438-10-005 and Michelle Griffith, 40 Van Natta 2086 (1988). Only after that calculation is made may we consider a contention that the record, as a whole, constitutes clear and convincing evidence that the degree of permanent partial disability suffered by the claimant is more or less than the entitlement indicated by the "standards". ORS 656.283(7) and 656.295(5).

In this case, the "standards" adopted effective July 1, 1988, (former OAR 436-35-001 et seq), as amended by temporary rules effective August 19, 1988, apply to the rating of claimant's permanent partial disability. Former OAR 436-35-010 through 436-35-260 apply to the rating of scheduled permanent partial disabilities. Former OAR 436-35-010(1).

Claimant is entitled to a value based upon his permanent loss of use or function in his left knee. The value given for claimant's lost range of motion in his left knee is based upon active degrees of motion. See Former OAR 436-35-010(3). To calculate a loss of motion one of two methods is provided for by the "standards". Id. The "standards" rate loss of motion by comparing the active degrees of motion of the injured body member to the degrees of motion possible in the contralateral normal joint, or by comparing the active degrees of motion of the injured member to the ranges of motion established, as normal, by the American Medical Association. Id. In this case, claimant's contralateral joint

(i.e. his uninjured right knee) was measured by Dr. James as having 0-150 active degrees of motion. The American Medical Association measured a normal knee joint as having 0-150 active degrees of motion. Therefore, the calculations would be the same under either method in this case. We rate claimant's lost range of motion by comparing his active degrees of motion in his injured knee to the ranges of motion established by the American Medical Association as normal.

Claimant's range of motion in his left knee, as measured by Dr. James, is 5 to 95 degrees. Claimant has retained 95 degrees flexion in his left knee. Pursuant to former OAR 436-35-220(1) claimant is entitled to a value of 19.5 percent. Claimant can extend only to 5 degrees and is, therefore, entitled to a value of 0.5 for loss of extension. Former OAR 436-35-220(2). Claimant's "added" total rating for loss of motion in his left knee is 20 percent. Former OAR 436-35-220(4); 436-35-240(2).

Pursuant to former OAR 436-35-230(3) claimant is entitled to a rating for instability. As measured by Dr. James, claimant has a 1+ valgus instability (less than 5 mm) and a 1+ Lachman (less than 5 mm) instability with no pivot shift. Dr. James' report does not allow us to determine whether or not claimant has more than minimal instability under the rules. Therefore, we award claimant a value of 5 percent for instability.

Claimant is also entitled to a value for weakness and atrophy. Former OAR 436-35-230(5)(a). The Referee awarded claimant 5 percent for weakness and atrophy. We agree. Pursuant to former OAR 436-35-230(5)(a), the range value which we are allowed to award for weakness and atrophy is 5 to 10 percent. We find that there is no evidence that claimant has experienced atrophy to the extent that we would award him 10 percent. Therefore, based upon the reports of Dr. James and the physical capacities evaluation, we find that claimant is entitled to a value of 5 percent for weakness and atrophy.

The employer argues that claimant is not entitled to a value under the standards for either of his left knee surgeries. On October 21, 1987, Dr. James performed an arthroscopic reconstruction of the anterior cruciate ligament and an open repair of the medial contralateral ligament. Dr. James' surgical report notes that there was slight hemorrhage at the mid portion of the meniscus at its attachment along the periphery, but the meniscus was still intact. On June 2, 1988, Dr. James performed an arthroscopic lysis of adhesion in the left knee. Again Dr. James' surgical report notes that the meniscus was intact with good articular surfaces. Former OAR 436-35-230(4)(c) provides for a rating for a complete meniscectomy or proportionate losses for less than a complete removal. The medical evidence does not suggest that the meniscus was removed in whole or in part. Therefore, claimant is entitled to no value for his surgical procedures.

To arrive at a total rating for impairment to claimant's left knee, the value for claimant's left knee lost range of motion (20 percent); the value for instability (5 percent); and the value for weakness and atrophy (5 percent) are combined (not added). See former OAR 436-35-220(4). The result of the combined values is 28 percent.

In addition, claimant is entitled to a value for disabling pain that results in a loss of use or function. Former OAR 436-35-010(2)(a) provides that pain can result in loss of use or function. When it does, it is rated based on the loss of use or function which results and no additional value is allowed for pain alone. The Board in Daniel M. Alire, 41 Van Natta 752 (1989) held that, inasmuch as the standards do not provide for a value range for impairment attributable to disabling pain, the Board on de novo review can consider the

evidence and award the claimant a value that adequately compensates him for his loss of use or function attributable to disabling pain.

In this case, the record establishes that claimant has a loss of use or function, attributable to disabling pain. Claimant experiences pain on a constant basis. Due to claimant's pain he is able to sit for no longer than 30 minutes. Under these circumstances, claimant is entitled to a value, based upon his disabling pain which has resulted in a loss of use or function, of 10 percent.

Having determined each value necessary to compute claimant's permanent disability under the "standards", we proceed to that calculation. When the total value for lost range of motion, instability and weakness and atrophy (28 percent) is combined with the value for disabling pain (10 percent) the result is 35 percent. Claimant's permanent disability under the "standards" is therefore, 35 percent.

The Referee found that claimant had proven by clear and convincing evidence that his disability was greater than that provided for under the standards. Dr. James, claimant's treating physician, found that claimant had retained 60 to 65 percent of the function of his left knee. Under these circumstances, we are not persuaded that claimant's loss of use or function is greater than that determined under the standards (35 percent).

ORDER

The Referee's order dated January 6, 1989 is modified. In lieu of the Referee's award and in addition to the Determination Order award of 21 percent (31.5 degrees) scheduled permanent disability for loss of use or function of the left leg, claimant is awarded 14 percent (21 degrees), for a total award to date of 35 percent (52.5 degrees). A client-paid fee, payable from the self-insured employer to its counsel, is approved, not to exceed $1,414.50.

May 14, 1990 Cite as 42 Van Natta 1058 (1990)

In the Matter of the Compensation of
HUARLEEN BAIN, Claimant
WCB Case No. 88-18747
ORDER ON REVIEW
Dennis O'Malley, Claimant Attorney
Terrall & Miller, Defense Attorneys

Reviewed by Board Members Cushing and Myers.

The self-insured employer requests review of those portions of Referee Quillinan's order which set aside its denial of a claim for a right knee injury. On review, the sole issue is compensability. We affirm.

FINDINGS OF FACT

Claimant is a bus driver who has preexisting degenerative changes in his right knee. He was being treated for right knee problems in June 1988. His then treating physician had recommended a tibial osteotomy.

On July 15, 1988, claimant's pants caught on the gear shift of his bus. He then tripped over a wastebasket and twisted his right knee.

The tripping incident accelerated claimant's degenerative condition and caused some acute tearing of the lateral meniscus. A torn lateral meniscus was revealed by arthroscopic surgery performed by Dr. Gripekoven in October 1988.

CONCLUSIONS OF LAW AND OPINION

Claimant has the burden of proving that an on-the-job injury occurred and that the injury was a material cause of claimant's need for medical treatment or disability. We conclude that claimant has sustained his burden of proof.

The employer argues that no incident occurred. It argues that claimant is not credible. We disagree. The Referee specifically found claimant credible. We find nothing in the record which causes us to question the Referee's credibility finding. Consequently, we conclude that an incident occurred.

The employer also argues that claimant has failed to prove that the incident was a material cause of claimant's surgery. Again, we disagree. It is true that even before the injury, Dr. Zimmerman had proposed knee surgery. However, Dr. Gripekoven, who actually performed the surgery, opined that if the injury occurred as claimant testified, then the injury accelerated claimant's degenerative changes and at least in part caused a traumatic tear of the lateral meniscus. Based on that unrebutted opinion, we conclude that the injury was a material cause of claimant's need for surgery notwithstanding the fact that claimant would have needed the surgery even without the injury.

ORDER

The Referee's order dated March 9, 1989 is affirmed. Claimant's attorney is awarded an assessed fee of $1,000, to be paid by the employer.

May 14, 1990 Cite as 42 Van Natta 1059 (1990)

In the Matter of the Compensation of
RONALD G. BOEHM, Claimant
WCB Case No. 88-17848
ORDER ON REVIEW
Peter O. Hansen, Claimant Attorney
Bullard, et al., Defense Attorneys

Reviewed by Board Members Cushing and Gerner.

The insurer requests review of Referee Galton's order which awarded claimant 19 percent (60.8 degrees) unscheduled permanent disability, whereas a Determination Order had awarded no permanent disability. On review, the issue is extent of unscheduled permanent disability. We reverse.

FINDINGS OF FACT

Claimant suffered a compensable low back injury on November 25, 1987. He lost two days from work and then returned to his regular job and worked continuously until the employer closed its business.

Claimant has found new employment with another employer in a job like his job at injury. Claimant has full range of motion in his thoracolumbar spine. He does not experience any permanent disabling pain.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant had 13 percent impairment based upon retained flexion of 10 degrees, retained extension of 15 degrees, retained left

and right flexion of 15 degrees and retained rotation of 20 degrees. The insurer contends that the Referee's findings are erroneous because they are not contained in any medical record, are made by the Referee while viewing claimant perform the various motions based on claimant's reenactment of his ranges of motion as he remembered them to be during a prior exacerbation that had completely resolved by the time of hearing when claimant was pain-free with full ranges of motion. We agree.

Extent of permanent disability is determined by claimant's condition as of the date of hearing, not as claimant's condition existed in the past. Gettman v. SAIF, 289 Or 609 (1980). On the date of hearing claimant had no limitations and no impairment. Therefore, he was not entitled to any value for impairment based on lost ranges of motion as they may have existed in the past.

Because claimant has no impairment, he is not entitled to an award of permanent disability under the standards. Former OAR 436-35-280(1). Therefore, it is unnecessary to address the values for Age, Education and Adaptability under the standards.

The Referee also found by "clear and convincing" evidence that claimant had lost 19 percent earning capacity. We disagree. Because claimant is free of disabling pain and has no impairment, he has not lost any earning capacity. James C. Kilburn, 40 Van Natta 814 (1988).

ORDER

The Referee's order dated February 3, 1989 is reversed. The Determination Order is reinstated in its entirety. The Board approves a client-paid fee, not to exceed $1,782.50, payable from the insurer to its counsel.

May 14, 1990 Cite as 42 Van Natta 1060 (1990)

In the Matter of the Compensation of
JEAN NOVOTNY, Claimant
WCB Case Nos. 88-10582, 88-10583, 88-14168 & 88-14169
ORDER ON REVIEW
Quintin B. Estell, Claimant Attorney
Saif Legal, Defense Attorney
Kevin L. Mannix, Defense Attorney

Reviewed by Board Members Speer and Howell.

Liberty Northwest Insurance Corporation requests review of that portion of Referee Holtan's order that: (1) set aside its denial of claimant's occupational disease claim for her current right elbow and bilateral hand and wrist conditions; and (2) upheld the SAIF Corporation's denial of claimant's aggravation claim for the same conditions. Claimant cross-requests review of that portion of the Referee's order that declined to award attorney fees. On review, the issues are responsibility and attorney fees. We affirm in part and modify in part.

FINDINGS OF FACT

The Board adopts the Referee's "Procedural Background Facts" and "Findings of Fact".

CONCLUSIONS OF LAW AND OPINION

The Board adopts the Referee's "Opinion" with the following supplementation.

Attorney Fees

The Referee concluded that claimant's right to compensation was not at issue and he found that claimant's counsel was not entitled to an attorney fee for services at hearing. We agree.

The current version of ORS 656.307 authorizes an insurer-paid attorney fee if claimant participates in the responsibility proceeding. Specifically, subsection (5) provides that, if claimant appears in any arbitration proceeding and "actively and meaningfully participates" in the proceeding through an attorney, the arbitrator may require that a reasonable attorney fee be paid by the insurer determined by the arbitrator to be the party responsible for paying compensation. This statutory language is essentially duplicated in OAR 438-15-090, effective January 1, 1988.

Although court decisions have relied upon language similar to that in ORS 656.307(5), none have interpreted or applied that provision. In a recent case, Daniel J. Bergmann, 42 Van Natta 949 (1990), we interpreted the provisions of ORS 656.307(5). We found "active and meaningful" participation in an arbitration proceeding where claimant's attorney submitted exhibits "and was further involved in the preparation of the case and in achieving settlement." While we made no finding that claimant had actively asserted that the insurer which ultimately accepted the claim was responsible, that finding was implicit in our decision.

In the present case, claimant's attorney participated in the arbitration proceeding by questioning a witness. However, the record does not indicate that claimant's attorney's participation was in any way "meaningful" in the ultimate determination of the responsible insurer. Under such circumstances, we cannot say that there was "active and meaningful" participation under ORS 656.307(5). An attorney fee is not appropriate.

On Board review, claimant's counsel only contended that one or the other of the insurers should be held responsible. Claimant's brief primarily addressed the issue of entitlement to attorney fees. Under the circumstances, we find that claimant's counsel did not meaningfully or actively participate at the Board level, and we conclude that an attorney fee for services on review is not merited.

ORDER

The Referee's order dated October 12, 1988, as reconsidered December 20, 1988, is affirmed in part and modified in part. That portion of the Referee's order which dismissed cases No. 88-14168 and 88-14169 is modified and those cases are reinstated. The remainder of the Referee's order is affirmed.

May 14, 1990 Cite as 42 Van Natta 1061 (1990)

In the Matter of the Compensation of
PETE S. STURZA, Claimant
WCB Case Nos. 86-05018 & 86-07975
ORDER ON REVIEW
Yturri, et al., Claimant Attorneys
Saif Legal, Defense Attorney
Bottini, et al., Defense Attorneys

Reviewed by Board Members Crider and Brittingham.

The SAIF Corporation requests review of the portions of Referee Mulder's order that: (1) set aside its denial of claimant's aggravation claim for his current cervical and right shoulder conditions; and (2) upheld Mission Insurance Company's (Mission's) denial of claimant's claim for temporary disability and

medical benefits relating to those same conditions. Claimant cross-requests review of the portions of the Referee's order that: (1) declined to assess a penalty and related attorney fee for SAIF's allegedly unreasonable resistance to the payment of compensation; and (2) declined to direct the insurers to pay the cost of a deposition. We reverse in part, modify in part, and affirm in part.

ISSUES

1. Preclosure Denials of Claims. Did Mission's denial of claimant's claim for temporary disability and medical benefits constitute a preclosure denial of future responsibility for previously accepted conditions? If not, responsibility for that condition.

2. Penalties and Attorney Fees. Was SAIF's contention that claimant's aggravation rights had expired concerning his 1980 claim, thereby precluding the issuance of a .307 order, unreasonable? If so, did SAIF resist the payment of compensation?

3. Deposition Costs. Was Dr. Garber a witness for the insurers during his deposition?

FINDINGS OF FACT

Claimant, a livestock auction yard worker, sustained numerous compensable injuries on February 14, 1980, when he was trampled by a bull while working for SAIF's insured. The initial diagnoses were a fractured right clavicle, two fractured ribs, a fractured left zygoma (cheekbone), abdominal and lung contusions, and facial abrasions. Shortly thereafter, he developed adhesive capsulitis (joint inflammation) of both shoulders. He treated conservatively with Dr. Toevs. SAIF accepted the injury claim as disabling.

In February, 1981, claimant was released to his former occupation which required lifting and feeding up to 100 ninety-pound bales to animals in the stockyard. His claim was closed by Determination Order on February 9, 1981, with no permanent disability award.

In September, 1982, Dr. Toevs requested that claimant's claim be reopened due to worsening pain in both shoulders, persistent rib pain and inadequate tearing in the left eye. The claim was reopened and later reclosed by Determination Order on January 10, 1983, with 40 percent unscheduled permanent disability for chest and bilateral shoulder conditions. Claimant requested a hearing on that order. Sometime in early 1983, claimant began working for Mission's insured as an auction yard manager.

Prior to hearing on the 1983 Determination Order, claimant was referred to Dr. Garber for an orthopedic consultation in April, 1984. At that time, claimant had pain in the neck, sternum and right shoulder. He also had problems with his hands "going to sleep," particularly at night. X-rays revealed marked degenerative changes in the cervical spine from C4 to C7, with narrowed joint spaces and large arthritic spurs. His left shoulder exhibited considerable narrowing of the gleno-humeral joint, a large spur present on the humeral head, and marked arthritic changes of the glenoid. The right shoulder had a nonunion of the clavicle secondary to the 1980 fracture.

After a hearing on the 1983 Determination Order, the Referee issued his order on May 24, 1984, awarding claimant 5 percent scheduled permanent disability for eye difficulties, 5 percent scheduled permanent disability for facial nerve damage, and an additional 15 percent unscheduled permanent disability for his cervical condition. Claimant did not seek medical treatment for his shoulder or neck conditions from May, 1984, to October, 1985, although he was never without pain.

On October 10, 1985, while working for Mission's insured, claimant was thrown from the back of a truck when the driver hit a drain ditch. A bale of hay landed on claimant's right shoulder. He filed a claim for "bruise-strain" involving the right shoulder and arm, and continued working. Mission accepted the claim as a nondisabling injury. Later that month, claimant saw Dr. Yaguchi, a chiropractor, with complaints of right shoulder pain and inability to raise his right arm above shoulder level. The diagnoses were an acromio clavicle sprain/strain, a contusion with tenosynovitis, and ankylosing capsulitis.

By January, 1986, claimant had neck pain with associated loss of motion, a "very painful" right shoulder, intermittent pain and numbness in the entire right arm. He was referred to Dr. Garber, who ultimately assumed claimant's primary care. Garber diagnosed cervical radiculopathy and prescribed outpatient traction and hot packs. When outpatient therapy failed to relieve symptoms, claimant was admitted for inpatient traction and observation on February 13, 1986. His symptoms improved and he was discharged several days later with a TNS unit.

Claimant's aggravation rights relating to the 1980 injury claim expired on February 9, 1986. Before the expiration of those rights, SAIF received medical reports from Drs. Garber and Yaguchi showing that claimant required treatment for worsening neck, right shoulder and arm symptoms.

On March 27, 1986, SAIF denied claimant's aggravation claim for medical treatment and disability relating to claimant's cervical and shoulder conditions, alleging that those conditions resulted from the 1985 injury. On May 12, 1986, Mission denied responsibility for claimant's current cervical and clavicle complaints, reasoning that they related to the 1980 injury. Mission had not yet closed the 1985 claim when it issued its denial.

On June 10, 1986, Mission clarified its position that it was contesting responsibility, not compensability, and agreed to the designation of a paying agent pursuant to ORS 656.307. SAIF, however, refused to concede compensability, contending that claimant's aggravation claim was in Own Motion status and a ".307" order should not be entered.

FINDINGS OF ULTIMATE FACT

1. Mission's denial of claimant's disability and need for treatment in 1986 issued before claim closure and denied future responsibility for previously accepted conditions.

2. SAIF's contention that claimant's aggravation rights had expired precluded issuance of a .307 order. Its contention was unreasonable and delayed payment of claimant's compensation.

3. Dr. Garber was a witness for both insurers during his deposition.

CONCLUSIONS OF LAW AND OPINION

Preclosure Denial by Mission

The Referee concluded that SAIF is responsible for claimant's disability and need for treatment in 1986, apparently reasoning that claimant sustained an aggravation of his 1980 injury with no independent contribution by the 1985 injury. We disagree with the Referee's analysis and ultimate conclusion.

Our analysis begins and ends with Mission's denial. At the time of claimant's 1985 nondisabling injury with Mission, ORS 656.268 required that

accepted claims for nondisabling injuries be closed. See Or Laws 1981, ch. 874, 13; see also Webb v. SAIF, 83 Or App 386, 390 (1987). Here, Mission has never closed the 1985 claim.

An insurer may not deny further responsibility for any condition arising from the accepted claim while the claim is in open status and before the extent of the accepted condition(s) has been determined pursuant to the statutory procedures for claim closure. Roller v. Weyerhaeuser Co., 67 Or App 583, amplified 68 Or App 743, rev den 297 Or 601 (1984); Safstrom v. Riedel International, Inc., 65 Or App 728 (1983); Arthur E. Matthews, 39 Van Natta 361 (1987).

In late October, 1985, Mission accepted claimant's claim for a "bruise-strain" involving the right shoulder and arm. At that time, claimant's symptoms were a painful right shoulder and inability to lift his right arm above shoulder level. Claimant was ultimately diagnosed with cervical radiculopathy in January 1986, and, in addition to neck pain which has persisted since the 1980 injury, continued to have right shoulder and arm problems which required hospitalization for traction in February 1986. We are persuaded that the right shoulder and arm symptoms resulting in claimant's disability and need for treatment in 1986 were a continuation of symptoms arising from the accepted 1985 injury with Mission. Thus, Mission's preclosure denial of responsibility was procedurally improper and must be set aside. See id.

By issuing the preclosure denial, Mission sought to shift responsibility for claimant's right shoulder and arm conditions back to SAIF, the previous insurer. However, the Board has declared that a later employer/insurer may not issue a preclosure denial of responsibility for a previously accepted condition in order to shift responsibility for that condition back to an earlier employer/insurer. Stephanie L. Vollendroff, 42 Van Natta 945 (1990) (citing Mason L. Asbury, 38 Van Natta 961 (1986)). Accordingly, we conclude that Mission remains responsible for claimant's disability and treatment in 1986.

Penalty and Attorney Fee

ORS 656.262(10) states that:

> "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."

A physician's report indicating a need for further medical services or additional compensation is a claim for aggravation. ORS 656.273(3).

Although SAIF initially issued a denial of responsibility, it later contended that claimant's aggravation rights under his 1980 claim had expired. Thus, SAIF asserted that claimant was not entitled to compensation except as provided under ORS 656.278. Yet, the parties stipulated at hearing that, before the expiration of claimant's aggravation rights on the 1980 claim, SAIF received Dr. Garber's hot pack and traction prescription for cervical radiculopathy dated January 13, 1986, Dr. Yaguchi's report dated January 21, 1986, and Yaguchi's 827 Form dated January 22, 1986. These physicians' reports indicated a need for further medical services and, hence, constituted a claim for aggravation.

Inasmuch as claimant's claim was filed before the expiration of his aggravation rights, the claim was not in Own Motion status as SAIF asserted. Considering the aforementioned medical reports, which SAIF admits that it had in its

possession, we conclude that there is no reasonable basis for SAIF's contention to the contrary. Thus, SAIF's refusal to accede to the issuance of a .307 order was unreasonable. Accordingly, despite our conclusion that Mission is responsible for the claim, we assess SAIF a penalty for its unreasonable resistance to the payment of compensation equal to 25 percent of the temporary disability due at the time of hearing under the Mission claim and a reasonable penalty-related attorney fee. See Industrial Indemnity Company v. Weaver, 81 Or App 493 (1986).

Deposition Cost

Former OAR 438-07-005(5) stated that:

> "Medical, surgical, hospital or vocational reports offered by the insurer will also be accepted as prima facie evidence provided the insurer agrees to produce the doctor or vocational expert for cross examination
> upon request of the claimant ***. The cost of cross examination of any doctor or vocational expert under this section shall be paid by the insurer."

See Hanna v. McGrew Bros. Sawmill, 44 Or App 189, 194-95 (1980); W. Craig Walker, 37 Van Natta 974 (1985).

In response to SAIF's request for information concerning claimant's condition, Dr. Garber wrote a one-page report dated July 23, 1986. When Mission requested information, Garber responded with another one-page report dated August 5, 1986. SAIF subsequently requested a check-the-box response, which Garber provided. Claimant's counsel received a copy of that response on October 9, 1986. Each of the above reports generally supported the respective insurer's position in the claim.

On October 23, 1986, claimant's counsel informed the two insurers that he would be deposing Dr. Garber, though he did not specify whether the deposition was being taken for the purpose of cross-examination. Subsequently, SAIF refused to pay for the deposition. Mission failed to respond to claimant's request for payment.

We are persuaded that Garber was a witness for the insurers, because they requested and offered his reports into evidence. Claimant's request for a deposition did not alter Garber's status as a defense witness. Furthermore, it is irrelevant that claimant did not specify whether the deposition was sought for the purpose of cross-examination, as opposed to further clarification of the doctor's opinion. Our rules do not require such specification. Because the deposition was of a defense witness, we hold that the insurers should bear the cost of Garber's deposition equally. See Hanna v. McGrew Bros. Sawmill, supra.

ORDER

The Referee's order dated April 27, 1987, is reversed in part, modified in part, and affirmed in part. SAIF's denial is reinstated and upheld. Mission's denial is set aside and the claim is remanded to Mission for processing according to law. The Referee's assessed fee award of $1,800 to claimant's attorney shall be paid by Mission. Each insurer shall pay one-half the cost of Dr. Garber's deposition. SAIF shall pay claimant a penalty equal to 25 percent of the temporary disability due under the Mission claim at the time of hearing. Claimant's attorney is awarded a penalty-related attorney fee of $500, to be paid by SAIF. The remainder of the order is affirmed.

In the Matter of the Compensation of
PETE SYMIONOW, Claimant
WCB Case No. 87-02857
ORDER ON REVIEW
Wilbur C. Smith, Jr., Claimant Attorney
Roberts, et al., Defense Attorneys

Reviewed by Board Members Cushing and Gerner.

Claimant requests review of Referee Wasley's order that affirmed a Determination Order which awarded no unscheduled permanent disability for eye and ear conditions. On review, the issue is extent of unscheduled permanent disability. We affirm.

FINDINGS OF FACT

On December 6, 1985, claimant sustained a compensable injury while working for the insured. The insurer on January 8, 1987 issued a denial for claimant's eye or "floaters" condition. Claimant was advised he could return to work without specific limitations on February 3, 1987. (Ex. 15-2). The insurer accepted the "floaters" condition asserting that it "may" have been caused by the compensable injury on August 7, 1987. (Ex. 26). An August 17, 1987 Determination Order found claimant was entitled to no permanent disability.

Claimant was a music teacher before the accident and after the onset of the eye "floaters" and ear "tinnitus" conditions. He can still read music and hear normally.

ULTIMATE FINDING OF FACT

Claimant has lost no earning capacity as a result of either the eye or ear conditions.

CONCLUSIONS OF LAW AND OPINION

The Referee found that neither claimant's ear nor eye condition has resulted in diminished earning capacity because neither condition has interfered with his work as a school teacher. We agree.

To prove entitlement to unscheduled disability, claimant must show by a preponderance of the evidence a permanent loss of earning capacity. See Hutcheson v. Weyerhaeuser, 288 Or 51, 56 (1979). 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 her physical impairment as reflected in the medical record, the testimony at hearing, and all 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. See Harwell v. Argonaut Insurance, 296 Or 505, 510 (1984); Fraijo v. Fred N. Bay News Co., 59 Or App 260, 269 (1982).

Extent of Disability for the Eye Condition

No physician found claimant's eye condition disabling. Dr. Rasmussen found claimant's left eye normal and that he could return to work without restrictions. (Ex. 12-2). Likewise, Dr. Christenson opined that claimant's eye condition was not disabling, and that he should be able to work normally. (Ex. 25).

Claimant could only speculate on the loss of productivity derived from the eye condition. He indicated that he had to work harder to overcome the condition. On cross-examination claimant acknowledged that his eye condition was not disabling enough to have informed the Department of Motor Vehicles regarding the disability. He admitted being able to read, comprehend and to understand the medical reports regarding his eye condition. In light of the medical and lay testimony, we find that claimant has not met his burden of showing a reduction in earning capacity due to his eye condition.

Extent of Disability for the Ear Condition

No physician found claimant's tinnitus condition disabling. Dr. Rasmussen, claimant's treating physician, reported that claimant could return to his job as a music teacher without restrictions. In addition, Dr. Morgan opined that claimant could return to work without specific limitations.

Claimant testified that the tinnitus condition did not interfere with his ability to hear. (Tr. 10). In addition, claimant was unable to say for sure whether his productivity had diminished because of the ear condition. (Tr. 11). In light of the medical and lay testimony, we find that claimant has not met his burden of showing a reduction in earning capacity due to his ear condition.

ORDER

The Referee's order dated June 30, 1988 is affirmed. A client-paid fee, not to exceed $951, payable from the insurer to its counsel, is approved.

May 14, 1990 Cite as 42 Van Natta 1067 (1990)

In the Matter of the Compensation of
DIANA M. VANKERCKHOVE, Claimant
And, In the Matter of the Complying Status of
Noeleen C. Conway, dba, ASCOT DOMESTIC SERVICE, Noncomplying Employer
WCB Case Nos. 88-13525, 88-13526 & 88-13804
ORDER ON REVIEW
Peter O. Hansen, Claimant Attorney
Ann Morgenstern, Attorney
David Fowler (Saif), Defense Attorney
Ernest W. Kissling, Attorney

Reviewed by Board Members Howell and Speer.

Claimant requests review of those portions of Referee Leahy's order which: (1) declined to award claimant temporary total disability compensation (TTD) for a two week period beginning May 18, 1987; and (2) which awarded claimant's attorney a $600 assessed fee for services at hearing. The noncomplying employer's (NCE's) attorney requests approval of a client-paid fee for services at hearing. On review, the issues are TTD and attorney fees. We affirm in part, modify in part and reverse in part.

FINDINGS OF FACT

Claimant worked for the NCE, Ascot Domestic Services, as a housekeeper cleaning private homes. She also worked about one hour several days per week as a telephone receptionist in the NCE's office. Claimant normally worked five days per week.

On May 18, 1987, claimant was compensably injured when she slipped and fell while cleaning a house. She sought medical treatment that day at a minor

emergency clinic. Her injury was diagnosed as a lumbosacral strain and contusion of the left flank. Claimant was advised to do no lifting for three to five days and to return for treatment if she did not improve during that period. Medications were prescribed and one was refilled three days later.

A week after her injury claimant was still unable to perform her regular work as a housekeeper. However, she did not seek further medical care because she could not afford it. Instead she used a whirlpool bath and the medication that had been prescribed. On June 1, 1987, she returned to her regular work.

CONCLUSIONS OF LAW

TTD

Claimant argues that she is entitled to TTD from May 18, 1987 to June 1, 1987. She has the burden to prove that she was unable to perform her regular work during that period because of her compensable injury. We find that she has met that burden.

Claimant testified that she was unable to work because of her injury during the period in question. Contemporaneous medical records tend to support claimant's testimony, as do statements she made to a Department of Insurance and Finance investigator. The Referee made no credibility findings. We find claimant's testimony to have been credible and to constitute a preponderance of the evidence as to her inability to work after May 18, 1987.

Attorney Fee

Claimant challenges the $600 fee awarded by the Referee. At hearing, the issues were: (1) whether claimant's claim had properly been classified as nondisabling, that is, whether claimant was entitled to TTD; and (2) whether Ascot was a subject but noncomplying employer. The Referee refused to award TTD and did not reclassify claimant's claim. Thus, the assessed fee awarded to claimant's attorney must have been for services with respect to the Department's order finding Ascot to be a NCE. We question whether claimant was a necessary party to a hearing on that issue, however, the SAIF Corporation has not objected to the fee. Assuming claimant was entitled to an attorney fee, we find the fee awarded by the Referee to have been adequate. OAR 438-15-010.

ORDER

That portion of the Referee's November 29, 1988 order, as supplemented December 5, 1988, which declined to award TTD is reversed. Claimant is awarded TTD for the period May 18, 1987 to June 1, 1987. An attorney fee of 25 percent of such compensation is approved. That portion of the order which awarded claimant's attorney a $600 assessed fee is affirmed. A client paid fee is approved for the NCE's attorney for services at hearing in an amount not to exceed $660.

In the Matter of the Compensation of
LYNDIA M. BRISTOL, Claimant
WCB Case No. 88-17682
ORDER ON REVIEW
Douglas L. Minson, Claimant Attorney
Roberts, et al., Defense Attorneys

Reviewed by Board Members Cushing and Myers.

Claimant requests review of Referee Quillinan's order which declined to grant permanent total disability and awarded 40 percent (128 degrees) unscheduled permanent disability for a low back condition and 15 percent (22.5 degrees) scheduled permanent disability for loss of use or function of her right leg, whereas a Determination Order had awarded no permanent disability. On review, the issue is permanent total disability. We affirm.

FINDINGS OF FACT

Claimant had preexisting low back problems from a 1979 injury that necessitated surgery. On November 14, 1985, claimant injured her right knee when she slipped and fell. She underwent knee surgery for a torn meniscus and her claim was eventually closed by Notice of Closure dated April 1, 1986. Four months later claimant's claim was reopened for additional knee surgery. During the course of rehabilitative knee exercises claimant injured her low back. Claimant underwent a L4-5 lumbar hemilaminectomy in February 1987.

Claimant was not cooperative with attempts to give her vocational and rehabilitative assistance. (Exs. 39, 47-4, 52-2; Tr. 64-65). She is overfocused on her pain and is consciously exaggerating her disabilities and pain complaints. (Exs. 45, 47-4, 47-5, 50-6). Claimant has no psychological disorders caused by the industrial injury. (Ex. 51-3). She is moderately disabled by pain. (Ex. 50).

Claimant is 48 years old. She is a high school graduate and has two and one-half years of college education. She is a Licensed Practical Nurse and holds certificates in pharmacology and inhalation therapy. Her past employment includes farm work, and nursing in both hospitals and private care facilities. Claimant has not worked since spring 1986. (Ex. 47-3). She has not looked for work. (Tr. 29).

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant was not permanently and totally disabled because she had not made reasonable efforts to seek work and because she was not willing to work. We agree.

To establish entitlement to permanent total disability benefits, claimant has the burden of proving that she is willing to seek regular and gainful employment and that she has made reasonable efforts to obtain such employment.

Claimant did not testify that she wants to work. She has not cooperated with the insurer's efforts to assist her in returning to work. Therefore, we conclude that claimant is not willing to obtain regular and gainful employment.

Claimant is also required to establish that she has made reasonable efforts to obtain regular and gainful employment. We find that a reasonable effort would include cooperation with the insurer's vocational assistance providers. Since claimant did not so cooperate, we conclude that claimant has not made reasonable efforts to obtain regular gainful employment, unless this failure is otherwise excused.

If a work search is futile, the failure to make a reasonable effort to obtain employment will be excused. Claimant believes it would be futile for her to seek work. However, her own perceptions of futility, while probative, are not controlling. Her testimony and beliefs of her abilities and disabilities are exaggerated and, therefore, we give them little weight. No vocational expert has opined that it would be futile for her to cooperate with vocational assistance or to make some form of job search. Claimant's attending physician has not opined that it would be futile to cooperate with vocational services or to make a job search. No independent medical examiner has opined that it would be futile for claimant to cooperate with vocational assistance or for her to seek employment. We conclude that it would not be futile for claimant to make reasonable efforts to obtain employment.

Because claimant has failed to establish that she is willing to seek regular gainful employment, and because she has failed to make reasonable efforts to obtain such employment, we conclude that she is not permanently and totally disabled.

Claimant makes no argument for an increase in her scheduled or unscheduled awards. The insurer makes no argument for reduction. While we note that the Referee did not apply the standards to evaluate claimant's disability as was required by the law in effect at the time of the Determination Order, we decline to adjust the award where neither party request us to do so.

ORDER

The Referee's order dated January 20, 1989 is affirmed. The Board approves a client-paid fee, not to exceed $1,525, payable from the insurer to its counsel.

In the Matter of the Compensation of
GREGG C. HAMPTON, Claimant
WCB Case No. 88-19517
ORDER ON REVIEW
Emmons, et al., Claimant Attorneys
Acker, et al., Defense Attorneys

Reviewed by Board Members Gerner and Myers.

The insurer requests review of Referee Brazeau's order which awarded claimant 22 percent (70.4 degrees) unscheduled permanent disability, whereas a Determination Order had awarded 17 percent (54.4 degrees) unscheduled permanent disability. On review, the issue is extent of unscheduled permanent disability. We affirm.

FINDINGS OF FACT

Claimant has the following cervical ranges of motion: 50 degrees flexion, 35 degrees extension, 20 degrees right and left lateral flexion and 60 degrees right and left rotation. He has the following thoracolumbar ranges of motion: 60 degrees flexion, 20 degrees extension, 20 degrees right and left flexion and 20 degrees right and left rotation. Claimant has mild disabling pain that limits use or function of his back. He is 45 years old and has a GED. There is no documentation demonstrating competence in some vocational pursuit. Claimant has returned to work for a different employer than the employer at injury. His job at injury required heavy lifting, his new job requires no more than sedentary lifting. Claimant successfully achieved his highest level of "SVP" profi

ciency of 4, for his work as a truck driver. Claimant has received a prior award of 8 percent unscheduled permanent disability.

CONCLUSIONS OF LAW AND OPINION

Impairment

The Referee concluded that claimant had sustained 15 percent impairment by concluding that claimant was entitled to additional impairment for disabling pain. The insurer argues that the Referee erred by allowing claimant any value for disabling pain. We agree with the Referee.

Claimant has 2 percent impairment in his cervical spine. Former OAR 436-35-360(1) thru (5). He has 8 percent impairment in his thoracolumbar spine. Former OAR 436-35-360(6) thru (9). Claimant has mild disabling pain that has resulted in a loss of use or function. We award 5 percent impairment. Daniel Alire, 41 Van Natta 752 (1989). Claimant's impairments are combined to yield 14.34 percent impairment.

Age

The appropriate value for claimant's age of 45 years is +1. Former OAR 436-35-290.

Education

The appropriate value for claimant's GED is +0. Former OAR 436-35-300(3).

Former OAR 436-35-300(4) adopts by reference the "SVP" (specific vocational preparation time) values assigned to various occupations by the Dictionary of Occupational Titles (DOT), published by the U.S. Department of Labor. The highest SVP level demonstrated by a claimant during the ten years prior to the date of injury is used to determine a value for skills. Former OAR 436-35-300(4). Claimant's highest SVP during the ten years prior to the date of injury was 4 as a truck driver. Therefore, the appropriate value for skills is +3. Former OAR 436-35-300(4).

Claimant has no documented training. Therefore, the appropriate value for training is +1. Former OAR 436-35-300(5). Claimant's total education value is +5, the formal education value plus the skills value plus the value for training. Former OAR 436-35-300(6).

Adaptability

The Referee assigned a value of +1.5 to the adaptability factor because, while claimant has returned to the same truck driving occupation he had at the time of injury, his new job is less physically demanding than was the job at injury. The insurer argues that because claimant has returned to the same occupation as his job at injury, that the adaptability value should be +0. We agree with the Referee's reasoning but not his adaptability value.

Former OAR 436-35-270(3)(a) defines "usual and customary work" as "...the job held at the time of injury, or the same job for a different employer." Claimant is working for a new employer in a job that has different lifting requirements. Whereas before he was required to load and unload his truck, now he only does the driving and paperwork and lets others do the loading and unloading. We conclude that claimant's new job is not the same as his job at injury and that he has returned to modified work. See former OAR 436-35-270(3)(b).

An adaptability value for a claimant who is unable to return to his or her usual and customary work but who has returned to modified work is determined from a matrix of values at former OAR 436-35-310(3)(a). That matrix compares the physical capacity of the claimant's usual and customary work with the physical capacity required by the modified work. This is true even though claimant may have the physical capacity to do heavier work than is required by the modified employment. Physical capacities are not defined by the "standards" generally. We utilize those definitions contained in former OAR 436-35-310(4)(a)-(d).

The Referee allowed claimant a factor of +1.5 by comparing claimant's residual physical capacity with the capacity required at the job at injury. However, the appropriate comparison is between claimant's modified job with the job at injury. In this case, claimant's job at injury required the physical capacity to do heavy work. Claimant's current modified job requires a sedentary physical capacity. Therefore, the appropriate adaptability value is +3. Former OAR 436-35-310(3)(a).

Calculation of Standards Disability

The Age and Education sum is +5. This value is multiplied by the Adaptability factor of +3 to yield the product +15. To this product is added the Impairment value of 14.34 percent to yield the total sum of 29.34 percent disability. See generally former OAR 436-35-280. This percentage is rounded up to the next higher whole number for a total of 30 percent unscheduled permanent disability. Former OAR 436-35-280(7). Considering the prior award of 8 percent unscheduled disability, we conclude, as did the Referee, that claimant is entitled to 22 percent unscheduled permanent disability for this injury.

ORDER

The Referee's order dated February 23, 1989, as supplemented March 7, 1989, is affirmed. Claimant's attorney is awarded $515 for services on Board review, to be paid by the the insurer. The Board approves a client-paid fee, not to exceed $1,077, payable from the insurer to its counsel.

May 15, 1990 Cite as 42 Van Natta 1072 (1990)

In the Matter of the Compensation of
TUONG CANH KHA, Claimant
WCB Case Nos. 88-15314 & 88-12565
ORDER ON REVIEW
Wilbur C. Smith, Jr., Claimant Attorney
Kevin L. Mannix, Defense Attorney

Reviewed by Board Members Gerner and Cushing.

Claimant requests review of those portions of Referee Howell's order which: (1) declined to award claimant additional temporary disability benefits after the medically stationary date and until the Determination Order issued; (2) affirmed the Determination Order which awarded no permanent disability for a low back injury; (3) upheld the self-insured employer's denial of future medical treatment; and (4) upheld the employer's partial denial of claimant's neck condition. On review, the issues are temporary disability, permanent disability, medical services and compensability. We affirm in part and reverse in part.

FINDINGS OF FACT

The Board adopts the Referee's "Findings of Fact."

CONCLUSIONS OF LAW AND OPINION

Temporary Disability Benefits

The Referee found that claimant was not entitled to additional temporary disability compensation because he was medically stationary on October 7, 1988 when his claim was closed. We agree.

Claimant asserts that temporary disability benefits should have been paid until the October 7, 1988 Determination Order was issued, because claimant's attending physician never released claimant to return to regular work. In the alternative, claimant asserts that he is entitled to temporary disability after the medically stationary date and until the attending doctor's conditional release.

The employer asserts that claimant has no substantive right to any additional temporary disability and that procedurally it had no duty to pay temporary disability payments after September 22, 1988, because the October 7, 1988 Determination Order, which awarded temporary disability benefits from May 3, 1988 through August 16, 1988, was issued before the next two-week installment of temporary disability became due. We agree with the employer.

Procedural Right to Temporary Disability Benefits

The determination of a worker's substantive entitlement to temporary disability compensation terminates any continuing procedural duty to pay under the statute. Former ORS 656.268(2), current 656.268(2)(c). Where, as here, the substantive entitlement is determined before the next installment of temporary disability is due, the procedural duty to pay does not mature and is replaced by new duties under the Determination Order or Notice of Closure. See David W. Woodward, 42 Van Natta 615 (1990).

At hearing, claimant conceded the last temporary disability check was received on September 29, 1988, paid one week in arrears. Procedurally the next payment was due approximately October 13, 1988. However, the October 7, 1988 Determination Order issued before that time and found claimant entitled to temporary disability only through August 16, 1988. The employer is under no obligation to bring temporary disability benefits current and to pay until the date of the Determination Order. Therefore, we find that claimant was not entitled to additional temporary disability benefits after September 22, 1988.

Substantive Right to Temporary Disability Benefits

Before a Determination Order issues, claimant is procedurally entitled to the continued payment of temporary disability until he is either both released to return to regular work and is medically stationary, or until a Determination Order issues. Fazzolari v. United Beer Distributors, 91 Or App 592 (1988). Carriers are prohibited from unilaterally suspending temporary disability payments until one of these two events occurs. However, once a Determination Order issues, claimant is only substantively entitled to temporary disability benefits until he is medically stationary. ORS 656.268; Julie A. Trujillo, 40 Van Natta 1892 (1988).

In this case, claimant was medically stationary on August 16, 1988 and remained medically stationary until October 7, 1988 when his claim was closed. He is only substantively entitled to temporary disability until August 16, 1988, the medically stationary date. Claimant has already received this compensation. Accordingly, claimant is entitled to no additional temporary disability and there is no basis for penalties and attorney fees for the employer's failure to pay additional compensation.

Medical Services Denial

The Referee upheld the August 30, 1988 denial. We agree in part, but reverse the portion of the denial which is prospective.

It is well settled that prospective denials are impermissible. A carrier may not deny its future responsibility for payment of medical services for a previously accepted claim. ORS 656.245(1); Evanite Fiber Corp. v. Striplin, 99 Or App 353 (1989). In the present case, the employer denied all further treatment past the August 30, 1988 denial. (Ex. 39). Such a denial is prospective and we set aside that portion of the denial. However, since the record indicates that claimant continued to receive medical treatment until hearing, the reasonableness and necessity of these post-denial services are also at issue. (Ex. 43); Hollie J. Rahim, 42 Van Natta 415 (1990); see Rater v. Pacific Motor Trucking Co., 77 Or App 418 (1978). We proceed to address the compensability of these medical services.

A claimant is entitled to all reasonable and necessary curative or palliative medical care required for a compensable injury. 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). Claimant has the burden of proving that the treatment is reasonable and necessary. Id.

On de novo review of the medical evidence, we are persuaded that claimant's medical services through the November 18, 1988 hearing were not reasonable and necessary.

Dr. Hoppert opined that claimant's neck pain was unrelated to his work incident of November 1987. (Ex. 37). Furthermore, in a report dated August 16, 1988, the Western Medical Consultants concluded that claimant could return to his regular work activities without limitations or restrictions, and that further curative or palliative treatment pertaining to the November 1987 injury was not reasonable or necessary. Finally, Dr. Butler concurred with the Consultants' findings. (Ex. 40).

Only Dr. Whitmire opined that claimant needed additional medical services. On October 4, 1988, he asserted that claimant needed treatment twice per month. Dr. Whitmire is claimant's treating physician, nonetheless, he provided no explanation for his opinion. (Ex. 43). In light of the other medical opinions, we find his opinion unpersuasive; since it is conclusory and without any explanation. See Van Woesik v. Pacific Coca-Cola Co., 85 Or App 9 (1987).

On referral by Whitmire, Dr. Billings also examined claimant and reported that he would need further spinal adjustments to preserve mobility in the cervical and lumbar spine. (Ex. 45). However, the Referee found that claimant was not a credible witness. We defer to this finding. A medical opinion formed exclusively or in significant part on a claimant's statements is valid only insofar as a claimant relates and the doctor receives an adequate picture of a claimant's condition. We are unable to determine the degree upon which Billings based his opinion on history that claimant provided. Consequently, we accord his medical opinion lesser weight.

Accordingly, we conclude that claimant's medical services after the August 30, 1987 denial through the November 18, 1988 hearing were not reasonable or necessary.

Neck Condition Denial

We adopt the Referee's conclusions regarding the issue of the employer's July 17, 1988 partial denial of claimant's neck condition.

Extent of Permanent Disability

We adopt the Referee's conclusions regarding the issue of permanent disability pertaining to the low back condition.

ORDER

The Referee's order dated November 18, 1988 is affirmed in part and reversed in part. The self-insured employer's denial, in so far as it denied medical services after the date of hearing, is set aside. The remainder of the Referee's order is affirmed. For services at hearing and on review concerning the prospective denial issue, claimant's attorney is awarded an assessed fee of $500, to be paid by the employer. A client-paid fee, not to exceed $739, payable from the employer to its counsel, is approved.

May 15, 1990 Cite as 42 Van Natta 1075 (1990)

In the Matter of the Compensation of
DANIEL T. ROWLAND, Claimant
WCB Case No. 88-03391
ORDER ON REVIEW
Bettis & Ricker, Claimant Attorneys
Yturri, et al., Defense Attorneys

Reviewed by Board Members Cushing and Myers.

The insurer requests review of that portion of Referee Fink's order which increased claimant's scheduled permanent disability to 20 percent (27 degrees) for loss of use or function of the right foot (ankle), whereas a Determination Order had awarded 4 percent (5.40 degrees). On review, the issue is extent of scheduled permanent disability. We affirm, but for different reasons.

FINDINGS OF FACT

We adopt the Referee's findings of fact as our own, with the following supplementation.

Claimant has disabling pain which limits the use and function of his right foot to walk on steep terrain, run, jump or climb and which limits the use of his foot in skiing, hunting and fishing. Claimant has ranges of motion of 10 degrees dorsiflexion and 40 degrees plantar flexion.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant had 4 percent permanent impairment for loss of range of motion. Neither party challenges this finding and we agree. Former OAR 436-35-190(6). However, the Referee found by "clear and convincing evidence" that claimant's disability was greater than that allowed by the standards and awarded 20 percent scheduled disability. We disagree.

Claimant is entitled to additional impairment for loss of use and function due to disabling pain. The Referee did not make a finding on the amount of impairment due to disabling pain before evaluating whether claimant's disability exceeded the disability under the standards. Tracey A. Fast, 41 Van Natta 835 (1989). We conclude that claimant has moderate impairment due to the loss of use or function due to disabling pain and we allow 15 percent impairment for this loss.

Claimant argues that he is entitled to additional impairment for the 1 inch atrophy in his right calf. (See Ex. 36-2). Former OAR 436-35-230(5)(a) allows up to 10 percent impairment for atrophy. Because there is no evidence on the severity of this atrophy finding nor evidence that this atrophy has significantly impacted loss of use or function, we assign a 2 value under the rule.

We combine claimant's various impairments. Former OAR 436-35-180(12). The combined impairment of 15 and 4 and 2 is 20. We conclude that under the standards claimant is entitled to 20 percent scheduled permanent disability for loss of use or function to his right foot.

Claimant argues that he has proven by clear and convincing evidence that he has lost more use or function than that allowed under the standards because his injury so dramatically affected his earning capacity as a logger and is causing him to lose a substantial amount of income. Loss of use or function is distinct from loss of earning capacity. The evidence is not highly persuasive that claimant's degree of loss of use or function is greater than that contemplated under the standards. See Riley Hill General Contractor Inc. v. Tandy Corp., 303 Or 390, 407 (1987). Accordingly, claimant is entitled to 20 percent scheduled disability.

Inasmuch as claimant did not timely submit a brief on review, no attorney fee shall be awarded. Shirley M. Brown, 40 Van Natta 879 (1988).

ORDER

The Referee's order dated January 26, 1989 is affirmed. The Board approves a client-paid fee, not to exceed $949, payable from the the insurer to its counsel.

May 15, 1990 Cite as 42 Van Natta 1076 (1990)

In the Matter of the Compensation of
RUTH L. WOOD, Claimant
WCB Case No. 88-02465
ORDER ON REVIEW
Charles G. Duncan, Claimant Attorney
Employers Defense Counsel, Defense Attorney

Reviewed by Board Members Myers and Gerner.

The insurer requests review of that portion of Referee Mirassou's order which set aside its denial of claimant's aggravation claim and of the compensability of her current condition. In her brief, claimant cross-requests review of that portion of the Referee's order which affirmed a Determination Order which awarded no permanent disability. On review, the issues are compensability and extent of disability. We reverse in part and affirm in part.

FINDINGS OF FACT

On May 25, 1987, claimant sustained a compensable injury to her right arm and shoulder, right ribs and thoracic spine when she slipped on a wet floor. She sought treatment from Dr. Hebert, chiropractor. Claimant was off work for ten days when she sustained another injury to the same body parts when she was hit by a freezer door.

A November 4, 1987 Determination Order closed claimant's claim with an award of temporary disability only. On December 22, 1987, when attempting to

obtain her medical records from Dr. Hebert's office, claimant alleges that she sustained an aggravation of her condition when Dr. Hebert's lawyer grabbed her right arm and shoulder and tried to escort her from the doctor's premises. Claimant changed attending doctors and sought care from Dr. Meece, chiropractor.

Claimant is not credible. Dr. Hebert is not credible.

CONCLUSIONS OF LAW AND OPINION

Aggravation and Current Condition Denial

The Referee concluded that because claimant was authorized 14 days of temporary disability and because he found that her condition was materially related to the original injury, that she had established a compensable aggravation claim. We disagree.

To establish an aggravation, claimant must show both a worsening of his condition since the last arrangement of compensation, Smith v. SAIF, 302 Or 396 (1986), and a causal connection between the worsening and the industrial injury. Brewer v. SAIF, 59 Or App 87 (1982). "Worsening" within this context means increased symptoms, or a worsened underlying condition, resulting in a diminishment of earning capacity. Id. "Worsening" is determined on a case-by-case basis as a matter of fact, not law. Perry v. SAIF, 307 Or 654 (1989). If claimant's condition has worsened, she may nonetheless not be entitled to a reopening of his claim if the last arrangement of compensation anticipated future worsenings (e.g. "waxing and waning" or "exacerbations") and the particular worsening at issue did not: (1) diminish her earning capacity longer or in greater degree than was anticipated; nor (2) result in 14 consecutive days of total disability or inpatient hospitalization. Gwynn v. SAIF, 304 Or 345 (1987), on rem 91 Or App 84 (1988); See generally Edward D. Lucas, 41 Van Natta 2272 (1989).

Claimant asserts that her condition worsened because of the incident with Dr. Hebert's lawyer on December 22, 1987. She relies upon her own testimony and Dr. Meece's time loss authorization to support her position.

We do not find claimant to be credible. Coastal Farm Supply v. Hultberg, 84 Or App 282, 285 (1987). Claimant's description of the events occurring on December 22, 1987 that she gave to the police when filing her assault charges against Dr. Hebert's lawyer was significantly different from her description of those events to the Referee at hearing. (Compare Ex. 13-6 with Tr. 28-29, 38-40). Her description of these events is also significantly different from the description given by witness Burke of the events as well as the description by the alleged assailant. (Compare Tr. 28-29, 38-40, 45-47, 107-108 with Tr. 63-64, 70 and Ex. 13-7). The Referee made no credibility finding regarding claimant's demeanor while testifying. However, she did find that witness Burke was credible. We defer to her express finding of credibility. Seriganis v. Fleming, 20 Or App 659 (1975). Since claimant's testimony was contradicted by her own statements to the police, and since her version of events is significantly different from witness Burke's and the alleged assailant's version, we find that claimant's testimony was not credible. See Timothy J. Swodeck, 39 Van Natta 341 (1987).

Claimant relies upon Dr. Meece's opinion that her condition worsened by the alleged December 22, 1987 assault. However, Dr. Meece's opinion is based entirely upon history and complaints provided by claimant. Since claimant is not credible, we give no weight to Dr. Meece's opinion either. See Miller v. Granite Construction Co., 28 Or App 473 (1977). Since no other evidence establishes that claimant's condition worsened after December 22, 1987, we conclude that claimant's condition has not worsened.

Moreover, were we convinced that claimant's condition worsened in December 22, 1987 as a result of the alleged assault, we are not convinced that claimant's condition "worsened" in the sense that she was less able to work after the alleged assault than she was at the time of the last arrangement of compensation. Since claimant has not worked since July 1987, we are unable to infer less ability to work after the alleged assault from the fact that she was not working after that time. Neither claimant's testimony, nor expert medical opinion establishes that claimant was less able to work after December 22, 1987. Smith v. SAIF, 302 Or 396 (1986). Therefore, we would also conclude that claimant has failed to prove any loss of earning capacity due to the alleged assault that would entitle her to claim reopening. ORS 656.273.

The insurer also denied the compensability of claimant's then-current condition. The Referee relied upon Dr. Meece to conclude that claimant's current condition was materially related to the original occupational injuries. However, we have already discounted the opinion of Dr. Meece and give it no weight. The Western Medical Consultants believed that claimant's current condition was due more to the alleged assault than to the occupational injuries. However, their opinion does not say that the occupational injuries continue to play a material causal role in her current disability and need for treatment; see Hutchenson v. Weyerhaeuser, 288 Or 51, 56 (1979), Van Blokland v. Oregon Health Sciences University, 87 Or App 694, 698 (1987); and they note potential secondary gain as a cause of claimant's current problems. In light of this we are unwilling to find that claimant's current condition is materially related to her occupational injuries.

Extent of Permanent Disability

Claimant alleges she is entitled to an award of unscheduled permanent disability. She relies upon her own testimony to support her case, and upon the opinion of her former treating physician, Dr. Hebert, that she has 10 to 15 percent objective "limitation." (Tr. 102).

We have found claimant not to be credible, therefore we give her testimony of her limitations and inabilities no weight. We also give the opinion of Dr. Hebert no weight. While he was the attending physician from June until December 1987, he represented to the insurer no knowledge that claimant had any prior motor vehicle accident's involving her injured body parts. (Ex. 4). However, under oath at hearing, he testified that he treated claimant for such a car accident just three weeks before her first occupational injury. (Tr. 73, 91). His opinion is also inconsistent with his concurrence with the Consultants' opinion. (Tr. 76). We give his opinion no weight. No other evidence exists in the record to assist us in determining whether and to what extent claimant has permanent residuals from her occupational injuries. Therefore, we conclude that claimant has failed to meet her burden of proving she has lost earning capacity due to the occupational injuries.

ORDER

The Referee's order dated November 1, 1988 is reversed in part and affirmed in part. That portion of the Referee's order which set aside the insurer's denial is reversed. The denial is reinstated and upheld. That portion which awarded claimant a $1,800 assessed attorney fee is reversed. That portion which ordered the insurer to pay Dr. Meece's medical bills is reversed. The remainder of the order is affirmed. The Board approves a client-paid fee, not to exceed $1,102, payable from the insurer to its counsel.

In the Matter of the Compensation of
DON G. CYSEWSKI, Claimant
WCB Case No. 88-15120
ORDER OF ABATEMENT
Pozzi, et al., Claimant Attorneys
Saif Legal, Defense Attorney

Claimant requests reconsideration of our April 19, 1990 order which reduced his scheduled permanent disability award for loss of use or function of the right leg from 30 percent (45 degrees) to 24 percent (36 degrees). Contending that the SAIF Corporation withdrew its request for review prior to our decision, claimant seeks withdrawal of our order and reinstatement of the Referee's order.

Before addressing claimant's motion, we request a response from SAIF within 10 days from the date of this order. Consequently, our April 19, 1990 order is withdrawn. Upon receipt of SAIF's response, we shall take this matter under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
JOHN C. WOOD, Claimant
WCB Case Nos. 88-20635, 89-01336, 89-06777, 89-01337, 89-01338, 89-01870 & 89-06778
ORDER DISMISSING REQUEST FOR REVIEW (REMANDING)
Max Rae, Claimant Attorney
Scheminske & Lyons, Defense Attorneys
Cummins, et al., Defense Attorneys
David R. Fowler (Saif), Defense Attorney
Sharon R. Schooley, Assistant Attorney General
Roberts, et al., Defense Attorneys
Davis & Bostwick, Defense Attorneys
Acker, et al., Defense Attorneys
Garrett, et al., Defense Attorneys

UAC has requested, and claimant has cross-requested, review of Referee Irving's February 27, 1990 interim order. Angell Transport has moved for dismissal of the requests, contending that the order is not a final, appealable order. We grant the motion.

FINDINGS OF FACT

Claimant requested a hearing concerning the compensability of and responsibility for a left shoulder condition. Several employers, insurers, and claim processors had either denied the claim or been joined as parties to the hearing.

Following lengthy discussions, the scheduled hearing was severed into two parts. The first portion concerned the issue of jurisdiction regarding Angell Transport and Camas Transport, while the second was proposed to address the merits of claimant's injury claim.

On February 27, 1990, the Referee found that Angell Transport was exempt from the requirements of the Oregon Workers' Compensation Law and that claimant

was not a subject worker for Camas Transport. The Referee's order did not contain a statement explaining the parties' rights of appeal pursuant to ORS 656.289(3). The order expressly provided that the "decision on the jurisdiction questions is an interim order pending a final order on the merits of the claim."

Within 30 days of the Referee's order, UAC and claimant requested review.

CONCLUSIONS OF LAW

A final order is one which disposes of a claim so that no further action is required. Price v. SAIF, 296 Or 311, 315 (1984). A decision which neither denies the claim, nor allows it and fixes the amount of compensation, is not an appealable final order. Lindamood v. SAIF, 78 Or App 15, 18 (1986); Mendenhall v. SAIF, 16 Or App 136, 139 (1974).

Here, the Referee's order did state that the SAIF Corporation's denial on behalf of Angell Transport and Camas Transport's denial were upheld. However, the Referee's conclusions had been conditioned on the understanding that the "decision on the jurisdiction questions is an interim order pending a final order on the merits of the claim." Moreover, the hearing concerning the merits of claimant's injury claim against all potentially responsible carriers has not yet convened.

Under these circumstances, we conclude that the Referee's order has neither finally disposed of, nor allowed, a claim, or fixed the amount of claimant's compensation. Instead, we consider the Referee's order to be "interim," designed to notify the parties that Angell Transport and Camas Transport would not be appearing at the forthcoming hearing concerning the merits of the claim and that the upholding of their respective denials would be incorporated into an eventual final, appealable order. A preliminary order such as this is in keeping with the Board's interest in avoiding piecemeal review of multiple issues arising in a single case. See Joseph Wilson, 40 Van Natta 66 (1988).

Inasmuch as further action before the Hearings Division is required as a result of the Referee's order, we conclude that it is not a final, appealable order. Price v. SAIF, supra; Lindamood v. SAIF, supra. Consequently, we lack jurisdiction to consider the issues raised by the requests.

Finally, assuming for the sake of argument that we had jurisdiction to consider the requests, we would consider the record, which lacks a hearing regarding the merits of claimant's injury claim against all potentially responsible carriers, to be incompletely or insufficiently developed. See ORS 656.295(5). Under such circumstances, remand to the Hearings Division would be an appropriate remedy.

IT IS SO ORDERED.

In the Matter of the Compensation of
ROBIN M. GLOVER, Claimant
WCB Case No. 88-18150
ORDER ON REVIEW
Roberts, et al., Defense Attorneys

Reviewed by Board Members Gerner and Cushing.

The self-insured employer requests review of that portion of Referee Bennett's order which awarded claimant 25 percent (80 degrees) unscheduled permanent disability, whereas a Determination Order awarded no unscheduled permanent disability. On review, the issue is extent of unscheduled permanent disability. We affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Impairment

The Referee concluded that claimant had sustained 9 percent impairment under the standards. The employer argues that the Referee applied the wrong standards to this case by applying those standards in effect on and after January 1, 1989, instead of those in effect on and after July 1, 1988. We agree.

Claimant's claim was closed by Determination Order dated September 13, 1988, therefore, the "standards" adopted effective July 1, 1988, (former OAR 436-35-001 et seq), as amended by temporary rules effective August 19, 1988, apply to the rating of claimant's permanent partial disability. OAR 438-10-010.

Under the appropriate standards, claimant's retained ranges of cervical motion result in no impairment. Former OAR 436-35-360(2) thru (5). The employer concedes that the Referee's impairment for the thoracolumbar spine was correctly found to be 3.5 percent.

The employer contests the Referee's award of 4 percent impairment for claimant's small herniated disc in her cervical spine because she has no clinically-related residual symptoms. We agree. Former OAR 436-35-350(2) requires "clinically-related residual symptoms" for there to be impairment. Claimant has no clinically-related residual symptoms from the herniated disc. Therefore, claimant is not entitled to the 4 percent impairment awarded by the Referee. Joseph Anger, 41 Van Natta 827 (1989).

Claimant's total impairment under the standards is 3.5 percent.

Other Factors

The employer does not challenge the Referee's conclusions that claimant is entitled to a value of +0 for Age but the employer asserts that claimant is entitled to a value of +3 for Education, rather than the +2 found by the Referee. We agree that the Referee failed to allow claimant a +1 value for lack of any documentation demonstrating competence in some vocational pursuit. Former OAR 436-35-300(5)(a). We conclude that claimant is entitled to a value of +3 for the Education factor.

The employer also challenges the Referee's Adaptability value of +8 because claimant was offered and returned to modified work, whereas the Referee concluded that while claimant was offered and returned to modified work, she was not working at the time of hearing because the employer had no work available and, therefore, claimant was entitled to the more favorable matrix values in former OAR 436-35-310(4). We agree with the Referee and adopt his reasoning in regard to this issue. See Jimmy D. Basham, 42 Van Natta 1045 (1990) (where a claimant is offered a job but not released to it, the more generous adaptability matrix is applied).

Calculation of Standards Disability

The Age and Education sum is +3. This value is multiplied by the Adaptability factor of +8 to yield the product +24. To this product is added the Impairment value of 3.5 percent to yield the total sum of 27.5 percent disability. See generally former OAR 436-35-280. This percentage is rounded up to the next higher whole number for a total of 28 percent unscheduled permanent disability. Former OAR 436-35-280(7). Since claimant has not cross-requested review or otherwise asked for an increase in her disability, we will not modify the Referee's award of 25 percent unscheduled permanent disability.

ORDER

The Referee's order dated February 9, 1989 is affirmed. The Board approves a client-paid fee, not to exceed $832, payable from the self-insured employer to its counsel.

May 17, 1990 Cite as 42 Van Natta 1082 (1990)

In the Matter of the Compensation of
JEANNIE S. HUBBARD, Claimant
WCB Case No. 88-05829
ORDER ON REVIEW
Ormsbee & Corrigall, Claimant Attorneys
Acker et al., Defense Attorneys

Reviewed by Board Members Crider and Brittingham.

The self-insured employer requests review of that portion of Referee Gruber's order that set aside its denial of claimant's aggravation claim for her cervical condition. On review, the issue is aggravation. We affirm.

FINDINGS OF FACT

The Board adopts the Referee's "Finding of Facts" with the following supplementation.

Claimant applied for unemployment compensation in late December 1987, and received benefits until she began working June 7, 1988.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant suffered an aggravation of her compensable cervical condition. We agree.

In order to prove a claim for aggravation of an unscheduled condition under ORS 656.273, claimant must show increased symptoms or a worsened underlying condition and a resultant diminishment of earning capacity. In cases where

the last award or arrangement of partial disability compensation anticipated increased symptoms or exacerbation of the condition accompanied by decreased earning capacity, claimant also must prove that her earning capacity was diminished longer or in greater degree than was anticipated or that the worsening resulted in 14 consecutive days of total disability or inpatient hospitalization. Edward D. Lucas, 41 Van Natta 2272 (1989).

Dr. Crocker reported on February 19, 1988 that claimant's compensable back and neck pain had worsened and that she required further physical therapy. We are persuaded by Dr. Crocker's opinion because he is claimant's treating physician and has had the opportunity to observe her condition over an extended period of time. Therefore, claimant has proven that symptoms of her compensable condition worsened.

At the time of the November 1987 hearing on the July 1987 Determination Order (claimant's last award or arrangement of compensation), claimant was capable of performing sedentary, light, and medium level work. In contrast, the record indicates that claimant was totally disabled at the time of the alleged aggravation. On March 10, 1988, Dr. Crocker noted that claimant was physically unable to perform any work and would be off work for a period of 2-4 weeks while she underwent physical therapy. Accordingly, we conclude that claimant's symptomatic worsening resulted in diminished earning capacity below the level determined at the time of the July 1987 Determination Order.

Whether or not the last award or arrangement of compensation contemplated future exacerbations, the Supreme Court has held that where earning capacity was diminished to the extent of total disability and resulted in 14 consecutive days of total disability or inpatient hospitalization, claimant has established an aggravation claim. See Gwynn v. SAIF, 304 Or 345 (1987); Lucas, supra. On March 10, 1988, Dr. Crocker indicated that claimant was totally disabled and unable to work for a period of 2-4 weeks as a result of increased neck symptoms. Accordingly, claimant has proven that she was totally disabled for more than 14 days as a result of a symptomatic exacerbation of her compensable injury.

In conclusion, we find that: (1) claimant sustained a symptomatic exacerbation of her neck condition; (2) which resulted in diminished earning capacity; and (3) as a result of the increased symptoms, claimant became totally disabled for more than 14 days. Therefore, we hold that claimant has met her burden of proof and established a compensable aggravation claim.

The employer asserts that claimant's aggravation claim should not be compensable as she was collecting unemployment benefits at the time. In applying for such benefits, claimant certified that she was able, available, actively seeking and unable to obtain employment. The employer argues that claimant can show no potential loss of wages. Therefore, the employer contends the award of temporary disability benefits was "inappropriate" as there was only a "hypothetical" loss of opportunity to earn wages, not a real one.

We disagree. The employer's argument goes to a claims processing issue, not the validity of the aggravation claim. See Wells v. Pete Walker's Auto Body, 86 Or App 739 (1987); D. L. Smith, 42 Van Natta 499 (1990). Where claimant has received unemployment benefits, the employer can offset the unemployment benefits against temporary disability benefits. Nevertheless, the receipt of unemployment benefits is not inconsistent with our finding that claimant's condition has worsened such that her claim must be reopened.

ORDER

The Referee's order, dated September 21, 1988, as reconsidered October 7, 1988, is affirmed. For services on review, claimant's attorney is awarded $1000, to be paid by the self-insured employer. A client-paid fee, payable from the employer to its counsel, not to exceed $850, is approved.

May 18, 1990 Cite as 42 Van Natta 1084 (1990)

In the Matter of the Compensation of
JOHN T. FERGUSON, Claimant
WCB Case No. 88-19302
ORDER ON REVIEW
Carney, et al., Claimant Attorneys
Roberts, Reinisch & Klor, Defense Attorneys

Reviewed by Board Members Myers and Gerner.

The self-insured employer requests review of Referee Quillinan's order which awarded claimant 31 percent (99.20 degrees) unscheduled permanent disability for a low back condition, whereas a Determination Order had awarded 21 percent (67.20 degrees) unscheduled permanent disability. On review, the issue is extent of unscheduled permanent disability. We modify.

FINDINGS OF FACT

Claimant has a compensable low back injury. He has the following ranges of motion: 55 degrees flexion, 5 degrees extension, 15 degrees right lateral flexion, 20 degrees left lateral flexion, 15 degrees right rotation and 25 degrees left rotation. Claimant has an unoperated disc bulge at L4-L5 with residual symptoms of numbness in the lower extremities. Claimant experiences mild disabling pain that limits his ability to stand walk or sit for great lengths of time.

Claimant is 41 years old. He has a high school education, but is able to read at the fifth-sixth grade level only after many years of "special education" classes. Claimant has a low borderline I.Q. He has achieved his highest level of "SVP" proficiency of 3 for his work as a janitor. There is no documentation demonstrating competence in some specific vocational pursuit. Claimant's job at injury is medium level work. He has returned to modified work in the medium to light category.

CONCLUSIONS OF LAW AND OPINION

The Referee increased claimant's unscheduled award by concluding that claimant had proven by clear and convincing evidence that his loss of earning capacity was greater than that provided by the standards. We disagree.

Impairment

Claimant's flexion of 55 degrees entitles him to 3.5 percent impairment, his extension of 5 degrees to 2.5 percent, his right flexion of 15 degrees to 1 percent, his left flexion of 20 degrees to zero percent, his right rotation of 15 degrees to 3 percent and his left rotation of 25 degrees to 1 percent. These percentages are added, not combined, for a total of 11 percent impairment.

Former OAR 436-35-360. Claimant's unoperated disc bulge with residual symptoms entitles him to 4 percent impairment. Claimant also has mild disabling pain. We award him an impairment of 5 percent for this pain. Daniel Alire, 41 Van Natta 752 (1989). The 11 percent for lost ranges of motion is combined with the 5 percent for pain and with the 4 percent for the disc for a total impairment of 18.81 percent. Former OAR 436-35-360(11).

Age

Claimant's age of 41 entitles him to a value of +1. Former OAR 436-35-290(4).

Education

The Referee acknowledged that claimant had a high school education and would be entitled to a value of zero for formal education. Former OAR 436-35-300(3)(a). However, by reasoning that claimant was only reading at a fifth or sixth grade level after graduating from "special education" classes, she nonetheless awarded a value of +1 for this factor. We disagree.

The administrative rule provides that workers who have a high school diploma or GED certificate are entitled to a value of zero for formal education. The Referees are bound to follow the Director's standards for the evaluation of disabilities. ORS 656.283(7). Accordingly, the value for claimant's high school education is zero, notwithstanding the perceived deficiencies in claimant's educational accomplishments.

Claimant's "SVP" proficiency of 3 entitles him to a value of +3 for skills. Former OAR 436-35-300(4). The lack of any documentation in the form of certificates or diplomas etc. establishing competence in some vocational pursuit entitles claimant to a value of +1 for training. Former OAR 436-35-300(5).

The total education value, claimant's formal education value plus his skills value plus his training value, is +5.

Adaptability

An adaptability value for a claimant who is unable to return to his or her usual and customary work [See former OAR 436-35-270(3)(a)] but who has returned to modified work is determined from a matrix of values at former OAR 436-35-310(3)(a). That matrix compares the physical capacity of the claimant's usual and customary work with the physical capacity required by the modified work. This is true even though claimant may have the physical capacity to do heavier work than is required by the modified employment. Physical capacities are not defined by the "standards" generally. We utilize those definitions contained in former OAR 436-35-310(4)(a)-(d).

In this case, claimant's usual and customary work required the physical capacity to do medium level work. Claimant's modified work requires a medium to light physical capacity. Therefore, the appropriate adaptability value is +1.5. Former OAR 436-35-310(3)(a).

Calculation of Standards Disability

The Age and Education sum is +6. This value is multiplied by the Adaptability factor of +1.5 to yield the product +9. To this product is added the Impairment value of 18.81 percent to yield the total sum of 27.81 percent disability. See generally former OAR 436-35-280. This percentage is rounded up to the next

whole number. Former OAR 436-35-280(7). Claimant's total disability under the standards is 28 percent.

The Referee increased claimant's unscheduled permanent disability to 31 percent, an increase of 10 percent over the Determination Order award, by reasoning that claimant's educational deficit and low I.Q. establish that he would be less employable than ordinary workers in the kind of jobs falling within his residual medium/medium-light physical capacity. We disagree. No evidence was presented at hearing as to how claimant's perceived educational deficits and low I.Q. effect his earning capacity. Without such evidence, the Referee erred by speculating as to the negative effects of these considerations. No other evidence was presented that convinces us it is highly probable that claimant suffers more loss of earning capacity than the 28 percent valued under the standards, therefore, we will not disturb that award.

ORDER

The Referee's order dated March 3, 1989 is modified. That portion of the Referee's order which increased claimant's unscheduled permanent disability by 10 percent (32 degrees), is modified to increase his disability only 7 percent (22.40 degrees), giving claimant a total award to date of 28 percent (89.6 degrees). The Board approves a client-paid fee, not to exceed $1,508.50, payable from the employer to its counsel.

In the Matter of the Compensation of
DONALD R. FUSSELL, Claimant
Own Motion No. 88-0403M
OWN MOTION ORDER
Francesconi, et al., Claimant Attorneys

The Evaluation Section has instructed the insurer to refer this neck and shoulder injury claim to the Board for closure under our own motion authority. We conclude that we have no authority to grant the own motion relief requested by the insurer as aggravation rights have not run on this claim.

The insurer accepted claimant's initial claim as a nondisabling injury. If a claim that a nondisabling injury has become disabling is not made within one year of the injury, the claim is treated as one for aggravation under ORS 656.273. Former ORS 656.262(10), now 656.262(12). Aggravation rights on a nondisabling injury run from the date of injury under former ORS 656.273(4)(b) whenever a properly processed nondisabling claim does not become disabling within one year after the injury.

Here, claimant did not request reclassification of his claim as disabling within one year of his injury. Therefore, if the nondisabling claim had been properly processed, claimant's aggravation rights would have run in 1985, and the claim would now be in own motion status.

However, the claim was not properly processed. The record in this case indicates that claimant was unable to perform his regular work immediately following his injury. Accordingly, we conclude that claimant's injury was initially disabling, and that the insurer misclassified the injury as nondisabling. Therefore, former ORS 656.262(10), now ORS 656.262(12), which provided that a nondisabling claim may be reclassified more than one year after the date of injury only pursuant to a claim for aggravation, is not applicable to this

case. Davison v. SAIF, 80 Or App 541 (1986); Darrell K. Falline, 42 Van Natta 919 (1990). Since the claim was disabling from the outset, aggravation rights must be calculated as for a disabling claim under former ORS 656.273(4)(a)--that is, the aggravation period extends for five years after the first determination order. Since no determination order has issued, aggravation rights have not begun to run.

Moreover, assuming the claim had been correctly classified as nondisabling, the insurer's claims processing was still improper. There is no evidence that the insurer's acceptance of the claim notified claimant of his right to reclassify the claim as disabling under former ORS 656.262(10). The record does not indicate that claimant otherwise received actual or constructive notice of that right. Under these circumstances, claimant's aggravation rights have not run, and he is entitled to an evaluation of the extent of his disability under ORS 656.268. Darrell K. Falline, supra; Richard M. Egli, 41 Van Natta 149 (1989). Cf. Davison v. SAIF, 80 Or App 541 (1986).

Accordingly, we are without jurisdiction to consider the insurer's closure request under our own motion authority. The request is denied.

IT IS SO ORDERED.

In the Matter of the Compensation of
BARBARA A. HESS, Claimant
WCB Case No. 88-16974
ORDER ON REVIEW
Mautz, Hallman, et al., Claimant Attorneys
Yturri, et al., Defense Attorneys

Reviewed by Board Members Gerner and Myers.

Claimant requests review of those portions of Referee Leahy's order which: (1) affirmed a Determination Order award of 15 percent (48 degrees) unscheduled permanent disability for a low back condition; (2) declined to find that the Determination Order prematurely closed the claim; (3) declined to order the insurer to reimburse claimant for child care expenses; (4) declined to order the insurer to pay additional mileage reimbursement; and (5) declined to assess penalties and attorney fees for the insurer's late denial of an aggravation claim. Claimant also objects to the admission of expert vocational testimony at hearing and seeks remand to the Referee for a new hearing. On review, the issues are extent of permanent disability, premature closure, related medical services, admissibility of evidence, remand, penalties and attorney fees. We affirm in part and reverse in part.

Admissibility of Evidence and Remand

At hearing, vocational expert Elliott was allowed to testify in both an expert and lay capacity. Claimant objects to his testimony because the insurer did not provide 20 days notice that the expert would be called to testify at hearing as required by our rules. Former OAR 438-07-016. The Referee made no ruling on the admissibility of the testimony. We conclude that claimant was prejudiced by the failure of the insurer to declare this witness in that claimant was given no opportunity to submit rebuttal evidence. See former OAR 438-07-015(6). Accordingly, we exclude all of Elliott's expert testimony, but

not his lay observations regarding claimant's lack of pain complaints and behavior.

We may remand a case to the Referee if we find that it has been improperly, incompletely or otherwise insufficiently developed. ORS 656.295(5). Inasmuch as we have excluded the expert testimony to which claimant objects, and since the record is sufficiently developed in all other respects to allow our review to proceed, we decline to remand the case for another hearing.

FINDINGS OF FACT

Claimant compensably injured her low back on March 23, 1986 when a patient became violent while she was performing nursing assistant duties. Claimant sought care from Dr. Fuchs, chiropractor. Claimant attempted to return to work on numerous occasions, but each time she would reinjure her low back. On June 1, 1988 claimant changed attending physicians to come under the care of Dr. Womack. Her claim was closed by a June 30, 1988 Determination Order which declared her medically stationary on May 13, 1988 and awarded her 15 percent unscheduled permanent disability. On October 27, 1988, the insurer received an aggravation claim from claimant. The insurer did not deny the claim within 60 days.

Claimant is 24 years old. She completed the 11th grade in school and later obtained her GED certificate. Claimant is a certified nurses aide who has worked in that capacity and as a housekeeper prior to her injury. Claimant has mild impairment in the form of a chronic low back strain that restricts her from activities involving heavy lifting, frequent bending, pushing, pulling and twisting. Due to her compensable injury claimant is precluded from returning to the occupation of nursing assistant.

CONCLUSIONS OF LAW AND OPINION

Premature Closure

The Referee declined to find that the Determination Order had prematurely closed claimant's claim. We agree.

It is claimant's burden to establish that she was not medically stationary when the claim was closed. Berliner v. Weyerhaeuser, 54 Or App 624, 628 (1981); Dale R. Bennett, 40 Van Natta 843 (1988). The resolution of the medically stationary date is primarily a medical question based on competent medical evidence. Harmon v. SAIF, 54 Or App 121, 125 (1985). We evaluate claimant's condition and the reasonable expectation of improvement as of the date of closure. Alvarez v. GAB Business Services, 72 Or App 524 (1985).

At the time of closure, claimant had been examined and evaluated by the doctors at the Northwest Pain Center and by the Western Medical Consultants, Dr. Hess and Dr. Weeks. Both the Northwest Pain Center doctors and the Consultants agreed that claimant was medically stationary. (Exs. 24-4, 55). Dr. Hess did not directly address whether claimant was or was not medically stationary. However, he commented upon claimant's permanent restrictions, recommended an occupational change and did not recommend any further treatment nor suggest there would be any future improvement. (Ex. 58). We conclude, on whole, that Dr. Hess was of the opinion that claimant was medically stationary.

Dr. Weeks, orthopedic surgeon, directly opined that claimant was medically stationary. (Ex. 59-2).

The only contrary opinion comes from claimant's new attending physician, Dr. Womack, chiropractor, who opined in a "check-the-box" answer that claimant was not medically stationary. (Ex. 57). Since Dr. Womack was a new attending physician, we give no special deference to his opinion because of his status as an attending physician. See David E. Gates, 40 Van Natta 798 (1988). Since his opinion was conclusory and without explanation, we discount his opinion. See Marshall v. Boise Cascade, 82 Or App 130, 133 (1986); see also Kenneth C. Snow, 39 Van Natta 743 (1987) ("check-the-box" opinions are not persuasive). Accordingly, we conclude that claimant was medically stationary by the date of closure and that her claim was not prematurely closed.

Extent of Permanent Disability

The Referee declined to award claimant additional unscheduled permanent disability because he was more persuaded by contrary medical reports that claimant exaggerated her disabilities. We disagree.

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 her physical impairment as reflected in the medical record, the testimony at hearing, 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. See Harwell v. Argonaut Insurance, 296 Or 505, 510 (1984).

Claimant does have somatic preoccupation with pain. (Ex. 24-4). She also has excessive complaints that are not substantiated by objective findings. (Ex. 55-4). However, claimant's long-time attending physician, Dr. Fuchs, is of the opinion that claimant would have permanent residuals from her injury. Dr. Weeks and Dr. Hess both suggested claimant change to lighter work than her work as a nurse's assistant. Both recommended restrictions on lifting, bending and standing. We defer to the opinion of the attending doctor and the two consulting doctors, over the opinion of the Consultants, that claimant does have real restrictions that reduce her earning capacity. These restrictions coupled with her other vocational and social factors leads us to conclude that she has lost 25 percent of her preinjury earning capacity. Accordingly, we modify the Determination Order to award a total of 25 percent (80 degrees) unscheduled permanent disability.

Mileage Reimbursement

Claimant submitted claims to the insurer for reimbursement of 185 mile travel expenses between Umatilla and Island City to visit her attending doctor. The insurer reduced this amount contending that the mileage was inaccurate and excessive. Claimant testified that the mileage between Umatilla and Island City was 185 miles round trip. (Tr. 25). The parties agreed to let the Referee decide the matter by reference to Oregon Department of Transportation maps which were neither offered nor admitted into evidence. No such maps are contained in the record as certified to us by the Referee. ORS 656.295(5).

Since our review is limited to the record, and since the parties did not offer nor have admitted the Oregon Department of Transportation maps, we are unable to resort to these sources to determine the distance between Umatilla and Island City. Groshong v. Montgomery Ward Co., 73 Or App 403 (1985). Accordingly, we find from claimant's uncontroverted testimony that she traveled 185 miles round trip and we order the insurer to reimburse her accordingly.

Child Care Cost Reimbursement

Claimant did not receive reimbursement for child care costs incurred while she was seeking medical care from her doctor. Claimant argues that OAR 436-60-070(2) (eff. 1/1/88) allows for reimbursement for child care services. However, this rule was not in effect on the date of claimant's injury, and is therefore inapplicable. Fromme v. Fred Meyer, Inc., 89 Or App 397 (1988); Larry L. Schutte, 38 Van Natta 467 (1986). Instead, former OAR 436-60-070 (eff. 1/1/86) governs this case and that rule did not provide for reimbursement of child care expenses. Furthermore, such expenses are not reimbursable under ORS 656.245. Lorenzen v. SAIF, 79 Or App 751 (1986). The current rule providing for child care reimbursement is authorized pursuant to ORS 656.325(1)(b), and not ORS 656.245. Claimant admitted that she did receive child care expenses when the insurer required independent medical examinations. (Tr. 23). She is not entitled to child care expenses incurred while seeking care from her own doctor.

Penalties and Attorney Fees for Unreasonable Failure to Accept or Deny Claimant's Aggravation Claim

The insurer admitted in closing argument that it failed to deny claimant's aggravation claim timely. (Closing Argument at 8). However, since it has not been determined whether claimant's aggravation claim is compensable or not, we are unable to find that the lateness caused an unreasonable delay or resistance to compensation. Robert C. Smith, 42 Van Natta 899 (1990). Furthermore, since claimant received interim compensation payments, there are no amounts "then due" upon which to assess a penalty. ORS 656.262(10). Accordingly, we deny claimant's request to assess penalties and attorney fees for the late denial of claimant's claim.

ORDER

The Referee's order dated February 16, 1989, as supplemented February 27, 1989, is reversed in part and affirmed in part. That portion of the Referee's order which declined to award claimant additional unscheduled permanent disability is reversed. Claimant is awarded an additional 10 percent (32 degrees) unscheduled permanent disability, for a total award of 25 percent (80 degrees) unscheduled permanent disability. The insurer shall reimburse claimant for travel expenses from Umatilla and Island City incurred prior to hearing on the basis of a 185-mile round trip. The remainder of the order is affirmed. Claimant's attorney is awarded 25 percent of the additional permanent disability compensation granted by this order, not to exceed $3,000 as a reasonable attorney's fee, payable directly to claimant's attorney. The Board approves a client-paid fee, not to exceed $752, payable from the insurer to its counsel.

In the Matter of the Compensation of
DONALD R. ROTH, Claimant
WCB Case No. 88-18489
ORDER ON REVIEW (REMANDING)
Ralph M. Yenne, Claimant Attorney
Thomas Andersen (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

Claimant requests review of Referee Mirassou's order which: (1) found that claimant had withdrawn his hearing request; and (2) dismissed his request for hearing. On review, the issue is the propriety of the Referee's dismissal. We remand.

FINDINGS OF FACT

On October 25, 1988, claimant timely filed a Request for Hearing. The Hearings Division issued a Notice of Hearing, which set a hearing for January 31, 1988. On December 6, 1988, the Referee entered an order dismissing claimant's request for hearing.

Claimant requested Board review, stating that, "The claimant believes that it was improper for the Hearings Division to dismiss a Hearing Request on its own motion."

FINDINGS OF ULTIMATE FACT

The record has been incompletely and 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). Here, the record does not contain any motions, correspondence, records of telephonic conversations or exhibits concerning the dismissal of claimant's request for hearing. The Order of Dismissal merely states, "The Request for Hearing filed in the above matter on October 26, 1988 has been withdrawn . . ." Furthermore, because the case was dismissed without a hearing, no transcript exists. Given cliamant's assertion on review and because we find nothing in the record to support the assertion that claimant did not wish to pursue his claim, we find that the record has been incompletely and insufficiently developed. See Robert J. Buckley, 41 Van Natta 1761 (1989).

We therefore remand this matter to the Referee with instructions to determine whether the dismissal was justified. Should the Referee find that claimant's hearing request should not be dismissed, this matter shall proceed to hearing on the merits of the issues raised in claimant's hearing request.

ORDER

The Referee's order, dated December 6, 1988, is vacated and this matter is remanded to the Referee for further proceedings consistent with this order.

In the Matter of the Compensation of
VICKI M. VON KLEIN, Claimant
WCB Case No. 88-14868
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Employers Defense Counsel, Defense Attorneys

Reviewed by Board Members Cushing and Myers.

Claimant requests review of Referee Seymour's order which declined to increase the rate of claimant's temporary disability to include the monetary value for the private use of a company owned car. On review, the issue is rate of temporary disability benefits. We affirm.

FINDINGS OF FACT

Claimant was paid $433.33 per week as a sales representative. Claimant was furnished a car to be used in her work. As part of the employment agreement, claimant was allowed to use a company car. When used for personal purposes, claimant would pay the employer a flat rate of 12 cents per mile for such use.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant was not entitled to have included in her base temporary total disability rate, the value of her company car, because it had not been shown that the employer expended more than the 12 cents per mile to give claimant her benefit. We agree.

Temporary total disability benefits are computed based on 66-2/3 percent of the worker's average weekly wage. ORS 656.210(1). Calculation of the amount of compensation, requires determining the weekly wages of the injured worker. ORS 656.210; Nelson v. SAIF, 302 Or 463 (1987). Here, claimant received a company owned car, however, claimant also reimbursed the employer for mileage incurred on personal time. The key question is whether claimant received the fringe benefit as part of her daily wage. See Nelson, supra.

Claimant must satisfy the threshold question, that she incurred a benefit from the personal use of the employer owned car. Claimant paid 12 cents per mile to the employer when she used the motor vehicle for personal purposes. She paid for gas when using the car for personal purposes. (Tr. 5). She did not declare the personal use of the employer owned car as wages for tax purposes, nor did she have an agreement, distinct from the employment agreement, with the employer that set out the terms for use of the car. (Tr. 9, 10). Claimant has failed to show that she received any value in excess of the 12 cents per mile that she paid to the employer while using the car for personal purposes. Accordingly, claimant is not entitled to have the value of the personal use of the employer owned vehicle included in her average wage for the purposes of computating the amount of her temporary disability benefits.

ORDER

The Referee's order, dated January 4, 1989, as corrected January 10, 1989, is affirmed. A client-paid fee, not to exceed $504, payable from the insurer to its counsel, is approved.

In the Matter of the Compensation of
MICHAEL E. CRIST, Claimant
WCB Case No. 88-13257
ORDER ON REVIEW
S. David Eves, Claimant Attorney
John B. Motley (Saif), Defense Attorney

Reviewed by Board Members Speer and Howell.

Claimant requests review of that portion of Referee Higashi's order that increased claimant's unscheduled permanent disability award from 25 percent (80 degrees), as awarded by a Determination Order, to 31 percent (99.2 degrees) for a low back injury. On review the issue is extent of permanent disability. We affirm.

FINDINGS OF FACT

We adopt the Referee's "Findings" and "Ultimate Findings."

CONCLUSIONS OF LAW AND OPINION

In determining the extent of claimant's permanent disability, the Referee applied the standards for evaluating permanent disability as adopted by the Director of the Department of Insurance and Finance pursuant to ORS 656.726(3)(f). See ORS 656.283(7). Specifically, the Referee applied former OAR 436-35-000 et seq, which was effective at the time of claimant's July 7, 1988 Determination Order. See OAR 438-10-005; 438-10-010. These are the rules which we apply as well. ORS 656.295(5); OAR 438-10-005; 438-10-010.

The Referee increased claimant's unscheduled permanent disability award for his low back condition from 25 percent (80 degrees) to 31 percent (99.2 degrees). We agree with the Referee's award; however we reach our conclusion in the following manner.

The hearing and Board review of the issue of permanent partial disability continues to be de novo on the hearing record. The underlying facts to which the "standards" are applied need only be established by a preponderance of the evidence. However, either party may establish that the record, as a whole, constitutes clear and convincing evidence that the degree of permanent partial disability suffered by the claimant is more or less than the entitlement indicated by the "standards". ORS 656.283(7) and 656.295(5).

The determination of permanent partial disability under the "standards" is made by determining the appropriate values assigned by the "standards" to the claimant's age, education, adaptability and impairment. Once established, the values for age and education are added and the sum is multiplied by the appropriate value for adaptability. The product of those two figures is then added to the appropriate value for impairment to yield the percentage of unscheduled permanent partial disability. Former OAR 436-35-280.

Age

The appropriate value for claimant's age of 31 years is 0. Former OAR 436-35-290.

Formal Education

The appropriate value for claimant's formal education is +1, since he has no high school diploma or GED. Former OAR 436-35-300(3).

Skills

Former OAR 436-35-300(4) adopts by reference the "SVP" (specific vocational preparation time) values assigned to various occupations by the Dictionary of Occupational Titles (DOT), published by the U.S. Department of Labor. The highest SVP level demonstrated by a claimant during the ten years prior to the date of injury is used to determine a value for skills. Former OAR 436-35-300(4). Claimant's highest SVP during the ten years prior to the date of injury was 7 as an autobody repairperson. (DOT #807.381-010). Therefore, the appropriate value for skills is +1. Former OAR 436-35-300(4).

Training

Claimant has no documented training. Therefore, the appropriate value for training is +1. Former OAR 436-35-300(5).
Claimant's total education value is +3, the formal education value plus the skills value plus the value for training. Former OAR 436-35-300(6).

Adaptability

An adaptability value for a claimant who is unable to return to his or her usual and customary work [see former OAR 436-35-270(3)(a)] and who has not returned to modified work is determined by the claimant's residual physical capacity, without regard to that claimant's physical capacity prior to the injury. Former OAR 436-35-310(4).

Claimant is unable to return to his usual and customary work and has not returned to, or been offered, regular, modified work since he became medically stationary (when permanent disability is rated). Claimant's physical capacity falls within the medium category. Thus, the appropriate adaptability value is +1. Former OAR 436-35-310(4)(c).

Impairment

The Referee awarded claimant 5 for claimant's laminectomy with single disectomy and an additional 4 for his unoperated conjoined nerve root at L-5 on the left. The Referee added these values together, resulting in a 9 impairment value for "general spinal findings." Former OAR 436-35-350(2). We agree.

The Referee awarded claimant 6 for his loss of flexion in his thoracolumbar spine. We agree. The medical evidence is sufficient to prove that claimant has lost 60 degrees of flexion and is therefore entitled to a 6 impairment value. Former OAR 436-35-360(6).

The Referee awarded claimant 1 for the loss of 10 degrees of extension in the thoracolumbar spine. We agree. The medical evidence is sufficient to prove that claimant has lost 10 degrees of extension and is therefore entitled to a 1 impairment value. Former OAR 436-35-360(7).

The Referee gave no rating to claimant's loss of left and right flexion. We disagree. The medical evidence is sufficient to prove that claimant has lost 5 degrees left flexion in his thoracolumbar spine and is therefore entitled to a 1 impairmant value. Former OAR 436-35-360(8).

The Referee awarded claimant 2 for the loss of 10 degrees right rotation and 5 for the loss of 25 degrees left rotation. We agree, based on the medical evidence. Former OAR 436-35-360(9).

The values for loss of range of motion in each area of the thoracolumbar spine are to be added (not combined) for a total impairment value that represents loss of range of motion of the spine. Former OAR 436-35-360(10). This value (15) is then combined with the value for other spinal findings (9, supra), resulting in a 22.65 impairment value for claimant's low back condition. OAR 436-35-360(11).

Finally, the Referee awarded claimant 5 for pain which has resulted in a loss of use and function. We agree. Former OAR 436-35-320(1)(a) provides that pain can result in loss of use or function. When it does, it is rated based on the loss of use or function which results and no additional value is allowed for the pain alone. The Board in Daniel M. Alire, 41 Van Natta 752 (1989), held that, inasmuch as the standards do not provide for a value range for impairment attributable to disabling pain, the Board on de novo review can consider the evidence and award the claimant a value that adequately compensated him for his loss of use or function attributable to the disabling pain.

In this case, the record establishes that claimant has continuing back pain and that he is not able to sit or stand for over two hours because of this pain. We find that the preponderance of the evidence demonstrates that claimant has a loss of use and function attributable to his pain, which is not otherwise accounted for by the impairment values previously discussed.

Inasmuch as the standards do not provide for a value range for impairment attributable to disabling pain, we consider a value of 5 in this particular case to be reasonable. Combining the aforementioned value with the 22.65 impairment value for loss of range of motion in the thoracolumbar spine results in a total of 26.52. This value represents claimant's total impairment value.

Computation of Unscheduled Disability.

Having determined each value necessary to compute claimant's permanent disability under the "standards," we proceed to that calculation. When claimant's age value (0) is added to his education value (+3) the sum is +3. When that value is multiplied by claimant's adaptability value (+1) the product is +3. When that value is added to claimant's impairment value of 26.5, the result is 29.5 percent unscheduled permanent partial disability. Former OAR 436-35-280(7). That disability figure is rounded to the next higher whole percentage. Id. Claimant's permanent disability under the "standards" is, therefore, 30 percent (115.2 degrees).

SAIF does not seek reduction of claimant's award under the disability standards. Therefore, the award will not be altered. Daniel M. Alire, supra.

ORDER

The order of the Referee dated January 18, 1988 is affirmed.

In the Matter of the Compensation of
PAUL G. CREBASSA, Claimant
WCB Case No. 88-15252
ORDER ON REVIEW
W. Daniel Bates, Claimant Attorney
H. Thomas Andersen (Saif), Defense Attorney

Reviewed by Board Members Crider and Brittingham.

Claimant requests review of Referee Gruber's order that increased claimant's scheduled permanent disability award for a left hand injury from 30 percent (45 degrees), as awarded by a Determination Order, to 32 percent (48 degrees). On review, the issue is extent of permanent disability. We modify.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following supplementation.

Claimant cannot apply any pressure to the ends of his amputated fingers because of pain. Once a musician, claimant cannot play the piano because the pressure required to depress the keys is too great. He cannot play the guitar because the pressure required to push the strings against the fretboard with his left hand is painful. He cannot reach into his pocket to pull out coins because of pain. The tips of claimant's middle and ring fingers are numb. The numbness combined with the pain makes it difficult for claimant to manipulate small objects and to do things like buttoning a shirt. He cannot use his amputated fingers for such tasks and must, instead, use his thumb and little finger.

ULTIMATE FINDINGS OF FACT

Claimant has lost 38 percent of the use or function of the left hand due to the compensable injury.

CONCLUSIONS OF LAW AND OPINION

Claimant maintains that he has a greater loss in his left hand than that awarded by the Referee, because the Referee neglected to rate the numbness and pain claimant experiences in his amputated fingers. We agree that the Referee erred in neglecting to rate for both numbness and pain. We consider these factors and evaluate claimant's disability de novo.

If a claimant became medically stationary after January 1, 1988, and his or her claim was closed on or after July 1, 1988, a subsequent determination by a referee or the Board of the claimant's permanent partial disability must be made pursuant to ORS 656.283(7) and 656.295(5), respectively. OAR 438-10-005 and Michelle Griffith, 40 Van Natta 2086 (1988). For purposes of determining injury-related permanent partial disability, ORS 656.283(7) and 656.295(5) require application of the standards for the evaluation of disabilities adopted by the director pursuant to ORS 656.726(3)(f)(A).

The Referee was correct in applying "standards." However, it is unclear from the record which version of the standards he applied. Those "standards" in effect on the date of the Determination Order from which the hearing was requested control the evaluation of permanent partial disability. OAR 438-10-010. Claimant became medically stationary on June 13, 1988, and the Determination Order issued on July 15, 1988. Thus, in this case, the "standards" adopted effective July 1, 1988, former OAR 436-35-001 et seq, apply to the rating of claimant's permanent partial disability. Former OAR 436-35-010 through 436-35-260 apply to the rating of scheduled permanent partial disabilities. Former OAR 436-35-010(1).

Ratings for amputation levels of the finger are governed by former OAR 436-35-030(6). No additional value is permitted for reduced grip strength because it is already figured in the amputation charts. Former OAR 436-35-110(3)(b). The Referee correctly rated amputation of the index finger proximal to the nail base level at 40 percent, and amputation of the middle and ring fingers at the distal interphalangeal disarticulation at 45 percent each.

Movement in a joint is measured in active degrees of motion. It is compared to the degrees of motion possible in the contralateral normal joint, or to ranges of motion (ROM) established by the AMA as normal. Former OAR 436-35-010(3). Claimant is unable to flex his index finger at the distal interphalangeal joint. Thus, the Referee's rating of 45 percent is correct. Former OAR 436-35-060(1). Claimant has lost 10 degrees ROM in the proximal interphalangeal joint of the middle and ring fingers. The Referee correctly rated each finger at 6 percent. Former OAR 436-35-060(3).

The SAIF Corporation concedes that the Referee failed to consider claimant's numbness, which SAIF rates at 13 percent for the middle finger and 14 percent for the ring finger. Loss of palmar sensation in the fingers is rated according to the location and quality of the loss. Former OAR 436-35-110(1). Claimant has no loss of sensation in the index finger. Dr. Cutler found moderate sensory loss in one-half the distal phalanx of the middle and ring fingers. Moderate sensory loss is equivalent to less than normal but more than protective sensation, and is rated at 13 percent for the middle finger and at 14 percent for the ring finger. Former OAR 436-35-110(1)(a).

SAIF argues that no additional value should be given for pain. SAIF cites former OAR 436-35-010(2)(a) and Daniel M. Alire, 41 Van Natta 752, recon denied 41 Van Natta 879 (1989) for the proposition that when pain results in loss of use or function, it is rated based on this loss and no additional value is allowed for the pain alone. SAIF misconstrues the law in this case. Disabling pain can result in loss of use or function beyond that to be expected from an amputation. When it does, it is rated based on the loss of use or function which results. Former OAR 436-35-010(2)(a). Inasmuch as the standards do not provide for a value range for impairment attributable to disabling pain, the Board on de novo review can consider the evidence and award the claimant a value that adequately compensates him for his loss of use or function attributable to disabling pain. Daniel M. Alire, supra.

Here, claimant credibly testified to loss of use or function of his amputated fingers due to pain. He can no longer play the piano or guitar because of pain. He cannot put his fingers in his pockets to pull out coins because of pain. Dr. Cutler, M.D., claimant's attending hand specialist, reported that the fingertips in the last distal 10 mm portion of claimant's index and middle fingers are essentially useless, as pain prevents him from applying pressure in those areas. As a result, we rate loss of use or function due to pain at 20 percent for each of those two fingers.

Loss of, or loss of use of, two or more digits may be converted to a value for loss in the hand if the worker will receive more compensation with the conversion. We compare the sum of claimant's loss for each individual finger with the value for loss in the hand with conversion to award him the maximum amount under the law. See OAR 436-35-070(1).

To rate the loss of individual fingers, loss of opposition is rated. Former OAR 436-35-040(3). Loss of opposition in the index and middle fingers is rated at 10 percent for amputation at the distal interphalangeal joint. Ratings are adjusted in steps of five percent, decreasing as the amputation gets closer to the fingertip. Id. Thus, we rate claimant's index finger at 5 percent and

his middle finger at 10 percent. The ring finger is rated at 5 percent for amputation at the distal interphalangeal joint. Id.

For multiple losses in any finger, each loss is rated separately. These ratings are then combined (not added) to find the total impairment of the finger. Former OAR 436-35-060(7). The total impairment of the index finger is 75 percent, the middle finger 68 percent, and the ring finger 58 percent. We then multiply these percentages by 24, 22 and 10 degrees respectively for each finger, see ORS 656.214(2)(k), which results in a total of 38.76 degrees.

The total value of loss in the hand is found by rating each digit, converting to values for loss in the hand, and adding (not combining) the converted values. Former OAR 436-35-070(2). Loss of opposition is already included in the conversion charts. Former OAR 436-35-070(3). Thus, we do not include loss of opposition in our calculation here. We combine to calculate loss in the index finger as 74 percent of the index finger, which converts to 19 percent loss of the hand. Former OAR 436-35-070(5). The loss in the middle finger is 64 percent, which converts to 13 percent loss of the hand. Former OAR 436-35-070(6). The loss in the ring finger is 57 percent, which converts to 6 percent loss of the hand. Former OAR 436-35-070(7). The values for each finger are then added for a total of 38 percent or 57 degrees. As this is the higher amount, we increase claimant's scheduled disability to a total of 38 percent (57 degrees).

ORDER

The Referee's order, dated January 26, 1989, is modified. In addition to the 32 percent (48 degrees) scheduled permanent disability awarded by Determination Order and the Referee's order, claimant is awarded 6 percent (9 degrees) scheduled permanent disability, giving him a total award to date of 38 percent (57 degrees) scheduled permanent disability for loss of use or function of the left hand. Claimant's attorney is awarded 25 percent of the increased compensation created by this order, payable directly to claimant's attorney. However, the total attorney fees awarded by the Referee and Board orders shall not exceed $3,800.

May 21, 1990 Cite as 42 Van Natta 1098 (1990)

In the Matter of the Compensation of
GERALD G. SAMPSON, Claimant
WCB Case No. TP-90027
THIRD PARTY ORDER
Mautz, Hallman, et al., Claimant Attorneys
Gray, et al., Attorneys

Claimant has petitioned the Board for the allowance of an extraordinary attorney fee for services rendered in connection with a third party settlement. Specifically, claimant seeks approval of an attorney fee equal to 40 percent of the $275,000 settlement. The SAIF Corporation, as paying agency, raises no objection to claimant's request. We find that extraordinary circumstances exist to justify the requested fee.

FINDINGS OF FACT

Claimant sustained a compensable injury. SAIF has accepted the claim and provided benefits.

Claimant engaged legal counsel to explore the possibility of bringing suit against a third party for his injury. Pursuant to his September 1985 executed

retainer agreement, claimant agreed that his counsel would receive one-third of any settlement reached before trial or hearing. If settlement was achieved after a trial had begun, the attorney fee would be 40 percent of the settlement proceeds. In the event of an "appeal, after trial," the agreement provided that claimant's counsel would receive 50 percent of the proceeds. Finally, the parties stated that claimant's attorney fee would be "geared to the degree of effort [claimant's counsel] spend on your case."

In September 1986 claimant initiated a lawsuit in the U.S. District Court of Oregon against the third party. When the third party's motion for summary judgment was granted, claimant appealed to the Ninth Circuit Court of Appeals. Claimant's counsel prepared the appeal and argued the case before the court. Thereafter, the court reversed the lower court's order and remanded for trial.

Before the commencement of the September 1989 trial, the third party again moved for summary judgment. The U.S. District Court then certified the question raised in the third party's motion to the Oregon Supreme Court under the Oregon Certification Statute. The Supreme Court accepted the question for certification. However, before claimant could present arguments to the Supreme Court, the Court of Appeals issued a decision interpreting the same statute which was at issue in the third party's motion for summary judgment.

Arguing that the Court of Appeals ruling favored his position, claimant moved for withdrawal of the certification question. The Supreme Court granted the motion and the case was again set for trial before the U.S. District Court.

Prior to trial, claimant and the third party agreed to the settlement of the action for $275,000. Considering the "very difficult questions of law involved" in the case, claimant characterizes the settlement as an "excellent result." SAIF has approved the settlement and has no objection to claimant's characterization of the case nor his petition for a 40 percent attorney fee.

CONCLUSIONS OF LAW

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). ORS 656.593(1) provides in exact detail how, and in what order, the proceeds of any damages shall be distributed.

Costs and attorney fees shall be initially disbursed. ORS 656.593(1)(a). The attorney fees in no event shall exceed the advisory schedule of fees established by the Board for third party actions. ORS 656.593(1)(a); Shipley v. SAIF, 79 Or App 149, 152-53 (1986).

The Board's advisory schedule concerning attorney fees in third party cases is set forth in OAR 438-15-095. The rule provides as follows:

> "Unless otherwise ordered by the Board after a finding of extraordinary circumstances, an attorney fee not to exceed 33-1/3 percent of the gross recovery obtained by the plaintiff in an action maintained under the provisions of ORS 656.576 and 656.595 is authorized."

Extraordinary attorney fees have been allowed in the past. In Leonard F. Kisor, 35 Van Natta 282 (1983), a 40 percent share of the proceeds was allowed where the third party litigation involved a complex asbestosis issue and the paying agency did not object to the fee. An extraordinary fee of 40 percent has

also been allowed where claimant's counsel expended nearly three full months in preparation for a 5-day malpractice trial and obtained an extremely favorable result. See John Galanopoulos, 35 Van Natta 548 (1983). Finally, in John P. Christensen, 38 Van Natta 613 (1986), claimant's counsel was granted an extraordinary fee of 50 percent where the case had been litigated over a 10-year period, including two presentations on procedural issues before the Oregon Supreme Court and one mistrial, and the paying agency had raised no objection to the request.

An extraordinary attorney fee was not allowed in David S. Holcomb, 41 Van Natta 195 (1989). In Holcomb, a $20,000 settlement of a third party action was achieved while claimant's appeal from a summary judgment order was pending. Although claimant's counsel had undoubtedly expended many hours in case preparation, the Board did not consider the case to be particularly complex nor did it find the litigation to have been lengthy as in Galanopoulos and Christensen. Finally, the Board noted that the paying agency objected to the allowance of an extraordinary attorney fee.

Here, claimant is requesting an extraordinary attorney fee equal to 40 percent of the third party settlement. In support of this request, he notes the following circumstances: (1) the complexity of the legal issue involved in the case; (2) the extensive research necessary in preparing the case for trial, responding to two motions for summary judgment, and representing claimant through two appellate forums; and (3) the excellent result obtained. Furthermore, claimant emphasizes that SAIF has raised no objection to the petition for an extraordinary attorney fee.

We find that these circumstances justify the allowance of an extraordinary fee. To begin, the case involved a complex legal issue which initially resulted in a summary judgment against claimant. It was only after a successful appeal to the Ninth Circuit Court of Appeals, certification of a legal question to the Oregon Supreme Court, and withdrawal of the certification question following a favorable Court of Appeals decision that the $275,000 settlement was achieved. Under such circumstances, which also includes SAIF's approval of the request, we conclude that claimant's counsel is entitled to an extraordinary attorney fee equal to 40 percent of the settlement proceeds.

In reaching this conclusion, we note that claimant's retainer agreement provides that his attorney fee shall be one-third of the proceeds if the settlement is reached before trial, 40 percent if settlement occurs after trial begins but before an appeal, and 50 percent in the event of an appeal after trial. Thus, the agreement does not expressly address the circumstances presented in claimant's petition.

Yet, the granting of an order of summary judgment results in a judgment as a matter of law without the convening of a trial. ORCP Rule 47C. Since such a judgment was initially granted and because claimant's counsel was required to successfully appeal the decision as well as to represent claimant's interests before a second appellate forum in order to finally achieve this settlement, we conclude that these circumstances exceed the situation depicted in the pre-trial section of claimant's retainer agreement.

Consequently, we are persuaded that claimant's counsel is entitled to an attorney fee in excess of one-third of the third party settlement. Our conclusion is also in keeping with the intention of the parties as expressed in their agreement, a provision of which states that the attorney fee is "geared to the degree of effort [claimant's counsel] spend on your case."

Accordingly, for the reasons expressed herein, we find that this case constitutes extraordinary circumstances justifying the allowance of an extraordinary attorney fee. Commensurate with the request from claimant's counsel, we further hold that the extraordinary attorney fee shall equal 40 percent of the settlement proceeds.

IT IS SO ORDERED.

In the Matter of the Compensation of
REBECCA B. VAN GROLL, Claimant
Own Motion No. 89-0384M
OWN MOTION ORDER ON RECONSIDERATION
Meyers & Radler, Attorneys

Claimant requests reconsideration of our April 5, 1990, Own Motion Order which denied her own motion request for reopening of the above-captioned claim. She contends that she requested claim reopening prior to the expiration of her aggravation rights. We agree.

In our April 5, 1990, order, we found that claimant's aggravation rights had expired and, in the exercise of our own motion authority, denied reopening of her claim based on a finding that she was seeking claim reopening for a psychological condition which had been denied by the employer. However, claimant was seeking claim reopening for an alleged worsening of her accepted low back condition, not a psychological condition. Indeed, the psychological condition was diagnosed by doctors who were examining claimant at the employer's request, and there is no indication that she was seeking benefits relating to that condition.

Moreover, after further review of this record, we conclude that claimant's claim for reopening is not subject to our own motion authority. Our own motion authority extends only to claims on which the aggravation rights have expired. See Miltenberger v. Howard's Plumbing, 93 Or App 475 (1988). Claimant's low back injury claim was first closed by Determination Order on February 27, 1984. Hence, she had five years from that date, or until February 27, 1989, in which to file an aggravation claim. See ORS 656.273(4). In February 1989, she wrote a letter to the self-insured employer, requesting that her claim be "reactivated" based on a worsening of her low back condition. That letter is stamped with a receipt date of February 27, 1989. Inasmuch as claimant's aggravation rights on her 1982 injury claim had not yet expired, her claim for reopening is not subject to our own motion authority but, rather, should be processed as an aggravation claim pursuant to ORS 656.273.

Our Own Motion Order dated April 5, 1990, is abated and withdrawn. On reconsideration, the request for own motion relief is dismissed for lack of jurisdiction. The parties' rights of reconsideration and appeal shall run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
IOLA P. CARR, Claimant
Own Motion No. 89-0730M
OWN MOTION ORDER
Peter O. Hansen, Claimant Attorney
Roberts, et al., Defense Attorneys

By Own Motion Order dated January 19, 1990, the Board reopened claimant's claim with temporary disability benefits for a worsening of her industrial injury requiring surgery on November 30, 1989. Before benefits were to be paid, however, the insurer requested abatement and reconsideration of the order on the basis that it had not been provided a copy of claimant's affidavit regarding her work search efforts and employment history prior to the worsening. We abated and withdrew our order on February 2, 1990. Claimant subsequently

provided the insurer with a copy of her affidavit. The insurer then requested that claimant sign a Release of Employment Records authorizing it to obtain any and all employment records and information from her former employers. Claimant declined to sign that release but, instead, provided limited authorization for the release of dates of hire, periods of employment, wages, total income, and description of duties performed. The insurer now contends that claimant's release is too limited and requests the issuance of an order directing claimant to sign its original release. We decline to do so.

To receive temporary disability benefits upon a worsening of her industrial injury, claimant must be in the work force at the time of the worsening. See Cutright v. Weyerhaeuser, 299 Or 290 (1985). A claimant is deemed to be in the work force if she is engaged in regular gainful employment or, although not employed, is willing to work and is making reasonable efforts to obtain employment. Dawkins v. Pacific Motor Trucking, 308 Or 254, 258 (1989). Here, claimant represented in her affidavit that, inter alia, she worked for one employer from November 1, 1988, through November 29, 1989, the day before she underwent her injury-related surgery. She has authorized that employer to provide the insurer's counsel with enough information to confirm whether she was indeed employed up to the date of surgery. If her representation is confirmed, it necessarily follows that claimant was in the work force at the time of her worsening. On the other hand, if her representation is disputed by the employer, she may then be required to authorize the release of further employment information in order to receive temporary disability benefits. At this point, however, we are not persuaded that the release of further employment information is necessary to determine claimant's entitlement to benefits.

The insurer's request for own motion relief is denied. The parties shall have 14 days from the date of this order to submit their arguments regarding claimant's entitlement to temporary disability benefits. Thereafter, an order shall issue in this matter.

IT IS SO ORDERED.

In the Matter of the Compensation of
RONALD V. DICKSON, Claimant
WCB Case No. 88-12834
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Gerner, Brittingham, and Myers.

Claimant requests review of that portion of Referee Galton's order that upheld the self-insured employer's denial of his occupational disease claim for headaches and a bleeding ulcer. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

Claimant began working as a "Loss Control Representative" for the self-insured employer, an insurer of long-haul trucking companies, on September 30, 1985. In this position, claimant's primary duty was to survey the records of potential customers to confirm compliance with federal Department of Transportation (DOT) regulations. This work required long hours and considerable travel.

In late 1986, the employer added the duties of a "Truck Safety Specialist" to claimant's job description. This work required claimant to make detailed inspections of the records of existing customers and to look for evidence of violations of DOT regulations and other, sometimes fraudulently concealed, information needed by the insurance company for rating purposes. This change in claimant's job description greatly increased his workload. He often worked 14 hours a day, 6 or 7 days per week and was away from home as many as 15 nights per month. In addition, claimant was uncomfortable personally with the confrontational nature of the duties of a Truck Safety Specialist.

About one year after claimant's job description was altered, he began to feel lethargic, to have difficulty concentrating and to experience daily headaches. As a result, he began taking 2 to 4 aspirin per day to control his headaches. About the same time, claimant's supervisor began to receive complaints that claimant's reports were often unclear and incomplete. Because of these deficiencies in claimant's reports, his supervisor placed him on probation for a six-month period beginning in January 1988. (Ex. 7D). As a result, claimant increased the dosage of aspirin he took for his headaches.

During the probationary period, claimant's supervisor assigned a co-worker to perform audits of some of the accounts serviced by claimant. These audits revealed that the insureds in claimant's territory were concealing rating information and, as a result, were paying insufficient premiums.

Claimant continued to experience daily, severe headaches during early 1988 and continued to gradually increase his dosage of aspirin. By June 1988, he was taking 10 to 15 aspirin per day. (Ex. 19-1).

In May 1988, while attending a work-related conference, claimant made some negative comments in the presence of a DOT official and others about a company whose records he had recently inspected. These comments prompted a DOT inspection of that particular company and caused the company to cancel its application for what would have been a very large account with claimant's employer. After receiving a complaint from the agent who had generated the application, claimant's supervisor flew from the employer's main office in Florida to the Northwest in an attempt to salvage the account and to discuss the situation with claimant. Thereafter, claimant's supervisor and another worker conducted a comprehensive inspection of claimant's files. They found most of them to be very disorganized and also found indications that the accounts were not being adequately serviced.

On June 6, 1988, in view of these major deficiencies, claimant's employment was terminated. That same day, claimant sought medical treatment for complaints of chronic headaches, concentration difficulties and fatigue.

On June 9, 1988, claimant filed a workers' compensation claim. However, he did not list a "body part," nor did he indicate the "nature of injury or disease." Claimant reported on the claim form that his condition "could be stress related, memory abnormalities."

In mid-July 1988, the employer denied claimant's claim, indicating that his "work activity is not a contributing cause of your current complaints." Claimant requested a hearing.

In early July 1988, claimant was diagnosed with a bleeding ulcer. The bleeding ulcer condition was caused by excessive ingestion of aspirin, which was taken to relieve his headache condition.

Claimant had experienced occasional headaches before beginning his employment with the employer. The problem worsened in late 1987 and early 1988 due to muscle tension generated by stress associated with his employment. Claimant continued to suffer headaches for three to four months after his employment was terminated. Claimant also has a long history of gastric problems, including ulcers. That condition worsened in late 1987 and early 1988 due to excessive aspirin consumption.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant had failed to meet his burden of proving that he sustained a compensable occupational disease. As a result, the Referee upheld the employer's denial of claimant's occupational disease claim for stress-related headaches and a resultant ulcer. While we agree with the end result reached by the Referee, we do so with different reasoning.

For an occupational disease claim, the date of "injury" is the date upon which the claimant was last exposed to the employment conditions which caused the disease. Johnson v. SAIF, 78 Or App 143, rev den 301 Or 240 (1986). Claimant filed his occupational disease claim on June 9, 1988, and his last exposure to working conditions, which he alleges caused his stress-related headaches and resultant ulcer, was in June 1988. Accordingly, the occupational disease law, which became effective January 1, 1988, is applicable. Donna E. Aschbacher, 41 Van Natta 1242 (1989); see Johnson, supra at 146-48.

To be compensable, claimant's occupational disease must fall within one of the three subsections of ORS 656.802(1).

Here, claimant filed a claim for both work-related stress headaches and an ulcer. The record is clear that claimant's bleeding ulcer is a direct result of excessive aspirin ingestion taken to relieve his headache condition. Therefore, our first analysis centers on claimant's claim for a headache condition.

Compensability of Stress-related Headaches

Claimant contends that the specific facts of his case should be analyzed under ORS 656.802(1)(a) as a "disease or infection" resulting from work "conditions." ORS 656.802(1)(a) provides that "occupational disease" means:

> "(a) Any disease or infection arising out of and in the course of employment caused by ingestion of, absorption of, inhalation of or contact with dust, fumes, vapors, gasses, radiation or other conditions or substances to which an employe is not ordinarily subjected or exposed other than during a period of regular actual employment therein, and which requires medical services or results in disability or death." (Emphasis added.)

Here, claimant contends that his physical conditions or symptoms (headaches) resulting from stress should be characterized as a "disease" under ORS 656.802(1)(a), as an "other condition." Essentially, in support of this contention, claimant argues that the use of the language "or other conditions" is a catchall phrase intended by the legislature to cover conditions such as claimant's stress-related headaches. We disagree.

Because claimant questions the meaning and scope of ORS 656.802(1), we now interpret the statute. In construing statutes, when construction is necessary, the primary or governing rule to be followed is to ascertain and declare the

legislative intent. All other rules of statutory construction are secondary in importance and are simple guidelines to aid in the application of the primary rule. Berry Transport v. Heltzel, 202 Or 161 (1954). See Donna E. Aschbacher, supra.

After our review of the legislative history relating to the passage of ORS 656.802(1), we conclude that the diseases covered by paragraph (a) are limited.

The legislative history of the 1987 amendments to ORS 656.802(1) supports this limited reading of paragraph (a). During the Senate Labor Committee's consideration of the amendments, counsel for the Committee asked Jim Edmunson, a member of the claimants' bar, to explain the meaning of the categories created by the new definition of occupational disease. See Minutes, House Task Force on Occupational Disease, October 8, 1986, at pp. 18-20 & Exhibit I. Edmunson stated that paragraph (a) was intended to cover "toxic exposure" or "contact-type" diseases and indicated that the phrase "other conditions or substances" referred to physical conditions or substances similar to those specified previously in the paragraph. See Minutes, Senate Committee on Labor, April 30, 1987, at 64-71, Tape 133, Side A; see also Minutes, House Task Force on Occupational Disease, October 8, 1986, pp. 11-12.

Moreover, there is specific legislative intent to restrict the meaning of "or other conditions." See Minutes, House Task Force on Occupational Disease, October 8, 1986, pp. 18-20 and exhibit I and pp. 11-12. See also Minutes, Senate Committee on Labor, April 30, 1987, pp. 64-71, Tape 133, Side A. Specifically, Mr. Edmunson noted that the phrase 'other conditions or substances' referred to physical conditions or substances similar to those specified previously in the paragraph. Id. Likewise, during a work session on LC 247-4, Ms. Borchers, Administrator, House Task Force on Occupational Disease, in responding to Representative Hayden's questions concerning the interpretation of paragraph (a), reported that the "existing limits in the paragraph would also control the words 'other conditions'." Borchers indicated that "as a matter of law, when a judge looks at a list of terms like this [referring to: dust, fumes, vapors, gasses, radiation or other conditions or substances], they look at the added words with the list, and will interpret it as being similar to those things." Id.

Administrator Borchers' comments to the effect that the "or other conditions" language of paragraph (1)(a) is not intended to be a "catchall" term is an apparent reference to the "doctrine of ejusdem generis." This doctrine is applicable where the statute sought to be construed contains an enumeration of specific words, the members within the enumeration suggest that a class was intended, the class is not exhausted by the enumeration, there is a general reference supplementing or following the enumeration, and there is not a clearly manifested intent that the general reference term be given a broader meaning than the doctrine requires. See 2A Sands, Sutherland Statutory Construction, 47.17 (4th ed. 1973).

Thus, by application of ejusdem generis to ORS 656.802(1)(a), both the particular and the general words are given effect by treating the particular words as indicating the class, and the general words as extending the provisions of the statute to everything embraced in that class, though not specifically named by the particular words. United States v. Faudman, 640 F.2d 20 (CA 6th, 1981).

The doctrine of ejusdem generis is applicable to ORS 656.802(1)(a). The statute contains an enumeration of specific words, i.e., "dust, fumes, vapors, gasses, radiation," which we find to suggest a class of "toxic or contact type" conditions. The class is not exhausted, as we find that the use of the language, "or other conditions or substances" is a general reference supplementing the

class. Further, we find no intent by the legislature to give the term "or other conditions" a broader meaning than the doctrine requires. In fact, we have specifically noted legislative intent to limit the types of occupational disease covered under ORS 656.802(1)(a).

Caselaw requires a similar limited reading of ORS 656.802(1)(a). Where general words follow specific words in a statutory enumeration, the general words are construed to embrace only objects similar in nature to those objects enumerated by the preceding specific words. Kirkley v. Portland Elec. Power Co., 136 Or 421 (1931); Hise v. City of North Bend, 138 Or 150 (1932); State v. Tucker, 28 Or App 29 (1977).

We acknowledge that the use of the phrase "or other conditions" is sometimes used as a catchall phrase under more general statutory construction rules. However, because we find specific legislative intent with respect to the legislature's desired interpretation of paragraph (1)(a), and because the doctrine of ejusdem generis is wholly applicable to the statute in question, there is no need to resort to the more generalized rule of construction, i.e., the "catch-all" rule.

After our review of the legislative history and application of statutory construction rules to the relative statute, we conclude that the scope of occupational diseases compensable under paragraph (a) is limited. Further, we conclude that the use of "or other conditions" modifies the existing list of toxins in that paragraph, i.e., dust, fumes, vapors, gasses, and radiation. Therefore, we conclude that ORS 656.802(1)(a) covers only occupational diseases of a "toxic-type" or "contact-type" nature. Consequently, the types of occupational diseases compensable under ORS 656.802(1)(a) are limited to that extent.

Here, claimant suffers from headaches which were caused by work-related stress. The issue, then, is whether claimant's condition of "stress" is like-kind in nature to "dust, fumes, vapors, gasses or radiation or other conditions or substances . . ." ORS 656.802(1)(a). We conclude that it is not.

After our review of the record, we find that claimant has presented no evidence to establish that his headaches were "caused by ingestion of, absorption of, inhalation of or contact with dust, fumes, vapors, gasses, radiation or other conditions or substances." "Stress" per se, is not a "condition" in like-kind to the other kinds of "toxic" exposures covered under paragraph (a).

Consequently, we conclude that claimant's stress-related headache condition is not compensable under ORS 656.802(1)(a).

We also conclude that claimant's stress-related headache condition is not compensable under ORS 656.802(1)(c). First, we conclude that "traumatic" refers only to physical trauma, rather than psychological trauma. Second, were we to read ORS 656.802(1)(c) to include psychological, as well as physical, trauma, ORS 656.802(1)(b) would be rendered superfluous.

ORS 656.802(1)(c) provides that an "occupational disease" means:

> "(c) Any series of traumatic events or occurrences arising out of and in the course of employment which requires medical services or results in physical disability or death."

To establish that claimant's stress-related headaches are compensable under ORS 656.802(1)(c), claimant would have to prove by a preponderance of the evidence that he had endured a "series of traumatic events or occurrences arising out of and in the course of employment" which required medical services or

resulted in physical disability or death. Claimant contends that his employer "overused" him in a job for which he was not originally hired, thus satisfying the requisites of a "series of traumatic events." We disagree.

The difficulty in interpreting paragraph (c) is determining what the legislature intended by use of the language "traumatic events." "Traumatic" is not defined in the Workers' Compensation Law. Again, we turn to legislative history to determine legislative intent.

Regarding paragraph (c), Edmunson stated that the phrase "series of traumatic events or occurrences" was intended to cover "overuse" of a body part such as a hip, elbow or wrist. See Tape Recording, Senate Committee on Labor, April 30, 1987, Tape 133, Side A, at 73-88. We interpret this to mean that "series of traumatic events" means "physical" traumatic events, rather than psychological events. We find no evidence suggesting that the legislature's intent was otherwise.

Additional support for this limited reading of paragraph (c) is found in statutory construction rules. There is one specific rule of statutory construction which provides support for the more narrow interpretation of the scope of occupational diseases compensable under ORS 656.802(1)(c): Effect must be given, if possible, to every word, clause and sentence of a statute. See 2A Sands, Sutherland Statutory Construction, 46.05 (4th ed. 1987). "A statute should be construed so that effect is given to all its provisions, so that no part will be inoperative or superfluous, void or insignificant, and so that one section will not destroy another, unless the provision is the result of obvious mistake or error." United States v. Menasche, 348 U. S. 528 (1955); Murphy v. Nilsen, 19 Or App 292 (1974); Wingfield v. Nat'l Biscuit Co., 8 Or App 408 (1972).

Thus, were we to conclude that paragraph (c) was intended to encompass psychological, as well as physical, events, i.e., trauma, the resulting scope of diseases found compensable under paragraph (c) may very well render paragraph (b) and its counterpart, ORS 656.802(2), meaningless.

The legislative history is clear that paragraph (b) was intended to cover "stress-related" conditions, both physical or psychological, not paragraph (c). See generally Minutes, House Task Force on Occupational Disease, October 8, 1986, Tapes 21-31; Minutes, Senate Committee on Labor, April 23, 1987, pp. 4-5, April 30, 1987, pp. 7-8, June 8, 1987, p. 1; Tape Recording, House Labor Committee, 1987 Regular Session, Tape 48; Tape Recording, Senate Committee on Labor, June 9, 1987, Tape 202, Side A, at 31-37. We note that there is no evidence that the specific inclusion of paragraph (b) was a mistake or error. Therefore, any condition, physical or psychological, resulting from a work-related stress, to be compensable as an occupational disease must be analyzed under paragraph (b), as well as ORS 656.802(2).

We conclude, then, that the legislature intended paragraph (c) to encompass only a series of "physical" traumatic events, rather than series of "psychological" traumatic events.

Therefore, while we find that the addition of confrontational-type duties to claimant's position description may very well have been a stressful event, in and of itself, we do not find that such a stressful event satisfies the requisites of paragraph (c). Consequently, given the psychological mechanism of claimant's headache condition, we conclude that claimant's headache condition is not compensable under ORS 656.802(1)(c).

In view of the above discussion, we conclude that the compensability of claimant's physical condition, resulting from mental stress, is a condition that does not meet the definitions set forth in either ORS 656.802(1)(a) or (c). Therefore, to be compensable at all, such conditions must be analyzed under ORS 656.802(1)(b) and (2).

As amended in 1987, ORS 656.802(1)(b) defines an "occupational disease" as:

> "(b) Any mental disorder arising out of and in the course of employment and which requires medical services or results in physical or mental disability or death."

The Referee analyzed the present case under the "mental disorder" provisions of ORS 656.802(1)(b) and (2). We agree.

Claimant alleges that the stress on the job resulted in headaches. Analyzing his claim under this section of the statute requires claimant to prove the elements contained in subsection (2).

Under subsection (2)(a), a "mental disorder" is not compensable unless the employment conditions producing the mental disorder exist in a real and objective sense. Assuming for a moment that claimant does suffer from a "mental disorder," the first issue is to determine whether claimant's employment conditions, which allegedly produced his "mental disorder", are real.

Here, the record establishes that claimant's work-related stress is real. The nature of his job duties changed from non-confrontational to confrontational. Further, there is ample evidence that this change in job duties caused claimant to suffer stress, ultimately resulting in the termination of his employment.

The more important issue, though, is whether claimant suffers from a "mental disorder." In order to make this determination, we must analyze paragraphs (2)(a) and (2)(c) together. Paragraph (2)(c) provides that a "mental disorder" is not compensable:

> "(c) Unless there is a diagnosis of a mental or emotional disorder which is generally recognized in the medical or psychological community."

First, we note that claimant has conceded that he does not suffer from a "mental disorder." See Appellant's Brief, p. 12.

Second, we note that there was no psychiatric "diagnosis" made of claimant. (Ex. 20-5). ORS 656.802(2)(c) provides specifically that a mental disorder will not be compensable unless there is a "diagnosis" of a mental or emotional disorder. We interpret this provision to mean that it is claimant's burden to prove that his specific "mental disorder" has been diagnosed by a qualified physician. Otherwise, he will have failed to meet his burden of establishing a compensable occupational disease under ORS 656.802(1)(b) and (2).

Finally, and most importantly, while we have found that claimant's "stress," in and of itself, is real, it is not a condition which is generally recognized in the mental and psychological community as a "mental disorder." See Diagnostic and Statistical Manual of Mental Disorders (3rd ed., revised).

Physical conditions resulting from work-related "stress" are not compensable under paragraph (b), unless a "mental disorder" has been diagnosed as the

underlying condition. Only in that situation, where physical conditions directly result from a diagnosed mental disorder, can a stress-related physical condition be found compensable under ORS 656.802(1)(b) and (2).

Therefore, we conclude that claimant has failed to establish the requisites of ORS 656.802(2)(a) and (c). Accordingly, we hold that claimant's headache condition is not compensable under ORS 656.802(1)(b).

Were we to find that claimant's work-related "stress" is a "mental disorder," claimant would then have to establish the particular employment conditions which produced his stress-related headaches are conditions "other than conditions generally inherent in every working situation or [other than] reasonable disciplinary, corrective or job performance evaluation actions by the employer, or cessation of employment." ORS 656.802(2)(b). We find that claimant has also failed to meet the requisites of this paragraph.

Here, the employer placed claimant on probation because of noted poor job performance. It is during this same time frame his headache condition worsened. As a result of continued poor performance, claimant's employment was terminated. We find and conclude that the actions by the employer were reasonable disciplinary actions. Thus, we conclude that claimant has failed to meet the requisites of ORS 656.802(2)(b).

In the present case, we conclude that claimant has failed to establish that he has been diagnosed as having a mental or emotional disorder which is generally recognized in the medical or psychological community. In addition, even if his headaches caused by stress could be considered a diagnosed mental disorder, claimant has failed to establish that the employment conditions allegedly producing his mental disorder were conditions other than conditions generally inherent in every working situation or reasonable disciplinary, corrective or job performance evaluation actions by the employer, or cessation of employment. We conclude, therefore, that claimant has failed to carry his burden of proof on those two elements of his claim and, hence, that his claim for headaches are not compensable under ORS 656.802(1)(b).

Compensability of Ulcer Condition

Inasmuch as we have found that claimant's stress-related headache condition is not compensable, we do not reach the issue of the resultant ulcer condition.

ORDER

The Referee's order dated November 23, 1988 is affirmed. A client-paid fee, not to exceed $3,112.50, payable from the employer to its counsel, is approved.

Board Member Myers, dissenting.

I dissent.

The majority finds:

> "Claimant had experienced occasional headaches before beginning his employment with the employer. The problem worsened in late 1987 and early 1988 due to muscle tension generated by stress associated with his employment. Claimant continued to suffer

> headaches for three to four months after his employment was terminated. Claimant also has a long history of gastric problems, including ulcers. That condition worsened in late 1987 and early 1988 due to excessive aspirin consumption."

In other words, the majority finds that a worsening of claimant's headaches and ulcers was caused by a series of real and stressful events at work. Notwithstanding this finding, the majority concludes that the headaches and ulcers are not compensable.

As amended in 1987, ORS 656.802(1) defines an "occupational disease" as:

> "(a) Any disease or infection arising out of and in the course of employment caused by ingestion of, absorption of, inhalation of or contact with dust, fumes, vapors, gasses, radiation or other conditions or substances to which an employe is not ordinarily subjected or exposed other than during a period of regular actual employment therein, and which requires medical services or results in disability or death.
>
> "(b) Any mental disorder arising out of and in the course of employment and which requires medical services or results in physical or mental disability or death.
>
> "(c) Any series of traumatic events or occurrences arising out of and in the course of employment which requires medical services or results in physical disability or death."

I conclude that this case fits under subsection (c).[1]

The majority states that claimant's headaches and ulcers do not fit under ORS 656.802(1)(a) or (c). It then reasons that if these conditions are compensable at all, then they must be compensable under ORS 656.802(1)(b) and (2). The apparent basis for this conclusion is that 802(1)(b) and (2) is the appropriate category under which physical conditions resulting from work-related stress should be analyzed. The majority jumps to the conclusion that because the headaches and ulcers were caused by stress, they may only be compensable if an underlying diagnosis of a "mental disorder" is made.

The majority states that to interpret subsection (c) as encompassing physical consequences of a series of psychologically stressful events would render paragraph (b) and section (2) meaningless. This statement rests on the fallacious notion that to be an occupational disease, the headaches and ulcers must be mental disorders. This fallacy apparently stems from the belief that 802(1)(b) and (2) deal with stress cases. While it is true that these sections are generally loosely referred to as the mental stress statute, in fact they are more accurately the mental disorder statute. There is nothing in them which even mentions stress. Rather than being a diagnosis of a mental disorder, stress merely means

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[1] I do not read subsection (a) as narrowly as does the majority; however, because this particular case really involves a series of traumatic events under subsection (c), I confine my analysis to subsection (c).

> "the sum of the biological reactions to any adverse stimulus, physical, mental, or emotional, internal or external, that tends to disturb the organism's hemeostasis; should these compensating reactions be inadequate or inappropriate, they may lead to disorders. The term is also used to refer to the stimuli that elicit the reactions." Dorland's Medical Dictionary (26th ed., 1981).

In this case the reaction to stress is physical.[2] ORS 656.802(1)(b) and (2) is a mental disorder statute. Its apparent purpose is to restrict what mental disorders are compensable. It says nothing about physical disorders which arise from psychological stressors. If a series of traumatic events, whether physical or psychological, results in a need for treatment or in disability or death, then the claim is compensable, unless the series of traumatic events results in a mental disorder. Only if it results in a mental disorder, must it meet the stricter standards of section (2) to be compensable. This interpretation gives effect to both subsection (b) and subsection (c).

Because claimant developed no mental disorder, only physical reactions to psychological stress, I do not consider it appropriate to analyze this case in terms of mental disorders.

I also disagree with the majority's conclusion that the phrase, "a series of traumatic events" means solely physically traumatic events. This ignores the plain and unambiguous meaning of the word traumatic. "Traumatic" both by popular usage and dictionary definition includes both physical and mental trauma. For example, Dorland's Medical Dictionary (26th ed. 1981) defines traumatic as "pertaining to, occurring as the result of, or causing trauma." Its first definition of trauma is "a wound or injury, whether physical or psychic." A second definition is: "2(a) a psychological or emotional stress or blow that may produce disordered feelings or behavior; (b) the state or condition of mental or emotional shock produced by such a stress or by a physical injury." Webster's Third New International Dictionary (unabridged 1966). See, also, Webster's New Collegiate Dictionary (1981). Furthermore, in common speech stressful events such as family deaths and divorce are referred to as traumatic. Thus, the plain and unambiguous meaning of the phrase "any series of traumatic events or occurrences" includes a series of psychologically stressful events as well as physical traumas.

The majority, relies on the testimony of Jim Edmundson, to support its conclusion that the phrase "any series of traumatic events or occurrences" is restricted solely to physically traumatic events or occurrences. While it is true that Mr. Edmundson testified, that subsection (c) was intended to cover overuse of a body part, there is no indication in the legislative history that it was the intent of the legislature to adopt Mr. Edmundson's interpretation of that phrase or to restrict it to a series of physically traumatic events. I would not abandon the plain meaning of the statute in favor of one passing reference in the legislative history.

In conclusion, I would hold that this case involves a series of psychologically traumatic events which resulted in the need for medical services and disability. It did not result in a mental disorder. Consequently, subsection (b) is inapplicable and subsection (c) applies. Based on the majority's own findings of fact, I would find this claim compensable under ORS 656.802(1)(c).

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[2] The Diagnostic and Statistical Manual of Mental Disorders (DSM IIIr) does recognize that a mental disorder may have physical manifestations; however, that is not the case here. In this case there is apparently no mental disorder, only physical reactions to stressful circumstances.

In the Matter of the Compensation of
CLARK D. GRIFFITH, Claimant
WCB Case No. 88-13263
ORDER ON REVIEW
Mark R. Malco, Claimant Attorney
Garrett, et al., Defense Attorneys

Reviewed by Board Members Speer and Howell.

Claimant requests review of that portion of Referee Higashi's order that increased his scheduled permanent disability award for loss of use or function of his left wrist and forearm from 13 percent (19.5 degrees), as awarded by Determination Order, to 20 percent (30 degrees). On review, the issue is extent of scheduled permanent disability. We affirm.

FINDINGS OF FACT

Claimant suffered a compensable injury to his left wrist in 1985. He underwent two carpal tunnel surgeries; then a June 16, 1987 Determination Order closed his claim. He had a third carpal tunnel surgery in January 1988, for which his claim was reopened. A July 27, 1988 Determination Order found claimant medically stationary as of June 9, 1988 and awarded 13 percent scheduled permanent disability.

Any loss of grip strength suffered in claimant's dominant left hand is not attributable to neurological impairment, atrophy or amputation. Claimant experiences some numbness in his hand and wrist, but we are unable to find that it is due to nerve impairment. He also suffers from disabling pain, which restricts his ability to use his left hand and wrist.

CONCLUSIONS OF LAW AND OPINION

The Referee increased claimant's scheduled permanent disability from 13 percent to 20 percent. Claimant contends that the award should be increased. We disagree.

If a claimant became medically stationary after January 1, 1988, and his or her claim was closed on or after July 1, 1988, a subsequent determination by a referee or the Board of the claimant's permanent partial disability must be made pursuant to ORS 656.283(7) and 656.295(5), respectively. OAR 438-10-005 and Michelle Griffith, 40 Van Natta 2086 (1988).

In this case, the "standards" adopted effective July 1, 1988, former OAR 436-35-001 et seq, apply to the rating of claimant's permanent partial disability. Former OAR 436-35-010 through 436-35-260 apply to the rating of scheduled permanent partial disabilities. Former OAR 436-35-010(1).

The Referee awarded a 5 percent rating for each of claimant's three carpal tunnel surgeries. We disagree. Under former OAR 436-35-001 et seq, no rating is provided for carpal tunnel surgery. Ellen D. Hope-Smith, 42 Van Natta 1032 (1990).

Claimant also contends that he is entitled to a permanent partial disability award, due to his loss of grip strength, decrease in palmar sensation, and disabling pain. We agree in part and disagree in part.

Claimant testified that he has lost grip strength in his left hand following his injury and subsequent surgeries. (Tr. 27, 43-4) This evidence is supported by Dr. Ellison's June 1988 closing evaluation, which noted a 25 per

cent loss in grip strength in claimant's left hand, translated to a 10 percent impairment of the arm. (Ex. 9C-2). Despite this finding, Dr. Ellison did not attribute claimant's loss of grip strength to atrophy, anatomical changes, or nerve damage. Under such circumstances, the record does not establish an award for loss of grip strength under the "standards." See OAR 436-35-110(3)(a), (d).

Claimant seeks an increased award for sensory loss. Although the Referee acknowledged loss of sensation in claimant's left palm, he found that it was not ratable. We agree. There is no evidence indicating that any sensory loss suffered by claimant is due to injury-related nerve impairment. See OAR 436-35-110.

Claimant seeks an additional rating for disabling pain which affects strength and limits repetitive activities. The Referee found such pain established by clear and convincing evidence and awarded 5 percent disability outside the standards. We agree with the Referee's conclusion that claimant suffers from disabling pain; however, the use of the clear and convincing standard was not appropriate. Former OAR 436-35-010(2)(a) allows an impairment value for loss of use or function due to pain. See Daniel Alire, 41 Van Natta 752, 757 (1989). Based on the medical and lay evidence, we find that claimant's pain limits his ability to use his injured forearm and that his impairment resulting from this disabling pain totals 20 percent.

Claimant argues that the record as a whole constitutes clear and convincing evidence that his left forearm disability, due to loss of grip strength, is greater than that indicated by application of the "standards." We disagree.

Although we have noted claimant's treating surgeon's rating of 10 percent arm impairment, based on 25 percent loss in grip strength (Ex. 9C-2), we note that his opinion is not unrebutted.

Dr. Nye examined claimant on two occasions. He concluded that claimant suffered no loss of grip strength or pinch strength. In light of Nye's opinion, we are not persuaded that claimant has met his burden of proving by clear and convincing evidence that he has permanent impairment due to loss of grip strength greater than indicated by application of he standards. We find the evidence to be less than highly persuasive, free from confusion, and distinct. See Riley Hill General Contractor Inc. V. Tandy Corp., 303 Or 390, 407 (1987).

ORDER

The Referee's order, dated January 18, 1989, is affirmed.

May 22, 1990 Cite as 42 Van Natta 1113 (1990)

In the Matter of the Compensation of
ELLEN D. HOPE-SMITH, Claimant
WCB Case No. 88-15874
ORDER ON RECONSIDERATION
Pozzi, et al., Claimant Attorneys
Meyers & Radler, Defense Attorneys

The self-insured employer requests reconsideration of our May 7, 1990 Order on Review that, among other things, reversed a Referee's award of 5 percent (7.5 degrees) scheduled permanent disability for loss of use or function of the right forearm. Specifically, the employer seeks permission to recover the scheduled permanent disability benefits paid pursuant to the Referee's order

against claimant's award of additional unscheduled permanent disability benefits granted under our order and any future awards of permanent disability.

The employer's request is contrary to law. ORS 656.313(2) expressly provides that if the Board subsequently orders that compensation paid to claimant pending review should not have been allowed or should have been awarded in a lesser amount than awarded, claimant shall not be obligated to repay any such compensation. See United Medical Laboratories v. Bohnke, 81 Or App 144 (1986); Hutchinson v. Louisiana-Pacific, 67 Or App 577, 581, rev den 297 Or 340 (1984).

Accordingly, our May 7, 1990 order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our May 7, 1990 order. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

May 22, 1990 Cite as 42 Van Natta 1114 (1990)

In the Matter of the Compensation of
KENNETH KJELLAND, Claimant
WCB Case No. 88-14691
ORDER OF ABATEMENT
Jolles, et al., Claimant Attorneys
Arthur Stevens (Saif), Defense Attorney

Claimant requests reconsideration of our April 30, 1990 order which modified the Referee's order and awarded 6 percent (19.2 degrees) unscheduled permanent partial disability in addition to the 3 percent (9.6 degrees) awarded by Determination Order, for a total award of 9 percent (28.8 degrees). Contending that the SAIF Corporation withdrew its request for review prior to our decision, claimant seeks withdrawal of our order and reinstatement of the Referee's order.

Before addressing the motion, we request a response from SAIF within 10 days from the date of this order. Consequently, our April 30, 1990 order is withdrawn. Upon receipt of the aforementioned response, we shall take this matter under advisement.

IT IS SO ORDERED

May 22, 1990 Cite as 42 Van Natta 1114 (1990)

In the Matter of the Compensation of
STEVEN A. MITZEL, Claimant
WCB Case No. 88-18496
ORDER ON REVIEW
Emmons, et al., Claimant Attorneys
Cooney, et al., Defense Attorneys

Reviewed by Board Members Gerner and Myers.

The insurer requests review of Referee Emerson's order which awarded claimant 10 percent (15 degrees) scheduled permanent disability for injury to his left leg (knee), whereas a Determination Order awarded 3 percent (4.5 degrees) scheduled permanent disability. On review, the issue is extent of scheduled permanent disability. We modify.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

The Referee increased claimant's scheduled permanent disability by increasing the impairment for a partial meniscectomy from the evaluator's 3 percent to 5 percent, and by awarding 5 percent impairment for three other surgical procedures. We disagree in part.

Former OAR 436-35-230 allows for up to 10 percent impairment for complete removal of either the lateral or medial meniscectomy. A proportional loss is allowed for less than a complete removal. There is no evidence indicating the degree of removal in this case. The Referee assigned 5 percent. Where there is a range of values allowable, the fact finder is delegated the discretion to choose an appropriate value within that range. We perceive no reason to change the Referee's assignment of 5 percent for claimant's partial meniscectomy.

The insurer argues that the Referee should not have assigned a value for "surgical excision of a plica in the suprapatellar pouch, excision of a fibrous band on the medial plica, excision of an enlarged ligament in the mucosa and patellar laxity." The Referee concluded that these conditions contributed to claimant's pain and swelling and that, therefore, it was highly probable that claimant had lost 10 percent use or function of his leg. We disagree.

Claimant is entitled to an additional value for permanent loss of use or function due to the disabling effects of pain. Former OAR 436-35-005(2)(a); Daniel Alire, 41 Van Natta 752 (1989). However, claimant's pain is only intermittent, (Tr. 9), and when he does have it, he did not prove that it prevents any activities or results in lost use or function. We award no impairment for pain. The other conditions used by the Referee do not convince us that it is highly probable that claimant's loss of use or function exceeds the 5 percent allowable under the standards, especially since claimant's attending doctor rates claimant's impairment at 5 percent.

ORDER

The Referee's order dated February 27, 1989 is modified. That portion of the Referee's order which increased claimant's scheduled permanent disability by 7 percent (10.5 degrees) is modified. In lieu of the Referee's award and in addition to the Determination Order award of 3 percent (4.5 degrees), claimant is awarded 2 percent (3.0 degrees) scheduled permanent disability, giving him a total award to date of 5 percent (7.5 degrees) for loss of use or function of the left leg (knee). The Board approves a client-paid fee, not to exceed $608, payable from the insurer to its counsel.

In the Matter of the Compensation of
RANDY STRAZI, Claimant
WCB Case No. 88-13933
ORDER ON REVIEW
Emmons, et al., Claimant Attorneys
Saif Legal, Defense Attorney

Reviewed by Board Members Howell and Speer.

The SAIF Corporation requests review of Referee Irving's order that: (1) reversed a Determination Order which had reduced claimant's scheduled permanent disability award for loss of use or function of his left arm from 70 percent (224 degrees), as awarded by an earlier Referee's order, to 11 percent (16.5 degrees); (2) declined to grant SAIF's offset request; and (3) awarded an insurer-paid attorney fee for prevailing against SAIF's offset request. On review the issues are extent of permanent disability, offset, and attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact."

CONCLUSIONS OF LAW AND OPINION

Extent of Permanent Disability and Offset

We adopt the Referee's conclusions with respect to the issues of the extent of claimant's permanent disability and SAIF's request for authorization to offset, with the following supplementation.

The Evaluation Section had authority to rate claimant's permanent partial disability at the time it last closed the claim. However, it had no authority to alter a prior award which had become final as a matter of law. Thus, we agree with the Referee that the Evaluation Section's reduction of claimant's prior award was invalid. Since the Evaluation Section had authority to determine claimant's permanent disability at the time of closure, the Determination Order, in effect, declined to award permanent disability beyond the 70 percent claimant had been previously awarded. Consequently, no overpayment of compensation exists.

Attorney Fees

The Referee held that claimant was entitled to an insurer-paid attorney fee because he prevailed on SAIF's request to offset an alleged overpayment. We disagree.

Claimant is entitled to an assessed fee if her compensation was not reduced or disallowed as a result of SAIF's contention. See ORS 656.382(2). The Board has previously concluded that an offset does not reduce compensation within the meaning of ORS 656.382(2). Lawrence N. Sullivan, 39 Van Natta 88, 97 (1987). Accordingly, claimant is not entitled to an assessed fee in this matter. Christine L. Davis, 42 Van Natta 397, 398 (1990).

ORDER

The Referee's order, dated November 22, 1988, is reversed in part and affirmed in part. The Referee's $1,300 award of attorney fees is reversed. For services on review concerning the permanent disability issue, claimant is awarded $450, to be paid by the SAIF Corporation. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
CIPRIANO VEGA, Claimant
WCB Case Nos. 88-14335 & 88-14336
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
Gail Gage (Saif), Defense Attorney

Reviewed by Board Members Speer and Howell.

Claimant requests review of Referee Daron's order which: (1) upheld the SAIF Corporation's denial of his aggravation claim for a nasal condition; and (2) upheld SAIF's partial denial of his claim for the same condition. On review the issue is compensability. We reverse in part.

FINDINGS OF FACTS

With the exception of the last three paragraphs, we adopt the Referee's Findings of Fact with the following supplementation.

Claimant has worked for the same employer as a farm worker for 15 years. (Tr. 9-10)

Due to his exposure to toxic sprays (Disyton) while working on the employer's farm on June 11, 1985, claimant sustained "acute intoxication from herbicide contact with 2nd degree burns" to his mouth and nose. (Exs. 4 & 5). Claimant's symptoms began immediately upon exposure to chemical farm spray and got progressively worse so that he was unable to sleep, he developed headaches, his face swelled, and he developed blisters around the outside of his nose and mouth. (Exs. 2A, 3, 4; Tr. 11-15). SAIF accepted a claim for claimant's injury on August 7, 1985. (Ex. 5). A September 13, 1985 Determination Order awarded only temporary disability benefits from June 13, 1985, through July 8, 1985. (Ex. 6).

In 1985 Dr. Montanaro, Assistant Professor of Medicine, Immunology, Allergy and Rheumatology, made a report regarding claimant's 1985 condition. Under the heading of "Allergy Skin Testing" Dr. Montanaro included the results of a "chlorinated pesticide screening test" which "revealed demonstrable levels of HCB ... and DDE ppb, representing comparative population ranking in the upper 3rd for DDE and in the middle 3rd for HCB." (Ex. 4-3).

On April 11, 1988, claimant compensably pulled his shoulder and received medical treatment from Dr. Green, who had treated claimant's toxic reaction in 1985. Claimant returned to work the same day he hurt his shoulder and while his co-worker was "fumigating" the ground (spraying with chemicals) claimant followed immediately behind, seeding. The fumes from the spray irritated claimant's nose; he got a "fantastic headache"; became nauseated and dizzy. (Tr. 30). Claimant became so ill that he could not work the next day. (Tr. 31). By the next day his face was swollen and blisters had developed around his nose and mouth and his lips were hard and swollen. (Tr. 30-32, 40-49).

Although he could not return to work the next day because he felt so ill, claimant waited to see the doctor until the next scheduled appointment for his shoulder. (Tr. 31). While treating claimant for the accepted shoulder condition, Dr. Green noted claimant's acute reaction to chemical spray and began treatment. (Ex. 9A).

On June 13, 1988, Dr. Green reported that claimant was unable to return to his previous occupation working on a commercial farm because his expo

sure to pesticides and herbicides was intolerable, and the nature of his illness was such that ongoing exposure could have potentially caused dire health consequences. (Ex. 9B).

Claimant has not worked since April 11, 1988, the day he left work sick from the heavy exposure to the chemicals. (Tr. 35).

CONCLUSIONS OF LAW AND OPINION

The Referee, relying on Dr. Montanaro's opinion, held that claimant experienced a mere temporary and symptomatic irritation reaction to exposure to farm chemicals, and not a worsening of his nasal condition. The Referee held that this reaction condition is not compensable because, as Dr. Montanaro opined, claimant's underlying nasal conditions are not work related, and are only symptomatically irritated by the chemical irritants.

Claimant urges alternative theories of occupational disease, injury or compensable aggravation of his 1985 claim.

In distinguishing claimant's claim as an injury or an occupational disease, we use the two-prong test for distinguishing between industrial injuries and occupational diseases described in O'Neal v. Sisters of Providence, 22 Or App 9, 16 (1975):

> "'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 not] sudden in onset.'" 22 Or App at 16 (alterations in the original) (quoting 1A A. Larson, The Law of Workmen's Compensation Sec. 41.31 (1973)).

The first prong of the test requires a retrospective estimation of the likelihood that the medical condition claimed would result from the kind, rate and duration of activity or exposure alleged to be the cause of the condition. The second prong requires definition of the phrase "sudden in onset." See Thelma T. Smartt, 40 Van Natta 602 (1988), aff'd Smartt v. Adult & Family Services, 95 Or App 617 (1989).

In the present case, we conclude that the kind, rate and duration of activity performed by claimant was unlikely to result in the condition claimed. We also conclude that a period of a few hours of exposure on April 11, 1988, was sufficiently discrete to satisfy the "sudden in onset" requirement. We hold, therefore, that claimant's claim relating to his work activity on April 11, 1988, is one for an industrial injury or an aggravation of the 1985 injury rather than occupational disease.

For purposes of a "new injury," claimant must prove that his work activity on April 11, 1988 was a material contributing cause of a need for medical services or disability. ORS 656.005(7)(a); see Harris v. Albertson's Inc., 65 Or App 254, 256-57 (1983); "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). Claimant need not show a pathological exacerbation of his underlying condition in order to prevail on an industrial injury theory. Harris v. Albertson's Inc., supra, 65 Or App at 256-57.

The causation of claimant's condition is of sufficient medical complexity that we turn to the medical evidence for guidance. See Kassahn v. Publishers Paper, 76 Or App 105 (1985). When medical evidence is divided, greater weight is given to the conclusions of a claimant's treating physician, absent persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810, 814 (1983).

In the present case, the Referee gave greater weight to the medical opinion of SAIF's expert, Dr. Montanaro. Our review of Dr. Montanaro's testimony and documentation indicates some internal inconsistencies, incomplete information, especially regarding the mechanism of the April 11, 1988 incident, and a failure to address the crucial issue of claimant's exposure and reaction to pesticides. We, therefore, do not find Dr. Montanaro's opinion persuasive. See Palmer v. SAIF, 78 Or App 151 (1986); Foley v. SAIF, 29 Or App 151 (1986). By contrast, Dr. Green, claimant's treating physician, offers a persuasive, well-reasoned opinion to the effect that claimant has sustained a chemical hypersensitivity with immune dysfunction. Secondary to this immune dysfunction caused by the exposure to the farm chemicals, claimant suffers from allergic rhinitis and infectious sinusitis. (Exs. 9B, 11 & 16). Further, Dr. Green reports that claimant is permanently unable to return to work on a commercial farm because further exposure to chemicals could result in "dire consequences."

Moreover, even Dr. Montanaro agreed that claimant suffered an adverse, acute reaction to a work-related chemical exposure on April 11, 1988. Witnesses testified to claimant's sudden onset of blisters around his mouth and nose, his obvious fatigue, headaches and nausea immediately after claimant was exposed to the toxic spray in April 1988. Additionally, Dr. Montanaro also recommended that claimant not work around farm chemicals anymore.

Accordingly, we conclude that Dr. Green's medical opinion, together with claimant's uncontroverted testimony as to the mechanism of injury, are sufficient to support the finding that claimant sustained a compensable injury on April 11, 1988.

We must next determine whether the April 1988 incident also may have constituted an aggravation of the compensable 1985 claim. We conclude that it did. Dr. Green's opinion links claimant's worsened condition after the 1988 incident in material part to the compensable 1985 injury.

In distinguishing claimant's claim as an "aggravation" from a "new injury," we look to our holding in Teresa L. Walker, 41 Van Natta 2283 (1989). There we held that in cases involving a single employer/insurer, "worsened symptoms" of a compensable injury represented an aggravation, while if a subsequent incident independently contributes to a worsening of the prior underlying condition, a new injury had occurred.

Here, Dr. Green reports that claimant, in 1988, had sustained a greater sensitivity to chemicals and that this major chemical exposure to herbicides and pesticides had caused claimant to suffer "newly developed allergic rhinitis" and "immune dysfunction." (Ex. 9B & 16). Accordingly, we conclude, that claimant has sustained a worsening of his underlying condition and, thus, a "new injury."

ORDER

The Referee's order, dated December 7, 1988, is reversed in part. The SAIF Corporation's August 17, 1988 partial denial is set aside and the claim is remanded to SAIF for processing according to law. The remainder of the Referee's order is affirmed. For services at hearing and on Board review, claimant's attorney is awarded a reasonable assessed fee of $2,400, to be paid by SAIF.

In the Matter of the Compensation of
JAY A. YOWELL, Claimant
Own Motion No. 90-0158M
OWN MOTION ORDER ON RECONSIDERATION
Saif Legal, Defense Attorney

Claimant requests reconsideration of the Board's Own Motion Order issued March 29, 1990, which denied him reimbursement for nonspecific treatment. Claimant contends that his request for reimbursement was for specific treatment for his corneal transplant and secondary glaucoma.

As a preliminary matter, we must determine whether claimant's request was timely filed. Claimant was not represented by an attorney. He directed his request for reconsideration to SAIF when it should have been mailed to the Board. SAIF received claimant's request on April 23, 1990. SAIF did not promptly forward the request to the Board, and we did not receive the request until May 10, 1990. Consequently, we did not receive the request within 30 days of the date of the Own Motion Order.

Strict adherence to filing deadlines promotes the important interest of final resolution of claims. However, the Board has great discretion under it own motion authority to process claims in the most equitable manner. Under the particular circumstances of this case, we conclude that an exception to the deadline is appropriate. Under OAR 438-05-075, SAIF was obligated to promptly forward claimant's misdirected request to the Board. If it had done so, the Board would have received the request within the 30 day period. The claimant in this case was not represented by an attorney. SAIF has not raised the timeliness issue with the Board. After considering these factors, we conclude that claimant's request for reconsideration was filed timely under OAR 438-12-065(2). We rescind our original order.

By letter dated March 5, 1990, claimant's ophthalmogist, Dr. Tsujimura, opined that claimant will require indefinite ongoing care for his aphakia and glaucoma left eye. In addition, by letter dated April 12, 1990, from Dr. Burris, we find that claimant will require routine followup of his corneal transplant for the rest of his life.

On reconsideration, we conclude that claimant's claim should be reopened indefintely for the payment of one annual exam by Dr. Burris, and for exams, no more than every 3 months, by Dr. Tsujimura. After provision of these services, SAIF should immediately close the claim pursuant to OAR 438-12-055. Reimbursement from the Reopened Claims Reserve is authorized to the extent allowed under ORS 656.625 and OAR 436, Division 45.

IT IS SO ORDERED.

In the Matter of the Compensation of
BRUCE W. HENION, Claimant
WCB Case No. 88-12633
ORDER ON REVIEW
Olson, Rowell & Walsh, Claimant Attorneys
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Gerner and Cushing.

Claimant requests review of those portions of Referee Higashi's order which: (1) did not allow claimant to choose his own attendant care provider in

the absence of having an attending physician; (2) did not reimburse claimant for expenses he incurred for attendant care; and (3) did not assess penalties and attorney fees for alleged unreasonable conduct in failing to reimburse claimant's expenses and allowing him his choice of attendant care providers. On review, the issues are medical services, penalties and attorney fees. We affirm.

FINDINGS OF FACT

Claimant is a C-5 quadriplegic who is permanently and totally disabled due to a February 1985 compensable injury. Claimant was ordered in a prior hearing to select his attending physician. The insurer was directed to contract with and provide 24-hour attendant care at claimant's home. It was also ruled that claimant did not have the right to select his own attendant care providers and deny access to the attendant care persons selected by the insurer.

Claimant, to date, has not selected an attending physician. The insurer has made available attendant care services and providers. However, instead of accepting such care, claimant hired several of his friends to care for him at his home. Claimant submitted a claim for these services in the sum of $9,555, including checks in the sum of $5,800, $2,850 of which had been made payable to individuals, and $2,950 of which had been made payable to a local store and a local tavern.

CONCLUSIONS OF LAW AND OPINION

Choice of Attendant Care

Claimant contends that he should have the right to choose his own attendant care provider in the absence of an attending physician. We disagree.

Claimant's right to medical services and care is stated in ORS 656.245. Subsection (1) states that "the insurer or the self-insured employer shall cause to be provided medical services" that are reasonable and necessary. Subsection (3) allows an injured worker to "choose an attending doctor or physician within the State of Oregon." While the statute grants claimant the power to choose his own attending doctor or physician, the statute does not give claimant the power to directly control or determine what medical services are reasonable and necessary nor who can provide them. The determination of which medical services are reasonable and necessary and who is to provide them is within the province of the attending physician. Claimant can only control what medical services are to be provided to the extent that he or she chooses an attending doctor or physician.

In the absence of an attending physician, claimant cannot choose his own attendant care provider, but the insurer still has a responsibility to assure that reasonable and necessary care is provided pursuant to ORS 656.245. In this case the insurer has done this by providing attendant care providers to claimant. The insurer's actions were appropriate. Cf Donald W. Box, 40 Van Natta 1576 (1988). Until such time as claimant chooses an attending physician who desires to change claimant's insurer-provided attendant care, claimant cannot change or choose attendant care providers.

Reimbursement

Claimant contends that he is entitled to reimbursement for the sums he allegedly paid to his friends for taking care of him at his home. We disagree.

To be reimbursed, claimant's request must be one for medical services. Reimbursable medical services can only be performed by providers who are authorized to do so. OAR 436-10-050. There is no evidence in this record that the friends who provided claimant's care were qualified to be attending physicians (OAR 436-10-050(1)), licensed providers authorized by an attending physician (OAR 436-10-050(2)), non-licensed providers under the direct control and supervision of an attending physician (OAR 436-10-050(2)), spiritual healers (OAR 436-10-050(3)), nor physician's assistants (OAR 436-10-050(4)). Because the services claimant seeks reimbursement for were not proven to have been provided by individuals qualified to render reimbursable medical services, claimant does not have a claim for medical services. Consequently, claimant is not entitled to be reimbursed for the sums he paid his friends to care for him.

Penalties and Fees

Based upon our conclusion that claimant does not have the right to choose his own attendant care provider in the absence of an attending physician, and the conclusion that claimant is not entitled to reimbursement for the sums he paid for services that he requested, the insurer has not been unreasonable in its actions in this case. Where the insurer has not been unreasonable, no penalty or attorney fee can be awarded.

ORDER

The Referee's order dated March 1, 1989 is affirmed. The Board approves a client-paid fee, not to exceed $1,863.50, payable from the insurer to its counsel.

May 23, 1990 Cite as 42 Van Natta 1122 (1990)

In the Matter of the Compensation of
DOROTHY JACKSON-DUNCAN, Claimant
WCB Case No. 88-07507
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Cowling & Heysell, Defense Attorneys

Reviewed by Board Members Myers and Gerner.

The self-insured employer requests review of Referee Gruber's order which set aside its partial denial of multiple conditions as unrelated to an accepted right shoulder and hip strain. On review, the issue is compensability. We affirm in part and reverse in part.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

We adopt the Referee's "conclusion and reasoning" in regard to the compensability of claimant's neck, shoulder and hip conditions generally.

The Referee concluded that the employer had prematurely denied claimant's "right short leg, z-spine, multiple thinned discs, lumbar facetal syndrome, cervical and lumbar lordosis" because claimant had made no "claim" for these conditions and there was no specific indication that claimant's treatment was related to those conditions. The employer argues that receipt of a bill listing the

above diagnoses was a claim that they had the duty to accept or deny pursuant to Billy J. Eubanks, 35 Van Natta 131, 132 (1983). We agree.

The employer is free to partially deny any condition which it reasonably believes could be a claim. Weyerhaeuser Co. v. Warrilow, 96 Or App 34 (1989). However, if the claimant contends that in fact he or she is not making a claim for those conditions, we will set aside the denial as prospective and ineffective for the time being, until such time as claimant actually makes a claim for such conditions. Shannon M. Evans, 42 Van Natta 227 (1990); Alvin H. Despain, 40 Van Natta 1823 (1988). Here, claimant argues on appeal that she made no claim for the above list of conditions and that the Referee correctly set aside the partial denial of these conditions as premature. We disagree. Claimant did not raise the issue of premature denial at the beginning of hearing and did not seek to have the partial denial set aside for those reasons. Instead, claimant proceeded to litigate the merits of the denial.

Claimant makes a "claim" for a condition when claimant chooses to litigate the merits of a condition at hearing, even if until that point the denial could be challenged and set aside as premature. Proceeding to litigate the merits is a waiver of the procedural defect of a premature denial. See Thomas v. SAIF, 64 Or App 193 (1983). (When a party fails to object to proceeding with a hearing that is conducted as a result of a premature request, the party has waived its right to object.) Accordingly, since claimant did not raise the issue of premature denial, and since claimant proceeded to litigate the merits of the employer's partial denial in its entirety, the Referee should have addressed the merits of the denial notwithstanding the lack of any specific treatment for the conditions in contention.

On this record, no medical evidence materially relates claimant's "right short leg, z-spine, multiple thinned discs, lumbar facetal syndrome, cervical and lumbar lordosis" to her compensable injury. Accordingly, we conclude that these conditions are not compensable.

ORDER

The Referee's order dated February 9, 1989 is affirmed in part and reversed in part. That portion of the Referee's order which set aside the self-insured employer's partial denial of claimant's "right short leg, z-spine, multiple thinned discs, lumbar facetal syndrome, cervical and lumbar lordosis" conditions is reversed. The partial denial of these conditions is reinstated and upheld. That portion of the order which set aside the employer's partial denial for claimant's neck, shoulder and hip conditions generally is affirmed. The Referee's award of a $2,500 attorney fee is reversed. Claimant's attorney is awarded $2,500 for services at hearing and on Board review in regard to the compensability of the neck, shoulder and hip conditions generally, to be paid by the employer. The Board approves a client-paid fee, not to exceed $639.50, payable from the employer to its counsel.

In the Matter of the Compensation of
THOMAS C. KREFT, Claimant
WCB Case Nos. 88-10741 & 88-12086
ORDER ON REVIEW
Charles D. Maier, Claimant Attorney
Garrett, et al., Defense Attorneys

Reviewed by Board Members Gerner and Cushing.

Claimant requests review of that portion of Referee Seymour's order which upheld the self-insured employer's medical services denial of chiropractic treatment. On review, the issue is medical services. We affirm.

FINDINGS OF FACT

On March 20, 1986, claimant sustained a compensable neck and back injury. A January 13, 1988 Determination Order awarded claimant 5 percent unscheduled permanent partial disability. Subsequently, a May 19, 1988 Opinion and Order awarded claimant an additional 10 percent unscheduled disability for a total award of 15 percent.

Claimant experienced a compensable low back injury on June 12, 1986. A June 16, 1988 Determination Order awarded claimant 10 percent unscheduled disability.

Claimant is in an authorized training program. He was medically stationary on January 27, 1988.

On July 5, 1988, the employer denied the reasonableness and necessity of claimant's continued palliative chiropractic care.

Claimant requires relief from back pain eight to ten days after chiropractic treatment. (Tr. 12).

CONCLUSIONS OF LAW AND OPINION

The Referee upheld the employer's denial of claimant's chiropractic care up to the denial date, but set aside the denial to the extent it purported to deny care beyond the date of the September 20, 1988 hearing date. We agree.

Prospective denials are impermissible. An insurer may not deny its future responsibility for payment of medical services for a previously accepted claim. ORS 656.245(1); Evanite Fiber Corp. v. Striplin, 99 Or App 353 (1989). In the present case, the employer denied all "future chiropractic care." Such a denial is prospective. However, since the record indicates that claimant continued to receive chiropractic treatment until the hearing date, the reasonableness and necessity of these post-denial treatments are also at issue. (Tr. 15); See Hollie J. Rahim, 42 Van Natta 415 (1990). We evaluate whether the treatments until the date of hearing were reasonable and necessary. Id.

A claimant is entitled to all reasonable and necessary curative or palliative medical care required for a compensable injury. 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). Claimant has the burden of proving that the treatment is reasonable and necessary. McGarry v. SAIF, supra.

Moreover, while claimant's testimony is probative, it is not dispositive, since the issue of whether the medical services are reasonable and necessary is a complex medical question. On our de novo review of the medical evidence, we are persuaded that claimant's chiropractic treatments until the September 20, 1988 hearing were not reasonable and necessary. Three physicians express opinions: Drs. Lawton, Bolin and Thompson. We evaluate three basic factors when assessing the persuasiveness of medical opinions: the source of the opinion, its factual basis and its logical force. Earl M. Brown, 41 Van Natta 287, 291 (1989). The source of the opinion includes the expertise and objectivity of the one giving it. The factual basis of the opinion includes completeness and correctness of the information upon which it is based. The logical force involves the depth, clarity and cogency of analysis.

Dr. Lawton, chiropractor, is of the opinion that his treatments are reasonable and necessary. Although the Board generally gives greater weight to the conclusions of a treating physician, it will not do so 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). Here, we find persuasive reasons to discount Dr. Lawton's opinion. Lawton has an inaccurate history. While he believed that claimant suffered from daily pain, claimant credibly testified that he can go ten days before he needs a chiropractic treatment to relieve back pain. (Ex. 31-2,3; Tr. 30). Dr. Lawton also believes claimant's condition is more serious than it actually is. (Ex. 20-1). Accordingly, we do not find Dr. Lawton's opinion to be persuasive.

Dr. Bolin, chiropractor, examined claimant on July 23, 1987. At that time he reported that claimant had responded well to treatment and that his condition was stationary without impairment. Bolin felt that claimant should receive treatment once a week. Subsequently, on June 22, 1988, Dr. Bolin opined that there was nothing in the record indicating that claimant needed ongoing chiropractic care relating to the June 1986 compensable injury. (Ex. 24).

Likewise, Dr. Thompson, orthopedic surgeon, who examined claimant on March 15, 1988, opined that claimant no longer needed continuing chiropractic manipulations. (Ex. 12). Thompson reasoned that claimant suffered an underlying inflammatory condition which would not be positively affected by chiropractic manipulations. Id.

We are persuaded by Drs. Bolin and Thompson's well reasoned and cogent opinions. See Somers v. SAIF, 77 Or App 259 (1986). Accordingly, we conclude that claimant's medical services after the January 27, 1988 denial and through the September 20, 1988 hearing date were not reasonable or necessary.

ORDER

The Referee's order dated December 13, 1988 is affirmed.

In the Matter of the Compensation of
DOUGLAS E. SHOCKLEY, Claimant
WCB Case No. 88-19364
CORRECTED ORDER ON REVIEW
Peter O. Hansen, Claimant Attorney
Roberts, et al., Defense Attorneys

Reviewed by Board Members Gerner and Cushing.

It has come to our attention that our May 22, 1990 Order on Review contains an erroneous analysis concerning the calculation of claimant's permanent impairment. To correct this oversight, we withdraw our prior order and replace it with the following order. This correction does not alter our ultimate conclusion that claimant is not entitled to additional permanent disability beyond that awarded by the Determination Order. Our corrected order is as follows.

Claimant requests review of Referee Leahy's order which affirmed a Determination Order award of 27 percent (86.4 degrees) unscheduled permanent disability and no scheduled permanent disability. On review, the issue is extent of scheduled and unscheduled permanent disability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact as our own, with the following supplementation.

Claimant has decreased sensation in the medial aspect of his right foot and right big toe. (Ex. 54).

CONCLUSIONS OF LAW AND OPINION

Unscheduled Permanent Disability

We adopt the Referee's "Rating Disability," "Rating This Claimant's Disability" and "Opinion and Conclusions of Law" regarding extent of unscheduled permanent disability, with the following comment.

The impairment for claimant's disc excision under former OAR 436-35-350(2) is combined (not added) to the impairment value for the fusion under subsection (3) of the rule. Former OAR 436-35-350(11). [Note: Various forms of intervertebral disc lesions within subsection (2) of former OAR 436-35-350 are added. See Michael E. Crist, 42 Van Natta 1093 (1990).] The combined value is 9.75 percent. That value is rounded to the next higher whole percentage. Former OAR 436-35-010(6). Thus, the value for claimant's impairment is 10 percent.

Claimant argues that he has proven by clear and convincing evidence that his disability is greater than that allowed under the standards. We disagree. Claimant presents no reason why the standards award is in error. We perceive no evidence in the record that convinces us to a high probability that claimant's loss of earning capacity exceeds the standards.

Scheduled Permanent Disability

The Referee declined to award claimant any scheduled permanent disability reasoning that because the sciatica from the low back injury is the cause of the complaints, that no separate award is allowable. We disagree. Where injury to an unscheduled body part has referred pain into a scheduled body part, claimant

is entitled to a scheduled award for loss of use or function due to the referred pain. John C. Holland, 42 Van Natta 800 (1990).

Claimant has decreased sensation in the "medial aspect" of his right foot and right big toe. Former OAR 436-35-200(1) allows for 5 percent impairment for partial loss of plantar sensation in the foot. However, we are unable to conclude that loss of sensation in the "medial aspect" of the foot is synonymous with loss of "plantar" sensation. Accordingly, we cannot award any impairment for loss of sensation in the "medial aspect" of the right foot.

Similarly, loss of plantar sensation in the big toe results in 5 percent impairment for that toe. Former OAR 436-35-170(1). However, once again, we are unable to conclude that loss of sensation in the "medial aspect" of the big toe is synonymous with loss of plantar sensation. Accordingly, we cannot award any impairment for loss of sensation in the "medial aspect" of the big toe.

Claimant may be entitled to scheduled impairment that results from the loss of use or function due to the disabling effects of pain. Former OAR 436-35-010(2)(a); Daniel Alire, 41 Van Natta 752 (1989). Claimant testified to many reduced activities due to pain. However, he did not relate this loss to the disabling effects of the leg pain, as opposed to the disabling effects of the low back condition and pain. Accordingly, claimant has failed to prove a loss of use or function due to the disabling effects of leg pain.

ORDER

The Referee's order dated February 24, 1989 is affirmed. The Board approves a client-paid fee, not to exceed $1,128, payable from the insurer to its counsel.

May 24, 1990 Cite as 42 Van Natta 1127 (1990)

In the Matter of the Compensation of
LORENZO G. PEREZ, Claimant
WCB Case No. 88-10175
ORDER ON REVIEW
Ralph Yenne, Claimant Attorney
Harland, et al., Defense Attorneys
Carl Davis, Assistant Attorney General

Reviewed by Board Members Brittingham and Crider.

Claimant requests review of Referee Foster's order that: (1) found claimant was not a subject worker; and (2) upheld the SAIF Corporation's denial of claimant's hernia condition. The alleged noncomplying employer cross-requests review on the issue of the timeliness of claimant's claim. On review, the issues are timeliness, subjectivity and compensability. We reverse.

FINDINGS OF FACT

Claimant was hired by Ed Ritter (K-Ed Ranch) on September 16, 1987, to maintain his 28 acre property in West Salem. On the property was the Ritter's private home, a guest house, three other homes, a pool, a barn, a large garden and a pasture upon which cattle grazed. Of the three homes not occupied by the Ritter family, one was occupied by claimant's family, in partial payment for his services, a second was occupied by the Ritter's granddaughter for a monthly rent

of $300, and a third was occupied by law students for a monthly rent of $225. Claimant was paid $100 per week in addition to the free rental.

Claimant worked hours varying from two or three to eight or nine hours per day depending on the weather and the work that needed to be performed. The vast majority of claimant's time was spent maintaining the grounds and building immediately surrounding the Ritter home, gardening, caring for the stock, mending fences and the like. He also was expected to rake leaves and keep the gutters clean at the rental homes. The parties stipulated that claimant was sent down to clean out the gutters and insulate the pipes of rental property on two different occasions. Claimant worked a few hours on one occasion.

Claimant was injured on April 2, 1988, while working on the employer's property. Claimant suffered a hernia while lifting bales of hay weighing approximately 80 pounds.

On May 12, 1988, claimant filed a claim against the employer for a hernia condition. On June 10, 1988, SAIF issued its denial upon instructions from the Workers' Compensation Division. The basis of SAIF's denial was that K-Ed Ranch was not a subject employer and claimant was not a subject worker.

The employer filed farm income, Schedule F Federal Tax returns, for the years 1985, 1986 and 1987 on the property claimant was employed to maintain. The employer also filed rent and royalty income, Schedule E Federal Tax returns, for the same years listing the rentals on the same property.

ULTIMATE FINDINGS OF FACT

Claimant's lifting hay bales while working for the employer was a material contributing cause of his hernia and need for treatment therefor.

Claimant engaged with the employer to furnish services for remuneration, subject to the direction and control of the employer. He was not employed to do work in or about the employer's private home.

CONCLUSIONS OF LAW AND OPINION

TIMELINESS

The employer argues that claimant failed to give him timely notice of his injury. ORS 656.265(5) states, "the issue of failure to give notice must be raised at the first hearing on a claim for compensation in respect to the injury or death." The employer failed to properly raise this issue at the hearing. Therefore, we need not address the merits of this issue.

In the alternative, if the issue had been raised and assuming that the claimant failed to give notice of the accident within the time prescribed by statute, there is no evidence that such failure prejudiced the employer in any way. Consequently, claimant is entitled to pursue the claim. ORS 656.265(4)(a).

SUBJECTIVITY

The Referee found that claimant was a nonsubject worker while living in a house on the employer's property and performing maintenance work on the employer's private residence. We disagree and find that claimant's maintenance work on the employer's residence is not exempt under ORS 656.027(2).

The employer argues that claimant is not a subject worker under the household exemption of ORS 656.027(2). The employer does not argue that he did not control claimant's actions. Therefore, the sole issue in this case is whether ORS 656.027(2) exempts claimant from coverage of the Workers' Compensation Act.

First we must determine whether the Referee properly classified the employer's residence as a "private home", thereby rendering claimant a nonsubject worker under ORS 656.027(2).

ORS 656.027(2) in pertinent part provides:

> "All workers are subject to ORS 656.001 to 656.794 except those nonsubject workers described in the following subsections: . . .
>
> "2) A worker employed to do gardening, maintenance, repair, remodeling or similar work in or about the private home of the person employing the worker."

The statutory term "private" distinguishes certain premises from business or commercial premises. The court in Fincham v. Wendt, 59 Or App 416 (1982), held: "the basis of the householder exemption is the character of the home as a private place, not as business premises." In addition, the court held that, the income derived from the employer's residence does not have to be the sole income or the primary income of the employer to take the employer's residence out of the householder exemption in ORS 656.027(2). Supra at 420; see also Carlile v. Greeninger, 35 Or App 51, rev den 283 Or 235 (1978).

The record in this case establishes that the employer's property was not a "private" residence for purposes of the Workers' Compensation Act but rather a business entity. In 1985, 1986 and 1987, the employer filed Schedule F Federal Income Tax returns. These returns indicate that the employer was operating his residence as a farm business.

The employer argues that his farm was not for profit and therefore can not be considered a business for purposes of coverage under the Workers' Compensation Act. However, the court in Fincham, supra, rejected the argument that a business effort must show a profit in order to constitute a business under ORS 656.027(2). Therefore, it is irrelevant for purposes of the Workers' Compensation coverage whether or not the employer derived a profit from his residence (i.e. his farm).

The employer also argues that his farm was for his own enjoyment because he did not sell its produce but instead consumed it for himself. Therefore, he contends he did not operate a farm business. While little may have been sold in recent years, the employer did both sell livestock and deduct farm expenses on his tax return. We, therefore, reject his contention that he was not involved in a farm business.

Because claimant was not employed to maintain the employer's private home, the exemption of ORS 656.027(2) does not apply. Under these circumstances, we find claimant was a subject worker.

COMPENSABILITY

Dr. Nadel's uncontradicted opinion was that claimant's left inguinal hernia was work related. In addition, the record establishes that at the time

claimant was injured he was engaged in work related activities (i.e. lifting bales of hay) on the employer's property. We find that claimant's hernia injury is related to his work activities. Therefore, we find claimant's hernia injury compensable.

ORDER

The Referee's order dated December 2, 1988 is reversed. The SAIF Corporation's denial is set aside and this claim is remanded to SAIF for processing according to law. For services at hearing and on review, claimant's attorney is awarded an assessed fee of $2,550, payable by SAIF on behalf of the noncomplying employer.

Board Member Crider, specially concurring:

I agree with the lead opinion's conclusion and reasoning. I also reject the Referee's conclusion that the small amount of work performed by claimant on the employer's rental property was insufficient to place claimant in the position of a subject employee. Claimant was hired to maintain all of his employer's property which included the three rental homes as well as a working farm. Therefore, I find that claimant is a subject employee under the Workers' Compensation Act.

May 25, 1990 Cite as 42 Van Natta 1130 (1990)

In the Matter of the Compensation of
MARTIN J. FOWLER, Claimant
WCB Case No. 88-12350
ORDER OF ABATEMENT
Charles D. Maier, Claimant Attorney
Merrily McCabe (Saif), Defense Attorney

The Board issued an Order on Review in the above-captioned matter on April 30, 1990. Claimant now requests that the Board reconsider its order on the ground that his permanent disability is greater than that awarded by the Board.

In order to allow sufficient time to consider claimant's request, the April 30, 1990 order is abated and withdrawn. The SAIF Corporation is requested to file a response to the motion within ten days. Thereafter, this matter shall be taken under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
SUSAN ALLEY, Claimant
WCB Case Nos. 88-01559, 88-01266, 87-17380 & 88-01267
ORDER ON REVIEW
Thomas O. Carter, Claimant Attorney
Mitchell, Lang & Smith, Defense Attorneys
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Howell and Speer.

NEC America (NEC), a self-insured employer, requests review of those portions of Arbitrator Schultz's order which: (1) set aside its denial of claimant's "new injury" claim for an upper back condition; and (2) upheld Beverly Enterprise's (Beverly), a self-insured employer, denial of claimant's aggravation claim for the same condition. On review, the issue is responsibility. We reverse.

FINDINGS OF FACT

On October 18, 1982, claimant had a compensable injury involving her right shoulder, arm, neck and right upper back. Beverly accepted the claim. Claimant received unscheduled permanent disability awards for the injury totaling 20 percent (64 degrees).

Claimant treated with many doctors following the injury and each of them reports, inter alia, pain in the upper right side of the back, the neck or the posterior portion of the right shoulder.

On October 10, 1986, Dr. Misko performed thoracic outlet decompression. On February 23, 1987, claimant reported to Dr. Snodgrass, an associate of Dr. Misko, that she was still "aching in the posterior shoulder and scapular area and in the right trapezius."

On May 6, 1987, claimant again reported to Dr. Snodgrass that, as a result of working at a new job, she began having an increasing amount of pain symptoms in her posterior neck, upper back and right shoulder.

On July 16, 1987, while working for NEC, claimant was lifting boxes of circuit boards off a pallet and onto a table when she began experiencing pain in her upper back, mainly on the right side.

Two 827 forms signed by claimant subsequent to the July 1987 incident report that the same body part had been injured at a previous job. Claims were filed with both employers and were denied. On January 26, 1988, an order issued pursuant to ORS 656.307. The issue of responsibility was referred to the Hearings Division and an arbitrator was appointed.

Claimant's temporary total disability rate would be higher under the NEC claim.

ULTIMATE FINDINGS OF FACT

The July 1987 incident resulted in an increase of claimant's right shoulder symptoms, but the incident did not independently contribute to a worsening of the underlying condition.

CONCLUSIONS OF LAW AND OPINION

Standard of Review

Claimant has established on the arbitration record that this case involves "a matter concerning a claim" because if NEC is the responsible insurer,

her temporary disability benefits would be greater. Accordingly, the standard of review is as provided for matters concerning a claim. ORS 656.307(2) and 656.704(3). See Jon E. Robinson, 42 Van Natta 512 (1990).

Responsibility

The Referee found that claimant suffered a distinct new injury on July 16, 1987, for which NEC was responsible. We disagree.

This case involves an accepted compensable injury followed by an increase in disability during employment with a later employer/insurer. In such a case, responsibility is fixed with the employer/insurer which accepted the claim. In order to shift responsibility, the original employer/insurer must prove affirmatively that a later employment independently contributed to a pathological worsening of the accepted condition. Spurlock v. International Paper Co., 89 Or App 461 (1988); Crowe v. Jeld-Wen, 77 Or App 81 (1985); Fred Meyer v. Benjamin Franklin Savings & Loan, 73 Or App 795 (1985); see Hensel Phelps v. Mirich, 81 Or App 290 (1986).

Considering claimant's prior injury and award as well as her history of continuing symptoms, we conclude that the issue of whether claimant's upper back condition was worsened by employment with NEC is a complex medical question. Thus, although claimant's testimony is probative, the resolution of this issue largely turns on an analysis of the medical evidence. Uris v. Compensation Dept., 247 Or 420, 426 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985).

Medical reports from the numerous doctors who treated claimant since the 1982 injury all indicate that claimant's main complaint was of continuing pain in her neck, posterior portion of her shoulder and/or upper back on the right side. Even after surgery, claimant saw Dr. Snodgrass and reported continuing pain in her upper back in the scapular area and right trapezius.

Claimant argues that Dr. McIllece's opinion should be given deference because he was the first doctor to examine her after the July 16, 1987 incident and render an opinion. However, when there is a dispute between medical experts, more weight is given to those opinions which are both well-reasoned and based on complete information. See Somers v. SAIF, 77 Or App 259, 263 (1986).

In this case, Dr. McIllece was the immediate care physician who first examined claimant. Claimant reported to him that she had just been moving boxes at work and experienced muscle spasms and pain. He concluded that she had suffered an on-the-job injury. However, Dr. McIllece had never seen claimant before, nor is his conclusion based upon a complete history of the preexisting pain in the right posterior portion of claimant's shoulder and upper back. Accordingly, we are not persuaded by Dr. McIllece's conclusion that claimant's work activity contributed to a worsening of her original injury. See Miller v. Granite Construction Co., 28 Or App 473, 476 (1977).

We are persuaded by the opinion of Dr. Misko, claimant's surgeon. Dr. Misko was familiar with claimant's condition and ongoing history of complaints of pain in the right posterior portion of her shoulder and upper back. He concluded that the July 1987 incident caused a temporary exacerbation of claimant's symptoms.

After de novo review of the medical and lay evidence, we are not persuaded that the July 1987 incident independently contributed to a worsening of claimant's underlying right shoulder condition. Accordingly, we conclude that Beverly remains responsible for claimant's condition.

The Referee awarded claimant's counsel an attorney fee for services rendered at hearing concerning the responsibility issue. At hearing, and on review, claimant's counsel took the position that NEC was responsible for claimant's condition. We have herein found to the contrary. Accordingly, claimant's counsel is not entitled to an attorney fee for meaningful participation in conjunction with the responsibility issue. See George K. O'Kelley, 42 Van Natta 173, 352 (1990).

ORDER

The Referee's order dated May 5, 1988 is reversed. NEC America's denial dated October 28, 1987 is reinstated and upheld. Beverly Enterprises' denial dated December 31, 1987 is set aside and this claim is remanded for processing according to law. That portion of the Referee's order which awarded claimant's attorney an assessed fee of $1,000 is reversed. A client-paid fee not to exceed $4,599.25, payable by NEC to its counsel, is approved. A client-paid fee not to exceed $1,657.50, payable by Beverly to its counsel, is approved.

In the Matter of the Compensation of
JAVIER CARRASCO, Claimant
WCB Case No. 88-18258
ORDER ON REVIEW
Max Rae, Claimant Attorney
Gail Gage (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

Claimant requests review of Referee Daron's order that upheld the SAIF Corporation's denial of his claim for a left arm injury. In his brief, claimant contends that the Referee erred in refusing to admit into evidence Exhibit 5. In its brief, SAIF contends that the Referee should have dismissed the hearing for claimant's failure to appear. On review, the issues are compensability, evidence and dismissal. We affirm.

FINDINGS OF FACT

The Board adopts the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

The Board adopts the Referee's "Opinion and Conclusions" with the following supplementation.

Evidence

The Referee found that claimant was not present at the hearing to testify and there was no evidence of an accident caused by or related to work activity. On review, claimant argues that the Referee erred in refusing to admit Exhibit 5, a transcript of SAIF's investigatory interrogation of claimant, into evidence.

We find that, under the circumstances, the Referee did not err by excluding Exhibit 5. Moreover, we conclude that even if the Referee had admitted the document, because it is a hearsay statement on the central issue in the case and because the declarant was unavailable for cross-examination, we would accord the exhibit little or no weight. We therefore agree with the Referee that claimant has not proven a compensable injury.

Dismissal

SAIF argues that the Referee should have dismissed the request for hearing because of claimant's failure to appear. SAIF argues that, under OAR 438-06-071, it is a waiver of appearance when either the party or the party's representative does not appear for the hearing. We disagree.

In Williams v. SAIF, 99 Or App 367 (1989), the court held that neither OAR 438-06-071 nor ORS 656.283(7) requires a claimant to personally attend a hearing. Because claimant's attorney appeared to litigate his case, it would not have been appropriate for the Referee to have dismissed the request for hearing. See Lynette K. Norton, 42 Van Natta 621 (1990).

ORDER

The Referee's order, dated March 30, 1989, is affirmed.

May 29, 1990 Cite as 42 Van Natta 1134 (1990)

In the Matter of the Compensation of
STEPHEN KENYON, Claimant
WCB Case Nos. 86-14557 & 87-15822
ORDER ON REVIEW
Stebbins & Coffey, Claimant Attorneys
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Crider and Brittingham.

CIGNA Insurance Companies requests review of those portions of Referee Michael Johnson's order that: (1) set aside its denial of claimant's aggravation claim for his current low back condition; and (2) upheld Weyerhaeuser Company's denial of claimant's aggravation claim for the same condition. On review, the issue is responsibility. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following corrections and additions.

Claimant's 1980 compensable injuries are the responsibility of Weyerhaeuser, a self-insured employer.

Claimant injured his low back, shoulders, left hip to the knee, upper back and neck, and had headaches in September 1980, not 1982.

Claimant's 1985 compensable injury, while working for Osmose Wood Preserving, is CIGNA's responsibility.

We disagree with the Referee's finding that claimant recuperated for six or seven months and did not seek work for one year as a result of his 1985 injury. Claimant did not seek work after the 1985 injury because of a depressed job market. Claimant rested a day after the injury and then would have been able to return to work had he wanted to do so.

There are no medical reports from claimant's 1985 injury when CIGNA was on the risk; the claim with CIGNA has never been closed.

In October 1986 Weyerhaeuser denied reopening of either of claimant's 1980 claims on the basis that there had been no worsening and that claimant's current condition was unrelated to his work injuries. Weyerhaeuser conceded compensability shortly before hearing.

In September 1987 CIGNA denied responsibility but not compensability, contending that claimant's condition might be an aggravation of claimant's 1980 injuries with Weyerhaeuser.

No ".307 order" issued in this case.

FINDINGS OF ULTIMATE FACT

CIGNA's denial denied a previously accepted condition prior to claim closure.

Both the 1980 and 1985 compensable injuries were to the low back.

CONCLUSIONS OF LAW AND OPINION

Relying on the responsibility analysis in Industrial Indemnity Co. v. Kearns, 70 Or App 583 (1984), the Referee placed responsibility on CIGNA because he was convinced the 1985 work incident was an injury, and because medical evidence was insufficient to prove that the 1980 injury with Weyerhaeuser last contributed independently to claimant's current condition. We affirm and adopt that portion of the Referee's opinion dealing with responsibility with the following amplification and comment.

Where there are multiple, accepted injuries to the same body part, any one of which could have contributed to the condition in question, there is a rebuttable presumption that claimant's last industrial injury contributed independently to the worsened condition and that the insurer at that time is responsible. Industrial Indemnity Co. v. Kearns, supra. The burden is on the carrier on the risk at the time of the most recent industrial injury to prove that an another employment exposure last independently contributed to the claimant's current condition. Here, CIGNA has not met its burden to prove that its accepted 1985 injury did not independently contribute to claimant's July 1986 back condition. CIGNA did not provide a medical report from the doctor who treated claimant the day of the 1985 injury. The January 1988 report from Dr. Lindsay indicates that he had no record of claimant's condition between June 1984 and July 10, 1986, during which time claimant experienced the CIGNA injury. Nor does Dr. Smith's September 1986 report address the 1985 injury. As a result, CIGNA is unable to establish whether its accepted injury was a mere flare-up of symptoms or that claimant's 1980 injury last independently contributed to claimant's current back condition. Therefore, CIGNA has not rebutted the Kearns presumption that places responsibility on itself.

The Referee incorrectly stated that the injury claim with CIGNA was in closed status. In fact, the claim is in open status and CIGNA's denial was an invalid preclosure denial of future responsibility for a previously accepted condition.

Claimant experienced a nondisabling injury on December 11, 1985, when CIGNA was on the risk. The law in effect at the time of injury governs whether an initial injury claim must be closed. See Webb v. SAIF, 83 Or App 386, 390 (1987); Stephanie L. Vollendroff, 42 Van Natta 945 (1990). At the time of claimant's 1985 injury, ORS 656.268 required closure of nondisabling injury claims. See Or Laws 1981, ch 854, 7a. There is no evidence that CIGNA closed claimant's claim for the 1985 nondisabling injury. Nor is there evidence that

CIGNA notified claimant of the right to request reclassification of the claim as disabling under ORS 656.262(10). See Richard M. Egli, 41 Van Natta 149 (1989). Accordingly, it was precluded from denying further responsibility for any inseparable part of that claim before the extent of the accepted condition had been determined pursuant to the statutory procedures for claim closure. See Roller v. Weyerhaeuser Co., 67 Or App 583, amplified 68 Or App 743, rev den 297 Or 601 (1984); Stephanie L. Vollendroff, supra.

Although an insurer may issue a preclosure denial of continued responsibility for an accepted condition where it appears that injuries or conditions attributable to a subsequent employment aggravate the condition such as to make a shift of insurer responsibility appropriate, Jimmy C. Lay, 37 Van Natta 583 (1985), there was no subsequent employment in this case. On the other hand, when, as here, an insurer of a second work injury seeks to shift responsibility backward, the question of the permanent effect of the second injury should first be decided by means of the claims closure process. Stephanie L. Vollendroff, supra; Mason L. Asbury, 38 Van Natta 961 (1986).

ORDER

The Referee's order dated August 3, 1988 is affirmed. The Board authorizes a client-paid fee, not to exceed $1,584, payable by the Weyerhaeuser Company to its former counsel. The Board authorizes a client-paid fee, not to exceed $2,101.75, payable by CIGNA Insurance Companies to its counsel. For services on Board review, claimant's counsel is awarded an assessed fee of $1,000, to be paid by CIGNA.

In the Matter of the Compensation of
VIRGIL E. MOON, Claimant
WCB Case No. 88-14914
ORDER ON RECONSIDERATION
Malagon, et al., Claimant Attorneys
Cummins, et al., Defense Attorneys

The self-insured employer requests reconsideration and clarification of our April 30, 1990 Order on Review that assessed a penalty based upon any unpaid temporary disability and/or permanent disability awarded by a Notice of Closure or Determination Order. Contending that no temporary disability benefits were left unpaid at the time of claim closure and that no permanent partial disability benefits were subsequently awarded, the employer seeks guidance concerning our assessment of a penalty for its unreasonable delay in closing the claim.

To begin, our review is based on the record as developed at the hearing, not upon subsequent developments as the claim has been processed. Thus, we decline to address the employer's request to the extent that it seeks specific advice as to whether a penalty is actually due under the post-hearing circumstances. Any comments concerning such matters would be advisory and inappropriate for purposes of review.

However, it is appropriate for us to clarify the parameters of the compensation upon which we assessed a penalty for the employer's conduct. With that goal in mind, we proceed with our reconsideration.

Pursuant to our order, the employer was assessed a penalty based upon any temporary disability benefits unpaid at the time of claim closure, be that Notice of Closure or Determination Order. In addition, the penalty was based

upon any permanent disability awarded by the subsequent closure order. Such an assessment would apply to any permanent partial disability benefits awarded by the closure order. In the event of a permanent total disability award, any penalty assessment would likely be encompassed within the penalty based upon the unpaid temporary disability benefits. Thus, if no temporary disability were left unpaid, no penalty based upon a permanent total disability award would likely be assessed. Finally, the penalty would not be based upon future permanent total disability benefits since the penalty is based on benefits awarded at the time of the closure order.

Accordingly, our April 30, 1990 order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our April 30, 1990 order, effective this date. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

May 29, 1990 Cite as 42 Van Natta 1137 (1990)

In the Matter of the Compensation of
ERNEST L. SMITH, Claimant
WCB Case No. 88-15465
ORDER ON REVIEW
Vick & Gutzler, Claimant Attorneys
Sharon Schooley (Saif), Defense Attorney

Reviewed by Board Members Crider and Brittingham.

The SAIF Corporation requests review of that portion of Referee Knapp's order that increased claimant's unscheduled permanent disability award for a low back injury from 20 percent (64 degrees), as awarded by a Determination Order to 34 percent (108.8 degrees). On review the issue is extent of unscheduled permanent partial disability. We modify.

FINDINGS OF FACT

The Board adopts the Referee's "Findings," with the following addition.

Claimant is restricted to light work.

FINDINGS OF ULTIMATE FACT

Claimant has suffered a 25 percent loss of earning capacity due to his compensable low back injury.

CONCLUSIONS OF LAW AND OPINION

The Referee rated claimant's disability for his compensable low back condition utilizing the standards for rating disability. First, he calculated claimant's impairment by assessing his loss of range of motion based on the report of Dr. Bussanich; combining a value for claimant's surgery; and relying again on Dr. Bussanich, adding an additional value of 12 for "nerve impairment." In allowing a value for nerve impairment, the Referee relied on his authority to award more or less than is indicated by the standards if clear and convincing evidence establishes that the claimant's disability is more or less than indicated by the standards. He then added the values for education, age and adaptability provided for by the standards and awarded 34 percent unscheduled permanent partial disability.

SAIF argues that the Referee's standards calculation was incorrect because the Referee should not have relied on Bussanich's report. SAIF also contends that the evidence is not clear and convincing that the standards do not adequately compensate claimant.

We find that Bussanich's measurements are the most reliable indication of claimant's loss of range of motion for two reasons. First, they are the most recent measurements. Second, his measurements vary little from those of Dr. Langston; thus each validates the other. We agree with SAIF, however, that the Referee erred in applying the clear and convincing evidence rule.

If a claimant became medically stationary after January 1, 1988 and his or her claim was closed on or after July 1, 1988, a subsequent determination by a referee or the Board of the claimant's permanent partial disability must be made pursuant to ORS 656.283(7) and 656.295(5) respectively. OAR 438-10-005 and Michelle Griffith, 40 Van Natta 2086 (1988).

For purposes of determining injury-related permanent partial disability, ORS 656.283(7) and 656.295(5) require application of the standards for the evaluation of disabilities adopted by the director pursuant to ORS 656.726(3)(f)(A). Those "standards", which were in effect on the date of the Determination Order from which the hearing was requested, control the evaluation of permanent partial disability. OAR 438-10-010.

The hearing and Board review of the issue of permanent partial disability continues to be de novo on the hearing record. The facts to which the "standards" are applied need only be established by a preponderance of the evidence. However, either party may establish that the record, as a whole, constitutes clear and convincing evidence that the degree of permanent partial disability suffered by the claimant is more or less than the entitlement indicated by the "standards". ORS 656.283(7) and 656.295(5).

A Determination Order issued on July 29, 1988 declaring claimant medically stationary March 2, 1988. The Determination Order was affirmed by another Determination Order dated August 18, 1988. Accordingly, the "standards" adopted effective July 1, 1988, former OAR 436-35-001 et seq, apply to the rating of claimant's permanent partial disability. Former OAR 436-35-270 through 436-35-440 apply to the rating of unscheduled permanent partial disabilities. Former OAR 436-35-270(1).

The determination of permanent partial disability under the "standards" is made by determining the appropriate values assigned by the "standards" to the claimant's age, education, adaptability and impairment. Once established, the values for age and education are added and the sum is multiplied by the appropriate value for adaptability. The product of those two figures is then added to the appropriate value for impairment to yield the percentage of unscheduled permanent partial disability. Former OAR 436-35-280.

The appropriate value for claimant's age of 39 years is 0. Former OAR 436-35-290(3).

Claimant has a high school education with two years of college. The appropriate value for his formal education is 0. Former OAR 436-35-300(3)(a).

Former OAR 436-35-300(4) adopts by reference the "SVP" (specific vocational preparation time) values assigned to various occupations by the Dictionary of Occupational Titles (DOT), published by the U.S. Department of Labor. The highest SVP level demonstrated by a claimant during the ten years prior to the date of injury is used to determine a value for skills. Former OAR 436-35-300(4). Claimant's highest SVP was 4, based on his storekeeper occupation. (DOT 222.387-058). Therefore, the appropriate value for skills is 3. Id.

Claimant has no documented training. The appropriate value for training is 1. Former OAR 436-35-300(5)(a). Claimant's total education value is 4, the formal education value plus the skills value plus the value for training. Former OAR 436-35-300(5)(sic).

Claimant is unable to return to his usual and customary work [See former OAR 436-35-270(3)(a)] and he has not returned to modified work. His adaptability value is, therefore, determined by his residual physical capacity, without regard to his physical capacity prior to the injury. Former OAR 436-35-310(4). Based on treating chiropractor Mower's restrictions, claimant's present physical capacity is in the light category which allows a value of 4. Multiplying claimant's age and education values by the adaptability factor yields a value of 16. Former OAR 436-35-280(6).

The final element necessary to determine disability under the "standards" is the impairment value. For loss of flexion (from 90 .o 60 degrees) claimant is entitled to an impairment value of 3 percent. Former OAR 436-35-360(6). For lost extension (from 30 to 20 degrees) claimant is entitled to an impairment value of 1 percent. The values for lost range of motion in claimant's spine are added (not combined) to obtain a single value. Former OAR 436-35-360(10). In this case the sum of the impairment values for lost spinal motion is 4 percent.

For a laminectomy with single discectomy claimant is entitled to an impairment value of 5 percent. The Referee correctly gave nothing for a non-symptomatic mild disc bulge at L3-4. Combining the surgery and lost range of motion values yields a value of 9. Former OAR 436-35-360(11).

Having determined each value necessary to compute claimant's permanent disability under the "standards", we proceed to that calculation. When claimant's age value (0) is added to his education value (4) the sum is 4. When that value is multiplied by claimant's adaptability value (4) the product is 16. When that value is added to claimant's impairment value (9) the result is 25 percent unscheduled permanent partial disability. Former OAR 436-35-280(7). Claimant's permanent disability under the "standards" is, therefore, 25 percent.

ORS 656.283(7) allows either party to establish by clear and convincing evidence that a claimant's permanent disability is more or less than the entitlement indicated by the "standards". We do not read that provision to require that any underlying fact be established by clear and convincing evidence. Instead, the statute requires that the Referee determine whether the hearing record, when viewed as a whole, constitutes clear and convincing evidence of permanent disability which is less than or more than the disability value obtained by application of the "standards". That is, is the record as a whole highly persuasive, free from confusion, fully intelligible and distinct in indicating more or less disability than would be awarded under the "standards"? See Riley Hill General Contractor Inc. v. Tandy Corp., 303 Or 390, 407 (1987).

On this record we do not find clear and convincing evidence that claimant's disability is more or less than 25 percent. Although Dr. Bussanich noted a 12 percent "spinal motor impairment rating" due to a 58 percent "nerve value" producing a 20 percent "loss of strength," we do not rely on this finding to increase claimant's award. We decline to do so because Dr. Bussanich's report neither explains the meaning of the computerized measurements of strength nor explains whether or not the loss of strength noted between June 1987 and October 3, 1988 is related to the compensable injury. Finally, we are not persuaded that the loss of spinal strength, if adequately explained, has, together with the other relevant factors, produced a greater loss of earning capacity than is indicated by the standards. Claimant is entitled to an award of 25 percent unscheduled permanent partial disability.

ORDER

The Referee's order dated December 28, 1988 is modified. In lieu of the Referee's award and in addition to the 20 percent (64 degrees) unscheduled permanent partial disability awarded by the Determination Order, claimant is awarded 5 percent (16 degrees) unscheduled permanent disability, giving him a total award to date of 25 percent (80 degrees) unscheduled permanent partial disability for a low back injury.

May 30, 1990 Cite as 42 Van Natta 1140 (1990)

In the Matter of the Compensation of
MARY L. GOUDY, Claimant
WCB Case No. 88-11152
ORDER ON REVIEW
Thomas C. Siel, Claimant Attorney
Stoel, et al., Defense Attorneys

Reviewed by Board Members Howell and Speer.

Claimant requests review of Referee Menashe's order that: (1) upheld the self-insured employer's denial of her claim for a neck and left shoulder condition; and (2) declined to assess a penalty and related fee for an alleged unreasonable denial. On review, the issues are compensability and penalties and attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

Claimant, 45 years old at the time of hearing, has worked for the employer as a quality control inspector for over 12 years. She inspects small connectors (about one-inch square) and places them in plastic mating frames.

In July 1987, the height of the desk at which claimant worked was raised. In September 1987, claimant commenced use of a plastic hand-held magnifying scope for inspecting the connectors. Previously, claimant had used a fixed scope that was at eye level. Claimant leaned forward over the desk when she did the inspection work with the hand scope instead of sitting upright looking straight ahead as she had been doing with the fixed scope.

From June 1987, until about March 1988, claimant worked ten hours per day, six days a week. In November or December 1987, claimant noticed tightness across the back of her neck. Over the next few months the pain spread to her left shoulder. By the end of March 1988, her symptoms extended down her left arm to her hand. Claimant had never experienced any prior neck, shoulder or arm symptoms.

Claimant sought medical treatment on March 31, 1988. She had pain in the left trapezius area and left arm, with numbness and tingling in the first three digits of her left hand.

Claimant was off work for about two weeks in April 1988. When she returned to work, she wore a neck brace and arm sling.

On June 1, 1988, claimant began treating with Dr. Flowers, chiropractor. X-rays at that time revealed preexisting discogenic spondylosis with mild spurring at C4-C7.

FINDINGS OF ULTIMATE FACT

Claimant's work activities were a material contributing cause of her preexisting degenerative spondylosis condition becoming symptomatic and requiring medical services.

CONCLUSIONS OF LAW AND OPINION

Occupational Disease or Industrial Injury

At hearing, claimant argued that her condition was compensable as either an occupational disease or as an industrial injury. Claimant credibly testified to a gradual onset of neck, shoulder and arm symptoms. This testimony is supported by the medical evidence. In addition, as noted by the Referee, the onset of such symptoms was not unexpected given the long hours claimant spent bent over her desk commencing in about September 1987.

Citing James v. SAIF, 290 Or 343 (1981), the Referee concluded that the claim was properly analyzed as an occupational disease. We agree.

Compensability

In order to qualify as a compensable occupational disease, the claim must be for a condition which meets one of the three definitions set forth in ORS 656.802(1). The Referee concluded that this claim was to be analyzed under ORS 656.802(1)(a). We do not agree. A claim is properly analyzed under subsection (1)(a) when it involves "ingestion of, absorption of, inhalation of or contact with dust, fumes, vapors, gasses, radiation or other conditions or substances." By contrast, subsection (1)(c) defines a compensable occupational disease as a "series of traumatic events or occurrences . . . which requires medical services or results in physical disability or death."

Here, claimant alleges that her disease results from the repetitive activity of sitting at a desk leaning forward looking through a hand-held scope. Her treating physician refers to the "cumulative trauma" of her work activities. We recently relied on legislative intent in interpreting a "series of traumatic events" as used in ORS 656.802(1)(c) to include "overuse of a body part." See Ronald Dickson, 42 Van Natta 1102 (1990). We conclude that claimant's claim is properly analyzed under subsection (1)(c), rather than (1)(a), of ORS 656.802.

The Referee held that, under subsection (1)(a), claimant must establish that her work activities were the major cause of her condition, or the worsening of a preexisting condition. However, the standard applied by the Referee is not the appropriate standard under subsection (1)(c). To establish that her condition is compensable under subsection (1)(c), claimant need only prove that her work exposure was a material cause of either increased symptoms or a worsening of her underlying condition requiring medical services or resulting in disability. Donna E. Aschbacher, 41 Van Natta 1242 (1989). The Referee concluded in this regard that the medical evidence established that claimant's work activity made claimant's preexisting condition symptomatic. We agree.

Claimant's treating physician, Dr. Flowers, opined that the cumulative trauma of claimant's daily work activities caused the onset of claimant's symptoms requiring treatment. Dr. Duncan, chiropractor, performed an independent medical examination in July 1988. Dr. Duncan concluded that it was possible that claimant's work activities resulted in increased symptoms of claimant's preexisting degenerative condition. Dr. Boyd, an industrial medicine specialist, was of the opinion that claimant had experienced worsened symptoms. These symptoms coincided with claimant's altered job activities. On the record as a

whole, we conclude that claimant has established that her work activities were a material cause of a symptomatic exacerbation of her underlying condition. Therefore, she has established a compensable claim under ORS 656.802(1)(c).

Penalties and Attorney Fees

At the time the employer issued its denial, the occupational disease law enacted by the 1987 Legislative Assembly had not yet been interpreted by the Board or the courts. It was, therefore, unclear whether claimant needed to establish that work activities were the major cause of a pathological worsening of her condition; or instead whether proof that her work activities were a material cause of a symptomatic exacerbation of her condition would suffice. In light of this uncertainty, the employer's denial was not unreasonable.

Claimant's counsel is statutorily entitled to a reasonable, insurer-paid attorney fee for services rendered at hearing and on Board review. Such a fee is defined as an "assessed fee." See OAR 438-15-005(2). However, we cannot award 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 presently be awarded. See OAR 438-15-010(5).

ORDER

The Referee's order dated October 20, 1988 is reversed in part. The self-insured employer's denial of claimant's occupational disease claim for her neck and left shoulder condition is set aside and the claim is remanded to the employer for processing in accordance with law. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
DEBORAH K. HARMON, Claimant
WCB Case No. 88-02658
ORDER ON REVIEW
Welch, Bruun & Green, Claimant Attorneys
David Smith (Saif), Defense Attorney

Reviewed by Board Members Perry and Howell.

Claimant requests review of Referee Peterson's order that: (1) declined to grant permanent total disability; and (2) increased claimant's award of unscheduled permanent partial disability for a low back injury from 25 percent (80 degrees), as awarded by Determination Order, to 35 percent (112 degrees). On review the issue is extent of permanent disability, including permanent total disability. We affirm.

FINDINGS OF FACT

The Board adopts the Referee's "Findings of Fact".

CONCLUSIONS OF LAW AND OPINION

To prove entitlement to permanent total disability, claimant must establish that she is unable to regularly perform work at a gainful and suitable occupation. ORS 656.206(1)(a); Wilson v. Weyerhaeuser, 30 Or App 403 (1977). A claimant who is not permanently totally disabled based upon physical disability alone may nevertheless establish permanent total disability under the so-called "odd-lot" doctrine. Under that doctrine, a disabled person with some residual

physical capacity may still be permanently and totally disabled due to a combination of her 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 Co., 72 Or App 397 (1985).

In order to qualify for permanent total disability benefits under the "odd-lot" doctrine, claimant must demonstrate that she is willing to reenter the work force and that she has made reasonable efforts to do so. ORS 656.206(3). However, claimant's obligation to seek work may be excused when such attempts would, in all practicality, be futile. See Butcher v. SAIF, 45 Or App 318 (1983).

In terms of her physical disability alone, claimant contends that she is permanently limited to working only four hours per day. The Referee did not make such a finding. We also decline to do so. We note that, in a February 10, 1988 report, Dr. Heatherington, claimant's treating osteopath, restricted her to working four hours per day. (Ex. 30A-3) However, we are not persuaded that this restriction is permanent rather than temporary. In this regard, Dr. Heatherington previously recommended that claimant return to a four-hour work day and then gradually increase the work period. (Ex. 17) Therefore, it is not clear that the February 1988 part-time restriction is a permanent restriction. Moreover, in a December 1987 report, Dr. Heatheringon opined that claimant's physical impairment is equivalent to a 25 percent total disability. Without commenting on the persuasiveness of a medical opinion as to the legal doctrine of "disability," we find that the December 1987 report further weighs against the conclusion that the part-time work restriction was intended to be permanent.

Claimant's primary argument on the merits is that, while she is admittedly not permanently totally disabled based on physical grounds alone, her preexisting psychological condition precludes her from regularly performing gainful and suitable work. In this regard, "preexisting disabilities" are considered in determining whether a claimant is permanently totally disabled. ORS 656.206(1)(a). On the other hand, a condition which exists before the industrial injury but which is not disabling, or which only becomes disabling after the injury for reasons unrelated to the injury, is not a "preexisting disability." Searles v. Johnson Cement 101 Or App 589 (1990); Fowler v. SAIF, 82 Or App 604 (1986).

Here, prior to the injury, claimant was diagnosed as suffering from a personality disorder with anti-social and passive/aggressive features. However, we are not persuaded that this psychological condition was disabling prior to the injury. There is no evidence that the condition limited the availability of employment to claimant. Claimant nevertheless contends that her preexisting psychological condition prevented her from retaining employment for more than brief periods of time. Claimant relies on a job history characterized by multiple short-term employments. However, the evidence does not persuade us of the existence of a causal relationship between claimant's work history and her psychological condition.

First, we note that claimant was employed in her at-injury employment for approximately two years prior to her injury. In addition, while claimant testified to holding no job, other than her at-injury employment, for more than one-and-one-half to two months, vocational records indicate that she held two out of three prior jobs for more than six months each. (Ex. 15-2) Moreover, claimant was fired from one of these employments not as a result of her psychological condition, but rather for allegedly stealing money as a cashier. Claimant left yet another employment because she did not enjoy it. Finally, no psychological expert has causally linked claimant's work history to her preexisting condition.

Dr. Heatherington opined that stress associated with claimant's prolonged disability following her compensable injury has resulted in an increase in claimant's psychological problems. However, Dr. Hughes, claimant's treating psychiatrist, has opined that claimant's psychological problems are not injury-related. We are more persuaded by the opinion of the psychological expert, Dr. Hughes, than we are the opinion of Dr. Heatherington.

Consequently, we conclude that claimant's psychological condition was not disabling prior to her injury and did not become disabling due to her injury. Therefore, it is not considered in addressing claimant's entitlement to a permanent total disability award. Excluding claimant's psychological condition from consideration, claimant is not permanently totally disabled.

In addition, we agree with the Referee's conclusion that claimant has not made reasonable efforts to obtain employment. She was noted as exhibiting poor vocational motivation as early as October 1984. (Ex. 6) In May 1986, vocational specialist Lageman reported that claimant saw herself "as totally disabled and gave every indication that she was not motivated to return to work." (Ex. 15) Similarly, Dr. Hughes noted in May 1987 that claimant's "motivation to correct her life style or deal with identified problems is simply lacking." Moreover, given claimant's transferrable skills and physical limitations, it would not be futile for her to seek employment.

With regard to the extent of claimant's permanent partial disability, we adopt the Referee's discussion of this issue noting only that Dr. Heatherington opined in December 1987 that claimant's impairment is equivalent to 25 percent total disability, and then, in February 1988, without explanation, he opined that claimant's "impairments" are moderately severe. We reject the "moderately severe" rating because its inconsistency with the December 1987 opinion is unexplained.

ORDER

The Referee's order dated May 25, 1988, as reconsidered June 14, 1988, is affirmed.

May 30, 1990 Cite as 42 Van Natta 1144 (1990)

In the Matter of the Compensation of
JACK HARRIS, II, Claimant
WCB Case No. 87-15776
ORDER ON REVIEW
Gary Wallmark (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

Claimant, pro se, requests review of Referee Foster's order which upheld the SAIF Corporation's denial, on behalf of a noncomplying employer, of his occupational disease claim for a psychological condition. The issue is compensability. We affirm.

FINDINGS OF FACT

Claimant worked for the employer as a long haul truck driver commencing in September 1986. Claimant sometimes was required to drive for extended periods of time with little sleep.

Commencing in approximately October 1986, claimant began to perceive that he was the subject of harassment in the form of unidentified voices over his CB radio. He heard these voices no matter what channel he used on his

radio. He believed that these were the voices of narcotics agents engaged in an investigation of drug trafficking in the trucking industry. He perceived that some of the comments were directed at him and included threats against his safety. He eventually became so unnerved by these voices that he had the CB radio removed from his truck. However, even after removal of the radio, he continued to hear the voices. He concluded that the narcotics investigators had installed some other communication device in his truck.

In addition to perceiving harassing conversation in his truck, claimant also reported voices in the wind at night, as well as hearing voices from the wall and air-conditioning unit of his hotel room. Claimant experienced a similar period of hearing voices in 1984. This period coincided with a marital separation and resolved without treatment. Claimant has used amphetamines both for recreational purposes as well at to keep awake while driving. He also has a longstanding alcohol problem.

Claimant discontinued work for the employer in February 1987. On February 28, 1987, he was admitted to the mental health unit of a Roseburg hospital where he was treated with antipsychotic drugs and psychotherapy.

Claimant suffers from atypical psychosis with paranoid delusions and hallucinations. This condition has resulted in claimant's misperception that he is being harassed by drug enforcement officials.

CONCLUSIONS OF LAW AND OPINION

Stress-caused claims for benefits arising out of mental and physical disorders are compensable if they flow from stressful conditions objectively existing on the job, and those work conditions, when compared to non-employment conditions, are the major contributing cause of claimant's mental disorder. Former ORS 656.802; McGarrah v. SAIF, 296 Or 145, 166 (1983). Claimant's reaction to the work events need not have been reasonable or rational. If claimant reacted to real events which were objectively stressful, he has a basis for a stress claim. See Leary v. Pacific Northwest Bell, 67 Or App 766 (1984).

In this regard, claimant alleges occupational stress in the form of: (1) long hours of driving without adequate time to rest; and (2) harassment from drug enforcement officials in the form of "voices" which, he believes, were somehow transmitted into the cab of his truck. This latter allegation is clearly the result of his psychological condition. It is not a "real event" capable of causing stress. See McGarrah, supra.

With regard to the possible connection between claimant's long hours of work and his psychological condition, the medical evidence is divided. Dr. Aflatooni, claimant's treating psychiatrist, believes that claimant's condition has been caused by work stress. Dr. Klein, psychiatrist, who performed an independent medical examination, opined that claimant's job stress was not "a primary cause" of the onset of claimant's problems.

Generally, the Board will give greater weight to the conclusions of claimant's treating physician, absent persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810, 814 (1983). We find persuasive reasons not to do so here. First, Dr. Aflatooni did not have an accurate and complete history to base his opinion on. See Miller v. Granite Construction Co., 28 Or App 473, 476 (1977). He was unaware that claimant had experienced a similar problem in 1984, long before his current employment. He was also apparently unaware that claimant underwent an alcohol treatment program in 1983. Moreover, he believed that the onset of claimant's problems did not occur until shortly before claimant sought treatment in April 1987. However, claimant testified that his problems first occurred shortly after he commenced work for the employer in late 1986.

By contrast, Dr. Klein had a complete and accurate history. Dr. Klein was aware of the extent of claimant's drug and alcohol use. In addition, Dr. Klein noted that both claimant's 1984 episode and his 1986-87 episode coincided with periods of marital separation. She hypothesized that claimant's use of drugs was the most likely cause of his psychotic episodes with possible contribution from marital stress. She noted that amphetamine use could cause a syndrome such as that displayed by claimant. Her opinion is thorough and persuasive. We accept it over the opinion of Dr. Aflatooni. See Somers v. SAIF, 77 Or App 259 (1986).

We, therefore, conclude that claimant has failed to establish that his work activities and exposures were the major cause of his psychological condition.

ORDER

The Referee's order dated June 14, 1988 is affirmed.

In the Matter of the Compensation of
CARLEEN M. KRIEGER, Claimant
WCB Case No. 87-05714
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Speer and Howell.

Claimant requests review of that portion of Referee Tuhy's order which upheld the self-insured employer's denial of chiropractic treatments. The employer cross-requests review of that portion of the order which set aside its partial denial of claimant's psychological condition. On review, the issues are medical services and compensability of the psychological condition. We affirm in part and modify in part.

FINDINGS OF FACT

Claimant's compensable injury of June 12, 1986 was originally diagnosed as upper back muscle strain. Claimant did not lose time from work until approximately two weeks after her injury when she came under the care of Dr. Berovic, chiropractor. He has since acted as her treating physician.

Claimant treated with Dr. Berovic either at his office or at his rehabilitation clinic on the average of one to three times a week for nearly two years. As of the date of the hearing her treating chiropractor did not consider her medically stationary.

A September 1986 MRI indicated disc protrusion at the C3-4, C4-5, C5-6 and C6-7 levels. The report noted a herniation at the C4-5 level. Claimant declined surgery recommended by Dr. Smith, neurosurgeon, but, rather, chose to continue treating with Dr. Berovic.

Because of claimant's herniated disc and underlying psychological factors, chiropractic manipulation was contraindicated. The only indication of improvement over the two years of treatments was claimant's statements at hearing and to other doctors who examined her that her subjective condition was slowly improving.

Claimant has a preexisting personality disorder characterized, inter alia, by passive dependency and depression.

Claimant became emotionally dependent upon routine passive physical treatment from her treating chiropractor.

ULTIMATE FINDINGS OF FACT

The treatments from Dr. Berovic were not reasonable and necessary.

The medical treatment claimant received for her compensable condition was a material contributing cause of a worsening of her preexisting psychological condition. Claimant's worsened psychological condition required medical treatment.

CONCLUSIONS OF LAW AND OPINION

Medical Services

The Referee upheld the self-insured employer's denial of treatment for continuing chiropractic care. We agree in part, but set aside the portion of the denial which is prospective.

Prospective denials are impermissible. A carrier may not deny its future responsibility for payment of medical services for a previously accepted claim. ORS 656.245(1); Evanite Fiber Corp. v. Striplin, 99 Or App 353 (1989). In the present case, the employer denied all further chiropractic treatment as unreasonable and unnecessary. Such a denial is prospective and we set aside that portion of the denial. However, since the record indicates that claimant continued to receive medical services until hearing, and because the parties treated those services as claimed and denied, the reasonableness and necessity of these post-denial services are also at issue. (Ex. 43); Hollie J. Rahim, 42 Van Natta 415 (1990). We proceed to address the compensability of these medical services.

For her 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 (1985). Additionally, medical expenses for purely palliative purposes are recoverable where they are necessarily and reasonably incurred in treatment that enables claimant to work. West, supra.

Here, claimant testified that her progress was very slow and at times it angered her that she was not progressing more quickly with all her treatments. The only doctor that unequivocally opined that claimant needed treatments was Dr. Berovic, her treating chiropractor. Dr. Nelson, D. O., to whom Dr. Berovic referred claimant, stated that continued chiropractic treatment was appropriate based on claimant's subjective statements that she was improving, but he also noted that "she does not seem to be making any steady improvement." (Ex. 63-3).

Dr. Zivin, neurologist, stated that if Dr. Berovic believed that claimant had multiple pinched nerves and deteriorating discs, the chiropractic manipulations were not in her best interest. Dr. Simpson, D.O., who conducted an independent medical examination, believed that additional chiropractic care was not warranted.

Claimant's treatments have not enabled her to work; she has not yet been released to work by Dr. Berovic. The record contains evidence that the treatments adversely affected claimant's personality disorder. For the above-mentioned reasons, we conclude that claimant's chiropractic treatments were not reasonable and necessary.

Compensability of Psychological Condition

The self-insured employer argues that claimant's psychological problems are not compensable because they stem from a long-standing personality disorder, that her compensable strain has not materially contributed to her preexisting condition, and that her unreasonable chiropractic treatments have exacerbated her condition.

As a general rule, a carrier is responsible for harmful effects of medical treatment if there is a material causal connection between the treatment and a compensable condition. Williams v. Gates, McDonald & Co., 300 Or 278, 281-82 (1985); see 1 A. Larson, The Law of Workmen's Compensation 13.21 (1985). This standard is the same regardless of whether the compensable condition for which treatment is sought is an injury or an occupational disease. See Janice G. Thon, 40 Van Natta 606, 607 (1988); see also Jeld-Wen, Inc. v. Page, 73 Or App 136, 138-39 (1985).

Treatment may be unreasonable, unnecessary or excessive from a medical standpoint or may be negligently or otherwise tortiously performed and still be causally related to a compensable condition. In such cases, the causal connection between the compensable condition, the improper or tortious treatment and the harmful effect of the treatment remains intact. When this occurs, the harmful effect is compensable even if the treatment which caused it is not. See 1 A. Larson, supra 13.21 at 3-415 & n. 84 (1985 & Supp 1988). When, on the other hand, the treatment is not causally related to a compensable condition or the causal relation is broken by the deliberate intention of the claimant to produce an injury, harm resulting from the treatment is not compensable. See ORS 656.156(1); 656.245; 1 A. Larson, supra 13.21 at 3-419 to 3-425; Terry L. Link, 41 Van Natta 297 (1989).

Claimant in the present case has been diagnosed by Drs. Simpson, Zivin and Tinker, who saw claimant on referral from Dr. Berovic, as having passive-aggressive and dependent personality disorders. Dr. Parvaresh stated that there is no question that claimant is being nurtured, psychologically speaking, by ongoing treatment which presumably has produced no benefit and, if anything, made claimant more disabled at the time of her examination in 1987 than she was at the time of her injury in June 1986.

We are persuaded that the causal connection between claimant's compensable condition, the chiropractic treatment she received and the harmful psychological effect remains intact. Accordingly, under these circumstances, the psychological condition is compensable irrespective of whether the treatment claimant received was reasonable and necessary.

Claimant is entitled to an attorney fee for services at hearing and on review concerning the prospective denial and on review concerning the psychological issue. However, because we have not received a statement of services, we cannot presently award a fee. See OAR 438-15-010(5).

ORDER

The Referee's order dated September 9, 1988 is affirmed in part and modified in part. The employer's medical services denial is set aside, in part, as prospective. The remainder of the order is affirmed. A client-paid fee not to exceed $1,214 is approved.

In the Matter of the Compensation of
DEAN A. MINTUN, Claimant
WCB Case No. 88-03011
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Stafford Hazelett, Defense Attorney

Reviewed by Board Members Howell and Speer.

The insurer requests review of Referee Menashe's order that set aside its denial of claimant's occupational disease claim for a right shoulder and neck condition. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

Claimant has been employed for many years as a ham boner. This work involves repetitive lifting, pushing, pulling and repetitive use of a knife to debone hams.

In April 1985, claimant was diagnosed as having nonindustrial lymphoma. As a result of this condition he has had three biopsies to the right neck area. The most recent biopsy occurred on November 17, 1987.

Claimant returned to work following his third biopsy on November 19, 1987.

On November 24, 1987, claimant returned to Dr. Chandler, the treating physician for the lymphoma, complaining of a very sore right shoulder since the surgery.

The following day, claimant returned to Dr. Kosta, the physician who performed the most recent biopsy. Dr. Kosta noted that claimant was experiencing local pain at the operative site.

Claimant left work on January 11, 1988 because of his shoulder condition.

Dr. Chandler subsequently referred claimant to Dr. Raether for a physiatry consultation. Dr. Raether examined claimant on February 4, 1988. Claimant was given a cortisone injection and daily home exercises were prescribed.

On March 29, 1988, Dr. Raether reported that claimant's right shoulder condition had nearly resolved.

An independent medical examination was performed by Dr. McNeill, orthopedic surgeon, on May 4, 1988.

Claimant's employer was purchased and, on January 15, 1988, all employees were laid off. Claimant has not returned to work. As of the date of hearing, he was not treating for the shoulder.

FINDINGS OF ULTIMATE FACT

Claimant's biopsy on November 17, 1987 resulted in an adhesive capsulitis condition. His work activities up to January 11, 1988 were a material contributing cause of a worsening of that condition to the point that it became disabling after January 1, 1988.

CONCLUSIONS OF LAW AND OPINION

Applicable Law

The injurious exposure alleged by claimant is the repetitive lifting, pushing, pulling and repetitive use of a knife inherent in his job duties. Claimant continued to perform his job duties until January 11, 1988. The reports of Dr. Raether and Dr. Chandler establish that claimant's work activities continued to contribute to a progression of his condition until claimant became disabled from work on January 11, 1988. Because claimant's last exposure contributing to his disability occurred on or after January 1, 1988, the claim is properly analyzed under current ORS 656.802(1), rather than former ORS 656.802(1). See Or Laws 1987, ch. 713, s. 8; Johnson v. SAIF, 78 Or App 143, rev den 301 Or 240 (1986); Donna E. Aschbacher, 41 Van Natta 1242 (1989).

Compensability

In order to qualify as a compensable occupational disease, the claim must be for a condition which meets one of the three definitions set forth in ORS 656.802(1). The Referee analyzed the claim under ORS 656.802(1)(c). He noted that claimant's theory was that repetitive arm motion had produced his condition. The Referee reasoned that repetitive forceful use of the arm and shoulder describes a "series of traumatic events" as that phrased is used in ORS 656.802(1)(c). We agree. We recently relied on legislative intent regarding the fact that a "series of traumatic events" as used in ORS 656.802(1)(c) was intended to include "overuse of a body part". See Ronald V. Dickson, 42 Van Natta 1102 (1990). Dr. Chandler opined in this regard that claimant's work exposure continually aggravated his shoulder condition. Claimant's condition is properly analyzed under ORS 656.802(1)(c).

The Referee next addressed the question of the degree of work contribution necessary to establish a compensable claim pursuant to ORS 656.802(1)(c). He concluded that it is claimant's burden to establish that his work activities and exposures were a material contributing cause, rather than major cause, of his condition. We agree. Donna E. Aschbacher, supra.

Finally, the Referee addressed the question whether claimant need establish that his work activities and exposures caused or worsened his underlying condition or, instead, whether it was sufficient that those activities resulted in increased symptoms of his condition resulting in disability or a need for medical treatment. The Referee concluded that he need not answer this question because the evidence established that claimant's work activity caused or worsened the adhesive capsulitis and tendinitis condition. We agree and adopt his discussion of this issue. Moreover, even if we were to conclude that claimant's work activities had materially contributed to a symptomatic exacerbation only, nevertheless his claim would be compensable. See Aschbacher, supra.

ORDER

The Referee's order dated June 21, 1988 is affirmed. Claimant's attorney is awarded an assessed fee of $450, to be paid by the insurer.

In the Matter of the Compensation of
RUTH E. PARKER, Claimant
WCB Case No. 88-18181
ORDER ON REVIEW
Vick & Gutzler, Claimant Attorney
Rankin, et al., Defense Attorneys

Reviewed by Board Members Brittingham and Crider.

Claimant requests review of Referee Knapp's order that declined to award permanent unscheduled disability for a low back condition. On review the sole issue is extent of unscheduled permanent disability. We affirm.

FINDINGS OF FACT AND ULTIMATE FACT

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

At the time of hearing, claimant had lost 10 degrees of flexion and extension, 20 degrees of right lateral flexion and 10 degrees of left lateral flexion compared with what is considered normal.

Claimant suffered intermittent low back pain for several years prior to the onset of more severe pain with work activity in early 1988. At the time of hearing, she continued to suffer intermittent pain which interfered with her ability to work.

CONCLUSIONS OF LAW AND OPINION

The Referee, finding that claimant had no lost range of motion, or other measurable impairment, awarded no permanent disability. We agree with the Referee's conclusion, but not with his reasoning.

The Referee found that claimant had no lost range of motion. We disagree. Drs. Trapp, Simpson and Kingston all performed range of motion testing which indicated that claimant has less than normal range of motion in her back. The measurements differed, however, as to the type of loss she suffered. One showed a loss of extension, another of flexion. The Referee, rather than attempting to ascertain which report most reliably reflected claimant's impairment at the time of hearing, concluded that claimant had lost no range of motion in the back. In so finding, he "mixed and matched" measurements from the three reports, relying always on the report that reflected no loss of range of motion in a particular plane. We disagree with this approach.

Although the Referee correctly noted that range of motion measurements may reflect in some degree a claimant's experience of pain and voluntary limitation, there is no reason to doubt that claimant exerted herself fully on each examination. We rely most heavily on Dr. Trapp's December 27, 1988 opinion, because it is both thorough and closest in time to the hearing. Dr. Trapp opined that claimant had lost 10 degrees of flexion and extension, 20 degrees of right lateral flexion and 10 degrees of left lateral flexion as compared to normal at the time of hearing.

The Referee also declined to make an award for pain under the standards. He reasoned that the standards do not allow an award for pain unless it results in "measurable impairment" otherwise rated in the standards. We disagree.

For purposes of determining injury-related permanent partial disability, ORS 656.283(7) and 656.295(5) require application of the standards for the evaluation of disabilities adopted by the director pursuant to ORS 656.726(f)(A).

Those "standards" in effect on the date of the Determination Order from which the hearing was requested control the evaluation of permanent partial disability. OAR 438-10-010.

In this case, because the claim was closed in October 1988, the "standards" adopted effective July 1, 1988, as amended effective August 1, 1988, former OAR 436-35-001 et seq., apply to the rating of claimant's permanent partial disability. Pain can result in loss of use of function. When it does, it is rated based on the loss of use or function which results and no additional value is allowed for the pain alone. Former OAR 436-35-320(a). We have interpreted that rule to allow an award for pain which causes loss of function not otherwise recognized by the standards. Daniel M. Alire, 41 Van Natta 752 (1989).

Claimant has credibly testified that she suffers from intermittent pain which interferes with her ability to work. To avoid such pain she must avoid lateral movement and must not remain in a seated position for long periods of time.

Nevertheless, we affirm the Referee's decision to make no award for permanent disability because we are unable to find that claimant's loss of range of motion and her disabling pain are related to the compensable injury. The evidence is insufficient to establish that relationship by a preponderance of the evidence.

Claimant suffered a preexisting, periodically symptomatic, low back condition. Therefore, the issue of causation of claimant's permanent impairment is a complex medical question. Drs. Trapp, Simpson and Kingston were aware of claimant's preexisting back condition. Although each reported impairment findings, none of them related the lost range of motion to claimant's industrial injury of February 3, 1988. Moreover, Dr. Duewell, claimant's family physician, and Drs. Martens and Simpson, examiners, all opined that claimant suffered a temporary exacerbation but no permanent impairment due to the injury. Dr. Kingston, the treating chiropractor, predicted that there would be no permanent impairment but never offered a more definitive opinion on the subject.

Consequently, we are unable to attribute claimant's permanent losses to the injury. Indeed, it appears likely that her impairment, including loss of use or function due to disabling pain, may not be related to the compensable injury. While we do not doubt that claimant has lost range of motion in her back and has ongoing pain, we find that claimant has not carried her burden of establishing that her disability is causally related to her injury.

ORDER

The Referee's order dated February 7, 1989 is affirmed. The Board approves a client-paid fee, not to exceed $873, payable by the self-insured employer to its counsel.

In the Matter of the Compensation of
RONALD L. SCHILLING, Claimant
WCB Case No. 87-09708
ORDER ON REVIEW
Peter O. Hansen, Claimant Attorney
John D. McLeod, Attorney
Gary Wallmark (Saif), Defense Attorney

Reviewed by Board Members Speer and Howell.

The alleged noncomplying employer requests review of Referee Shebley's order that: (1) found that claimant was a subject worker; (2) found that claimant's low back claim was timely; and (3) set aside the employer's denial of claimant's low back condition. In its brief, the employer contends that the Referee should have assigned responsibility to a subsequent employer. On review, the issues are subjectivity, timeliness, compensability and responsibility. We affirm.

FINDINGS OF FACT

The Board adopts the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

The Board adopts the Referee's Conclusions of Law and Opinion with the following supplementation.

Responsibility

The SAIF Corporation contends that the Referee erred by not addressing the issue of responsibility. SAIF argues that claimant's 1982 compensable injury involved the same part of the body as that injured in 1978. SAIF contends that the 1982 injury independently contributed to claimant's current condition, as evidenced by worsened symptoms after the 1982 incident.

We conclude that the Referee correctly refused to address responsibility. Claimant's subsequent employer was not represented at hearing. Because SAIF failed to join the subsequent employer in the proceeding, it is not entitled to assert the last injurious exposure rule as a defense. See Runft v. SAIF, 303 Or 493 (1987). SAIF argues that the parties agreed to allow such a defense. We can find no such agreement in the record of the litigation of the present claim.

ORDER

The Referee's order dated September 1, 1988 is affirmed. For services on Board review, claimant's attorney is awarded an assessed fee of $800, to be paid by the SAIF Corporation on behalf of the alleged noncomplying employer.

In the Matter of the Compensation of
DUANE G. TAYLOR, Claimant
WCB Case No. 86-16368
ORDER ON REVIEW
Royce, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Howell and Speer.

The insurer requests review of those portions of Referee Fink's order that: (1) set aside its partial denial of claimant's psychological claim; and (2) awarded claimant an assessed fee for services resulting in the insurer's prehearing acceptance of claimant's hearing loss claim. In his brief, claimant argues that the Referee's assessed attorney fee awards are inadequate and should be increased, and that the penalty for untimely denial of his hearing loss claim should be increased. If the Board finds the psychological claim not compensable, claimant also argues entitlement to an increased award of permanent disability, including permanent total disability. On review the issues are compensability, penalty, attorney fees, and extent of permanent disability, including permanent total disability.

The Board affirms in part, modifies in part, and reverses in part.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact with the following supplementation.

Claimant's attorney obtained medical documentation regarding claimant's hearing loss and filed a claim as a "NEW CLAIM" by letter on May 18, 1987. (Ex. 58, 60A).

The insurer made no response to the claim until it accepted the claim on January 15, 1988 -- 8 months after the claim had been filed, but prior to hearing. (Ex. 75).

CONCLUSIONS OF LAW AND OPINION

Compensability of Psychological Condition

We adopt the Referee's opinion on this issue with the following supplementation.

In order to find claimant's psychological condition compensable, claimant must show by a preponderance of the evidence that his compensable back injury was a material cause of his psychological condition. Jeld-Wen, Inc. v. Page, 73 Or App 136 (1985). The Referee found claimant's psychological condition compensable. We agree.

Dr. Worthington, Ph.D., psychologist, preliminarily diagnosed claimant's condition as "major depression with accompanying acute anxiety." (Ex. 79-1). Later, referring to the DSM-III, Dr. Worthington diagnosed claimant's condition as: Axis I --- 296.23 Major Depression, Single Episode, with Melancholia, 316.00 psychological factors affecting physical condition. (Ex. 81-3).

Dr. Worthington opined that claimant's psychological condition is a direct result of his chronic pain and loss of previous physical life activities

subsequent to his compensable back condition. (Ex. 81). Under Dr. Worthington's direction, claimant took the MMPI test which indicates that claimant is in a "relatively serious depression," with an "intense preoccupation with his physical condition . . . " (Ex. 81-3).

In March 1988, Dr. Turco, an independent medical psychiatric examiner, reported that claimant had no diagnosable psychiatric condition. (Ex. 82-4). However, in deposition, Dr. Turco said that he would have "no particular argument if someone said [claimant] had an adjustment disorder with some depressive features . . . [even though] I did not particularly make that kind of a diagnosis at the time I saw him . . . I would have no particular disagreement with other people [doing so]." (Ex. 96-8). Dr. Turco cited several causal stressors in claimant's life, all related to his compensable condition and the subsequent vocational rehabilitation (pain and inappropriate vocational rehabilitation treatment), as the reasons he would agree that an adjustment disorder diagnosis would be appropriate for claimant and that such a disorder is amenable to psychiatric treatment. (Ex. 96-8 - 96-13).

Dr. Turco noted that claimant's MMPI depression scales are abnormal. (Ex. 96-21).

Based on these aforementioned medical opinions, we conclude that claimant has shown by a preponderance of the evidence that his compensable back injury was a material cause of his psychological condition.

Penalty and Related Attorney Fee -- Hearing Loss Claim

Unreasonable failure to timely accept or deny claims may result in the assessment of a penalty and related attorney fee. ORS 656.262(10). The insurer conceded that its acceptance of claimant's hearing loss claim was untimely. The Referee assessed a penalty of 10 percent and a penalty-related attorney fee of $50. Claimant contends that these amounts are inadequate.

Although the insurer's acceptance was untimely, we note that the parties were negotiating a settlement during a portion of the delay. Accordingly, we conclude that the Referee's assessment of a 10 percent penalty is appropriate. However, we further conclude that the Referee's penalty-related attorney fee award does not adequately compensate claimant's attorney for his services on this issue. Accordingly, in lieu of the Referee's award, we award a penalty-related attorney fee of $250 for the insurer's unreasonable resistance to the payment of compensation. See ORS 656.382(1).

Assessed Fee on Hearing Loss Claim

The Referee awarded claimant's attorney an assessed fee of $250 for services resulting in the insurer's acceptance of the hearing loss claim. However, entitlement to attorney fees in workers' compensation cases is governed by statute and unless specifically authorized by statute, attorney fees cannot be awarded. Forney v. Western States Plywood, 297 Or 628 (1984). Subsequent to the Referee's order, the Board has recently concluded that claimants are not entitled to assessed fees when an employer has rescinded a denial prior to a hearing on the matter. Duane L. Jones, 42 Van Natta 875 (1990). Here, the matter was resolved prior to the hearing. Accordingly, we reverse the Referee's award of an assessed fee concerning the rescinded denial. See Arliss C. Hughes, 42 Van Natta 935 (1990).

ORDER

The Referee's order, dated November 4, 1988, is affirmed in part, modified in part, and reversed in part. In lieu of the Referee's award of a $50 penalty-related attorney fee, claimant's attorney is awarded a fee of $250, to be paid by the insurer. The Referee's award of a $250 assessed fee for prevailing prior to hearing regarding claimant's hearing loss claim is reversed. The remainder of the Referee's order is affirmed. For services on review concerning the compensability issue, claimant's attorney is awarded an assessed fee of $1,100, to be paid by the insurer. The Board approves a client-paid fee, not to exceed $1,998.50, payable by the insurer to its counsel.

In the Matter of the Compensation of
DICK A. WRIGHT, Claimant
WCB Case Nos. 88-14573 & 88-03936
ORDER ON REVIEW
Callahan et al., Claimant Attorneys
Acker, et al., Defense Attorneys
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Howell and Speer.

Liberty Northwest Insurance Corporation requests review of those portions of Referee Harri's order that: (1) set aside its "new injury" denials of claimant's claim for a low back condition; (2) upheld Argonaut Insurance Company's denial of claimant's aggravation claim for the same condition; and (3) denied Liberty Northwest's motion to sever. On review, the issues are joinder and responsibility.

The Board affirms in part and reverses in part.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" with the following supplementation regarding the issue of severance.

Argonaut moved for joinder on August 17, 1988. Argonaut sent Liberty Northwest certified copies of the motion. At the time, former OAR 438-06-065(2) was in effect which provided that the party to be joined "shall receive at least ten (10) days notice of hearing on the merits [of the motion to join]." The Order of Joinder was signed and entered on August 23, 1988.

On September 26, 1988, Liberty Northwest issued its denial of claimant's back condition. (Ex. 28). On October 26, 1988, Liberty Northwest responded to the Department of Insurance and Finance's October 21, 1988 notice of ".307" processes. (No. ".307" order issued.) On October 27, 1988, Liberty Northwest's counsel sent its Motion to Sever.

CONCLUSIONS OF LAW AND OPINION

Severance

Liberty Northwest argues that because Argonaut did not act immediately when it first knew of the responsibility issue, because the deposition of Dr.

Taylor was taken before Liberty Northwest was joined, and because the Order of Joinder was signed before the 10-day period of OAR 438-06-065(2) had expired, "the orderly process mandated by the rules was subverted in this case, and the order of Joinder of Referee Borchers should have been rescinded, and Liberty Northwest and Kellogg Lumber should have been severed (with immunity) from the proceedings which took place on November 14, 1988." We disagree.

Liberty Northwest did not object to the Order of Joinder until October 27, 1988 -- long after it had denied claimant's claim on September 26, 1988, when it thereby became a necessary party, and after responding to the Department of Insurance and Finance's October 21, 1988 notice of ".307" processes on October 26, 1988. Its motion to sever is not timely. Admittedly, the Order of Joinder was issued prior to expiration of the ten-day notice period. However, even if joinder had not been appropriate, it was proper to consolidate claimant's request for hearing from Argonaut's June 24, 1988 denial with his request for hearing from Liberty Northwest's September 26, 1988 denial. See former OAR 438-06-065(1).

Responsibility

Where there is an accepted compensable injury followed by an increase in disability during or after employment with a later employer/insurer, responsibility is initially fixed with the employer/insurer which accepted the claim. In order to shift responsibility, the original employer/insurer must prove affirmatively that a later employment independently contributed to a pathological worsening of the accepted condition. Spurlock v. International Paper Co., 89 Or App 461 (1988); Crowe v. Jeld-Wen, 77 Or App 81, 86 (1985); Fred Meyer v. Benjamin Franklin Savings & Loan, 73 Or App 795 (1985); see Hensel Phelps v. Mirich, 81 Or App 290 (1986); Linda L. Wise, 42 Van Natta 115 (1990).

The Referee held that Liberty Northwest is responsible. The Referee based his conclusion on what he interpreted as Dr. Taylor's, D.C., the treating physician's conclusion that claimant's condition had worsened, even though slightly, while working for Liberty Northwest's insured. We disagree with the Referee's interpretation of Dr. Taylor's deposition testimony and we disagree that Liberty Northwest is responsible.

When asked if the work at Liberty Northwest's insured "contributed independently even slightly to the worsening of (claimant's) condition which occurred in early 1988," Dr. Taylor replied, "Well, um, I would have to agree to that as it is stated." (Ex. 27-10). However, in the very next exchange, Dr. Taylor stated that claimant's current condition is unchanged from when he initially treated claimant on August 26, 1987, prior to the date claimant commenced employment with Liberty Northwest's insured. (Ex. 27-10, 27-11).

Later, during cross examination, Dr. Taylor was asked whether there had been any worsening of any underlying condition. Dr. Taylor replied, "No...," and proceeded to expand his answer by explaining that his clinic specifically evaluated claimant to determine if there was "any underlying condition that would have worsened" and that they found that there was not. (Ex. 27-16).

Furthermore, Dr. Brett, neurosurgeon, who examined claimant on referral from Dr. Taylor, opined that claimant had not experienced a pathological worsening of his condition. Accordingly, we conclude that the weight of the evidence establishes that claimant's employment with Liberty Northwest's insured did not independently contribute to a pathological worsening of claimant's condition as accepted by Argonaut in September 1987. Argonaut remains responsible.

ORDER

The Referee's order, dated December 21, 1988, is affirmed in part and reversed in part. Liberty Northwest's September 26, 1988 and October 19, 1988 denials are reinstated and upheld. Argonaut's denial is set aside and Argonaut shall process the claim according to law. The assessed attorney fee awarded by the Referee shall be paid by Argonaut rather than Liberty Northwest. The remainder of the Referee's order is affirmed. The Board approves a client-paid fee, not to exceed $1,359, payable by Liberty Northwest to its counsel. The Board approves a client-paid fee, not to exceed $1,694, payable by Argonaut to its counsel.

In the Matter of the Compensation of
DANIEL L. BANTA, Claimant
WCB Case No. 88-18761
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
E. Jay Perry, Defense Attorney

Reviewed by Board Members Speer and Perry.

The insurer requests review of Referee McCullough's order which increased claimant's unscheduled permanent disability award for a low back injury from 17 percent (54.4 degrees), as awarded by a Determination Order, to 26 percent (83.2 degrees). On review, the issue is extent of permanent disability. We affirm.

FINDINGS OF FACT

The Board adopts the Referee's "Findings of Fact."

CONCLUSIONS OF LAW AND OPINION

The Board adopts the Referee's "Opinion and Conclusions" with the following comments.

Claimant's adaptability factor is dependent upon his physical capacity to lift. Former OAR 436-35-310(4). In this regard, claimant is precluded from lifting over 30-40 pounds from bench weight and over 20 pounds from the ground. The insurer argues that because lifting ability as defined in former OAR 436-35-310(4) does not make reference to a starting level, claimant's ability to lift from bench height should be considered in arriving at an adaptability value. We conclude, however, that the ability to lift for purposes of former OAR 436-35-310(4) is measured from the floor level. Accordingly, the Referee correctly concluded that claimant's preclusion from lifting over 20 pounds from the floor level puts him in the light category. Former OAR 436-35-310(4)(c).

Rather than a total impairment value of 14, as calculated by the Referee, claimant's impairment value is equal to a total of 14.5 percent. Former OAR 436-35-360(11); Leland M. Pollack, 42 Van Natta 925 (1990). Consequently, claimant's final unscheduled permanent disability value is 26.5 percent which is rounded up to 27 percent. See former OAR 436-35-280(7). Because claimant has not cross-requested review or otherwise asked for an increase in his disability, we will not modify the Referee's award of 26 percent unscheduled permanent disability. See Robin M. Glover, 42 Van Natta 1081 (1990).

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 award 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 presently be awarded. See OAR 438-15-010(5).

ORDER

The Referee's order dated February 23, 1989 is affirmed. A client-paid fee not to exceed $910, payable by the insurer to its counsel, is approved.

May 31, 1990 Cite as 42 Van Natta 1159 (1990)

In the Matter of the Compensation of
GERALD D. BRYAN, Claimant
WCB Case No. 88-11735
ORDER ON REVIEW
Charles N. Isaak, Claimant Attorney
Davis & Bostwick, Defense Attorneys

Reviewed by Board Members Cushing and Myers.

Claimant requests review of Referee Podnar's order which upheld the self-insured employer's denial of his injury claim for a low back condition. In his brief, claimant requests that the case be remanded for a new hearing for the taking of additional evidence. On review, the issues are remand and compensability. We affirm.

FINDINGS OF FACT

We adopt the findings of fact as set forth in the "Findings" section of the Referee's order with the following supplementation.

Claimant was not performing his work in a satisfactory manner. He would have been terminated the day after his alleged injury, had he come to work in the morning. Claimant is not credible.

CONCLUSIONS OF LAW AND OPINION

Remand

Claimant presents additional evidence in his brief in support of his claim. We treat the presentation of new evidence on appeal as a motion for remand. Judy A. Britton, 37 Van Natta 1262 (1985). Claimant has also requested that we remand this case on the basis that he did not receive an impartial hearing.

The Board may remand a case for the receipt of additional evidence if it determines 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).

Here, the new evidence consists of additional testimony and documentation from claimant, new testimony from other witnesses, including claimant's wife,

and observations and testimony by claimant's former attorney. We have evaluated this new evidence and have determined that all of it was obtainable with due diligence at the time of hearing. Accordingly, we decline to remand this case for admission of further evidence.

Claimant also requests remand alleging that the Referee decided adversely to him due to bias. He requests that he be granted a new hearing with a different Referee.

With regard to this allegation, claimant has neither presented nor referred us to any evidence to support his contention that he did not receive a fair and impartial hearing. Moreover, our review of the record reveals nothing to suggest that the hearing was conducted in any manner other than a manner that would achieve substantial justice to all parties. Accordingly, claimant is not entitled to a new hearing on this basis.

We conclude that this record has not been incompletely or otherwise insufficiently developed and we decline to remand the matter for a new hearing. We proceed to review on the merits without considering any new information not already contained in the record. ORS 656.295(5). In reaching this conclusion, we note that claimant contends that his counsel was ineffective at hearing. Assuming arguendo that claimant is correct, this fact does not merit remand.

Compensability

We adopt the conclusions and reasoning as set forth in the "Conclusions" and "Opinion" sections of the Referee's order with the following supplementation.

To establish the compensability of his condition, claimant has the burden of proving that a work incident occurred on April 27, 1988 which materially caused disability or a need for medical treatment. Hutcheson v. Weyerhaeuser, 288 Or 51, 56 (1979).

The Referee found that no injury occurred at work because claimant's demeanor at hearing undermined his credibility. (O&O at 3). We defer to a Referee's credibility findings based upon demeanor. See Widener v. Louisiana Pacific Corp., 40 Or App 3 (1979). Since only claimant's testimony establishes the circumstances and event of injury, and since claimant is not credible, we must conclude that claimant has not met his burden of proving that a work injury occurred on April 27, 1988, as he alleges. See Timothy J. Swodeck, 39 Van Natta 341 (1987).

ORDER

The Referee's order dated October 19, 1988, is affirmed. A client-paid fee, not to exceed $2,508, is approved, payable by the self-insured employer to its counsel.

In the Matter of the Compensation of
JACK E. EMERALD, Claimant
WCB Case No. 86-14340
ORDER ON REVIEW
Emmons, et al., Claimant Attorneys
John Motley (Saif), Defense Attorney

Review by Board Members Howell and Speer.

Claimant requests review of Referee Seifert's order which increased his award of unscheduled permanent disability for a neck and hip injury from 20 percent (64 degrees), as awarded by Determination Orders, to 30 percent (96 degrees). On review, the issue is the extent of scheduled and unscheduled permanent disability. We affirm.

FINDINGS OF FACT

Claimant was 35 years old on the date of hearing. He had received a GED in 1987. During the 10 years prior to December 1985, he had worked as a head rigger, rigging slinger, hook tender, and second rigger. The job of head rigger required very heavy physical exertion.

On December 16, 1985, while working for the employer as a head rigger, claimant was compensably injured. He was hit by several logs and experienced neck, posterior hip, and low back pain, shoulder weakness, and left hand and foot numbness. Among his injuries were torn ligaments in his neck, a fractured right inferior C-4 facet, subluxation and facet locking of the C4-5 vertebrae, and a 10 percent compression fracture of the C-6 vertebra. No boney abnormalities were found in claimant's hip or low back. A C4-5 fusion was performed on the date of injury.

Claimant became medically stationary in September 1986. An October 10, 1986 Determination Order closed the claim and awarded 20 percent unscheduled permanent disability. Claimant began an authorized training program on March 2, 1987. On November 11, 1987, claimant fell and aggravated his low back, neck, and shoulder injuries. He received chiropractic treatment and was once again medically stationary by April 1988.

Despite the aggravation of his injury, claimant successfully completed training as a meat cutter on November 30, 1987. He graduated from that program in December 1987. On February 25, 1988, he began work as a meat cutter. An August 3, 1988 Determination Order closed the claim with no award of permanent disability.

After becoming medically stationary, claimant had injury-related limitations in the active motion of his cervical and thoracolumbar spine due primarily to pain. Cervical flexion was 32 degrees, extension was 32 degrees, right lateral flexion was 15 degrees, left lateral flexion was 25 degrees, right rotation was 45 degrees, and left rotation was 15 degrees. Thoracolumbar flexion was 70 degrees, extension was 30 degrees, right lateral flexion was 20 degrees, left lateral flexion was 20 degrees, left and right rotation were normal. Upper extremity reflexes, motor function, and strength were normal. Shoulder motion was full. Dr. Pederson who examined claimant for his attending physician on April 23, 1988, felt that claimant suffered a 25 percent injury-related permanent impairment. Dr. Peterson, who examined claimant for SAIF on April 27, 1988, felt claimant suffered a 15 to 20 percent permanent injury-related impairment.

At the time of hearing, claimant was unable to return to his usual and customary work. He continued working as a meat cutter. That work required frequent lifting of up to 20 pounds. Claimant was limited in his ability to repetitively bend or twist at the waist, sit for long periods, and climb stairs by low back pain.

CONCLUSIONS OF LAW

If a claimant became medically stationary after January 1, 1988, and his or her claim was closed on or after July 1, 1988, a subsequent determination by a Referee or the Board of the claimant's permanent partial disability must be made pursuant to ORS 656.283(7) and 656.295(5), respectively. OAR 438-10-005 and Michelle Griffith, 40 Van Natta 2086 (1988).

For purposes of determining injury-related permanent partial disability, ORS 656.283(7) and 656.295(5) require application of the standards for the evaluation of disabilities adopted by the director pursuant to ORS 656.726(3)(f)(A). Those "standards" in effect on the date of the Determination Order from which the hearing was requested control the evaluation of permanent partial disability. OAR 438-10-010.

In this case, the "standards" adopted effective July 1, 1988, former OAR 436-35-001, et seq, apply to the rating of claimant's permanent partial disability. Former OAR 436-35-010 through 436-35-260 apply to the rating of scheduled permanent partial disabilities. Former OAR 436-35-010(1).

Claimant argues that he is entitled to scheduled permanent disability for loss of use of his arms. We find insufficient evidence to establish that claimant suffers any permanent scheduled impairment under the applicable "standards." We conclude, therefore, that claimant is entitled to no scheduled permanent disability award under the "standards." Nor has claimant established that the record as a whole constitutes clear and convincing evidence of permanent scheduled disability. Drs. Pederson and Peterson examined claimant after he last became medically stationary and found no abnormalities in his upper extremities. Claimant is not entitled to a scheduled permanent disability award.

We look then to claimant's unscheduled permanent disability. Former OAR 436-35-270 through 436-35-440 apply to the rating of unscheduled permanent partial disabilities. Former OAR 436-35-270(1).

The determination of unscheduled permanent partial disability under the "standards" is made by determining the appropriate values assigned by the "standards" to the claimant's age, education, adaptability, and impairment. Once established, the values for age and education are added and the sum is multiplied by the appropriate value for adaptability. The product of those two figures is then added to the appropriate value for impairment to yield the percentage of unscheduled permanent partial disability. Former OAR 436-35-280.

The appropriate value for claimant's age of 35 years is 0. Former OAR 436-35-290(3).

The appropriate value for formal education, claimant having obtained a GED, is 0. Former OAR 436-35-300(3)(b).

Former OAR 436-35-300(4) adopts by reference the "SVP" (specific vocational preparation time) values assigned to various occupations by the Dictionary of Occupational Titles (DOT), published by the U.S. Department of Labor. The highest SVP level demonstrated by a claimant during the ten years prior to the date of injury is used to determine a value for skills. Former OAR 436-35-300(4). Claimant's highest SVP during the 10 years prior to the date of injury was 6 as a hook tender (DOT # 921.131-010). Therefore, the appropriate value for skills is 1. Former OAR 436-35-300(4).

While claimant was trained as a meat cutter, neither party "provided" documentation demonstrating competence in a specific vocational pursuit.

"Documentation" as used in former OAR 436-35-300(5) means a certificate, diploma, degree, etc. No such documentation is in the record and none was offered or provided pursuant to the rule. Claimant's training value is, therefore, 1. Former OAR 436-35-300(5)(a). Claimant's total education value is 2, the formal education value plus the skills value plus the value for training. Former OAR 436-35-300(6).

An adaptability value for a claimant who is unable to return to his or her usual and customary work [See former OAR 436-35-270(3)(a)] but who has returned to modified work is determined from a matrix of values at former OAR 436-35-310(3)(a). That matrix compares the physical capacity of the claimant's usual and customary work with the physical capacity required by the modified work. This is true even though claimant may have the physical capacity to do heavier work than is required by the modified employment. Physical capacities are not defined by the "standards" generally. We utilize those definitions contained in former OAR 436-35-310(4)(a)-(d).

In this case, claimant's usual and customary work required the physical capacity to do very heavy work. Claimant's modified work required a light to medium physical capacity. Therefore, the appropriate adaptability value is 2.5. Former OAR 436-35-310(3)(a).

The final element necessary to determine unscheduled permanent disability under the "standards" is permanent injury-related impairment. Claimant has reduced ranges of cervical and thoracolumbar motion, a cervical fusion, a cervical vertebra compression fracture, a fracture of a posterior element of the C-4 vertebra, and mildly disabling low back pain.

For range of motion figures we rely upon Dr. Peterson's findings, as they are the most recent and most detailed in the record.

For cervical flexion (32 degrees retained), extension (32 degrees retained), and right rotation (45 degrees retained) claimant is entitled to no value. Former OAR 436-35-360 (2), (3) & (5). For reduced left lateral cervical flexion (25 degrees retained), claimant is entitled to a value of 1 percent and for reduced right lateral cervical flexion (15 degrees retained), claimant is entitled to 1.5 percent. Former OAR 436-35-360(4). For reduced left cervical rotation (15 degrees retained), claimant is entitled to a value of 1.5 percent. Former OAR 436-35-360(5). The values for reduced range of motion in the cervical spine are added (not combined) to obtain a single figure for impairment due to reduced cervical motion. Former OAR 436-35-360(10). In this case the total is 4 percent.

For reduced thoracolumbar flexion (70 degrees retained), claimant is entitled to a value of 2 percent. Former OAR 436-35-360(6). Claimant is entitled to no values for reduced thoracolumbar extension, lateral flexion, or rotation. Former OAR 436-35-360(7),(8)&(9). The total value for impairment due to reduced thoracolumbar motion is 2 percent.

Claimant is entitled to a 2 percent value for the C-6 compression fracture that he suffered. Former OAR 436-35-350(1)(a). He is entitled to a 2 percent value for the fusion of 2 cervical vertebrae in a favorable position. Former OAR 436-35-350(3). He is also entitled to a 3 percent value for the fracture of a posterior element of the C-4 vertebra. Former OAR 436-35-350(1)(c).

Finally we find that claimant suffers a permanent impairment of 5 percent for disabling low back pain. Former OAR 436-35-320(1)(a) and Daniel M. Alire, 41 Van Natta 752 (1989).

The values for cervical range of motion, thoracolumbar range of motion, compression fracture, fusion, fracture of a posterior vertebral element, and for disabling pain are combined (not added) to obtain a single impairment value. Former OAR 436-35-360(11). Here the values of 4 percent, 2 percent, 2 percent, 2 percent, 3 percent, and 5 percent combine to a value of 16.7 percent (to the nearest 1/10th percent).

Having determined each value necessary to compute claimant's permanent disability under the "standards," we proceed to that calculation. When claimant's age value 0 is added to his education value 2, the sum is 2. When that value is multiplied by claimant's adaptability value 2.5, the product is 5. When that value is added to claimant's impairment value 16.7, the result is 21.7 percent unscheduled permanent partial disability. Former OAR 436-35-280(7). That disability figure is rounded to the next higher whole percentage. Former OAR 436-35-280(7). Claimant's permanent disability under the "standards" is, therefore, 22 percent.

Considering the record as a whole, and the impairment assessments of Drs. Pederson (25 percent) and Peterson (15-20 percent), claimant's youth, average education, and successful retraining, we do not find clear and convincing evidence that claimant's permanent disability is more than that provided for by application of the "standards." Because SAIF did not request a reduction of the Referee's award, we affirm.

ORDER

The Referee's order dated January 17, 1989 is affirmed.

In the Matter of the Compensation of
ROBERT M. FISK, Claimant
WCB Case No. 88-14400
ORDER ON REVIEW
Emmons, Kyle, et al., Claimant Attorneys
John B. Motley (Saif), Defense Attorney

Reviewed by Board Members Speer and Howell.

Claimant requests review of Referee Garaventa's order which: (1) increased claimant's unscheduled permanent disability award for his low back injury from 26 percent (83.2 degrees), as awarded by Determination Order, to 28.5 percent (91.2 degrees); (2) increased claimant's scheduled permanent disability award for loss of use or function of his right leg (knee) from 16 percent (24 degrees), as awarded by Determination Order, to 21 percent (31.5 degrees); and (3) increased claimant's scheduled permanent disability award for loss of use or function of his left foot (ankle) from 5 percent (6.75 degrees), as awarded by Determination Order, to 10 percent (13.5 degrees). On review, the issue is extent of scheduled and unscheduled permanent partial disability.

The Board affirms in part and modifies in part.

FINDINGS OF FACT

We adopt the the Referee's Findings of Fact with the following supplementation.

The physical capacity necessary to perform claimant's usual and customary work as a tow truck operator at the time of the accident is medium. (Ex.

26). Claimant's current physical capacity is restricted to light work and he is unable to work on rough ground, do any climbing or any repetitive lifting, squatting, bending or stooping. (Ex. 42). Claimant is working as a service advisor for a car servicing center. (Tr. 7). This position is not a sedentary position; it requires some sitting standing, and minimal lifting. (Tr. 7-9).

CONCLUSIONS OF LAW AND OPINION

Unscheduled Permanent Disability (low back condition)

The Referee increased claimant's unscheduled permanent disability award for his low back injury from 26 percent, as awarded by Determination Order, to 28.5 percent. Applying the appropriate set of standards, as described below, we find that claimant has met his burden of proving that he has sustained a permanent loss of earning capacity greater than that found by the Referee.

Claimant became medically stationary after January 1, 1988 (June 25, 1988), and his claim was closed after July 1, 1988 (July 25, 1988). Therefore, a subsequent determination by a referee or the Board of the claimant's permanent partial disability must be made pursuant to ORS 656.283(7) and 656.295(5), respectively. OAR 438-10-005 and Michelle Griffith, 40 Van Natta 2086 (1988).

In this case, the "standards" adopted effective July 1, 1988, former OAR 436-35-001 et seq, apply to the rating of claimant's permanent partial disability. Former OAR 436-35-270 through 436-35-440 apply to the rating of unscheduled permanent partial disabilities. Former OAR 436-35-270(1).

The hearing and Board review of the issue of permanent partial disability continues to be de novo on the hearing record. The underlying facts to which the "standards" are applied need only be established by a preponderance of the evidence. However, either party may establish that the record, as a whole, constitutes clear and convincing evidence that the degree of permanent partial disability suffered by the claimant is more or less than the entitlement indicated by the "standards." ORS 656.283(7) and 656.295(5).

The determination of permanent partial disability under the "standards" is made by determining the appropriate values assigned by the "standards" to the claimant's age, education, adaptability and impairment. Once established, the values for age and education are added and the sum is multiplied by the appropriate value for adaptability. The product of those two figures is then added to the appropriate value for impairment to yield the percentage of unscheduled permanent partial disability. Former OAR 436-35-280.

Age

The appropriate value for claimant's age of 42 years is +1. Former OAR 436-35-290(4).

Education

Formal education: The appropriate value for claimant's 12 years of formal education is 0. Former OAR 436-35-300(3)(a).

Skills

Former OAR 436-35-300(4) adopts by reference the "SVP" (specific vocational preparation time) values assigned to various occupations by the Dictionary of Occupational Titles (DOT), published by the U.S. Department of Labor. The highest SVP level demonstrated by a claimant during the ten years prior to the date of injury is used to determine a value for skills. Former OAR 436-35-300(4). Claimant's highest SVP during the ten years prior to the date of injury

was 3 as a tow truck driver (DOT #919.663-026). Therefore, the appropriate value for skills is +3. Former OAR 436-35-300(4).

Training

Claimant has no documented training. Therefore, the appropriate value for training is +1. Former OAR 436-35-300(5)(a).

Claimant's total education value is +4, the formal education value plus the skills value plus the value for training. Former OAR 436-35-300(6).

Adaptability

An adaptability value for a claimant who is unable to return to his or her usual and customary work [See former OAR 436-35-270(3)(a)] but who has returned to modified work is determined from a matrix of values at former OAR 436-35-310(3)(a). That matrix compares the physical capacity of the claimant's usual and customary work with the physical capacity required by the modified work. This is true even though claimant may have the physical capacity to do heavier work than is required by the modified employment. Physical capacities are not defined by the "standards" generally. We utilize those definitions contained in former OAR 436-35-310(4)(a)-(d).

Basing her calculations on a loss of physical capacity from heavy to light, the Referee found a 2.5 factor as an adaptability value. The Evaluation Division calculated that claimant has sustained a loss from medium to light. Based upon the record, we agree with the Evaluation Division's assessment that claimant's usual and customary work required the physical capacity to do medium work. Claimant's modified work requires a light physical capacity. Therefore, the appropriate adaptability value is 2. Former OAR 436-35-310(3)(a).

Impairment

In rating the total impairment of claimant's back, consideration is given to restrictions on claimant's ranges of motion as well as compression fractures of vertebrae. Additionally, impairment may be allotted for disabling pain. Former OAR 536-35-320(1)(a); and Daniel M. Alire, 41 Van Natta 752 (1989).

General Spinal Impairment

Claimant sustained "mild", 25 percent, compression fractures at L2 and L4. (Ex. 42). For a compression fracture in two or more vertebrae, the rating for each 25 percent compressed vertebra, 5 percent, is combined with the other to arrive at an impairment value of 9.75. Former OAR 436-35-350(1)(a) and (b).

Impairment of Spinal Range of Motion

Claimant has thoracolumbar flexion limited to 70 degrees and is entitled to an impairment value of 2 percent. Former OAR 436-35-360(6); (Ex. 42).

Claimant has thoracolumbar extension of 20 percent and is entitled to an impairment value of 1 percent. Former OAR 436-35-360(7); (Ex. 42).

Claimant is able to flex left and right in the thoracolumbar region, 25 degrees for an impairment value of 0 percent. Former OAR 436-35-360(8); (Ex. 42).

Claimant was able to rotate right or left in the thoracolumbar region 20 degrees for an impairment value of 2 percent each, or 4 percent. Former OAR 436-35-360(9); (Ex. 42).

The values for lost motion in claimant's spine are added (not combined) to obtain a single value. Former OAR 436-35-360(10). In this case, the sum of the impairment values for lost ranges of spinal motion is 7 percent.

Loss Of Use Due To Pain

Former OAR 436-35-320(1) allows for an award for impairment in unscheduled disability cases based on loss of use or function due to pain. The Referee awarded a value of 5 percent for the loss of use due to pain. We agree.

To obtain a total spinal impairment value, the impairment values for pain, lost motion and general spinal impairment are combined (not added) for a value of 20.26 percent. Former OAR 436-35-360(11).

Computation of unscheduled disability

Having determined each value necessary to compute claimant's permanent disability under the "standards," we proceed to that calculation. When claimant's age value +1 is added to his education value +4 the sum is 5. When that value is multiplied by claimant's adaptability value +2 the product is 10. When that value is added to claimant's impairment value of 20.26 percent, the result is 30.26 percent unscheduled permanent partial disability. Former OAR 436-35-280(7). This figure is rounded up to the next higher whole number. Former OAR 436-35-280(7). Claimant's unscheduled disability under the standards is 31 percent.

Scheduled Disability for Loss of Function of Right Knee (leg)

The Referee found that claimant was entitled to 21 percent scheduled permanent disability for loss of use or function of his right leg (knee). After our de novo review of the record and analysis of claimant's loss of use or function in his right knee, we find that claimant has not met his burden of proving that he has suffered a permanent loss of use or function greater than that found by the Referee.

Former OAR 436-35-010 through 436-35-260 apply to the rating of scheduled permanent partial disabilities. Former OAR 436-35-010(1).

Claimant is entitled to a value based upon his permanent loss of use of function in his right knee. The value given for claimant's lost range of motion in his right knee is based upon active degrees of motion. See Former OAR 436-35-010(3). To calculate a loss of motion one of two methods is provided for by the "standards." Former OAR 436-35-010(3). The "standards" rate loss of motion by comparing the active degrees of motion of the injured body member to the degrees of motion possible in the contralateral normal joint, or by comparing the active degrees of motion of the injured member to the ranges of motion established, as normal, by the American Medical Association. Id. In the instant case, we rate claimant's lost range of motion by comparing claimant's injured right knee to the ranges of motion established, as normal, by the American Medical Association.

Documented range of motion of claimant's right knee is, "full extension and flexion to 135 degrees." (Ex. 42-4). Therefore, claimant's impairment values are 5.5 percent for flexion and 0 percent for extension, for a total rating of 5.5 percent for loss of motion in his right knee. Former OAR 436-35-220(1), (2) and (4).

Claimant contends that he should be awarded an additional amount for instability of his right knee. Former OAR 436-35-230(3) provides a value for

joint instability if there is evidence of a joint opening. However, there is no evidence of a joint opening in this record.

Claimant had knee surgery and a "portion" of the lateral meniscus was removed. (Ex. 23). Former OAR 436-35-230(4)(c) provides ratings for a complete meniscectomy and states: "Proportionate losses will be allowed for less than a complete removal." 10 percent is the value given for a complete removal of a single lateral meniscus. The Referee apparently calculated the rating as if claimant had a complete meniscectomy and found a 10 percent loss of function due to the surgery. Considering the language of the rule as cited, we consider that 5 percent is appropriate for loss of function due to the surgery removing a portion of the lateral meniscus.

To find a total rating for impairment to claimant's right knee, the rating for decreased motion -- 5.5 percent -- is combined with the value for the surgery -- 5 percent -- for a total combined value of 10.225. Former OAR 436-35-230(4).

The Referee increased claimant's scheduled permanent disability as indicated by the "standards" based upon swelling in the knee which causes pain and limits claimant's ability to stand, walk, or maintain his knee in one position for an extended period of time. Former OAR 436-35-020(2)(a) provides that pain can result in loss of use or function. When it does, it is rated based on the loss of use or function which results and no additional value is allowed for pain alone. In Daniel M. Alire, 41 Van Natta 752 (1989), we held that, inasmuch as the standards do not provide for a value range for impairment attributable to disabling pain, the Board on de novo review can consider the evidence and award the claimant a value that adequately compensates him for his loss of use or function attributable to disabling pain.

In this case, the record establishes that claimant has a loss of use or function attributable to disabling pain. BBV Medical Services reports that x-rays indicate that claimant's right knee is showing signs of degenerative joint disease (arthritis) and swelling. (Ex. 42-5). Claimant testifies that his right knee painfully catches and gives-way occasionally. (Tr. 23, 24). We agree with the Referee's assignment of 5 percent to the loss of function due to disabling pain.

Having determined each value necessary to compute claimant's scheduled permanent right knee disability under the "standards," we proceed to that calculation. When the total value given pursuant to the "standards" for lost range of motion and surgeries (10.225 percent) is combined with the value for disabling pain (5 percent) the result is 14.71 percent scheduled permanent disability. Former OAR 436-35-010(6). This figure is rounded up to the next higher whole number. Former OAR 436-35-010(6). Claimant's disability under the standards is 15 percent. However, because the SAIF Corporation does not request a reduction, we affirm the Referee's award of 21 percent.

Scheduled Disability for Loss of Function of Left Ankle (Foot)

The Referee awarded claimant a total value of 10 percent scheduled permanent disability for loss of the left foot. Claimant argues that an additional 20 percent should be applied for instability in the left ankle. We agree with claimant that that the record establishes that there is "mild medial joint space widening" in his left ankle and that this widening is recognized under the standards as causing rateable ankle instability. Former OAR 436-35-200(2); (Ex. 42-5).

Claimant suffers from ankle joint instability with a documented "mild medial joint space widening." "Mild" joint space opening equals a 10 percent loss of function. Former OAR 436-35-200(2).

Dorsiflexion on the left ankle is 7 degrees which entitles claimant to a 4.9 percent loss. Former OAR 436-35-190(6). (Ex. 42-5). Plantar flexion is 45 degrees bilaterally for a 0 percent loss. Former OAR 436-35-190(8). He has 30 degrees inversion for a 0 percent loss. Former OAR 436-35-190(2). He has eversion of 10 degrees for a 2 percent loss. Former OAR 436-35-190(4). These figures are added and the sum is 6.9. Former OAR 436-35-190(12).

The loss of range of motion sum is combined with the joint instability value for a total of 16.21 percent loss of function of the left ankle. Former OAR 436-35-190(12).

The Referee increased claimant's scheduled permanent disability for his left ankle by 5 percent based upon daily swelling which causes pain and results in loss of function in the form of decreased endurance. The ankle swells up just about every day, causing increased pain. (Tr. 21). We find the record supports a finding of loss of use or function due to disabling pain totalling 5 percent.

Having determined each value necessary to compute claimant's permanent scheduled left ankle disability under the "standards," we proceed to the calculation for a total figure. When the total value given pursuant to the "standards" for lost motion and ankle joint instability (16.21 percent) is combined with the value for disabling pain (5 percent) the result is 20.4 percent scheduled permanent disability for loss of use or function of claimant's left ankle. Former OAR 436-35-010(6). This figure is rounded up to the next higher whole percentage. Former OAR 436-35-010(6). Claimant's disability under the standards is 21 percent.

Disability Outside of the Standards

Claimant argues that the record constitutes clear and convincing evidence that his disabilities are greater than indicated by application of the "standards."

"Clear and convincing evidence" means that the truth of the facts is highly probable. The evidence must be free from confusion, fully intelligible and distinct. Riley Hill General Contractor, Inc. v. Tandy Corp., 303 Or 390, 407 (1987). In examining for clear and convincing evidence, the record is viewed as a whole. Thomas L. Swanger, 42 Van Natta 887 (1990).

On this record, we do not find clear and convincing evidence that claimant's disabilities are greater than 31 percent for loss of earning capacity due to his back condition, 21 percent for loss of use or function of his right leg (knee), and 21 percent for loss of use or function of his left ankle.

ORDER

The Referee's order, dated December 8, 1988, is affirmed in part and modified in part. In lieu of the Referee's increased award and in addition to the Determination Order award of 26 percent (83.2 degrees) unscheduled permanent disability, claimant is awarded 5 percent (16 degrees), giving him a total of 31 percent (99.2 degrees) unscheduled permanent disability for his low back condition. The Referee's award of 21 percent (31.5 degrees) for loss of use or function of claimant's right leg (knee) is affirmed. In lieu of the Referee's increased award and in addition to the Determination Order award of 5 percent

(6.75 degrees) scheduled permanent left foot (ankle) disability, claimant is awarded 16 percent (21.6 degrees), giving him a total award to date of 21 percent (28.35 degrees) scheduled permanent disability for loss of use or function of his left foot (ankle). Claimant's attorney is awarded 25 percent of the increased compensation created by this order, payable directly to claimant's attorney. However, the total attorney fees awarded by the Referee and Board orders shall not exceed $3,800.

May 31, 1990 Cite as 42 Van Natta 1170 (1990)

In the Matter of the Compensation of
MAGDALENA I. FLORES, Claimant
WCB Case No. 88-07025
ORDER ON REVIEW
Rasmussen & Henry, Claimant Attorneys
Employers Defense Counsel, Defense Attorney

Reviewed by Board Members Gerner and Cushing.

Claimant requests review of those portions of Referee Michael V. Johnson's order which: (1) upheld the insurer's denial of claimant's occupational disease claim for a "mental disorder" and resulting hypertension; and (2) did not award claimant's attorney an assessed fee for an alleged unreasonable denial. On review, the issues are compensability, penalties and attorney fees. We affirm.

FINDINGS OF FACT

The Board adopts the Referee's Findings of Fact and Ultimate Findings of Fact as our own.

CONCLUSIONS OF LAW AND OPINION

Compensability of Mental Disorder

The Board adopts the Referee's Conclusions of Law, as set forth in the "Opinion" and "Conclusions of Law" portions of the Order, with respect to the compensability of claimant's mental disorder.

Compensability of Hypertensive Condition

The Referee analyzed claimant's hypertensive condition under ORS 656.802(1)(b) and concluded that it was not compensable as claimant failed to meet the requisites of ORS 656.802(2)(b). While we agree that claimant's hypertensive condition is not compensable, we do so for different reasons.

In Ronald V. Dickson, 42 Van Natta 1102 (1990), we recently held that, when the claimant suffers from physical conditions which are the direct result of a mental disorder, such physical conditions will not be compensable unless the underlying "mental disorder" is found compensable.

Here, claimant suffers from a diagnosable mental disorder; i.e., major depressive episode, severe, reactive. (Ex. 8-2). Further, claimant's hypertensive condition was caused by that episode. (Ex. 5-1). Therefore, we find that claimant's hypertensive condition is a direct result of claimant's mental disorder.

However, we have found that claimant's mental disorder is not compensable. Therefore, we conclude that claimant's hypertensive condition also is not compensable.

Interim Compensation

The Board adopts the Referee's Conclusions of Law, as set forth in the "Opinion" and "Conclusions of Law" portions of the order, with respect to the issue of interim compensation.

Penalties and Attorney Fees

The Referee failed to address claimant's contention that the insurer's denial of her occupational disease claim was unreasonable. We do so now.

Where the insurer has a legitimate doubt as to its liability, and issues a denial based on that doubt, its denial is not unreasonable. Brown v. Argonaut Insurance Co., 93 Or App 588 (1988).

Here, we find that claimant has suffered from a preexisting hypertension condition for approximately ten years. Based on this evidence, we find that the insurer would have had a legitimate doubt as to its liability. Accordingly, we do not consider the denial to be unreasonable and do not assess penalties and associated attorney fees.

ORDER

The Referee's order dated December 28, 1988, is affirmed. A client-paid fee, not to exceed $1,001, payable by the insurer to its counsel, is approved.

May 31, 1990 Cite as 42 Van Natta 1171 (1990)

In the Matter of the Compensation of
RANDOLPH P. GAUL, Claimant
WCB Case No. 88-17849
ORDER ON REVIEW
Peter O. Hansen, Claimant Attorney
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Cushing and Myers.

The self-insured employer requests review of those portions of Referee Emerson's order which: (1) admitted a medical report offered by claimant; (2) denied the employer's request for a continuance of the hearing to rebut the admitted medical report; and (3) set aside the employer's denial of claimant's medical services claim. On review, the issues are compensability and the Referee's evidentiary rulings. We affirm.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact," with the following supplementation.

During the January 13, 1987 hearing, claimant's counsel received a medical report from Dr. Clifford, dated January 12, 1987. The report was admitted into evidence as Exhibit 22. The Referee offered to keep the record open to permit the employer to cross-examine Dr. Clifford. The employer declined the offer and requested a continuance, so that it could generate additional evidence in response to Exhibit 22. (Tr. 42). The Referee denied this request.

CONCLUSIONS OF LAW AND OPINION

Evidentiary Ruling

OAR 438-07-018(1) requires a carrier to submit its exhibits 20 days prior to hearing. However, nothing in the rules precludes admission of other documents provided they have been timely disclosed.

OAR 438-07-015 requires the parties to disclose claims documents within 15 days of the initial request and to disclose subsequently obtained documents within 7 days of receipt. OAR 438-07-018(4) vests the referee with discretion to exclude documents not disclosed within the time prescribed by OAR 438-07-015 if there is prejudice to the other party. See also OAR 438-07-015(5). The rule does not, however, vest the Referee with discretion to exclude timely-disclosed documents because the documents could have been obtained at an earlier time.

Where, as here, a medical report is produced within seven days of receipt as required by the rule, but the other party is put at a disadvantage by the delay in obtaining the report, the referee may continue the hearing to allow post-hearing cross examination and/or rebuttal. The Referee may not simply exclude the report. See OAR 438-07-015(6).

Here, since the medical report was produced within seven days of receipt, the Referee appropriately admitted the report into evidence. The employer asked for a continuance in order to generate new evidence to rebut the admitted report. However, the Referee would only permit a continuance in order to cross-examine the author of the report.

The Referee has the discretion to grant a continuance during the hearing. See former OAR 438-06-091. Here, the Referee did not abuse his discretion by not granting the employer's request for a continuance. He offered to keep the record open to permit the employer an opportunity to cross-examine Dr. Clifford, who was the author of Exhibit 22 as well as prior reports already in the record. The employer declined. Accordingly, we find that Exhibit 22 was appropriately admitted into evidence, and that the Referee did not abuse his discretion by refusing to grant the employer's request for a continuance.

Medical Services

We adopt the Referee's reasoning associated with this issue.

ORDER

The Referee's order dated January 30, 1989 is affirmed. Claimant's attorney is awarded $1,200 for services on Board review, to be paid by the self-insured employer. The Board approves a client-paid fee, not to exceed $3,137.50, payable from the self-insured employer to its counsel.

May 31, 1990 Cite as 42 Van Natta 1172 (1990)

In the Matter of the Compensation of
RAMONA K. HALFMOON, Claimant
WCB Case Nos. 88-07074, 88-12880 & 88-12881
ORDER ON REVIEW
Reynolds & Smith, Claimant Attorneys
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Gerner and Cushing.

Claimant requests review of Referee Knapp's order which upheld the self-insured employer's denial of claimant's occupational disease claim for bilateral carpal tunnel syndrome. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

Claimant has worked for the employer since July 1986. She first filed a claim for hand and wrist symptoms in June 1987. (Ex. 1). The employer's denial

of the claim was upheld by an earlier referee and the Board. Ramona K. Halfmoon, 40 Van Natta 447 (1988).

Claimant returned to her same job following carpal tunnel surgery in January 1988. On March 21, 1988, claimant filed the present workers' compensation claim. (Ex. 26). On July 6, 1988, the employer denied the claim for bilateral carpal tunnel syndrome. (Ex. 40).

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant had not sustained a compensable carpal tunnel condition, because she had failed to meet her burden of proof. We agree.

Because claimant's last work exposure which could have contributed to her condition arose in 1988, claimant must prove that her work exposure was a material cause of her condition. ORS 656.802(1)(c); Donna E. Aschbacher, 41 Van Natta 1242 (1989). Carole J. Damm, 42 Van Natta 225 (1990).

Claimant's carpal tunnel syndrome symptoms were first litigated in June 1987. Consequently, similar symptoms predated the March 1988 claim for the same condition. Under such circumstances, we consider the causation of claimant's carpal tunnel syndrome condition to be a complex medical question. Thus, while her testimony is probative, the resolution of this case turns on medical evidence. Kassahn v. Publishers Paper Co., 76 Or App 259, 263 (1986). Claimant has failed to meet her burden.

Turning to the medical evidence, Dr. Thiel, orthopedist, concluded that claimant's present carpal tunnel syndrome is related to her work. (Ex. 37-2). However, Thiel examined claimant only after the second carpal tunnel syndrome claim had been filed. Moreover, he was not provided a complete medical history. Specifically, his reports do not suggest that he knew that claimant's pre-1988 employment had been held not to be a contributing factor in her underlying condition. He also did not explain how claimant's condition was related to work subsequent to January 1988. Additionally, Dr. Thiel noted that claimant's position required "repeated motions of flexion of wrist and fingers." We have previously found this description to be inconsistent with the nature of claimant's work. Halfmoon, supra. (Ex. 37-2; 25A-1). Finally, Dr. Thiel never had an opportunity to review a nerve conduction study he had ordered or explain how it affected his opinion. Since Thiel based his opinion on an inaccurate and incomplete history, we find his opinion unpersuasive. See Miller v. Granite Construction Company, 28 Or App 473 (1976).

Dr. Carpenter, orthopedic surgeon, conclusively diagnosed that claimant suffered from tendinitis. (Ex. 29). He provided no analysis regarding the causal connection between claimant's work activities and the tendinitis condition. We find his opinion unpersuasive; it is merely a conclusion that is not supported by any explanation. See Kelso v. City of Salem, 87 Or App 630 (1987); Van Woesik v. Pacific Coca-Cola Co. 85 Or App 9 (1987).

On the other hand, Dr. Nathan, hand specialist, had an opportunity to examine claimant before and after litigation of claimant's first claim for her bilateral carpal tunnel condition. Under such circumstances, he is in a better position to offer an opinion as to her current condition. See Kienow's Food Stores v. Lyster, 79 Or App 416 (1986). Moreover, following this initial adjudication, Nathan's opinion was considered to be persuasive concerning the lack of causal connection between claimant's work activities and her condition. Regarding the present claim, Nathan opined that claimant's carpal tunnel condition was a continuation of the original disease process. (Ex. 44-4, 21). We are persuaded by this well-reasoned and thorough opinion. See Sommers v. SAIF, 77 Or App 259 (1986).

Accordingly, we conclude that claimant has not proven that her work exposure was a material cause of her condition. See ORS 656.802(1)(c).

ORDER

The Referee's order dated November 8, 1988 is affirmed. A client-paid fee, not to exceed $1,743.75, payable from the employer to its counsel, is approved.

May 31, 1990 Cite as 42 Van Natta 1174 (1990)

In the Matter of the Compensation of
RICKEY J. JACKSON, Claimant
WCB Case No. 88-16192
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Robert Jackson (Saif), Defense Attorney

Reviewed by Board Members Perry, Howell and Speer.

The SAIF Corporation requests review of that portion of Referee Seymour's order which disapproved SAIF's reduction of claimant's permanent total disability benefits and found claimant entitled to additional permanent total disability benefits for his spouse to whom he was not married at the time of his injury, and for his third child who was not then born. On review, the issue is the amount of permanent total disability benefits to which claimant is entitled. We reverse.

FINDINGS OF FACT

Claimant sustained a compensable disabling injury on October 18, 1977. At the time of the injury, he had two dependent children but was not married.

Claimant was married on December 11, 1978. His third child was born on April 29, 1979.

By Determination Order dated August 5, 1987, claimant was awarded permanent total disability benefits beginning June 13, 1987.

CONCLUSIONS OF LAW AND OPINION

The Referee interpreted ORS 656.206(2) to mean that the amount of permanent total disability benefits is determined on the date that the permanent total disability award begins. In this case that date was June 13, 1987. We disagree.

The Court of Appeals in SAIF v. Brannon, 62 Or App 768 (1983), stated that "[t]he date of injury is the date on which a worker's status conclusively determines his rate of compensation." Id. at 771 (emphasis supplied). Accordingly, because claimant was not married on the date of his injury, and because his third child had not yet been born, we conclude that claimant is not entitled to permanent total disability benefits for his spouse and third child. See Donald L. Waldron, 38 Van Natta 461 (1986). Claimant's argument, that Brannon stands only for the proposition that the law in effect on the date of injury controls, is contrary to both the language of that opinion and the holding as to the amount of benefits due.

ORDER

The Referee's order dated January 30, 1989 is reversed. Claimant is not entitled to permanent total disability benefits for his spouse or his child born after the date of his compensable injury.

Board Member Speer, dissenting.

One of the objectives of the Workers' Compensation Law is declared to be as follows:

> "To provide . . . fair, adequate and reasonable income benefits to injured workers and their dependents . . . ."
> (emphasis added). ORS 656.012(2)(a).

The result in this case does not support that objective, I therefore dissent. I agree with claimant's position that the cases cited in support of the majority opinion have wrongly construed the law and should be disavowed.

In the Matter of the Compensation of
GREG A. KENNEDY, Claimant
WCB Case No. 88-15855
ORDER ON REVIEW
Emmons, et al., Claimant Attorneys
Gary Wallmark (Saif), Defense Attorney

Reviewed by Board Members Crider and Brittingham.

Claimant requests review of Referee Foster's order that: (1) upheld the SAIF Corporation's denial of claimant's low back injury claim; and (2) declined to assess penalties and attorney fees for an alleged unreasonable denial. On review, the issues are compensability, and penalties and attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

In January 1988 claimant started working for SAIF's insured as a car buffer and cleaner. On February 19, 1988, claimant injured his low back in the course of his employment by moving a diesel engine across the shop room floor. While trying to lift the front of the motor so that a floor jack could be slid underneath it, claimant felt a pop in his back and a burning sensation in his lower back.

Claimant's supervisor, who is also the owner's son, was aware that claimant and another employee had moved the engine. Just after moving the engine, the supervisor asked claimant whether he had been hurt. Claimant responded that he was exhausted and in some pain but would probably be okay. Although in pain, claimant was able to complete his shift that day.

The next day claimant went to a hospital emergency room due to the back pain. Shortly thereafter, claimant was seen by Dr. Yamaguchi because of severe low back pain with radiation down the back of the left leg. Yamaguchi noted that claimant had complained of intermittent severe backache for the past three years and surmised that he may have injured his back while working in the construction industry. Yamaguchi prescribed medications and briefly released claimant from work.

Claimant continued to suffer back pain following his return to work, and the pain continued throughout the remainder of his employment. He resigned his employment in late May or early June 1988. He thereafter filed the instant claim. SAIF denied the claim, contending that claimant's file did not establish that his low back condition was related to his employment for SAIF's insured.

Claimant has not had any other injuries or accidents since the February 1988 injury.

FINDINGS OF ULTIMATE FACT

The February 19, 1988 work incident is a material contributing cause of claimant's low back disability and need for medical treatment.

SAIF's denial of the claim was not unreasonable.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant's testimony was verified by his girlfriend and a fellow worker, and denied by the owner, his son, and the company secretary. The Referee also found claimant's delay in filing his claim made the matter highly questionable. He did not believe that claimant was intentionally misleading, but rather that he was guilty of some rationalization. Consequently, the Referee found that claimant had failed to meet his burden of proving a compensable industrial injury. We disagree.

To establish a compensable injury, claimant must prove that a work event was a material contributing cause of his low back disability or need for medical treatment. See ORS 656.005(7); Harris v. Albertson's Inc., 65 Or App 254 (1983).

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, 363 (1982). However, when the Referee's conclusion is based not on demeanor, but on an objective evaluation of the substance of a witness's testimony, the Referee has no greater advantage in determining credibility than we do. Coastal Farm Supply v. Hultberg, 84 Or App 282, 285 (1987); Davies v. Hanel Lumber Company, 67 Or App 35, 38 (1984).

Following our de novo review of the record, we find claimant's testimony to be credible. His testimony regarding how the injury occurred and his supervisor's inquiry as to whether he was hurt was corroborated by the employee who helped him move the engine. It was also corroborated by his girlfriend, who testified regarding claimant's comments about the incident when he got home from work on that date. Finally, we note that there is no evidence that the injury did not happen the way that claimant said it did.

The medical evidence supports claimant's account: both the independent medical examiners, Western Medical Consultants, and Dr. Grobman, D.C., found claimant's condition to be consistent with the type of accident he described.

Following the injury, when asked by his supervisor how he was doing, claimant minimized the extent of the injury; he acknowledged some discomfort but said that he would probably be okay. We do not find this dispositive of the issue of whether claimant sustained a compensable injury. Given claimant's explanation that he was afraid of losing his job due to the injury, we do not find it surprising that claimant tried to discount the incident. This fear of becoming unemployed also explains claimant's delay in filing his claim.

Accordingly, we conclude that claimant has established by a preponderance of the evidence the compensability of his injury.

Penalties and attorney fees may be assessed when a carrier "unreasonably delays or unreasonably refuses to pay compensation." ORS 656.262(10); 656.382(1). The reasonableness of a carrier's denial of compensation must be gauged based upon the information available to the carrier at the time of its denial. Brown v. Argonaut Insurance Company, 93 Or App 588 (1988); Price v. SAIF, 73 Or App 123, 126 n. 3 (1985).

Based on the information in Dr. Yamaguchi's chart notes, suggesting a history of intermittent backache over a three-year period preceding the injury, and considering the late filing of the claim, we are persuaded that SAIF had a legitimate doubt concerning its responsibility for the claim. Thus, we do not find SAIF's denial to have been unreasonable. Therefore no penalties and attorney fees are warranted.

ORDER

The Referee's order dated January 13, 1989 is reversed in part. The 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 review, claimant's attorney is awarded an assessed fee of $1,600, to be paid by the SAIF Corporation. The remainder of the order is affirmed.

In the Matter of the Compensation of
PAUL R. LEWIS, Claimant
WCB Case Nos. 88-19061 & 88-19062
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Bullard, et al., Defense Attorneys

Reviewed by Board Members Cushing and Gerner.

The insurer requests review of those portions of Referee Myzak's order that: (1) awarded 17 percent (25.5 degrees) scheduled permanent disability for the loss of use or function of claimant's left knee (leg), whereas a Notice of Closure had awarded no permanent disability; and (2) assessed a penalty and a penalty-related fee for the insurer's alleged unreasonable claim closure. On review, the issue is extent of scheduled permanent disability and penalties and attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

Claimant compensably injured his left knee in February 1986. After one week of time loss, claimant returned to modified work, restricted to working on flat ground. Claimant continued to complain of left knee pain until he retired in June 1986. His claim was closed by a September 24, 1986 Determination Order which awarded no permanent disability.

Claimant continued to experience left knee pain through March 9, 1988, at which time he sought treatment from Dr. Nagel, orthopedic surgeon. The following day, claimant underwent arthroscopic repair of his left knee. His claim was reopened. His condition became medically stationary on June 28, 1988.

In September 1988, Nagel "checked the box" on a follow-up medical report indicating that claimant's impairment was permanent. However, Nagel added, next to the box, that claimant would suffer "occasional medial joint discomfort." On September 23, 1988, the insurer closed the claim with a Notice of Closure and awarded no permanent disability. Claimant requested a hearing.

Since the surgery, claimant has returned to some part-time work similar to his prior full-time work for the employer.

Claimant's left knee condition has not permanently worsened since his claim was initially closed in September 1986.

CONCLUSIONS OF LAW AND OPINION

Extent of Permanent Partial Disability

The Referee evaluated the extent of claimant's permanent disability under the standards and concluded that he suffered 17 percent scheduled permanent disability as a result of his compensable 1986 knee injury. The insurer contends that claimant has not proven a worsening of his compensable condition, thereby eliminating the need to evaluate the extent of scheduled permanent disability. We agree.

In order for claimant to qualify for a permanent disability award upon closure of his aggravation claim, he must show that he suffered a permanent worsening of his left knee condition, since the claim was closed by Determination Order in September 1986. Stepp v. SAIF, 304 Or 375 (1987). Claimant has failed to prove such a worsening.

Claimant's testimony at hearing, in addition to the medical records, establishes that his knee condition has improved as a result of his 1988 surgery. This same evidence establishes that claimant's condition has not worsened since the initial knee injury. In fact, claimant's condition has actually improved since the initial injury. (Ex 8-1, 8-5, Tr. 5 and 11).

Therefore, we conclude that claimant has failed to prove a permanent worsening of his 1986 compensable knee injury and, therefore, is not entitled to a rating of permanent partial disability.

Alleged Unreasonable Claim Closure - Penalties and Attorney Fees

The Referee found that there was evidence that claimant suffered permanent impairment. As a result, the Referee concluded that the insurer's issuance of the September 1988 Notice of Closure was unreasonable and awarded claimant's attorney a fee equal to 25 percent of the scheduled permanent disability awarded by the order.

The insurer contends that such a Notice of Closure was reasonable, arguing that there is no evidence that such impairment exists. Claimant, on the other hand, argues that because there was evidence of permanent impairment, self-closure by the insurer was improper. The issue, however, is not whether there was evidence of permanent impairment. Rather, the issue is whether the insurer complied with the appropriate closure statute.

ORS 656.268(3)(a) provides that,

> "When the worker's condition has become medically stationary and the worker has returned to work, the claim may be closed by the insurer . . ., without the issuance of a determination order by the Department of Insurance and Finance."

Here, claimant's condition became medically stationary in June 1988. Therefore, the remaining issue is whether claimant had returned to work.

Claimant retired in 1986 from his regular truck driving employment. However, after the surgery, he returned to occasional part-time work similar to what he performed full-time for the employer after the initial knee injury.

OAR 436-30-005(9) provides that,

> "'Return to Work' means that a worker has been hired in a permanent job (defined as permanent employment in OAR 436-110-005(6)) and has demonstrated the physical capacity to perform that job."

Because we find that claimant has returned to "occasional" part-time work, we conclude that he has not been hired in a permanent job. Therefore, the insurer's issuance of the Notice of Closure was improper, as claimant had not "returned to work." Consequently, we conclude that the insurer's self-closure under ORS 656.268(3)(a) was improper and unreasonable.

The Referee assessed a penalty equal to 25 percent of the scheduled permanent disability award. However, we have already found that claimant is not entitled to a permanent disability award. Therefore, there are no "amounts then due" upon which to base a penalty. Further, because there has been no unreasonable resistance to the payment of compensation, we do not assess an attorney fee. Lloyd L. Cripe, 41 Van Natta 1774 (1989).

ORDER

The Referee's order dated February 22, 1989 is affirmed in part and reversed in part. That portion of the Referee's order which awarded 17 percent (25.5 degrees) scheduled permanent disability is reversed. The Notice of Closure is reinstated and affirmed. That portion of the order which assessed a penalty and a penalty-related attorney fee of $300 for unreasonable claim closure is reversed. The remainder of the order is affirmed. A client-paid fee, not to exceed $1,463, payable by the insurer to its counsel, is approved.

May 31, 1990 Cite as 42 Van Natta 1179 (1990)

In the Matter of the Compensation of
HAROLD L. McALLISTER, Claimant
WCB Case No. 88-16720
ORDER ON REVIEW
Phil H. Ringle, Jr., Claimant Attorney
Jerome Larkin (Saif), Defense Attorney

Review by Board Members Howell and Speer.

The SAIF Corporation requests review of Referee Galton's order which: (1) awarded 16 percent (51.2 degrees) unscheduled permanent partial disability in addition to 23 percent (73.6 degrees) awarded by Determination Order; (2) awarded temporary total disability compensation (TTD) for the period September 3, 1987 through October 1, 1987 in addition to that awarded by Determination Order; and (3) authorized SAIF to deduct $1,349.83 in overpaid temporary disability compensation from the increased award of permanent disability compensation. On review the issues are extent of permanent disability, temporary dis

ability, and overpayment offset. We affirm in part, reverse in part and vacate in part.

FINDINGS OF FACT

We adopt the Referee's "FINDINGS OF FACT" with the following modification and supplementation:

Claimant has no documented training. During the ten years prior to his compensable injury on May 7, 1986, claimant worked as a metal fabricator, prototype woodstove builder, dairy route salesman and retail salesman. When claimant became medically stationary in mid-1988, his treating orthopedic surgeon, Dr. Hoppert, considered his permanent injury-related impairment to be mild. Claimant's injured right shoulder was then slightly tender over the surgical site. He could abduct his injured shoulder to 160 degrees, actively flex the shoulder to 180 degrees, extend to 80 degrees, internally rotate 30 degrees and externally rotate to 90 degrees, all without pain (Dr. Hoppert's chart note of June 28, 1988 appears to have reversed external and internal rotation findings). No crepitation, atrophy, or neurological abnormalities were present. Claimant was considered unable to do overhead work or lift over 50 pounds repetitively. Claimant was considered able to repetitively lift up to 25 pounds and perform medium work.

A September 14, 1988 Determination Order last closed claimant's claim. He was awarded 23 percent unscheduled permanent partial disability, TTD from October 2, 1987 through March 16, 1988, and temporary partial disability from March 17, 1988 through July 11, 1988.

Since last becoming medically stationary claimant has been unable to perform his usual and customary work and he has not returned to other work. He could, at the time of hearing, lift 50 pounds close to his body but less than 20 to 25 pounds with his right arm extended to the side or overhead. He could not lift 50 pounds repetitively. Claimant is able to return to medium or lighter work which involves no overhead use of his right arm.

CONCLUSIONS OF LAW

Permanent Partial Disability

If a claimant became medically stationary after January 1, 1988, and his or her claim was closed on or after July 1, 1988, a subsequent determination by a referee or the Board of the claimant's permanent partial disability must be made pursuant to ORS 656.283(7) and 656.295(5), respectively. OAR 438-10-005 and Michelle Griffith, 40 Van Natta 2086 (1988).

For purposes of determining injury-related permanent partial disability, ORS 656.283(7) and 656.295(5) require application of the standards for the evaluation of disabilities adopted by the director pursuant to ORS 656.726(3)(f)(a). Those "standards" in effect on the date of the Determination Order from which the hearing was requested control the evaluation of permanent partial disability. OAR 438-10-010.

The hearing and Board review of the issue of permanent partial disability continues to be de novo on the hearing record. The underlying facts to which the "standards" are applied need only be established by a preponderance of the evidence. However, either party may establish that the record, as a whole, constitutes clear and convincing evidence that the degree of permanent partial disability suffered by the claimant is more or less than the entitlement indicated by the "standards." ORS 656.283(7) and 656.295(5).

In this case, the "standards" adopted effective July 1, 1988, (former OAR 436-35-001 et seq), as amended by temporary rules effective August 19, 1988, apply to the rating of claimant's permanent partial disability. Former OAR 436-35-270 through 436-35-440 apply to the rating of unscheduled permanent partial disabilities. Former OAR 436-35-270(1).

The determination of permanent partial disability under the "standards" is made by determining the appropriate values assigned by the "standards" to the claimant's age, education, adaptability and impairment. Once established, the values for age and education are added and the sum is multiplied by the appropriate value for adaptability. The product of those two figures is then added to the appropriate value for impairment to yield the percentage of unscheduled permanent partial disability. Former OAR 436-35-280.

The appropriate value for claimant's age of 42 years is 1. Former OAR 436-35-290(3).

The appropriate value for claimant's education, consisting of a GED, is 0. Former OAR 436-35-300(3)(a).

Former OAR 436-35-300(4) adopts by reference the "SVP" (specific vocational preparation time) values assigned to various occupations by the Dictionary of Occupational Titles (DOT), published by the U.S. Department of Labor. The highest SVP level demonstrated by a claimant during the ten years prior to the date of injury is used to determine a value for skills. Former OAR 436-35-300(4). Claimant's highest SVP during the ten years prior to the date of injury was 5 as a metal fabricator (DOT # 809.381-010). Therefore, the appropriate value for skills is 2. Former OAR 436-35-300(4).

Claimant has no documented training. Therefore, the appropriate value for training is 1. Former OAR 436-35-300(5). Claimant's total education value is 3, the formal education value plus the skills value plus the value for training. Former OAR 436-35-300(6).

An adaptability value for a claimant who is unable to return to his or her usual and customary work [See former OAR 436-35-270(3)(a)] and who has not returned to modified work is determined by the claimant's residual physical capacity, without regard to that claimant's physical capacity prior to the injury. Former OAR 436-35-310(4).

Claimant is unable to return to his usual and customary work and has not returned to, or been offered, regular, modified work since he became medically stationary (when permanent disability is rated). Claimant's physical capacity falls within the medium category according to lifting capacity based both upon his treating physician's assessment and claimant's credible testimony. Thus, the appropriate adaptability value is 1. Former OAR 436-35-310(4)(b).

Claimant has normal right shoulder flexion, extension, abduction, and external rotation. Claimant has reduced internal rotation (30 degrees retained) for which he is entitled to a 1 percent impairment value. Former OAR 436-35-330(9) (Temp.).

Additionally, claimant has reduced right shoulder strength from physical damage to the shoulder. However, Dr. Hoppert provided no percentage loss of strength as is required for the determination of an impairment value under former OAR 436-35-335(19) (Temp.). We cannot, therefore, value claimant's loss of strength.

Claimant has had a right distal clavicle resection on two occasions. The same surgery was performed at the same site with no evidence that the second surgery resulted in any greater residual impairment than a single such surgery. Thus, the presumed residual impairment value provided for by the "standards" is awarded once only. Claimant is entitled to a 5 percent impairment value for clavicle resection. Former OAR 436-35-335(13).

The only other impairment for which the applicable "standards" assign a value is claimant's disabling pain. Former OAR 436-35-320(1)(a) and Daniel M. Alire, 41 Van Natta 752 (1989). That pain limits claimant's ability to use his shoulder to push, pull and work overhead. Those limitations are especially disabling for repetitive activity. Those disabilities are not taken into account by the lifting limits incorporated into the adaptability values at former OAR 436-35-310(4). We value claimant's disabling pain at 10 percent of the whole person, based upon his credible testimony.

Claimant's impairment values for range of motion, surgery and disabling pain are combined (not added) for a total impairment value of 15.36 percent.

Having determined each value necessary to compute claimant's permanent disability under the "standards," we proceed to that calculation. When claimant's age value 1 is added to his education value 3, the sum is 4. When that value is multiplied by claimant's adaptability value 1, the product is 4. When that value is added to claimant's impairment value 15.36, the result is 19.36 percent unscheduled permanent partial disability. Former OAR 436-35-280(7). That disability figure is rounded to the next higher whole percentage. Former OAR 436-35-280(7). Claimant's permanent disability under the "standards" is, therefore, 20 percent.

We find that the permanent disability value obtained by application of the appropriate "standards" is not clearly and convincingly more or less than claimant's actual disability. In that regard we note that the uncontradicted medical evidence is that claimant's permanent injury-related impairment is mild. That evidence, with claimant's testimony regarding impairment as well as his age, education, work experience and need to adapt to medium or lighter work do not clearly and convincingly establish a permanent disability which is less than or greater than 20 percent.

Because SAIF did not request a reduction of the award of permanent disability made by the Determination Order, we decline to reduce that award.

Overpayment Offset

SAIF requested authorization to offset overpaid temporary disability compensation paid for the periods prior to October 2, 1987, and after July 11, 1988, against additional permanent disability compensation. Claimant did not request an award of additional temporary disability compensation.

The Referee found that claimant was substantively entitled to TTD prior to October 2, 1987 and, thus, that compensation paid for that period did not constitute an overpayment. SAIF's request to offset that compensation was, therefore, denied. We agree and affirm the Referee's holding in that regard. However, the Referee, without being requested to do so, modified the Determination Order and awarded claimant additional TTD. Because neither party raised that issue we vacate the Referee's award.

We adopt that portion of the Referee's order authorizing SAIF to offset overpaid temporary disability paid for the period after July 11, 1988.

ORDER

That portion of the Referee's December 14, 1988 order which awarded additional permanent disability compensation is reversed. That portion of the order which awarded additional temporary disability compensation is vacated. The Determination Order award of temporary disability and 23 percent (73.6 degrees) unscheduled permanent disability is reinstated. The remainder of the order is affirmed.

May 31, 1990 Cite as 42 Van Natta 1183 (1990)

In the Matter of the Compensation of
ANTON V. MORTENSEN, Claimant
WCB Case No. 87-05699
ORDER ON REVIEW
Garry L. Kahn, Claimant Attorney
Miller, Nash, et al., Defense Attorneys

Reviewed by Board Members Cushing and Gerner.

Claimant requests review of Referee Quillinan's order on remand which dismissed claimant's request for hearing on a Determination Order for lack of jurisdiction on an untimely appeal. On review, the issue is jurisdiction. We affirm.

FINDINGS OF FACT

The Referee found the following facts, which we adopt as our own:

"1) A Determination Order issued November 28, 1984.

"2) That Determination Order was mailed by regular mail as provided by former ORS 656.268(6).

"3) The employer received its copy of the Determination Order the day after the Determination Order issued.

"4) The Determination Order was addressed to claimant's correct address at the time, despite a subsequent change by the post office in claimant's Zip Code after July, 1985.

"5) Claimant did not receive his copy of the Determination Order and did not become aware of its existence until March, 1987.

"6) Claimant filed a Request for Hearing on April 13, 1987.

"7) It is the usual and customary business practice of the Workers' Compensation Department Evaluation Division to mail the Determination Order to claimant and copies to other parties on the day the Determination Order issues. There is no indication of actual mailing to claimant made on the Determination Order or otherwise.

"8) The file copy of the Determination Order shows by inference that the worker's copy was mailed to claimant."

FINDING OF ULTIMATE FACT

Claimant did not request a hearing within one year from the mailing of the Determination Order.

CONCLUSIONS OF LAW AND OPINION

The Referee made the following conclusions, which we adopt as our own:

> "Claimant has the affirmative burden of rebutting the presumption of mailing, namely by proving that the Evaluation Division failed to comply with its statutory duty to mail a copy of the Determination Order to claimant. Merely showing that claimant did not receive the Determination Order is insufficient to toll the running of the statutory period for filing a Request for Hearing in light of former ORS 656.268(6) which in 1984 specifically stated that claimant had one year from the date of mailing of the Determination Order in which to request a hearing. Giusti Wine Company v. Adams, 94 Or App 175 (1988), (running of the statutory filing time is triggered by mailing, not receipt). The applicable statute is thus one of mailing, not receipt, and in this case former ORS 656.268(6) only required mailing by ordinary mail. Furthermore, where a statute provides for notice by mail, deposit of notification in the mail satisfies the statute, even if the notice is never received. Stroh v. SAIF, 261 Or 117 (1972). A presumption exists that the Determination Order was mailed to all parties on the date of issue. Berliner v. Weyerhaeuser Co., 92 Or App 264 (1988).
>
> "The conclusion that claimant's copy was mailed on the date of issue of the Determination Order is supported by the fact that the employer received its copy the day following the Determination Order. While various theories and explanations for why claimant did not receive the Determination Order can be posited, there are no facts showing any processing errors, incorrect address, lack of mailing, actual delivery, or any other circumstance which would rebut the presumption that the Determination Order was mailed to claimant on November 28, 1984.
>
> "[We] conclude that the Determination Order was mailed on November 28, 1984 and that claimant's Request for Hearing on April 13, 1987 is untimely. Pursuant to [former] ORS 656.268, claimant's Request for hearing is barred, and this forum lacks jurisdiction. This matter is thus dismissed."

Claimant argues that former Board rule OAR 438-05-065 requires registered or certified mailing of the Determination Order and that because the Determination Order was mailed by regular mail, that the mailing is insufficient. We disagree.

Former OAR 438-05-065, like its successors, is a Board promulgated rule governing mailings by insurers and self-insured employers. The rule did not regulate Evaluation Division practices and procedures which were under the

authority of the Workers' Compensation Director, not this Board. Former OAR 436-30-030(7) is a Director promulgated rule which requires mailing only. It is this rule that governs the Evaluation Section's duties under the statute. The Board rule is inapposite.

Claimant argues that the fact he did not receive the Determination Order is sufficient to rebut the evidence in this case that it was mailed. We disagree. The preponderance of the evidence establishes that the Determination Order was mailed.

Claimant argues that the fact that he did not receive the Determination Order is an extenuating circumstance that should relieve claimant of the requirement of timely filing. Claimant cites to Norton v. Compensation Dept., 252 Or 75, 78 (1968). We disagree. Wright v. Bekins Moving & Storage Co., 97 Or App 45 (1989).

ORDER

The Referee's order dated February 17, 1989 is affirmed. The Board approves a client-paid fee, not to exceed $1,687, payable from the self-insured employer to its counsel.

May 31, 1990 Cite as 42 Van Natta 1185 (1990)

In the Matter of the Compensation of
JOSEPH E. PICCHI, Claimant
WCB Case No. 88-12131
ORDER ON REVIEW
Pozzi, Wilson et al., Claimant Attorneys
Les Huntsinger (Saif), Defense Attorney

Reviewed by Board Members Crider and Brittingham.

The SAIF Corporation requests review of Referee Peterson's order that affirmed a Determination Order which declined to terminate claimant's permanent total disability for a low back and cervical spine injury. In his respondent's brief, claimant has moved to strike from the record surveillance films and certain testimony by investigators due to the investigators' contact with claimant without prior permission from claimant's counsel. In reply, SAIF agrees that the investigators' testimony concerning their interview with claimant should be excluded. On review the issues are: (1) evidence; and (2) permanent total disability.

We affirm and adopt the Referee's order with the following additional finding and comments concerning the evidentiary issue.

Claimant is unable to regularly perform gainful work due to the compensable injury and his preexisting disability.

Claimant argues that the testimony of two SAIF investigators, which was based on their conversations with claimant, should be stricken because the contacts occurred without prior permission from claimant's counsel. Claimant contends that such contacts violated a disciplinary rule of the Oregon Code of Professional Responsibility, DR 7-104. SAIF concedes in its brief that this testimony should be stricken, and we therefore agree to strike the testimony.

Claimant argues that the films taken by the investigators should be stricken also because they are tainted by the prohibited conversations. We are

not persuaded that the films are in any way derivative of the conversations. Consequently, the films were properly admitted.

Claimant is entitled to an insurer-paid attorney fee for services on review. See ORS 656.382(2). However, because no statement of services has been received, such a fee cannot presently be awarded. OAR 438-15-010(5).

ORDER

The Referee's order dated December 27, 1988 is affirmed.

Board Member Crider writing separately.

I concur entirely with the lead opinion. I am further persuaded that the SAIF Corporation should not be granted the relief it seeks because it does not have standing to seek termination of a permanent total disability award by request for hearing when the Director, in the exercise of his authority under ORS 656.206(5) and 656.325(3), has chosen not to reduce claimant's compensation. See Paulette D. Lehman, 42 Van Natta 493 (1990) (dissent).

In the Matter of the Compensation of
JOSE RODRIQUEZ, Claimant
WCB Case No. 88-16926
ORDER ON REVIEW
Ginsburg, et al., Claimant Attorneys
Sharon Schooley (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

Claimant requests review of those portions of Referee Knapp's order which: (1) affirmed a Determination Order that did not award scheduled permanent disability for claimant's bilateral wrist tendinitis condition; (2) declined to increase the rate of his temporary disability benefits; and (3) did not assess a penalty and associated attorney fee for alleged unreasonable calculation of his temporary disability (TTD) benefits rate. On review, the issues are extent of scheduled permanent disability, rate of temporary disability benefits, and penalties and associated attorney fees.

FINDINGS OF FACT

The Board adopts the Referee's "Findings of Fact."

CONCLUSIONS OF LAW AND OPINION

The Board adopts the Referee's "Conclusion of Law and Opinion" with the following comments.

Claimant argues that the extent of scheduled permanent disability of both his left and right arms should be determined after the claim for his right arm was closed by Determination Order on August 2, 1988. We disagree.

The claim for claimant's left arm was closed by a Determination Order dated October 9, 1987. That Determination Order awarded no scheduled permanent disability, and claimant did not timely appeal. Consequently, in order for claimant to receive another determination of the extent of permanent disability concerning his left arm, he must establish that his left arm condition has

permanently worsened since the unappealed October 1987 Determination Order. See Stepp v. SAIF, 304 Or 375 (1987). Inasmuch as neither the medical nor lay evidence supports such a finding, claimant's left arm condition shall not be redetermined.

Claimant also argues that the employer did not provide complete wage records to the SAIF Corporation so that it could calculate the rate of TTD. Claimant subpoenaed the records but did not receive all that were necessary. However, there is no evidence in the record that claimant requested an order compelling production or that he requested a continuance of the hearing pursuant to OAR 438-06-091 in order to obtain the required records. It is claimant's burden to prove that the rate of TTD was incorrect and he has not met his burden in this case. Accordingly, we affirm the Referee on the issue of the rate of temporary disability.

ORDER

The Referee's order dated January 20, 1989 is affirmed.

May 31, 1990 Cite as 42 Van Natta 1187 (1990)

In the Matter of the Compensation of
HENRY H. STINNETT, Claimant
WCB Case No. 88-18490
ORDER ON REVIEW
Robert J. Guarrasi, Claimant Attorney
Cummins, et al., Defense Attorneys

Reviewed by Board Members Gerner and Myers.

The self-insured employer requests review of Referee Brazeau's order that increased claimant's unscheduled permanent disability award for a low back injury from 28 percent (89.6 degrees), as awarded by Determination Order, to 40 percent (128 degrees). On review, the issue is extent of unscheduled permanent disability. We modify.

FINDINGS OF FACT

The Board adopts the Referee's Findings of Fact as our own, except for the finding that "claimant has lost 40 percent of his earning capacity as a result of his compensable injury." Instead, we find that claimant has lost 36 percent of his earning capacity as a result of his compensable injury.

CONCLUSIONS OF LAW AND OPINION

The Board adopts the Referee's Conclusions of Law, as set forth in the "Conclusions of Law and Opinion" portion of the order, with the exception of the final paragraph on page 4 of the order.

The Referee concluded that, under the standards, claimant suffers 36 percent unscheduled permanent disability resulting from his 1988 compensable injury. In addition, the Referee concluded that claimant had proven by clear and convincing evidence that claimant suffered an additional 4 percent unscheduled permanent disability. We agree with the Referee's assessment of disability under the standards, but disagree that claimant suffers permanent disability outside the standards.

The Referee concluded that there was clear and convincing evidence that: (1) claimant is precluded from many of the jobs he has done throughout his life; (2) claimant, because of his age (56 years) and meager education, must rely on his physical abilities in order to be employed; (3) many of claimant's prior employments required a strong back, which claimant no longer has; and (4) considering claimant's social and vocational factors, claimant suffers permanent impairment over and above the disability awarded by the standards.

We find that the items referred to by the Referee as proven by clear and convincing evidence have already been taken into consideration under an application of the standards. Therefore, we do not award claimant any disability beyond that calculated under the standards.

Therefore, we conclude that claimant has proven that he suffers 36 percent unscheduled permanent disability resulting from his 1988 compensable low back injury.

ORDER

The Referee's order dated February 3, 1989, as supplemented February 10, 1989, is modified. In lieu of the Referee's increased unscheduled permanent disability award, and in addition to the 28 percent (89.6 degrees) unscheduled permanent disability awarded by Determination Order, claimant is awarded 8 percent (25.6 degrees) unscheduled permanent disability, for a total of 36 percent (115.2 degrees) unscheduled permanent disability. A client-paid fee, not to exceed $1,906.50, payable by the employer to its counsel, is approved.

In the Matter of the Compensation of
KENNETH E. TIBBETS, Claimant
WCB Case No. 85-09148
ORDER ON REVIEW
Peter O. Hansen, Claimant Attorney
Miller, et al., Defense Attorneys

Reviewed by Board Members Cushing and Gerner.

Claimant requests review of that portion of Referee Bennett's order which: (1) declined to grant permanent total disability; and (2) awarded claimant 90 percent (288 degrees) unscheduled permanent disability for a back and neck condition, whereas a Determination Order awarded 70 percent (224 degrees). On review, the issue is permanent total disability. We affirm.

FINDINGS OF FACT

Claimant is 52 years old and finished the eighth grade in school. His work history includes carpentry work, heavy construction and driving heavy equipment.

Claimant compensably injured his neck in 1980. In October 1980, he underwent a cervical laminectomy but continued to have symptoms. On April 20, 1981, he underwent a second cervical laminectomy. On May 18, 1981, claimant underwent a lumbar laminectomy. Claimant had a discectomy and interbody fusion at C5-6 and C6-7 on January 21, 1987. (Ex. 209).

In November 1982, claimant entered the Pain Clinic at Good Samaritan Hospital. After discharge from the Pain Clinic in 1983 he continued to have great difficulty in daily functioning. He experienced depression and believed he was unable to work in a competitive environment. (Ex. 60-2). Dr. Mason, claimant's treating physician, noted that there were jobs claimant could do, including security officer work, automotive generator and starter repairman, automat attendant and hotel/motel manager. (Ex. 79).

Claimant underwent a work hardening program in June 1985. At the end of the program, his tolerances were sitting, 5 to 15 minutes, and sitting/standing combination, 30 to 45 minutes. (Ex. 110-3). In July 1985, claimant re-entered the Pain Clinic. At that time his neck and back pain were constant; he was awakened every hour by pain; and he was able to drive for only 15 minutes. (Ex. 116).

In October 1985, claimant entered an authorized training program to become a wastewater treatment plant operator. He completed the program in October 1986. A December 17, 1987 Determination Order awarded claimant 70 percent unscheduled permanent partial disability and 5 percent scheduled permanent disability for his left leg. (Ex. 231).

Claimant has constant pain. Activity increases his pain. He is able to work in his garden and on his lawn for 15 to 20 minutes at a time. He has lost strength in his left leg and has numbness and tingling in the leg. He can ride in a car for 30 to 45 minutes. Depending on his condition, sometimes he can sit for 15 to 25 minutes, and sometimes he is up and down constantly. The same is true for standing.

The wastewater treatment plant operator position is gainful and suitable employment.

FINDINGS OF ULTIMATE FACT

Claimant is not permanently incapacitated from performing regular work at a suitable, gainful occupation.

Claimant has not made reasonable efforts to secure regular work at a suitable, gainful occupation.

CONCLUSIONS OF LAW AND OPINION

The Referee declined to award claimant permanent total disability because he found claimant was employable, and that he did not make reasonable efforts to obtain suitable and gainful employment. We agree.

Claimant must prove by a preponderance of the evidence that he is permanently totally disabled. Harris v. SAIF, 292 Or 683 (1982). There are two types of permanent total disability: (1) that arising entirely from physical or mental incapacity; and (2) permanent disability, under the "odd-lot" doctrine, arising from less than total physical incapacity plus non-medical factors, such as age, education, work experience, training and mental capacity, which together result in permanent total disability. Welch v. Bannister Pipeline, 70 Or App 699 (1984); Wilson v. Weyerhaeuser Co., 30 Or App 403 (1977). In addition, claimant has the burden to establish that he has made reasonable efforts to obtain work at a gainful and suitable occupation, unless it is shown that efforts would be futile. ORS 656.206(3); Butcher v. SAIF, 45 Or App 318 (1983).

The first step in determining whether claimant is permanently and totally disabled requires an evaluation of his physical condition. We find that claimant is physically capable of performing sedentary to light level work. (Ex. 221-5).

Claimant asserts that he cannot work in a sedentary to light capacity because of the pain level associated with his back condition. We are not persuaded by claimant's testimony. Claimant exaggerates his pain condition in order to maintain his disabled status. (Exs. 240, B-5). He has demonstrated physical capacities beyond his own testimony of pain. For example, claimant was able to complete the waste water operator program, tend his yard and weatherize his boat. Additionally, claimant's physicians do not believe claimant is as disabled by pain as he represents. They are of the opinion that he uses his pain in a manipulative manner as a cloak against returning to work. Despite his pain, claimant's physicians still believe that he is able to work. (Exs. 242-1, 243, 244, 245). Accordingly, we discount claimant's complaints of pain and find that claimant is able to work in a sedentary to light capacity.

We next turn to the non-medical factors. Claimant is 52 years old and finished the eighth grade in school. His work history includes carpentry work, heavy construction and driving heavy equipment. Claimant has transferable skills in the area of mechanical work. He also served with the Marine Corps from 1952 through 1961.

The uncontroverted expert vocational evidence is that claimant can return to work. (Tr. 68-70, 81, 84).

Mr. Miles, claimant's supervisor during the waste water treatment program, indicated that claimant worked for him from October 1985 through October 1986. During that period Miles indicated that claimant performed well. However, upon claimant's return to the plant in January 1988, Miles noted that claimant appeared to be moving slowly and with deliberation and opined that claimant could not perform the waste water job. Miles' opinion was based on his observation of claimant's actions. Since we have found claimant's perceptions of his pain exaggerated, we are equally unpersuaded by his physical manifestations of that pain. We accord Mr. Miles' opinion lesser weight since it is based in part on claimant's exaggerated pain behavior. (Exs. 240, B-5).

Claimant asserts that because his physical impairment adds up to more than 100 percent impairment, that he is permanently and totally disabled. We disagree. This proposition is not supported by case or statutory law. Assuming that claimant's permanent impairment does add up to over 100 percent, this is not determinative of permanent total disability. Permanent total disability occurs when a worker is permanently incapacitated from performing work at a gainful and suitable occupation. ORS 656.206(1). This is not synonymous with having 100 percent impairment. We conclude that claimant is not permanently totally disabled because he is 100 percent permanently partially disabled.

Claimant must also establish that he has made reasonable efforts to obtain gainful and suitable employment. See ORS 656.206(a). We find that claimant has not made reasonable efforts to obtain suitable and gainful employment. Claimant's vocational rehabilitation counselor opined that there were several gainful and suitable occupations that were reasonable for claimant to have made an effort to obtain. (Tr. 68-70). The occupations included, waste water management, recreation area management and security positions. Id. Claimant argues that he need not have applied for these jobs because they would have required him to relocate. However, claimant was first willing to relocate for training and employment. (Ex. 89-4). Only later, after completion of training, did he decide not to relocate, which in turn limited him to the waste water

treatment position only. (Tr. 70). The vocational experts concluded that claimant did not do enough to find employment. We find that a reasonable work search would include a search outside claimant's current home locale because he agreed to, and his training course contemplated, working in a different geographic area after training.

Furthermore, because claimant successfully completed an authorized program in wastewater treatment and because he capably worked virtually full-time for one year in such a job, we conclude a reasonable search would have included an attempt to find employment in another such position. (Tr. 73, 75). However, claimant refused to take the certification test for waste water treatment operator and he did not seek any such job. Since claimant neither applied for a job as a waste water treatment operator, nor sought work outside his immediate geographic area, we conclude that claimant did not make a reasonable effort to obtain suitable and gainful employment.

If a work search is futile, the failure to make an effort to obtain employment will be excused. Whether it would be futile for claimant to seek work is not a subjective test viewed through the eyes of claimant; it is an objective test determined from the record as a whole. While claimant's own impressions of futility are probative, whether a work search is futile or not is determined objectively by evaluation of the totality of the record. Here, none of claimant's medical doctors opined it would be futile for claimant to attempt to seek work. (Exs. 70, 246, 247, 242-1, 70-1). Likewise, claimant's vocational counselor opined that claimant was capable of seeking and obtaining work. (Tr. 82). Only claimant believes a work search to be futile because it hurts too much to work. For the same reasons as stated above, we do not find claimant's testimony persuasive. In light of the medical and vocational evidence, we conclude that it would not have been futile for claimant to have sought gainful and suitable employment.

Claimant also has the burden to show that he is motivated and willing to seek regular gainful employment. See ORS 656.206(3). We find that claimant is not motivated to return to work. Claimant's physicians opined that he was using his emotional difficulties as a shield against returning to work, and that his financial security rested on his disability status. (Ex. 246, 247, 242-1). Claimant's vocational counselor noted that he had refused to take the certification test for waste water, even though it would have been an important asset while seeking regular gainful employment. (Tr. 80). Claimant testified that he did not want to return to work because of the pain level generated by his back condition. (Tr. 57). Accordingly, we conclude claimant is not willing to seek regular employment. See ORS 656.206(3).

Inasmuch as claimant is employable, has not made reasonable efforts to obtain gainful and suitable employment and is not motivated and willing to seek work, we conclude that he is not entitled to permanent total disability.

ORDER

The Referee's order, dated December 2, 1988, is affirmed. The Board approves a client-paid fee, not to exceed $1,380, payable from the employer to its counsel.

In the Matter of the Compensation of
DON G. CYSEWSKI, Claimant
WCB Case No. 88-15120
ORDER OF DISMISSAL
Pozzi, et al., Claimant Attorneys
Peter Preston, Attorney

On May 16, 1990, we abated our April 19, 1990 Order on Review, to consider a motion for reconsideration filed by claimant. He contended that the SAIF Corporation had withdrawn its request for review of the Referee's order prior to our decision. Before addressing the motion, we granted SAIF an opportunity to respond within 10 days from our abatement order.

No response from SAIF has been received within the aforementioned time period. Under such circumstances, we consider SAIF's silence as a concession that the representations contained in claimant's motion are accurate and that SAIF accepts the Referee's conclusions concerning the extent of claimant's scheduled permanent disability for loss of use or function of the right leg (knee).

Accordingly, we withdraw our prior orders. The request for review is dismissed and the Referee's order is final by operation of law.

IT IS SO ORDERED.

In the Matter of the Compensation of
DONALD A. HANSON, Claimant
WCB Case Nos. 88-13657, 88-10249, 88-13658 & 88-10248
ORDER OF DISMISSAL
Cook & Seims, Claimant Attorneys
Davis & Bostwick, Defense Attorneys
Thomas Sheridan (Saif), Defense Attorney

On May 9, 1990, we abated our April 30, 1990 Order on Review (Remanding), to consider a motion for reconsideration filed by the SAIF Corporation, on behalf of Northwest Woodland Services. SAIF (Northwest Woodland) contended that SAIF, on behalf of Triple T, had withdrawn its request for review of the Referee's order prior to our decision. Before addressing the motion, we granted SAIF (Triple T) an opportunity to respond within 10 days from our abatement order.

No response from SAIF (Triple T) has been received within the aforementioned time period. Under such circumstances, we consider SAIF's (Triple T) silence as a concession that the representations contained in the motion from SAIF (Woodland Services) are accurate and that SAIF (Triple T) accepts responsibility for the claim, as previously found by the Referee.

Accordingly, we withdraw our prior orders. The request for review is dismissed and the Referee's order is final by operation of law.

IT IS SO ORDERED.

In the Matter of the Compensation of
BARBARA L. PARTRIDGE, Claimant
WCB Case No. 88-12173
ORDER ON REVIEW
Vick & Gutzler, Claimant Attorneys
Stafford J. Hazelett, Defense Attorney

Reviewed by Board Members Cushing and Myers.

Claimant requests review of Referee Mulder's order which increased claimant's award of unscheduled permanent disability for a back condition from 8 percent (25.6 degrees), as awarded by Determination Order, to 12 percent (38.4 degrees). On review, the issue is extent of unscheduled permanent disability. We affirm.

FINDINGS OF FACT

We affirm and adopt the Referee's order with the following supplementation.

Following her compensable injury, claimant returned to modified work. Thereafter, she left this work for reasons unrelated to her compensable injury. Under such circumstances, we agree with the Referee's assessment of a 2.5 adaptability factor. See former OAR 436-35-310(3); Robin Glover, 42 Van Natta 1081 (1990) (where worker returned to modified work, but not working at the time of hearing because job no longer available, worker entitled to more favorable matrix value for adaptability).

Order

The Referee's order dated November 8, 1988, as reconsidered December 15, 1988, is affirmed.

In the Matter of the Compensation of
PHILIP V. BERNING, Claimant
WCB Case No. 88-14499
ORDER ON REVIEW
Burt, et al., Claimant Attorneys
Gail M. Gage (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

The SAIF Corporation requests review of Referee Foster's order that set aside its denial of claimant's occupational disease claim for a stress-related myocardial infarction. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

Claimant has worked as a corrections officer for the past 20 years. On May 27, 1988, he suffered a myocardial infarction.

Before the 1988 incident, claimant had undergone a triple by-pass surgery. His treating physician diagnosed him as having underlying coronary vascular disease.

Claimant's last work exposure was May 27, 1988.

Claimant was under considerable stress brought on by conditions at his job at the prison.

CONCLUSIONS OF LAW AND OPINION

The Referee agreed with the opinion of claimant's treating physician that claimant's underlying vascular disease was accelerated by the chronic stress of his employment. Without reaching a conclusion concerning the effect of stress on claimant's underlying condition, we reverse.

Claimant argued that his condition was compensable as an occupational disease under 656.802(1). Because claimant's last exposure to working conditions involving stress was May 27, 1988, his claim is analyzed under the occupational disease law which became effective January 1, 1988. See Johnson v. SAIF, 78 Or App 143, rev den 301 Or 240 (1986); Donna E. Aschbacher, 41 Van Natta 1242 (1989).

Claimant argued that his myocardial infarction was caused by a series of psychologically stressful work events and should be compensable under ORS 656.802(1)(c). We disagree.

ORS 656.802(1)(c) defines an occupational disease as "[a]ny series of traumatic events or occurrences arising out of and in the course of employment which requires medical services or results in physical disability or death."

We have recently held that "traumatic" as used in ORS 656.802(1)(c) refers only to physical trauma, not psychological trauma. See Ronald V. Dickson, 42 Van Natta 1102 (1990). Accordingly, claimant's myocardial infarction is not compensable as having been caused by a series of traumatic events under 656.802(1)(c). Claimant's disease did not result from exposure to radiation or substances included in ORS 656.802(1)(a), and is not compensable under that subsection. Id. Additionally, because claimant does not have a diagnosed mental disorder, his claim is not compensable under ORS 656.802(1)(b). Id.

ORDER

The Referee's order dated February 8, 1989 is reversed. The SAIF Corporation's denial is reinstated and upheld. The Referee's award of a $1,750 assessed attorney fee is reversed.

June 5, 1990 Cite as 42 Van Natta 1194 (1990)

In the Matter of the Compensation of
RAY P. COOPER, JR., Claimant
WCB Case No. 87-14196
ORDER ON REVIEW
Francesconi & Associates, Claimant Attorneys
John Motley (Saif), Defense Attorney

Reviewed by Board Members Brittingham and Crider.

Claimant requests review of Referee Hayduke's order that: (1) declined to grant him permanent total disability benefits; (2) increased his unscheduled permanent disability award for a neck injury from 50 percent (160 degrees), as awarded by Determination Order, to 90 percent (288 degrees); and (3) affirmed the Determination Order awards of 10 percent (10 degrees) scheduled permanent disability for the loss of use or function of the right eye and 15 percent (28.80 degrees) scheduled permanent disability for the loss of use or function

of the left arm. Claimant also moves the Board to admit into evidence a letter dated February 7, 1990, which notified him that his eligibility for further vocational assistance had ended.

The parties previously resolved a related attorney fee issue by stipulation which we approved by interim order dated October 13, 1988. That order shall be incorporated into this Order on Review.

We affirm and adopt the Referee's order with the following supplement.

ISSUES

1. Remand. Has this case been insufficiently developed or heard by the Referee?

2. Permanent total disability. Did the compensable injury permanently incapacitate claimant from regularly performing work at a gainful and suitable occupation?

FINDINGS OF ULTIMATE FACT

1. We do not find that this case has been insufficiently developed or heard by the Referee.

2. We do not find that the compensable injury permanently incapacitated claimant from regularly performing work at a gainful and suitable occupation.

CONCLUSIONS OF LAW AND OPINION

Remand

We interpret claimant's motion to admit new evidence as a motion for 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).

Permanent disability is rated based on conditions existing at the time of hearing. Gettman v. SAIF, 289 Or 609, 614 (1980); Delbert E. Norton, 38 Van Natta 903, 904 (1986). Here, the document submitted by claimant is dated almost two years after the February 18, 1988, hearing and is not probative of any conditions in existence at the time of hearing. For those reasons, we do not find that this record is insufficiently developed without the additional document. Claimant's motion for remand is denied.

Permanent Total Disability

The Referee found that claimant had substantial permanent impairment as a result of his injury, but nevertheless concluded that he was not permanently and totally disabled. We agree.

In order to establish permanent total disability, claimant must prove either that: (1) he is completely physically disabled and therefore precluded from gainful employment; or (2) his physical impairment, combined with a number of social and vocational factors, effectively prohibit gainful employment under the "odd-lot" doctrine. See Wilson v. Weyerhaeuser, 30 Or App 403 (1977). Claimant has not sustained his burden of proof on either basis.

Dr. Knox, the treating neurologist, declared claimant "totally and permanently disabled *** and unable to engage in gainful employment of any type." (Ex. 80-2). Knox based his opinion on physical and neurological findings. Knox

reported that claimant's physical capacities allow for limited sitting, standing and walking, lifting and carrying of up to 10 pounds occasionally, repetitive use of the right hand only, repetitive use of both feet, and occasional bending and squatting. He added, however, that claimant's cognitive problems and attendant memory difficulties would interfere with his ability to return to gainful employment or to retrain for a new vocation. He expressed concern about claimant's ability to deal with prolonged physical or psychological stress and added that neurological deficits would become more prominent with fatigue.

Drs. Barth and Fleshman rated claimant's disability as moderately severe. They opined that he cannot return to construction, logging or any other type of heavy work and, because of his memory problems, would probably need to be in a sheltered workshop situation. (Ex. 69).

Dr. Binder, a clinical neuropsychologist, could not think of any suitable occupation for claimant in the light of his physical and cognitive functioning problems (Ex. 75-3). However, Binder later conceded that he did not know whether claimant could return to gainful employment.

Mr. McNaught, a vocational rehabilitation counselor, identified a number of entry-level jobs which claimant could learn on the job after a short adaptation period and perform within the limitations reported by Dr. Knox. They are security monitor, gate tender, fire watch, tool crib attendant, photofinishing lab worker, parking garage attendant, cashier and mail sorter. (Tr. 149-50). McNaught opined that claimant's memory problems would not be an important factor in those jobs because they are repetitive, unskilled jobs that do not involve abstract information. (Tr. 152-53, 155). This view is corroborated by claimant's performance of many tasks in a May 20, 1987 vocational assessment. McNaught added that the jobs are available in the state and within commuting distance from claimant's home in Sweet Home. (Tr. 155-57).

We are most persuaded by McNaught's opinion. Unlike the doctors, McNaught considered claimant's condition in the context of the labor market in Oregon and found specific jobs which were within claimant's vocational and medical limitations. Although those jobs pay little more than minimum wage, it is not improper to deny claimant the maintenance benefits of permanent total disability when he is capable of earning a living, even at a rate below his original wage. Harold H. Garoutte, 42 Van Natta 657 (1990).

ORDER

The Referee's order dated July 21, 1988, as amended July 25, 1988, is affirmed. The Interim Order Approving Stipulation dated October 13, 1988, is hereby incorporated by reference.

In the Matter of the Compensation of
PATRICK A. GETTY, Claimant
WCB Case Nos. 87-11538, 87-14394 & 87-14395
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Rankin, et al., Defense Attorneys
Underwood, et al., Defense Attorneys
Bottini, et al., Defense Attorneys

Reviewed by Board Members Crider and Brittingham.

Claimant requests review of Referee Knudsen's order that upheld denials of his bilateral carpal tunnel condition issued by EBI Companies, Liberty Northwest Insurance Corporation and Safeco Insurance Company. On review, the issues are the propriety of EBI's alleged "back-up" denial, compensability and responsibility. We reverse, in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact. We also adopt as findings those portions of claimant's testimony that are summarized by the Referee in the first three paragraphs of her "Summary of Evidence" section. We make the following additional findings.

On July 21, 1987, claimant completed a Form 801 which identified his problem as work-related bilateral carpal tunnel syndrome. The record includes a copy of the form signed by EBI's representative on September 10, 1987. The "accepted" and "injury" boxes at the bottom of the signed form are checked. The other portions of the form to be completed by the carrier are blank.

EBI issued a formal denial of claimant's carpal tunnel condition on December 10, 1987.

FINDINGS OF ULTIMATE FACT

EBI accepted claimant's bilateral carpal tunnel syndrome when its representative signed the Form 801 on September 10, 1987.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant's work activity was not the major contributing cause of his carpal tunnel syndrome. Accordingly, she upheld the denials issued by EBI, Liberty Northwest and Safeco.

Claimant contends that EBI accepted claimant's condition when its representative signed the Form 801 on September 10, 1987, so that its subsequent denial on December 10, 1987 was an improper "back-up" denial. Accordingly, claimant contends that EBI is responsible for his carpal tunnel condition. Claimant raised this argument at hearing, but the Referee failed to address it in her order. We are persuaded by claimant's argument.

Once a claim is accepted under ORS 656.262(6), the carrier may not, after 60 days have elapsed from notice or knowledge of the claim, deny the compensability of that claim unless there is a showing of fraud, misrepresentation or other illegal activity. Bauman v. SAIF, 295 Or 788 (1983). Here, EBI's representative signed a Form 801 on September 10, 1987 that specifically identified claimant's condition as bilateral carpal tunnel syndrome. Such a duly executed Form 801 is a valid acceptance of the condition specified on the form. See Nancy V. Storey, 41 Van Natta 1951 (1989). We are unable to tell from the

record whether claimant received a copy of the executed form before EBI issued its denial. However, notice to claimant is not required for a valid acceptance. Id. The question of whether the executed form was mailed to claimant is one of claims processing, not a question of whether or not a claim has been accepted. Id.

We, therefore, conclude that EBI accepted claimant's bilateral carpal tunnel condition on September 10, 1987 when its representative signed the Form 801. EBI has made no showing of fraud, misrepresentation or other illegal activity in regard to that acceptance. We, therefore, conclude that EBI's December 10, 1987 denial was an invalid "back-up" denial of claimant's previously accepted bilateral carpal tunnel condition. Bauman v. SAIF, supra.

EBI argues that the acceptance box on the Form 801 was a clerical error and was never intended to be an acceptance. However, it has offered no evidence to support that contention other than the fact that EBI did not complete portions of the form for which it was responsible. Such assertions are insufficient to persuade us that the executed document was not a valid acceptance.

Accordingly, we reverse the Referee and set aside EBI's denial.

ORDER

The Referee's order dated February 4, 1988, as reconsidered February 10, 1988, is reversed in part and affirmed in part. EBI Companies' denial is set aside and the claim is remanded to EBI for further processing under the law. The remainder of the order is affirmed. For services at hearing and on review, claimant's attorney is awarded an assessed fee of $3,000, payable by EBI. The Board approves a client-paid fee for counsel for EBI Companies, not to exceed $875. The Board approves a client-paid fee for counsel for Liberty Northwest Insurance Corporation, not to exceed $645. The Board approves a client-paid fee for counsel for Safeco Insurance Corporation, not to exceed $1,168.

In the Matter of the Compensation of
BETSY C. CRICK, Claimant
WCB Case No. 87-18372
ORDER ON RECONSIDERATION
Malagon, et al., Claimant Attorneys
Saif Legal Department, Defense Attorney

The SAIF Corporation requests reconsideration of that portion of our April 25, 1990 Order on Review that affirmed a Referee's order which set aside its denial of claimant's injury claim. SAIF seeks further consideration of our conclusion that the injury occurred within the course and scope of claimant's employment, specifically in light of Cope v. West American Ins. Co., 309 Or 232 (1990), and Sheri V. Hiltner, 42 Van Natta 1039 (1990). On May 21, 1990, we withdrew our order for further consideration. After completing our reconsideration, we reach the following conclusions.

The cases upon which SAIF relies are distinguishable. In Cope, the Supreme Court held that when a worker is injured on a public sidewalk over which the employer has no control, and on which there are no employer-created hazards, the connection between the injury and the employment is insufficient to make the injury compensable. Cope, supra, at page 240. Here, claimant was not injured on a public sidewalk. Rather, she was injured while exiting her employer's building by means of the only handicapped access entrance. We agree with the

Referee's conclusion that the handicapped access ramp was an extension of the employer's premises over which the employer had control.

Hiltner is similarly distinguishable. In Hiltner, we held that where a claimant was injured in the lobby of a multistory, multipurpose commercial office building, in which the employer was a tenant, the injury did not occur on the employer's premises. Here, the building in which claimant worked was multistory, but it was not composed of multipurpose commercial offices. Rather, the building was state-owned and primarily comprised of divisions of claimant's employer, a state agency. Considering such circumstances, we continue to conclude that claimant's injury occurred while on her employer's premises.

Accordingly, our April 25, 1990 order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our prior order, effective this date. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

June 6, 1990 Cite as 42 Van Natta 1199 (1990)

In the Matter of the Compensation of
SAMUEL SCOTT, Claimant
WCB Case No. TP-90024
THIRD PARTY ORDER
Vick & Gutzler, Claimant Attorneys
Saif Corp Legal, Defense Attorney

Claimant has petitioned the Board for resolution of a dispute concerning a proposed settlement of a third party action. See ORS 656.587. We approve the settlement.

FINDINGS OF FACT

In October 1987 claimant sustained a compensable injury as a result of a motor vehicle accident. Specifically, the vehicle claimant was operating struck another vehicle shortly after he drove through an intersection. The other vehicle was exiting a parking lot located just beyond the intersection.

Claimant admits that he was exceeding the posted speed limit, attempting to cross the intersection before the stop light turned red. However, an independent witness is "fairly certain" that the light was red prior to claimant entering the intersection.

As a result of the accident, claimant has suffered headaches, as well as neck and back complaints. He has received conservative treatment for these problems, primarily consisting of chiropractic treatments.

To date, the SAIF Corporation, as paying agency, has incurred actual claim costs totalling $9,447.21. These costs include medical expenses and temporary disability compensation, as well as an unscheduled permanent disability award.

Claimant has engaged legal representation to pursue a cause of action for negligence against the driver of the other vehicle. The third party insurer and claimant have agreed to settle the action for $5,000. SAIF has declined to approve the settlement.

FINDINGS OF ULTIMATE FACT

The third party settlement offer of $5,000 is reasonable.

CONCLUSIONS OF LAW

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. Dorotha M. Clarke, 40 Van Natta 1125 (1988); Kathryn I. Looney, 39 Van Natta 1140 (1987).

After reviewing the purported strengths and weaknesses of claimant's action against the third party driver and considering the aforementioned standard, we conclude that a settlement offer of $5,000 is reasonable. Consequently, we approve the settlement. Accordingly, proceeds of the settlement shall be distributed in accordance with ORS 656.593(3).

IT IS SO ORDERED.

June 6, 1990 Cite as 42 Van Natta 1200 (1990)

In the Matter of the Compensation of
DARRELL L. WILSON, Claimant
WCB Case No. 88-12951
ORDER ON REVIEW
Francesconi & Associates, Claimant Attorneys
Stafford Hazelett, Defense Attorney

Reviewed by Board Members Brittingham and Crider.

Claimant requests review of Referee Podnar's order that increased a Determination Order award of 15 percent (48 degrees) unscheduled permanent disability to 21 percent (67.2 degrees) for claimant's cervical condition. On review, the issue is extent of unscheduled permanent disability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following supplementation.

Claimant was medically stationary as of May 27, 1988. A Determination Order issued July 20, 1988 awarding claimant 15 percent (48 degrees) unscheduled permanent disability for claimant's cervical condition.

Claimant experiences pain which results in a loss of use or function. Claimant is required to lie down two or three times a week and becomes nauseated from the pain he experiences which is the result of his compensable injury.

FINDINGS OF ULTIMATE FACT

Claimant has sustained a 21 percent loss of earning capacity.

CONCLUSIONS OF LAW AND OPINION

If a claimant became medically stationary after January 1, 1988 and his or her claim was closed on or after July 1, 1988, a subsequent determination by a referee or the Board of the claimant's permanent partial disability must be made pursuant to ORS 656.283(7) and 656.295(5), respectively. OAR 438-10-005 and Michelle Griffith, 40 Van Natta 2086 (1988).

The Referee found under the standards that claimant was entitled to a +1 value for his age (51) and a value of 20 percent for his lost range of motion and surgeries. The Referee added these values and found that claimant was entitled to 21 percent unscheduled permanent partial disability. We agree with the Referee's award; however, we reach our conclusion in the following manner.

In this case, the "standards" adopted effective July 1, 1988, former OAR 436-35-001 et seq, apply to the rating of claimant's permanent partial disability. Former OAR 436-35-270 through 436-35-440 apply to the rating of unscheduled permanent partial disabilities. Former OAR 436-35-270(1).

The hearing and Board review of the issue of permanent partial disability continues to be de novo on the hearing record. The underlying facts to which the "standards" are applied need only be established by a preponderance of the evidence. However, either party may establish that the record, as a whole, constitutes clear and convincing evidence that the degree of permanent partial disability suffered by the claimant is more or less than the entitlement indicated by the "standards". ORS 656.283(7) and 656.295(5).

The determination of permanent partial disability under the "standards" is made by determining the appropriate values assigned by the "standards" to the claimant's age, education, adaptability and impairment. Once established, the values for age and education are added and the sum is multiplied by the appropriate value for adaptability. The product of those two figures is then added to the appropriate value for impairment to yield the percentage of unscheduled permanent partial disability. Former OAR 436-35-280.

Claimant was released for regular work by his treating physician, Dr. Ordonez, on March 16, 1987. Claimant did return to his job as a car salesman for three weeks then left for reasons unrelated to his injury. Since claimant was released for and returned to his regular and customary work he is entitled to no value for age, education or adaptability. See former OAR 436-35-290(2)(b); 436-35-300(2)(b); 435-35-310(2)(b).

Claimant is entitled to an impairment value for his lost range of motion in his cervical spine. We find that claimant is entitled to a value of 1 percent for 20 degrees of retained active right lateral flexion. Former OAR 436-35-360(4). Claimant is entitled to a value of 1.5 percent for 15 degrees of retained active left lateral flexion. Id.

The values for lost range of motion in each area of the cervical spine are to be added (not combined) for a total impairment value that represents lost range of motion of the spine. Former OAR 436-35-360(10). When these values are added, we find that claimant is entitled to a total 2.5 percent impairment value for lost range of motion.

In addition, claimant is entitled to a value for his surgery and the resulting impairment. We find claimant is entitled to a value for 5 percent for his cervical discectomy. Former OAR 436-35-350(2). Claimant is also entitled to a value of 2 percent for his fusion at the C5-6 level. Former OAR 436-35-350(3). These values are combined (not added) as they represent multiple residuals. See former OAR 436-35-360(11). These values combine for a total of 6.9 percent.

Claimant is entitled to a value for pain which has resulted in a loss of use or function. Former OAR 436-35-320(1)(a) provides that pain can result in loss of use or function. When it does, it is rated based on the loss of use or function which results and no additional value is allowed for the pain alone. The Board, in Daniel M. Alire, 41 Van Natta 752 (1989), held that, inasmuch as

the standards do not provide for a value range for impairment attributable to disabling pain, the Board on de novo review can consider the evidence and award the claimant a value that adequately compensated him for his loss of use or function attributable to the disabling pain.

In this case, the record establishes that claimant experiences pain which results in a loss of use or function. Claimant is required to lie down due to nausea associated with the pain from his compensable injury two or three times a week. Claimant has reduced the number of hours that he works because of the pain and he has given up playing golf.

Inasmuch as the standards do not provide for a value range for impairment attributable to disabling pain, we consider a value of 10 percent in this particular case to be reasonable.

To arrive at a total impairment finding, we combine (not add) the impairment value for claimant's lost range of motion (2.5) with the impairment value for claimant's surgeries (6.9). The result of this combination is 9.228. Combining the aforementioned value (9.228) with the 10 percent impairment value for claimant's disabling pain results in a total of 18.305 percent. This value represents claimant's total impairment value.

Computation of unscheduled disability.

Having determined each value necessary to compute claimant's permanent disability under the "standards," we proceed to that calculation. When claimant's age value 0 is added to his education value 0 the sum is 0. When that value is multiplied by claimant's adaptability value 0 the product is 0. When that value is added to claimant's impairment value 18.305 the result is 18.305 percent unscheduled permanent partial disability. Former OAR 436-35-280(7). That disability figure is rounded to the next higher whole percentage. Id. Claimant's permanent disability under the "standards" is, therefore, 19 percent.

In addition, claimant argues that he is entitled to a greater disability award than that given under the standards because he has proven by clear and convincing evidence that his disability, (i.e. loss of wage earning capacity) is greater than the 21 percent awarded by the Referee. Claimant argues that the differential in his earning capacity between the time he was injured and his current earning capacity should be considered in rating his disability. We are not persuaded by the evidence that claimant is unable to obtain his pre-injury earning capacity as a result of his compensable injury. He initially returned to his prior work, then quit for reasons unrelated to the compensable injury. Claimant has failed to establish that the differential between his pre-injury wage and current earnings is due to the injury. Therefore, we find that claimant has failed to prove by clear and convincing evidence that his disability is greater than that awarded by the standards.

Accordingly, we find that claimant's total permanent disability is equal to 19 percent. However, we will not reduce claimant's award in this instance as the insurer has not requested a reduction. See Alire, supra.

ORDER

The Referee's order dated October 20, 1988 is affirmed.

In the Matter of the Compensation of
RENIA BROYLES, Claimant
WCB Case No. 88-19676
ORDER ON REVIEW
Zbinden & Curtis, Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Myers and Cushing.

The self-insured employer requests review of Referee Peterson's order which set aside its denial of claimant's left knee injury claim. In its brief, the employer also contends that the Referee erred in not reopening the record for admission of further evidence. On review, the issues are admission of evidence and compensability. We affirm.

FINDINGS OF FACT

Claimant worked for the employer as an insurance sales representative. For each insurance policy sold by claimant, she receives a commission and the employer received the balance of the premium.

In July 1988, claimant took part in a softball game between the employer's staff office and the employer's out-of-town representatives. She had been invited to play by the district manager who told her that it would be a good opportunity to get to know the staff and to sell insurance to the staff. She was the only sales representative from the local area to participate in the contest.

The game took place shortly after 5:00 p.m. on a work day. It was played at a local park. The employer sponsored the game and provided T-shirts for all the players. During the course of the game, claimant attempted to sell an insurance policy to one of the other players but was unsuccessful. Thereafter, she sustained an injury to her left knee when another player ran into her.

The hearing was held on February 14, 1989. The record was closed after the completion of testimony that day. Three days following the hearing, the employer's counsel submitted an affidavit of another witness and requested that the Referee reopen the record to allow the affidavit into the record. The Referee denied the request for reopening.

CONCLUSIONS OF LAW AND OPINION

Admission of Evidence

The employer contends that the Referee erred in not reopening the record for admission of further evidence. We disagree.

OAR 438-07-025(1) allows a Referee discretion to reopen the record for consideration of new material evidence. OAR 438-07-025(2) provides that a party moving for reconsideration must provide an explanation why such new evidence could not have reasonably been discovered and produced at the hearing.

The employer requested that the Referee reopen the record, three days after hearing, for submission of an affidavit from a witness who had not testified at the hearing. The employer contended that it had first learned of the witness during the course of claimant's testimony. The witness was a former co-worker of claimant's and had been present at the softball game in which claimant was injured.

We conclude that the Referee did not abuse his discretion in declining to reopen the record. The employer's explanation is not sufficient to establish that the proffered affidavit could not have been reasonably discovered and produced at hearing. Further, the employer's counsel did not ask for a continuance of the hearing upon learning the identity of the witness. Under these circumstances, the Referee was within his discretion in declining to reopen the record for the admission of further evidence.

Compensability

We adopt the "Conclusions of Law and Opinion" as set forth in the Referee's order.

ORDER

The Referee's order dated March 6, 1989, is affirmed. For services rendered on review, claimant's counsel is awarded a reasonable assessed fee of $1,000, payable by the employer. A client-paid fee, not to exceed $1,740.50 is approved, payable by the employer to its counsel.

June 7, 1990 Cite as 42 Van Natta 1204 (1990)

In the Matter of the Compensation of
LINDA E. HOXSIE, Claimant
WCB Case No. 88-20626
ORDER ON REVIEW
Burt, Swanson, et al., Claimant Attorneys
Gail Gage (Saif), Defense Attorney

Reviewed by Board Members Brittingham and Crider.

Claimant requests review of Referee Irving's order that upheld the SAIF Corporation's denial of medical services for claimant's right hand condition. On review the issue is medical services. We reverse.

FINDINGS OF FACT

While employed with SAIF's insured as a clerical worker, claimant developed pain, numbness, tingling and a loss of coordination in her right hand and arm. Claimant's job duties included manipulating pieces of paper into small tubes attached to large spindles.

Claimant filed an occupational disease claim for carpal tunnel syndrome in her right hand on January 26, 1986. The claim was accepted by SAIF.

On February 4, 1986, Dr. DeHammer performed a right carpal tunnel release. Claimant continued to experience right hand symptoms following the surgery.

A Determination Order issued October 21, 1986. Claimant was awarded 10 percent (15 degrees) scheduled permanent disability for loss of use of her right hand. By Stipulation dated February 11, 1986, claimant's permanent disability was increased to 25 percent (37.5 degrees) scheduled permanent disability for loss of use of her right hand.

Claimant moved out of state in June of 1986. Following her move claimant was employed as a circulations secretary which involved typing, filing and answering telephones. Claimant was then employed out of state in a clerical position which required her to spend 70 percent of her time working at a computer and the other 30 percent sending mail and making photocopies. At the time of the hearing claimant continued to work for this out-of-state employer.

Claimant experiences numbness and tingling in her right thumb and index finger, sensitivity across her right palm, swelling in her right wrist and cramps at the base of her little finger.

Claimant first treated with Dr. Whitney, an out-of-state orthopedist, in August of 1987. On October 21, 1988, Dr. Whitney requested approval for a re-exploration of claimant's right median nerve.

SAIF issued a denial of claimant's treatment on November 4, 1988.

FINDINGS OF ULTIMATE FACT

Claimant's right wrist carpal tunnel disease, which SAIF accepted in 1986, is a material contributing cause to claimant's current need for treatment.

Claimant's out-of-state employment did not independently contribute to a worsening of her underlying carpal tunnel condition.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant had failed to establish the causation of her present condition as to her Oregon employment. Therefore, the Referee upheld SAIF's medical services denial for claimant's right wrist condition. As a result, the Referee did not address SAIF's argument that it was relieved of responsibility because claimant did not file a claim with the out-of-state employer.

The Referee concluded that claimant's current condition is not causally related to her employment with SAIF's insured. We disagree. Claimant's burden is to prove that her compensable right carpal tunnel condition was a material contributing cause to her need for treatment. See Grable v. Weyerhaeuser Co., 291 Or 387 (1981). We find that claimant has met her burden.

Claimant has an accepted 1986 right carpal tunnel disease claim with SAIF. She underwent a right carpal tunnel release in February 1986, and the claim was closed with an award of 25 percent scheduled permanent disability. Claimant credibly testified that she has continued to experience right wrist symptoms since her surgery. Dr. Whitney attributed the origin of some of these symptoms to claimant's compensable claim and surgery. Moreover, there is no evidence of any supervening event sufficient to break the chain of causation between claimant's accepted claim and her current condition. Under these circumstances, we find that claimant's compensable condition remains a material contributing cause to her current need for treatment.

Accordingly, SAIF remains responsible for claimant's condition unless it is absolved of responsibility because claimant did not file a claim against her out-of-state employer. An Oregon insurer is not automatically relieved of responsibility for a worsening of a claimant's compensable injury when another jurisdiction may be responsible. Rather, the Oregon insurer is relieved of responsibility only if the injury in the other jurisdiction independently contributed to a worsening of the underlying condition. See Miville v. SAIF, 76 Or App 603 (1985); Harry W. Clark, 38 Van Natta 808 (1986).

We are persuaded by the record that claimant's out-of-state employment did not independently contribute to a worsening of her condition. Dr. Whitney only stated that her out-of-state employment contributed to a worsening of her symptoms. Under these circumstances, we find that there is a lack of evidence to establish that claimant's out-of-state employment worsened her condition. Therefore, SAIF must continue to pay for claimant's medical services.

ORDER

The Referee's order dated February 16, 1989 is reversed. The SAIF Corporation's denial is set aside and the claim is remanded to the SAIF Corporation for further processing in accordance with the law. For services at hearing and on review regarding the issue of medical services, claimant's attorney is awarded an assessed fee of $2,000, payable by SAIF.

In the Matter of the Compensation of
KAREL L. NELSON, Claimant
WCB Case No. 88-07923
ORDER ON REVIEW
Peter O. Hansen, Claimant Attorney
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Myers and Cushing.

Claimant requests review of Referee Podnar's order which: (1) found that claimant became medically stationary on December 24, 1987; and (2) increased claimant's scheduled permanent disability for loss of use or function of the right forearm to 40 percent (60 degrees), whereas a Determination Order had awarded 20 percent (30 degrees); and (3) authorized an offset of temporary disability paid beyond the medically stationary date against claimant's permanent disability award. On review, the issues are temporary disability, scheduled permanent disability, and offset.

We affirm and adopt the Referee's order with the following supplementation.

On review, claimant asserts that her claim was prematurely closed. However, the issue of premature closure was introduced for the first time during closing arguments. Moreover, the insurer contends that it objected to the introduction of the issue at such a late date. Claimant does not dispute the insurer's representation. Under such circumstances, we decline to address the issue. See Edward R. Rankin, 41 Van Natta 2133 (1989).

ORDER

The Referee's order dated February 13, 1989 is affirmed. The Board approves a client-paid fee, not to exceed $1,080.50, payable from the insurer to its counsel.

In the Matter of the Compensation of
JACKSON P. SHULL, Claimant
WCB Case No. 87-17844
ORDER ON REVIEW
Max Rae, Claimant Attorney
Saif Legal Department, Defense Attorney

Reviewed by Board Members Crider and Brittingham.

The SAIF Corporation requests review of Referee Davis' order that: (1) set aside its denial of claimant's claim for cardiac arrhythmia and respiratory/pneumonia conditions; and (2) assessed an attorney fee of $4,500. On review the issues are evidence, compensability, and attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

The Board adopts the Referee's "Findings," with the following addition.

On August 9, 1988 Deborah Fischer, a registered nurse employed by SAIF, was deposed by claimant's attorney as an adverse witness. SAIF objected, on the

basis of relevance, to a question directed to whether it was customary for the witness to make diagnoses of conditions such as mycoplasma pneumonia.

At hearing, over SAIF's objection, claimant's attorney was allowed to spray a can of Krylon paint into a plastic bag to demonstrate the smell of the fumes.

FINDINGS OF ULTIMATE FACT

The inhalation of paint fumes at work was a material contributing cause of claimant's cardiac arrhythmia and hospitalization.

Claimant's pneumonia condition is unrelated to his employment exposure to paint fumes.

The Referee's attorney fee award was reasonable.

CONCLUSIONS OF LAW AND OPINION

Evidence

During the deposition of registered nurse Fisher, SAIF objected to questions posed under direct examination. On review, SAIF argues that the Referee erred by failing to rule on the objections which were made.

Common law or statutory rules of evidence and procedure are not binding on the Referee. The Referee has discretion as to the manner in which the hearing is conducted, provided "substantial justice" is afforded the parties. ORS 656.283(7).

Here, since Fisher was deposed as an adverse witness, claimant was engaged in appropriate cross-examination and was properly questioning the witness as to the degree of her knowledge. Therefore, we find that the Referee acted within his discretion pursuant to ORS 656.283(7) and assume that SAIF's objections were overruled. Substantial justice was afforded the parties.

SAIF also challenges the Referee's handling of an evidentiary issue at hearing. A can of Krylon paint similar to the one claimant used on the afternoon of the onset of his cardiac arrhythmia was admitted into the record. Claimant's attorney was permitted to spray an amount of the paint into a plastic bag to demonstrate the smell of Krylon paint. SAIF alleges that the Referee abused his discretion in allowing the demonstration because the hearings room did not accurately reproduce the conditions of the original incident and because the probative value of the demonstration was outweighed by it prejudicial value.

Under Oregon Evidence Code 403 relevant evidence may be excluded if its probative value is substantially outweighed by the danger of unfair prejudice. The commentary indicates that "unfair prejudice" means an undue tendency to suggest decisions on an improper basis. Here, the finder of fact was a professional Referee. Such a factfinder is less likely to allow his decision to be improperly influenced. We note that the Referee acknowledged that the conditions of the work incident at issue were not reproduced in the demonstration. Further, Referees have broad discretion under ORS 656.283(7) to choose procedures not prohibited by regulation or statute. See Elsie Lumpkins, 40 Van Natta 1571 (1988). We find that the demonstration was not prohibited by regulation or statute and within the Referee's broad discretion. Accordingly, we affirm the Referee's evidentiary rulings.

Compensability

Cardiac Arrhythmia

The Board adopts that portion of the Referee's Conclusions of Law and Opinion regarding claimant's cardiac arrhythmia.

Respiratory/Pneumonia Condition

The Referee accepted the view of Dr. Sims, M.D., claimant's treating physician, with regard to the causation of claimant's pneumonia. Dr. Sims felt that the spray paint in the lungs and the resulting mucous provided a bed in which bacteria could develop rapidly. Therefore, he concluded that the exposure was a material cause of claimant's development of pneumonia. We disagree.

Although the Board generally gives greater weight to the conclusions of a treating physician, it will not do so 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). Here, we find persuasive reasons not to defer to the opinion of Dr. Sims. Dr. Sims based his analysis on the assumption that claimant's pneumonia was caused by bacterial infection. Dr. Lonigan, a pulmonary specialist, reported that serologic tests for bacterial pneumonia were negative. (Ex 43-3). Dr. Lonigan opined that claimant probably suffered a viral pneumonia. He did not offer an opinion on its cause. Dr. Lonigan's conclusion, which was based on objective testing, convinces us that claimant's pneumonia was not bacterial in nature.

Dr. Sims is the only physician on record who felt that the fumes caused claimant's pneumonia through increased mucous production. Inasmuch as his understanding of the nature of claimant's disease was erroneous, we do not rely on his opinion. Consequently we find that claimant has not carried his burden of proving that his pneumonia was caused by his employment.

Attorney Fees

SAIF challenges the Referee's award of a $4,500 assessed fee. The Referee awarded that fee for prevailing at hearing against SAIF's denial of his cardiac arrhythmia and respiratory/pneumonia conditions. We have concluded above that the latter condition is not compensable. Consequently, claimant's attorney is not entitled to an assessed fee in regard to that condition. Nevertheless, we conclude that the $4,500 assessed fee is reasonable even if we only consider services rendered at hearing regarding the compensable cardiac arrhythmia condition. Resolution of that issue involved complex medical questions. A deposition was taken in the case which was relevant to this issue. Claimant's hearing presentation on this issue was of high quality, as was his written closing argument. Claimant's attorneys devoted approximately 60 hours to litigation of this case at hearing, although some of these hours were "duplicative" because of claimant's decision to change attorneys in the course of the litigation. After considering these factors in light of the criteria set forth in OAR 438-15-010(6), we conclude that $4,500 is a reasonable fee for services at hearing regarding compensability of the cardiac arrhythmia condition.

ORDER

The Referee's order dated January 17, 1989 is reversed in part and affirmed in part. That part of the order which set aside the SAIF Corporation's denial of claimant's pneumonia condition is reversed. The denial of the pneumonia condition is reinstated and upheld. The remainder of the order is affirmed. For services on review regarding the compensability of the arrhythmia condition, claimant's attorney is awarded an assessed fee of $1,300, payable by SAIF.

In the Matter of the Compensation of
CLAUDIA J. PERCY, Claimant
WCB Case No. 86-01171
ORDER ON REVIEW
Gatti & Gatti, Claimant Attorneys
Saif Corp Legal, Defense Attorney

Reviewed by Board Members Crider and Brittingham.

Claimant requests review of Referee Foster's order that increased claimant's scheduled permanent disability for loss of use or function of the left leg (knee) from 13 percent (19.5 degrees), as awarded by a Determination Order, to 25 percent (37.5 degrees). We affirm.

FINDINGS OF FACT

We adopt the Referee's "Findings" with the following supplementation.

On November 7, 1985, Dr. Witczak, osteopath, performed a left knee arthroscopy with arthroscopic partial medial menisectomy and arthroscopic patellar shavings. During this procedure the medial portal and the debris about the anterior portion of the meniscus were resected. In addition, the tear at the posterior horn was trimmed and the edge smoothed and the tear at the anterior portion of the meniscus and the flap tear were trimmed.

On June 27, 1986, Dr. Witczak performed an arthroscopy of the left knee and a partial medial meniscectomy.

On March 19, 1987, Dr. Neumann, orthopedist, performed an arthroscopy of claimant's left knee. A large tear in the medial meniscus and posterior horn was found. Dr. Neumann then performed a resection of the torn portion of the medial meniscus.

CONCLUSIONS OF LAW AND OPINION

If a claimant became medically stationary after January 1, 1988 and his or her claim was closed on or after July 1, 1988, a subsequent determination by a referee or the Board of the claimant's permanent partial disability must be made pursuant to ORS 656.283(7) and 656.295(5), respectively. OAR 438-10-005; Michelle Griffith, 40 Van Natta 2086 (1988).

Board review of the issue of permanent partial disability continues to be de novo on the hearing record. The underlying facts to which the "standards" are applied need only be established by a preponderance of the evidence. See ORS 656.283(7); 656.295(5); Michelle Griffith, supra.

In this case, the "standards" adopted effective July 1, 1988, former OAR 436-35-001 et seq., apply to the rating of claimant's permanent partial disability. Former OAR 436-35-010 through 436-35-260 apply to the rating of scheduled permanent partial disabilities. Former OAR 436-35-010(1).

The Referee found that claimant was entitled to a 25 percent (37.5 degrees) scheduled disability for loss of use or function that has resulted from claimant's compensable left knee injury. We agree with the Referee's conclusion. However, we reach our conclusion for different reasons.

Claimant is entitled to a value based upon her permanent loss of use or function in her left knee. The value given for claimant's lost range of motion in her left knee is based upon active degrees of motion. See former OAR 436-35-010(3). To calculate a loss of motion one of two methods is provided for by the

"standards". Id. The "standards" rate loss of motion by comparing the active degrees of motion of the injured body member to the degrees of motion possible in the contralateral normal joint, or by comparing the active degrees of motion of the injured member to the ranges of motion established, as normal, by the American Medical Association. Id. In the instant case, we rate claimant's lost range of motion by comparing claimant's injured left knee to the ranges of motion established, as normal, by the American Medical Association.

The Referee awarded claimant a value of 11 percent for her lost range of motion. We disagree. Claimant's range of motion in her left knee, as measured by Dr. Neumann, is 0 to 125 degrees. Claimant has retained 125 active degrees of flexion in her left knee. Pursuant to former OAR 436-35-220(1), claimant is entitled to a 9 percent value. Claimant can extend to 0 degrees and is therefore, entitled to no value for loss of extension. See former OAR 436-35-220(2). Claimant's total rating for loss of motion in her left knee is 9 percent. Former OAR 436-35-220(4); 436-35-240(2).

Claimant is entitled to a value pursuant to the "standards" for her partial medial meniscectomy. Former OAR 436-35-230(4)(c). Claimant has had two surgical procedures in which a portion of the medial meniscus was removed. We conclude that claimant is entitled to a value for only one surgical procedure unless there is evidence that claimant suffered a greater degree of impairment as a result of the second procedure. We find no such evidence in this case. Therefore, we conclude that claimant is entitled to a 5 percent value for a partial medial meniscectomy. Id.

To arrive at a total rating for impairment to claimant's left knee, the value for claimant's left knee lost range of motion (9 percent) and the value for her surgeries (5 percent) are combined (not added). See former OAR 436-35-220(4). The result of the combined values is 14 percent.

The Referee increased claimant's scheduled permanent disability as indicated by the "standards" based upon disabling pain, swelling and limitation which the Referee found decreased claimant's motion due to pain. Former OAR 436-35-010(2)(a) provides that pain can result in loss of use or function. When it does, it is rated based on the loss of use or function which results and no additional value is allowed for pain alone. The Board in Daniel M. Alire, 41 Van Natta 752 (1989), held that, inasmuch as the standards do not provide for a value range for impairment attributable to disabling pain, the Board on de novo review can consider the evidence and award the claimant a value that adequately compensates him for his loss of use or function attributable to disabling pain.

In this case, the record establishes that claimant has a loss of use or function attributable to disabling pain. Dr. Neumann concluded that claimant suffers from disabling pain that has resulted in a loss of use or function. Claimant's ability to stand for prolonged periods of time, her ability to sit for extended periods and her ability to lift, bend, stoop and squat are limited by pain. Under these circumstances, we conclude that claimant is entitled to a value, based upon her disabling pain which has resulted in a loss of use or function, of 10 percent.

Having determined each value necessary to compute claimant's permanent disability under the "standards", we proceed to that calculation. When the total value given pursuant to the "standards" for lost range of motion and surgeries (14 percent) is combined with the value for disabling pain (10 percent) the result is 23 percent scheduled permanent disability. Former OAR 436-35-220(4). We find that 23 percent scheduled permanent disability for loss of use or function of claimant's left leg (knee) adequately reflects claimant's disability from this injury. However, we do not reduce the Referee's award because

SAIF withdrew its contention that claimant's award should be reduced. See Daniel M. Alire, supra.

ORDER

The Referee's order dated November 10, 1988 is affirmed. Our November 16, 1989 Interim Order of Dismissal is republished.

June 8, 1990 Cite as 42 Van Natta 1211 (1990)

In the Matter of the Compensation of
GERALD DAVIDSON, Claimant
WCB Case No. TP-90030
THIRD PARTY DISTRIBUTION ORDER
Rasmussen & Henry, Claimant Attorneys
Michael O. Whitty (Saif), Defense Attorney

Claimant has petitioned the Board for resolution of a dispute concerning a proposed settlement of a third party action. See ORS 656.587. In the event that we find the settlement offer reasonable, claimant seeks a determination concerning the "just and proper" distribution of settlement proceeds. See ORS 656.593(3). We approve the settlement and conclude that a distribution in accordance with ORS 656.593(1) is "just and proper."

FINDINGS OF FACT

In August 1988, claimant sustained a compensable injury while performing his work activities as a truck driver. The injury occurred while claimant was unloading empty bread carts at the facilities of a third party. Claimant sustained injuries to his chest, forehead, nose, and mouth when a bread cart struck him and pinned him against a loading dock.

Claimant engaged legal representation to pursue a cause of action against the owner of the facility where the injury occurred. A complaint, alleging negligence and violation of the Employer's Liability Act, has been filed.

In preparation for trial, information has been obtained which suggests that the third party was aware of potential safety deficiencies in claimant's employer's trailers and had provided the employer with instructions concerning the modification of such trailers. Moreover, information was also uncovered which indicated that claimant was aware of these deficiencies and modifications. The aforementioned information was primarily provided by the safety manager for the third party and claimant.

Officials from claimant's employer did not assist in the preliminary investigation or trial preparation. The employer's safety director advised claimant that the information relevant to his lawsuit could be provided by the third party.

Contending that claimant was barred from recovering damages because he was in charge and control of the injury-producing activity, the third party filed a motion for summary judgment. Rather than proceed further in the case, the third party and claimant have agreed to settle the action for $27,500.

The SAIF Corporation, as paying agency, has asserted a third party lien totalling $49,275.73. It has declined to approve the settlement.

FINDINGS OF ULTIMATE FACT

The third party settlement offer of $27,500 is reasonable. A distribution of the settlement proceeds in accordance with ORS 656.593(1) is "just and proper."

CONCLUSIONS OF LAW

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. Dorotha M. Clarke, 40 Van Natta 1125 (1988); Kathryn I. Looney, 39 Van Natta 1140 (1987).

Here, after evaluating the purported strengths and weaknesses of claimant's action against the third party and considering the aforementioned standard, we conclude that the proposed settlement offer of $27,500 is reasonable. Consequently, we approve the settlement.

We turn to the issue of a "just and proper" distribution of the settlement proceeds.

After the deduction of attorney fees, litigation costs, and claimant's statutory 1/3 share, the paying agency shall be paid and retain the balance of the third party 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 claims under ORS 656.001 to 656.794. See ORS 656.593(1)(c). Such other costs do not include any compensation which may become payable under ORS 656.273 or 656.278. Id. The balance of the recovery shall be paid to the worker or beneficiaries. ORS 656.593(1)(d).

If the worker settles the third party claim with paying agency approval, the agency is authorized to accept as its share of the proceeds "an amount which is just and proper," provided that 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 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). We take such an approach to avoid making "equitable distributions on an ad hoc basis and to permit the parties to generally know where they stand as they seek to settle a third party action. See Marvin Thornton, 34 Van Natta 999, 1002 (1982).

Here, claimant contends that a distribution in which SAIF either does not receive a share or receives a reduced share of the settlement proceeds would be "just and proper." Specifically, claimant asserts that SAIF's insured's failure to cooperate in the preparation and litigation of the third party case, resulted in a less substantial recovery.

We find no persuasive reason to depart from the statutory distribution formula. To begin, it is unclear how the employer's failure to cooperate in claimant's third party claim diminished his recovery of damages. Moreover, based on the information already received from claimant and the safety manager from the third party, it would appear that the third party's defense to the claim, with or without the cooperation of claimant's employer, was formidable. In fact, it is at least arguable that the employer's participation may have been detrimental to claimant's case.

Finally, even assuming that claimant's contention could be substantiated, he would be advancing 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. See William C. Smith, 40 Van Natta 1259, 1261. We have consistently rejected such a position, reasoning that in the long run, the results of such an approach would probably be random, standardless, and, thus, inequitable. See Smith, supra; Cavil, supra; Thornton, supra.

Accordingly, the third party settlement is approved. We further hold that a distribution of settlement proceeds in accordance with ORS 656.593(1) is "just and proper." See ORS 656.593(3). Claimant's counsel is directed to distribute the proceeds of the third party settlement in accordance with ORS 656.593(1).

IT IS SO ORDERED.

In the Matter of the Compensation of
RONALD W. DAVIS, Claimant
WCB Case Nos. 83-08268, 83-07641 & 83-07640
ORDER ON REVIEW
Cummins, et al., Attorneys
Quintin B. Estell, Claimant Attorney
Dennis S. Martin (Saif), Defense Attorney

Reviewed by Board Members Nichols, Brittingham and Crider.

Robert Buker (dba Bob Buker Trucking), an alleged noncomplying employer, requests review of the portion of Referee Howell's order that found claimant's claim for injuries sustained in a motor vehicle accident compensable. The SAIF Corporation, as the insurer for Wes Roberts Automatic Fire Sprinklers ("Roberts"), cross-requests review of the portions of the order that: (1) found claimant's claim for the same injuries compensable; and (2) found it responsible for those same injuries. Ohio Casualty Insurance Company, the insurer for R & R Truck Brokers ("R & R"), cross-requests review of the portions of the order that: (1) found claimant's claim for the same injuries compensable; and (2) awarded an assessed fee to claimant's attorney for services rendered at hearing on the compensability issue.

We reverse and find claimant's claim not to be compensable.

ISSUES

1. Backup Denials of Claims. Did Buker or his processing agent SAIF accept the compensability of claimant's claim prior to the issuance of an order designating a paying agent pursuant to ORS 656.307?

2. Compensability.

a. Was claimant a subject worker employed by Buker, Roberts or R & R?

b. Did claimant's injury arise out of and in the course of his employment?

3. If compensable, responsibility.

4. If compensable, assessed fees.

FINDINGS OF FACT

This claim arises from a motor vehicle accident on June 16, 1983, involving a single tractor-trailer driven by claimant. In early 1983 claimant was employed as a truck driver for Buker, who owned and operated a trucking firm based in Turner, Oregon. Claimant initially trained under Buker and, in about April or May, 1983, began taking short driving trips on his own. Buker paid claimant a percentage of earnings for each assignment.

R & R is in the business of arranging with shippers and truckers for the transportation of goods. Its salesmen solicit orders from shippers who want loads delivered, while dispatchers locate available truckers for those loads. When the goods are delivered, R & R bills the shipper for its fee, keeps a percentage of the fee as its commission, and sends the rest to the trucker.

Roberts, a fire sprinkler installation firm based in Grants Pass, Oregon, contacted R & R in early June, 1983, to secure transportation for pipe which was being shipped from the Port of Vancouver, Washington. R & R agreed to arrange the transportation from the Port of Vancouver to Grants Pass.

On or about June 14, 1983, Buker allowed claimant to take his first long driving assignment delivering a load of roofing material from Portland to Woodenville, Washington, using Buker's truck. Before the assignment, Buker told claimant not to consume any alcohol and not to carry any passengers. Claimant was supposed to deliver the load and return to Turner that same day. Meanwhile, Buker had tentatively arranged with R & R to transport Roberts' sprinkler pipe from Vancouver to Grants Pass on June 15 or 16.

Claimant left Turner and picked up the load of roofing material in Portland on June 14, 1983. He drove to Washington but did not deliver his load that day. Instead, he telephoned Buker to advise that he would not be returning that night. He also telephoned truck brokers to secure another load. On June 14 or 15, 1983, claimant arranged with Horizon Transportation, a truck broker, to pick up a load of sheetrock in Tacoma on the morning of June 16. Horizon advanced claimant an expense check for the trip. However, claimant had also arranged through R & R to pick up Roberts' sprinkler pipe in the Port of Vancouver on the morning of June 16. R & R contacted Buker to obtain approval for the arrangement. Buker agreed to that arrangement.

Horizon arranged for a crew to work early in Tacoma on the morning of June 16 in order to load Buker's truck. Claimant failed to appear, though he cashed the expense check advanced to him by Horizon. Horizon called Buker to find out what happened. Buker then called R & R and left a message for claimant with a dispatcher to bring his truck directly back to Turner when the loading of Roberts' sprinkler pipe was completed.

On the morning of June 16, 1983, Roberts' sprinkler pipe was loaded onto Buker's truck at the Port of Vancouver. After loading was completed, claimant called R & R and was told by a dispatcher that Buker wanted him to return his truck to Turner. R & R advanced claimant an expense check, which he then cashed.

While traveling south on Interstate-5, claimant stopped at a truck stop in Portland. He left Portland with a passenger, Chris Evans, with whom he had been acquainted for a month. Claimant also picked up his ex-wife and their four-year-old son in Stayton. While doing so, he drove within a mile of Buker's Turner residence but did not contact him. By that time, Buker was anxious to find claimant and had another driver waiting to drive the load of sprinkler pipe to Grants Pass.

With his three passengers, claimant continued south on I-5. They stopped briefly at Canyonville, Oregon, where claimant had part of a mixed drink. At about 7:25 p.m., eight miles north of Grants Pass on I-5, the truck left the roadway, skidded along the the shoulder onto an embankment, rolled over and slid down the embankment. Chris Evans was thrown from the truck and died an hour later. Claimant, his ex-wife and son were trapped for about an hour. After being extricated from the truck, claimant was taken to the hospital and treated for injuries to his chest, left leg, face and left shoulder.

On June 28, 1983, claimant completed an initial workers' compensation claim form for the accident. Because Buker was neither insured nor self-insured at the time of the accident, the Workers' Compensation Department forwarded the claim to SAIF, the processing agent for noncomplying employers. Based on its investigation of the accident, the Department instructed SAIF to deny the claim on the ground that claimant was not a subject employee of Buker. On August 2, 1983, SAIF issued a denial on behalf of Buker. (Ex. 16).

The Department also forwarded claimant's claim to SAIF for processing on behalf of its insured Roberts in accordance with ORS 656.029. On August 2, 1983, SAIF denied the compensability of and responsibility for the claim on Roberts' behalf, alleging that claimant was not a subject employee of Roberts on the date of the accident. (Ex. 15). That same day, SAIF, as Roberts' insurer, wrote the Department, requesting the designation of a paying agent pursuant to ORS 656.307. (Ex. 14). No copy of the request was sent to Buker. No notice was mailed to Buker indicating the compensability portion of the claim had been conceded by SAIF. In the letter to the department no mention was made of Buker as a potentially responsible employer, just that they were processing the claim under .029. In that letter, SAIF wrote that compensability is not at issue and that Ohio Casualty, as R & R's insurer, may be responsible.

On August 22, 1983, Ohio Casualty denied responsibility for claimant's claim on R & R's behalf, alleging that SAIF was responsible. (Ex. 18). On August 30, 1983, the Department issued an order pursuant to ORS 656.307, finding that compensability is not at issue, referring the matter for hearing on the responsibility issue, and designating SAIF as the paying agent pending the responsibility determination. (Ex. 20).

On June 23, 1986, the first day of hearing, Buker orally denied the compensability of claimant's claim on his own behalf. (6/23/86 Tr. 1). On September 22, 1986, Ohio Casualty also denied the compensability of the claim, alleging that claimant's injuries did not arise out of the course and scope of his employment. (Ex. 25).

FINDINGS OF ULTIMATE FACT

1. We do not find that either Buker or his processing agent, SAIF, accepted the compensability of claimant's claim prior to issuance of an order pursuant to ORS 656.307.

2. Claimant was a subject worker of Buker; however, we do not find that his injury arose out of and in the course of his employment.

CONCLUSIONS OF LAW AND OPINION

Backup Denial

Citing Bauman v. SAIF, 295 Or 788 (1983), the Referee held that Buker and his processing agent SAIF were barred from denying the compensability of claimant's claim at hearing because SAIF had already conceded that the claim was compensable and was therefore bound by that concession. We find, however, that SAIF has never conceded compensability on Buker's behalf. In pertinent part, SAIF's denial reads:

> "We are unable to accept responsibility under [Robert Buker] as you were not a subject employee of Robert Buker, doing business as Bob Buker Trucking, on the date of your injury. Therefore, without waiving further questions of compensability, this formal denial is made."

(Ex. 16) (Emphases added).

The contention that claimant was not a subject employee of Buker at the time of injury arguably raises an issue of compensability, not only responsibility, because it challenges claimant's entitlement to compensation. See ORS 656.005(8). Furthermore, the denial letter expressly declines to waive further questions of compensability.

The Department is statutorily required to issue an order designating a paying agent, if responsibility is at issue and the employers/insurers all admit that the claim is otherwise compensable. See ORS 656.307(1). Where the employers/insurers concede compensability and a ".307" order subsequently issues, we treat that order as a formal acceptance of compensability by the employers/insurers. Judy Witham, 40 Van Natta 1982, 1986 (1988). Thereafter, the employers/insurers may not deny the compensability of the claim absent a showing of fraud, misrepresentation or other illegal activity. See Bauman v. SAIF, supra, 295 Or at 794.

Here, SAIF had never expressly conceded compensability on Buker's behalf. Hence, the .307 order was invalid, and we decline to treat it as a formal acceptance of compensability by Buker or his agent SAIF. Absent specific acceptance of the compensability of claimant's claim, Bauman v. SAIF, supra, does not apply to preclude Buker or his agent SAIF from denying compensability.

Compensability

On the merits, we adopt the portions of the Referee's conclusions and opinion that: (1) found claimant's testimony not to be credible; (2) found claimant to be a subject worker employed by Buker; (3) did not find him to be an employee of either R & R or Roberts; and (4) found that claimant's injury did not arise out of and in the course of his employment with Buker, because he refused to return Buker's truck and, instead, continued his journey south of Turner on I-5. (Opinion and Order, pp. 5-7).

Inasmuch as claimant was injured outside the course of his employment with Buker and claimant was not an employee of either R & R or Roberts, we conclude that his claim is not compensable. Accordingly, the remaining issues --- responsibility and assessed fees --- are moot.

ORDER

The Referee's order dated May 28, 1987, is reversed in part and affirmed in part. Those portions of the order that set aside Robert Buker's denial of June 23, 1986, Ohio Casualty Insurance Company's denial of September 22, 1986, and the SAIF Corporation's denial of August 2, 1983, are reversed. Those denials are reinstated and upheld. The Referee's assessed fee award of $2,400 to claimant's attorney is reversed. The remainder of the Referee's order is affirmed. The Board approves the following client-paid fees: (1) not to exceed $400, payable to Robert Buker's counsel; and (2) not to exceed $2,139, payable to Ohio Casualty's counsel.

Board Member Crider dissenting.

Claimant was injured while driving truck as Buker's employee. R & R, the trucking broker, had entered into an agreement with Buker whereby Buker would haul loads procured by the broker. R & R also entered into a contract with Roberts' Automatic Fire Sprinklers, Inc. whereby the broker would engage to deliver goods from one point to another. Buker did not carry workers' compensation insurance. Therefore, R & R, which had awarded the contract pursuant to which Buker was doing the haul for Roberts, was obligated to provide workers' compensation coverage for claimant. ORS 656.029(1). R & R is responsible for the claim.

The majority errs in several respects en route to denying claimant workers' compensation benefits. First, the majority holds that compensability is at issue because the .307 order was erroneously issued. I disagree. SAIF, on behalf of Roberts, its insured, denied "responsibility". The denial expressly stated that compensability was not an issue and that R & R Truck Brokers might be responsible. Another denial issued for Buker on the same day stated that claimant was not its employee on the date of injury. SAIF, on behalf of Buker, the noncomplying employer, denied responsibility saying, "we are unable to accept responsibility under this employer as you were not a subject employee of Robert Buker...on the date of your injury." Ohio Casualty, as insurer of R & R Truck Brokers, issued a denial stating that SAIF Corporation was responsible. In short, contrary to the majority's finding, none of the denials contended that claimant was not a subject worker. The dispute was not whether he was a subject worker but rather by whom he was employed. Such issues are classic grist for resolution pursuant to ORS 656.307. Therefore, the .307 order correctly issued.

Nevertheless, the question remains whether Buker was entitled to raise the compensability issue although SAIF, as processing agent, while denying the claim, conceded compensability.

Assuming, for the purposes of argument, that the noncomplying employer may raise a compensability issue which neither SAIF nor Ohio Casualty raised, I believe the majority errs in concluding that claimant was not within the course of employment when he was injured.

Claimant was hired by Buker to drive truck. Claimant arranged with R & R and his employer to pick up a load of Roberts' pipe for delivery to Grants Pass. He was injured in a motor vehicle accident north of Grants Pass.

The majority holds that claimant was not in the course and scope of employment when the accident occurred because claimant had disobeyed instructions delivered by the R & R dispatcher, on behalf of Buker, to bring the truck in at Turner.

In Patterson v. SAIF, 64 Or App 652 (1983), the court observed that an employee "overstepping the boundaries defining his ultimate job responsibilities" may lose his coverage under the workers' compensation law; the court also held, however, that disobedience of instructions regarding the manner of performing his responsibilities is not tantamount to leaving the course and scope of employment. In Patterson, the employee was instructed to take an unruly patient to the edge of the Oregon Health Sciences University premises and to release him there. Instead, the employee handcuffed the patient, drove him to downtown Portland and then let him go. The employee was hurt while again seeking to restrain the patient and force him into the vehicle. The court held that the injury was compensable because claimant had violated instructions concerning the manner of doing his job but had not overstepped the boundaries of his ultimate job duties.

The same reasoning applies here. Claimant's job was to drive truck. He was injured doing so. While he disobeyed the employer's instructions to stop in Turner, the instructions did not terminate his employment. Therefore, claimant remained in the course and scope of employment when he was injured. See e.g., 1A Larson, Workmen's Compensation Law 6-7, section 31.00 (1979); Brown v. Forum Ins. Co., 507 S.W.2d 576 (Tex Civ App 1974); Liberty Mutual Ins. Co. v. Boggs, 66 S.W. 2d 787 (Tex Civ App 1933). The majority errs in concluding that mere disobedience of an instruction is equivalent to exceeding the boundaries of the employee's employment. Therefore, I dissent.

In the Matter of the Compensation of
KATHERINE T. HECKER, Claimant
WCB Case No. 87-09449
ORDER ON REVIEW
Malagon & Moore, Claimant Attorneys
Cummins, et al., Defense Attorneys

Reviewed by Board Members Brittingham and Crider.

The self-insured employer requests review of Referee Livesley's order that set aside its denial of claimant's occupational disease claim for bilateral carpal tunnel syndrome. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

Claimant began working at the employer's mill on November 17, 1986. Her first job consisted of pulling lumber on the rough drychain. After two weeks on that job, she transferred to the Number 4 planer chain, where she worked until around mid-February 1987.

The Number 4 planer chain job consisted of pulling lumber from the chain and placing it in "pockets", or stacks. The lumber was mostly green and of varied widths, with lengths ranging from 6 to 24 feet. The average size was 2" x 8" and the average length was 16 to 18 feet.

On the planer chain, claimant used a bilateral palmar pinch type of grasp to pull the lumber forward about two feet from the chain. She would then press down on the lumber with the proximal portion of both hands to start the lumber

gliding over a set of rollers onto a stack. As the lumber cleared the chain, she used a bilateral hook-type of grasp to support the lumber while placing it on the stack. It was a very repetitive task, occurring 2 to 4 times each minute, sometimes 5 to 6 times each minute. Three full loads every two hours were pulled. A full load consisted of some 224 boards, 2" x 6" in size.

About three weeks after she began working on the Number 4 planer chain, in December 1986, claimant first began having problems with her hands. She had stiffness in her fingers and numbness in her hands. The stiffness became worse over the months. On March 13, 1987, claimant filed her claim.

Claimant had no previous problems with her hands and wrists before working for the employer, and no outside causative activities were identified.

Claimant first saw Dr. Carter, an orthopedic surgeon, in April 1987. Dr. Carter diagnosed an overuse flexor tenosynovitis of the flexor tendon sheaths of both hands, and a secondary carpal tunnel syndrome, mild to moderate in severity, both directly related to her work activities.

Dr. Nathan performed an independent medical examination on May 26, 1987. Nerve conduction studies were performed, which indicated nerve abnormality, and showed significant asymmetry of measured median nerve conduction at the wrists, with severe median nerve slowing on the right. Nathan noted that claimant's use of her upper extremities in her job appeared to be essentially equal. Dr. Nathan diagnosed bilateral carpal tunnel syndrome, severe on the right, moderate on the left and of idiopathic origin, and bilateral triggering. He recommended bilateral carpal tunnel release surgery.

Claimant terminated her employment in July 1987, and began more sedentary employment with another employer. Thereafter, her wrist complaints subsided. By November 1987 she had only some weakness, awkwardness, and an occasional throbbing pain in her hands.

Claimant was examined by independent medical examiner Dr. Ellison, a hand surgeon, in November 1987. He diagnosed bilateral carpal tunnel syndrome, industrially related.

FINDINGS OF ULTIMATE FACT

Claimant's symptoms are attributable to carpal tunnel syndrome, which is defined as a complex of symptoms resulting from compression and oxygen deprivation of the median nerve in the carpal tunnel. Claimant's work activities with the employer were the major contributing cause of the onset of her carpal tunnel syndrome.

CONCLUSIONS OF LAW AND OPINION

The employer contends that the Referee erred in concluding that claimant had demonstrated a compensable occupational disease. We disagree.

Claimant must demonstrate that her work with the employer was the major contributing cause of her occupational disease. Former ORS 656.802, Dethlefs v. Hyster Co., 295 Or 298 (1983).

The causation issue in this case is the type of complex medical question that requires expert medical analysis. The record contains relevant medical opinions from treating orthopedic surgeon Dr. Carter, and Drs. Nathan and Ellison, both hand surgeons. The opinions of the medical experts support the following findings and conclusions. First, claimant experienced no difficulties

with her hands before she began working for the employer. Second, claimant's work with the employer was the major contributing cause of her bilateral hand and wrist symptoms. Third, those symptoms are attributable to "carpal tunnel syndrome", defined as a complex of symptoms resulting from compression and oxygen deprivation of the median nerve in the carpal tunnel.

Accordingly, if "carpal tunnel syndrome" is the "occupational disease" in this case, claimant has demonstrated a compensable disease. However, the employer disagrees with this characterization of claimant's disease. It relies, instead, on an alternative definition put forth by Dr. Nathan. Nathan defined claimant's disease as the underlying nerve pathology, i.e., the slowing of the median nerve identified in electrodiagnostic tests. He did not believe that the carpal tunnel disease could reasonably be attributed to her work.

Dr. Ellison diagnosed bilateral carpal tunnel syndrome. He believed that claimant's work activity was ample explanation for the onset of symptoms and that they were the proximate cause of her continuing problems. (Ex. 12-6). Ellison opined that claimant's carpal tunnel syndrome was caused, aggravated, and accelerated by her work activity.

Dr. Ellison did not specifically state that claimant's work activities were the major contributing cause of her condition. (In addition, Dr. Carter concluded that claimant's work activities were a major contributing cause of the development of bilateral hand stiffness and nocturnal paresthesias indicative of bilateral carpal tunnel syndrome. (Ex. 11). However, "magic words" need not necessarily be used. See McClendon v. Nabisco Brands, Inc. 77 Or App 412 (1986). After reviewing the aforementioned physician their statements clearly indicate that they found claimant's occupation to be the major cause, if not the sole cause, of her disability.

We further note that even if Dr. Carter was in error concerning whether tenosynovitis could give rise to some symptoms of carpal tunnel syndrome, as Dr. Nathan suggested, this is not cause to discount his opinion. We consider Dr. Carter's opinion to be supportive of Dr. Ellison's opinion that the carpal tunnel syndrome was brought on by claimant's work.

Finally, when there is a dispute between medical experts, we give more weight to those medical opinions which are both well-reasoned and based on complete information. See Somers v. SAIF, 77 Or App 259 (1986). We find that Dr. Ellison's opinion meets both criteria and accordingly give his opinion the greatest weight.

Thus, we find that the preponderance of the medical evidence shows that the major contributing cause of the onset of claimant's carpal tunnel syndrome was her work activities. Accordingly, we conclude that claimant's carpal tunnel syndrome is a compensable occupational disease, and affirm the Referee's decision.

ORDER

The Referee's order dated April 6, 1988, as amended August 5, 1988, is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $875, payable by the self-insured employer. The Board authorizes a client-paid fee, not to exceed $2,744.50, payable by the employer to its counsel.

In the Matter of the Compensation of
DANIEL R. POWERS, Claimant
WCB Case Nos. 88-13366, 88-18827 & 88-18829
ORDER ON REVIEW
Kent Hickam, Claimant Attorney
Stafford Hazelett, Defense Attorney
Garrett, et al., Defense Attorneys
Rankin, et al., Defense Attorneys

Reviewed by Board Members Crider and Brittingham.

O & S requests review of Referee Seifert's order that: (1) set aside Liberty Northwest Insurance Corporation's denial, on behalf of O & S, of claimant's low back condition; (2) upheld Liberty Northwest's denial of the same condition, on behalf of Lebanon Servco Company; and (3) upheld Liberty Northwest's denial of the same condition, on behalf of Associated Industrial Contractors. On review, the issue is responsibility. We affirm.

FINDINGS OF FACT

Claimant is a welder. He has worked for a series of contractors on relatively short term jobs. The nature of the jobs varies.

On January 14, 1988, while working for O & S, claimant suffered a lifting injury. He continued to work despite back pain, thinking that he had suffered a muscle pull. He reported the incident to his supervisor who urged him to seek medical attention. Claimant did not seek medical attention although he continued to experience back pain and, consequently, avoided heavy lifting. No claim was filed at that time. Claimant's last day on the O & S job was January 16, 1988.

Claimant then worked for Associated Industrial Contractors (AIC) for two weeks; was without work for two weeks; and then began work for Servco. He worked for Servco until April 6, 1988. He worked for AIC for two weeks in April 1988 and again from mid-May through much of July 1988.

Claimant's back pain continued throughout this period. He suffered no discrete injury to the back. Nevertheless, the pain was exacerbated with activity, particularly heavy lifting, and became sharp when he lay on his back. In late May or early June, claimant began to notice numbness in the left leg and foot in addition to the back symptoms. He, therefore, made an appointment with Dr. Wessels, his family doctor. Dr. Wessels imposed a 20 pound lifting restriction and referred claimant to Dr. Melgard, neurosurgeon.

At that point, claimant filed a claim with O & S.

Dr. Melgard took claimant off work July 21, 1988. Claimant has a bulging disc at L5-S1, but his symptoms are not likely to be caused by that defect. The L4-5 interspace appears normal. Claimant improved considerably with conservative care.

O & S initially denied the claim on the ground that the claim was not compensable because it did not result in the need for medical care. Thereafter, O & S conceded compensability but denied responsibility.

Servco and AIC also denied responsibility only. No .307 order issued.

FINDINGS OF ULTIMATE FACT

Claimant's back condition is materially related to the January 14, 1988 injury while working for O & S. Claimant's subsequent work activities while employed by AIC and Servco did not independently contribute to a worsening of his condition.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant's employment following his January 1988 injury did not independently contribute to the causation of his back condition. He concluded that responsibility for claimant's back condition, therefore, must be assigned to O & S. We agree.

Claimant sustained a compensable injury in January 1988 although no claim was processed at that time. Therefore, O & S, his employer at the time of injury, remains responsible for medical services and disability which is materially related to the injury unless subsequent on-the-job injury or work exposure independently contributed to a worsening of claimant's condition. This means that subsequent work activities must have contributed not only to greater disability but also to a worsening of the underlying condition. Hensel Phelps v. Mirich, 81 Or App 290 (1986).

Dr. Wessels, Dr. Melgard and Dr. Kaesche, an independent medical examiner, all attributed claimant's condition solely to the January 1988 injury immediately following examination of claimant. Dr. Melgard and Dr. Kaesche both stated, upon inquiry by counsel, that claimant's post-January work could have contributed. However, Dr. Melgard made that statement in part based on the assumption that claimant's clinical problems might be related to a herniated disc; further study suggested that they were not. Moreover, the question before us is not whether the work could have contributed but whether it did contribute. We find that it did not.

O & S contends that responsibility should be assigned to the employer for whom claimant was working at the time claimant first missed work and sought treatment for his injury unless work for that employer could not have caused the condition. We disagree. The date of disability is key to the assignment of responsibility only in occupational disease cases. This case is not an occupational disease case. Claimant suffered a discrete injury in January 1988. The injury caused disability although claimant was able to continue working. Therefore, the injury was compensable.

In this case, there is absolutely no evidence that later employment caused the worsened condition. Further, the evidence is not in equipoise: It strongly suggests that all pathological damage was done in January 1988 and that subsequent activity merely affected claimant's symptoms. Consequently, we affirm the Referee's assignment of responsibility to O & S. Hensel Phelps, supra.

ORDER

The Referee's order, dated March 2, 1989, is affirmed. The Board authorizes a client-paid fee of $1,890, payable by Liberty Northwest Insurance Corporation, on behalf of Associated Industrial Contractors, to its counsel.

In the Matter of the Compensation of
CHARLES H. BURT, Claimant
WCB Case No. 88-18501
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
Garrett, et al., Defense Attorneys

Reviewed by Board Members Gerner and Cushing.

Claimant requests review of Referee Emerson's order that: (1) found that his back and right shoulder injury claim was not prematurely closed; (2) upheld the insurer's denial of his aggravation claim; (3) awarded 2 percent (6.4 degrees) unscheduled permanent disability for a cervical and lumbar spine injury, whereas a Determination Order awarded claimant no permanent disability; (4) upheld the insurer's unilateral termination of temporary total disability benefits; and (5) declined to assess penalties and associated attorney fees for an alleged unreasonable failure to pay compensation. On review, the issues are premature claim closure, aggravation, extent of unscheduled permanent disability, temporary total disability and penalties and attorney fees. We affirm in part, modify in part and reverse in part.

FINDINGS OF FACT

The Board adopts the Referee's Findings of Fact, with the following supplementation.

As of August 24, 1988, claimant was medically stationary, but had not been released to return to regular work.

Claimant suffers 3 percent permanent loss of earning capacity resulting from his compensable neck and right shoulder injury.

The Board adopts the Referee's "Findings of Ultimate Fact," except for the finding that, "As of August 24, 1988, claimant was medically stationary and was released to perform his regular work."

CONCLUSIONS OF LAW

Premature Claim Closure

The Board adopts the Referee's Conclusions of Law, as set forth in the "Conclusions and Opinion" portion of the order, with respect to the issue of premature claim closure.

Aggravation

The Board adopts the Referee's Conclusions of Law, as set forth in the "Conclusions and Opinion" portion of the order, with respect to the issue of aggravation.

Extent of Unscheduled Permanent Disability

The Referee awarded claimant 2 percent unscheduled permanent disability. We modify.

In determining the extent of claimant's permanent disability, the Referee applied the standards, former OAR 436-35-000 et seq, which were effective at the time of the September 1988 Determination Order. See OAR 438-10-005; 438-10-010;

ORS 656.726(3)(f); see ORS 656.283(7). These are the rules which we apply as well. ORS 656.295(5); OAR 438-10-005; 438-10-010.

The determination of permanent partial disability under the standards is made by determining the appropriate values assigned by the standards to the claimant's age, education, adaptability and impairment. Once established, the values for age and education are added and the sum is multiplied by the appropriate value for adaptability. The product of those two figures is then added to the appropriate value for impairment to yield the percentage of unscheduled permanent partial disability. Former OAR 436-35-280.

Age

The appropriate value for claimant's age of 33 is 0. Former OAR 436-35-290.

Education

Claimant has not returned to usual or customary work, and has not refused an offer of employment. He holds a high school diploma and has attended community college for three years. Therefore, no value is given under former OAR 436-35-300(3). Claimant has successfully performed the work of a rough carpenter during the ten years preceding the date of injury. The specific vocational preparation (SVP) for carpentry is 7. Thus, the appropriate value for skills is 1. Former OAR 436-35-300(4). Claimant holds a certificate of training as a body and fender mechanic. Thus, the appropriate value for claimant's training is 0. Former OAR 436-35-300(5). Therefore, the total value for claimant's education under former OAR 436-35-300 is 1.

Adaptability

An adaptability value for a claimant capable of performing heavy work, who is not working, is 1. Former OAR 436-35-310(4).

Impairment

The Referee found that claimant suffered 1 percent impairment resulting from his compensable November 1987 neck and right shoulder injury. We disagree.

In December 1988, claimant's range of motion findings in his dorsolumbar spine included 90 degrees flexion, 25 degrees extension, 25 degrees left and right lateral flexion and 50 degrees left and right rotation. Claimant's range of motion findings in his cervicodorsal spine included 35 degrees flexion, 45 degrees extension, 80 degrees left and right rotation and 34 degrees left and right lateral flexion.

Therefore, claimant is entitled to a value of .5 for retaining 25 degrees dorsolumbar extension. He is entitled to a value of .5 for retaining 34 percent cervicolumbar left lateral flexion and .5 for retaining 34 percent cervicolumbar right lateral flexion, for a total of 1 percent cervicolumbar impairment. Former OAR 436-35-360. After rounding up, claimant's total spinal impairment value is 2. Former OAR 436-35-360.

Computation of Unscheduled Disability

Having determined each value necessary to compute claimant's permanent disability under the standards, we proceed to that calculation. When claimant's age value (0) is added to his education value (+1), the sum is +1. When that value is multiplied by claimant's adaptability value (+1), the product is +1.

When that value is added to claimant's impairment value of 2, the result is 3 percent unscheduled permanent partial disability. Former OAR 436-35-280(7). Claimant's permanent disability under the standards is, therefore, 3 percent (9.6 degrees).

Unilateral Termination of Temporary Total Disability

The Referee found that claimant was released to regular work and medically stationary and concluded that the insurer's unilateral termination of temporary total disability was proper. We disagree.

An injured worker is entitled to temporary disability compensation until the worker is released to regular work and medically stationary or the worker becomes medically stationary and the claim is closed. Fazzolari v. United Beer Distributors, 91 Or App 592 (1988).

Claimant contends that he is entitled to temporary total disability from August 24, 1988 to September 22, 1988 because he was at no time released to return to regular work. We agree.

After our review of the record, we find that at the time the insurer unilaterally terminated temporary disability compensation, there was no medical evidence to conclude that claimant had, in fact, been released to regular work. The evidence consists of a hand-written note saying claimant is "released to work", and another document that has a list of potential limitations. Since the releaser did not authorize a "return to regular work" and there was a document that appeared to place restrictions on claimant, the evidence preponderates against a finding that claimant was released to regular work. Consequently, we find that, at the time temporary disability benefits were terminated, claimant had not been released to regular work.

Because claimant was not released for regular work, the insurer was not authorized to unilaterally terminate temporary disability compensation payments. Fazzolari v. United Beer Distributors, supra. Claimant is entitled to temporary total disability benefits from August 24, 1988 to September 22, 1988, the date of claim closure.

Penalties and Attorney Fees

The Referee declined to assess a penalty and attorney fee, finding that at the time the insurer terminated compensation, it had evidence from claimant's physician that claimant was released to regular work and was medically stationary. We disagree.

As we have already found, there was sufficient evidence at the time of the unilateral termination of compensation for the insurer to find that claimant had been released to modified work, rather than regular work. Because so, we found claimant entitled to temporary disability compensation from August 24, 1988 to September 22, 1988.

ORS 656.262(10) provides that an insurer is liable for a penalty and attorney fee, if the insurer unreasonably refuses to pay compensation. Given the information available to the insurer at the time it unilaterally terminated compensation, we find that the insurer's unilateral termination was unreasonable. See Petersen v. SAIF, 78 Or App 167, 172, rev den 301 Or 193 (1986). Claimant is awarded a penalty of 15 percent of the entire amount of unpaid temporary total disability benefits, and a related attorney fee.

ORDER

The Referee's order dated March 30, 1989 is affirmed in part, modified in part and reversed in part. In addition to Referee's increased unscheduled permanent disability award, claimant is awarded 1 percent (3.2 degrees) unscheduled permanent disability, for a total of 3 percent (9.6 degrees) unscheduled permanent disability. Claimant is awarded temporary total disability benefits from August 24, 1988 through September 22, 1988. Claimant is also awarded a penalty equal to 15 percent of the temporary disability awarded by this order and a penalty related fee of $300, payable by the insurer. Claimant's counsel is awarded 25 percent of the increased compensation created by this order, not to exceed $3,800, payable directly to claimant's attorney. A client-paid fee, not to exceed $945.50, payable by the insurer to its counsel, is approved.

June 11, 1990 Cite as 42 Van Natta 1226 (1990)

In the Matter of the Compensation of
VERA A. GRAY, Claimant
WCB Case Nos. 88-14728 & 88-05923
ORDER ON REVIEW
George W. Sohl, Claimant Attorney
Cowling & Heysell, Defense Attorneys

Reviewed by Board Members Gerner and Cushing.

The insurer requests review of Referee Podnar's order which set aside its denial of claimant's aggravation claim for a low back injury. On review, the issue is aggravation. We reverse.

FINDINGS OF FACT

In September 1987, claimant sustained a compensable injury to her low back. The compensable injury was a low back strain. She sought treatment for this injury from Dr. Casey, orthopedist. At that time, x-rays revealed pre-existing degenerative disc disease (osteoarthritis) and a large bone spur at L1.

In October 1987, the insurer issued a partial denial of claimant's pre-existing osteoarthritis and bone spur at L1. This denial was upheld by an earlier referee. The referee's order was not appealed and became final by operation of law.

Claimant stopped treating with Dr. Casey in January 1988. At that time, claimant's lumbar strain had resolved, however, she was still experiencing symptoms due to her osteoarthritis. In March 1988, claimant consulted with Dr. Laubengayer. A March 1988 Determination Order closed claimant's claim and did not award any permanent disability. The Determination Order was not appealed and became final by operation of law.

In May 1988, claimant consulted Dr. Bolton with complaints of pain in her back, right shoulder, arm and wrist as well as pain in her right hip and left knee. Dr. Bolton recommended consultation with a rheumatologist and a psychiatrist. This was the only time Bolton examined claimant. Between January 1988 and May 1988, claimant sought no medical treatment, with the exception of the one-time consultation with Dr. Laubengayer.

In August 1988, claimant began treating with Dr. Scheer, chiropractor. Between May 1988 and August 1988, claimant sought no medical treatment. On

August 22, 1988, the insurer denied Dr. Scheer's treatment on the basis that claimant's current condition was not related to her industrial injury.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant's industrial injury was a material contributing cause to her current condition. We disagree.

In order to establish a compensable aggravation, claimant must prove a worsened condition resulting from the compensable injury. ORS 656.273(1).

Inasmuch as claimant has preexisting osteoarthritis and did not seek any significant medical treatment between late January 1988 and August 1988, we conclude that the issue of whether the industrial injury is a material contributing cause of claimant's current condition is a complex medical question. Thus, although claimant's testimony is probative, the resolution of this issue largely turns on an analysis of the medical evidence. Kassahn v. Publishers Paper Co., 76 Or App 106, 109 (1985).

Dr. Casey opined that claimant's work-related strain had resolved by January 1988. He further reported that claimant had continuing symptoms, but opined that they were secondary to her noncompensable osteoarthritis. Dr. Laubengayer, who examined claimant in March 1988, reported that claimant had no significant residuals from the industrial injury and opined that there were no objective findings to support a diagnosis of continuing problems resultant from her compensable injury. Finally, in May 1988, Dr. Bolton opined that claimant should have recovered from the strain by that time.

Conversely, Dr. Scheer, who began treating claimant in August 1988, opined that claimant's current condition was secondary to the industrial injury. Scheer reported that her condition was complicated by congental anomalies in the lumbar spine.

We are persuaded by the opinion of Dr. Casey and the supporting opinion of Dr. Laubengayer. Dr. Casey originally treated claimant for the compensable injury and followed claimant for approximately five months thereafter. Inasmuch as he was claimant's original treating physician, he was in the best position to offer an opinion concerning the relationship between the compensable injury and claimant's current condition. See Kienow's Food Stores v. Lyster, 79 Or App 416 (1986).

By contrast, Dr. Scheer, who is currently treating claimant, did not begin treating her until approximately 11 months after the industrial injury. Further, Dr. Scheer does not adequately explain his conclusion that claimant's current condition is solely related to the industrial injury, particularly in light of her preexisting osteoarthritis. We, therefore, are not persuaded by Dr. Scheer's opinion. See David E. Gates, 40 Van Natta 798 (1988).

Under these circumstances, we conclude that claimant has not established that her compensable low back strain is a material contributing cause of her current low back condition. As we have found no material relationship, it follows that the aggravation claim is not compensable.

ORDER

The Referee's order dated March 14, 1989, is reversed. The insurer's denial is reinstated and upheld. The Referee's award of temporary disability benefits is reversed. The Referee's award of an assessed attorney fee of $2,400, to claimant's counsel is reversed. A client-paid fee, not to exceed $483.50 is approved, payable by the insurer to its counsel.

In the Matter of the Compensation of
LARRY B. NUNES, Claimant
WCB Case No. 88-14734
ORDER ON REVIEW
Muller & Dexter, Claimant Attorneys
Thomas Sheridan (Saif), Defense Attorney

Reviewed by Board Members Speer and Howell.

Claimant requests review of those portions of Referee Leahy's order that: (1) affirmed a Determination Order award of 40 percent (128 degrees) unscheduled permanent partial disability for a low back injury; (2) declined to award scheduled permanent partial disability for a left hip, leg and foot injury; and (3) declined to grant additional vocational assistance. In its brief, the SAIF Corporation contends that the Board does not have jurisdiction to determine the issue of vocational assistance. In addition, claimant has moved the Board for consideration of medical evidence which was not made part of the record. We construe the motion as a request for remand. On review, the issues are extent of unscheduled and scheduled permanent disability, remand and jurisdiction. We reverse in part and affirm in part.

FINDINGS OF FACT

The Board adopts the Referee's Findings of Fact with the following supplementation.

Claimant was 35 years old at hearing. He has 12 years of formal education and has no documented competence in a specific vocational pursuit.

From 1971 to 1983, claimant worked as a timber faller and a heavy equipment operator. Between 1983 and 1984, claimant worked as a musician. From 1985 to 1987, claimant was employed as a timber faller.

Claimant had disc herniation at the L5-S1 level and underwent laminectomy, diskectomy, and fusion surgery in 1987. Following the surgery, claimant broke both facet screws and underwent fusion surgery again in 1987.

Claimant's flexion of the cervical spine is 45 degrees. Extension of the cervical spine is 30 degrees with lateral flexion of 30 degrees bilaterally, rotation 90 degrees bilaterally without other features of abnormality.

Claimant's flexion of the dorsolumbar spine is 40 degrees. Lateral flexion of the dorsolumbar spine is 15 degrees and extension is 0 degrees. Rotation is normal.

Claimant has disabling pain in his left thigh, calf, and foot. Claimant's walking, sitting, driving and stair climbing are limited by his disabling pain.

CONCLUSIONS OF LAW AND OPINION

Remand

We construe claimant's motion for consideration of additional evidence as a request for remand. See ORS 656.295(5). The Board may remand a case to the Referee if it determines that the record has been improperly, incompletely or otherwise insufficiently developed. Id. Here, the additional evidence that

claimant wishes the Board to consider consists of a follow-up letter from Dr. Newby, claimant's treating physician.

After reviewing the document, we are not persuaded that the record below was improperly, incompletely or otherwise insufficiently developed. Accordingly, we decline to grant claimant's motion to remand this case for admission of additional evidence.

Permanent Disability

If a claimant became medically stationary after January 1, 1988 and his or her claim was closed on or after July 1, 1988, a subsequent determination by a referee or the Board of the claimant's permanent partial disability must be made pursuant to ORS 656.283(7) and 656.295(5), respectively. OAR 438-10-005 and Michelle Griffith, 40 Van Natta 2086 (1988).

The hearing and Board review of the issue of permanent partial disability continues to be de novo on the hearing record. The underlying facts to which the "standards" are applied need only be established by a preponderance of the evidence. However, either party may establish that the record, as a whole, constitutes clear and convincing evidence that the degree of permanent partial disability suffered by the claimant is more or less than the entitlement indicated by the "standards." ORS 656.283(7) and 656.295(5).

In this case, the "standards" adopted effective July 1, 1988, former OAR 436-35-001 et seq, apply to the rating of claimant's permanent partial disability.

Scheduled Permanent Disability

The Referee found that claimant had not shown any evidence that he was entitled to an award of scheduled disability for his left leg. We disagree.

Former OAR 436-35-010 through 436-35-260 apply to the rating of scheduled permanent partial disabilities. Former OAR 436-35-010(1). Claimant is entitled to an award based upon recognized impairment values for permanent loss of use of his left leg. A June 3, 1988 examination of claimant by Dr. Eisler, M.D., reported that claimant's gait was normal and he could squat and stand normally. The results of left leg sensory examination were also normal.

Claimant argues that he should be awarded permanent disability for pain which has resulted in a loss of use or function. We agree. Former OAR 436-35-320(1)(a) provides that pain can result in loss of use or function. When it does, it is rated based on the loss of use or function which results and no additional value is allowed for the pain alone. The Board, in Daniel M. Alire, 41 Van Natta 752 (1989), held that, inasmuch as the standards do not provide for a value range for impairment attributable to disabling pain, the Board on de novo review can consider the evidence and award claimant a value that adequately compensates him for his loss of use or function attributable to the disabling pain.

In this case, the record establishes that claimant has pain radiating down the back of his left thigh and calf and occasionally into his left foot. The pain in claimant's left leg limits him to walking one-quarter mile before he is required to rest due to leg pain and numbness. Claimant's sitting is limited to one-half hour at a time due to left back and left leg pain and numbness. Claimant's stair climbing is limited to ten steps before he is required to stop and rest.

Inasmuch as the standards do not provide for a value range for impairment attributable to disabling pain, we consider a value of 20 percent to be reasonable in this particular case.

Unscheduled disability

The Referee found that claimant had not proven entitlement to more than 40 percent unscheduled permanent partial disability under the standards. We agree.

Former OAR 436-35-270 through 436-35-440 apply to the rating of unscheduled permanent partial disabilities. Former OAR 436-35-270(1).

The determination of permanent partial disability under the "standards" is made by determining the appropriate values assigned by the "standards" to the claimant's age, education, adaptability and impairment. Once established, the values for age and education are added and the sum is multiplied by the appropriate value for adaptability. The product of those two figures is then added to the appropriate value for impairment to yield the percentage of unscheduled permanent partial disability. Former OAR 436-35-280.

The appropriate value for claimant's age of 35 years is 0. Former OAR 436-35-290(3).

The appropriate value for claimant's twelve years of formal education is 0. Former OAR 436-35-300(3)(a).

Skills.

Former OAR 436-35-300(4) adopts by reference the "SVP" (specific vocational preparation time) values assigned to various occupations by the Dictionary of Occupational Titles (DOT), published by the U.S. Department of Labor. The highest SVP level demonstrated by a claimant during the ten years prior to the date of injury is used to determine a value for skills. Former OAR 436-35-300(4). Claimant's highest SVP during the ten years prior to the date of injury was 4 as an all-round logger (DOT # 454.684-018). Therefore, the appropriate value for skills is 2. Former OAR 436-35-300(4).

Training.

Claimant has no documented training. Therefore, the appropriate value for training is 1. Former OAR 436-35-300(5). Claimant's total education value is 3, the formal education value, plus the skills value, plus the value for training. Former OAR 436-35-300(6).

Adaptability.

An adaptability value for a claimant who is unable to return to his or her usual and customary work [See former OAR 436-35-270(3)(a)] and who has not returned to modified work is determined by the claimant's residual physical capacity, without regard to that claimant's physical capacity prior to the injury. Former OAR 436-35-310(4).

Claimant is unable to return to his usual and customary work and has not returned to, or been offered, regular, modified work since he became medically stationary (when permanent disability is rated). Claimant's physical capacity falls between the light and medium categories as defined in former OAR 436-35-310(4). In such cases the values for the two categories are averaged to obtain the appropriate adaptability value. Former OAR 436-35-310(4). The average of 1, the value for medium physical capacity, and 4, the value for light physical capacity, is 2.5.

Impairment.

The final element necessary to determine disability under the "standards" is the impairment value. For reduced thoracolumbar flexion (from 90 degrees to 40 degrees) claimant is entitled to an impairment value of 5 percent. Former OAR 436-35-360(6). For reduced thoracolumbar extension (from 30 degrees to 0 degrees) claimant is entitled to an impairment value of 3 percent. Former OAR 436-35-360(7). Claimant's reduced thoracolumbar lateral flexion, as rated by the American Medical Association evaluation guides, entitles him to an impairment of 5 percent. Former OAR 436-35-360(7). For normal thoracolumbar rotation (30 degrees retained), claimant is entitled to no impairment value. The values for lost motion in claimant's thoracolumbar spine are added (not combined) to obtain a single value. Former OAR 436-35-360(10). In this case, the sum of the impairment values for lost thoracolumbar spinal motion is 13 percent.

For reduced lateral cervical flexion (from 40 degrees to 30 degrees bilaterally), claimant is entitled to 1 percent for each side. The sum of the impairment values for lost cervical spinal motion is 2 percent.

In addition to reduced spinal motion, claimant has a symptomatic residual, unoperated disc lesion. Claimant is entitled to an impairment value of 4 percent for that clinically significant disc derangement. Former OAR 436-35-350(2). For a single level discectomy at the L5-S1 level, claimant is entitled to an impairment of 5 percent. For his disc lesions and surgical procedures under former OAR 436-35-350(2), claimant is entitled to an impairment value of 4 percent added to 5 percent, for a total of 9 percent impairment value for his low back condition. Michael E. Crist, 42 Van Natta 1093 (1990).

Claimant has also undergone a fusion of the L4 and L5 vertebrae. He is entitled to an impairment value of 3 percent for that two-element fusion. Former OAR 436-35-350(3). Although that same surgery was repeated at the same site, there is no evidence of greater impairment resulting for the second surgery than is presumed by the rule to result from the first. We, therefore, grant the award for impairment due to fusion but once. Claudia J. Percy, 42 Van Natta 1209 (1990).

As described above, claimant is entitled to a value for pain which has resulted in a loss of use and function. Former OAR 436-35-320(1)(a). In this case, the record establishes that claimant suffers pain while standing and driving. Claimant is unable to run. On occasion, claimant is required to lie down with a pillow under his legs to relieve his pain. Inasmuch as the standards do not provide for a value range for impairment attributable to disabling pain, we consider a value of 10 percent to be reasonable in claimant's case.

The impairment values for claimant's disc derangement, lost cervical and lost thoracolumbar spinal motion, two-element fusion, and disabling pain are combined (not added) to obtain a single impairment value. Former OAR 436-35-360(11). However, former OAR 436-35-001 et seq, does not define the term "combine." We note then that current OAR 436-30-005(2) (effective January 1, 1988) and current OAR 436-35-005(4) (effective January 1, 1989) do define that term. Current OAR 436-35-005(2) defines "combine" as a means of putting two percentages together by use of the formula A% + B% (100% - A%) where A and B are written as decimals. (100% is presumably written as 1.00) We utilize that formula to combine percentages where required by former OAR 436-35-001 et seq. Here, 13 percent, 2 percent, 9 percent, 3 percent, and 10 percent combine to a value of 32.3 percent (to the nearest 1/10th of one percent).

Having determined each value necessary to compute claimant's permanent disability under the "standards," we proceed to that calculation. When

claimant's age value, 0, is added to his education value, 3, the sum is 3. When that value is multiplied by claimant's adaptability value, 2.5, the product is 7.5. When that value is added to claimant's impairment value 32.3 the result is 39.8 percent unscheduled permanent partial disability. Former OAR 436-35-280(7). That disability figure is rounded to the next higher whole percentage. Former OAR 436-35-280(7). Claimant's permanent disability under the "standards" is, therefore, 40 percent.

Jurisdiction

The Referee did not address the issue of entitlement to vocational rehabilitation. On review, claimant asserts that he has not received any vocational training although SAIF has made preparations for the provision of such training.

SAIF contends that the issue of vocational assistance cannot be determined on review because the Hearings Division did not have jurisdiction over the issue. We agree.

ORS 656.283(2) provides that if a claimant is dissatisfied with an action of the insurer regarding vocational assistance, he must first apply to the Director for administrative review of the matter before requesting a hearing on that matter. When claimant's entitlement to or participation in vocational assistance is at issue, it is a matter "regarding vocational assistance" within the meaning of ORS 656.283(2). cf. Gloria A. Severson, 41 Van Natta 2109 (1989). Because we are unable to find evidence that claimant first applied to the Director for administrative review on the issue, we agree that the Hearings Division did not have jurisdiction to determine his entitlement to vocational assistance. Argonaut Ins. Co. v. Workers' Compensation Dept., 89 Or App 591, rev den 305 Or 671 (1988).

ORDER

The Referee's order dated December 16, 1988, as supplemented January 6, 1989, is reversed in part and affirmed in part. That portion of the order that declined to award scheduled permanent disability is reversed. Claimant is awarded 20 percent (30 degrees) scheduled permanent disability for loss of use and function of his left leg. The remainder of the Referee's order is affirmed. Claimant's attorney is awarded 25 percent of the increased compensation created by this order, but the total fees approved by the Referee and the Board shall not exceed $3,000.

June 11, 1990 Cite as 42 Van Natta 1232 (1990)

In the Matter of the Compensation of
RUSSELL S. WILLIAMS, Claimant
WCB Case No. 88-21382
ORDER ON REVIEW
Charles D. Maier, Claimant Attorney
Cummins, et al., Defense Attorneys

Reviewed by Board Members Myers and Gerner.

The insurer requests review of those portions of Referee Foster's order which: (1) affirmed a Determination Order's award of temporary partial disability from September 2 through November 23, 1988; (2) assessed a penalty and attorney fee for the insurer's failure to pay temporary partial disability benefits for that period; and (3) awarded claimant 10 percent (19.2 degrees) scheduled permanent disability to the left arm, whereas a Determination Order had

awarded no scheduled permanent disability. Claimant cross-requests review of those portions of the Referee's order which: (1) found that the Determination Order did not prematurely close the claim; (2) failed to award temporary partial disability benefits through November 27, 1988; (3) upheld the partial denial of December 20, 1988; (4) failed to grant an award for unscheduled permanent disability; and (5) awarded claimant 10 percent (19.2 degrees) scheduled permanent disability for the left arm. On review, the issues are medically stationary date, penalty, attorney fees, compensability and extent of scheduled and unscheduled permanent disability. We affirm in part and reverse in part.

FINDINGS OF FACT

Claimant is an 18 year old who was working in the employer's mill in August 1988. On August 17, 1988, while pulling green chain, claimant's left elbow was struck by a piece of lumber causing a small abrasion and a contusion. Only the soft tissues around the elbow were injured. Claimant's treating doctor released him to regular work on September 1, 1988. By September 1, 1988 there was no reasonable expectation that claimant's condition would improve either through further treatment or the passage of time. Shortly thereafter, claimant returned to light-duty work at his regular pay. He worked for about ten days and then quit work for reasons unrelated to his compensable injury.

Claimant saw several medical doctors between the date of injury and December 1988. The physicians uniformly reported that claimant's subjective complaints far outweighed any objective findings. Claimant made no complaints of any problems other than the elbow until late October when he began complaining of shoulder problems. By November his complaints had shifted to his neck and upper back.

Claimant began seeing Dr. Kelley, a chiropractor, in December 1988. Dr. Kelley diagnosed "subacute traumatic moderate left SI syndrome with resultant referred left leg pain, acute traumatic moderate left costovertebral facet syndrome with resultant neuralgia and paresthesia, possible cervical intervertebral disc syndrome with resultant left upper body extremity paresis, and subacute moderate traumatic left lateral epicondylitis." The insurer denied compensability of all those conditions. Dr. Kelley concluded that those conditions were caused by claimant's accepted injury. He based that conclusion on his belief that claimant's injury involved having his left armed pinned against his body and being twisted and thrown back. That is not the way the injury happened.

CONCLUSIONS OF LAW AND OPINION

Medically Stationary Date

We conclude that claimant was medically stationary by September 1, 1988. At that time he was released to regular work. The preponderance of the medical evidence is that by that time the soft-tissue injury to his elbow had resolved. Consequently, from that time, there was no reasonable expectation that claimant's accepted left elbow injury would improve either with treatment or the passage of time. Claimant was not entitled to temporary partial disability from September 1, 1988 forward as awarded by the Determination Order, which was affirmed by the Referee. Consequently, we reverse.

Penalty and Attorney Fee

Likewise, claimant has failed to prove that the insurer was procedurally unreasonable in failing to pay temporary partial disability benefits from September 2, 1988 through the date of the Determination Order. Claimant admittedly returned to work at regular pay shortly after September 1, 1988. Claimant testified that he left work because of his pain; however, he also testified that

he told his supervisor that he was leaving work because he did not know what was wrong and did not want to endanger his future career aspirations by worsening his injury. Based on claimant's own testimony, we conclude that he did not leave work due to the effects of his compensable injury. Rather he left work due to fear of reinjury. Because claimant had returned to work at his regular pay, his rate of temporary partial disability was zero. Having left work for reasons other than his injury, he continued to be entitled to temporary partial disability benefits at the rate of zero. Safeway Stores v. Owsley, 91 Or App 475 (1988). Accordingly, the insurer was not unreasonable in failing to pay temporary disability benefits after September 1, 1988. No penalty or associated attorney fee is due.

Compensability

Claimant has the burden of proving by a preponderance of the evidence that the compensable injury is a material cause of the denied conditions. We conclude that claimant has failed to sustain his burden of proof.

The only doctor who links the compensable injury with the denied conditions is Dr. Kelley. We give Dr. Kelley's opinion little weight because we find that it is based on an erroneous history. Dr. Kelley believes that claimant was struck so forcefully with the piece of lumber that his arm was pinned against his body and he was twisted and thrown back.

Claimant's testimony was consistent with Dr. Kelley's history, albeit not as dramatically stated. However, claimant's co-worker testified that when he flipped a board back it merely hit claimant on the elbow. He specifically denied that claimant had been thrown back by the force of the board.

We give the co-worker's testimony greater weight than that of claimant. We do so because of numerous inconsistencies in this record. For example, claimant adamantly testified that he had reported back problems to all physicians dating back to a few days after the elbow injury. The medical reports reveal no mention at all of back complaints until two months after the injury. Furthermore, all physicians who have seen claimant, except Dr. Kelley, have noted that claimant's subjective complaints have far outweighed any objective findings. The inconsistencies as well as claimant's preoccupation with his symptoms cause us to question the reliability of claimant's testimony and the histories he has given. Accordingly, we give claimant's testimony no weight.

Because Dr. Kelley's opinion is based on an inaccurate history, we give it little weight and; therefore, conclude that claimant has failed to prove that it is more likely than not that the compensable injury is a material cause of the denied conditions.

Extent of Disability

Because we are upholding the partial denial and because absent the denied conditions, there are no effects to an unscheduled body part, the issue of extent of unscheduled disability is moot.

We disagree with the Referee that claimant has proven entitlement to scheduled disability. The only evidence that claimant has lost any use or function of the arm is his own testimony and the histories he has given to doctors. Because we have found his histories and testimony unreliable, we conclude that he has, likewise, failed to prove that he has lost any use or function of the arm due to the compensable injury.

ORDER

The Referee's order dated April 3, 1989 is affirmed in part and reversed in part. Those portions of the Referee's order which awarded claimant 10 percent (19.2 degrees) scheduled permanent disability to the left arm, affirmed a Determination Order award of temporary partial disability from September 2, 1988 through November 23, 1988, a penalty and a related attorney fee of $500, are reversed. The balance of the Referee's order is affirmed. The Board approves a client-paid fee, not to exceed $2,458.50, to be paid by the insurer to its attorney.

June 11, 1990 Cite as 42 Van Natta 1235 (1990)

In the Matter of the Compensation of
MARCELLA L. WOLTERSDORF, Claimant
WCB Case No. 88-17931
ORDER ON REVIEW
Vick & Gutzler, Claimant Attorneys
Meyers & Radler, Defense Attorneys

Reviewed by Board Members Cushing and Gerner.

The self-insured employer requests review of Referee Higashi's order which set aside its partial denial of claimant's claim for a temporomandibular condition (TMJ). In its brief, the employer also contends that the Referee erred in declining to admit an exhibit. On review, the issues are admission of evidence and compensability. We reverse.

FINDINGS OF FACT

Claimant began working for the employer in 1985 as a teacher's aide. In August 1985 she was involved in a nonwork-related automobile accident in which her car was struck from behind. As a result of the accident claimant sought treatment for severe neck pain and numbness on the right side of her face.

On October 25, 1985, claimant sustained an injury to her left shoulder when a room divider fell on her. This injury was accepted by the employer as nondisabling. On October 29, 1985, claimant was struck on the right side of the head by a soccer ball while on playground duty. She experienced temporary pain on the right side of her head.

On December 10, 1985, claimant was hit on the top of the head by a basketball. She experienced symptoms in her right neck, face and head. Her condition was diagnosed as a cervical strain and was accepted by the employer. In February 1986, it was noted that claimant had some dysfunction at the temporomandibular joints. In March 1986, claimant was involved in a second nonwork-related automobile accident which caused increased symptoms in her neck and back.

Claimant was off work during most of 1986. She took a job as a bank teller in December 1986, but left that job in September 1987 due to increased neck and back symptoms. A November 1986 Determination Order closed her claim awarding 10 percent unscheduled permanent disability for her compensable neck and upper back condition.

In June 1987, claimant was examined by Dr. Dougherty, dentist. He reported that claimant was suffering from TMJ. In June 1988, the employer denied claimant's TMJ condition.

CONCLUSIONS OF LAW AND OPINION

Admission of Evidence

The employer contends that the Referee erred in not admitting Exhibit 49. We disagree.

Exhibit 49 is a report from an independent medical examination that was prepared subsequent to the hearing. The employer requested that the Referee leave the record open for submission of this report on the basis that the author had not had time to complete it prior to the hearing.

Former OAR 438-06-091 provides that the parties shall be prepared to present all evidence at the time of hearing. The Referee, however, is allowed the discretion to grant a continuance for submission of further evidence provided that the party requesting a continuance can show, inter alia, extraordinary circumstances for failure to submit the evidence prior to or at hearing. See former OAR 438-06-081.

In this case, the employer had sent claimant to three independent medical examinations prior to the hearing. The report in question was generated from a fourth independent medical examination conducted three days prior to the hearing. In light of the fact that the employer had three independent medical reports already in evidence, we conclude that it has not established extraordinary circumstances which would account for its failure to submit Exhibit 49 in a timely fashion. Accordingly, the Referee did not abuse his discretion in declining to admit exhibit 49 into the record. We therefore have not considered Exhibit 49 on review.

Compensability

The Referee concluded that claimant's TMJ condition was compensably related to her industrial injuries. We disagree.

Claimant has sustained numerous injuries both work-related and nonwork-related. Therefore, the issue of whether her TMJ condition is compensably related to her industrial injuries is a complex medical question. Thus, although claimant's testimony is probative, the resolution of this issue largely turns on an analysis of the medical evidence. Uris v. Compensation Department, 247 Or 420, 426 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985).

Dr. Rosenbaum, neurologist, noted that claimant had some dysfunction in her right temporomandibular joint, but opined that it was not related to any of claimant's injuries. Dr. Judy, claimant's treating dentist, opined that claimant had mandibular dysfunction complicated by periodontitis. He attributed this condition to claimant's automobile accident of August 1985.

By contrast, Dr. Morris, chiropractor, opined that the automobile accident and the school yard incidents aggravated claimant's chronic TMJ condition. One panel from the Orthopaedic Consultants also reported that the school yard incidents aggravated claimant's condition. A second panel from the Orthopaedic Consultants reported that while claimant had TMJ symptoms, the etiology was unknown.

We are persuaded by the opinion of Dr. Judy, claimant's treating dentist. Neither Dr. Morris nor the first panel of the Orthopaedic Consultants offer any explanation for their conclusion that the school yard incidents aggravated claimant's TMJ condition. Further, while both Morris and the Consultants are

qualified to render an opinion, we accord greater weight to Dr. Judy as he specializes in the field of dentistry. See Gloria Serna, 42 Van Natta 54, 57 (1990). Accordingly, claimant has not established that her TMJ condition is compensably related to her industrial injuries.

ORDER

The Referee's order dated March 6, 1989, is reversed. The insurer's denial is reinstated and upheld. The Referee's award of an assessed attorney fee of $2,986, to claimant's counsel is reversed. A client-paid fee, not to exceed $1,526.70 is approved, payable by the insurer to its counsel.

June 12, 1990 Cite as 42 Van Natta 1237 (1990)

In the Matter of the Compensation of
JUDITH C. BRUGGER, Claimant
WCB Case No. 89-01114
ORDER ON REVIEW
Brownstein, et al., Claimant Attorneys
Randolph Harris (Saif), Defense Attorney

Reviewed by Board Members Speer and Howell.

Claimant requests review of Referee Leahy's order that: (1) upheld the SAIF Corporation's denial of her claim for reimbursement for medical services; and (2) declined to assess penalties and attorney fees for an alleged unreasonable denial. On review, the issues are medical services and penalties and attorney fees. We reverse.

FINDINGS OF FACT

The Board adopts the Referee's Findings of Fact with the following supplementation.

Claimant's acupuncture treatments are reasonable, necessary and due to the compensable injury.

SAIF has not formally denied any of the medical services claims in issue.

CONCLUSIONS OF LAW AND OPINION

Medical Services

The Referee dismissed claimant's request for hearing on the grounds that her grievance was against her treating acupuncturist, not against SAIF. The Referee found that claimant's acupuncturist had probably violated the billing procedures of OAR 436-10-110 and he concluded that it was not unreasonable for SAIF to refuse to reimburse claimant. We disagree.

Claimant contends that SAIF cannot deny her medical treatment because her physician refused to follow proper billing requirements. In Madden v. SAIF Corporation, 64 Or App 820 (1983), the court held that a claimant's medical benefits cannot be denied because of a physician's violation of administrative rules. The court found that there was nothing in the administrative rules that justified a unilateral decision by the insurer to refuse to pay medical bills. The court held that the the insurer's remedy in such a case was a complaint to the Director. Id at 824.

Claimant contends that the burden to file a complaint with the Director should be upon SAIF because the rule violated by her physician regulates the relationship between the physician and the insurer, not the physician and claimant. Claimant argues that SAIF's remedy is to pursue enforcement of the requirements, rather than to terminate her medical services benefits. We agree.

The issue of whether claimant's acupuncturist has violated billing and reporting rules adopted by the Director pursuant to ORS 656.248; 656.252 and 656.254, is not relevant to the compensability of medical services provided to claimant. On this record, it appears that the acupuncturist, Dr. Hung, may have violated former OAR 436-10-090(1),(2) and (5). SAIF could pursue a complaint against Dr. Hung through the Director and seek recourse under ORS 656.327. However, such proceedings are independent of the necessary determination in this case.

We do not agree with the argument that SAIF can refuse to pay for claimant's medical services. To be compensable, medical services must be reasonable, necessary and due to the compensable injury. See ORS 656.245. SAIF has not challenged claimant's entitlement to medical services on any of these grounds, and in fact, SAIF has not issued a formal denial of the claims in issue.

Claimant's attending physician has opined that her acupuncture treatment was reasonable and necessary on a long-term, palliative basis. SAIF has not asserted that the bills are not compensable under former OAR 436-10-040(4). Moreover, at hearing, SAIF admitted that it was willing to pay claimant's medical bills as long as it could do so under the rules. Under the circumstances, we conclude that SAIF may not refuse to pay for claimant's medical services, regardless of whether her acupuncturist failed to comply with proper billing procedure.

Penalties and Attorney Fees

The Referee did not assess penalties and attorney fees for SAIF's failure to reimburse claimant for medical services bills. SAIF argues that its decision was based upon a reasonable interpretation of the administrative rules. We disagree.

Although SAIF has cited OAR 436-10-090(1) and (2) in support of its argument that it was reasonable to stop payment of claimant's medical services, we conclude that those rules provide billing form requirements only. SAIF was entitled to seek recourse against Dr. Hung, but the rules that provide for billing requirements do not supply an adequate basis for SAIF's "de facto" denial of claimant's medical services claim. We find SAIF's refusal to pay compensation to have been unreasonable and to warrant a penalty of 25 percent of the medical services in dispute and a $100 attorney fee.

ORDER

The Referee's order dated February 28, 1989 is reversed. The SAIF Corporation's "de facto" denial of claimant's medical services is set aside and the claims are remanded to SAIF for payment. For services at the hearing and on review, claimant's counsel is awarded an assessed fee of $1,100, to be paid by SAIF. Claimant is awarded 25 percent of the compensation due in this matter as a penalty and claimant's attorney is awarded a $100 fee in association with that penalty.

In the Matter of the Compensation of
BRUCE A. HATLELI (Deceased), Claimant
WCB Case Nos. 89-09905 & 89-14144
ORDER DENYING MOTION TO DISMISS
Malagon, Moore, et al., Claimant Attorneys
David O. Horne, Defense Attorney
Dennis Ulsted (Saif), Defense Attorney

Claimant has moved the Board for an order dismissing Wausau Insurance Companies' request for review on the ground that a copy of the request was not served on all parties. We deny the motion.

FINDINGS OF FACT

The Referee's order issued May 1, 1990. Wausau's request for review of the Referee's order was received by the Board on May 21, 1990. The request included a certificate of mailing, which indicated that copies of the request had been mailed to claimant's attorney, the SAIF Corporation and the Board on May 18, 1990. The request did not indicate that a copy had been provided to claimant.

On May 24, 1990, the Board mailed a computer-generated letter to all parties acknowledging the request.

CONCLUSIONS OF LAW

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, Wausau's request for Board review of the Referee's May 1, 1990 order was mailed to the Board on May 18, 1990, within 30 days of its issuance. Thus, the request is timely. See ORS 656.289(3).

"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, Wausau neglected to mail a copy of its request for review to claimant. However, claimant's attorney did receive a copy of the request. Moreover, no contention has been made that claimant has been prejudiced by not directly receiving a copy of Wausau's request for review. Absent such a finding, we hold that claimant's counsel's timely service 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, page 850-51; Nollen v. SAIF, supra.

Furthermore, computer-generated letters acknowledging Wausau's request were mailed to all parties to the proceeding on May 24, 1990. Since the Board's

acknowledgment letter was mailed to all parties to the hearing 23 days after the Referee's order, we conclude that it is more probable than not that claimant received actual notice of Wausau's request for review within the statutory 30-day period. See ORS 40.135(1)(q); John M. Carranza, 40 Van Natta 773 (1988); John D. Francisco, 39 Van Natta 332 (1987).

Accordingly, claimant's motion to dismiss is denied. Upon receipt of the hearing transcript, copies will be provided to the parties. Thereafter, the Board will implement a briefing schedule.

IT IS SO ORDERED.

June 12, 1990 Cite as 42 Van Natta 1240 (1990)

In the Matter of the Compensation of
KENNETH KJELLAND, Claimant
WCB Case No. 88-14691
ORDER OF DISMISSAL
Jolles, et al., Claimant Attorneys
Ray Miller (Saif), Defense Attorney

On May 22, 1990, we abated our April 30, 1990 Order on Review to consider a motion for reconsideration filed by claimant. Claimant contended that the SAIF Corporation had withdrawn its request for review of the Referee's order prior to our decision.

SAIF has responded by acknowledging that on February 17, 1989, it withdrew its request for review. We treat such an acknowledgment as a concession that the Referee's order shall stand unaltered. Accordingly, we withdraw our prior orders. The request for review is dismissed and the Referee's order is final by operation of law.

IT IS SO ORDERED.

June 12, 1990 Cite as 42 Van Natta 1240 (1990)

In the Matter of the Compensation of
TIMOTHY E. MOXLEY, Claimant
WCB Case No. 88-21700
ORDER ON REVIEW
William Bassett, Claimant Attorney
Carrol J. Smith (Saif), Defense Attorney

Reviewed by Board Members Speer and Howell.

Claimant requests review of Referee Quillinan's order that dismissed his request for hearing. On review, the issue is dismissal. We affirm.

FINDINGS OF FACT

Claimant attended an Informal Dispute Resolution Conference in which the SAIF Corporation's claims examiner advised that claimant's case was open for negotiation and compromise. On the Friday before the Monday morning scheduled hearing date, the SAIF examiner called claimant's counsel and reported that SAIF did not believe the case could be compromised or settled. On that same Friday, claimant mailed an affidavit and a written request for postponement to the Referee, stating that he had relied upon statements made in the informal dispute conference and was unprepared to proceed at the Monday hearing. That affidavit

was received by the Hearings Division on the same day as the 9 a.m. Monday hearing.

Claimant's counsel made commitments to other clients to appear in District Court at the time of the Monday morning scheduled hearing date. Neither claimant nor his counsel appeared at the hearing. The Referee dismissed claimant's request for hearing and subsequently denied his request for postponement because claimant's affidavit did not set forth facts demonstrating that claimant or his counsel could not have appeared at the time of hearing.

CONCLUSIONS OF LAW AND OPINION

The Referee dismissed claimant's request for hearing because neither claimant nor his counsel appeared at the hearing. We agree with the Referee that dismissal was proper. See former OAR 438-06-071.

The Referee denied claimant's motion to reconsider the dismissal order. She concluded that claimant had not provided reasons sufficient to justify a postponement. We agree.

We conclude that claimant's reliance upon SAIF's statement that the claim was still negotiable and the commitments of his counsel to other clients do not constitute extraordinary circumstances beyond the control of the party requesting postponement. See ORS 656.283(4) and OAR 438-06-081. The Referee therefore properly denied claimant's motion to reconsider the order of dismissal and postpone the hearing.

ORDER

The Referee's order dated March 13, 1989, as reconsidered March 24, 1989, is affirmed.

June 12, 1990 Cite as 42 Van Natta 1241 (1990)

In the Matter of the Compensation of
BRENDA K. SEALUND, Claimant
WCB Case No. 88-16081
ORDER ON RECONSIDERATION
Malagon, et al., Claimant Attorneys
Schwabe, et al., Defense Attorneys

Claimant has requested reconsideration of that portion of our May 15, 1990 Order on Review that awarded claimant's attorney an assessed fee of $1,200 for services at hearing and on Board review concerning the issue of the insurer's medical services denial. Specifically, claimant requests that her attorney fee award be increased.

The insurer objects to claimant's request on several grounds. Noting that it has recently appealed our order, the insurer suggests that the court would be the appropriate forum to consider claimant's request. Secondly, the insurer argues that the listing of claimant's attorney's time, as submitted with the motion, does not differentiate between time spent at hearing concerning the medical services denial and other issues not addressed in our order. Finally, the insurer states that claimant's counsel did not advance the "prospective denial" theory upon which our decision was based.

The insurer's appeal notwithstanding, we have authority to withdraw our order for reconsideration. See ORS 656.295(8); SAIF v. Fisher, 100 Or App 288,

291-92 (1990). Under these circumstances, we choose to exercise this authority and proceed to consider claimant's request for an increased attorney fee.

After consideration of the parties' respective positions and following our review of claimant's counsel's statement of services and itemized time listing in light of the factors set forth in OAR 438-15-010(6), we award claimant's attorney an additional $500 as a reasonable fee for services at hearing and on Board review concerning the prospective denial issue.

Accordingly, our May 15, 1990 order is withdrawn. On reconsideration, as modified herein, we adhere to and republish our May 15, 1990 order. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
THOMAS B. SPAIN, Claimant
WCB Case No. 88-17429
ORDER ON REVIEW
Vick & Gutzler, Claimant Attorneys
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Howell and Speer.

Claimant requests review of Referee Mills' order which: (1) affirmed a Determination Order that did not award unscheduled permanent partial disability for his neck and back condition; and (2) upheld the self-insured employer's denial of claimant's chiropractic care for the same condition. On review, the issues are unscheduled permanent disability and medical services.

The Board affirms in part and reverses in part.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact."

CONCLUSIONS OF LAW AND OPINION

We adopt the Referee's "Conclusions and Opinion" subject to the following discussion regarding the medical services issue.

The September 9, 1988 denial letter, in part, states:

> "...The medical evidence that has been obtained states that the effects of the 5-6-87 injury have resolved and that no additional treatment would be related to that injury. Accordingly, and for that reason, we issue this formal partial denial of chiropractic treatment." (Ex. 29-1).

There is no evidence of bills due at the time of the denial. We, therefore, construe this to be a "prospective denial." Prospective denials are impermissible. A carrier may not deny its future responsibility for payment of medical services for a previously accepted claim. ORS 656.245(1); Evanite Fiber Corp. v. Striplin, 99 Or App 353 (1989)

However, the record indicates that claimant continued treatment with Dr. Urban after the denial and up to the time of hearing. Because the parties treated those services as claimed and denied, the compensability of these post-denial services is at issue. See Hollie J. Rahim, 42 Van Natta 415, on recon 42 Van Natta 415 (1990); Rater v. Pacific Motor Trucking Co., 77 Or App 418 (1978).

On the merits, the Referee concluded that claimant's need for treatment was not causally related to his compensable injury. We agree and adopt his discussion in that regard.

We, therefore, set aside the employer's denial insofar as it prospectively denies claimant's medical services for his condition arising from the compensable May, 1987 injury. We uphold the denial insofar as it pertains to post-denial and prehearing treatment for nonwork-related injuries, diseases and conditions.

ORDER

The Referee's order, dated January 31, 1989, is affirmed in part and reversed in part. The employer's denial is set aside to the extent that it was prospective. The remainder of the Referee's order is affirmed. The unpaid treatments rendered between the date of the denial and the hearing are not compensable. For services at hearing and on review regarding the prospective denial issue, claimant's attorney is awarded an assessed fee of $200. The Board approves a client-paid fee, not to exceed $1,647.50, to be paid by the employer to its counsel.

June 12, 1990 Cite as 42 Van Natta 1243 (1990)

In the Matter of the Compensation of
IRIS J. WERTH, Claimant
WCB Case No. 87-00672
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Howell and Speer.

The self-insured employer requests review of those portions of Referee Shebley's order which: (1) set aside its denial insofar as it denied claimant's claim for a thoracic spinal injury; and (2) assessed a penalty and related fee for an alleged unreasonable denial. Claimant cross-requests review of that portion of Referee Shebley's order which did not award an assessed fee for services rendered on review. On review, the issues are compensability, penalties and attorney fees.

The Board affirms in part and reverses in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following supplementation.

On August 20, 1986, claimant was struck in the back by a door that opened behind her.

On October 3, 1986, claimant began treatment with Dr. Ordonez for her upper thoracic spine. (Ex. 4).

On October 8, 1986, claimant filed her claim regarding the August 20, 1986 injury. Her claim was deferred on October 27, 1986. (Ex. 1).

Claimant's claim was denied on December 17, 1986. The denial, in pertinent part, stated that the August 20, 1986 injury did not result in disability and/or need for medical services. (Ex. 9).

On September 10, 1987, a hearing was held on compensability of claimant's upper-mid and lower back conditions and the December 17, 1986 denial. By Opinion and Order dated September 30, 1987, Referee Shebley upheld the employer's denial insofar as it denied compensability of claimant's lower back condition but set aside the denial insofar as it denied compensability of claimant's upper-mid back condition. The Referee also awarded a penalty and related attorney fee on the basis that the upper-mid back denial was unreasonable.

On October 19, 1987, the employer requested review of Referee Shebley's September 30, 1987 Opinion and Order arguing that the denial should be fully reinstated and the penalty and attorney fee award stricken.

On February 8, 1988, claimant responded, alleging the Referee erred in allowing testimony about a statement from claimant, taken by an investigator, when the employer had failed to produce that statement after it was requested by claimant. Claimant moved to have the Board strike the testimony of the investigator. Claimant did not contest the Referee's finding that her lower back condition was not compensable.

On January 31, 1989, the Board issued an Order on Review (Remanding) which vacated Referee Shebley's order and returned the matter to the Referee. The Board directed the employer to disclose the investigator's statement to claimant. Claimant could then decide whether to offer the statement into evidence. If claimant chose to offer the statement into evidence, the Referee was to reconsider the claim in light of the new evidence.

On February 6, 1989, claimant asked the Board to reconsider its order remanding because it did not address claimant's request for attorney fees.

On February 22, 1989, the Board issued its Order on Reconsideration (Remanding), republishing its February 6, 1989 order, but noting on remand that "if the Referee subsequently concludes that claimant's compensation should not be disallowed or reduced as a result of the employer's request for Board review, he is directed to award claimant's counsel an attorney fee for services rendered on review."

On remand, claimant advised Referee Shebley that she did not wish to submit the investigator's statement. On March 16, 1988, the Referee issued an Order on Remand which "ratified and republished" his September 30, 1987 Opinion and Order. The Referee did not address the attorney fee issue.

CONCLUSIONS OF LAW AND OPINION

Compensability

The Referee found that claimant had clearly proven a work-related injury to her mid and upper back that required medical services and resulted in time loss. The Referee further held that claimant had not sustained her burden of proof that her low back condition was compensably related to her August 1987 injury. We adopt the Referee's discussion of these issues.

Penalty and Related Attorney Fee

The Referee found that, at the time the employer issued its denial, there was no medical or lay evidence casting any doubt upon the compensability of the upper back claim. Therefore, the Referee found the denial to be unreasonable and assessed a 25 percent penalty, and awarded a $250 penalty-related attorney fee. On review, the employer argues that it had a legitimate doubt as to the compensability of the claim and its denial was not unreasonable.

The reasonableness of the employer's denial of compensation must be gauged based upon the information available to the employer at the time of its denial. Price v. SAIF, 73 Or App 123, 126 n.3 (1985). In the present case, the employer received claimant's October 1986 claim indicating the August 1986 door incident caused her back condition. The employer deferred acceptance. The employer then received two physicians' reports indicating that the physicians were proceeding as if claimant's condition was work related based upon claimant's subjective history. These reports contained no independent evaluation of a causal relationship with claimant's employment. Additionally, the employer received Dr. Ordonez's October 1986 report indicating that he was merely leaning towards finding a work relationship based upon claimant's subjective history. The reports submitted to the employer prior to its denial present a weak substantiation of work-related causation. Accordingly, we find that the employer did have a legitimate doubt as to the compensability of claimant's condition and its subsequent denial was not unreasonable.

Attorney Fee for Services Rendered on Board Review

Claimant requests an attorney fee for services rendered on Board review resulting in Board remand of the matter. Under ORS 656.382(2), the Board shall award a reasonable assessed attorney fee where the employer requests Board review and the Board does not reduce or disallow claimant's compensation. The Board in its Order on Reconsideration (Remanding) directed the Referee to award claimant's attorney a reasonable assessed fee for services rendered before the Board if the Referee concluded that claimant's compensation should not be reduced. The Referee in his Order on Remand, ratified and republished his Opinion and Order finding claimant's upper and mid back condition compensable and denying claimant's low back condition. However, the Referee did not award an assessed fee. On review, we affirm on the merits. Therefore, our assessed attorney fee award will reflect claimant's counsel's services resulting in both our prior remand order and this order regarding compensability of claimant's mid and upper back condition.

ORDER

The Referee's order, dated September 30, 1987, as republished by Order on Remand dated March 16, 1989, is affirmed in part and reversed in part. The Referee's award of a penalty and related attorney fee of $250 for unreasonable denial is reversed. The remainder of the Referee's order is affirmed. For claimant's attorney's prior services on review and for her attorney's current services on review for prevailing on compensability of claimant's upper and mid back condition, claimant's attorney is awarded an assessed fee of $1,300. The Board approves a client-paid fee, not to exceed $1,721.25.

In the Matter of the Compensation of
GARY D. BURYA, Claimant
WCB Case Nos. 89-00115 & 88-20352
ORDER ON REVIEW
Merrill Schneider, Claimant Attorney
Stafford Hazelett, Defense Attorney

Reviewed by Board Members Howell and Speer.

Claimant requests review of that portion of Referee Hoguet's order that declined to assess penalties and attorney fees for alleged unreasonable claims processing. On review, the issue is penalties and attorney fees. We affirm.

FINDINGS OF FACT

The Board adopts the stipulations of the parties and the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

The Referee found that the insurer's claims processing of claimant's right foot claim as nondisabling (and later, as disabling), was not unreasonable. We agree, but we base our conclusion upon the following reasoning.

The parties stipulated that the only medical report received by the insurer was the 827 form. The form describes claimant's foot injury and releases him to return to work. The work release was with some limitations but it cannot be determined if the limitations precluded claimant from his regular work. The insurer did not have additional evidence of medical treatment and it classified the right foot claim as nondisabling because claimant was released for work with regard to his foot claim and was already off work because of his back claim. Under the circumstances, we agree that the insurer's actions in initially failing to designate the claim as disabling were not unreasonable.

The insurer argues that, regardless of whether or not it was reasonable to designate the claim as disabling, the issue is moot because there was no compensation delayed or denied. The Determination Order pertaining to the right foot claim authorized payment of temporary partial disability and authorized offset of temporary total disability paid pursuant to the back claim. Because claimant had simultaneously been authorized time loss for his disabling back injury, no additional compensation was due solely to claimant's foot claim.

We agree with the insurer. No compensation was due, so any delay or denial could not result in penalties or attorney fees under ORS 656.262(10) and 656.382(1).

ORDER

The Referee's order dated February 27, 1989 is affirmed.

In the Matter of the Compensation of
KRISTI L. CHASE, Claimant
WCB Case Nos. 87-02944 & 87-01208
ORDER ON REVIEW
Francesconi & Associates, Claimant Attorneys
Meyers & Associates, Defense Attorneys
Saif Corp Legal, Defense Attorney

Reviewed by Board Members Perry, Howell and Speer.

The noncomplying employer requests review of Referee Emerson's order which: (1) declined to set aside the SAIF Corporation's acceptance, on its behalf, of claimant's injury claim for her left foot; and (2) awarded claimant 15 percent (20.25 degrees) scheduled permanent partial disability for loss of use or function of her left foot, whereas a Determination Order had awarded no permanent disability. On review, the issues are compensability and extent of permanent disability. We affirm.

FINDINGS OF FACT

The Board adopts the "Findings of Fact" as set out in the Referee's order with the following supplementation.

By letter dated November 13, 1986, the Compliance Division referred claimant's injury claim to SAIF for processing. SAIF accepted a left foot contusion, on behalf of the employer, on January 5, 1987, and notified the employer of this acceptance by letter dated January 7, 1987. The employer filed a request for hearing on February 24, 1987, within 60 days of SAIF's letter notifying it of acceptance but more than 60 days after referral of the claim to SAIF.

CONCLUSIONS OF LAW AND OPINION

Compensability

This case presents the question of whether a noncomplying employer, by virtue of its failure to comply with the coverage requirements of ORS 656.017(1), can defeat a claim under circumstances in which a complying employer could not.

In an ordinary case, a self-insured employer or an insurer must accept or deny a claim within 60 days of the employer's receipt of notice of the claim. ORS 656.262(6). If the claim is accepted, it may nonetheless be denied provided the 60-day period has not elapsed. If, however, the self-insured employer or insurer has accepted the claim, it may not deny the compensability of the claim more than 60 days after notice of the claim unless it can establish fraud, misrepresentation or other illegal activity capable of affecting acceptance. Ebbtide Enterprises v. Tucker, 303 Or 459 (1987); Bauman v. SAIF, 295 Or 788 (1983). The question here is whether, more than 60 days after a claim is referred to SAIF, as processing agent for a noncomplying employer, and after acceptance of the claim by SAIF, the noncomplying employer may challenge and potentially defeat the compensability of the claim absent a showing of fraud, misrepresentation or other illegal activity.

The Referee concluded that the noncomplying employer was precluded from challenging SAIF's acceptance of claimant's claim absent a showing of fraud, misrepresentation or other illegal activity. See Bauman v. SAIF, 295 Or 788 (1983). The Referee further concluded that the employer had failed to sustain its burden on that issue. Therefore, the Referee determined that the claim

would remain in accepted status. We reach the same conclusion. However, due to subsequent developments in the case law, we offer the following reasoning.

The Referee's holding that the noncomplying employer had the burden of establishing fraud, misrepresentation or other illegal activity was based upon upon our decision in Stephen L. Dokey, 38 Van Natta 788 (1983). In Dokey, we stated:

> "[W]e read Bauman to preclude all retroactive denials, except those specifically enumerated therein. Bauman does not distinguish between retroactive denials made by private insurers and those made by insurers assigned by operation of law. The policy of Bauman is to protect the interests of the injured worker and to preserve the stability of the workers' compensation system. We find we must apply Bauman to the present case as we would any other." 38 Van Natta at 1561.

Accordingly, in Dokey we held that Bauman applied to a noncomplying employer who challenged, by request for hearing, SAIF's acceptance of a claim on its behalf, just as if the noncomplying employer was attempting to deny the claim. The employer sought review.

On judicial review, the court affirmed. Derryberry v. Dokey, 91 Or App 533 (1988). However, the court expressly declined to address the Bauman issue discussed in our order. Instead, the court held that the noncomplying employer did not properly deny the claim, because a denial must inform claimant of her hearing rights and be mailed to her pursuant to former ORS 656.262(8). Therefore, the court concluded, because SAIF properly accepted the claim and no party had ever denied the claim, claimant was entitled to compensation.

Subsequently, in Clark v. Linn, 98 Or App 393 (1989), the court disavowed that portion of Derryberry which suggests that it is a noncomplying employer's responsibility to accept or deny a claim. The court held that a noncomplying employer could request a hearing on SAIF's acceptance of a claim if it contested compensability whether or not the employer denied the claim pursuant to ORS 656.262. Accordingly, the court concluded that the employer was entitled to have the question of compensability determined. However, the court again did not address the Bauman issue.

Therefore, our conclusion in Dokey that the rule in Bauman applies to a noncomplying employer which challenges SAIF's acceptance has not been addressed by the court. Here, the employer argues that we should disavow our holding in Dokey. We decline to do so. Rather, for the reasons stated below, we reaffirm our holding in Dokey.

ORS 656.054(1) provides:

> "A compensable injury to a subject worker while in the employ of a noncomplying employer is compensable to the same extent as if the employer had complied with ORS 656.001 to 656.794. The director shall refer the claim for such an injury to the State Accident Insurance Fund Corporation within 60 days of the date the director has notice of the claim. A claim for compensation made by such a worker shall be processed by the State Accident Insurance Fund Corporation in the same manner as a claim made by a worker employed by a carrier-insured employer, except that the time within which the first instalment of compensation is to be paid, pursuant to ORS 656.262(4), shall not begin to run until the director has referred the claim to the State Accident Insurance Fund Corporation." (emphasis added)

A self-insured employer or insurer is required to accept or deny a claim within 60 days of notice of the claim. ORS 656.262(6). Likewise, upon referral from the director, SAIF, as processing agent for noncomplying employers pursuant to ORS 656.054, is required to accept or deny a claim within the 60 days provided in ORS 656.262(6). OAR 436-80-060(1)(d).

As noted above, in the usual case once 60 days have passed after notice of a claim which is later accepted, that claim cannot be denied and it remains compensable absent fraud, misrepresentation or other illegal activity. Bauman v. SAIF, supra. ORS 656.054 guarantees subject workers of noncomplying employers that their work-related injuries shall be compensable to the same extent as if the injury was suffered in the employ of a complying employer. It follows that a noncomplying employer may not defeat the compensability of a claim under circumstances in which a complying employer or its insurer could not.

Receipt of notice of a claim by a self-insured employer or insurer begins the 60 day period within which the claim must be accepted or denied. ORS 656.262(6). The equivalent point in time in a case in which a subject worker of a noncomplying employer files a claim is when SAIF, the statutorily designated claims processing agent for the noncomplying employer, receives notice of the claim on referral from the director. See ORS 656.054. In other words, once SAIF has accepted a claim and more than 60 days have passed since the claim was referred to SAIF (that is, SAIF received notice of the claim) the noncomplying employer may not be allowed to defeat the compensability of the claim without proving fraud, misrepresentation or other illegal activities capable of affecting acceptance. To hold otherwise would be to hold that accepted injuries of subject workers of noncomplying employers are compensable to a lesser extent than injuries suffered by workers in the employ of complying employers. This is true because otherwise, under ORS 656.283, a noncomplying employer could at any time request a hearing in an attempt to defeat an accepted claim. This could lead to years of uncertainty and would preclude subject workers of noncomplying employers from obtaining the same finality as to the compensability of their claims that is provided for other workers, a result prohibited by ORS 656.054(1).

As a corollary to the foregoing, if SAIF accepts the claim referred by the Director, it may nonetheless deny it provided that 60 days has not elapsed from the date of referral. Similarly, if the noncomplying employer requests a hearing challenging compensability of the accepted claim within 60 days of the referral to SAIF, then a litigation order finding the claim noncompensable operates to relieve SAIF of the duty to pay and such an order need not be based upon a finding of fraud, misrepresentation or other illegal activity. If, however, the request for hearing is filed more than 60 days from referral, a litigation order may relieve SAIF of the duty to pay only upon a showing of fraud, misrepresentation or other illegal activity.

Here, the employer did not file its request for hearing within 60 days of the referral. Therefore, the employer was required to prove fraud, misrepresentation or other illegal activity capable of affecting the acceptance. The Referee concluded that the employer had failed to sustain this burden. We agree and adopt his discussion of that issue.

Extent of Permanent Disability

We adopt the Referee's "Conclusion and Reasons" with regard to the extent of permanent disability issue.

ORDER

The Referee's order dated October 1, 1987 is affirmed. Claimant's attorney is awarded a reasonable assessed fee of $600 for services on Board review, payable by the SAIF Corporation, on behalf of the noncomplying employer. A client-paid fee, not to exceed $940, payable by the noncomplying employer to its counsel, is authorized.

June 13, 1990 Cite as 42 Van Natta 1250 (1990)

In the Matter of the Compensation of
JAMES E. GARNER, Claimant
WCB Case Nos. 88-14239 & 88-12545
ORDER ON REVIEW
Pozzi, Wilson, et al., Claimant Attorneys
Stafford Hazelett, Defense Attorney
Jerry Larkin (Saif), Defense Attorney

Reviewed by Board Members Brittingham and Nichols.

The SAIF Corporation requests review of those portions of Referee Podnar's order that: (1) set aside its denial of claimant's L4-5 herniated disc; (2) assessed a penalty and attorney fee for untimely disclosure of discovery documents; and (3) awarded a $4,450 assessed attorney fee. On review, the issues are compensability, penalties and attorney fees. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's "Findings."

FINDING OF ULTIMATE FACT

Claimant's L4-5 herniated disc is not materially related to his industrial injury of 1977.

CONCLUSIONS OF LAW AND OPINION

Compensability

SAIF contends that the Referee erred in concluding that claimant's 1977 compensable injury that resulted in a L3-4 herniated disc materially contributed to his current L4-5 herniated disc, for which he seeks medical treatment. We agree.

The Referee relied on the opinion of Dr. Wells, orthopedist, claimant's former treating surgeon. Wells opined that surgery to the L3-4 disc caused increased stress at the adjacent disc levels, which then accelerated the disease process and enhanced the possibility of a disc herniation at L4-5. However, Wells also stated that claimant's L4-5 disc condition was a new pathology and an expected progression of his underlying degenerative disc disease. We are not persuaded by Wells' opinion for the following reasons.

Claimant had no evidence of an L4-5 problem in 1977. Dr. Wells did not causally relate the L4-5 problem to the compensable accident itself. Nor did he offer objective proof to support his opinion that the previous surgery accelerated the L4-5 herniation, which became symptomatic more than 10 years after the L3-4 surgery. In addition, Wells offered no explanation as to how long the L4-5

problem would have taken to become symptomatic without the 1977 injury and ensuing surgery.

In contrast to the opinion of Wells, we find persuasive the opinion of Dr. Nelson, orthopedist and claimant's current treating doctor, that claimant's L4-5 condition was unrelated to claimant's previous herniation and accepted condition at L3-4.

Nelson, who reviewed claimant's eleven-year medical history, agreed with Dr. Norton, M.D., SAIF's medical administrator, who opined that claimant's condition is a poorly understood, naturally occurring degenerative disc disease found throughout the patient's lumbar spine. Nelson noted that there was radiographic evidence of severe disc degeneration in an advanced state in 1977, when claimant first developed back pain. Claimant's disease was considered premature for his age. Although Nelson stated that the 1977 injury was responsible for the L3-4 disc herniation and subsequent surgery, he opined that over the past ten years claimant has slowly developed disc degeneration at L4-5 with a left L5 radiculopathy as a result of the generalized spondylolysis. He further opined that claimant developed new pathology as a consequence of his naturally progressive, naturally occurring degenerative disc disease and that it developed independently and subsequent to the 1977 injury. We are persuaded by this rationale. Accordingly, we conclude that claimant has not established that his 1977 injury materially contributed to his L4-5 herniated disc.

Penalties and Attorney Fees for Untimely Discovery

The Referee assessed SAIF a 25 percent penalty for untimely provision of discovery documents. SAIF contends that claimant failed to prove a discovery violation because he did not establish when SAIF produced the documents so that the "amounts then due" could be calculated upon which to base a penalty. Alternatively, SAIF argues that the time for determining the "amounts then due" is at the time of compliance, rather than at the time of hearing, as the Referee determined.

Failure to provide documents pertaining to claims within 15 days of a request for hearing may be an unreasonable delay or refusal under ORS 656.262(10). OAR 438-07-015(2). Claimant filed a Request for Hearing on July 22, 1988. A letter from SAIF to claimant's attorney indicates that some of the documents were provided on September 14, 1988 and others on September 29, 1988. SAIF provided no explanation for the delay. As a result, we find that SAIF's failure to provide discovery timely was unreasonable. Thus, a penalty based on "amounts then due" may be assessed. ORS 656.262(10). Here, claimant had no procedural right to interim compensation at the time of the violation, as the claim was in own motion status. Nor did he have any substantive right to compensation, as his claim is not compensable. Consequently, there are no "amounts then due" on which to assess a penalty.

Unlike a penalty, an award of attorney fees is assessed under ORS 656.382(1), for unreasonably resisting the payment of compensation. Here, SAIF did not unreasonably resist payment of compensation where there was no procedural right to interim compensation and where the "claim" was unrelated to claimant's compensable injury. Therefore, no attorney fee should be assessed.

Assessed Attorney Fee

SAIF argues that the Referee's award of a $4,450 assessed fee is excessive. Because we find claimant's claim to be noncompensable, claimant is not entitled to an assessed fee in any amount. Accordingly, we reverse the Referee's assessed fee award.

ORDER

The Referee's order dated November 17, 1988 is reversed in part and affirmed in part. That portion of the order that set aside the SAIF Corporation's denial is reversed. The denial is reinstated and upheld. The penalty and associated $300 attorney fee assessed by the Referee against SAIF is reversed. The Referee's award of a $4,450 assessed fee, payable by SAIF, is reversed. The remainder of the Referee's order is affirmed.

June 14, 1990 Cite as 42 Van Natta 1252 (1990)

In the Matter of the Compensation of
MARTIN J. FOWLER, Claimant
WCB Case No. 88-12350
ORDER ON RECONSIDERATION
Charles D. Maier, Claimant Attorney
Merrily McCabe (Saif), Defense Attorney

On May 25, 1990 we issued an Order of Abatement stating that we had decided to reconsider our Order on Review dated April 30, 1990. In our initial order, we awarded claimant an additional 5 percent (7.5 degrees) scheduled permanent disability, for a total award of 7 percent (10.5 degrees) for loss of use or function of claimant's right leg (knee).

On reconsideration, claimant contends he is entitled to an additional value of 5 percent for loss of repetitive use and 5 percent for instability of his right knee, for a total award of 16 percent. Inasmuch as the administrative rule OAR 436-35-010(7), upon which claimant bases his request for "repetitive use" disability is not applicable to this case, we disagree. See OAR 438-10-005; 438-10-010. Moreover, after further consideration of claimant's contention that he suffers knee joint instability, we continue to conclude that he is not entitled to such an award because the record does not establish a measured degree of instability. See OAR 438-35-230(3).

Accordingly, our prior orders are withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our April 30, 1990 order in its entirety. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

June 14, 1990 Cite as 42 Van Natta 1252 (1990)

In the Matter of the Compensation of
JULIE A. GANNON, Claimant
WCB Case No. 88-21593
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
Cooney, Moscato, et al., Defense Attorneys

Reviewed by Board Members Gerner and Myers.

The insurer requests review of Referee Schultz's order that increased claimant's unscheduled permanent disability award for her contact irritant dermatitis condition from 8 percent (25.6 degrees), as awarded by Determination Order, to 29 percent (92.8 degrees). On review, the issue is extent of unscheduled permanent disability. We modify.

FINDINGS OF FACT

The Board adopts the Referee's Findings of Fact as our own, with the following supplementation.

Claimant is capable of performing light to medium work.

Claimant has sustained a 25 percent loss of earning capacity resulting from her compensable occupational disease.

CONCLUSIONS OF LAW AND OPINION

The Referee increased claimant's unscheduled permanent disability award from 8 percent to 29 percent. In making his determination, the Referee concluded that claimant had proven "by clear and convincing evidence" that she suffered permanent disability in excess of that awarded by a strict application of the standards. We disagree.

After our de novo review of the record and analysis of claimant's impairment based on the standards, we find that claimant has met her burden of proving that she has suffered a loss of earning capacity that is greater than that awarded by the November 10, 1988 Determination Order. However, we find that claimant's loss of earning capacity is not as great as that found by the Referee.

The determination of permanent partial disability under the "standards" is made by determining the appropriate values assigned by the "standards" to the claimant's age, education, adaptability and impairment. Once established, the values for age and education are added and the sum is multiplied by the appropriate value for adaptability. The product of those two figures is then added to the appropriate value for impairment to yield the percentage of unscheduled permanent partial disability. Former OAR 436-35-280.

Age

The appropriate value for claimant's age of 28 years is 0. Former OAR 436-35-290.

Education

Claimant is a high school graduate. Therefore, claimant's value for formal education is 0. Former OAR 436-35-300(3). Claimant has successfully performed the work of an insurance clerk during the ten years preceding the date of injury. The specific vocational preparation (SVP) for an insurance clerk is 4. Thus, the appropriate value for skills is 3. Former OAR 436-35-300(4). There is no documentation demonstrating competence in a specific vocational pursuit. Therefore, the appropriate value for claimant's training is 1. Former OAR 436-35-300(5). After adding claimant's values for education together, we find that the appropriate total value for education is 4.

Adaptability

An adaptability value for a claimant who is unable to return to his or her usual and customary work [See former OAR 436-35-270(3)(a)] and who has not returned to modified work is determined by the claimant's residual physical capacity, without regard to that claimant's physical capacity prior to the injury. Former OAR 436-35-310(4).

Claimant is unable to return to her usual and customary work and has not returned to, or been offered, regular, modified work since she became medically stationary. Claimant's physical capacity falls between the medium and light

categories as defined in former OAR 436-35-310(4)(b)&(c). In such cases, the values for the two categories are averaged to obtain the appropriate adaptabiltiy value. Former OAR 436-35-310(4). The average of the two categories, +1 for medium and +4 for light, is 2.5.

Impairment

The Referee concluded that claimant's impairment resulting from her dermatological condition fell under Class 2, finding that claimant required intermittent treatment and that there is limitation in the performance of claimant's activities of daily living. Former OAR 436-35-440. Consequently, the Referee found that claimant's permanent impairment value was 15. We adopt the Referee's findings and conclusions on this issue.

Computation of unscheduled disability.

Having determined each value necessary to compute claimant's permanent disability under the "standards," we proceed to that calculation. When claimant's age value (0) is added to his education value (4) the sum is 4. When that value is multiplied by claimant's adaptability value (2.5) the product is 10. When that value is added to claimant's impairment value (15), the result is 25 percent unscheduled permanent partial disability. Former OAR 436-35-280(7). Claimant's permanent disability under the "standards" is, therefore, 25 percent.

Permanent Disability Outside the Standards

The Referee found that "there was no way to rate claimant's adaptability under the standards because she has a compensable condition that has resulted in permanent restrictions that cannot be measured simply by comparing her pre-injury and post-injury physical strength." The Referee went on to award claimant an additional 10 percent unscheduled permanent disability after taking judicial notice "of the fact that there are significant number of occupations that claimant is now foreclosed from working in." We disagree.

First, judicial notice may not be taken of clearly disputed facts. ORS 40.060 to 40.085. The issue of whether there are a number of occupations claimant is foreclosed from performing is a disputed fact. Judicial notice of adjudicative facts may be taken when such facts are generally known or capable of accurate and ready determination. ORS 656.065. This is not the case.

Second, the Referee rated claimant's adaptability under the "clear and convincing" standard. However, as we have already found, claimant's adaptability value is rateable under the standards, and we have so rated. Therefore, we disagree with the Referee's application of the clear and convincing evidence standard.

There is no clear and convincing evidence that claimant has sustained permanent partial disability in excess of that awarded under the standards. Consequently, we conclude that claimant has sustained 25 percent unscheduled permanent disability resulting from her 1988 compensable occupational disease.

ORDER

The Referee's order dated March 29, 1989, is modified. In lieu of the Referee's increased award, and in addition to the Determination Order award of 8 percent (25.6 degrees) unscheduled permanent disability, claimant is awarded 17 percent (54.4 degrees) unscheduled permanent disability, for a total of 25 percent (80 degrees) unscheduled permanent disability. A client-paid fee, not to exceed $962, payable by the insurer to its counsel, is approved.

In the Matter of the Compensation of
CAROLYN D. HAINES, Claimant
WCB Case No. 88-05830
ORDER ON REVIEW
Aller & Morrison, Claimant Attorney
Employers Defense Counsel, Defense Attorney

Reviewed by Board Members Gerner and Cushing.

The insurer requests review of that portion of Referee Danner's order that set aside its denial of claimant's occupational disease claim for her wrist and neck conditions. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

Claimant began working for the employer in April 1987. Claimant's work duties included operating a raimann machine, which involved repetitive handling of thin strips of plywood veneer, and repetitive lifting of a large steel table to unplug the machine.

After eight months of working for the employer, claimant began complaining of wrist pain. She sought treatment from Dr. Wiltse, M.D., in January 1988 for that condition. Wiltse diagnosed tendinitis in both wrists. (Ex. 4). Thereafter, the pain moved from her wrists into her arm and neck area.

Claimant filed an occupational disease claim in February 1988, and indicated that her symptoms began in December 1987 and early January 1988. She stopped working in February 1988 because of her condition. A March 1988 MRI revealed degenerative disc disease and spondylitic changes plus spinal canal stenosis at C5-6. (Ex. 8, 11).

The insurer issued a denial of claimant's "wrist, forearm, cervical and thoracic conditions" in March 1988. Claimant requested a hearing.

Claimant has a history of back injuries, stemming from 1974. She underwent a lumbar laminectomy and a laminectomy and fusion in 1974 and 1976, respectively, by Dr. Young, orthopedic surgeon.

Claimant's work activities involved a series of traumatic events which materially caused claimant's bilateral tendinitis and her current cervical condition.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant had met her burden of proving a compensable occupational disease. We agree.

For an occupational disease claim, the date of "injury" is the date upon which the claimant was last exposed to the employment conditions which cause the disease. Johnson v. SAIF, 78 Or App 143, rev den 301 Or 240 (1986). Claimant's last exposure to working conditions which could have caused her disease occurred in February 1988. Therefore, the occupational disease law, which became effective January 1, 1988, is applicable.

Here, claimant alleges that her wrist and cervical conditions began while working on a raimann machine, which required her to repetitively handle strips of veneer and lift a heavy steel table. We conclude that claimant's claim is for a condition resulting from a "series of traumatic events or occurrences" pursuant to ORS 656.802(1)(c).

Therefore, to establish that her condition arose out of and in the course of her employment, claimant must prove that her work exposure involved a series of traumatic events and was a material cause of her need for medical services and physical disability. ORS 656.802(1)(c); Donna E. Aschbacher, 41 Van Natta 1242 (1989); Carole J. Damm, 42 Van Natta 225 (1990). We find that she has met her burden.

Claimant has established that her work activities involved a series of traumatic events. She testified that the repetitive lifting of the heavy steel plate, part of the raimann machine which she operates at work, caused the onset of her wrist pain, pain which ultimately radiated up her arm and into her cervical spine. We find, therefore, that claimant's work activities involved a series of traumatic events.

The remaining issue, then, is whether claimant's traumatic work activities materially caused her need for medical services and her resultant disability. This issue is made more complex by the fact that claimant suffers from two conditions: bilateral wrist tendinitis and a cervical spine disorder. Furthermore, because claimant has a long history of back injuries, and because claimant's current cervical problems are intertwined with those past back problems, we find that the causation of claimant's current condition is of sufficient complexity that we cannot decide it without expert opinion. Uris v. Compensation Department, 247 Or 420, 424-26 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985).

Claimant's conditions have been evaluated by five physicians.

Claimant's treating physician, Dr. Wiltse, provided an evaluation of claimant's conditions in June 1988. He noted claimant's previous two lumbar laminectomies for disc protrusion, one in 1974 and another in 1976, but concluded that claimant's previous cervical problems are irrelevant to her present problem. He concluded, however, that disc protrusion, generally, relates to activity. (Ex. 22-1). After taking this into consideration, Wiltse then opined that claimant's "cervical disc problem is related to the activity of her employment, both as an aggravation of her previously existing cervical arthritis with bar formation; and as a primary cause of disc protrusion due to her activity and sometimes stressful work . . ." (Ex. 22).

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). We do not find the opinion of Dr. Wiltse to be persuasive as it lacks logical reasoning.

The mere fact that activity causes disc protrusion, a condition which claimant experienced many years prior to becoming employed with the employer, does not lead to the conclusion that claimant's current spondylosis changes were caused by her work activities. Furthermore, because claimant's disc protrusion surfaced in 1974 and again in 1976, it does not follow that claimant's current work activities with the employer are the "primary cause" of her disc protrusion. Therefore, we do not find the opinion of claimant's treating physician, Dr. Wiltse, to be persuasive.

Dr. Freeman, M.D., performed an independent medical evaluation in late June 1988. Freeman concluded that, "although predisposed to injury,

[claimant's] injury occurred at work." (Ex. 22A-2). Freeman made this determination without providing reasoning for his conclusion. At best, Freeman's opinion is conclusory. Therefore, we do not find it persuasive. Somers v. SAIF, 77 Or App 259, 262 (1986)

Dr. McHolick, M.D., evaluated claimant in April 1988. McHolick opined that claimant's current wrist condition is related to her work activities operating the raimann machine. However, he concluded, without a review of claimant's spine x-rays, that claimant's neck complaints are related solely to degenerative changes, not to her work activities. (Ex. 16). He further concluded that he did not relate claimant's neck condition "to the industrial overuse situation." (Ex. 19-3).

After our review of McHolick's opinions, we do not find them to be persuasive. He specifically noted that he had not reviewed claimant's spinal films. Rather, he based his opinion on one MRI. Finally, we note that he concluded his April 1988 report by stating that, "[i]t would be helpful to review the standard cervical spine films as the only other study to assist me in this assessment." (Ex. 19-3). Consequently, because McHolick's opinion is admittedly based on incomplete information, we do not find it persuasive. See Somers v. SAIF, supra.

Dr. Serbu, neurological consultant, evaluated claimant in March 1988. Serbu, in a cursory report, noted that the spondylitic bars in claimant's neck would not be aggravated by the repetitive lifting, such as required as part of claimant's work activities. (Ex. 10). He did not, however, offer any basis for this opinion. Further, he did not offer an opinion as to the causation of claimant's wrist condition. We find, therefore, that Serbu's opinion is conclusory, and as such, is not persuasive. Somers, supra.

Dr. Smith, M.D., the only other physician to evaluate claimant's condition, performed an independent medical examination in April 1988. Smith reviewed the history of claimant's medical condition, performed both a physical and neurological examination of claimant, and evaluated an MRI scan. Smith opined that claimant's cervical spondylosis was aggravated by the frequency and repetitive nature of her work activities, and concluded that claimant's wrist and cervical conditions are the result of her work activities. (Ex. 15-3).

We consider Smith's opinion to be thorough, well-reasoned, and based on complete information. Consequently, we find his opinion to be persuasive. See Somers v. SAIF, supra.

Accordingly, we hold that claimant has met her burden of proving that her current conditions were materially caused by her work activities with the employer.

ORDER

The Referee's order dated February 17, 1989, is affirmed. For services on Board review, claimant's attorney is awarded a reasonable assessed fee of $700, to be paid by the insurer. A client-paid fee, not to exceed $1,050, payable by the insurer to its counsel, is approved.

In the Matter of the Compensation of
DONNIE JENKINS, Claimant
WCB Case No. 88-19606
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
Employers Defense Counsel, Defense Attorneys

Reviewed by Board Members Myers and Cushing.

The insurer requests review of Referee Seymour's order which awarded claimant 5 percent (7.5 degrees) scheduled permanent disability for his right forearm and 15 percent (48 degrees) unscheduled permanent disability for his right shoulder, whereas a Determination Order had granted no award for permanent disability. On review, the issue is extent of permanent disability, both scheduled and unscheduled. We modify in part and reverse in part.

FINDINGS OF FACT

Claimant compensably fractured his right humerous in a logging accident on March 30, 1987. Dr. McHolick diagnosed a fractured right humerous and radial palsey. He repaired the fracture by inserting metal rods. One rod was later removed.

As a result of the compensable injury, claimant has some loss of finger dexterity and some altered sensation at the web of the thumb and over the mid portion of the radial aspect of the right forearm.

Claimant is capable of returning to his regular work.

CONCLUSIONS OF LAW AND OPINION

To establish entitlement to scheduled permanent disability, claimant has the burden of proving by a preponderance of the evidence that as a result of the compensable injury he has lost some use and function of his right forearm.

The Referee found claimant's testimony unreliable. We defer to that finding. Dr. McHolick opines that claimant has some loss of dexterity in his fingers and some altered sensation at the web of the thumb and on the distal radial aspect of the forearm. He attributes these problems to claimant's compensable injury. All other sensory problems, he ascribes to alcohol. Pursuant to former OAR 436-35-110(3)(a), the applicable rule, claimant is entitled to 3 percent scheduled permanent disability to the forearm for these losses.

The Referee awarded claimant 5 percent scheduled permanent disability based on clear and convincing evidence. We find no clear and convincing evidence that claimant has lost more than the 3 percent scheduled permanent disability he is entitled to under the standards.

Under the standards for rating disability, to establish entitlement to unscheduled permanent disability, claimant must first prove by a preponderance of the evidence that he has some impairment to an unscheduled body part as a result of his compensable injury. We conclude that claimant has failed to prove impairment.

Because claimant has retained over 150 degrees of shoulder abduction and shoulder elevation, we conclude that claimant has sustained no impairing loss of range of motion in the shoulder. Dr. McHolick notes that claimant has some grating and tenderness in the shoulder; however, there is no evidence that these

conditions impair claimant's use of his shoulder. Thus, there is no evidence that claimant's shoulder is disabling.

ORDER

The Referee's order dated March 16, 1989, as amended April 12, 1989, is modified in part and reversed in part. Those portions of the Referee's order which awarded claimant 15 percent (48 degrees) unscheduled permanent disability are reversed. Those portions of the Referee's order which awarded claimant 5 percent (7.5 degrees) scheduled permanent disability are modified; in lieu of the 5 percent award, claimant is awarded 3 percent (4.5 degrees) scheduled permanent disability to the right forearm. The Board approves a client-paid fee, not to exceed $1,099, to be paid by the insurer to its attorney.

June 14, 1990 Cite as 42 Van Natta 1259 (1990)

In the Matter of the Compensation of
BULAH REID, Claimant
WCB Case No. 88-12947
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Cushing and Myers.

The insurer requests review of Referee Foster's order which set aside its denial of claimant's occupational disease for a left wrist condition. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

Claimant is employed as a janitor. She has experienced right wrist pain since 1983. (Ex. 1-1). On November 19, 1986, claimant underwent a silastic implant of the right trapezium (right wrist). (Ex. 1-7). Claimant returned to work in January 1987. (Ex. 4-2). She did not have full use of her right hand because of residuals left over from the surgery. (Tr. 14).

Claimant filed a workers' compensation claim regarding her left wrist on February 21, 1988. The left wrist became swollen following each work shift. (Exs. 4-3, 4-4, 5, Tr. 12). Claimant's symptoms are the same in the left wrist as they were in the right wrist prior to the 1986 surgery. (Tr. 19). Claimant suffers from arthritis of the left wrist. (Exs. 7, 9-1, 9-2). She has no significant off work activities which require active use of her hands and wrists. (Tr. 16).

On June 8, 1988, the insurer denied claimant's claim for her left wrist condition. The insurer contended that the condition was not related to her employment duties. (Ex. 11).

Claimant underwent left wrist implant surgery on September 9, 1988. (Ex. 11). This was the same operation as the 1986 right wrist implant procedure.

During the eight years claimant has been employed as a custodian, her duties have remained approximately the same. (Tr. 4). Claimant does heavy mopping, sweeping, buffing, cleaning chalkboards, sweeping with a heavy push-broom seven outdoor entrances and changing lights. During the summer, claimant must clean overhead lights. This entails climbing tall ladders and taking

lights apart and cleaning them. (Tr. 4). Claimant's regular work activities involved a series of traumatic events.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant's left wrist condition was compensable, reasoning that her work was a material contributing cause of the wrist condition. We agree.

For an occupational disease claim, the date of "injury" is the date upon which the claimant was last exposed to the employment conditions which cause the disease. Johnson v. SAIF, 78 Or App 143, rev den 301 Or 240 (1986). Here, claimant's last work exposure which could have caused or contributed to her left wrist condition occurred in January 1988. Accordingly, the new occupational disease law, which became effective January 1, 1988, is applicable. Donna E. Aschbacher, 41 Van Natta 1242 (1989)

To be compensable under the new law, claimant's occupational disease must fall within one of the three subsections of ORS 656.802(1). Here, claimant worked for the employer as a custodian, a position which involves repetitive and physically demanding wrist exertion. We conclude that claimant's claim is for a condition resulting from a "series of traumatic events or occurrences" pursuant to ORS 656.802(1)(c).

To establish that her condition arose out and in the course of her employment, claimant must prove that her work exposure was a material cause of her condition. ORS 656.802(1)(c); Donna E. Aschbacher, supra; Carole J. Damm, 42 Van Natta 225 (1990). The causation of claimant's left wrist condition is a complex medical question. Thus, while claimant's testimony is probative, the resolution of this case largely turns on medical evidence. Kassahn v. Publishers Paper Co., 76 Or App 259, 263 (1986). Claimant has met her burden.

It is not necessary that physicians use the "magic words" required for meeting a legal test; rather the doctor's wording may strongly suggest that the applicable legal requirements have been met. See McLendon v. Nabisco Brands, Inc., 77 Or App 412 (1986). Dr. Steele, claimant's treating surgeon, began treating claimant in February 1988. He concluded that claimant suffered from traumatic arthritis of the left wrist. (Ex. 7). Steele noted that claimant's vigorous overuse of her left wrist at work had been a contributing cause to the acceleration of the arthritis and the subsequent need for medical treatment. (Ex. 11). Steele acknowledged that off work activities also contributed to the arthritis, nevertheless, he noted that claimant's work activity had been a "contributing cause" for the need for medical treatment. (Ex. 11).

On the other hand, Dr. Button, surgeon, diagnosed that claimant suffered from "degenerative idiopathic osteoarthritis" in the left wrist. (Ex. 9-1). He indicated that claimant's work activities had not materially altered the natural course of her preexisting arthritic process. Notwithstanding this opinion, Button noted that claimant's work exposure may have made her arthritic condition variably symptomatic. (Ex. 9-2)

We find Dr. Steele's opinion as claimant's treating physician, to be thorough and well reasoned. Weiland v. SAIF, 64 Or App 810 (1983); Somers v. SAIF, 77 Or App 259 (1986). Furthermore, we note that even Dr. Button conceded the existence of a causal relationship between claimant's symptoms and her work activities. Accordingly, claimant has established that her work exposure was a material contributing cause of her left wrist disability and need for medical treatment.

ORDER

The Referee's order dated November 25, 1988 is affirmed. For services on Board review, claimant's attorney is awarded an assessed fee of $750, to be paid by the insurer. The Board approves a client-paid fee, not to exceed $2,467.50, payable from the insurer to its counsel.

June 14, 1990 Cite as 42 Van Natta 1261 (1990)

In the Matter of the Compensation of
CHUCK H. SIBLEY, Claimant
WCB Case No. 88-09196
ORDER ON REVIEW
Peter McSwain, Claimant Attorney
Ronald K. Pomeroy (Saif), Defense Attorney

Reviewed by Board Members Speer and Howell.

The SAIF Corporation requests review of Referee Mongrain's order which set aside its denial of claimant's stress-related occupational disease claim. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

The Board adopts the Referee's "Findings of Fact."

CONCLUSIONS OF LAW AND OPINION

The Referee found claimant's occupational disease claim for stress-related hypertension compensable under ORS 656.802(1)(c). He reasoned that claimant had experienced traumatic job-related stress which was a material contributing cause of a worsening of his preexisting hypertensive condition. Moreover, he concluded that "traumatic events" as used in subsection (1)(c) of ORS 656.802 included psychologically traumatic occurrences. We disagree.

We have recently held that "traumatic" as it is used in ORS 656.802(1)(c) refers only to physical trauma, rather than psychological trauma. Ronald V. Dickson, 42 Van Natta 1102 (1990). Accordingly, claimant's hypertension is not compensable under ORS 656.802(1)(c) as being caused by a series of traumatic events. Furthermore, because claimant's disease did not result from exposure to radiation or substances included in ORS 656.802(1)(a), it is not compensable under that subsection. Id. Finally, since claimant does not have a diagnosed mental disorder, his claim is not compensable under ORS 656.802(1)(b). Id.

ORDER

The Referee's order dated January 17, 1989 is reversed. The SAIF Corporation's denial is reinstated and upheld. The Referee's award of an assessed fee to claimant's attorney of $4,000 is reversed.

In the Matter of the Compensation of
ROBERT F. SYKES, Claimant
WCB Case No. 88-05848
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Cushing and Gerner.

Claimant requests review of Referee Seifert's order that: (1) declined to award permanent total disability; and (2) affirmed a Determination Order which increased claimant's unscheduled permanent disability award of 5 percent (16 degrees), as awarded by an earlier referee, to 25 percent (80 degrees), for a 1982 myocardial infarction. On review, the issue is permanent total disability. We affirm.

FINDINGS OF FACT

Claimant suffered a prior compensable myocardial infarction in 1972 while working for the employer as a truck driver. A 1974 Determination Order awarded him 25 percent unscheduled permanent disability resulting from his 1972 myocardial infarction.

Claimant suffered a second compensable myocardial infarction in 1974 while working for the employer. He filed a second claim, which was closed by an August 1975 Determination Order, which awarded temporary disability, but no additional permanent disability.

In May 1975, claimant was referred to Dr. Bassford, M.D., for depression. By September 1975, claimant had recovered from both his emotional illness and myocardial infarction conditions. Claimant began treating with Dr. Lorenz, claimant's treating physician, in November 1977.

Claimant suffered a third myocardial infarction in July 1982. In August 1982, he filed an aggravation claim concerning his 1974 claim. In late August 1982, he underwent a quadruple bypass, under the treatment of Lorenz. That same month, the employer denied claimant's aggravation claim, as his aggravation rights had expired in 1979.

Claimant then filed a "new injury" claim. In November 1982, the employer denied that claim, which allegedly occurred on or about July 7, 1982, and denied responsibility for claimant's August 1982 bypass surgery. Claimant requested a hearing.

By Opinion and Order dated April 29, 1983, the employer's November 15, 1982 denial of responsibility for claimant's "new injury" claim for his July 1982 myocardial infarction and the medical services connected therewith was set aside. The employer's denial of responsibility for claimant's bypass surgery in August 1982 and the medical services therewith was upheld. (Ex. 31).

Claimant's "new injury" claim was closed by a December 1983 Determination Order, which awarded claimant no additional permanent disability. Claimant requested a hearing. By Opinion and Order dated January 25, 1985, claimant was awarded 5 percent unscheduled permanent disability for the July 1982 myocardial infarction.

In March 1985, claimant was laid off. When the mill reopened, it offered claimant work in a job pool. He declined the offer because Dr. Lorenz restricted him to light work. Because no light jobs were available, claimant did not return to work, and he has not worked since that time.

Claimant filed a physical aggravation claim in April 1985. The employer denied that claim three days later. In October 1985, the employer issued a denial of claimant's psychiatric condition, allegedly related to his accepted heart condition.

By Amended Opinion and Order dated April 1986, the employer's April 1985 physical aggravation denial was upheld, and the October 1985 denial of claimant's psychiatric condition, a sequela of his compensable myocardial infarction, was set aside.

Claimant's psychiatric condition was evaluated in December 1987 by the Psychiatric Associates. (Ex. 47).

An April 1988 Determination Order awarded claimant an additional 20 percent unscheduled permanent disability, making his total unscheduled permanent disability resulting from the 1982 myocardial infarction 25 percent. Claimant requested a hearing.

Claimant, 58 years of age at hearing, has a 7th grade education and has worked in the lumber industry his entire adult life.

ULTIMATE FINDINGS OF FACT

Claimant is capable of regularly performing work at a gainful and suitable occupation.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant had not proven entitlement to permanent total disability. We agree.

Permanent Total Disability

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" is "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." ORS 656.206(1)(a).

The preponderance of the evidence establishes that neither claimant's heart condition, nor his psychiatric condition, permanently incapacitates him from regularly performing work at a gainful and suitable occupation.

Claimant contends that the combination of his physical condition and his psychiatric condition entitles him to permanent total disability. In so contending, claimant relies on the opinion of Dr. Carter, claimant's treating physician. We disagree.

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). We find that there are persuasive reasons not to give greater weight to Carter's opinion.

Carter is the only physician to report that claimant is not capable of returning to regular gainful employment. He opined that claimant is "too severely impaired by both his physical and emotional illness to function regularly in any vocational setting where he might earn a living." (Ex. 48-1). Further, Carter was the only physician to opine that claimant continued to suffer from "emotional illness" resulting from his 1982 compensable myocardial infarction. Id. As a result, Carter recommended against claimant's return to work. Id. Claimant suggests the Board rely on Carter's opinion, and conclude that claimant is unable to return to regular gainful employment.

After our review of Carter's entire opinion, we do not find it to be persuasive as to permanent total disability. Carter noted in his February 1988 opinion that, "[i]f [claimant's] concerns about his perceived adverse interaction between he and [the employer] could be allayed, then much of his apprehension, anxiety, reactive depression, hostility and frank distrust would dissipate and his condition would be improved. In that case, there would be less permanent impairment than currently exists . . . ." (Ex. 48-1).

Consequently, we find that Carter's opinion that claimant is incapable of returning to work is based solely on claimant's inability to return to work for his previous employer, not the possibility of returning to other gainful and suitable work.
He did not render a specific opinion whether claimant was capable of regularly performing other suitable work. Under the circumstances, then, we do not find the opinion of Dr. Carter to be persuasive as to claimant's total disability.

The Psychiatric Associates, in December 1987, after a thorough evaluation, concluded that claimant does "not have any psychiatric or mental disorder that would permanently incapacitate him from regularly performing work at a gainful and suitable occupation. The emotional features of his adjustment disorder [as diagnosed by Dr. Holland in 1985] have resolved to the extent that he could return to gainful and suitable employment from a psychiatric standpoint." (Ex. 47-6, 47-7). We also note that the Associates took into consideration claimant's obsession that the employer treated him unfairly when formulating their opinion. (Ex. 47-2).

Further support that claimant's psychiatric condition does not prevent him from work is the opinion of Dr. Lorenz, another physician who had treated claimant. Lorenz, in June 1988, opined that claimant's "mental status is currently not playing a significant factor in his ongoing health problems." (Ex. 52). Lorenz reported that claimant was capable of sedentary part-time work. Id.

We find the opinion of Lorenz and the Associates to be more objective, well-reasoned and thorough. Therefore, we find their opinions to be more persuasive. Somers v. SAIF, 77 Or App 259, 262 (1986)

Finally, there is no medical evidence that claimant's heart condition, alone, is preventing him from returning to gainful employment. The result, then, is that there is no persuasive medical evidence that claimant is not capable of returning to regular gainful employment. The record is likewise devoid of any vocational evidence that claimant is incapable of returning to some kind of work.

Under the circumstances, then, we conclude that claimant is not permanently physically incapacitated from performing regular gainful employment, and is therefore not permanently and totally disabled.

Permanent total disability may also be proven under the "odd-lot" doctrine, which includes an analysis of claimant's vocational pursuits. However, in this case, claimant has failed to offer any competent vocational evidence that he is unable to regularly perform work at a gainful and suitable occupation. In fact, the Associates and Lorenz opined that claimant was capable of returning to gainful employment. Because claimant has failed to prove that he is unable to perform work at a gainful and suitable occupation, we find that claimant is not permanently totally disabled under the "odd-lot" doctrine.

ORDER

The Referee's order dated March 2, 1989, is affirmed. A client-paid fee, not to exceed $2,630.25, payable by the employer to its counsel, is approved.

June 14, 1990 Cite as 42 Van Natta 1265 (1990)

In the Matter of the Compensation of
JIMMIE C. WARD, Claimant
WCB Case No. 88-12202
ORDER ON REVIEW
Galton, et al., Claimant Attorneys
Thomas Ewing (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

Claimant requests review of Referee St. Martin's order which: (1) declined to grant permanent total disability; and (2) affirmed prior Determination Orders awarding a total of 44 percent (140.8 degrees) unscheduled permanent disability for a back injury and 14 percent (21 degrees) scheduled permanent disability for loss of use of the right leg. On review, the sole issue is permanent total disability. We affirm.

FINDINGS OF FACT

Claimant has a history of back injuries, the most recent being a compensable injury diagnosed as acute lumbosacral sprain, occurring on May 13, 1985.

Claimant was diagnosed as having arachnoiditis which is likely to be secondary to a myelogram. An MRI showed a prominent disc bulge at the L4-5 level, but no herniation.

Vocational services were terminated as futile because claimant views himself as being totally incapacitated with regard to his right lower extremity. His pain behavior precludes vocational rehabilitation efforts. He continuously uses crutches, wrist braces and wears a slipper on his right foot.

Claimant has a number of transferable skills including a broad range of mechanical skills which might be applicable to the manufacture, maintenance, or repair of light mechanical devices such as power tools and appliances. His experience in welding might qualify him for a quality control position in that

area. However, his physical presentation, including the use of crutches and pain behavior, precludes a viable job search.

Claimant is somatically focused and consciously accentuates his disability and pain complaints. He has not worked since May 1985, and is not motivated to return to work.

Claimant was 50 years old at the time of hearing. He has a GED and possesses numerous transferable skills as identified by vocational counselors.

It would not be futile for claimant to seek regular, gainful employment.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant was not permanently and totally disabled because he had not made reasonable efforts to seek work and because he was not willing to work. We agree.

To establish entitlement to permanent total disability benefits, claimant has the burden of proving that he is willing to seek regular and gainful employment and that he has made reasonable efforts to obtain such employment. ORS 656.206(3).

Claimant has stated that he considers himself retired due to his disabilities. His vocational assistance was terminated due to futility because of his exaggerated pain behavior. We conclude that claimant is not willing to return to regular and gainful employment.

Claimant is also required to establish that he has made reasonable efforts to obtain regular and gainful employment. We find, given claimant's transferable skills, that a reasonable effort would include cooperation with the vocational assistance providers. Because claimant did not so cooperate, nor is he motivated to cooperate, we conclude that claimant has not made reasonable efforts to obtain regular gainful employment.

If a work search is futile, the failure to make a reasonable effort to obtain employment will be excused. Butcher v. SAIF, 45 Or App 318 (1983). Claimant believes it would be futile to seek work because he believes he is totally disabled. However, his own perceptions of futility, while probative, are not controlling. His subjective testimony and beliefs of his abilities and disabilities are exaggerated and, therefore, we give them little weight. Vocational experts have opined that it would be counterproductive to provide vocational assistance because of claimant's exaggerated pain behavior and use of crutches and wrist braces. We conclude that it would not be futile for claimant to make reasonable efforts to obtain employment by cooperating with vocational assistance.

Because claimant has failed to establish that he is willing to seek regular gainful employment, and because he has failed to make reasonable efforts to obtain such employment, we conclude that he is not permanently and totally disabled.

Claimant makes no argument for an increase in his scheduled or unscheduled permanent partial disability awards. The insurer makes no argument for reduction. While we note that the Referee did not apply the standards to evaluate claimant's disability as was required by the law in effect at the time

of the Determination Order, we decline to adjust the award where neither party requests us to do so. Lyndia M. Bristol, 42 Van Natta 1069 (May 15, 1990).

ORDER

The Referee's order dated January 20, 1989 is affirmed.

June 14, 1990 Cite as 42 Van Natta 1267 (1990)

In the Matter of the Compensation of
SALLY A. WEBB, Claimant
WCB Case Nos. 88-17922 & 88-17923
ORDER ON REVIEW
Vick & Gutzler, Claimant Attorneys
Jerome Larkin (Saif), Defense Attorney
Ronald Rhodes, Defense Attorney

Reviewed by Board Members Speer and Howell.

North Pacific Insurance Company (North Pacific) requests review of Referee Foster's order which: (1) set aside its denial of claimant's aggravation claim for a low back condition; and (2) upheld the SAIF Corporation's denial of a "new injury" claim for the same condition. On review, the issue is responsibility. We affirm.

FINDINGS OF FACT

The Board adopts the Referee's "Findings of Fact" with the following supplementation.

Claimant originally injured her back in 1974 while working in California. In 1984, claimant again injured her back, which was accepted by North Pacific. Eventually, by stipulation, claimant received 10 percent unscheduled permanent partial disability for that injury.

In July 1985, claimant reported occasional left sciatica. (Ex. 14-4).

In February 1986, claimant had a worsening of her back symptoms and again in May 1986, claimant had another episode of worsening of symptoms. (Exs. 21 & 27).

On January 21, 1987, claimant complained of pain in her left leg that "seems to radiate from her left heel up to her left hip." (Ex. 43-3).

Claimant was off work most of 1987. She began work with SAIF's insured in 1988.

CONCLUSIONS OF LAW AND OPINION

This case involves an accepted compensable injury followed by an increase in disability during employment with a later employer/insurer. In such a case, responsibility is initially fixed with the employer/insurer which accepted the claim. In order to shift responsibility, the original employer/insurer must prove affirmatively that a later employment independently contributed to a pathological worsening of the accepted condition. Spurlock v. International Paper Co., 89 Or App 461 (1988); Crowe v. Jeld-Wen, 77 Or App 81 (1985); Fred

Meyer v. Benjamin Franklin Savings & Loan, 73 Or App 795 (1985); see Hensel Phelps v. Mirich, 81 Or App 290 (1986).

Here, the preponderance of evidence indicates that claimant continued to experience periodic work-related episodes of symptomatic worsening of her back condition. In February and May of 1986, Dr. McIntosh, claimant's treating chiropractor, reported that work incidents resulted in gradual worsening of symptoms from the 1984 injury.

Claimant argues that after the incident in August 1988 her symptoms were different than those she had experienced after the 1984 injury. Specifically, when asked at hearing to compare her symptoms of 1988 with the injury in 1984, claimant stated that the difference in 1988 was that she had "that pain that came from the back of my heel up the back of my leg." She stated that she did not remember leg pain previously.

However, claimant's testimony about the leg pain in 1988 is in direct contrast to the examination report of Dr. Bolin dated January 21, 1987. In that report, Dr. Bolin stated that "on the date of this examination, [claimant] complains of pain in the left leg, that seem to radiate from her left heel up to her left hip."

Additionally, claimant reported left sciatica in July 1985 when being examined by Dr. Clayton, D. C. Dr. McIntosh concurred completely with Dr. Clayton's opinion.

Claimant was examined by Medical Consultants Northwest on October 13, 1988. She expressed to them that she was off work most of 1987 because of her back. At hearing, she testified that she did not work because she had married and her husband said she did not have to work. After a complete physical examination and review of x-rays provided by Dr. McIntosh, the Consultants concluded that there was no evidence of a material worsening of claimant's condition, either clinically or radiographically, as a result of the August 1988 incident.

Claimant's treating physician, in a statement that provided no reasoning, said that it was his opinion that there was a significant and material worsening of claimant's condition as a result of her work for her employer in August 1988. We afford that opinion little weight because it is conclusory. Moe v. Ceiling Systems, 44 Or App 429 (1980); Weiland v. SAIF, 64 Or App 810 (1983). Accordingly, for the abovementioned reasons, we find that claimant's underlying condition has not been shown to have been worsened as a result of work with SAIF's insured.

ORDER

The Referee's order dated February 21, 1989 is affirmed.

In the Matter of the Compensation of
GARRY L. STILES, Claimant
WCB Case No. 88-16159
ORDER ON REVIEW
David Hollander & Associates, Claimant Attorneys
Daryll E. Klein, Defense Attorney

Reviewed by Board Members Cushing and Gerner.

The insurer requests review of Referee Schultz's order which set aside its denial of claimant's causalgia condition. Claimant cross-requests review of those portions of the Referee's order which: (1) declined to find that the denial constituted an invalid preclosure denial; and (2) declined to assess penalties and attorney fees for an alleged unreasonable denial. On review, the issues are compensability, claims processing, penalties and attorney fees. We affirm.

FINDINGS OF FACT

On May 17, 1988, claimant was injured twice at work while running plywood through a table saw. Both times, the plywood kicked back from the table saw. The first time, the plywood struck him about two inches below the navel causing a slight abrasion. Shortly thereafter, another piece of plywood kicked back and struck claimant sharply at waist level in the area of his left hip. Claimant felt immediate sharp pain. He kept working.

The following day, claimant reported to work. However, he began experiencing increasing pain in the left hip. Claimant, accompanied by his supervisor, then went to the emergency room. At that time, claimant was observed limping. He was taken off work for five days. X-rays of claimant's pelvis revealed no evidence of bony pathology. The next day claimant began to experience pain running down his leg.

Claimant first saw Dr. Krupa, chiropractor, on June 3, 1988. At that time, claimant experienced numbness which extended to his toes. He also felt sharp pains shooting down his leg and hip through to the calf. (Tr. 23). He was taken off work.

Claimant returned to work on June 10, 1988, and completed an 801 form. (Ex. 1). Thereafter, he left work and has not returned.

On September 12, 1988, the insurer denied claimant's injury claim, contending the medical evidence did not support the alleged left hip and leg injury to the degree that it would create his disability. (Ex. 12).

Claimant is a credible witness. At the time of hearing, claimant was experiencing pain which was aggravated by standing too long, sitting and walking. The pain only subsides when he relaxes. Claimant experiences shooting pain when he puts weight on his left leg. (Tr. 25).

At hearing, the insurer partially accepted a contusion to claimant's left hip and abdomen on May 17, 1988. The insurer continued to deny that claimant's causalgia condition was related to the accepted injury. (Tr. 2). The causalgia condition is inseparable from claimant's accepted condition.

CONCLUSIONS OF LAW AND OPINION

Preclosure Denial

Addressing the merits of the insurer's denial, the Referee found claimant's causalgia condition to be causally related to his work incident. In doing so, the Referee found that the insurer had not issued a preclosure denial, reasoning that the causalgia condition was a separable condition. We disagree with the Referee's conclusion that the insurer's denial was valid.

In Boise Cascade Corp. v. Katzenbach, 307 Or 391, 394 (1989), the Supreme Court held that a preclosure partial denial was not procedurally invalid where no one authorized to do so had found the worker's two conditions "inseparable." Here, we find claimant's accepted condition and his so called "causalgia" condition to be inseparable.

Specifically, there are no divergent diagnoses of claimant's medical conditions. The medical experts may disagree as to the etiology of claimant's current complaints, e.g., Drs. Underhill, chiropractor, and Hee, chiropractor, ascribing claimant's causalgia condition as not being work related. However, we do not view their opinions as offering new diagnoses or conditions.

We conclude that the denial was issued prematurely insofar as it concerned claimant's causalgia condition. Because this denial was procedurally invalid, we do not reach the merits regarding the compensability of the condition.

Additionally, the insurer based its denial on the separability of the hip injury and the causalgia condition and on the lack of a causal connection between the compensable hip injury and the causalgia condition. Based on the evidence available to it at the time of its denial, we conclude that the insurer had a legitimate doubt concerning the separability of the two conditions and whether a causal relationship had been established between the compensable injury and the causalgia condition. Brown v. Argonaut Insurance Company, 93 Or App 588 (1988). Therefore, the insurer's denial was not unreasonable.

ORDER

The Referee's order dated December 19, 1988 is affirmed. For services on review concerning the compensability issue, claimant's attorney is awarded an assessed fee of $600, to be paid by the insurer. The Board approves a client-paid fee, not to exceed $423, payable from the insurer to its counsel.

In the Matter of the Compensation of
CURTIS BEST, Claimant
Own Motion No. 87-0401M
OWN MOTION ORDER ON RECONSIDERATION
Malagon, et al., Claimant Attorneys
Saif Legal Department, Defense Attorney

The SAIF Corporation requests reconsideration of our October 20, 1989, Own Motion Order on Reconsideration which set aside our June 2, 1988, Own Motion Determination as premature and remanded claimant's claim to SAIF for further processing according to law. In order to allow sufficient time to consider claimant's motion, we abated and withdrew our Own Motion Order on Reconsideration on November 1, 1989. Claimant contends that SAIF improperly terminated the payment of temporary disability benefits before we closed his claim on June 2, 1988, and requests that a penalty and attorney fee be assessed for its allegedly unreasonable claim processing.

By Own Motion Order dated September 23, 1987, we reopened this claim for a worsening of claimant's right elbow condition requiring surgery and ordered payment of temporary total disability "until closure pursuant to ORS 656.278." We reclosed the claim by Own Motion Determination dated June 2, 1988. However, we abated and withdrew that determination by order dated October 20, 1989, for lack of evidence that claimant had become medically stationary since undergoing compensable treatment for pain therapy and drug rehabilitation. On November 1, 1989, we abated and withdrew the October 20, 1989, order to allow SAIF additional time to gather further medical evidence. By letter dated January 24, 1990, SAIF requested further information from Dr. Rothman, claimant's treating physician for pain therapy and drug rehabilitation, regarding claimant's medically stationary status. However, Rothman has not responded, nor has claimant provided any additional information regarding his condition or treatment.

The most recent medical report is Dr. Newton's chart note dated March 1, 1988. Despite SAIF's efforts to gather further information, there is no evidence in the record that claimant sought treatment after that date. Hence, given the state of this record, we find that claimant was medically stationary as of March 1, 1988.

Therefore, our June 2, 1988, order is abated and withdrawn. On reconsideration, claimant's claim is closed with an award of temporary disability benefits from July 30, 1987, through March 1, 1988, less any time worked. We are not authorized to grant claimant any additional award of permanent disability benefits. Independent Paper Stock v. Wincer, 100 Or App 625 (1990); Orville D. Shipman, 40 Van Natta 537 (1988).

On the penalty and attorney fee issue, we agree with claimant that SAIF was directed by our September 23, 1987, order to continue payment of temporary disability compensation until closure. Although there is evidence in the record that claimant was released for work on March 1, 1988, there is no indication that claimant actually returned to work on that date or that he returned to work at his regular wage prior to claim closure. Inasmuch as claim closure was not accomplished until June 2, 1988, we order SAIF to pay claimant temporary disability benefits for the period from March 2, 1988, through June 2, 1988, less any time worked. In addition, for its unreasonable refusal to comply with our order, we assess SAIF a penalty in the amount of 25 percent of the amounts of temporary disability benefits due from March 2, 1988 through June 2, 1988. Claimant's attorney is awarded a penalty-related attorney fee of $100, to be paid by SAIF.

IT IS SO ORDERED.

In the Matter of the Compensation of
IOLA P. CARR, Claimant
Own Motion No. 89-0730M
OWN MOTION ORDER ON RECONSIDERATION
Peter O. Hansen, Claimant Attorney
Roberts, et al., Defense Attorneys

By Own Motion Order dated January 19, 1990, the Board reopened claimant's claim for the payment of temporary disability benefits. That order was abated and withdrawn on February 2, 1990. By order dated May 22, 1990, the Board denied the insurer's request for an order directing claimant to sign a general release of her employment records; however, we allowed the parties 14 days from the date of the order to submit their arguments regarding claimant's entitlement to temporary disability benefits.

No new evidence has been submitted by either party. However, the insurer advises that it has not yet received information on the amount of time that claimant worked prior to her worsening, and requests that we qualify its obligation to pay temporary disability benefits by indicating that it shall "pay temporary total or temporary partial disability as dictated by the hours which claimant worked." The insurer also asks that we order claimant's employer prior to her worsening to provide information regarding dates and hours of work. The insurer's contention appears to be that the rate or amount of claimant's temporary total disability benefits should be based on claimant's earnings and/or the number of hours she worked prior to the recent worsening of her condition. We disagree. Claimant is entitled to temporary total disability benefits calculated in accordance with the law at the time of her injury. ORS 656.202(2); see Frank T. Schufa, 41 Van Natta 1488, 1489 (1989). At the time of claimant's injury in 1977, ORS 656.210 provided that temporary total disability benefits shall be based on the worker's wage at the time of injury. See Or Laws 1975, ch. 663, 1. Claimant's benefits shall be calculated and paid accordingly.

Therefore, on reconsideration, we adhere to and republish our January 19, 1990, order in its entirety. The parties rights of reconsideration and appeal shall run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
CATHY J. DONEY, Claimant
WCB Case Nos. 88-17757 & 88-17758
ORDER ON REVIEW
Rick Roll, Claimant Attorney
Rankin, et al., Defense Attorneys

Reviewed by Board Members Brittingham and Nichols.

Claimant requests review of that portion of Referee Tenenbaum's order that: (1) upheld the insurer's denial of claimant's bilateral carpal tunnel syndrome; and (2) declined to assess a penalty and associated attorney fee for the insurer's alleged unreasonable denial. On review, the issues are compensability, penalties and attorney fees. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact relating to claimant's carpal tunnel syndrome, beginning with the third full paragraph on page 2, with the following supplementation.

On July 8, 1988, claimant consulted Dr. Tesar, orthopedic surgeon, her treating physician, for pain in both wrists. She filed a claim for both wrists on July 18, 1988. By the end of July 1988 she returned to Tesar complaining of cramping in her left hand. Tesar referred her to Dr. Leonard, neurologist, who ordered a nerve conduction evaluation, which revealed severe left carpal tunnel syndrome.

On August 23, 1988, Tesar requested permission to do a carpal tunnel release on the left wrist. Claimant began light duty work on August 24, 1988.

The insurer denied claimant's claim for her wrist condition on September 1, 1988.

Claimant was examined by Dr. Nathan, orthopedic surgeon, on September 26, 1988. Claimant last worked in October 1988, after which she had carpal tunnel release surgery on her left wrist.

FINDINGS OF ULTIMATE FACT

While working for the employer, performing manual work which subjected her wrists to repetitive trauma, claimant's carpal tunnel symptoms worsened, although the underlying disease process did not. Claimant's work activities are a material contributing cause of her worsened symptoms.

The insurer's denial of claimant's wrist condition was reasonable.

CONCLUSIONS OF LAW AND OPINION

Compensability

The Referee and the parties presented this claim as an occupational disease claim that required claimant to establish that her work activities were the major contributing cause of her condition and that her work conditions caused a worsening of the underlying condition. See Dethlefs v. Hyster Co., 295 Or 298 (1983); Weller v. Union Carbide, 288 Or 27 (1979). We analyze this case differently.

ORS 656.802, Oregon's occupational disease law, was amended effective January 1, 1988. Claimant's last exposure to work activity that could have affected her condition occurred in 1988. Therefore, we analyze this case under the new statute. See Donna E. Aschbacher, 41 Van Natta 1242, recon denied 41 Van Natta 1334 (1989).

Any series of traumatic events or occurrences arising out of and in the course of employment which requires medical services or results in physical disability or death is an occupational disease. ORS 656.802(1)(c). Claimant's work entailed repetitive use of her hands and wrists and resulted in the need for surgery. Therefore, her claim should be assessed under this statute. Unlike occupational disease claims prior to January 1, 1988, under the amended statute a claimant need not prove a worsening of the preexisting condition itself. Rather, a claimant need only show that: (1) symptoms of the preexisting condition have increased; (2) the increase in symptoms caused greater disability

or need for medical services; and (3) the work exposure was a material contributing cause of those increased symptoms. Donna E. Aschbacher, supra; Raymond E. Meredith, Jr., 42 Van Natta 816 (1990).

Dr. Tesar, orthopedic surgeon and claimant's attending doctor, and Dr. Nathan, the orthopedic surgeon who conducted the independent medical examination, were in agreement that claimant had an underlying carpal tunnel condition that became so symptomatic that they each recommended surgery. Thus, claimant has established the first two elements of her occupational disease claim.

As to the third element, Dr. Nathan opined that claimant's disease was idiopathic, based on his inability to isolate a particular work activity or group of activities responsible for its initiation or aggravation. We are unable to determine whether Nathan used the term "aggravation" to refer to a worsening of symptoms, or to a pathological worsening. If he meant to say that he was unable to find that work activities worsened the underlying condition, then the opinion is addressed to an irrelevant issue. If, on the other hand, he meant to say that he was unable to find that work activities worsened the symptoms, then his opinion does bear on our inquiry. As a result of this ambiguity, his analysis is inadequate for our purposes under the new statute.

Dr. Leonard, neurologist, gave an opinion based on the assumption that no particular work activity could be isolated as likely to be responsible for initiating claimant's symptoms. Therefore, his opinion, like Nathan's, did not address whether claimant's work contributed to a flare-up of her symptoms.

Dr. Tesar, on the other hand, opined that claimant's work contributed to her current carpal tunnel symptoms. Tesar was familiar with claimant's employment duties. He had treated claimant for her previous left finger injury and had treated her since the onset of the current flareup of symptoms. We defer to the opinion of claimant's treating physician unless there are persuasive reasons not to do so. No such reasons have been raised in this case.

As a result, claimant has carried her burden to prove that her work conditions were a material contributing cause of her current carpal tunnel symptoms. Therefore, we reverse the Referee on the compensability issue.

Penalty and Related Attorney Fee

On review, claimant raised but did not argue the issue of a penalty for the insurer's alleged unreasonable denial of claimant's carpal tunnel condition. The claim was denied on September 1, 1988. Aschbacher, supra, which established the proper analysis of an occupational disease claim under ORS 656.802(1)(c), did not issue until 1989. Under the pre-1988 law, as interpreted in Aschbacher, claimant was required to show that his or her work activities were the major contributing cause of the condition and that the work activities caused a worsening of the underlying condition. The only medical report the insurer had at the time of the denial was that of Dr. Tesar. Although Tesar stated that claimant's repetitive work was the cause of her carpal tunnel syndrome, he also stated that her current symptoms -- not the worsening of her underlying condition -- were due to her work. Therefore, we find that the insurer's denial was not unreasonable. Therefore, no penalty or attorney fee is due.

ORDER

The Referee's order, dated February 8, 1989, is reversed in part and affirmed in part. The insurer's denial of claimant's carpal tunnel condition is set aside and the claim is remanded to the insurer for processing according to

law. The remainder of the order is affirmed. For services at hearing and on review regarding the compensability issue, claimant's attorney is awarded an assessed fee of $1,300, payable by the insurer. The Board approves a client-paid fee, not to exceed $675, payable by the insurer to its counsel.

June 18, 1990 Cite as 42 Van Natta 1275 (1990)

In the Matter of the Compensation of
BARBARA A. HESS, Claimant
WCB Case No. 88-16974
ORDER OF ABATEMENT
Mautz, Hallman, et al., Claimant Attorneys
Yturri, et al., Defense Attorneys

The Board has received the insurer's Motion for Abatement and Reconsideration of our Order on Review dated June 14, 1990.

In order to allow sufficient time to consider the motion, the above noted Board order is abated and claimant is requested to file a response to the motion within ten days.

IT IS SO ORDERED.

June 18, 1990 Cite as 42 Van Natta 1275 (1990)

In the Matter of the Compensation of
DAVID A. HICKEY, Claimant
WCB Case No. 88-18614
ORDER ON REVIEW
Northwest Legal Services, Claimant Attorneys
Acker, et al., Defense Attorneys

Reviewed by Board Members Cushing and Gerner.

The insurer requests review of that portion of Referee Tenenbaum's order which increased claimant's unscheduled permanent disability award for a low back injury from 14 percent (44.8 degrees), as awarded by Determination Order, to 28 percent (89.6 degrees). On review, the issue is extent of unscheduled permanent disability. We modify.

FINDINGS OF FACT

We adopt the findings of fact as set forth in the "Findings" section of the Referee's order with the following modification.

In March 1988, Dr. Franks performed a laminectomy with diskectomy and medial foraminotomy at L4-5. Claimant did not undergo bilateral facetectomies at L4-5 at that time.

Claimant can no longer perform heavy work and is limited to work in the medium range.

CONCLUSIONS OF LAW AND OPINION

In determining the extent of claimant's permanent disability, the Referee applied the standards for evaluating permanent disability as adopted by the Director, pursuant to ORS 656.726(3)(f). See ORS 656.283(7). Specifically, the

Referee applied former OAR 436-35-001 et seq, which was effective at the time of the October 5, 1988 Determination Order. See OAR 438-10-005; 438-10-010. These are the rules which we apply as well.

Following the application of the disability standards, the Referee awarded 14 percent unscheduled permanent disability for a total of 28 percent. We modify.

The hearing and Board review of the issue of permanent partial disability continues to be de novo on the hearing record. The underlying facts to which the "standards" are applied need only be established by a preponderance of the evidence. However, either party may establish that the record, as a whole, constitutes clear and convincing evidence that the degree of permanent partial disability suffered by the claimant is more or less than the entitlement indicated by the "standards". ORS 656.283(7) and 656.295(5).

The determination of permanent partial disability under the "standards" is made by determining the appropriate values assigned by the "standards" to the claimant's age, education, adaptability and impairment. Once established, the values for age and education are added and the sum is multiplied by the appropriate value for adaptability. The product of those two figures is then added to the appropriate value for impairment to yield the percentage of unscheduled permanent partial disability. Former OAR 436-35-280.

Age.

The appropriate value for claimant's age of 33 years is 0. Former OAR 436-35-290.

Formal education.

The appropriate value for claimant's 10 years of formal education is +1. Former OAR 436-35-300(3).

Skills.

Former OAR 436-35-300(4) adopts by reference the "SVP" (specific vocational preparation time) values assigned to various occupations by the Dictionary of Occupational Titles (DOT), published by the U.S. Department of Labor. The highest SVP level demonstrated by a claimant during the ten years prior to the date of injury is used to determine a value for skills. Former OAR 436-35-300(4). Claimant's highest SVP during the ten years prior to the date of injury was 7 as an auto mechanic (DOT # 620.261-010). Therefore, the appropriate value for skills is +1. Former OAR 436-35-300(4).

Training.

Claimant has no documented training. Therefore, the appropriate value for training is +1. Former OAR 436-35-300(5). Claimant's total education value is +3, the formal education value plus the skills value plus the value for training. Former OAR 436-35-300(6).

An adaptability value for a claimant who is unable to return to his or her usual and customary work [See former OAR 436-35-270(3)(a)] but who has returned to modified work is determined from a matrix of values at former OAR 436-35-310(3)(a). That matrix compares the physical capacity of the claimant's usual and customary work with the physical capacity required by the modified work. This is true even though claimant may have the physical capacity to do heavier work than is required by the modified employment. Physical capacities are not

defined by the "standards" generally. We utilize those definitions contained in former OAR 436-35-310(4)(a)-(d).

In this case, claimant's usual and customary work required the physical capacity to do heavy work. Claimant's modified work required a medium physical capacity. Therefore, the appropriate adaptability value is +2. Former OAR 436-35-310(3)(a).

Impairment

The Referee found that claimant was entitled to a value of 5 percent for his laminectomy and diskectomy at L4-5. We agree with and adopt this finding. See former OAR 436-35-350(2).

The Referee further found that claimant was entitled to a value a 6 percent for bilateral facetectomies. We disagree. The operative report of Dr. Frank describes the procedure as a bilateral diskectomy and medial foraminotomy at L4-5. There is no evidence that claimant underwent a bilateral facetectomies therefore, we conclude that claimant is not enititled to the 6 percent impairment rating awarded by the Referee for bilateral facetectomies.

The Referee also found that claimant was entitled to a 4 percent value for post-surgical disc derangement at L4-5 with clinically related residual symptoms. We disagree. Former OAR 436-35-350(2) provides that a value of 4 percent may be awarded for an unoperated disc derangement with any clinically-related residual symptoms. [Emphasis supplied]. This provision, however does not provide for a similar value where claimant has an operated disc. Accordingly, we conclude that claimant is not entitled to a 4 percent value for post-surgical disc derangement.

Finally, the Referee found that claimant was entitled to an additional 5 percent value for loss of repetitive use of an unscheduled body part. This is not an appropriate award under the standards in effect at the time claimant's claim was closed. Therefore, claimant is not entitled to an additional 5 percent for loss of repetitive use.

Claimant is entitled to additional impairment if he establishes loss of use or function due to pain. Former OAR 438-35-320(1). The Board in Daniel M. Alire, 41 Van Natta 752 (1989), held that, inasmuch as the standards do not provide for a value range from impairment attributable to disabling pain, the Board on de novo review can consider the evidence and award the claimant a value that adequately compensates him for his loss of use or function attributable to disabling pain.

In this case, the record establishes that claimant has limited ability to sit or stand due to disabling pain. We find that a preponderance of the evidence demonstrates that claimant has a loss of use or function attributable to his pain.

Inasmuch as the standards do not provide a value range for impairment attributable to disabling pain, we consider a value of 5 percent in this particular case to be reasonable. Combining the aforementioned value with the 5 percent impairment value for the laminectomy and diskectomy results in a total of 10 percent. This value represents claimant's total impairment value.

Computation of unscheduled disability.

Having determined each value necessary to compute claimant's permanent disability under the "standards," we proceed to that calculation. When

claimant's age value (0) is added to his education value (+3) the sum is +3. When that value is multiplied by claimant's adaptability value (+2) the product is +6. When that value is added to claimant's impairment value (10) the result is 16 percent unscheduled permanent partial disability. Former OAR 436-35-280(7).

ORDER

The Referee's order dated February 23, 1989, is modified. In lieu of the Referee's award, and in addition to the Determination Order award of 14 percent (44.8 degrees), claimant is awarded 2 percent (6.4 degrees) unscheduled permanent disability for a total of 16 percent (51.2 degrees) unscheduled permanent disability. A client-paid fee, not to exceed $1,323, is approved, payable by the insurer to its counsel.

June 18, 1990 Cite as 42 Van Natta 1278 (1990)

In the Matter of the Compensation of
DANIEL C. REDDEKOPP, Claimant
WCB Case No. 88-13246
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
Saif Legal Department, Defense Attorney

Reviewed by Board Members Nichols and Brittingham.

The SAIF Corporation requests review of Referee Neal's order that granted permanent total disability effective July 30, 1988, whereas a Determination Order awarded 35 percent (112 degrees) unscheduled permanent disability for a low back condition, and 5 percent (7.5 degrees) scheduled permanent disability for loss of use or function of the right leg. The issue on review is permanent total disability. We reverse.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" except for the last half of the last sentence of the first paragraph of page two of the order.

CONCLUSIONS OF LAW AND OPINION

The Referee found that the medical evidence from Dr. Flaming and Dr. Poulson indicate that claimant was unable to work with his current back problems. She also found that it would be futile for claimant to look for work. We disagree.

Dr. Poulson examined the claimant only one time, in April 1988. At that time he reported that claimant should be encouraged to get back to some type of work. Dr. Poulson, in October 1988, authored a report, without seeing claimant, wherein he finds that claimant is permanently and totally disabled based on his limited ability to work and his limited education and background. In that report, Dr. Poulson gives no reason for his change of opinion from his April report.

Dr. Flaming has followed claimant since his surgeries; however, it is difficult to tell from this record when he last saw claimant. The last report from Dr. Flaming, aside from a physical capacities form, was dated September 1988. In that report he states that claimant has not worked since the first surgery. The doctor does not explain what he means by work, thus his report is

suspect because the record and the testimony of claimant confirm the fact that claimant was indeed working up to within a few days of his hearing.

We find the medical opinion of Dr. Poulson to be unpersuasive because he has changed his opinion without explanation and because he bases his opinion that claimant is permanently totally disabled on other than medical reasons. We also find the opinion of Dr. Flaming to be questionable as it appears to be based on either an incomplete or incorrect history. With these reservations regarding the medical opinions, we do not believe that claimant is medically permanently and totally disabled. Consequently, claimant can prevail only by proving he falls within the "odd lot" doctrine. Under that doctrine, a disabled person, 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 (1985).

The Referee also found that claimant was permanently totally disabled under the "odd lot" doctrine and that it would be futile for him to make reasonable efforts to seek work. We disagree. Claimant continued to work at his shop after each surgery up to a few days before the hearing when he sold his interest in the business to his partner. Claimant has made no effort to find any other employment since he sold his business. We do not believe that claimant is permanently totally disabled on an "odd lot" basis; thus it would not be futile for this claimant to make reasonable efforts to seek work. He has not. Consequently, claimant has failed to carry his burden of proving permanent total disability. ORS 656.206(3).

ORDER

The Referee's order dated December 8, 1988 is reversed. The Determination Order is reinstated and affirmed.

June 18, 1990 Cite as 42 Van Natta 1279 (1990)

In the Matter of the Compensation of
RICHARD A. REGEHR, Claimant
WCB Case No. 88-13596
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
Gleaves, et al., Defense Attorneys

Reviewed by Board Members Gerner and Cushing.

The self-insured employer requests review of that portion of Referee Higashi's order that granted claimant permanent total disability, whereas a Determination Order had awarded 32 percent (102.4 degrees) unscheduled permanent disability for an injury and 10 percent (15 degrees) scheduled permanent disability for loss of use or function of the left leg. Claimant cross-requests review of that portion of the Referee's order that upheld the employer's partial denial of his bilateral carpal tunnel syndrome. On review, the issues are compensability and permanent total disability. We reverse the Referee's order concerning the compensability issue and vacate the permanent total disability award as premature.

FINDINGS OF FACT

Claimant compensably injured his right hip, left knee and lower back in December 1986 when he was hit by a 1,300 pound roll of paper while working for

the employer. He was treated conservatively by Dr. Straub, claimant's treating physician.

Claimant underwent left knee surgery in 1987. He was bedridden until mid-January 1988, at which time he began using crutches and started a physical therapy program. By March 1988, claimant was walking with the use of a cane. He continues to use the cane for support.

Claimant began treating with Dr. Mundell, M.D., in June 1987. Claimant first complained to Mundell of numbness in both hands in March 1988. That condition was diagnosed as bilateral carpal tunnel syndrome.

In June 1988, vocational services began, but claimant was unable to participate in such services because of residuals due to his compensable injury. That same month, the employer issued a partial denial of claimant's bilateral carpal tunnel syndrome, indicating that it did not arise out of or in the scope of his employment.

A July 1988 Determination Order awarded claimant temporary total disability from December 8, 1986 through June 16, 1988, 32 percent unscheduled permanent disability and 10 percent scheduled disability for the loss of use or function of his left leg. Claimant requested a hearing.

Claimant's current bilateral carpal tunnel syndrome is a natural consequence of his compensable 1986 injury.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant was permanently and totally disabled. He did not find claimant's bilateral carpal tunnel syndrome compensable. We disagree.

Compensability of Bilateral Carpal Tunnel Syndrome

Claimant contends that his bilateral carpel tunnel syndrome is a natural sequela caused by treatment he received for his 1986 compensable injury. We agree.

Claimant has an accepted claim for an industrial injury. It is well settled that the employer is liable for the natural consequences flowing from a compensable injury. Williams v. Gates McDonald & Co., 300 Or 278, 281 (1985); Pattitucci v. Boise Cascade Corp., 8 Or App 503, 507-08 (1972); Randolph P. Gaul, 42 Van Natta 592 (1990).

The Referee acknowledged that claimant's treating physician, Dr. Mundell, opined that claimant had preexisting bilateral carpal tunnel syndrome which was materially worsened by the weight training and use of the cane which claimant used in the treatment of his compensable conditions. Regardless of the fact that this opinion was not medically contradicted, the Referee concluded that Mundell's opinion was not sufficiently explained and was not convincing. We disagree.

The only physician to treat claimant's wrist problems, bilateral carpal tunnel syndrome, was Dr. Mundell. He is the only physician to render an opinion whether or not claimant's work activities or compensable injury was a material contributing cause of his need for medical treatment relative to the carpal tunnel syndrome. His opinion was not contradicted in the record.

Therefore, we find that claimant's bilateral carpal tunnel syndrome is a natural consequence of his 1986 compensable injury, and, as such, is likewise compensable.

Permanent Total Disability

Because we have found that claimant's bilateral carpal tunnel syndrome is compensable, we do not reach the issue of permanent total disability. There is insufficient evidence in the record to determine whether claimant's bilateral carpal tunnel syndrome condition is medically stationary. Therefore, we are unable to rate extent of permanent disability. See Kociemba v. SAIF, 63 Or App 557, 559-60 (1983); Harmon v. SAIF, 54 Or App 121 (1981). Consequently, the Referee's award of permanent total disability is vacated.

ORDER

The Referee's order dated February 13, 1989, is reversed. The employer's January 16, 1988 partial denial of claimant's bilateral carpal tunnel syndrome is set aside and remanded to the employer for processing according to law. For services at hearing and on Board review, concerning the issue of compensability of the bilateral carpal tunnel syndrome, claimant's attorney is awarded a reasonable assessed fee of $1,700, payable by the employer. The Referee's award of permanent total disability is vacated. A client-paid fee, not to exceed $772.50, payable by the employer to its counsel, is approved.

June 18, 1990 Cite as 42 Van Natta 1281 (1990)

In the Matter of the Compensation of
WILLA D. TUCKER, Claimant
WCB Case Nos. 88-08601 & 88-09097
ORDER ON REVIEW
Charles E. Woods, Claimant Attorney
Rick Dawson (Saif), Defense Attorney

Reviewed by Board Members Nichols and Brittingham.

The SAIF Corporation requests review of those portions of Referee Foster's order that: (1) affirmed the Determination Order award of 25 percent (80 degrees) unscheduled permanent disability for a low back condition; (2) declined to reduce claimant's award of temporary disability benefits; and (3) awarded claimant's attorney an assessed fee for prevailing against SAIF's cross-request for a reduction of the temporary and permanent disability awards. Claimant cross-requests review of those portions of the order that: (1) declined to set aside the Determination Order as premature; and (2) affirmed the Determination Order award of 25 percent (80 degrees) unscheduled permanent disability and no scheduled permanent disability.

ISSUES

1. Premature claim closure. Was claimant medically stationary when the Determination Order issued on May 20, 1988?

2. If the claim was not prematurely closed, temporary disability compensation. When did claimant become medically stationary?

3. If the claim was not prematurely closed, extent of permanent partial disability, scheduled and unscheduled. Has claimant sustained any permanent

loss of earning capacity due to her compensable injury? Has claimant sustained any permanent loss of use or function of her left leg, arms or forearms?

4. Assessed fees.

We affirm on the premature claim closure issue but reverse on the remaining issues.

FINDINGS OF FACT

Claimant, a 36-year-old assistant donut maker, was compensably injured on October 23, 1987, when she slipped on a wet floor and fell on her left side. She immediately felt pain along her left side and left upper extremity. She sought chiropractic treatment for pain in the neck, shoulders and middle back. She was taken off work and ultimately diagnosed with a neck and upper back strain. SAIF accepted the claim for a disabling cervical strain.

Prior to this industrial injury, in either June or August, 1987, claimant injured her right shoulder and middle back while pulling down a lever with all of her weight. At the time, she was working for the same employer who was insured by a different carrier. That injury resulted in one week of time loss from work and had not yet resolved at the time of her October, 1987, industrial accident. Indeed, prior to the October accident, she continued to have symptoms in her middle back, right shoulder and arm, including pain, spasms and loss of strength.

By April, 1988, in addition to her previous complaints, claimant began complaining of worsening low back pain. She is approximately 5'6" in height and, at that time, weighed 286 pounds. Based on claimant's subjective complaints, her treating chiropractor restricted her from prolonged standing or walking and from using her arms in an extended position. He further recommended that she lose weight to reduce stress on the low back and legs.

Claimant's claim was closed by Determination Order on May 20, 1988, with 25 percent unscheduled permanent disability for her low back condition. Additionally, she was declared medically stationary as of April 29, 1988, and awarded temporary disability benefits through that date.

At hearing in August, 1988, claimant testified to having pain all along her back up into her neck and head. She also complained of pain in both arms, particularly the left shoulder, and numbness in the fingers and left-foot toes.

FINDINGS OF ULTIMATE FACT

1. Claimant became medically stationary on April 4, 1988.

2. Claimant did not suffer any permanent loss of earning capacity or permanent loss of use or function of any scheduled body part due to this compensable injury.

CONCLUSIONS OF LAW AND OPINION

Medically Stationary Date

"Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). Claimant's medically stationary status is primarily a medical question to be decided based on competent medical evidence. Harmon v. SAIF, 54 Or App 121, 125 (1981); Austin v. SAIF, 48 Or App 7, 12 (1980).

The Referee concluded that the Determination Order correctly found claimant medically stationary as of April 29, 1988. However, the record is devoid of any medical evidence supporting that finding. On December 1, 1987, the Orthopaedic Consultants found no objective findings to support claimant's complaints and declared that her condition had "stabilized." (Ex. 4-6). On April 4, 1988, Drs. Paluska and Barth of BBV Medical Services also found that subjective complaints were not substantiated by objective findings and declared that the accepted injury had "stabilized." (Ex. 7-3). On April 18, 1988, Dr. McFie, the treating chiropractor, indicated that he could not comment on claimant's medically stationary status "until she has returned to a equable pre-injury occupation." (Ex. 7A).

Although we generally give greater weight to the treating physician's opinions, see Weiland v. SAIF, 64 Or App 810, 814 (1983), we decline to do so here because McFie expressly reserved his opinion until claimant had returned to an "equable pre-injury occupation." Claimant's vocational status should have no bearing on her medically stationary status. See William N. Suydam, 41 Van Natta 95, 96 (1989). McFie also reported that claimant is seeking further care on an as-needed basis and suggested that there was no reason to set more frequent appointments unless her condition worsened. Those statements support a finding that no further material improvement is anticipated. Therefore, based on the independent medical examination reports of the Orthopaedic Consultants and BBV Medical Services, we find that claimant became medically stationary as of April 4, 1988. Inasmuch as the Determination Order issued after that date, it was not issued prematurely. However, the order shall be modified to disallow the payment of temporary disability benefits for any period after that date. See Taylor v. SAIF, 40 Or App 437, 440, rev den 287 Or 477 (1979).

Permanent Disability

Claimant bears the burden of proving by a preponderance of the evidence that she is entitled to permanent disability benefits. Hutcheson v. Weyerhaeuser, 288 Or 51 (1979). To be entitled to such benefits, she must prove that she suffered permanent impairment due to the compensable injury. E.g., Jason L. Bail, 41 Van Natta 2255, 2258 (1989).

McFie is the only physician who opines that claimant suffers permanent impairment as a result of the compensable injury. (Exs. 7B, 10, 12). His opinion is based primarily on claimant's subjective complaints. However, the reliability of those complaints, which extend from head to foot, is at least questionable. All of the independent medical examiners concluded that there were no objective findings to support those complaints. (Exs. 4-6, 7-3, 11-4).

Dr. Peterson, a chiropractor, examined claimant at SAIF's request and, on the basis of numerous inconsistent findings, concluded that the physical findings elicited were non-organic and "may be based upon preconceived ideas of expected symptoms, hysteria, chronic behavior or malingering." (Ex. 11-4). Peterson elaborated further at hearing and concurred with the other independent examiners' conclusion that claimant suffers no permanent impairment. (Tr. 60-67). Therefore, based on the overwhelming evidence that claimant's complaints are inconsistent and non-organic, we do not find claimant to be reliable. Consequently, we discount her testimony and the opinion of her treating physician. Because we are not persuaded that claimant has suffered any permanent impairment due to the compensable injury, we conclude that she is not entitled to any permanent disability benefits.

Assessed Fee

ORS 656.382(2) allows a referee to assess an insurer-paid fee if an insurer initiates a request for hearing and the referee finds that the compensation awarded to claimant should not be disallowed or reduced. Here, SAIF cross-requested a hearing to challenge the Determination Order awards of permanent and temporary disability benefits. Because the Referee declined to reduce or disallow those awards, he awarded claimant's attorney an assessed fee of $1,200, to be paid by SAIF. On Board review, however, we are reducing claimant's temporary disability award and disallowing her permanent partial disability award. For that reason, claimant's attorney is not entitled to an assessed fee under ORS 656.382(2). That fee is disallowed.

ORDER

The Referee's order, dated September 22, 1988, is reversed in part and affirmed in part. The portions of the order that declined to reduce or disallow claimant's permanent and temporary disability awards and awarded claimant's attorney an assessed fee are reversed. The Determination Order dated May 20, 1988, is modified to disallow both the unscheduled permanent partial disability award and the award of temporary partial disability benefits for the period from April 5, 1988, through April 29, 1988. Additionally, the medically stationary date is modified to read April 4, 1988. The SAIF Corporation is permitted to recover the aforementioned temporary partial disability benefits paid pursuant to the Determination Order against claimant's future awards of permanent disability. The Referee's assessed fee award of $1,200 is reversed. The remainder of the Referee's order is affirmed.

June 18, 1990 Cite as 42 Van Natta 1284 (1990)

In the Matter of the Compensation of
JOSEPH I. VERNAZA, Claimant
WCB Case No. 88-17727
ORDER ON REVIEW
Francesconi & Associates, Claimant Attorneys
Daryll E. Klein, Defense Attorney

Reviewed by Board Members Cushing and Myers.

Claimant requests review of Referee Mills' order which: (1) upheld the self-insured employer's denial of claimant's occupational disease claim for bilateral carpal tunnel syndrome; and (2) declined to assess a penalty and attorney fee for an allegedly unreasonable denial. On review, the issues are compensability and penalties and attorney fees. We reverse in part and affirm in part.

FINDINGS OF FACT

Claimant compensably injured his back in July 1988 while driving for the employer. Prior to that time, claimant experienced tingling and numbness in his hands. Claimant's treating physicians for his back condition are Dr. Beeson, D.C., and Christensen, D.C. Beeson referred claimant to Dr. Nathan, M.D.

Claimant's work duties included driving a truck and trailer, or a tractor and semi. He made two distribution runs daily, each involving approximately 140 turns, 128 of which were hard left and hard right turns at 90 degree angles. Claimant also made about 10 360-degree turns made from a dead stop position daily. His truck driving job required constant, heavy and repetitive use and twisting of his hands, wrists and arms.

Claimant first sought treatment for a hand condition in late September 1988. Nathan diagnosed bilateral carpal tunnel syndrome that same month.

Claimant's wrist condition was evaluated by three other physicians: Dr. Jewell, M.D., Dr. Baum, D.O., and Dr. Nye, M.D.

In October 1988, the employer denied claimant's occupational disease claim for bilateral carpal tunnel syndrome. Claimant requested a hearing.

Claimant's compensable back injury prevented claimant from returning to work.

Claimant's work activities, involving constant repetitive use of his hands, wrists and arms are "traumatic." His work activities materially caused his bilateral carpal tunnel syndrome.

CONCLUSIONS OF LAW AND OPINION

Compensability

The Referee found that claimant had not proven his occupational disease claim. In doing so, the Referee concluded that "claimant's work activities were not responsible for the [carpal tunnel syndrome], the worsening of that disease, or for the symptoms or any worsening on the symptoms associated with the disease." We disagree.

Because claimant's last exposure to working conditions which could have caused his bilateral carpal tunnel syndrome was in July 1988, the occupational disease law, which became effective January 1, 1988, is applicable. ORS 656.802. Further, because claimant's hand and wrist pain began while working as a truck driver, which required repetitive use of his hands, wrists and arms, we conclude that his claim is for a condition resulting from a "series of traumatic events or occurrences" pursuant to ORS 656.802(1)(c).

Therefore, to establish that his bilateral carpal tunnel syndrome arose out of and in the course of employment, claimant must prove not only that his condition resulted from a series of traumatic events, but that his work exposure was a material cause of his need for medical services or physical disability. ORS 656.802(1)(c); Donna E. Aschbacher, 41 Van Natta 1242 (1989); Carole J. Damm, 42 Van Natta 225 (1990).

After our de novo review of the medical and lay evidence, we find that claimant's work activities, involving constant, heavy and repetitive use of his hands, wrists and arms, are traumatic. Dean A. Mintun, 42 Van Natta 1149 (1990); Mary L. Goudy, 42 Van Natta 1140 (1990). In reaching this conclusion, we note that Dr. Jewell recited a work history requiring "considerable strength and considerable physical effort" and that Dr. Nye described work activities consisting of "repetitive hand gripping." These opinions, in conjunction with claimant's description of his work activities, establish that these repetitive activities were traumatic.

The remaining question, then, is whether those work activities are a material cause of his need for medical services.

The preponderance of the evidence establishes that claimant's work activities were a material cause of his current condition. Drs. Jewett, Baum and Nye each evaluated claimant's wrist condition. Each of the three opined that claimant's bilateral carpal tunnel syndrome is work-related. (Ex. 16(A), 17 and 22).

Jewett opined that claimant's condition is "job-related." (Ex. 16(A)). Baum "checked the box" indicating that claimant's work activities are the "major contributing cause" of his current condition. (Ex. 17). Nye noted that claimant has a 20 year history of truck driving. He opined that "repetitive hand gripping [sic] obvious major contributing cause of [claimant's] carpal tunnel syndrome." (Ex. 22).

We conclude, then, that claimant has met his burden of proving that his work activities were a material cause of his bilateral carpal tunnel syndrome.

Penalties and Attorney Fees - Alleged Unreasonable Denial

Claimant contends that the employer's denial was unreasonable. The Referee did not address the issue. We do so now.

Where the carrier has a legitimate doubt as to its liability and issues a denial based on that doubt, its denial is not unreasonable. Brown v. Argonaut Insurance Co., 93 Or 588 (1988).

At the time of the denial, the employer had no information with which to determine whether the condition was, or was not, work-related. Therefore, we find that the employer had a legitimate doubt as to its liability when it issued the denial.

Under the circumstances, we find that the issuance of the denial was reasonable. Therefore, claimant is not entitled to a penalty and associated attorney fee.

ORDER

The Referee's order dated February 13, 1989, is reversed in part and affirmed in part. The employer's denial of claimant's bilateral carpal tunnel syndrome is set aside and the claim is remanded to the employer for processing according to law. For services at hearing and on Board review, concerning the compensability issue, claimant's attorney is awarded a reasonable assessed fee of $2,500, payable by the employer. The remainder of the Referee's order is affirmed. A client-paid fee, not to exceed $468, payable by the employer to its counsel, is approved.

In the Matter of the Compensation of
WILLIAM H. BAY, Claimant
WCB Case Nos. 88-10084 & 88-10083
ORDER ON REVIEW
Brothers, Drew, et al., Claimant Attorneys
Lester Huntsinger (Saif), Defense Attorney

Reviewed by Board Members Speer and Howell.

Claimant requests review of Referee Nichols' order that: (1) upheld the SAIF Corporation's denial of claimant's aggravation claim for his myocardial infarction; and (2) upheld SAIF's denial of claimant's occupational disease claim for the same myocardial infarction. On review the issue is compensability on either an aggravation or occupational disease theory. We affirm.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact with the following supplementation.

Claimant has a mental disorder -- an adjustment disorder with depressed mood (DSM-III coding 309.9) -- which is generally recognized in the medical or psychological community. (Exs. 4 & 33-2).

CONCLUSIONS OF LAW AND OPINION

Aggravation

Claimant sustained a stress-related claim which was accepted in 1985. To establish a compensable aggravation, claimant must show: (1) a worsening of his accepted stress-related claim since the last arrangement of compensation; and (2) a material relationship between the worsening and his compensable condition. ORS 656.273(1); Grable v. Weyerhaeuser Company, 291 Or 387, 400-01 (1981); Smith v. SAIF, 302 Or 396 (1986). In this regard, claimant alleges that his current myocardial infarction is a sequela of his compensable stress-related claim and, as such, the myocardial infarction is the worsening of his accepted stress-related claim.

In addition to establishing that his alleged increased stress is work-related, claimant must also show that the stress is, within reasonable medical probability, a material contributing cause of his myocardial infarction. Coday v. Willamette Tug & Barge, 250 Or 39, 47 (1968); Adams v. Gilbert Tow Service, 69 Or App 318, 321 (1984). We agree with the Referee that a preponderance of the medical evidence in the record does not support a finding that stress is a material contributing cause of claimant's heart condition. We adopt her discussion of this issue.

Occupational Disease

Claimant contends that his myocardial infarction is compensable as an occupational disease claim. He alleges that on-going work-related stress has caused a worsening of his preexisting heart disease. The Referee held that claimant had failed to show that work-related stress is the major contributing cause of a worsening of claimant's preexisting heart disease.

For an occupational disease claim, the date of "injury" is the date upon which the claimant was last exposed to the employment conditions which he alleges caused the disease. Johnson v. SAIF, 78 Or App 143, rev den 301 Or 240 (1986). Claimant's last exposure to the work-related stress which he alleges caused his myocardial infarction was March 1988. Accordingly, the occupational disease law, which became effective January 1, 1988, is applicable. See Johnson, supra at 146-48; Donna E. Aschbacher, 41 Van Natta 1242 (1989).

In order to be compensable as an occupational disease, claimant's stress-related physical condition must qualify under ORS 656.802(1)(b). See Ronald V. Dickson, 42 Van Natta 1102 (1990) (Compensability of a physical condition, resulting from mental stress, is a condition which does not meet the definitions set forth in either ORS 656.802(1)(a) or (c)). In Donna E. Aschbacher, supra, we concluded that a claimant whose occupational disease falls within subsection (b) is no longer required to prove by a preponderance of the evidence that his work exposure was the major cause of a disease before the disease will be found compensable. Instead, a claimant in such cases need only prove that his work exposure was a material cause of his disability or need for treatment. See Ellen L. Crawford, 41 Van Natta 1257 (1989).

Physical conditions resulting from work-related "stress" are not an occupational disease under ORS 656.802(1)(b), unless they represent a "mental disorder" which has been diagnosed and which is generally recognized as a mental disorder in the medical or psychological community. See ORS 656.802(2)(c). Only in that situation, where physical conditions constitute a diagnosed mental disorder, can a stress-caused physical condition be found to be a compensable occupational disease. See Dickson, supra. Here, claimant's myocardial infarction has not been diagnosed as a mental disorder. Therefore, claimant has failed to establish the compensability of his myocardial infarction as an occupational disease.

ORDER

The Referee's order, dated January 24, 1989, is affirmed.

June 19, 1990 Cite as 42 Van Natta 1288 (1990)

In the Matter of the Compensation of
PATRICK P. HORSTMAN, Claimant
WCB Case No. 88-04768
ORDER ON REVIEW
Richard O. Nesting, Claimant Attorney
Carrol J. Smith (Saif), Defense Attorney

Reviewed by Board Members Brittingham and Nichols.

Claimant requests review of that portion of Referee Leahy's order which upheld the SAIF Corporation's denial of his claim for his current right shoulder condition. On review, the issue is compensability. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact, except those contained in paragraphs four and six that conclude claimant did not sustain a new injury. In addition, we supplement with the following findings of fact.

Claimant's work on a lathe, over a two and one-half day period, caused an increase in shoulder symptoms.

FINDINGS OF ULTIMATE FACT

Claimant's right shoulder medical condition was unexpected from the activity performed.

Claimant's right shoulder medical condition was sudden in onset.

Claimant's employment October 6-9, 1987 materially contributed to the symptomatic worsening of his preexisting right shoulder condition.

Work activity for the employer did not cause worsening of claimant's preexisting right shoulder nonunion.

CONCLUSIONS OF LAW AND OPINION

The Referee found that neither the testimony nor the medical evidence established a causal relationship between claimant's work activities and his current right shoulder condition. We disagree.

Claimant argues an aggravation theory of compensability. He contends that work on a lathe, over a period of two and one-half days, made his preexisting right shoulder condition more symptomatic. Although claimant argues aggravation, for an aggravation claim to exist, claimant must already have established a compensable injury. Consolidated Freightways v. Foushee, 78 Or App 509, 512 (1986). Claimant has never asserted that his preexisting condition is compensable, nor has it ever been found to be compensable. Therefore, we do not analyze his claim under an aggravation theory.

The threshold question, then, is whether claimant can establish a compensable claim on either a new injury or an occupational disease theory. The two-prong test for distinguishing between industrial injury and occupational disease requires a determination whether the claimed medical condition was unexpected or expected, and whether the onset was sudden or gradual. James v. SAIF, 290 Or 343, 348 (1981); Valtinson v. SAIF, 56 Or App 184, 187 (1982); O'Neal v. Sisters of Providence, 22 Or App 9, 16 (1975).

The first prong of this test requires a retrospective estimation of the likelihood that the medical condition claimed would result from the kind, rate and duration of activity or exposure alleged to be the cause of the condition. Carol A. Fisher, 42 Van Natta 921 (1990); O'Neal v. Sisters of Providence, supra, 22 Or App at 17. 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 second prong of the test requires definition of the phrase "sudden onset." In Valtinson v. SAIF, supra, 56 Or App at 188, the court did not equate "sudden" with instantaneous. It ruled that the onset of a condition is "sudden" if it occurs as a result of a "discrete period" of work activity or exposure, as compared to the onset of an occupational disease over a long period of time.

In the present case, we conclude that a worker's activity of operating lathes and tightening the lathes with a "T"-handled wrench for only two and one-half days was unlikely to result in the condition claimed. We also conclude that a period of two and one-half days of such activity was sufficiently discrete to satisfy the "sudden in onset" requirement. See Valtinson v. SAIF, supra; Carol A. Fisher, supra. We find, therefore, that onset was traumatic in nature and the result of an injury rather than a disease. See Harris v. Albertson's Inc., 65 Or App 254, 256-57 (1983). Accordingly, we hold that claimant's claim relating to his work activity on October 6-9, 1987, is one for industrial injury rather than occupational disease.

In order to establish the compensability of his right shoulder condition on an industrial injury theory, claimant has the burden of proving that his work activity was a material contributing cause of his disability or need for medical services. Hutcheson v. Weyerhaeuser, 288 Or 51, 56 (1979); James v. Kemper Ins. Co., 81 Or App 80, 81 (1986); Harris v. Albertson's, Inc., supra, 65 Or App at 256-57. "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). Claimant need not show a pathological exacerbation of his underlying condition in order to prevail on an industrial injury theory. Harris v. Albertson's, Inc., supra, 65 Or App at 256-57.

Accordingly, claimant must prove that the industrial injury of October 1987 materially contributed to his current right shoulder symptoms and need for treatment. The issue of whether claimant's current disability and need for medical services are causally related to his industrial injury is a complex medical

question. The resolution of this issue largely turns on an analysis of the medical evidence. Uris v. Compensation Department, 247 Or 420, 426 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985). We find that claimant has met this burden of proof.

In October 1987, while working on one of several lathes for his employer, claimant had the onset of severe grinding pain in the right shoulder, unlike any he had ever experienced. His prior treating physician, Dr. Bachhuber, orthopedic surgeon, examined him and noted the recent onset of symptoms due to increased shoulder use. The doctor opined that claimant's employment had caused a temporary symptomatic worsening of the preexisting nonunion of his shoulder. The doctor testified via deposition that claimant's symptoms had worsened with work activity but subsided when claimant stopped working. He further noted that a nonunion cannot be worsened; claimant continues to need repeat arthrodesis to repair the prior unsuccessful procedure.

Dr. Gambee, orthopedic surgeon, performed an independent medical examination in October 1987, and opined that unless claimant had sustained a rotator cuff tear, the only treatment that was required was for symptoms of overuse syndrome. The need for repeat arthrodesis has remained the same since unsuccessful surgery in 1977. Dr. Bachhuber reviewed Dr. Gambee's report and subsequently has advised that there is no such tear.

Drs. Hopkins and Phipps, orthopedist and neurologist respectively, performed a second independent medical examination in May 1988. They noted that claimant had some pain on forced abduction and grinding in the shoulder. Pertinent diagnosis was status aggravation of the right shoulder (strain). They reported that claimant's current shoulder symptoms were related to his work for employer.

Dr. Hoppert, claimant's treating orthopedic physician for an unrelated carpal tunnel condition, reviewed Drs. Hopkins and Phipps' report and indicated that he agreed with their findings without explaining the basis for his conclusion. However, there is no evidence that Dr. Hoppert ever examined or treated claimant's shoulder.

All the physicians who have examined claimant since October 1987 concur that claimant sustained a worsening of symptoms due to his injury October 6-9, 1987. When a work-related injury causes a preexisting noncompensable condition to become more symptomatic and require medical treatment and/or result in disability, the symptoms are compensable. See Jameson v. SAIF, 63 Or App 553, 556 (1983); Stephen A. Scarratt, 42 Van Natta 607 (1990). As there are no medical opinions to the contrary, we conclude that this work activity was a material contributing cause of claimant's right shoulder symptoms resulting in disability and need for medical services.

Accordingly, we hold that the symptomatic worsening of claimant's right shoulder condition is compensable. In reaching this conclusion, we wish to emphasize that we have found only claimant's worsening symptoms resulting from the October 1987 injury to be compensable. Inasmuch as the medical evidence persuasively establishes that claimant's underlying right shoulder nonunion has not been worsened by his injury, that condition is not a compensable part of the claim. See, Stephen A. Scarratt, supra.

Claimant is entitled to an insurer-paid attorney fee for services at hearing and on review. See ORS 656.386(1). However, because no statement of services has been received, such a fee cannot presently be awarded. OAR 438-15-010(5).

ORDER

The Referee's order dated August 18, 1988 is affirmed in part and reversed in part. The SAIF Corporation's denial, insofar as it pertains to claimant's right shoulder symptoms attributable to the October 1987 injury, is set aside and the claim is remanded to SAIF for processing according to law. The remainder of the Referee's order is affirmed.

June 19, 1990 Cite as 42 Van Natta 1291 (1990)

In the Matter of the Compensation of
DOUGLAS S. METHVIN, Claimant
WCB Case No. 88-17115
ORDER ON REVIEW
Zbinden & Curtis, Claimant Attorneys
Dave Uyemura (Saif), Defense Attorney

Reviewed by Board Members Brittingham and Nichols.

Claimant requests review of Referee Mills' order that upheld the SAIF Corporation's denial of claimant's left ankle injury claim. On review, the issue is whether claimant's injury arose out of and in the course of employment.

We affirm and adopt the Referee's order with the following supplementation.

The ultimate inquiry, in determining whether an injury arose out of and in the course of employment, is whether the relationship between the injury and the employment is sufficient so that the injury should be considered work-related. Rogers v. SAIF, 289 Or 633 (1980). Seven factors have been identified to consider in deciding whether the injury is work-related:

> a. Whether the activity was for the benefit of the employer;
>
> b. Whether the activity was contemplated by the employer and employee either at the time of hiring or later;
>
> c. Whether the activity was an ordinary risk of, and incidental to, the employment;
>
> d. Whether the employee was paid for the activity;
>
> e. Whether the activity was on the employer's premises;
>
> f. Whether the activity was directed by or acquiesced in by the employer;
>
> g. Whether the employee was on a personal mission of his own.

Jordan v. Western Electric, 1 Or App 441, 443-4 (1970); quoted with approval, Mellis v. McEwan, Hanna, Grisvold, 74 Or App 571, 574 (1985).

Here, the activity claimant was engaged in, looking for his wallet after his regular work hours, was not for the benefit of his employer. Claimant was on

a personal mission of his own. He was not paid for this activity. Looking for a wallet could not be said to be an ordinary risk of, and incidental to, claimant's employment as a laborer. There is no indication that this activity was contemplated by the employer and employee either at the time of hiring or later. However, being on the premises after his regular work hours was contemplated, as evidenced by the fact that claimant occasionally performed work at night with his employer's knowledge. Finally, claimant's search for his wallet did take place on the employer's premises and the employer gave his permission for claimant to look for it.

After weighing all of these factors, we are not persuaded that there is a sufficient relationship between claimant's search for his wallet and his employment for claimant's injury claim to be work-related. Therefore, the ankle injury he sustained while leaving the premises following his search, is not compensable.

In reaching our conclusion, we find support in 1A Larson, Workmen's Compensation Law, 21.60 (1987), which states that:

> "within the before-and-after [working hours] period, a personal deviation can of course break the link with employment. [footnotes and cites omitted]."

We particularly note the cases from other jurisdictions cited by Larson at footnote 30 in support of this statement. See Fouts v. Anderson, 219 Va. 666, 250 S.E.2d 746 (1978); Faulkner v. Industrial Comm'n, 4 Ariz. App. 567, 422 P.2d 398 (1967); Martin v. Krolis Poultry Co., 12 Ill App. 3d 453, 297 N.E.2d 610 (1973). These cases involved employees who were injured on their employer's premises, outside of working hours, who were present for personal reasons and whose injuries were found to be not compensable.

ORDER

The Referee's order dated January 25, 1989 is affirmed.

June 20, 1990 Cite as 42 Van Natta 1292 (1990)

In the Matter of the Compensation of
WCB Case No. 87-16838
RAYMOND R. BIRD, Claimant
ORDER ON REMAND
Olson, Rowell & Walsh, Claimant Attorneys
Stafford Hazelett, Defense Attorney

This matter is before the Board on remand from the Court of Appeals. Liberty Northwest Insurance Corp. v. Bird, 99 Or App 560 (1989). The court has reversed our prior order, Raymond R. Bird, 41 Van Natta 398 (1989), which set aside the insurer's denial of claimant's left hand surgery claim. In so doing, we reasoned that the claim was not barred by the doctrine of res judicata. Concluding that our prior order did not contain a determination of whether claimant's condition changed since he first sought authorization for surgery, the court has remanded "for a determination of that question." We proceed with our reconsideration.

Claimant requests review of Referee Myers' order that upheld the insurer's denial of claimant's left hand surgery claim. On review, the issues are res judicata and compensability.

FINDINGS OF FACT

We adopt the findings of fact contained in the Court of Appeals' opinion, with the following supplementation.

Claimant injured his thumb and wrist at work in 1986. The insurer accepted his claim. Later, several doctors examined claimant and made varying diagnoses. Dr. Ellison, orthopedic surgeon, diagnosed left trigger thumb and carpal tunnel syndrome and requested authorization for trigger thumb release surgery. (See Ex. 14-4). The insurer denied authorization for surgery on February 17, 1987, stating that it was not reasonable and necessary and that claimant's condition resulted from an unrelated psychological condition. Claimant requested a hearing.

On May 26, 1987, the insurer refused a second request for medical benefits, stating that the treatment did not result from the accepted injury. Claimant again requested a hearing, and the cases were consolidated. However, claimant withdrew his requests for hearings on both refusals, and the Referee dismissed the case on August 6, 1987.

Later, in August 1987, Dr. LaFrance, neurologist, performed nerve conduction studies that confirmed the diagnoses of left trigger thumb and carpal tunnel syndrome. He referred claimant to Dr. Henshaw, orthopedic surgeon, who requested authorization for left trigger thumb and left carpal tunnel release surgeries. (Ex. 48).

The insurer refused the authorization on October 12, 1987. This time it stated that claimant's conditions did not result from his employment or from his accepted injury. Claimant requested a hearing, and the Referee held that the latter claim was barred by res judicata.

ULTIMATE FINDINGS

Claimant's condition did not change between Dr. Ellison's request for authorization for surgery and Dr. Henshaw's later request.

CONCLUSIONS OF LAW AND OPINION

The Referee noted that the insurer's first surgery denial became final after claimant withdrew his request for hearing and the request was dismissed. Therefore, the Referee reasoned that, as a matter of law, claimant's condition at the time of the first denial was not causally related to his compensable injury. In addition, the Referee found that claimant's testimony established that his condition remained essentially the same since shortly after his compensable injury.

In conclusion, the Referee observed: "Claimant has made no showing that the condition for which he is currently seeking benefits is any different than the condition at the time of the first denial." (O&O 4). Consequently, he held that res judicata barred the current claim. We agree.

When a claim for medical services is reasserted after being once denied, the question is whether the claimant's condition has changed so as to have created a new set of operative facts that previously could not have been litigated. See Argonaut Ins. Co. v. Rush, 98 Or App 730 (1989); Kepford v. Weyerhaueser, 77 Or App 363, rev den 300 Or 722 (1986).

Here, claimant described his current symptoms of pain in his thumb, slight tingling in the middle two fingers and grinding and pain in the thumb

with movement. (Tr. 19). He stated that his thumb always hurt, since his 1986 injury, but the tingling in his fingers varied with activity. (Tr. 20-22). Claimant further testified that he had had pain in his thumb since the injury, that it was always in the same area and that the intensity varied. He stated that the wrist pain started with the compensable injury, that it was always in the same location and that it, too, varied in intensity with differing activities. (Tr. 26-27).

Claimant's testimony concerning the continuing character of his symptoms and the unchanged nature of his condition is corroborated by the medical reports of the examining physicians.

On June 23, 1987, prior to the dismissal of claimant's hearing request regarding the insurer's first surgery denial and denial of medical benefits, Dr. Ellison, the surgeon who made the first surgery request, issued another report. Ellison noted that claimant continued to have grating, grinding and intermittent pain at the base of his thumb, as well as intermittent tingling along the themar eminence and the radial aspect of the thumb. (Ex. 42-2).

Following the dismissal order, claimant was examined by Drs. LaFrance, neurologist, and Henshaw, orthopedist. They noted claimant's "chronic" and "persisting" symptoms and signs compatible with left carpal tunnel syndrome and left trigger thumb. (Exs. 44, 45, 47). Based on these complaints, Henshaw sought authorization for surgery.

Claimant's testimony and the aforementioned medical reports establish that the second surgery request was based on a continuation of claimant's symptoms. Claimant was experiencing these complaints at the time of the first surgery denial, as well as the dismissal order. Based on the aforementioned medical and lay evidence, we are persuaded that claimant's condition did not change.

Furthermore, claimant's first claim was for left trigger thumb release surgery. His later surgery claim was for both left trigger thumb and left carpal tunnel release surgeries. Clearly, the left trigger thumb portion of the later claim had been made previously. Moreover, based on our findings, it had been made for the same condition. Because the denial of the first claim became final, the second claim for left trigger thumb release surgery is barred by application of the doctrine of res judicata.

The claim for left carpal tunnel release surgery was first made in conjunction with the second claim for left trigger thumb release surgery. The claim for carpal tunnel release related to the same condition which existed at the time of the first claim. However, we are less certain that claimant should have and could have asserted the claim for carpal tunnel release at the time of the earlier claim. Nevertheless, the court remanded to us to determine if claimant's condition changed between surgery claims. The court held, "[u]nless it has, the claim is barred."

We have found that claimant's condition did not change. Accordingly, we hold that claimant is barred by the doctrine of res judicata from asserting the present surgery claim.

The Referee's order dated January 26, 1988 is affirmed.

IT IS SO ORDERED.

In the Matter of the Compensation of
STEVE N. JONES, Claimant
WCB Case No. 87-15519
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Employer Defense Counsel, Defense Attorneys

Reviewed by Board Members Nichols and Brittingham.

The insurer requests review of that portion of Referee Baker's order that set aside its denial of claimant's accidental injury claim relating to his neck and upper back. We affirm.

ISSUES

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

2. Whether claimant's injury occurred as a result of his active participation in an assault or combat.

FINDINGS OF FACT

Claimant worked in the packaging department of the employer's lumber mill and sometimes assisted other workers on the greenchain. On September 18, 1987, claimant began his shift in the packaging department. He later noticed that the workers on the greenchain could use some assistance and walked to the greenchain area. As he neared the area, he noticed that one of the workers on the greenchain, Jody Leonard, was sweating profusely. He commented in a joking manner to another worker that it looked like Leonard "took a shower." Leonard overheard this comment, approached claimant and asked angrily, "Did you say something about me?" Claimant replied, "Yeah, it looks like you took a shower this morning." Leonard then began pushing claimant. Claimant moved aside and Leonard stumbled. Claimant then turned and walked away.

A short time later, claimant and Leonard happened to encounter one another in another part of the employer's mill. Leonard brought up the matter of claimant's earlier comment. Claimant replied that the comment was nothing to fight about and that Leonard should "just drop it." Leonard retorted, "Well, we'll take care of this in the parking lot." Claimant did not respond to this comment and walked away.

A short time after that, claimant left the plant on his morning break to go by car to get food at a store for himself and his coworkers. Upon leaving the plant, claimant began crossing a public highway to the employer's parking lot. Leonard confronted claimant on the highway, struck claimant in the chest with both fists and knocked him backward onto the pavement. He then jumped onto claimant, grabbed claimant's clothing and bounced claimant's back on the highway several times. Claimant did not attempt to fight back. As a result of Leonard's attack, claimant sustained disabling injuries to his neck and upper back.

FINDINGS OF ULTIMATE FACT

There was a material causal relation between claimant's injuries and his employment.

Claimant's injuries did not result from his active participation in an assault or combat.

CONCLUSIONS OF LAW AND OPINION

The insurer makes two arguments against the compensability of claimant's injuries. First, it contends that the injuries did not arise out of and in the course of claimant's employment because they resulted from a personal comment made by claimant which was not part of his assigned task and were sustained on a public highway during a break from work activity. In the alternative, it argues that the injuries are not compensable because they resulted from claimant's active participation in an assault or combat. We reject both arguments.

Arising Out of and in the Course of Employment

The ultimate inquiry in determining whether claimant's injury arose out of and in the course of his employment is whether the relationship between the injury and the employment was sufficient that the injury should be compensable. Former ORS 656.005(8); Rogers v. SAIF, 289 Or 633 (1980). To answer this question, we apply the seven-part test of Mellis v. McEwen, Hanna, Gisvold, 74 Or App 571 (1985).

The activity resulting in the injury was a confrontation between claimant and Leonard resulting from the latter's anger over a remark claimant made in jest about Leonard. The activity cannot be said to benefit the employer, or to have been acquiesced in by the employer. Claimant was not on the employer's property at the time of the injury. Rather, he was on a public highway running between the mill and the employee parking lot, and there is no evidence that the employer had any control over the highway. These factors weigh in favor of finding the claim noncompensable.

On the other hand, claimant had to cross the highway in order to reach the employer's parking lot where his car was parked, and he was paid by the employer for his break time. More importantly, we are persuaded that claimant's confrontation with Leonard was incidental to and an ordinary risk of his employment. The remark was made in the course of normal work activity and was prompted by the fact Leonard was sweating profusely from working the greenchain. Claimant's remark is best characterized as verbal horseplay closely associated with his employment rather than, as the insurer would characterize it, a personal affront regarding Leonard's "bathing habits." Injuries which result from such horseplay are compensable. See Stark v. SIAC, 103 Or 80 (1922); James Collins, 20 Van Natta 141 (1977).

After weighing the factors discussed above, we conclude that claimant's injury was sufficiently related to his work to be compensable. The fact that claimant's injuries were actually inflicted during a break from work activity, approximately 45 minutes after claimant's remark to Leonard, is not fatal to the claim under a unitary work-connection analysis.

The insurer cites two cases which, it contends, require a different result: Robinson v. Felts, 23 Or App 126 (1975) and Kenneth Hollin, 27 Van Natta 837 (1979). In Robinson, a jilted paramour came to the claimant's place of employment and fatally wounded her. The court concluded that there was an insufficient causal relation between the employment and the death to render it compensable. In that case, the relationship between the assailant and the decedent and the motivations for the attack had no material relation to the decedent's employment. 23 Or App at 132-34. We have no difficulty distinguishing Robinson from the present case. The relationship between claimant and Leonard was related to their employment and the motivation for the assault was offense taken at work-related horseplay.

Hollin is more difficult to distinguish. In that case, the claimant was assaulted by a coworker after the claimant told other employees about the fact that the coworker had attempted suicide. Before the assault, the coworker had threatened the claimant with bodily harm if he continued talking about him. The only relationship between the claimant and the coworker was their work association. Here, the confrontation was related to a remark made by claimant about the fact that the assailant was perspiring heavily as a result of performing his job duties. The comment falls within the realm of customary, work-related horseplay. In addition, the assailant in Hollin had expressed personal animosity for the claimant before the claimant made the comment which led to the assault. In the present case, there was no evidence of personal animosity between claimant and Leonard before claimant made his comment.

In any event, we conclude in the present case that there is a sufficient causal relation between claimant's injuries and his employment to satisfy the unitary work-connection test.

The Assaults or Combats Exclusion

The Board established guidelines for interpreting the assault exclusion of former ORS 656.005(8)(a) in Andrew A. Johansen, 40 Van Natta 1967 (1988). There, the Board noted several possible interpretations of the exclusion and ruled that the purpose of the exclusion would best be served by interpreting it in accordance with the intentional tort of assault. See also Paul M. Marston, 40 Van Natta 868 (1988), aff'd without opinion, 96 Or App 290 (1989). Under tort law, an assault is the apprehension of an imminent harmful or offensive contact. W. Prosser, The Law of Torts 37 (4th ed. 1971). No actual physical contact is required for an assault, but there must be some actions or words or combination thereof which put the victim in imminent apprehension of a harmful or offensive contact with his person. Id. at 37-40.

Claimant's comment regarding Leonard's perspiration was not an assault under this definition. The statement in no way threatened any harmful or offensive contact with Leonard's person. All of the physical contact between claimant and Leonard was initiated by Leonard and claimant made every effort to pacify the situation. Under these circumstances, claimant was not an active participant in an assault or combat and his claim is not barred under that exclusion.

ORDER

The Referee's order dated March 14, 1988 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $885, payable by the insurer. The Board approves a client-paid fee, not to exceed $936, payable by the insurer to its counsel.

June 20, 1990 Cite as 42 Van Natta 1297 (1990)

In the Matter of the Compensation of
HECTOR J. LARIVIER, Claimant
WCB Case No. 87-04289
ORDER ON REVIEW
Flaxel, et al., Claimant Attorneys
Dennis Ulsted (Saif), Defense Attorney

Reviewed by Board Members Speer and Howell.

Claimant requests review of that portion of Referee Higashi's order which reduced claimant's unscheduled permanent disability for an upper back

injury from 20 percent (64 degrees), as awarded by prior Determination Orders, to 17 percent (54.4 degrees). The SAIF Corporation requests on review that we authorize an offset of alleged overpaid permanent disability against future awards. On review, the issues are extent of unscheduled permanent disability and offset. We reverse in part.

FINDINGS OF FACT

The Board adopts the Referee's "Findings."

CONCLUSIONS OF LAW AND OPINION

Claimant's back claim was closed by Determination Order on March 10, 1987, reopened for surgery and subsequently closed by Determination Order on November 2, 1988. Accordingly, the "standards" adopted effective July 1, 1988, (former OAR 436-35-001 et seq), as amended by temporary rules effective August 19, 1988, apply to the rating of claimant's permanent partial disability. Former OAR 436-35-270 through 436-35-440 apply to the rating of unscheduled permanent partial disabilities. Former OAR 436-35-270(1).

The hearing and Board review of the issue of permanent partial disability continues to be de novo on the hearing record. The underlying facts to which the "standards" are applied need only be established by a preponderance of the evidence. However, either party may establish that the record, as a whole, constitutes clear and convincing evidence that the degree of permanent partial disability suffered by the claimant is more or less than the entitlement indicated by the "standards." ORS 656.283(7) and 656.295(5).

The determination of permanent partial disability under the "standards" is made by determining the appropriate values assigned by the "standards" to the claimant's age, education, adaptability and impairment. Once established, the values for age and education are added and the sum is multiplied by the appropriate value for adaptability. The product of those two figures is then added to the appropriate value for impairment to yield the percentage of unscheduled permanent partial disability. Former OAR 436-35-280.

Age

The appropriate value for claimant's age of 60 years is 1. Former OAR 436-35-290.

Formal education

The appropriate value for claimant's 14 years of formal education is 0. Former OAR 436-35-300(3).

Skills

Former OAR 436-35-300(4) adopts by reference the "SVP" (specific vocational preparation time) values assigned to various occupations by the Dictionary of Occupational Titles (DOT), published by the U.S. Department of Labor. The highest SVP level demonstrated by a claimant during the ten years prior to the date of injury is used to determine a value for skills. Former OAR 436-35-300(4). Claimant's highest SVP during the ten years prior to the date of injury was 7 as an electrician (DOT # 824.261-010). Therefore, the appropriate value for skills is +1. Former OAR 436-35-300(4).

Training

Claimant has no documentation of training in a specific vocational pursuit. Therefore, the appropriate value for training is 1. Former OAR 436-35-300(5). Claimant's total education value is +2, the formal education value plus the skills value plus the value for training. Former OAR 436-35-300(6).

Adaptability

An adaptability value for a claimant who is unable to return to his or her usual and customary work (see former OAR 436-35-270(3)(a)) but who has returned to modified work is determined from a matrix of values at former OAR 436-35-310(3)(a). That matrix compares the physical capacity of the claimant's usual and customary work with the physical capacity required by the modified work. This is true even though claimant may have the physical capacity to do heavier work than is required by the modified employment. Physical capacities are not defined by the "standards" generally. We utilize those definitions contained in former OAR 436-35-310(4)(a)-(d).

In this case, claimant's usual and customary work required the physical capacity to do medium work. Claimant's modified work required a light physical capacity. Therefore, the appropriate adaptability value is +2. Former OAR 436-35-310(3)(a).

Impairment

Claimant is entitled to 5 percent impairment for his laminectomy with single discectomy. Former OAR 436-35-350(2). He is also entitled to 2 percent for a favorable cervical fusion. Former OAR 436-35-350(3).

The medical evidence is sufficient to prove that claimant has lost 50 percent of flexion and is therefore entitled to a 2 percent impairment value. Former OAR 436-35-360(2).

The medical evidence is sufficient to prove that claimant has lost 15 degrees of extension and is therefore entitled to a 2 percent impairment value. Former OAR 436-35-360(3).

The medical evidence is sufficient to prove that claimant has lost 20 degrees each of left and right lateral flexion and is therefore entitled to a 2 percent impairment value. Former OAR 436-35-360(4).

The medical evidence shows that claimant has lost 20 degrees of right rotation. For that he receives 2 percent impairment. Former OAR 436-35-360(5). He retains full range of motion in turning to the left. The values for lost range of motion in claimant's neck are added (not combined) to obtain a single value. Former OAR 436-35-360(11). In this case the total range of motion value is 8 percent.

The impairment values for claimant's laminectomy with single discectomy, cervical fusion and lost cervical spinal motion are combined (not added) to obtain a single impairment value. See former OAR 436-35-360(11); Darrell L. Wilson, 42 Van Natta 1200 (1990). Here, 5 percent, 2 percent, and 8 percent combine to a value of 14.4 percent (to the nearest 1/10 of one percent.)

Having determined each value necessary to compute claimant's permanent disability under the "standards," we proceed to that calculation. When claimant's age value (1) is added to his education value (2) the sum is 3. When that value is multiplied by claimant's adaptability value (2) the product is 6. When that value is added to claimant's impairment value (14.4) the result is 20.4 percent unscheduled permanent partial disability. Former OAR 436-35-280(7). That disability figure is rounded to the next higher whole percentage. Former OAR 436-35-280(7). Claimant's permanent disability under the "standards" is, therefore, 21 percent.

Moreover, on this record we do not find clear and convincing evidence that claimant's disability is greater than 21 percent for loss of earning capacity due to his back condition. See Thomas L. Swanger, 42 Van Natta 887 (1990).

The Determination Order dated March 10, 1987 awarded 20 percent unscheduled permanent disability. The Determination Order dated November 2, 1988 did not award additional unscheduled disability. The Referee reduced claimant's award to 17 percent. We conclude that claimant is entitled to an additional 4 percent (12.8 degrees) unscheduled permanent partial disability.

Offset

As a result of our conclusion on the extent issue, SAIF's request for authorization to offset an alleged overpayment of permanent disability is moot.

ORDER

The Referee's order dated February 22, 1989 is reversed. In addition to claimant's prior total award of 17 percent (54.4 degrees) unscheduled permanent disability, claimant is awarded 4 percent (12.8 degrees) unscheduled permanent partial disability compensation for a total award to date of 21 percent (67.2 degrees) unscheduled permanent partial disability. An attorney fee is approved for claimant's attorney in the amount of 25 percent of the increased compensation made payable by this order, not to exceed $3,000. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
SUSAN D. TROXELL, Claimant
WCB Case No. 88-18160
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
David Jorling, Defense Attorney

Reviewed by Board Members Howell and Speer.

The self-insured employer requests review of Referee Shebley's order which set aside its denial of claimant's occupational disease claim for her neck and shoulder condition. In her brief, claimant argues that the Referee improperly denied her motion to amend her Request for Hearing to seek a penalty for an alleged unreasonable denial. On review the issues are compensability and the Referee's refusal to grant claimant's motion to amend. We affirm.

FINDINGS OF FACT

With the exception of his "Ultimate Findings of Fact," we adopt the Referee's "Findings of Fact."

CONCLUSIONS OF LAW AND OPINION

Compensability

The Referee found that claimant's condition is compensable under ORS 656.802(1)(a). We agree that claimant's condition is compensable, however, we find claimant's condition compensable under ORS 656.802(1)(c). We base our conclusion upon the following reasoning.

For an occupational disease claim, the date of "injury" is the date upon which the claimant was last exposed to the employment conditions which caused the disease. Johnson v. SAIF, 78 Or App 143, rev den 301 Or 240 (1986). Claimant's last exposure to the "injurious" employment conditions was in September 1988. Therefore, the new occupational disease law which became effective January 1, 1988, is applicable.

Claimant alleges that her work site next to the customer desk required her to consistently reach across her desk and a counter top, stretching her arm out some 39 inches between 45 and 120 times per day. We recently relied on legislative intent in interpreting a "series of traumatic events" as used in ORS 656.802(1)(c) to include "overuse of a body part." See Ronald V. Dickson, 42 Van Natta 1102 (1990). Because claimant alleges that her condition arose from repetitive physical action, we conclude that claimant's claim is properly analyzed under subsection (1)(c), rather than (1)(a), of ORS 656.802. See Mary L. Goudy, 42 Van Natta 1140 (1990). In order to establish that her condition arose out of and in the course of her employment under ORS 656.802(1)(c), claimant must prove that her work exposure was a material cause of her condition. Donna E. Aschbacher, 41 Van Natta 1242 (1989); Carole J. Damm, 42 Van Natta 225 (1990)

Claimant's treating physician reports that, "it is obvious that [claimant's] condition is solely the result of and caused by the activities she performed while doing her job. History revealed no other contributing factor..." (Ex. 9-2). Claimant testified that once she began receiving treatment and once her desk position was changed, removing the need for her to reach over the counter and desk, her condition improved. We conclude that claimant has established, by a preponderance of the evidence, that her work exposed her to a "series of traumatic events or occurrences" which are a material cause of her neck and shoulder condition under ORS 656.802(1)(c).

Motion to Amend Request for Hearing

At the commencement of the January 20, 1989 hearing, the parties agreed that the only issue was the compensability of claimant's occupational disease claim. At the conclusion of her case, claimant moved to amend her request for a hearing to include the issue of entitlement to a penalty and attorney fee for an alleged unreasonable refusal to pay compensation by way of the employer's October 6, 1988 denial. The Referee denied the motion. Claimant renews the motion on review.

Former OAR 438-06-031 provides that amendments "shall be freely allowed up to the date of hearing..." And, "If, during the hearing, the evidence supports an issue not previously raised, the referee may allow the issue to be raised during the hearing," or, "The referee may continue the hearing..." (emphasis added). Therefore, whether a party is allowed to raise an issue for the first time during the course of a hearing is a matter within the Referee's discretion.

We consider it to be the preferred practice, generally, to allow such amendments. That is the case particularly when, as here, the additional issue is a penalty and attorney fee issue closely related to the compensability issue previously raised. However, we cannot say that the Referee in this case abused his discretion by denying claimant's motion. We affirm the Referee's denial of claimant's motion to amend her request for hearing.

Because claimant attempted to raise the issue of entitlement to a penalty and attorney fee during the course of the hearing in this matter, that issue cannot be said to have been waived by claimant's proceeding to hearing on the issue of compensability. Cf. Mavis v. SAIF, 45 Or App 1059 (1980), (claimant must either raise penalty issue at hearing or the issue is waived).

ORDER

The Referee's order, dated February 10, 1989, is affirmed. For services on review concerning the compensability issue, claimant's attorney is awarded an assessed fee of $600, to be paid by the employer.

June 21, 1990 Cite as 42 Van Natta 1302 (1990)

In the Matter of the Compensation of
PAULA M. PATERSON, Claimant
WCB Case No. 88-15627
ORDER ON REVIEW
Quintin B. Estell, Claimant Attorney
Pamela Schultz, Defense Attorney
Meyers & Associates, Attorneys

Reviewed by Board Members Nichols and Brittingham.

Claimant requests review of Referee Howell's order that: (1) increased claimant's unscheduled permanent disability award for a low back and right hip injury from 13 percent (41.6 degrees), as awarded by Determination Order, to 21 percent (67.2 degrees); (2) held that claimant's rate of temporary total disability compensation was properly calculated without inclusion of bonus payments; and (3) declined to assess a penalty and attorney fee for failure to include bonuses in the temporary total disability calculation. The insurer requests reduction of the Referee's award of unscheduled permanent partial disability. On review, the issues are extent of unscheduled permanent partial disability, rate of temporary total disability compensation, penalties and attorney fees. We modify in part and reverse in part.

FINDINGS OF FACT

Claimant was 32 years of age at the time of hearing. She has a high school education. She has been employed, during the last ten years, as a ranch hand on a horse ranch, a cook, a seamstress in a factory, a flag person, and, at the time of injury, as a grader trainee in a wood products mill. She has raised and trained horses for a living on a self-employed basis. She learned the necessary skills by working on a ranch without pay.

In August 1986 claimant began working for the employer. She initially worked for the employer as a cleanup person but, by the time of injury, had become a grader trainee. As a grader trainee, she pulled green lumber as large in dimension as 2 x 12 and 6 x 6 and as long as 22 feet.

Claimant was hired as a temporary employee for a wage of $6.25 per hour. At the time of hire, she was advised that when she became a regular employee, she would be eligible for production bonuses. She was told that employees were entitled to production bonuses if they worked at least 32-40 hours per week and did not miss scheduled work time. The amount of the bonus was based on the output of the crew to which she would be assigned and on the company's profit on output in excess of a specified amount. Claimant was at no time given any written explanation of the bonus program.

Claimant became a regular employee on September 25, 1986. For each of the pay periods thereafter, until the time of her compensable injury, claimant was paid $6.25 per hour plus a bonus. The bonuses varied in amount. The bonus amount varied from $145.52 to $332.26 per semimonthly pay period and ranged from about 25 to 40 percent of her gross pay.

On December 10, 1986, claimant was compensably injured when a piece of wood struck her on the left upper leg. She received emergency treatment but continued to work until December 18, 1986 when she saw Dr. Dahlstrom, chiropractor.

Claimant treated with Dr. Dahlstrom, and later with Dr. Isaacson, an orthopedic surgeon, for low back pain and a left sacroiliac joint disorder related to the compensable injury.

Claimant became medically stationary July 28, 1988. Claimant at that time could flex her low back to 90 degrees with some pain and a catch upon straightening. Extension was 25 degrees and lateral flexion was 30 degrees bilaterally. Rotation was 45 degrees bilaterally. Claimant was unable to lift even 10 pounds from the floor continuously but could carry 10 pounds continuously. An August 31, 1988 Determination Order closed the claim with an award of 13 percent unscheduled permanent disability.

At the time of hearing claimant continued to experience some low back and left hip pain with certain activities. Because of that pain she was limited in her ability to lift more than 10 pounds repetitively, could not repetitively bend at the waist, and had difficulty riding a bicycle. After sitting more than about one-half hour claimant's left hip became stiff and painful. Occasionally, with extended periods of standing, claimant experienced left leg cramping and pain. The symptoms resulted from excessive movement or improper alignment of the left sacroiliac joint, which was unstable as a result of her compensable injury.

Claimant was unable to return to her at injury work due to limitations imposed as a result of the compensable injury. At the time of hearing she was performing modified work in a used bookstore. Her work at the bookstore did not require much bending, stooping or squatting. The books sold were paperbacks.

FINDINGS OF ULTIMATE FACT

Claimant has lost 18 percent of her earning capacity as a consequence of her compensable back injury.

Claimant regularly earned incentive pay while working for the employer.

The insurer unreasonably failed to include incentive pay in its calculation of temporary total disability compensation thereby delaying and resisting payment of compensation.

CONCLUSIONS OF LAW AND OPINION

Extent of Disability

The Referee increased the award of unscheduled permanent disability awarded by Determination Order. Claimant contends that the Referee's award did not adequately compensate her for the loss in ability to perform jobs which she performed before the injury. The insurer, on the other hand, contends that the Referee's award was excessive. The insurer objects to the Referee's reliance on claimant's testimony concerning the pain she suffers and its affect on her ability to function: The insurer argues that claimant's testimony was inconsistent with the reports of her physicians and that greater reliance should be placed on the medical reports than on the testimony.

On de novo review, we also credit claimant's testimony concerning the consequences of the injury for her day to day functioning. We note, as did the

Referee, that claimant's treating physician testified by deposition that she believed that claimant's report of her symptoms and limitations was reliable. We further note that claimant's reported lifting limitations parallel those imposed by Dr. Dahlstrom and Dr. Isaacson. The physicians also placed limitations on continuous sitting and standing which are not inconsistent with claimant's testimony concerning the affects of extended periods of sitting and standing. Consequently, we concur in the Referee's findings concerning claimant's functional limitations.

We also agree with the Referee's comments concerning the applicable law and his assignment of values under the standards for age, formal education, skills, documented training and impairment. We differ, however, in our understanding of the proper application of former OAR 436-35-310, regarding the adaptability factor. Therefore, we adopt part "A)" of the Referee's Conclusion except for the discussion of the adaptability factor and the final paragraph which computes the award. We add the following:

Claimant is unable to return to her former type of work owing to the limitations necessitated by her compensable injury. Unlike the Referee, however, we conclude, based on claimant's testimony at hearing, that she has returned to modified work. Therefore, claimant's adaptability value must be ascertained by using the table at former OAR 436-35-310(3)(a). We conclude, based on record descriptions of claimant's actual work activity as a lumber grader trainee, that claimant was doing heavy work at the time of injury. She was pulling green lumber of substantial size. Following the compensable injury, she was doing light work in a paperback bookstore. Therefore, she is entitled to a value of 2.5 for adaptability.

When claimant's age value (0) is added to her education value (2), the sum is 2. When that value is multiplied by claimant's adaptability value (2.5), the product is 5. When that value is added to claimant's impairment value (12.4), the result is 17.4. Former OAR 436-35-280(7). That value is rounded to the next higher whole number. Id. Under the standards, therefore, claimant is entitled to an award of 18 percent unscheduled permanent disability.

Although claimant does not specifically argue that we should award in excess of that indicated by the standards, she does argue that because she has many skills which she can no longer make use of consistent with her physical disability, she has lost in excess of 18 percent of her earning capacity. While claimant's argument has some merit, given her youth and the variety of skills that she has developed, we are not persuaded that it is highly probable that she has lost in excess of what is allowed under the standards. Consequently, we modify the Referee's award to allow 18 percent.

Rate of Temporary Total Disability Compensation

The Referee concluded that claimant's bonus pay should not be included in her wages for purposes of calculating temporary total disability because the bonuses are discretionary in nature. We disagree.

First, we find that incentive payments in the form of production bonuses were an integral part of the employer's wage structure. Claimant was advised of the production bonus scheme when she was hired. The employer had established rules to govern allowance of production bonuses. During the period of claimant's employment, employees were never told that the bonus program had been or would be discontinued. Finally, bonuses were awarded every pay period during which claimant was an employee. They were a regular and substantial part of claimant's compensation package.

The Referee was apparently persuaded that bonuses were not a regular part of claimant's compensation because there is a document in the file, Ex. 43, which states that participation in the bonus program is within the discretion of the manager and that the program might be changed or discontinued by the manager at any time. The document was never authenticated. There is nothing on the face of the document or elsewhere in the record that establishes that the document is related to the employer at injury, that the document was created during claimant's employment or that it was ever distributed to employees. Moreover, even if we were able to find that the document had been given to the employer's employees at the time of claimant's employment, in light of the employer's explanation of the program to claimant and the regular payment of substantial bonuses, we would nevertheless conclude that bonuses were a part of claimant's wages at the time of injury.

Former OAR 436-60-020(7)(j) provides, with respect to employees employed with incentive pay: "Incentive pay provided by contract of employment shall be considered only when regularly earned. If incentive pay earnings vary, use average as in subsection (a)." For the purposes of this rule, the contract of employment, provided none exists in writing, must refer to the wage structure in effect at the time of injury. See ORS 656.005(26).

We have found that the employer's wage structure at the time of claimant's injury included a $6.25 hourly rate and regular incentive payments of varying amounts. Consequently, the insurer should have considered claimant's incentive pay in calculating her temporary disability compensation in reliance on former OAR 436-60-020(7)(j). See Donna J. Russell, 40 Van Natta 568 (1988).

Penalties and Attorney Fees

The Referee, having concluded that claimant was not entitled to inclusion of bonus payments in her wages for purposes of computation of benefits, also concluded that the insurer's conduct in calculating temporary disability compensation was not unreasonable. The Director's rule clearly controls bonus payments provided they are regularly paid. The evidence is clear that claimant received bonus pay pursuant to an established compensation program, not merely on an occasional basis at the employer's whim. Therefore, the insurer unreasonably failed to include bonus payments in claimant's wages. In so doing, the insurer delayed claimant's compensation. We assess a penalty of 25 percent of the additional temporary disability compensation payable under this order.

Further, the insurer's unreasonable conduct constitutes a resistance to the payment of compensation. Therefore, we assess an attorney fee, payable by the insurer.

ORDER

The Referee's order dated April 7, 1989 is reversed in part and modified in part. That portion of the order that declined to award additional temporary total disability compensation is reversed. Claimant is awarded additional temporary total disability benefits which are also based on her bonus payments. The claim is remanded to the insurer for further processing consistent with this order. The insurer shall pay to claimant a penalty equal to 25 percent of the additional temporary disability benefits due as a result of this order. For services at hearing and on review on the temporary disability issue, claimant's attorney is awarded 25 percent of the additional compensation due under this order, not to exceed $2,800. For services at hearing and on review regarding the penalty issue, claimant's attorney is awarded a fee of $500, payable by the insurer. In lieu of the Referee's award and in addition to the 13 percent (41.6 degrees) unscheduled permanent disability awarded by Determination Order,

claimant is awarded 5 percent (16 degrees) unscheduled permanent disability, for a total award of 18 percent (57.6 degrees) unscheduled permanent disability for injury to the low back. The Board approves a client-paid fee, not to exceed $704, payable by the insurer to its counsel.

June 22, 1990 Cite as 42 Van Natta 1306 (1990)

In the Matter of a Fee for a Deposition by
F. OWEN BLACK, M.D., Petitioner
WCB Case No. 89-17333
ORDER OF DISMISSAL
Malagon, et al., Attorneys
Cummins, et al., Defense Attorneys

Dr. Black requests review of Referee Bennett's order which declined to set aside a Director's order that had found $700 to be an appropriate fee for Black's deposition. We have reviewed the request to determine whether we have jurisdiction to consider the matter. We dismiss.

FINDINGS OF FACT

On August 2, 1989, the Director issued a Proposed and Final Order; Notice concluding that the $700 fee paid by the employer for Dr. Black's deposition was appropriate. Thereafter, Dr. Black requested a hearing on the Proposed and Final Order. A hearing was held before the Referee, who declined to set aside the Director's order. Dr. Black then requested Board review.

CONCLUSIONS OF LAW AND OPINION

If any party requests a hearing on a Director's proposed order regarding a medical fee dispute, the hearing shall be held by a Referee of the Hearings Division. OAR 436-10-090(6); 436-10-110(5). When a Referee issues an order, it is then a final order of the Director and must be appealed directly to the Court of Appeals. OAR 436-10-110(5)(a); Stanley Wilson, 40 Van Natta 387 (1988).

Here, Dr. Black requested a hearing concerning a Director's order regarding a medical fee dispute. Upon the issuance of the Referee's order, the Director's order became a final order of the Director which is subject to judicial review. OAR 436-10-110(5)(a). Consequently, we are not the appropriate appellate forum to consider this matter.

Accordingly, the request for Board review is dismissed.

IT IS SO ORDERED.

June 22, 1990 Cite as 42 Van Natta 1306 (1990)

In the Matter of the Compensation of
PATRICK A. GETTY, Claimant
WCB Case Nos. 87-11538, 87-14394 & 87-14395
ORDER ON RECONSIDERATION
Pozzi, et al., Claimant Attorneys
Rankin, et al., Defense Attorneys
Underwood, et al., Defense Attorneys
Bottini, et al., Defense Attorneys

EBI Companies has requested reconsideration of that portion of our June 5, 1990 Order on Review that concluded that it had accepted claimant's bilateral carpal tunnel condition when its claims representative checked the "accepted"

box on a Form 801 and then signed the form on behalf of the insurer. On reconsideration, EBI asks the Board to reconsider our finding in light of the court's decision in EBI Insurance Company v. CNA Insurance, 95 Or App 448 (1989).

In that case, the court held that the insurer did not accept a claim by signing and filing a Form 1502, which is a report prepared for the Workers' Compensation Division (now Workers' Compensation Department) of the current status of a claim. In reaching its decision, the court noted that the Form 1502 did not include certain information and advice to the claimant required by ORS 656.262(6). It concluded that the Form 1502 was not intended to be a notice to the claimant of acceptance, denial or anything else.

Here, EBI's claims representative partially completed and signed a Form 801. Unlike a Form 1502, a Form 801 is intended as a notice to claimant, and the back of the Form 801 does contain the information required by ORS 656.262(6). In light of this important distinction, we conclude that the decision in EBI Insurance Company v. CNA Insurance, supra, is not controlling in the present case.

We, therefore, adhere to our ruling that EBI accepted claimant's bilateral carpal tunnel condition, so that its subsequent denial of the condition is prohibited under Bauman v. SAIF, 295 Or 788 (1983). Accordingly, our June 5, 1990 order is abated and withdrawn. As supplemented herein, we adhere to and republish our June 5, 1990 order in its entirety. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

June 22, 1990 Cite as 42 Van Natta 1307 (1990)

In the Matter of the Compensation of
PATRICK LANE, Claimant
WCB Case No. 88-11721
ORDER ON REVIEW
John Motley (Saif), Defense Attorney

Reviewed by Board Members Perry and Speer.

The SAIF Corporation requests review of that portion of Referee Myzak's order that declined authorization to offset an alleged overpayment of temporary disability benefits. SAIF seeks to have a pre-hearing audit sheet included in the record. On review, the issues are remand and offset.

We affirm and adopt the Referee's order, with the following supplementation.

The Referee found that SAIF's audit sheet was obtainable prior to hearing. We agree and find no abuse of discretion in her refusal to reopen the record to admit the document. OAR 438-07-025(2)(b).

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); Bernard L. Osborn, 37 Van Natta 1054, 1055 (1985), aff'd mem 80 Or App 152 (1986). As we have stated, SAIF's audit sheet was obtainable prior to hearing. Consequently, we do not remand.

On the merits of the offset issue, the Referee held that SAIF has the burden of proving an overpayment. We agree.

SAIF is entitled to an offset of benefits that have been paid only if the evidence shows that claimant was not entitled to the benefits. Fazzolari v. United Beer Distributors, 91 Or App 592, 595 (1988). SAIF failed to timely introduce available evidence, which was necessary to prove its entitlement to offset. We agree that SAIF has not carried its burden. Metro Rigging Co. v. Tallent, 94 Or App 245 (1988).

ORDER

The Referee's order, dated February 10, 1989, is affirmed.

In the Matter of the Compensation of
MICHAEL F. MAY, Claimant
WCB Case No. 88-10095
ORDER ON REVIEW
Kevin L. Mannix, Defense Attorney

Reviewed by Board Members Speer and Perry.

Claimant, pro se, requests review of Referee Wasley's order that: (1) found that claimant lacked "good cause" for failing to timely file his hearing request from the self-insured employer's denial of his low back injury claim; and (2) upheld the employer's denial of his low back injury claim. We conclude that the Referee lacked jurisdiction to hear claimant's hearing request. Accordingly, we vacate the Referee's order and dismiss claimant's request for hearing.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact."

CONCLUSIONS OF LAW AND OPINION

Claimant filed a request for hearing more than 60 days, but less than 180 days, after notice of the denial. He did not request a hearing within 60 days because he chose to pursue an alternative remedy. The Referee found that claimant's pursuit of an aggravation claim in the State of Washington did not justify his untimely request. We agree.

Claimant's choice to pursue a claim in another state was not due to "mistake, inadvertence, surprise or excusable neglect," as these words are used in ORCP 71B(1) and cases decided thereunder. Brown v. EBI Companies, 289 Or 455 (1980); Naught v. Gamble, Inc., 87 Or App 145 (1987). Inasmuch as claimant has not provided evidence of "good cause" for failure to file his request by the 60th day after notification of denial, the request for hearing was untimely. ORS 656.319. The Referee did not have jurisdiction to address the merits of the claim. Sweeden v. City of Eugene, 95 Or App 577 (1989). Accordingly, claimant's request for hearing must be dismissed.

ORDER

The Referee's order dated August 26, 1988 is vacated and claimant's June 16, 1988 request for hearing is dismissed. A client-paid fee, paid by the self-insured employer to its attorney, not to exceed $901, is approved.

In the Matter of the Compensation of
RANDOLPH T. SLOAN, Claimant
WCB Case Nos. 88-07599, 86-09221, 86-13026, 88-01265 & 88-07598
ORDER ON REVIEW
Rosenthal & Greene, Claimant Attorneys
Schwabe, et al., Defense Attorneys
Steven Moore, Defense Attorney
Emmons, et al., Attorneys

Reviewed by Board Members Howell and Speer.

Claimant requests review of that portion of Referee Neal's order which declined to award an insurer-paid attorney fee for services rendered in obtaining the issuance of an ORS 656.307 order. KOT Inc., a noncomplying employer, cross-requests review of that portion of the order which set aside the SAIF Corporation's denial, on its behalf, of claimant's injury claim and upheld Wausau Insurance Company's denial, on behalf of U. S. Transportation, of the same injury. On review, the issues are attorney fees and responsibility. We affirm.

FINDINGS OF FACT

The Board adopts the Referee's "Findings of Fact."

CONCLUSIONS OF LAW AND OPINION

The Board adopts the Referee's "Opinion" with the following comment on the attorney fee issue.

Claimant alleges entitlement to an assessed attorney fee under ORS 656.386(1). Although claimant's counsel may have been instrumental in obtaining a concession of compensability, he is not entitled to a fee under ORS 656.386(1). That statute provides for an assessed attorney fee only where claimant finally prevails in a hearing before a Referee. See ORS 656.386(1); Duane L. Jones, 42 Van Natta 875 (1990).

Here, claimant did not finally prevail in a hearing before a Referee. To the extent that he prevailed concerning the issue of compensability, he did so prior to any hearing. Under such circumstances, claimant is not entitled to an assessed fee pursuant to ORS 656.386(1). See Duane L. Jones, supra; Ernest C. Richter, 42 Van Natta 955 (1990).

ORDER

The Referee's order dated August 10, 1988, as reconsidered October 7, 1988, is affirmed.

In the Matter of the Compensation of
ROBERT D. ARMSTRONG, Claimant
WCB Case No. 86-02776
THIRD ORDER ON REMAND
Brian R. Whitehead, Claimant Attorney
Acker, et al., Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Asten-Hill Co. v. Armstrong, 100 Or App 559 (1990). Unable to determine whether

substantial evidence existed to support the Board's conclusion on compensability, the court has remanded for reconsideration. See ORS 183.482(8)(c) and 656.298(6); Garcia v. Boise Cascade Corp., 309 Or 292 (1990). We proceed to our reconsideration.

We adopt our prior findings and conclusions subject to the following supplementation.

The issue in this case is compensability of claimant's occupational disease claim for chronic rhinitis. In order to establish compensability, claimant must prove that his work exposure was the major cause of a pathological worsening of his underlying rhinitis condition. Former ORS 656.802(1); Devereaux v. North Pacific Insurance Co., 74 Or App 388, 391 (1985). The first issue we addressed in our prior order on remand was whether claimant's preexisting rhinitis condition had worsened, either temporarily or permanently. Robert D. Armstrong, 41 Van Natta 79, 81 (1989). On this issue, the record contains the opinions of two medical experts: Dr. Parosa and Dr. Montanaro. We concluded that both physicians believed that claimant's preexisting rhinitis condition had pathologically worsened.

The court disagreed. The court found that the only reasonable reading of Dr. Montanaro's testimony is that he believed that only claimant's symptoms, not the preexisting condition, had worsened. Reasoning that it could not know what we would have concluded had we not misinterpreted Dr. Montanaro's testimony, the court remanded for reconsideration. On reconsideration, we adhere to our prior conclusion that claimant's rhinitis condition is compensable.

In reaching this conclusion, we rely upon the opinion of Dr. Parosa over the contrary opinion of Dr. Montanaro. Dr. Parosa was claimant's treating physician. When the medical evidence is divided, we give greater weight to the conclusions of a treating physician, absent persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810, 814 (1983). In this regard, Dr. Parosa examined and treated claimant during the period of claimant's exacerbated condition. Because Parosa actually examined and treated claimant during the period of exacerbation, we conclude that he is in the better position to determine whether claimant's underlying condition had worsened at that time.

Further, while Dr. Montanaro inspected claimant's work site, we question the diagnostic advantage obtained by this single visit. Like the Referee, we are unpersuaded that the conditions observed by Dr. Montanaro represented the conditions under which claimant typically worked. The credible lay testimony of claimant and other mill employees describes conditions which are significantly more dusty than those observed by Dr. Montanaro.

In sum, we find no persuasive reasons not to give greater weight to the opinion of Dr. Parosa.

Claimant is entitled to an attorney fee for services rendered before the Court of Appeals. ORS 656.388(1). However, we cannot presently award such a fee because no statement of services has been received. OAR 438-15-010(5).

Accordingly, on reconsideration, as supplemented herein, we adhere to and adopt our January 12, 1989 Order on Remand.

IT IS SO ORDERED.

In the Matter of the Compensation of
DOROTHY J. HAYES, Claimant
WCB Case Nos. 88-06310 & 88-08392
ORDER ON REVIEW
Rasmussen & Henry, Claimant Attorneys
Dennis Ulsted (Saif), Defense Attorney
Meyers & Radler, Defense Attorneys

Reviewed by Board Members Howell and Speer.

The self-insured employer requests review of Referee Emerson's order which awarded claimant an employer-paid attorney fee pursuant to ORS 656.386(1). On review the issue is attorney fees. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following supplementation.

A hearing convened on July 12, 1988. The hearing was continued and the record kept open for submission of additional evidence. Before the hearing reconvened, the parties entered into a Stipulation and Order effective November 21, 1988, which, in part states:

> "That the parties wish to resolve all issues raised or raisable as follows:
> "...(2) [the employer's] May 3, 1988 denial including all later amendments or clarifications shall be affirmed." (Stipulation and Order, p. 2).

CONCLUSIONS OF LAW AND OPINION

The Referee held that because the employer's denial of compensability resulted in rescission of the ".307" order, necessitated a hearing and claimant's attorney's active and meaningful participation, the employer should be assessed claimant's attorney fees pursuant to ORS 656.386(1). We disagree.

In Karen J. Bates, 39 Van Natta 42 (1987), relied upon by the Referee, the Board expressly noted that the employer's denial of compensability was overcome. Here, by contrast, the parties' Stipulation and Order states that the employer's denial is affirmed. Accordingly, claimant has not, "finally prevailed" in overcoming the employer's denial of compensability and, therefore, the employer is not liable for claimant's attorney fees under ORS 656.386(1).

ORDER

The Referee's order, dated November 21, 1988, as reconsidered January 4, 1989, is reversed. The Board approves a client-paid fee, not to exceed $1,997, payable by the employer to its counsel.

In the Matter of the Compensation of
PAUL W. LUHRS, Claimant
WCB Case No. 88-11359
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Cummins, et al., Defense Attorneys

Reviewed by Board Members Speer and Howell.

The self-insured employer requests review of those portions of Referee Higashi's order that: (1) set aside its partial denial of claimant's psychological condition; and (2) assessed penalties and attorney fees for an alleged unreasonable denial. On review, the issues are compensability and penalties and attorney fees.

We affirm and adopt the Referee's order with the following supplementation.

The Referee was persuaded by the opinion of Dr. Henderson, claimant's treating psychiatrist, who concluded that claimant's mental condition is directly connected to his work, injury and related events. The Referee found no contradicting evidence and concluded that claimant's psychological condition is compensable. We agree.

The employer contends, based on the chronology of events, that claimant's marital problems and other family conflicts were the primary stressors responsible for his depression and anxiety. Moreover, it asserts that the treating physician was unaware of claimant's family conflicts. Finally, arguing that Dr. Henderson's opinion is based on an incomplete history, the employer contends that the opinion should be discounted.

Claimant bears the burden of proving that his psychological condition is compensably related to his right knee injury. Poole v. SAIF, 69 Or App 503 (1984). To carry that burden, he must show that his industrial injury was a material contributing cause of his psychological condition. Jeld-Wen, Inc. v. Page, 73 Or App 136 (1985). Considering the multiplicity of potential causes in this case, we conclude that the question of causation is complex enough to require expert medical analysis. Uris v. Workers' Compensation Department, 247 Or 420, 426 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105 (1985).

In an August 1988 report, Dr. Henderson noted psychosocial stressors related to claimant's industrial injury, including complications in vocational retraining and uncertainty about his vocational future. (Ex. 34-6). He concluded that claimant's psychiatric disorder "was primarily related to his job-related injury and its sequelae. . ." (Ex. 35-1). Henderson further attributed claimant's marital problems to the compensable injury. (Ex. 35-2). Considering the thoroughness of Henderson's reports, including his discussion of claimant's domestic situation, we conclude that his opinion was based on a complete history.

Dr. Davies, psychologist, performed an independent medical examination and admitted that he did not have enough information to say what was or was not a material contributing factor to claimant's psychological condition. (Tr. 68). Considering Davies' inability to formulate an opinion, we do not find the opinion persuasive.

We give great weight to the conclusions of a claimant's treating physician, absent persuasive reasons to do otherwise. Weiland v. SAIF, 64 Or App 810, 814 (1983). Here, we find no such persuasive reasons to discard the

opinion of Dr. Henderson. Based on Dr. Henderson's thorough and well-reasoned opinion, we conclude that claimant's psychological condition is compensable. Somers v. SAIF, 77 Or App 259 (1986).

The Referee held that the employer unreasonably denied claimant's claim for his psychological condition. Consequently, the Referee assessed penalties and attorney fees. We affirm the result, for different reasons.

The standard for determining an unreasonable denial is whether the employer had a legitimate doubt as to its liability. Unreasonableness and "legitimate doubt" are to be considered in the light of all the evidence available to the employer at the time. Brown v. Argonaut Insurance Co., 93 Or App 588 (1988), citing Norgard v. Rawlinsons, 30 Or App 999, 1003 (1977); See Carol J. Knapp, 41 Van Natta 851, 854 (1989).

The employer contends that its denial of claimant's need for psychological treatment was reasonable because it was aware of "obvious events which overshadow any work contribution. . ." These "events" were apparently reports of claimant's domestic problems, which it apparently received and relied on when it denied the claim for medical services. (Ex. 32-1). No such reports appear in this record. In fact, the only contemporaneous report in the record (Dr. Henderson's May 15, 1988 report) attributes claimant's psychological condition to his compensable injury. (Ex. 30).

Accordingly, based on the record before us, we find nothing that would have provided the employer with a legitimate doubt concerning the compensability of claimant's psychological condition at the time of its denial. Consequently, we affirm the Referee's assessment of penalties and attorney fees relating to an unreasonable denial. ORS 656.262(10); ORS 656.382(1).

ORDER

The Referee's order, dated January 11, 1989, is affirmed. For services on review concerning the compensability issue, claimant's attorney is awarded a reasonable attorney fee of $1,000, to be paid by the self-insured employer. A client-paid fee, payable from the employer to its counsel, is approved, not to exceed $1,164.

June 25, 1990 Cite as 42 Van Natta 1313 (1990)

In the Matter of the Compensation of
CLYDE S. MELVIN, Claimant
WCB Case Nos. 88-17198 & 88-22260
ORDER ON REVIEW
Martin J. McKeown, Claimant Attorney
Cowling & Heysell, Defense Attorneys
Ronald K. Pomeroy (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

Claimant requests review of Referee Brazeau's order that upheld the SAIF Corporation's denial of responsibility for his occupational disease claim for hearing loss. On review the issue is responsibility.

The Board affirms and adopts the order of the Referee, except the last two sentences of the "Conclusions and Opinion" section, with the following supplementation.

The Referee decided that the SAIF Corporation is not responsible for claimant's hearing loss, because his later exposure, while Liberty Northwest

Insurance Corporation was on the risk, could have caused or worsened his condition. The Referee also found Liberty Northwest not liable, because of a March 1989 Disputed Claim Settlement (DCS). We agree.

A carrier may not assert the "last injurious exposure rule" defensively to avoid responsibility where it fails to join other potentially responsible carriers. Runft v. SAIF, 303 Or 493, 501 (1987). Here, however, claimant, by way of the DCS, and not the application of the last injurious exposure rule, defeated his rights to compensation from Liberty Northwest. He initially joined Liberty Northwest, a potentially responsible carrier. Then, pursuant to the DCS, he withdrew his hearing request and conceded that that carrier was not liable for his condition. Under these circumstances, SAIF bears no responsibility for the fact that Liberty Northwest is no longer a party to this proceeding. Consequently, based on the procedural aspects of this case, SAIF should not be barred from using the rule defensively because claimant, in exchange for $2,500, conceded that Liberty Northwest was not liable for his condition. Connie A. Martin, 42 Van Natta 495 (1990). See also Kenneth D. Johnson, 42 Van Natta 997 (1990) (where DCS allowed claimant to risk losing benefits).

ORDER

The Referee's order dated April 13, 1989, is affirmed.

June 25, 1990 Cite as 42 Van Natta 1314 (1990)

In the Matter of the Compensation of
NANCY A. RISSBERGER, Claimant
WCB Case No. 88-21768
ORDER ON REVIEW
Starr & Vinson, Claimant Attorneys
Davis & Bostwick, Defense Attorneys

Reviewed by Board Members Howell and Speer.

Claimant requests review of Referee Myzak's order which awarded claimant 11 percent (35.2 degrees) unscheduled permanent disability award for a low back injury whereas a Determination Order did not award any additional permanent disability beyond the 10 percent (32 degrees), previously awarded by stipulated order. On review, the issue is extent of unscheduled permanent disability. We affirm.

FINDINGS OF FACT

The Board adopts the Referee's "Findings of Fact" through the second full paragraph on page two of the Opinion and Order with the following supplementation.

Claimant's back condition improved after her surgery to the extent that she no longer had back or leg pain.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant's back surgery represented a permanent worsening that makes her less able to work. We do not agree.

To prove entitlement to additional permanent disability, claimant must show that the condition giving rise to the original award of compensation has permanently worsened since the last award or arrangement of compensation and

that such worsening rendered claimant permanently less able to work. Stepp v. SAIF, 78 Or App 438 (1986).

Here, the last arrangement of compensation was a May 5, 1987 Stipulation whereby claimant was awarded 10 percent unscheduled permanent disability. After the Stipulation, claimant's condition became progressively worse. She subsequently underwent surgery on November 13, 1987.

Claimant had experienced chronic back pain for years, even before her compensable injury. Four months after her surgery, claimant's surgeon reported that "she was delighted with the result." Claimant had practically no pain in her back and no sciatic pain at all.

Eight months after her surgery her surgeon reported that she had done extremely well and was back at work full time without any back or leg pain.

Based on the foregoing post-surgery reports, we conclude that claimant's condition as a whole did not permanently worsen since her last arrangement of compensation but, rather, has greatly improved. Furthermore, she has demonstrated no permanently increased loss of earning capacity since the May 5, 1987 Stipulation. Accordingly, claimant has failed to prove entitlement to any additional permanent disability. Stepp, supra. However, because the insurer does not argue that the Referee's award should be reduced, we affirm the Referee's order.

ORDER

The Referee's order dated April 14, 1989 is affirmed. A client-paid fee, payable from the insurer to its counsel, not to exceed $769 is approved.

June 25, 1990 Cite as 42 Van Natta 1315 (1990)

In the Matter of the Compensation of
RICHARD J. ROTH, JR., Claimant
WCB Case No. 88-11980
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
Arthur W. Stevens (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

Claimant requests review of that portion of Referee Mills' order that increased claimant's unscheduled permanent disability award for a low back injury from 43 percent (137.6 degrees), as awarded by a Determination Order, to 47 percent (150.4 degrees). In its brief, the SAIF Corporation contends that claimant has failed to mitigate the effects of his injury. On review, the issue is extent of unscheduled permanent disability. We affirm.

FINDINGS OF FACT

The Board adopts the Referee's Findings of Fact with the following supplementation. Claimant has not returned to work since he became medically stationary. He is limited to working in jobs requiring physical exertion between the sedentary and light categories.

CONCLUSIONS OF LAW AND OPINION

Unscheduled Permanent Disability

In determining the extent of claimant's permanent disability, the Referee applied the standards for evaluating permanent disability as adopted by the Director, pursuant to ORS 656.726(3)(f). See ORS 656.283(7). Specifically,

the Referee applied former OAR 436-35-001 et seq, which was effective at the time of the July 6, 1988 Determination Order. See OAR 438-10-005; 438-10-010. These are the rules which we apply as well.

Following the application of the disability standards, the Referee awarded 4 percent permanent disability in addition to the Determination Order award of 43 percent unscheduled permanent disability. We affirm based upon the following reasoning.

The determination of permanent partial disability under the "standards" is made by determining the appropriate values assigned by the "standards" to the claimant's age, education, adaptability and impairment. Once established, the values for age and education are added and the sum is multiplied by the appropriate value for adaptability. The product of those two figures is then added to the appropriate value for impairment to yield the percentage of unscheduled permanent partial disability. Former OAR 436-35-280.

In the present case, the parties do not dispute the values assigned by the Referee for claimant's age, education and adaptability. We therefore accept those values and discuss only the issue of impairment.

The Referee found that claimant was entitled to a value of 5 percent for each of his two laminectomies and discectomy. In addition, he found that claimant was entitled to 3 percent for his facetectomy and 4 percent for his unoperated disc at the L5-S1 level. The Referee added the findings for a total impairment value of 17 percent.

At the outset, we note that we do not agree with the Referee's finding that claimant was entitled to a value of 5 percent for each of his two laminectomies and discectomy. Claimant has had two prior surgeries at the L4-5 level. We conclude that claimant is entitled to a single impairment value for his surgical procedures unless there is evidence that he suffered a greater degree of impairment as a result of the second procedure. See Claudia J. Percy, 42 Van Natta 1209 (1990). We find no such evidence in this case. Therefore, claimant is entitled to a 5 percent value for his laminectomy and discectomy at the L4-5 level.

Claimant contends that, under former OAR 436-35-350(2), he is entitled to a value for a recurrent disc problem with related residual symptoms at L4-5. We disagree. Former OAR 436-35-350(2) provides that a value of 4 percent may be awarded for an unoperated disc derangement with any clinically-related residual symptoms. In this case, claimant has had disc surgery at L4-5. We conclude that the rule cited by claimant does not provide for a value where claimant has an operated disc. David A. Hickey, 42 Van Natta 1275 (1990).

In addition to an impairment value of 5 percent for his laminectomy and discectomy at the L4-5 level, claimant's facetectomy entitles him to a value of 3 percent, and for his unoperated disc derangement at the L5-S1 level with clinically-related residual symptoms, he is entitled to a value of 4 percent. Former OAR 436-35-350(2). A single "intervertebral disc lesion" value under former OAR 436-35-350(2) is obtained by adding the applicable values. Those values are 5 percent plus 3 percent plus 4 percent for a total of 12 percent impairment value for his low back condition. See Michael E. Crist, 42 Van Natta 1093 (1990).

The Referee did not award claimant an impairment value for sleep disturbance related to his compensable injury. We agree with the Referee's conclusion that claimant is not entitled to a value for his sleep disturbance condition, but we do so based upon the following reasoning.

Former OAR 436-35-400(4)(b)(B) allows an impairment value of between 10-45 percent when claimant has a depressive reaction that results in disturbances of eating and sleeping patterns. Claimant testified that he was currently having sleeping problems and Dr. Rich, M.D., a sleeping disorder specialist and physician, has related the disorder to the compensable injury. Nonetheless, claimant has not provided any expert medical opinion that his condition is permanent, as required by former OAR 436-35-400(4). In addition, we do not consider claimant's testimony or the opinion of Dr. Rich to be persuasive in reaching our conclusion, as the standards require that a permanent state of psychoneurosis must be diagnosed by a psychiatrist or psychologist. See e.g. Joel L. Whitmore, 41 Van Natta 1382 (1989).

Utilizing the uncontested values for age, education, and adaptability determined by the Referee, with the impairment value we have determined, we compute claimant's permanent disability under the "standards." When claimant's age value, 0, is added to his education value, 5, the sum is 5. When that value is multiplied by claimant's adaptability value, 6, the product is 30. When that value is added to claimant's impairment value 12 the result is 42 percent unscheduled permanent partial disability. Former OAR 436-35-280(7). Claimant's permanent disability under the "standards" is, therefore, 42 percent.

Finally, claimant contends that he is entitled to disability in addition to that awarded by the standards, if there is clear and convincing evidence that the standards do not adequately reflect his loss of earning capacity. See ORS 656.283(7). Claimant argues that he has significant restrictions that are not compensated under the standards, such as restricted work activities and limitations on walking, standing, sitting, bending and pushing.

In support of his argument, claimant notes that subsequent amendments to the disability standards provide impairment value for limitations on walking, standing, bending and squatting. OAR 436-35-310(4). In addition, the amended standards award a value for loss of repetitive motion due to chronic conditions. OAR 436-35-320(4). Claimant argues that the amended statutes constitute clear and convincing evidence that he has not been adequately compensated under the prior standards. We disagree.

We have previously rejected arguments that the current standards are clear and convincing evidence per se that claimant was undercompensated by his award under the prior standards. See e.g. Joseph Anger, 41 Van Natta 827 (1989). Moreover, we find that in the application of the disability standards, former OAR 436-35-000 et seq, which were effective at the time of the July 6, 1988 Determination Order, claimant's physical limitations have been considered.

We conclude that claimant is entitled to 42 percent unscheduled permanent disability. However, because SAIF has not requested a reduction of the amount awarded by the Referee, we affirm his award of 47 percent unscheduled disability.

Mitigation of Damages

SAIF argues that claimant is not entitled to an increase in permanent disability because he has failed to mitigate the effects of the injury. SAIF contends that claimant's treating physician, Dr. Schmidt, stopped giving claimant pain medication due to claimant's drug dependency problem. SAIF also argues that claimant did not comply with drug and alcohol treatment programs and failed to keep appointments with his psychologist.

It is the carrier's burden of proof to persuade the trier of fact that the worker unreasonably failed to follow needed medical advice or otherwise to

mitigate his damages. Nelson v. EBI Companies, 296 Or 246 (1984). In the present case, however, we are unable to find evidence that, if claimant had continued his drug and alcohol treatment programs, his low back condition would have continued to improve. Nelson, 296 Or at 252 (1984). Instead, we conclude that claimant's actions are evidence of his lack of motivation, which is further proof that he has failed to show clear and convincing evidence that his loss of earning capacity is greater than that awarded under the standards.

ORDER

The Referee's order dated December 5, 1988 is affirmed.

June 26, 1990 Cite as 42 Van Natta 1318 (1990)

In the Matter of the Compensation of
TERRY L. BABCOCK, Claimant
WCB Case No. 88-20883
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Employers Defense Counsel, Defense Attorney

Reviewed by Board Members Myers and Cushing.

The insurer requests review of that portion of Referee Livesley's order which set aside its denial of claimant's occupational disease claim for an eye condition. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

Claimant began working for the employer, a newspaper, as a crew dispatcher advisor/clerk typist in March 1985. Claimant has a preexisting eye condition known as strabismus. In August 1987, claimant was assigned to a full-time typing position. At the time claimant switched jobs she had no eye symptoms. (Tr. 8).

Claimant created newspaper lay outs. She would type instructions on a keyboard which then appeared as a layout on a computer screen. (Tr. 4-7). The length of claimant's shift depended on the amount of work to be done. Six to eight months after claimant began working full time as a clerk-typist, she developed recurring headaches, blurry vision, double vision and watering eyes. (Tr. 8). Claimant's work activities were repetitive and traumatic.

Claimant filed her 801 form on October 5, 1988. (Ex. 2). The insurer denied claimant's claim on December 1, 1988. (Ex. 9).

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant had established a compensable occupational disease claim, reasoning that her work exposure was a major contributing cause of the worsening of claimant's underlying eye condition.

For an occupational disease claim, the date of "injury" is the date upon which the claimant was last exposed to the employment conditions which caused the disease. Johnson v. SAIF, 78 Or App 143, rev den 301 Or 240 (1986). Here, claimant's last work exposure occurred during February 1988. Accordingly, the new occupational disease law which became effective January 1, 1988, is applicable.

To be compensable under the new law, claimant's occupational disease must fall within one of the three subsections of ORS 656.802(1). Here, claimant worked for the employer as a full time clerk-typist, a position which involved repetitive and physically demanding use of her eyes. Because claimant's work activities were repetitive and because they rendered claimant's eye condition symptomatic, we conclude that her work activities constituted a series of traumatic events. See Mary L. Goudy, 42 Van Natta 1140 (1990); Dean A. Mintun, 42 Van Natta 1149 (1990). Thus, claimant's claim is for a condition resulting from a "series of traumatic events or occurrences" pursuant to ORS 656.802(1)(c).

To establish that her condition arose out and in the course of her employment, claimant must prove that her work exposure was a material cause of her condition. ORS 656.802(1)(c); Donna E. Aschbacher, 41 Van Natta 1242 (1989). The causation of claimant's strabismus is a complex medical question. Thus, while her testimony is probative, the resolution of this case turns on medical evidence. Kassahn v. Publishers Paper Co., 76 Or App 259, 263 (1986). Claimant has met her burden.

Dr. Spangler, ophthalmologist, first examined claimant in September 1987. At that time claimant had, "...16 diopters of exophoria at distance and 20 diopters of exophoria-tropia at near". (Ex. 1). Subsequently, in July 1988, Spangler reported that claimant's deviation was now 25 diopters of the exotropia. Id. Although claimant's exotropia or strabismus condition was not caused by her work conditions, Spangler stated that her eye condition was worsened by close work activities. (Ex. 5).

Dr. Marusich, optometrist, opined that claimant's eye condition worsened as her occupational visual demands increased. Marusich determined that her occupational visual demands were the major contributing cause of her deteriorating vision condition. (Ex. 1). Likewise, Dr. Mumford, microsurgeon, opined that claimant's work activities had "definitely accentuated" claimant's already preexisting strabismus or eye muscle problem. (Ex. 6-2).

A claimant who suffers a preexisting condition may establish a compensable occupational disease claim under ORS 656.802(1)(c) without proving a worsening of the preexisting condition itself, provided that an increase in symptoms of a preexisting condition causes greater disability or need for medical services. Aschbacher, supra. Further, because the relevant portion of the statute no longer requires that the agent of the condition be one to which claimant "is not ordinarily subjected or exposed other than during a period of regular actual employment therein," claimant need only show that the work exposure was a material contributing cause of those increased symptoms. See Aschbacher, supra; Raymond E. Meredith Jr., 42 Van Natta 816 (1990). Claimant has carried her burden of proof.

Claimant's work exposure was a material contributing cause of increased symptoms of the preexisting eye condition. Dr. Marusich noted that claimant's vision had deteriorated from an exophoria-tropia of 20 Diopters to an exotropia of 25 Diopters. He further opined that claimant's occupational visual demands were the major contributing cause of claimant's worsened visual condition. (Ex. 1-1). In addition, Dr. Spangler concluded that claimant's visual symptoms were increased by close work activities. (Ex. 5). Likewise, Dr. Mumford concluded that claimant's job situation had accentuated claimant's already existing strabismus or eye condition. (Ex. 6-2). Therefore, claimant's eye condition is compensable.

ORDER

The Referee's order dated April 25, 1989 is affirmed. For services on Board review, claimant's attorney is awarded $750, to be paid by the insurer. The Board approves a client-paid fee, not to exceed $490, payable from the insurer to its counsel.

In the Matter of the Compensation of
PHYLLIS J. CONNER, Claimant
WCB Case No. 88-17813
ORDER ON REVIEW
Vick & Gutzler, Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Gerner and Myers.

The self-insured employer requests review of Referee Harri's order that: (1) increased claimant's unscheduled permanent disability award for a low back and right leg injury from 25 percent (80 degrees), as awarded by Determination Order, to 37 percent (118.4 degrees); and (2) awarded 3 percent (4.5 degrees) scheduled permanent disability for the loss of use or function of claimant's right leg, whereas a Determination Order had awarded no scheduled permanent disability. On review, the issue is extent of permanent disability, scheduled and unscheduled. We affirm.

FINDINGS OF FACT

The Board adopts the Referee's Findings of Fact and Findings of Ultimate Fact as our own.

CONCLUSIONS OF LAW AND OPINION

Unscheduled Permanent Disability

The Board adopts the Referee's Conclusions of Law, as set forth in the "Conclusions and Opinion" portion of the order, as our own, concerning the issue of unscheduled permanent disability.

Scheduled Permanent Disability

The Board adopts the Referee's Conclusions of Law, as set forth in the "Conclusions and Opinion" portion of the order, as our own, concerning the issue of scheduled permanent disability, with the following supplementation.

The Referee found that claimant suffered 3 percent scheduled permanent disability for the loss of use or function of his right lower extremity (leg). The Referee based his finding on knee give way, disabling pain, and achy sensations including numbness and reduced strength. He also noted that claimant suffered from weakness or atrophy of his right foot.

The employer contends that there is insufficient objective medical evidence with which to rate scheduled permanent disability. We disagree.

Former OAR 436-35-230(5) provides that where there are objective findings of weakness or atrophy in the lower extremity, such impairment may be rated from 0 to 10 percent. Here, Dr. Wilson, D.C., performed a consultation, examination and testing of claimant and reported a "mild foot drop." (Ex. 41-11). That finding has not been contradicted. Therefore, we find that the Referee's award of 3 percent impairment resulting from his right heel foot drop was appropriate.

ORDER

The Referee's order dated March 2, 1989, is affirmed. For services on review, claimant's attorney is awarded a reasonable assessed fee of $600. A client-paid fee, not to exceed $1,235, payable by the employer to its counsel, is approved.

In the Matter of the Compensation of
DALE W. EBERLY, Claimant
WCB Case No. 88-21003
ORDER ON REVIEW
Merrill Schneider, Claimant Attorney
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Gerner and Myers.

Claimant requests review of those portions of Referee Quillinan's order that: (1) declined to award temporary disability after March 16, 1986; (2) declined to assess penalties and attorney fees for the insurer's failure to pay temporary disabilty; and (3) declined to assess penalties and attorney fees for alleged improper claims processing. On review, the issues are temporary disability and penalties and attorney fees. We affirm in part, and reverse in part.

FINDINGS OF FACT

The Board adopts the Referee's findings of fact as supplemented below.

As a result of the compensable injury, claimant underwent rotator cuff surgery on September 16, 1986.

ULTIMATE FINDINGS OF FACT

As of February 3, 1987, no further material improvement in claimant's compensable condition would reasonably be expected from medical treatment or the passage of time.

From the date of injury, January 27, 1986, until his retirement on March 16, 1986, claimant continued to perform his regular work activities.

On March 16, 1986, claimant retired, and left work for reasons unrelated to his compensable injury.

Claimant was unable to work from the date of surgery, September 16, 1986, until February 3, 1987.

The insurer's failure to pay temporary disability from the September 16, 1986 surgery, until February 3, 1987, was not unreasonable.

The insurer's failure to pay temporary disability pursuant to the September 16, 1988 Determination Order was unreasonable.

CONCLUSIONS OF LAW AND OPINION

Temporary Disability

The Referee concluded that claimant was not entitled to temporary disability from March 16, 1986, the effective date of claimant's retirement, onwards. We disagree in part.

An insurer must pay a worker temporary disability until the worker is released to regular work and is medically stationary or the worker becomes medically stationary and the claim is closed. Fazzolari v. United Beer Distributors, 91 Or App 592 (1988). However, a worker who has voluntarily withdrawn from the work force is not entitled to such compensation. Cutright v. Weyerhaeuser, 299 Or 290 (1985).

The critical time for determining whether a claimant has withdrawn from the work force is at the time of his disability. Dawkins v. Pacific Motor Trucking, 308 Or 254 (1989). Even though a claimant has applied for and received pension and retirement benefits before his disability, he may be entitled to temporary total disability benefits if he can show that he is willing to work, although not employed at the time and not making reasonable efforts to obtain employment because of a work-related injury, where such efforts would be futile. Weyerhaeuser Co. v. Kepford, 100 Or App 410, 414 (1990).

Here, claimant requested union retirement benefits in December 1985. While still working, he suffered his January 1986 right shoulder injury. Although he missed no time from work, he did seek residual medical treatment and was restricted from heavy lifting. Despite this restriction, claimant continued to perform his regular work activities until just prior to his retirement. The effective date of his retirement was March 16, 1986, after the compensable right shoulder injury.

Although claimant retired from his employer on March 16, 1986, we do not consider this a withdrawal from the work force. Claimant testified that he planned on returning to work. And in fact did so in May 1988. Thus, claimant had not voluntarily withdrawn from the work force at the time of his disability, i.e., the medical treatment he received prior to his retirement. Therefore, claimant was procedurally entitled to temporary disability compensation when he left work on March 16, 1986.

However, even though claimant had not voluntarily withdrawn from the work force on March 16, 1986, he did leave his work with this employer for reasons unrelated to the compensable injury, i.e., his retirement from his employer. Thus, this insurer was not required to begin paying temporary total disability benefits after claimant retired. Rather, claimant was only entitled to the amount that he could have received on account of his disability had he not retired. In this case, claimant's actual earnings had not been diminished as a result of his work restrictions. In other words, despite his work restrictions, claimant was receiving his regular wages. Thus, his temporary partial disability benefits would be zero. See Safeway Stores v. Owsley, 91 Or App 475 (1988). As such, he is not substantively entitled to temporary disability after March 16, 1986. Owsley, supra.

However, prior to claim closure, claimant underwent rotator cuff surgery on September 16, 1986. This surgery was related to the compensable right shoulder injury. Therefore, as of September 16, 1986, claimant was totally disabled from performing work. Thus, temporary total disability benefits were payable.

The September 16, 1988 Determination Order awarded temporary partial disability from February 22, 1986 through September 15, 1986, and temporary total disability from September 16, 1986 through February 3, 1987. This order was amended by an October 19, 1988 Determination Order which awarded temporary partial disability, less time worked, from February 22, 1986 through April 30, 1986. Both Determination Orders found claimant medically stationary on February 3, 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). On February 3, 1987, Dr. Gambee, claimant's surgeon, indicated that he saw no reason to follow claimant any longer unless there were problems. There is no requirement for the physician to use "magic words" in determining whether or not a claimant is medically stationary. Dr. Gambee's report of May 20, 1988 recommending claim closure does not change this. We interpret this

report as mere confirmation of claimant's medically stationary status, not in response to treatment or follow-up examination. Therefore, we conclude that claimant's medically stationary date is February 3, 1987.

Thus, claimant was entitled to temporary total disability from the date of his September 16, 1986 surgery, until he became medically stationary on February 3, 1987.

Penalties and attorney fees for failure to pay temporary disability.

Because the Referee found no compensation due, she declined to assess a penalty and attorney fee for failure to pay temporary disability. We agree that a penalty and attorney fee should not be assessed, but on different grounds.

As long as an insurer has a legitimate doubt of its liability, its conduct is not unreasonable. Norgard v. Rawlinsons, 30 Or App 999, 1003 (1977). In Weyerhaeuser v. Kepford, supra, the court found that it was not unreasonable for the carrier to conclude that benefits for temporary total disability are not payable to a retired worker. The court stated, "that in view of some confusion in the state of law at that time, employer's conduct in that respect was not unreasonable." Weyerhaeuser v. Kepford, 100 Or App at 415. In Kepford, "at that time" referred essentially to the summer of 1986. See Charles M. Kepford, 41 Van Natta 573 (1989).

Here, the circumstances are sufficiently similar, as those in Kepford, to conclude that a penalty and attorney fee should not be assessed. At the time the insurer decided not to pay claimant temporary total disability due to the surgery, the current status of the law raised a legitimate doubt about the insurer's legal obligation to pay a "retired worker" temporary disability.

Penalties and attorney fee for improper claims processing

Concluding that since claimant was not entitled to temporary disability after March 16, 1986, the effective date of his retirement, the Referee also declined to assess a penalty and attorney fee for the insurer's failure to pay temporary disability pursuant to the September 16, 1988 Determination Order. We disagree.

The insurer must pay temporary disability payments within 14 days upon receipt of a Determination Order. OAR 436-60-150(3)(e). Appeal does not stay payment of temporary disability benefits. Georgia-Pacific Corporation v. Piwowar, 305 Or 494 (1988); C. D. English, 37 Van Natta 572 (1985).

Here, the insurer, without explanation, failed to pay the temporary disability as awarded by the September 16, 1988 Determination Order. The Determination Order awarded payment for temporary disability. Regardless of the ultimate conclusion concerning claimant's substantive entitlement to such benefits, the temporary disability was due and payable within 14 days of the order. Therefore, a penalty and attorney fee will be assessed for failure to pay temporary disability as an unreasonable resistance to the payment of compensation. ORS 656.262(10); Georgia-Pacific Corporation v. Piwowar, 305 Or at 506-507.

As noted above, the amount of temporary partial disability owing from February 22, 1986 until September 15, 1986 as awarded by the September 16, 1988 Determination Order was zero. Therefore, while the insurer was required to calculate and pay temporary partial disability benefits awarded by the Determination Order, those benefits equaled zero. However, the Determination Order also awarded temporary total disability from September 16, 1986 through February 3,

1987. These benefits were due and payable 14 days from the date of the Determination Order. Inasmuch as these benefits were not timely paid, a 25 percent penalty based on such unpaid benefits and an attorney fee shall be assessed.

Claimant also requests the assessment of a penalty and attorney fee against the insurer for failure to properly classify this claim as disabling. We disagree. Inasmuch as claimant missed no time from work and continued to perform his regular work activities until just before his retirement, we do not consider the insurer's conduct in classifying the claim as nondisabling to be unreasonable.

ORDER

The Referee's order dated March 23, 1989, is affirmed in part, and reversed in part. The October 19, 1988 amended Determination Order is modified to award temporary total disability from September 16, 1986 through February 3, 1987. Claimant's attorney is awarded an approved attorney fee of 25 percent of the increased compensation created by this order, not to exceed $3,800. For its unreasonable failure to comply with the September 16, 1988 Determination Order, the insurer shall pay to claimant a penalty equal to 25 percent of the temporary disability awarded. Claimant's attorney is also awarded a penalty-related assessed fee of $500, payable by the insurer directly to claimant's attorney. The remainder of the Referee's order is affirmed. A client-paid fee, payable from the insurer to its counsel, is approved, not to exceed $1,525.90.

In the Matter of the Compensation of
THOMAS M. GREEN, Claimant
WCB Case No. 88-09234
ORDER ON REVIEW
John E. Uffelman, Claimant Attorney
Arthur Stevens (Saif), Defense Attorney

Reviewed by Board Members Brittingham and Nichols.

Claimant requests review of that portion of Referee Mulder's order that increased a Determination Order award of 30 percent (96 degrees) unscheduled permanent disability for his low back condition to 65 percent (208 degrees), but declined to grant permanent total disability. On review, the issue is permanent total disability.

FINDINGS OF FACT

On November 7, 1985, claimant injured his left leg, back and hip while working as a cement finisher. Claimant suffered contusions and a back strain superimposed on degenerative disc disease. Claimant has not returned to employment since his injury.

Claimant is 56 years old. He has a fifth grade education. Claimant is able to read somewhat. He has difficulty writing or spelling and he has difficulty with simple math. His past relevant work includes digging ditches and packing lumber for carpenters. In 1960 claimant joined the Cement Masons Union and has worked as a cement mason since that time.

Claimant cannot return to his former occupation as a cement mason. Claimant has been released to return to modified work. He is capable of performing light to medium work. Claimant participated in a vocational rehabilitation evaluation, but made no other efforts to seek work. Claimant no longer

bowls, hunts or fishes. He performs some limited gardening and cares for animals which he owns.

Claimant is limited in his ability to sit, stand and walk. Claimant has pain in his hip and low back. He has a "burning" sensation in his crotch. Claimant is limited in his ability to bend.

A Determination Order issued May 20, 1988, awarding claimant 30 percent (96 degrees) unscheduled permanent disability for his low back condition.

FINDINGS OF ULTIMATE FACT

Claimant is not physically incapacitated to the extent that he cannot regularly perform gainful and suitable employment.

Claimant is not foreclosed from gainful employment due to a combination of medical and nonmedical factors.

Claimant did not make reasonable efforts to find work and a work search would not have been futile.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant did not establish his entitlement to permanent and total disability benefits under ORS 656.206(1)(a). The Referee found that claimant was capable of modified work and that he had failed to prove that it was futile for him to seek employment. Therefore, the Referee concluded that claimant had failed to satisfy the seek work requirement of ORS 656.206(3). We agree.

To establish permanent total disability, claimant must prove that he is unable to perform any work at a gainful and suitable occupation. Wilson v. Weyerhaeuser, 30 Or App 403 (1977). Permanent total disability may be established through medical evidence of physical incapacity, or through the "odd-lot" doctrine, under which a disabled person may remain capable of performing work of some kind, but still be permanently disabled due to a combination of medical and nonmedical disabilities which effectively foreclose him from gainful employment. Welch v. Banister Pipeline, 70 Or App 699, 701 (1984).

The nonmedical factors to be considered in an "odd-lot" analysis include age, education, adaptability to nonphysical labor, mental capacity and emotional condition, as well as the conditions of the labor market. Welch, supra, 70 Or App at 701; Livesay v. SAIF, 55 Or App 390, 394 (1981). Because application of an "odd-lot" analysis presupposes some capacity for employment, an injured worker is statutorily required to be willing to work and to make reasonable efforts to find work, although he need not engage in job seeking activities that, in all practicality, would be futile. ORS 656.206(3); SAIF v. Orr, 101 Or App 612, (May 23, 1990); SAIF v. Simpson, 88 Or Ap 638, 641 (1987); Welch, supra, 70 Or App at 701.

Extent of Impairment

The first step in determining whether claimant is permanently and totally disabled requires an evaluation of his physical condition. The Orthopaedic Consultants diagnosed: (1) Chronic lumbar musculoligamentous strain aggravating a L4-5 and L5-S1 degenerative disc disease; (2) Exogenous obesity; and (3) Anteromedial proximal left tibial contusion. The Consultants opined that claimant was physically capable of performing work in the light to medium category.

Claimant's treating chiropractor, Dr. Stellflug concurred with the conclusions of the Consultants.

This record persuades us that claimant is not permanently and totally disabled from a medical standpoint; rather we find that he is able to perform work in the light to medium categories.

Odd-Lot Doctrine

Claimant argues that it would be futile for him to make reasonable seek work efforts. We disagree. Claimant is capable of performing light to medium work. Claimant's treating physician released claimant to return to modified work.

At the time of the hearing, claimant was 56 years old and had a fifth grade education. Claimant is able to read somewhat but has difficulty writing or spelling. Claimant also has difficulty with simple math. Claimant has been employed as a ditch digger, a laborer, and, since 1960, a cement mason.

The Orthopaedic Consultants concluded that claimant was capable of returning to work in a modified capacity in which he would lift not more than 30 pounds occasionally, and bend, sit and walk no more than 60 minutes at a time with 15 minute break between intervals, as well as a 60 minute standing restriction. Dr. Stellflug concurred with the findings of the Consultants.

Scott T. Stipe, vocational counselor and expert, testified at the hearing that claimant was employable. Mr. Stipe identified a number of suitable positions, including small production assembly, parking lot attendant, meter reader, taproom attendant, cashier, gate guard or service station attendant. Claimant argues that he is not capable of performing any of the positions identified by Mr. Stipe because of a combination of medical and nonmedical factors. We disagree. Rather, we are persuaded by the evidence that claimant is capable of performing the work identified by Mr. Stipe. At the very least the record established that it would not be futile for claimant to make reasonable seek work efforts, which we find claimant has failed to do.

In light of these facts, we find that claimant has not established permanent total disability status under the "odd lot" doctrine. We further find that a work search in this case would not have been futile; therefore, claimant is not excused from the seek work requirement. Claimant did not make a reasonable attempt to find work.

In sum, claimant has not shown that he is foreclosed from gainful employment due to his physical incapacity or under the "odd lot" doctrine. Therefore, we hold that claimant is not permanently and totally disabled.

ORDER

The Referee's order dated October 11, 1988, is affirmed.

June 26, 1990 Cite as 42 Van Natta 1326 (1990)

In the Matter of the Compensation of
MARY J. HART, Claimant
WCB Case No. 88-08517
ORDER ON REVIEW
Charles G. Duncan, Claimant Attorney
Employers Defense Counsel, Defense Attorney

Reviewed by Board Members Cushing and Myers.

The insurer requests review of that portion of Referee Seifert's order which set aside its partial denial of claimant's degenerative and osteoarthritic foot conditions. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

Claimant sustained a stress fracture of her left second metatarsal sometime in 1980 or 1981. No claim was filed for that condition. In 1983, she sustained a stress fracture of her right second metatarsal in her right foot. No claim was filed for that injury.

In October 1985, claimant treated with Dr. Roy, sports medicine specialist, who prescribed orthotics for her right foot. (Ex. OA-1). In November 1985, claimant filed a claim for a stress fracture of her fourth metatarsal. The insurer accepted the claim.

In February 1986, Roy diagnosed a third metatarsal stress fracture in claimant's right foot. Claimant's right foot was placed into a posterior splint. In June 1987, Roy diagnosed "bursitis of the first metatarsal head, right foot." (Ex. 3-1).

Claimant began treating with Dr. McCrory, D.C., in February 1988 for continued chronic bilateral foot pain, neck and shoulder pain. He treated her feet until mid-March 1988, at which time all foot care, except as supportive, was terminated due to the lack of subjective improvement.

The following month, Roy first noted pain in both claimant's feet and diagnosed bilateral foot pain, more on the right side. (Ex. 3-2). In April 1988, the insurer issued a partial denial of medical treatment for bilateral foot pain, as unrelated to her November 1985 claim. The insurer indicated that such pain is due to "degenerative changes and osteoarthritic changes." Claimant requested a hearing.

In November 1988, claimant underwent an independent medical examination by Dr. Schachner, M.D.

In December 1988, the insurer issued a second denial. This time the insurer denied claimant's occupational disease claim for degenerative arthritis in her feet, contending that claimant's present degenerative condition is related to the fracture of her right second metatarsal, not the fourth metatarsal. Claimant requested a hearing on this denial.

CONCLUSIONS OF LAW AND OPINION

Preliminary Matter - The Denials

The Referee upheld the insurer's December 1988 denial of claimant's occupational disease claim for the degenerative conditions in her feet, but set aside the insurer's April 1988 denial. On review, the parties arguments focus on whether claimant's degenerative conditions are attributable to her 1985 compensable injury. We conclude that claimant's degenerative and osteoarthritic changes are unrelated to the 1985 compensable injury. Therefore, we reverse as to the April 1988 denial.

Precautionary Denial

In the present case, the insurer denied claimant's bilateral foot problems as degenerative and arthritic in nature, and not related to claimant's accepted claim for her right foot fourth metatarsal stress fracture. We note that no formal claim was submitted for left foot problems. Rather, the insurer denied the left foot condition in response to medical reports which indicated, for the first time, that claimant was seeking treatment for both feet. Under some circumstances, a "precautionary" denial is proper. See Johnson v. Spectra Physics, 303 Or 49, 57 (1987); Sidney M. Brooks, 38 Van Natta 925, 926 (1986).

Compensability

It is well settled that a carrier is liable for the natural consequences flowing from a compensable injury. Williams v. Gates McDonald & Co., 300 Or

278, 281 (1985); Patitucci v. Boise Cascade Corp., 8 Or App 503, 507-8 (1972). Therefore, to establish the compensability of claimant's current right foot conditions, claimant has the burden of proving by a preponderance of the evidence that her 1985 compensable injury is a material cause of her current degenerative and osteoarthritic conditions. See Harris v. Albertson's, Inc., 65 Or App 254, 256-57 (1983). "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). Claimant has failed to meet her burden.

The issue, here, is whether claimant's claimant's current right foot pain, specifically the degenerative changes and the osteoarthritis in the right foot, is materially related to claimant's 1985 compensable right foot, fourth metatarsal, stress fracture. We find that it is not related.

First, we note that claimant has had problems with her right foot since 1983. She has had stress fractures in her second, third and fourth metatarsals of her right foot, and bursitis in her right metatarsal of her right foot. Only the fourth metatarsal stress fracture has been found to be compensable. Therefore, we find that the causation of claimant's current right foot conditions is of sufficient medical complexity that we cannot decide it without expert opinion. Uris v. Compensation Department, 247 Or 420, 424-26 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985).

Three physicians provided opinions for the record. Claimant's treating physician, Dr. Roy, diagnosed "bilateral foot pain, more on the right side, related to degenerative change of the right first cuneiform/metatarsal joint." (Ex. 3-2). Roy, therefore, opines that claimant's degenerative changes are related to a right foot, first metatarsal foot fracture.

Dr. McCrory, claimant's chiropractor for her neck, back and foot problems, opined that claimant's current degenerative and osteoarthritic conditions of her right foot are caused by a combination of her stress fractures in her right foot, including the first, second, third and fourth metatarsals, and her work activities.

Finally, Dr. Schachner, independent medical examiner, after a thorough review of all claimant's medical records, x-rays and both Roy and McCrory's reports, opined that the delayed union of the 1983 second metatarsal fracture was the actual cause of her present residual symptoms which are secondary to arthritic deterioration. (Ex. 8-4, 8-5). Thus, Schachner opines that claimant's current right foot problems are related to her 1983 noncompensable right stress fracture of her second metatarsal.

In summary, Roy related claimant's right foot condition to the bursitis in her first metatarsal. Schachner related claimant's condition to her noncompensable second metatarsal stress fracture. McCrory related claimant's condition to a combination of claimant's stress fractures and her work activities. We find these reports equally persuasive.

Therefore, claimant has not met her burden of proof. See Michelle Rabideau, 40 Van Natta 2025, 2027 (1988).

ORDER

The Referee's order dated February 2, 1989, is reversed. The insurer's April 18, 1988 denial is reinstated and upheld. The Referee's award of an assessed fee of $1,000, is reversed. A client-paid fee, not to exceed $287, payable by the insurer to its counsel, is approved.

In the Matter of the Compensation of
BARBARA J. JELMELAND, Claimant
WCB Case No. 88-16849
ORDER ON REVIEW
Merrill Schneider, Claimant Attorney
Stafford J. Hazelett, Defense Attorney

Reviewed by Board Members Gerner and Myers.

Claimant requests review of that portion of Referee Mulder's order that upheld the insurer's denial of claimant's chiropractic treatments in excess of the Director's guidelines. In its brief, the insurer cross-requests review of that portion of the order that assessed penalties and related attorney fees for alleged improper claims processing. On review, the issues are compensability of medical services and penalties and attorney fees. We reverse.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact as supplemented below.

Although claimant's chiropractic care was partially denied on September 7, 1988, claimant continued to treat in excess of the administrative guidelines.

Claimant missed three days of work immediately following the compensable injury. Thereafter, she returned to modified work for approximately one week. Following the one week of modified work, she returned to regular work. Claimant's wage at modified work was the same as for regular work.

ULTIMATE FINDINGS OF FACT

Claimant's continuing chiropractic care constitutes necessary and reasonable medical services.

The insurer's delay in classifying the claim as disabling is not unreasonable.

CONCLUSIONS OF LAW AND OPINION

Compensability of chiropractic care

The Referee upheld the insurer's partial denial of claimant's chiropractic care. We disagree.

For her compensable injury, claimant is entitled to medical services "for such period as the nature of the injury of 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 (1985). Additionally, medical services for purely palliative purposes are recoverable where they are necessarily and reasonably incurred in treatment that enables claimant to work. West, supra.

Claimant's treating physician, Dr. Belhumeur, has indicated that claimant was not medically stationary until December 12, 1988. Additionally, he found claimant had suffered mild permanent residuals as a result of the injury. Dr. Belhumeur further indicated that, throughout the course of treatment, claimant has shown slow, but continued and progressive, improvement. Although not precise, the pattern of weekly chiropractic care confirms an overall frequency reduction of weekly treatment sessions. Thus, claimant's chiropractic care

throughout this period, up and until she was medically stationary on December 12, 1988, was curative in nature.

The November 1, 1988, independent medical examination by Western Medical Consultants does not alter our conclusion. The Consultants found that claimant had some myofascial residual of the cervical and left shoulder muscle strain. They opined she was medically stationary, and required no further chiropractic care. However, as persuasively explained by Dr. Belhumeur's letter of December 12, 1988, claimant's symptomatology was at a minimal level at the time of the Consultants' examination, and that subsequent to the examination, she continued to show improvement in her condition.

Finally, claimant's treatments have enabled her to work. Claimant initially missed three days of work immediately following the injury. After approximately a week of modified duty, claimant returned to regular work.

For the above mentioned reasons, we conclude that claimant's chiropractic treatments were necessary and reasonable medical services. Consequently, the insurer's denial shall be set aside.

Penalties and related attorney fees

The Referee found the insurer's classification of the claim as "nondisabling" to be unreasonable. Accordingly, the Referee assessed a penalty and related attorney fee. We disagree.

The claim was initially accepted, per the 801, as nondisabling. When the insurer issued its partial denial on September 7, 1988, the accompanying 1502 form also reflected a nondisabling status. However, when the insurer requested claim closure on November 29, 1988, the request was on the basis of a disabling claim. Finally, on December 7, 1988, the insurer formally notified claimant of the reclassification of her claim to disabling, indicating that no compensation was due.

The record is unclear as to why a reclassification of the claim was made in late November of 1988 from nondisabling to disabling. The independent medical examination accomplished on November 1, 1988, indicated no impairment and further stated claimant would be able to work at her employment as she did pre-injury. It was not until the receipt of Dr. Belhumeur's December 12, 1988 report, that it became evident that claimant may have permanent impairment resulting from the compensable injury. The insurer's reclassification of the claim for nondisabling to disabling had occurred on November 29, 1988. Under such circumstances, we do not consider the insurer's claims processing to be unreasonable.

However, even assuming the insurer's conduct was unreasonable, there was nothing "then due" upon which to base a penalty. ORS 656 262(10). Claimant is not entitled to temporary disability for the first three days missed due to the compensable injury. ORS 656.210(3). Since claimant missed only three days of work, she is not entitled to temporary disability. Moreover, although claimant was on modified duty for one week, she was paid her regular wage. Thus, no temporary partial disability was due. Accordingly, no temporary disability was due and owing to claimant as a result of the compensable injury. Safeway Stores v. Owsley, 91 Or App 475 (1988).

Additionally, since the insurer requested the issuance of a Determination Order upon the first notice that claimant was stationary, no permanent partial disability award was delayed by its alleged unreasonable failure to properly classify the claim. Nor is a penalty and attorney fee under ORS 656.268(3)(f)

warranted. Claimant has not challenged the correctness of the notice of closure, nor has she alleged that the insurer has refused to close the claim.

Finally, because no compensation was delayed or unpaid as a result of the insurer's conduct, there has been no unreasonable resistance to the payment of compensation. Therefore, claimant is also not entitled to a attorney fee under ORS 656.262(10). Ellis v. McCall Insulation, 308 Or 74 (1989).

ORDER

The Referee's order dated January 23, 1989, as amended March 13, 1989, is reversed. The insurer's denial is set aside and the claim is remanded to the insurer for processing according to law. For services at hearing and on Board review concerning the denial issue, claimant's attorney is awarded $1,500, to be paid by the insurer. The Referee's awards of penalties and related $300 attorney fees are reversed.

June 26, 1990 Cite as 42 Van Natta 1331 (1990)

In the Matter of the Compensation of
LORI D. MARTIN, Claimant
WCB Case Nos. 88-21416 & 88-21417
ORDER ON REVIEW
Diane L. Gruber, Claimant Attorney
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Myers and Cushing.

The insurer requests review of Referee Mulder's order which set aside its denial of claimant's claim for an injury of November 25, 1988. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

Claimant compensably injured her shoulder on November 24, 1988. On November 25, 1988, claimant went to see her treating physician for her compensable injury. After seeing the physician she walked a few blocks to her place of employment to fill out claim forms on the November 24th injury. She entered the building in which her employer was a tenant and walked down a flight of stairs to her employer's offices. The stairs were not part of the employer's premises and were not under the employer's control. Claimant slipped on the stairs, injuring her low back.

CONCLUSIONS OF LAW AND OPINION

We note that the Referee questioned claimant's credibility concerning certain details of her fall. However, we infer that overall he found claimant credible because his findings of fact are based in large part on claimant's unrebutted testimony. Accordingly, we also base our findings on claimant's unrebutted testimony.

The parties approach this case by arguing whether claimant's slip on the stairs was within the course and scope of her employment. We conclude that the case is better analyzed under the notion of "quasi-course of employment" advanced by Larson and adopted by the Oregon Court of Appeals in Fenton v. SAIF, 87 Or App 78, 82-3 (1987).

> "'Since, in the strictest sense, none of the consequential injuries we are concerned with are in the course of employment, it becomes necessary to contrive a new concept, which we may for convenience call 'quasi-course of employment.' By this expression is meant activities undertaken by the employee following upon his injury which, although they take place outside the time and space limits of the employment, and would not be considered employment activities for usual purposes, are nevertheless related to the employment in the sense that they are necessary or reasonable activities that would not have been undertaken but for the compensable injury. 'Reasonable' at this point relates not to the method used, but to the category of activity itself....Quasi-course activities would include, for example, making a trip to the doctor's office.' 1 Larson Workmen's Compensation Law, Section 13.11(d), 3-379(1985)." Fenton, supra at 82.

In Fenton, the court held:

> "[W]hen a worker is injured in an accident which occurs during a trip to see a physician for treatment of a compensable injury, the new injury also is compensable." Fenton supra at 83.

We conclude that claimant's fall on the stairs is a compensable injury because both the trip to the physician[1] and the trip from the physician's office to the employer's office to fill out the claim forms were activities which were necessary and reasonable and would not have been undertaken but for the compensable injury of November 24.

ORDER

The Referee's order dated April 5, 1989, as supplemented and amended on May 5, 1989, is affirmed. For services on Board review, claimant's attorney is awarded an assessed fee of $800, to be paid by the insurer. The Board approves a client-paid fee, not to exceed $2,241, to be paid by the insurer to its attorney.

1. The Fenton court indicated that it would also consider a return trip from a doctor as within the quasi-course of employment. The court cited with approval Moreau v. Zayre Corp., 408 A2d 1289 (Me 1979) in which the Maine court found a motor vehicle accident compensable which occurred during a return trip from seeing a doctor for a compensable injury.

June 26, 1990 Cite as 42 Van Natta 1332 (1990)

In the Matter of the Compensation of
JILL M. MEEUWSEN-MOORE, Claimant
WCB Case No. 88-21793
ORDER ON REVIEW (REMANDING)
Vick & Gutzler, Claimant Attorneys
Meyers & Radler, Defense Attorneys

Reviewed by Board Members Myers and Gerner.

Claimant requests review of Referee Leahy's order which dismissed her request for hearing. On review, the issue is the propriety of the order of dismissal. We remand.

FINDINGS OF FACT

Claimant filed a request for hearing on December 14, 1988. The matter was set for hearing on March 16, 1988. On March 17, 1988, the self-insured employer's attorney wrote the Referee to

> "confirm our telephone conversation of March 15, 1989 wherein I advised that claimant was withdrawing her hearing request....Both the telephone call and this correspondence were initiated with the agreement of claimant's attorney...."

The employer's attorney again wrote the Referee on April 18, 1989 reminding the Referee that a dismissal was requested. On May 3, 1989, the Referee issued the following order:

> "This matter is dismissed per OAR 438-06-071.
>
> "IT IS SO ORDERED."

Claimant requested review on May 17, 1989.

CONCLUSIONS AND OPINION

Claimant contends that the Referee's order is insufficient for review, citing Armstrong v. Asten-Hill Co., 90 Or App 200 (1988). Because the Board reviews de novo, the rationale of Armstrong does not directly apply to referees' orders. The Board does not review for substantial evidence, but makes its own findings, therefore, the Board does not reverse or remand simply because a referee's order is not sufficient for substantial evidence review. A referee's order must meet the requirements of substantial evidence review only if the Board chooses to adopt the referee's order as its own. Accordingly, we disagree with claimant that this case should be reversed and remanded simply because the Referee's order contains no findings of fact.

Claimant also asserts that

> "this case was actually taken off the docket on the basis of a possible settlement, with the plan that if it became a problem to finalize, then dismissal or withdrawal of claimant's attorney might occur. The Dismissal Order was entered before details concerning settlement had been finalized."

As claimant correctly notes, we are unable to determine from this record that this assertion is correct. In fact, we are unable to determine from this record what actually occurred. On this record, there is no direct evidence whether claimant withdrew her request for hearing.

Under ORS 656.295(5), we may remand upon a finding that the record was "improperly, incompletely or otherwise insufficiently developed or heard by the referee." We so find.

Accordingly, we remand to the Referee with instructions to take evidence and make findings concerning the question of whether there is a proper basis for dismissing claimant's request for hearing. If the Referee finds no basis for dismissal, he shall proceed with a hearing on the merits. A client-paid fee, not to exceed $1,657.70, payable from the employer to its counsel, is approved.

IT IS SO ORDERED.

June 26, 1990 Cite as 42 Van Natta 1334 (1990)

In the Matter of the Compensation of
ELLA J. MERCER, Claimant
WCB Case No. 86-13205
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Beers, et al., Defense Attorneys

Reviewed by Board Members Myers and Gerner.

Claimant requests review of those portions of Referee Neal's order which: (1) upheld the insurer's denial of claimant's psychological condition; (2) declined to grant permanent total disability, whereas a Determination Order awarded 30 percent (96 degrees) unscheduled permanent disability; and (3) declined to award a carrier-paid attorney fee. The insurer cross-requests review of that portion of the Referee's order which declined to reduce the unscheduled disability award granted by the Determination Order. On review, the issues are compensability, extent of disability including permanent total disability, and attorney fees. We affirm in part, modify in part, and reverse in part.

FINDINGS OF FACT

The Board adopts the Referee's Findings of Fact, as set forth on pages 1 through 6 of the order, as our own, with the following supplementation.

Claimant's current physical limitations, in conjunction with her disabling psychological condition, make it futile for her to secure gainful employment.

Claimant is permanently and totally disabled.

CONCLUSIONS OF LAW AND OPINION

Compensability of Psychological Condition

The Board adopts the Referee's Conclusions of Law, as set forth in the "Opinion" portion of the order, with respect to the issue of compensability of claimant's psychological condition.

Extent of Permanent Disability/Permanent Total Disability

The Referee concluded that claimant had not proven entitlement to permanent total disability. We disagree.

Claimant must prove by a preponderance of the evidence that she is permanently totally disabled. Harris v. SAIF, 292 Or 683 (1982). There are two types of permanent total disability: (1) that arising entirely from physical or mental incapacity; and (2) permanent disability, under the "odd-lot" doctrine, arising from less than total physical incapacity plus non-medical factors, such as age, education, work experience, training and mental capacity, which together

result in permanent total disability. ORS 656.206(1); Shaw v. SAIF, 78 Or App 588 (1986); Clark v. Boise Cascade Co., 72 Or App 397 (1985); Welch v. Bannister Pipeline, 70 Or App 699 (1984); Wilson v. Weyerhaeuser Co., 30 Or App 403 (1977).

In addition, claimant has the burden to establish that she has made reasonable efforts to obtain work at a gainful and suitable occupation, unless it is shown that efforts would be futile. ORS 656.206(3); Butcher v. SAIF, 45 Or App 318 (1983).

Here, claimant is not totally physically incapacitated because of her June 1984 compensable back and hand injury. At most, claimant's impairment due to that injury is moderate, as rated by Dr. Heatherington, claimant's treating osteopath, and the Orthopaedic Consultants. However, Dr. Heatherington, the Consultants, and claimant's treating psychiatrist, Dr. Swarner, opined that claimant is totally physically incapacitated when claimant's preexisting psychological condition is considered in conjunction with her physical impairment resulting from her 1984 compensable injury.

We generally assign greater weight to the opinion of claimant's treating physician, unless there are persuasive reasons to do otherwise. Weiland v. SAIF, 64 Or App 810 (1983).

In July 1987, Heatherington opined that, "in view of claimant's overall condition, I feel that she is . . . permanently and totally disabled." (Ex. 71) Claimant's overall condition included continued complaints of pain in her back, her left hip and thigh, frequent severe disabling headaches, incontinence, memory loss, restricted range of motion, bilateral carpal tunnel syndrome and psychological factors. Heatherington concluded that claimant's mental alertness appeared to be decreasing. Id.

Further support that claimant is permanently and totally disabled comes from the independent medical evaluation performed by the Consultants. The Consultants concluded that "claimant's psychological problems are of such magnitude that it is extremely unlikely that [she could return to work with limitations] and it is doubtful that she is employable in any capacity. . . . her psychological problems are such that she could not return to even sedentary work." (Ex. 80-7)

Finally, claimant's treating psychiatrist, Swarner, reported that claimant suffers from a "somatization syndrome, which is a chronic personality disorder," intermittent in nature. (Ex. 90-14). In a September 1987 deposition, Swarner opined that claimant is "disabled at this point, and severely so," and that her preexisting disabling (though noncompensable) psychological condition, which has remained unchanged since 1983, causes claimant to be unemployable. (Tr. 89-11, 89-12).

The only contrary evidence is that of Dr. Wicher, psychiatrist. Wicher reported that claimant had not been disabled in any way as a result of her June 1984 injury. (Ex. 90-17, 90-18). However, Wicher did not opine whether claimant was permanently and totally disabled when considering both her preexisting psychological condition and the impairment resulting from claimant's 1984 compensable injury. Under the circumstances, we find Wicher's opinion less persuasive. Weiland, supra.

Given the opinions of Drs. Heatherington, Swarner and the Consultants, we conclude that claimant has established by persuasive medical evidence that, given her preexisting psychological condition, it would be futile, at this time, for claimant to seek gainful employment.

Therefore, we find that claimant is permanently and totally disabled.

Attorney Fees

The Referee declined to award a carrier-paid attorney fee, without reasoning. Claimant argues that she is entitled to a carrier-paid attorney fee because she successfully defended against the insurer's cross-request for hearing. We agree.

Claimant successfully defended against the insurer's cross-request to reduce the award of the Determination Order and, thus, is entitled to reasonable attorney fees under ORS 656.382(2). Kordon v. Mercer Industries, 308 Or 290 (1989); Gary W. Atwood, 41 Van Natta 2082 (1989). For similar reasons, claimant is also entitled to a reasonable attorney fee for successfully prevailing against the insurer's cross-request for review.

ORDER

The Referee's order dated February 9, 1988, is affirmed in part, modified in part and reversed in part. That portion of the Referee's order which declined to award an assessed fee for services at hearing is reversed. For services at hearing in successfully defending the insurer's contention that the Determination Order be reduced and on review for successfuly prevailing against the insurer's cross-request for review, claimant's attorney is awarded a reasonable assessed fee of $1,000, to be paid by the insurer. In lieu of the Determination Order award of 30 percent (96 degrees) unscheduled permanent disability, claimant is awarded permanent total disability as of January 14, 1988. Claimant's attorney is awarded 25 percent of the increased compensation created by this order, not to exceed $6,000. The remainder of the Referee's order is affirmed.

June 26, 1990 Cite as 42 Van Natta 1336 (1990)

In the Matter of the Compensation of
DAVID H. OLSON, JR., Claimant
WCB Case Nos. 86-10645, 86-15560 & 86-16539
ORDER ON REVIEW
Kirkpatrick & Zeitz, Claimant Attorneys
Bottini, et al., Defense Attorneys
Schwabe, et al., Defense Attorneys
Judy Johnson (Saif), Defense Attorney

Reviewed by Board Members Nichols and Brittingham.

The SAIF Corporation, and its insured, Iseli Nursery, request review of those portions of Referee Schultz' order that: (1) set aside its denial of responsibility for claimant's aggravation claim for a low back condition; (2) upheld SAFECO Insurance Companies' denial of responsibility on behalf of Moller's Nursery for claimant's aggravation claim for the same condition; and (3) upheld SAFECO's denial of responsibility on behalf of J. Frank Schmidt & Son Nursery for claimant's 1986 "new injury" claim for the same condition. The sole issue on review is responsibility. We affirm.

FINDINGS OF FACT

The Board adopts the Referee's "Findings of Fact" with the following supplementation.

On July 14, 1986, SAFECO, insurer for Schmidt & Son, issued a partial denial of claimant's claim for a low back injury.

On October 3, 1986, SAFECO, insurer for Moller's Nursery, denied claimant's low back aggravation claim in connection with his compensable 1985 injury.

On November 5, 1986, SAIF, insurer for Iseli Nursery, denied claimant's low back aggravation claim in connection with his compensable 1984 injury.

On December 12, 1986 and again on May 22, 1986, SAFECO, insurer for Schmidt & Son, denied compensability of claimant's low back injury claim.

On March 12, 1987, a .307 Order issued, thereby naming SAIF the paying agent until responsibility for claimant's low back condition could be determined.

ULTIMATE FINDINGS OF FACT

Claimant's injury while employed with Moller's Nursery did not independently contribute to the worsening of his condition.

Claimant's employment with J. Frank Schmidt & Son did not independently contribute to the worsening of his condition.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that SAFECO had successfully rebutted the presumption that claimant's compensable 1985 injury with Moller's contributed independently to his worsened condition and, therefore, found that SAIF remained responsible for claimant's then current condition. We agree.

Where there are multiple accepted injuries to the same body part, a rebuttable presumption exists that a claimant's last accepted industrial injury contributed independently to the worsened condition and that the insurer at that time is responsible. Industrial Indemnity Co. v. Kearns, 70 Or App 583 (1984). Therefore, a presumption exists that SAFECO, as insurer for Moller's, is responsible. It can overcome the presumption and shift responsibility by showing that work exposure at J. Frank Schmidt & Son independently contributed to the condition or that the work exposure at SAIF's insured last independently contributed to the condition. In other words, as to SAIF's insured, SAFECO would have to show that the work activities at Moller's did not independently contribute.

Here, we find that claimant did not suffer any distinct traumatic injury to his back while working for his last employer, J. Frank Schmidt & Son, insured by SAFECO. In October 1987 Dr. Pasquesi, orthopedic surgeon, offered the only opinion which indicated that the 1986 injury could have independently contributed to claimant's condition. He opined that all of claimant's motions, on and off the job, contributed independently to a worsening of claimant's condition. However, Pasquesi did not specifically address what effect, if any, the 1986 injury had on claimant's condition. Given the complex medical circumstances surrounding claimant's case, we decline to draw a specific inference from Dr. Pasquesi's general statement of an independent contribution from the 1986 injury.

Because we find that claimant's employment with Schultz & Son did not independently contribute to a worsening of his condition, the burden is on Moller's, insured by SAFECO, to show that the injury incurred during claimant's employment with them did not independently contribute to his worsened condition.

We agree with the Referee that Dr. Gilleux, osteopath, who has treated claimant from the beginning of this claim to the present, has provided the most well-reasoned opinion regarding the etiology of claimant's condition. Dr. Gilleux's opinion that the 1984 injury remains the cause of claimant's problems establishes that claimant's 1985 injury at Moller's did not independently contribute to his underlying low back condition. This is supported by claimant's testimony that he never recovered from the original injury.

We find no persuasive reasons to depart from our deference to treating physician Gilleux's opinion in this case. We do not find persuasive the opinion of Dr. Franks, consulting neurosurgeon, because he changed his opinion of the cause of claimant's complaints. On November 12, 1986, he stated that claimant's work with Moller's "is the most significant to his present problem of low back pain. . ." However, Dr. Franks had previously stated in July 1986 that he found no significant abnormality and deferred to the opinion of Dr. Gilleux. Then, on November 26, 1986, he opined that claimant would have required the same medical care if he had not experienced the work incident with Moller's in 1985. He further stated that he could not determine whether the 1984, 1985 or 1986 injuries caused claimant's current problems. Because of the inconsistencies in Dr. Frank's opinion, we give it little weight.

For these reasons, we find that Moller's, insured by SAFECO, has carried its burden of establishing that claimant's work with them did not independently contribute to his low back condition. Accordingly, responsibility should be assigned to SAIF. The Referee's order is affirmed.

ORDER

The Referee's order dated December 4, 1987 is affirmed. The Board approves a client-paid fee, not to exceed $938.75, payable by SAFECO, as insurer for J. Frank Schmidt & Son, to its counsel.

June 26, 1990 Cite as 42 Van Natta 1338 (1990)

In the Matter of the Compensation of
KENTON A. PARSONS, Claimant
WCB Case Nos. 87-15507 & 87-13850
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Beers, et al., Claimant Attorneys
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Howell and Speer.

Claimant requests review of that portion of Referee Brazeau's order which found that claimant's aggravation claim with EBI Companies was not filed within the five-year aggravation period provided by ORS 656.273(4)(a). Claimant contends that he "filed" his aggravation claim before the expiration of his aggravation rights. In the event the Board finds that the aggravation claim was filed timely, EBI seeks remand for the opportunity to appear at another hearing and introduce additional evidence. On review, the issues are timeliness of the aggravation claim and, alternatively, remand.

FINDINGS OF FACT

The Board adopts the Referee's "Findings" with the following supplementation.

Claimant's attorney's September 15, 1987 letter requesting reopening of claimant's claim for an aggravation was date stamped as received by EBI on September 17, 1987. (Ex. A).

CONCLUSIONS OF LAW AND OPINION

We adopt the Referee's "Opinion" with the following supplementation.

The Referee found that claimant had not met his burden of proving that he had timely filed an aggravation claim. We agree. Additionally, we note that the letter dated September 15, 1987, sent by claimant's attorney as notice of an aggravation claim, is date stamped as having been received by EBI on September 17, 1987. Claimant's five-year aggravation rights expired on September 15, 1987. Under such circumstances, we conclude that claimant did not file his aggravation claim within the five-year period required by statute. See Sandra J. Sealey, 41 Van Natta 929 (1989).

ORDER

The Referee's order dated December 18, 1987, as reconsidered March 28, 1988, is affirmed. A client-paid fee, payable from Pope and Talbot to its counsel, not to exceed $447, is approved.

June 26, 1990 Cite as 42 Van Natta 1339 (1990)

In the Matter of the Compensation of
GLORIA J. RITCHEY, Claimant
WCB Case No. 88-13096
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Saif Legal Department, Defense Attorney

Reviewed by Board Members Howell and Speer.

The SAIF Corporation requests review of that portion of Referee Higashi's order that assessed penalties and attorney fees for an unreasonable failure to timely submit claimant's claim for closure. In its brief, SAIF contends that the Referee's attorney fee award was excessive. On review, the issue is penalties and attorney fees. We affirm.

FINDINGS OF FACT

The Board adopts the Referee's findings of fact, as set forth in the "Findings" section of the Opinion and Order.

CONCLUSIONS OF LAW AND OPINION

The Board adopts the Referee's "Opinion and Conclusion," with the following supplementation.

Penalties and attorney fees

The Referee concluded that it was reasonable for SAIF to seek confirmation of claimant's treating physician's report that she was medically stationary, but once it had received the information, it was not reasonable to request the confirmation a second time. The Referee found that SAIF's actions were unreasonable, particularly because its own expert had concluded that claimant was medically stationary. We agree.

SAIF, by trying to obtain a medically stationary date concurrence from claimant's treating doctor, may argue that it was acting in a cautious manner before submitting the claim for closure. However, we are not convinced that such action was reasonable.

SAIF could have submitted the claim for closure in a timely fashion after claimant's treating physician had found her medically stationary and when the independent medical examiner found claimant to be medically stationary. It then could have sought to obtain a second declaration from claimant's treating doctor that claimant was medically stationary if it felt that was necessary. Rather, SAIF further delayed submitting the claim for closure without reasonable justification. Under the circumstances, we conclude that SAIF's actions were unreasonable and the Referee properly assessed penalties and attorney fees.

Amount of attorney fees

The Referee assessed SAIF $800 in attorney fees for prevailing on the issue of unreasonable closure. Ater reviewing claimant's counsel's statement of services and considering the factors provided in OAR 438-115-010(6), we find the Referee's assessed fee of $800 to be reasonable.

Claimant's counsel submits a statement of services at the Board level. However, penalties and atorney fees are not "compensation" within the meaning of ORS 656.382(2). Saxton v. SAIF, 80 Or App 631 (1986); Dotson v. Bohemia, Inc., 80 Or App 233 (1986). Consequently, claimant is not entitled to an attorney fee award for successfully defending those awards on review. Dotson, supra.

ORDER

The Referee's order dated November 30, 1988, as reconsidered December 19, 1988 and March 10, 1989, is affirmed.

June 26, 1990 Cite as 42 Van Natta 1340 (1990)

In the Matter of the Compensation of
ARDIS M. ROSS, Claimant
WCB Case No. 88-16235
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Meyers & Radler, Defense Attorneys

Reviewed by Board Members Cushing and Gerner.

The insurer requests review of Referee Hoguet's order that granted permanent total disability, whereas a Determination order awarded 32 percent (102.4 degrees) unscheduled permanent disability for a low back injury. On review, the issue is extent of permanent disability, including permanent total disability. We reverse and modify.

FINDINGS OF FACT

Claimant, 53 years of age at hearing, is a high school graduate. She spent 20 years of her adult life as a homemaker, raising eight children. She began working for the employer in 1979 as a swimming instructor. Her previous occupations include homemaking and cake decorating.

In November 1987, she compensably injured her low back, experiencing severe sharp pain with radiation to her left leg/foot. She treated with Dr.

Chamales, M.D., and was then referred to Dr. Leonard, neurologist. After continued chronic low back and left leg pain, claimant was referred by Leonard to the Northwest Pain Center in May 1988.

A September 1988 Determination Order closed claimant's claim and awarded her 32 percent unscheduled permanent disability, finding her medically stationary in August 1988. Claimant requested a hearing.

Vocational assistance began in October 1988, with claimant motivated to return to work and actively participating in vocational services.

Claimant's condition was reevaluated by Leonard in January 1989. She is capable of sedentary work.

Claimant's spinal range of motion findings include 80 degrees retained flexion, 10 degrees retained extension and 20 degrees retained left and right lateral flexion. She suffers from one clinically significant unoperated disc lesion and disabling pain.

FINDINGS OF ULTIMATE FACT

Claimant is not permanently physically or mentally incapacitated as a result of her compensable injury or as a result of a combination of the effects of her injury and educational/social/vocational factors.

She is capable of working part-time at suitable and gainful employment. She is able to sell her services on a regular basis in a hypothetically normal labor market.

Claimant suffers 41 percent permanent loss of earning capacity as a result of her 1987 compensable low back injury.

CONCLUSIONS OF LAW AND OPINION

Permanent Total Disability

The Referee found claimant permanently and totally disabled under the "odd-lot" doctrine, relying on the opinions of Dr. Leonard, neurologist, and the Northwest Pain Center. We disagree.

Claimant must prove by a preponderance of the evidence that she is permanently totally disabled. Harris v. SAIF, 292 Or 683 (1982). There are two types of permanent total disability: (1) that arising entirely from physical incapacity; and (2) that arising under the "odd-lot" doctrine, arising from less than total physical incapacity plus non-medical factors, such as age, education, work experience, training and mental capacity, which together may result in permanent total disability. Welch v. Bannister Pipeline, 70 Or App 699 (1984); Wilson v. Weyerhaeuser Co., 30 Or App 403 (1977); Shaw v. SAIF, 78 Or App 588 (1986).

In addition, claimant has the burden to establish that she has made reasonable efforts to obtain work at a gainful and suitable occupation, unless it is shown that efforts would be futile. ORS 656.206(3); Butcher v. SAIF, 45 Or App 318 (1983).

Claimant first contends that she is permanently and totally physically incapacitated. We disagree.

There is no evidence that claimant is permanently and totally physically incapacitated. Claimant's back condition was treated by two physicians: Dr. Chamales, her treating physician, and Dr. Leonard, her treating neurologist. Her condition also was evaluated by the Northwest Pain Center (NPC). Both Leonard and the NPC's physicians and physical therapist found claimant capable of returning to at least sedentary work. Chamales is the only physician to opine that claimant is not capable of returning to any kind of work. Chamales did not, however, find claimant permanently and totally physically incapacitated.

Therefore, since neither of the physicians opined that claimant was permanently and totally physically incapacitated, the preponderance of the medical evidence establishes that claimant is not permanently and totally physically incapacitated.

In the alternative, claimant argues, as the Referee found, that she is permanently and totally disabled under the "odd-lot" doctrine. We disagree.

Claimant argues that the opinion of claimant's "treating physician," Dr. Chamales, should be deferred to under Weiland v. SAIF, 64 Or App 810 (1983). However, in this case, we find that both Chamales and neurologist Leonard treated claimant's condition. Therefore, to defer to one and not the other would be inappropriate in this instance.

Both Leonard and the NPC opine that claimant, given her physical restrictions and chronic pain, is not capable of returning to her previous occupation. However, they opined that she was capable of performing regular sedentary work.

Further support that claimant is capable of regular gainful work is the testimony of claimant's vocational counselor and expert, Carter. Carter specifically opined that claimant is employable in the general labor market within the constraints of the most severe physical limitations placed upon her by her treating physicians. (Ex. 35). Carter identified several transferable skills and identified specific occupations, such as cake decorating and telemarketing, which are available and within claimant's sedentary work capacity. Carter noted that these occupations fall within the physical capacity restrictions set forth by Dr. Chamales and Dr. Leonard.

After considering claimant's age, education, transferable skills and physical restrictions, Carter opined that claimant was employable in a sedentary occupation. While Chamales opined that claimant could not return to work, we note that we have already relied upon the opinions of the NWP and Leonard in finding that claimant was capable of returning to sedentary work.

As previously discussed, the only physician to find claimant not capable of working is Dr. Chamales. While his opinion as a treating physician is probative, we note that his opinion, unlike that of Dr. Leonard, does not take into account other factors which could affect claimant's ability to return to regular gainful employment. Such factors include claimant's motivation, physical improvement and increased ability to deal with the pain associated with her injury. Both the NWP and Leonard considered these factors in making their conclusions regarding claimant's ability to return to gainful employment.

Claimant, 53 years of age at hearing, graduated from high school. She is capable of performing sedentary work, and possibly light work with increased rehabilitation efforts. Her previous occupations include cake decorating and homemaking. Claimant does not suffer from other disabling physical or mental conditions.

Therefore, the preponderance of the evidence, i.e, the medical opinions of Dr. Leonard and the NPC, the vocational opinion of Carter, and claimant's non-medical factors, establishes that claimant is able to sell her services on a regular basis in a hypothetically normal labor market and is not permanently and totally disabled. Bohrer v. Weyerhaeuser Co., 93 Or App 751 (1988).

Extent of Unscheduled Permanent Disability

Claimant's low back condition became medically stationary on August 12, 1988 and her claim was closed by Determination Order on September 15, 1988. Therefore, the standards adopted effective July 1, 1988, former OAR 436-35-001 et seq, apply to the rating of claimant's permanent partial disability. Former OAR 436-35-270 through 436-35-440 apply to the rating of claimant's unscheduled permanent partial disability. Former OAR 436-35-270(1).

Age

The appropriate value for claimant's age of 53 years is 1. Former OAR 436-35-290.

Education

Claimant has been released to modified work, but has not returned to work. She has a high school diploma. The appropriate value for claimant's formal education is 0. Claimant's highest SVP during the ten years prior to the date of injury was 8 as a swimming instructor (DOT # 153.227-018). Therefore, the appropriate value for skills is 1. Former OAR 436-35-300(4). There is no documentation in the record demonstrating competence in any specific vocational pursuit. Therefore, the appropriate value for training is 1.

The total value for claimant's education is 2. Former OAR 436-35-300(5).

Adaptability

Claimant is unable to return to her usual and customary work and has not returned to, or been offered, regular, modified work since she became medically stationary. Claimant's physical capacity falls within the sedentary category. Thus, the appropriate adaptability value is 8. Former OAR 436-35-310(4)(d).

Impairment

Physical impairment and disabling pain are combined to establish claimant's total physical impairment.

Here, claimant's loss of range of motion findings in her thoracolumbar region include retention of 80 percent flexion, for a value of 1 and retention of 10 degrees extension, for a value of 2. The total value for claimant's loss of range of motion findings is 3.

Claimant also suffers from an intervertebral disc lesion; i.e., an unoperated disc derangement with clinically-related residual symptoms, at L4-5. The appropriate value for the disc derangement is 4. Former OAR 436-35-350(2).

Disabling pain which results in loss of use or function is ratable under the standards as impairment. Daniel M. Alire, 41 Van Natta 752 (1989). Claimant suffers from disabling pain which prevents her from bending, squatting, and twisting. It also prevents her from lifting and performing her hobbies of swimming and horseback riding without disabling pain. Therefore, we find that claimant suffers from 10 percent disabling pain.

Claimant's total impairment, the combined values from loss of range of motion (3), disabling pain (10) and the unoperated disc derangement (4), is 17.

Computation of Unscheduled Disability

Having determined each value necessary to compute claimant's permanent disability under the "standards," we proceed to that calculation. When claimant's age value (1) is added to his education value (2) the sum is 3. When that value is multiplied by claimant's adaptability value (8) the product is 24. When that value is added to claimant's impairment value (17) the result is 41 percent unscheduled permanent partial disability. Former OAR 436-35-280(7). Claimant's permanent disability under the "standards" is, therefore, 41 percent.

ORDER

The Referee's order dated February 24, 1989, is reversed and modified. The Referee's award of permanent total disability is reversed. In addition to the 32 percent (102.4 degrees) unscheduled permanent disability awarded by Determination Order, claimant is awarded 9 percent (28.8 degrees) unscheduled permanent disability, for a total of 41 percent (131.2 degrees) unscheduled permanent disability. Claimant's attorney is allowed 25 percent of the increased compensation created by this order, provided that the total attorney fee allowed and paid pursuant to the Referee's order and this order does not exceed $3,800. A client-paid fee, not to exceed $1,832, payable by the insurer to its counsel, is approved.

IT IS SO ORDERED.

In the Matter of the Compensation of
FREDA M. BOESCH, Claimant
WCB Case No. 88-06805
ORDER ON REVIEW
Brian Whitehead, Claimant Attorney
Rick Dawson (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

Claimant requests review of that portion of Referee Nichols' order which affirmed a Determination Order that awarded no additional unscheduled permanent disability beyond that previously awarded by Determination Order. Claimant also argues in her brief that she is entitled to penalties and associated attorney fees for the SAIF Corporation's alleged "back-up" denial. The issues on review are extent of permanent disability following aggravation, penalties and attorney fees. We affirm.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact."

CONCLUSIONS OF LAW AND OPINION

We adopt the Referee's "Opinion and Conclusion" with the following supplementation.

Claimant was in a motor vehicle accident subsequent to her compensable injury. SAIF's reopening for aggravation was not a concession or acceptance of

a permanent worsening of claimant's compensable condition. SAIF is not precluded by Bauman v. SAIF, 295 Or 278 (1983), from arguing that claimant suffered no permanent compensable residuals from the motor vehicle accident. That is, the fact that a noncompensable injury temporarily worsened a separate compensable condition does not logically compel the conclusion that the compensable condition was permanently worsened, simply because the noncompensable injury involved permanent residuals.

In order to be entitled to an increase in her permanent disability rating, claimant has the burden to prove that her compensable condition has permanently worsened since the last award or arrangement of compensation, and that the compensable injury remains "a material cause" of the permanently worsened condition. Stepp v. SAIF, 304 Or 375 (1987). We agree with the Referee that claimant has not sustained her burden.

ORDER

The Referee's order, dated February 7, 1989, is affirmed.

June 27, 1990 Cite as 42 Van Natta 1345 (1990)

In the Matter of the Compensation of
MICHAEL J. EBY, Claimant
WCB Case No. 88-14116
ORDER ON REVIEW
Royce, Swanson & Thomas, Claimant Attorneys
Roy Miller (Saif), Defense Attorney

Reviewed by Board Members Brittingham and Nichols.

The SAIF Corporation requests review of that portion of Referee Hoguet's order which set aside its denial of claimant's occupational disease claim for chronic toxic encephalopathy. On review, the issue is compensability. We reverse in part and affirm in part.

FINDINGS OF FACT

The Board adopts the Referee's "Findings of Fact."

FINDINGS OF ULTIMATE FACT

Claimant has chronic toxic encephalopathy with impairment of sustained concentration and attention, new learning, and memory.

Claimant's chronic toxic encephalopathy is due to the combined effects of workplace solvent exposure, excessive alcohol use, and excessive marijuana use.

Claimant's workplace exposure was not the major contributing cause of his chronic toxic encephalopathy.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant has organic brain impairment with loss of memory and that the major contributing cause was claimant's exposure to solvents while working for the employer. We disagree.

The legislature amended the occupational disease statute effective January 1, 1988. Claimant was last exposed to solvents at work in 1986. Thus,

claimant's last exposure to work activity that could have affected his condition occurred prior to 1988. For this reason, we find that this case should be analyzed under the statute in effect through December 31, 1987, former ORS 656.802(1)(a). See Donna E. Aschbacher, 41 Van Natta 1242 (1989).

In order to establish a compensable occupational disease, claimant must prove by a preponderance of the evidence that he has a disease and that work activity or exposure is the major contributing cause of the onset or worsening of his condition. 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). "Major contributing cause" means an activity or exposure or combination of activities or exposures which contributes more to the onset of the condition than all other activities or exposures combined. See McGarrah v. SAIF, 296 Or 145, 166 (1983); Dethlefs, supra; Clark v. Erdman Meat Packing, 88 Or App 1, 5 (1987).

Claimant has undergone extensive neuropsychological testing with medical psychologists Drs. Crossen and Wiens. They have diagnosed Chronic Toxic Encephalopathy [CTE] with deficits in memory, attention, and new learning abilities. We accept their expert opinions as to diagnosis and find that claimant does have a significant neuropsychological impairment.

Claimant must, therefore, prove that work place exposure was the major contributing cause of his CTE condition or its worsening. The issue of whether claimant's neuropsychological impairment is causally related to inhalation of toxic paint solvents while working for the employer is a complex medical question. The resolution of this issue largely turns on an analysis of the medical evidence. Uris v. Compensation Department, 247 Or 420, 426 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985).

In concluding that claimant's condition is compensable, the Referee relied on the reports and testimony of consulting physician Morton, a specialist in occupational medicine and preventative medicine. He opined that workplace exposure was the major contributing cause of claimant's CTE. Although there are conflicting medical reports in the record, the Referee found Dr. Morton to be credible and his conclusions to be persuasive.

SAIF asserts that the medical evidence is insufficient to establish that claimant's CTE was caused by exposure to paint solvents at work, and that a more plausible explanation for claimant's current psychological deficits is his polysubstance abuse, especially marijuana. SAIF contends that the Referee's reliance on Dr. Morton's reports and testimony to support causation is misplaced. It notes that other physicians were either silent on the issue or opined that work exposure to solvents was not the major contributing cause of claimant's disease. SAIF further asserts that the credibility and value of Dr. Morton's opinion are highly questionable because he relied on flawed data and failed to follow procedures to verify claimant's history of marijuana and alcohol use. We agree.

We evaluate three basic factors when assessing the persuasiveness of medical opinions: the source of the opinion, its factual basis, and its logical force. Earl M. Brown, 41 Van Natta 287, 291 (1989). The factual basis of the opinion includes completeness and correctness of the information upon which it is based.

We find that Dr. Morton's opinion lacks factual basis. Dr. Morton's conclusions were based on a flawed history of exposure to toxic substances. Dr. Morton testified that the most important factor in diagnosis is history -- history of intake and history of onset of symptoms in relation to the different types of exposure the worker has had. Nevertheless, Dr. Morton failed to follow

his own published procedures and investigate claimant's off-work exposure to solvents.

Dr. Morton believed that claimant's work solvent exposure began in 1979 and that claimant's memory problems began in 1981. Therefore, he concluded that work place exposure was the major contributing cause of claimant's condition because his history of heavy alcohol and marijuana use began after his cognitive impairment appeared, and alcohol use diminished after his work place exposure ceased. However, claimant actually began working for the employer in 1981 and exposure began in 1981 and increased until 1986 when claimant quit work. Psychological examination in 1986 revealed no memory or concentration problems. Claimant's psychological condition was not diagnosed until 1988. Therefore, the doctor's historical cause and effect analysis fails.

Furthermore, Dr. Morton neglected to document the quantity of claimant's alcohol consumption. Dr. Morton testified that alcohol is a solvent just like paint solvents, and that it causes the same central nervous system damage; every time there is clinical intoxication, there is some death of nerve cells. He also explained that there is no clean distinction between encephalopathy due to solvent exposure and encephalopathy due to alcohol exposure. The effects of solvent injury and alcohol use are the same. Although Dr. Morton conceded that claimant had a long history of heavy alcohol use, he neglected to record the alcohol history that claimant related to him.

In addition, Dr. Morton relied on neuropsychological testing performed by Drs. Crossen and Wiens in 1988 that was also based on an inaccurate history. The doctors were of the impression that claimant had no toxic solvent exposure after 1986 when he ceased working for the employer. To the contrary, the record in fact reveals that claimant continued his steady marijuana use right up to the time of that 1988 examination. Dr. Morton acknowledged in his testimony that marijuana use effects memory and concentration.

Finally, Dr. Morton's conclusions are disputed by Drs. Bardana and Burton. Claimant was referred to Dr. Bardana, an allergy and immunology specialist, for evaluation in July 1987. In July 1988, Dr. Bardana reviewed Drs. Crossen and Wiens' neuropsychological report and suggested that claimant's deficits were attributable to cannabis abuse. In October 1988, Dr. Burton, a specialist in occupational diseases and industrial toxicology, also examined claimant. He concluded that the major contributing cause of claimant's impairment is long term marijuana use.

On this record, we conclude that claimant has failed to meet his burden of proof that his toxic solvent exposure with the employer, in comparison with his alcohol and marijuana use, was the major contributing cause of his CTE condition.

ORDER

The Referee's order dated November 30, 1988, is reversed in part and affirmed in part. The SAIF Corporation's denial is reinstated and upheld. The $3,000 assessed fee awarded by the Referee is reversed. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of the Beneficiaries of
THERESA J. LESTER (Deceased), Claimant
WCB Case No. TP-90028
THIRD PARTY ORDER OF DISMISSAL
Goldberg & Mechanic, Claimant Attorneys
Mautz, Hallman, et al., Defense Attorneys

Jill E. Golden, as personal representative for the estate of the deceased worker (hereafter "claimant"), has petitioned the Board for resolution of a dispute concerning a proposed settlement of a third party action. ORS 656.587. Inasmuch as claimant has neither accepted the proposed settlement nor has she requested a determination as to whether the settlement offer is reasonable, we consider her petition to be premature. Consequently, the petition is dismissed.

FINDINGS OF FACT

In July 1988, while performing her work activities as a flagger for an asphalt paving company, the deceased worker was killed when struck by a motor vehicle. The claim was accepted and processed.

Each of the decedent's two surviving minor children and her surviving spouse have received death benefits. The children are receiving monthly support benefits of $150, while the spouse receives $806.84. The paying agency has established indemnity reserves for these beneficiaries, totalling $46,205 for the children and $174,248 for the surviving spouse.

Claimant, as personal representative for the decedent's estate, retained legal counsel to pursue a cause of action for wrongful death against the driver of the motor vehicle. A third party action has been filed. Rather than proceed to trial, the third party insurer has offered to settle the case for $300,000.

The paying agency has raised no objection to the amount of the settlement offer. Noting that all beneficiaries of the estate are also beneficiaries under the Workers' Compensation law, the paying agency contends that its lien for claim costs attaches to all shares of the proposed third party settlement proceeds after distribution is directed by the probate court.

Claimant disagrees with the paying agency's contention, arguing that the agency's lien for a particular beneficiary applies only to that beneficiary's share of the proceeds to be granted by the probate court. Based on the paying agency's position concerning the distribution of proceeds, claimant will not accept the settlement offer. However, if the Board advises that it agrees with claimant's proposed distribution approach, claimant will accept the offer.

No dispute concerning the reasonableness of the settlement offer has been presented for the Board's resolution.

CONCLUSIONS OF LAW

Pursuant to ORS 656.587, we are 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. Dorotha M. Clarke, 40 Van Natta 1125 (1988); Kathryn I. Looney, 39 Van Natta 1140 (1987). However, where a claimant has not accepted

the settlement offer, no third party compromise exists for us to consider. Delores M. Shute, 41 Van Natta 1028 (1989).

Here, claimant has not accepted the third party settlement offer. Inasmuch as no compromise between the worker and the third party currently exists, we are without authority to proceed under ORS 656.587. Shute, supra.

Moreover, pursuant to ORS 656.593(3), we are authorized to resolve any conflict concerning the "just and proper distribution" of the remaining proceeds from a third party settlement. See Estate of Troy Vance v. Williams, 84 Or App 616, 619-20 (1987). However, where no third party settlement has been reached, there are no proceeds from which we can determine a "just and proper" distribution. See ORS 656.593(3); Shute, supra. Thus, any petition for resolution of such a "dispute", where no settlement has been achieved, is considered to be a request for an advisory opinion, which we are not empowered to issue. Shute, supra.

Here, should we concur with her projected distribution of settlement proceeds, claimant asserts that the offer will be accepted. Yet, if we agree with the proposed distribution advanced by the paying agency, claimant concedes that she will not accept the settlement offer. We have previously interpreted such conditional language as a request for an advisory opinion, which exceeds our limited statutory authority in third party matters. Shute, supra.

In conclusion, based on the reasoning expressed above, we hold that we are without authority to grant claimant's petition. Accordingly, this matter is dismissed.

IT IS SO ORDERED.

In the Matter of the Compensation of
FLORENCE J. MCDONALD, Claimant
WCB Case No. 88-20769
ORDER ON REVIEW (REMANDING)
Myrick, et al., Claimant Attorneys
James Dodge (Saif), Defense Attorney

Reviewed by Board Members Nichols and Brittingham.

Claimant requests review of Referee Mongrain's order that dismissed her request for hearing. Claimant seeks to have the matter remanded for a hearing on the merits. We remand.

FINDINGS OF FACT

A claim was filed in May 1988 for an injury which allegedly occurred on November 11, 1987. The SAIF Corporation denied the claim on September 8, 1988. Claimant, in her own behalf, mailed a request for a hearing to SAIF which was received by SAIF on November 7, 1988. SAIF forwarded the request to the Workers' Compensation Board, and it was received by the Board on December 2, 1988. A hearing was set for February 27, 1989 and notice was sent to the parties.

Neither claimant nor anyone in her behalf appeared at the hearing. The Referee issued an Order of Dismissal on February 28, 1989. On March 10, 1989, Attorney Richard Adams wrote to the Referee requesting that the dismissal order

be abated and that the claimant be allowed an opportunity to show good cause for failure to appear. An affidavit, signed by claimant was received by the Board on March 16, 1989. The affidavit stated that claimant was in California, and had been since August 1988, caring for a terminally ill relative and was unable to appear at hearing, but had made arrangements for her husband to appear in her stead. Unbeknownst to claimant, her husband had an insulin reaction the morning of the hearing and was also unable to attend due to that illness.

Claimant did not seek the advice of an attorney on her claim until after the Order of Dismissal had been received. On March 27, 1989, Attorney Adams filed a request for Board review. On March 30, 1989, the Referee denied the request to abate the order.

CONCLUSIONS OF LAW AND OPINION

The Referee apparently relied on former OAR 438-06-071 which provides authority for a Referee to dismiss for failure to appear. Under that rule the matter shall be dismissed unless a postponement is granted. We consider the Referee's ruling on the motion to abate as a ruling on the postponement issue. The Referee apparently failed to find extraordinary circumstances. We disagree.

Based on claimant's unrebutted affidavit, we are persuaded that she was unable to appear at the hearing because she was attending to the needs of her terminally ill relative in California. We further note that claimant took this action, without advising the Hearings Division of these circumstances prior to the scheduled hearing, without benefit of legal counsel. Thus, on the facts presented in this case, we conclude that claimant has established extraordinary circumstances beyond her control which would justify the postponement of the hearing. See former OAR 438-06-081.

Accordingly, we vacate the Referee's dismissal order and remand for a hearing on the merits.

IT IS SO ORDERED.

June 27, 1990 Cite as 42 Van Natta 1350 (1990)

In the Matter of the Compensation of
BARBARA E. RADCLIFFE, Claimant
WCB Case No. 88-19397
ORDER ON REVIEW
Vick & Gutzler, Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Howell and Speer.

The insurer requests review of Referee Menashe's order which set aside its denial of claimant's injury claim. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

The insured leases office space on the 9th floor of a multistory multipurpose commercial office building. On September 1, 1988, claimant slipped and fell on the wet front steps of the office building while on her way to work. The fall occurred as claimant approached one of four public entrances to the building. The employer did not own or control the steps on which claimant fell.

CONCLUSIONS OF LAW AND OPINION

Claimant argues that the steps approaching the entrance of a multi-story, multipurpose commercial office building in which her employer leases space is the equivalent of the employer's premises because she had to enter the building via the steps in order to reach her employer's premises. We disagree.

Injuries occurring while coming to and going from work are ordinarily not work-related, unless the employer exercises some control over the place where the injury is sustained. Cope v. West American Ins. Co., 309 Or 232, 239 (1990); Betsy C. Crick, 42 Van Natta 1198 (1990); Sheri V. Hiltner, 42 Van Natta 1039 (1990). Here, the employer did not own the steps approaching the building nor did it exercise any control over the steps. Claimant was exposed to no greater risk than the general public. We conclude that claimant was not injured on premises within the employer's control. Her injury did not occur in the course of her employment and is not, therefore, compensable.

ORDER

The Referee's order dated March 9, 1989 is reversed. The insurer's denial is reinstated and upheld. The award of a $1,300 attorney fee to claimant's attorney is reversed. A client-paid fee not to exceed $2,791.50 is approved.

June 27, 1990 Cite as 42 Van Natta 1351 (1990)

In the Matter of the Compensation of
MARTIN SCHILLER, Claimant
Own Motion No. 90-0140M
OWN MOTION ORDER
Bottini, et al., Claimant Attorneys
Saif Legal Department, Defense Attorney

The SAIF Corporation has voluntarily reopened the above claim pursuant to ORS 656.278. Claimant's aggravation rights have expired. SAIF has accepted responsibility for claimant's current right knee condition, and asks the Board to authorize reimbursement from the Reopened Claims Reserve.

Under 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 claimant's compensable injury has worsened requiring surgery. Accordingly, claimant's claim is reopened with temporary disability benefits to commence the date he is hospitalized for the proposed surgery. SAIF shall continue paying temporary disability compensation until claimant is medically stationary and the claim is closed, or claimant returns to regular work at the regular wage, 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 SAIF pursuant to OAR 438-12-055.

Finally, we note that claimant has a pending request for hearing on a Determination Order that issued March 22, 1989 (WCB Case No. 89-09603). At that hearing, the Referee should rate permanent disability based on claimant's

condition at the time of hearing if he is medically stationary at that time. Pauline Travis, 37 Van Natta 194 (1985); Jeffrey Barnett, 36 Van Natta 1636 (1984). If claimant is not medically stationary at the time of hearing, the Referee should rate permanent disability as of the date he was last medically stationary. Pauline Travis, supra.

IT IS SO ORDERED.

June 27, 1990 Cite as 42 Van Natta 1352 (1990)

In the Matter of the Compensation of
RONALD L. SCHILLING, Claimant
WCB Case No. 87-09708
ORDER OF ABATEMENT
Peter O. Hansen, Claimant Attorney
John D. McLeod, Defense Attorney
Gary Wallmark (Saif), Defense Attorney

The SAIF Corporation requests reconsideration of our May 30, 1990 order that affirmed a Referee's order that: (1) found that claimant was a subject worker; (2) found that claimant's low back claim was timely; and (3) set aside the employer's denial of claimant's low back condition. In its brief, SAIF contended that the Referee erred by not addressing the issue of responsibility. We concluded that the Referee correctly refused to address responsibility, as we found that the later employer was not joined in the proceeding.

On reconsideration, SAIF argues that, in a prior hearing convened before Referee Podnar on March 2, 1988, it reserved its right to assert the responsibility defense. Claimant has filed a response to SAIF's motion.

In order to allow sufficient time to consider the motion and claimant's response, our May 30, 1990 order is abated and withdrawn. We shall take this matter under advisement. After we have completed our further consideration of this matter, an order on reconsideration will issue.

IT IS SO ORDERED.

June 27, 1990 Cite as 42 Van Natta 1352 (1990)

In the Matter of the Compensation of
DAVID W. SOUNDERS, Claimant
WCB Case No. 88-19104
ORDER ON REVIEW
Merrill Schneider, Claimant Attorney
Tooze, et al., Defense Attorneys

Reviewed by Board Members Speer and Howell.

The insurer requests review of Referee Mulder's order which affirmed a Determination Order that reclassified claimant's hearing loss claim from nondisabling to disabling. In his brief, claimant challenges that portion of the Referee's order which declined to award penalties and attorney fees for alleged unreasonable claims processing. On review, the issues are reclassification of a claim and penalties and attorney fees. We reverse on the reclassification issue.

FINDINGS OF FACT

Claimant's claim for noise-induced hearing loss was accepted as nondisabling on December 14, 1987. The Evaluation Division reclassified it as disabling on September 15, 1988.

Audiograms indicate that claimant has some high frequency hearing loss.

Claimant has not lost work nor received temporary disability benefits due to his hearing loss.

Claimant has no permanent impairment due to his compensable hearing loss.

CONCLUSIONS OF LAW AND OPINION

Claimant argues that even though he may not be entitled to receive permanent partial disability benefits, his claim should, nevertheless, be reclassified as disabling. We do not agree. In order for a compensable injury to be disabling it must be such that it "entitles the worker to compensation for disability or death." ORS 656.005(7)(b). An injury which requires only medical services is a nondisabling compensable injury. ORS 656.005(7)(c).

In this case, claimant's hearing loss was originally accepted as nondisabling. Claimant lost no time from work due to his compensable hearing problem. However, he did receive medical services in the form of hearing aids.

On September 15, 1988, at claimant's request, the Evaluation Division directed that the insurer reclassify claimant's injury from nondisabling to disabling. The insurer argues that reclassification was improper. We agree.

Claimant has admitted that he has no temporary disability with respect to his hearing loss. Additionally, there is no evidence in the record to show that claimant has permanent disability because of the hearing loss.

Claimant's entitlement to permanent disability compensation is controlled by the "standards" adopted by the Director pursuant to ORS 656.726(2)(f)(A). ORS 656.283(7); 656.295(5); OAR 438-10-010; and Former OAR 436-35-002 & 436-35-003. We note that there is no audiogram in the record upon which hearing loss could be based for purposes of determining the extent of his disability. Former OAR 436-35-250(3). However, even when claimant's hearing loss is calculated based on his most recent audiogram, taking into consideration hearing loss due to presbycusis, we find no compensable hearing loss. Former OAR 438-35-250(4)(c).

Claimant's hearing loss in each ear was calculated as follows:

Right Ear	Frequency	Audiogram Findings (In decibels lost)
	500	0
	1000	5
	2000	20
	3000	55
	4000	65
	6000	65
	Total	210

Claimant's total hearing loss must be offset by presbycusis. Former OAR 436-35-250(2)(b). The presbycusis correction value for claimant, age 54, is 76. Former OAR 436-35-250(4)(b). Subtracting that value from the totaled audiogram findings we arrive at a total work-related monaural hearing loss in the right ear of 134 decibels. Former OAR 436-35-250(4)(b).

Left Ear	Frequency	Audiogram Findings (in decibels lost)
	500	5
	1000	10
	2000	25
	3000	60
	4000	65
	6000	55
	Total	220

Subtracting the presbycusis correction value (76) from the audiogram findings we arrive at a total monaural work-related hearing loss in the left ear of 144 decibels. Former OAR 436-35-250(4)(b).

In order to be entitled to permanent disability for work-related hearing loss, claimant must have lost at least 151 decibels of hearing. Former OAR 436-35-250(4)(c). Here, claimant has not lost the required decibels. Similarly, claimant has no binaural work-related hearing loss. See former OAR 436-35-250(5)(a). Accordingly, because we find that claimant has failed to prove by a preponderance of the evidence any compensable work-related hearing loss, we conclude that there is no basis for the reclassification of his hearing loss from a nondisabling to disabling injury.

Claimant argues that, because the insurer failed to submit an updated audiogram as requested by the Evaluation Section, he is entitled to penalties and attorney fees for improper claims processing. We agree that the insurer's failure to submit an audiogram may have been unreasonable because the insurer offered no explanation for its inaction; however, because there were no amounts "then due," there is no basis upon which to award a penalty. ORS 656.262(10). Moreover, claimant is not entitled to an attorney fee under ORS 656.382(1) for unreasonable resistance to compensation because claimant has not established entitlement to compensation for his hearing loss.

ORDER

The Referee's order dated March 7, 1989 is reversed. The September 15, 1988 Determination Order is set aside. Claimant's hearing loss claim shall remain classified as nondisabling. The Referee's award of a $1,400 assessed attorney fee, payable by the insurer is reversed.

In the Matter of the Compensation of
DALE L. THIME, Claimant
WCB Case No. 89-00192
ORDER ON REVIEW
Peter O. Hansen, Claimant Attorney
Cooney, et al., Defense Attorneys

Reviewed by Board Members Nichols and Brittingham.

Claimant requests review of Referee Podnar's order that: (1) upheld the self-insured employer's denial of claimant's low back injury claim; and (2) did

not address the employer's denial of claimant's occupational disease claim for bilateral hand pain and numbness. Claimant has also submitted copies of medical reports generated after the hearing. We treat this submission as a motion for remand to the Referee for the admission of additional evidence. On review, the issues are remand and compensability.

We may remand to the Referee should we find that the record has been "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(5). To merit remand, it must be clearly shown that material evidence was not obtainable with due diligence at the time of the hearing. Kienow's Food Stores v. Lyster, 79 Or App 416 (1986); Bernard L. Osborn, 37 Van Natta 1054, 1055 (1985), aff'd mem, 80 Or App 152 (1986).

Here, claimant's submission consists of two one-page medical reports authored by Dr. Brett, who has apparently become claimant's treating surgeon since the hearing. In a conclusory fashion, Brett opines that claimant's low back condition and bilateral carpal tunnel syndrome are "work-related."

We are not persuaded that, without the aforementioned reports, the record concerning the compensability of claimant's low back and bilateral hand claims has been either improperly, incompletely or otherwise insufficiently developed. Since Dr. Brett apparently became claimant's treating surgeon after the hearing, Brett's reports were unobtainable with due diligence at the time of hearing. However, because the record already contains several medical opinions discussing claimant's conditions and their relationship to his work activities, we consider the evidentiary value of Brett's reports to be merely cumulative concerning the causal relationship issues. Accordingly, we hold that remand is not appropriate.

Turning to the merits of this case, we affirm and adopt the order of the Referee with the following supplementation.

In addition to denying the compensability of claimant's low back injury claim, the employer's denial also pertained to claimant's occupational disease claim for bilateral hand pain and numbness. However, reasoning that the latter claim was "not a part of this hearing", the Referee declined to address the issue of compensability.

We disagree with the Referee's conclusion. Inasmuch as claimant requested a hearing seeking the reversal of the employer's denial and since that denial pertained to claimant's occupational disease claim for bilateral hand complaints, we hold that the issue was properly before the Referee. We further conclude that the record concerning this compensability issue is adequately, properly, and sufficiently developed for us to render a decision without first remanding to the Referee. See generally David L. Fleming, 38 Van Natta 1321 (1986), aff'd mem Fleming v. Daeuble Logging, 89 Or App 87 (1987). (Board may determine the extent of permanent disability, without first remanding to the Referee, when sufficient evidence in the record exists upon which to determine the issue).

We proceed to consider claimant's occupational disease claim for bilateral hand complaints. After conducting our de novo review of the medical and lay evidence, we are not persuaded that claimant's work activities were a material contributing cause of either his bilateral hand/wrist condition or its symptoms. See ORS 656.802(1)(c); Donna E. Aschbacher, 41 Van Natta 1242 (1989).

In reaching our conclusion, we defer to the Referee's express finding that claimant's testimony lacked "candor." See Humphrey v. SAIF, 58 Or App 360, 363 (1982). In addition, we concur with this finding after conducting an objective

evaluation of the substance of claimant's testimony in relation to the record as a whole. See Coastal Farm Supply v. Hultberg, 84 Or App 282, 285 (1987).

In view of claimant's lack of credibility, we do not consider medical opinions based upon the accuracy and veracity of claimant's history and complaints to be persuasive. See Miller v. Granite Construction Co., 28 Or App 475 (1977). Thus, we do not rely upon the opinion authored by Dr. Long, who concluded that the findings concerning claimant's hands were related to his work activities. Our conclusion is further supported by the fact that Dr. Long was under the mistaken impression that claimant worked continuously from March 1988 through November 1988, when in actuality claimant stopped working in April 1988 and did not return to his work activities until September 1988.

Inasmuch as we neither rely upon claimant's testimony nor the medical opinion supporting a causal relationship between his work activities and his bilateral hand/wrist complaints, we conclude that claimant has not established that his work activities were a material contributing cause of his bilateral hand/wrist condition or its symptoms. Consequently, the employer's denial of claimant's occupational disease claim is upheld.

ORDER

The Referee's order dated April 28, 1989 is affirmed. A client-paid fee, payable from the self-insured employer to its counsel, is approved, not to exceed $1,304.50.

June 28, 1990 Cite as 42 Van Natta 1356 (1990)

In the Matter of the Compensation of
ALFRED P. ADENT, Claimant
WCB Case No. 89-26085
ORDER DENYING MOTION TO DISMISS
Brian R. Whitehead, Claimant Attorney
Tom Ewing (Saif), Defense Attorney

Claimant has moved the Board for an order dismissing the SAIF Corporation's request for Board review on the grounds that: (1) service of the request was not timely; (2) a copy of the request was not served on all parties; and (3) no reason for requesting review was indicated on the request. The motion is denied.

FINDINGS OF FACT

The Referee's order issued May 14, 1990. On June 15, 1990, the Board received SAIF's request for review. The request was neither mailed by registered nor certified mail. However, the request included a Certificate of Service and Mailing, which certified that SAIF's counsel had mailed the request to the Board on June 13, 1990. SAIF's counsel also certified that copies of the request had been mailed to claimant's attorney and the employer on June 13, 1990. The request did not specify a reason why SAIF was requesting Board review.

CONCLUSIONS OF LAW

A Referee's order is final unless, within 30 days after the date of 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 May 14, 1990 order was June 13, 1990. Since SAIF's request was neither mailed by registered nor certified mail and was actually received by the Board on June 15, 1990, after the date for filing, it is presumed to be untimely until SAIF establishes that the mailing was timely. See OAR 438-05-046(1)(b). However, included with SAIF's request is a Certificate of Service and Mailing from its counsel, certifying that the request was mailed to the Board on June 13, 1990. The postmark date on the envelope further confirms that mailing date. These circumstances establish that the request for review was timely mailed to the Board. Consequently, the presumption of untimeliness has been overcome. See OAR 438-05-046(1)(b).

Claimant also contends proper service was not made on all parties. While the request for Board review did not indicate that a copy was mailed to claimant, the request did indicate that a copy of the request had been provided to claimant's attorney.

"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, at 850-51; Nollen v. SAIF, 23 Or App 420, 423 (1975), rev den (1976); Robert C. Jaques, 39 Van Natta 299 (1987).

Here, no contention has been made that claimant has been prejudiced by not directly receiving a copy of SAIF's request for review. Lacking such a finding, we hold that timely service of a request for review upon claimant's attorney is adequate compliance with ORS 656.295(2) to vest jurisdiction in the Board.

Finally, claimant contends that SAIF's request for review should be dismissed because it does not contain any statement of the reason review is requested. In asserting his argument, claimant relies upon OAR 438-11-005(3) which provides that the request for Board review "should contain a brief statement of the reasons review is requested." We disagree with claimant's contention.

Pursuant to ORS 656.295(1), a request for Board review of a Referee's order need only state that the party requests a review of the order. ORS 656.295 is incorporated by reference into the Board's procedural rules. OAR 438-11-005(1). Considering the clear directive of ORS 656.295, we are not authorized to limit our jurisdiction to less than that provided by the statute. Kimberly L. Murphy, 42 Van Natta 847 (1989).

In Murphy, we concluded that the aforementioned portion of OAR 438-11-005(3) is not jurisdictional. Rather, it is implemented as an informational aid, designed to assist the parties and the Board in identifying the specific case and the matters at issue. Murphy, supra.

Accordingly, based on the above reasoning, the motion to dismiss is denied. Upon receipt of the hearing transcript, copies will be provided to the parties. Thereafter, the Board will implement a briefing schedule.

IT IS SO ORDERED.

June 28, 1990 Cite as 42 Van Natta 1358 (1990)

In the Matter of the Compensation of
DONALD R. BAILEY, Claimant
And, in the Matter of the Complying Status of
TOM NECKER and DONNA NECKER, dba Necker Enterprises, Inc.
And, in the Matter of the Alleged Responsibility of
LARRY JONES, JONEL BRENNER and KATHLEEN BRAGG, dba J.W. Trucking Co-op, Employer, and TOM NECKER AND DONNA NECKER, dba Necker Enterprises, Inc., Employer
WCB Case Nos. 86-16949, 87-01922, 88-08667, 88-07801 & 88-07802
ORDER DENYING RECONSIDERATION
Welch, Bruun & Green, Claimant Attorneys
Cooney, et al., Defense Attorneys
Schwabe, et al., Defense Attorneys
Davis & Bostwick, Attorneys

Turner Trucking requests reconsideration of our June 6, 1990 order which found that it was a subject employer and that claimant was its subject employee on the date of injury.

Specifically, the noncomplying employer states that we erroneously refused to decide whether Turner Trucking had provided workers' compensation coverage for claimant through United Pacific Insurance, the insurance carrier for Active Beaver Trucking. We have concluded that it is not a question of whether Turner Trucking paid Active Beaver to have claimant carried on its policy but, rather, whether claimant was an employee of Active Beaver so as to be covered by their policy. In our order we found that claimant was not an employee of Active Beaver Trucking at the time of his injury and, consequently, Active Beaver's workers' compensation insurance did not cover him.

Because we do not consider whether Turner Trucking paid premiums to cover claimant to be relevant to the issues before us, we adhere to our June 6, 1990 order and decline to reconsider it. The parties' rights of appeal shall run from the date of our prior order.

IT IS SO ORDERED.

June 28, 1990 Cite as 42 Van Natta 1358 (1990)

In the Matter of the Compensation of
WAYNE P. BURKE, Claimant
WCB Case No. 88-17159
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Luvaas, Cobb, et al., Defense Attorneys

Reviewed by Board Members Brittingham and Nichols.

Claimant requests review of Referee Holtan's order that upheld the insurer's denial of claimant's chiropractic and acupuncture treatments. On review the issue is medical services. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact as set forth in the Referee's order, with the following supplementation.

In January 1988, claimant fell and struck his chin while employed as a special education aide. As a result of this compensable injury, claimant suffers from temporomandibular joint (TMJ) disorder.

Claimant received chiropractic and acupuncture treatments for his TMJ condition in May and June 1988. Billings for these treatments were received by the insurer in June 1988, with the exception of one acupuncture bill received October 17, 1988.

On September 16, 1988, the insurer issued a denial of claimant's "additional" chiropractic and acupuncture treatments.

Claimant returned for another chiropractic treatment, coincidentally, on September 16, and again on September 19, 1988. On December 20, 1988, the insurer paid all outstanding bills for chiropractic and acupuncture treatments through September 16, 1988. The only bill which had not been paid by the date of the hearing was the bill for the chiropractic treatment of September 19, 1988.

CONCLUSIONS OF LAW AND OPINION

The Referee upheld the insurer's denial of further chiropractic and acupuncture treatment. We agree in part, but set aside the portion of the denial which is prospective.

Prospective denials are impermissible. An insurer may not deny its future responsibility for payment of medical services for a previously accepted claim. ORS 656.245(1); Evanite Fiber Corp. v. Striplin, 99 Or App 353 (1989). In the present case, the insurer denied all "additional" chiropractic and acupuncture treatments as not reasonable or necessary. Such a denial is an impermissible denial of future treatments. Accordingly, we set aside that portion of the denial which is prospective.

However, since the record indicates that claimant received one chiropractic treatment after the denial was issued (on September 19, 1988), the reasonableness and necessity of that post-denial unpaid service is also at issue. Hollie J. Rahim, 42 Van Natta 415 (1990). We proceed to address the compensability of that medical service.

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 (1985).

Considering the complexity of claimant's TMJ disorder and the variety of its potential causes, we conclude that the issue of whether particular medical services are reasonable and necessary for the treatment of the disorders is a complex medical question. Thus, although claimant's testimony is probative, the resolution of this issue largely turns on an analysis of the medical evidence.

Uris v. Compensation Department, 247 Or 420, 426 (1967). Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985).

Here, claimant had acupuncture treatments with Dr. Finkelstein in May and June, 1988. Thereafter, in August 1988, claimant began treating with Dr. Hammon, a dentist, oral surgeon and TMJ specialist who treated claimant with a splint and anti-inflammatory and pain medications.

Dr. Duncan, a chiropractor, who performed an independent medical examination of claimant in August 1988, concluded that additional chiropractic treatment would not be helpful for claimant's TMJ condition. Claimant's treating physician, Dr. Hammon, was unaware of any documented scientific literature supporting the use of chiropractic treatment for TMJ pathology. As a specialist in TMJ disorders we accord Dr. Hammon's opinion great weight. See Gloria Serna, 42 Van Natta 54, 57 (1990). Dr. Bond, an osteopathic physician, who performed an independent medical examination of claimant, agreed with Dr. Hammon. Finding no support in the medical literature for chiropractic treatments, Bond supported Dr. Hammon's treatment as being correct.

The aforementioned medical opinions persuade us that claimant's post-denial unpaid chiropractic treatment was reasonable and necessary. Therefore, we uphold the insurer's denial insofar as it pertains to that treatment.

ORDER

The Referee's order dated March 20, 1989 is reversed in part and affirmed in part. The insurer's denial, insofar as it pertains to future acupuncture and chiropractic treatments, is set aside. The insurer's denial is upheld insofar as it pertains to the unpaid chiropractic service subsequent to the denial, which remained unpaid at the time of the hearing. The remainder of the order is affirmed. For services at hearing and on review concerning the prospective denial, claimant's attorney is awarded an assessed fee of $1,000, to be paid by the insurer. A client-paid fee not to exceed $675.50 is approved.

June 28, 1990 Cite as 42 Van Natta 1360 (1990)

In the Matter of the Compensation of
KATHLEEN PEARCE, Claimant
WCB Case No. 88-19344
ORDER ON REVIEW
Richard A. Sly, Claimant Attorney
Terrall & Miller, Defense Attorneys

Reviewed by Board Members Brittingham and Nichols.

Claimant requests review of Referee Bennett's order that upheld the insurer's denial of her claim for injury to the left foot on the grounds the claim was untimely. On review, the issue is timeliness of the injury claim and compensability. We reverse.

FINDINGS OF FACT

We adopt the Referee's "FINDINGS".

FINDINGS OF ULTIMATE FACT

The Port of Portland (Port) and Barrett Business Services (Barrett) were joint employers of claimant at the time of injury.

Claimant's employer had knowledge of claimant's left foot injury within 30 days after the injury.

Claimant's left foot injury while working for the Port materially contributed to her fracture.

CONCLUSIONS OF LAW AND OPINION

Timeliness of Claim

ORS 656.265 excepts a claimant from providing written notice of an injury to the employer within 30 days if: (1) the employer otherwise had notice of the injury; (2) the employer is not prejudiced by failure to receive notice; or (3) the notice is given within one year and the worker had good cause for failure to give notice. The Referee found that claimant had mentioned her injury to her immediate supervisor at the Port on August 20, 1987, the day after she was injured, but did not notify Barrett until July 16, 1988. The Referee concluded that claimant's claim was not compensable because Barrett was prejudiced and because claimant did not have good cause for failure to give notice within 30 days.

Claimant argues that the employer had timely notice because claimant informed her supervisor at the Port of her injury on the day after it happened. Barrett argues that notice was not timely because it did not receive written notice of claimant's injury until September 1988.

Claimant informed her immediate supervisor at the Port of her injury the day after it occurred. Knowledge of an injury by individuals in supervisory positions may be imputed to the employer. See Colvin v. Industrial Indemnity, 301 Or 743, 745-46 (1986). Thus, we conclude that the Port had knowledge of claimant's injury.

We further conclude that the Port's knowledge of the injury should be imputed to Barrett. For purposes of workers' compensation, an employee can have more than one employer. ORS 656.005(13) and (27); Blacknall v. Westwood Corp., 89 Or App 145, 147-48 (1987); Robert J. Hunt, 42 Van Natta 1047 (1990). Barrett conceded at hearing that Barrett and the Port were joint employers of claimant. (Tr. 4). Where a joint employee suffers a compensable injury, both employers are fully responsible for the employee's injury. Mission Insurance Co. v. Miller, 73 Or App 159, 163 (1985); Robert J. Hunt, supra. Imputing the Port's knowledge of the injury to Barrett is consistent with this policy of joint responsibility.

The fact that claimant was instructed to notify Barrett of an injury is immaterial. The court has held that notice need not be given to the individual actually responsible for processing claims for the employer. See Colvin, supra. Similarly, we conclude that notice to either of two joint employers is sufficient, regardless which employer actually is responsible for processing claims. Thus, we find this claim is not barred for failure to give timely notice of the injury directly to Barrett.

Compensability

Claimant contends that her left foot fracture is compensably related to her 1987 injury. In order to prevail, claimant must establish that her compensable injury was a material cause of the fracture. Dr. Wilson, orthopedic consultant, compared the x-rays taken on September 14, 1987, less than a month after claimant's injury, with x-rays taken on May 9, 1988, when the fracture was diagnosed, and with x-rays taken on July 13, 1988. Wilson found an indistinct

fracture of the left medial sesamoid of claimant's left great toe in the 1987 x-rays that was much more visible in May 1988 and that had even greater widening by July 1988. Wilson connected the fracture to claimant's injury of August 19, 1987. He was supported in his conclusion by Dr. Schoen, orthopedist. This conclusion is consistent with claimant's history of continuing pain and discomfort since her 1987 injury. As a result, we conclude that claimant's industrial injury of August 19, 1987 was a material contributing cause of her left foot fracture. Accordingly, we find it compensable.

ORDER

The Referee's order dated March 8, 1989 is reversed. The insurer's denial is set aside and the claim is remanded to the insurer for processing according to law. For services at hearing and on review, claimant's attorney is awarded an assessed fee of $3,000, payable by the insurer. The Board approves a client-paid fee, not to exceed $1,236, payable by the insurer to its counsel.

June 28, 1990 Cite as 42 Van Natta 1362 (1990)

In the Matter of the Compensation of
DAWN PENDLETON, Claimant
WCB Case No. 88-12450
ORDER ON REVIEW
Black, et al., Claimant Attorneys
David Schieber (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

Claimant requests review of Referee Mongrain's order that upheld the SAIF Corporation's partial denial of her temporomandibular joint (TMJ) condition. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

The Board adopts the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

The Board adopts the Referee's conclusions of law and opinion as set forth in the "Conclusions" section of the Opinion and Order, with the following supplementation.

In the absence of fraud, misrepresentation or other illegal activity, an insurer who accepts a claim for compensation may not later deny the same claim. Bauman v. SAIF, 295 Or 788, 794 (1983). The Bauman rule applies only to a claim 'specifically' or 'officially' accepted by the insurer. Johnson v. Spectra Physics, 303 Or 49, 52 (1987).

On review, claimant argues that on her 801 form, she indicated that the body part affected was "all" (her entire body). Claimant contends that because SAIF accepted the claim by issuing a form 1502 on May 21, 1987, without specifying which conditions were accepted, the TMJ condition was also accepted. We do not agree that SAIF failed to specify the accepted condition.

In a Notice of Claim Acceptance dated May 19, 1987, SAIF notified claimant that her claim had been accepted for a "lumbar sprain condition." No other conditions were listed in the acceptance. Under the circumstances, we

conclude that SAIF's specific acceptance of a lumbar sprain condition does not preclude its denial of claimant's TMJ condition under Bauman.

ORDER

The Referee's order dated December 22, 1988, as reconsidered March 6, 1989, is affirmed.

June 28, 1990 Cite as 42 Van Natta 1363 (1990)

In the Matter of the Compensation of
JESUS S. SERNA, Claimant
WCB Case No. 88-15601
ORDER ON REVIEW
Black, et al., Claimant Attorneys
Cowling & Heysell, Defense Attorneys

Reviewed by Board Members Cushing and Myers.

Claimant requests review of that portion of Referee Mongrain's order which dismissed his hearing request concerning penalties and attorney fees for the insurer's alleged unreasonable claim closure. On review, the issues are timeliness and penalties and attorney fees. We reverse.

FINDINGS OF FACT

Claimant sustained a compensable injury to his right hand in December 1985. The injury ultimately resulted in an amputation of one of the fingers on his right hand. In March 1986, the insurer issued a Notice of Closure awarding temporary disability benefits through January 14, 1986.

On June 10, 1986, a Determination Order issued which set aside the insurer's Notice of Closure.

In April 1988, a Determination Order closed claimant's claim and awarded 20 percent scheduled permanent disability for loss of use or function of the right hand. Claimant requested a hearing on this Determination Order. In his request for hearing, claimant also raised the issue of penalties and attorney fees alleging that the March 1986 Notice of Closure was unreasonable.

The Referee dismissed the request for hearing concerning the penalty and attorney fee issue on the basis that it was untimely filed.

CONCLUSIONS OF LAW AND OPINION

The Referee dismissed claimant's hearing request concerning penalties and attorney fees on the basis that it was untimely. We disagree.

Former ORS 656.268(3), which was in effect at the time the insurer issued its March 1986 Notice of Closure, allowed an insurer or a self-insured employer to close a claim if claimant had become medically stationary and if the claim was disabling but without permanent disability. That section also provided a method by which an insurer or a self-insured employer would be liable for penalties if the closure was adjudged unreasonable.

The relevant section of former ORS 656.268(3) provides:

> "If an insurer or self-insured employer has closed a claim pursuant to this subsection, if the reasonableness of that closure decision is at issue in a hearing on the claim and if a finding is made at the hearing that the closure decision was not supported by substantial evidence, a penalty shall be assessed against the insurer or self-insured employer and paid to the worker in an amount equal to 25 percent of all compensation determined to be owing between the date of original closure and the date upon which the claim is closed by determination order. The penalty shall not be less than $500."

A clear reading of the subsection reveals that a claimant may raise the issue of reasonableness of an insurer's or a self-insured employer's closure "in a hearing on the claim." The subsection does not provide any time limitation in which such an issue must be raised. Here, the March 1986 Notice of Closure was set aside by the June 1986 Determination Order. The claim was not closed until the April 1988 Determination Order issued. Thereafter, claimant requested a hearing, which raised, among other issues, the reasonableness of the insurer's March 1986 claim closure. Under these circumstances, we conclude that claimant's request for hearing concerning penalties and attorney fees for an alleged unreasonable claim closure was timely and was properly before the Referee.

As we find the record to be fully developed, we proceed to the merits of the penalty and attorney fee issue.

At the time the insurer issued its Notice of Closure, reports and chart notes from claimant's treating physician indicated that claimant was not medically stationary. Further, claimant had undergone partial amputation of three fingers and had a loss of grip strength. There is no contrary evidence. Under these circumstances, we conclude that the insurer's Notice of Closure was not supported by substantial evidence. In fact, all evidence available to the insurer supports a conclusion that claimant was not medically stationary. Accordingly, the Notice of Closure was not reasonable and claimant is entitled to a penalty equal to 25 percent of all compensation owing between the March 1986 Notice of Closure and the April 1988 Determination Order.

We further conclude that the issuance of the March 1986 Notice of Closure constituted unreasonable resistance to the payment of compensation. Therefore, claimant's counsel is entitled to an assessed attorney fee. ORS 656.382(1); Lloyd L. Cripe, 41 Van Natta 1774 (1989).

ORDER

The Referee's order dated December 16, 1988, as amended April 4, 1989, is reversed. Claimant is awarded a penalty equal to 25 percent of all compensation owing between the March 28, 1986 Notice of Closure and the April 5, 1988 Determination Order or $500, whichever is greater. As a penalty-related attorney fee, claimant's counsel is awarded a reasonable assessed fee of $900, payable by the insurer. A client-paid fee, not to exceed $370, is approved, payable by the insurer to its counsel.

In the Matter of the Compensation of
LOREN P. CURTIS, Claimant
WCB Case No. 88-12404
ORDER ON REVIEW
Phil Ringle Jr., Claimant Attorney
Chelsea Mohnike (Saif), Defense Attorney

Reviewed by Board Members Nichols and Brittingham.

The SAIF Corporation requests review of Referee Peterson's order which: (1) found that claimant had established "good cause" for an untimely hearing request; (2) set aside its partial denial of claimant's low back condition; and (3) assessed penalties and attorney fees for an unreasonable denial. On review, the issues are good cause for an untimely hearing request, and alternatively, compensability, penalties and attorney fees. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's "Findings of Facts" with the following supplementation.

Claimant's parent's address was his mailing address, but was not claimant's last known residential address.

FINDINGS OF ULTIMATE FACT

Claimant had good cause for filing a late request for hearing.

Claimant's compensable knee injury was a material contributing cause of his low back disability and need for treatment.

The SAIF Corporation's denial of claimant's low back condition was not unreasonable.

CONCLUSIONS OF LAW AND OPINION

Timeliness of Hearing Request

SAIF asserts that the Referee erred by hearing claimant's case as the request was filed untimely and without good cause. Claimant responds that extenuating circumstances existed -- he never received the denial notice.

The test for determining if good cause exists has been equated with the standard of "mistake, inadvertance, surprise or excusable neglect" under ORCP 71B(1) and former ORS 18.160. Anderson v. Publishers Paper Co., 78 Or App 513, 517, rev den 301 Or 666 (1986); see also Brown v. EBI Companies, 289 Or 455 (1980). Claimant has the burden of proving good cause. Cogswell v. SAIF, 74 Or App 234, 237 (1985). We find that claimant has met his burden.

Here, claimant moved frequently, and therefore, provided a mailing address to SAIF. His father received and signed for the March 14, 1988 certified denial letter from SAIF. After that, he does not remember what he did with it. Claimant testified that he never received the denial letter. His testimony is corroborated by the chart notes of his treating physician, Dr. Hoppert. The Referee found claimant's testimony to be credible, and, on review, we find no reason to disturb that finding.

The negligence of a non-attorney may be excusable neglect. Here, claimant's father was not charged with the responsibility for recognizing and correctly handling a message of denial that constituted legally crucial notice from which time to respond was measured. See Brown v. EBI Companies, supra at 460. Accordingly, we find that, despite reasonable diligence, claimant did not receive actual notice of denial until August 16, 1988, when he was informed by his treating physician that his bill for his back surgery was outstanding and that SAIF had denied his claim. Claimant contacted an attorney the following day and filed a request for a hearing. Under these circumstances, we conclude that claimant could not reasonably be expected to file a request for hearing on the denial prior to that date. Accordingly, we find good cause for his delay in filing the hearing request. See Giusti Wine Co. v. Adams, 102 Or App 329 (1990). The hearing request is not barred. See ORS 656.319(1)(b).

Compensability

In order to establish the compensability of his low back condition, claimant must prove that his compensable knee injury was a material contributing cause of his low back disability and need for treatment. Hutcheson v. Weyerhaeuser, 288 Or 51 (1979). Claimant has the burden of proving his contentions by a preponderance of the evidence. Id. We find that claimant has carried his burden of proof.

Dr. Hoppert, claimant's treating orthopedic surgeon, concluded that claimant's low back problem developed while claimant was performing physical therapy to rehabilitate his knee following his fourth knee surgery. There is no contrary opinion in the file. The Orthopaedic Consultants performed an extensive independent medical examination, but were unable to determine whether claimant's back condition was related to his compensable knee condition or not.

SAIF proposes the alternative theory that claimant injured his back in a motor vehicle accident in August 1987. We are not persuaded by this argument. SAIF presents no evidence to support this theory. The hospital Emergency Room [ER] records at the time of the car accident show that claimant reported no back/spine problems. The examination performed by the ER physician noted no signs of a back problem or injury.

SAIF further contends that the onset of back problems seven months after claimant's last physical therapy [PT] session casts doubt on that therapy as the causative factor. The record in fact demonstrates that claimant engaged in strenuous, perhaps too strenuous, activity as a part of his home-designed PT program after the completion of his formal therapy sessions. Dr. Hoppert's chart notes show that claimant was still exercising at home as of December 15, 1987.

In summary, there are no medical reports which attribute claimant's back condition to anything other than his compensable knee injury. Accordingly, we conclude that claimant has proven the compensability of his back condition.

Penalty and Attorney Fees

Penalties and attorney fees may be assessed when a carrier "unreasonably delays or unreasonably refuses to pay compensation." ORS 656.262(10); 656.382(1). The reasonableness of a carrier's denial of compensation must be gauged based upon the information available to the carrier at the time of its denial. Brown v. Argonaut Insurance Co., 93 Or App 588 (1988); Price v. SAIF, 73 Or App 123, 126 n. 3 (1985).

The Referee found the employer's denial of claimant's low back condition to be unreasonable. He relied on the fact that the treating orthopedic surgeon causally related claimant's low back disc to his physical therapy to rehabilitate his knee, and the fact that there was no contrary medical opinion. We, however, do not consider the denial to have been unreasonable.

We have set aside the denial. Nevertheless, we find that, at the time of its March 1988 denial, SAIF had a legitimate doubt concerning whether claimant's low back condition was materially related to his compensable knee condition. At that time, SAIF had received the Orthopaedic Consultants' report in which they stated that they were unable to ascertain whether there was a relationship between claimant's compensable knee injury and his low back difficulties. Further, there was information in the file that claimant had been involved in a motor vehicle accident in August 1987, at which time his car hit a pole and turned over.

Under these circumstances, we do not find SAIF's denial to have been unreasonable. The uncertainty regarding causation as reported by the Orthopaedic Consultants and the intervening automobile accident did cast doubt on whether claimant's compensable knee injury was a material contributing cause of his low back condition. See Brown v. Argonaut Insurance Co., supra. Accordingly, penalties and attorney fees are not warranted.

ORDER

The Referee's order dated December 1, 1988 is affirmed in part and reversed in part. That portion of the order which assessed penalties and related $200 attorney fee for unreasonable denial is reversed. The remainder of the order is affirmed. For services on review, concerning the good cause and compensability issues claimant's attorney is awarded an assessed fee of $800, payable by the SAIF Corporation.

June 29, 1990 Cite as 42 Van Natta 1367 (1990)

In the Matter of the Compensation of
DENNIS L. EDDY, Claimant
WCB Case No. 86-03730
ORDER ON REVIEW
Wilbur C. Smith, Jr., Claimant Attorney
Thomas M. Sheridan (Saif), Defense Attorney

Reviewed by Board Members Brittingham and Nichols.

The SAIF Corporation requests review of Referee Leahy's order which granted permanent total disability, whereas a Determination Order awarded 24 percent (76.8 degrees) unscheduled permanent disability for a low back injury. On review, the issue is permanent total disability. We reverse.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact," except his finding that there is no job claimant can do without retraining. In addition, we supplement with the following findings of fact.

An October 1986 EMG was indicative of S1 and left L4-5 nerve root involvement. A subsequent December 1986 MRI revealed a non-surgical L4-5 disc with diffuse bulging, but without evidence of herniation or impingement of the nerve

roots. A myelogram performed in May 1987 confirmed diffuse L5-S1 disc bulging without neural compression.

Claimant was medically stationary in December 1987. At that time, he had 50 percent decreased range of motion in all directions, muscle spasm, and referred right leg pain. There was no evidence of sensory, motor, or neurological deficits.

A Determination Order issued August 29, 1988, awarding claimant 24 percent unscheduled permanent partial disability.

Claimant has mild to moderate impairment and can lift up to 35 pounds. He should avoid repetitive bending and stooping, and sitting or standing for more than two hours at a time.

Claimant has an underlying hysterical and passive-aggressive personality disorder, and is overfocused on his physical problems. Nevertheless, claimant does not have any psychological problem as a consequence of this injury. Claimant has refused pain medication and pain clinic therapy.

SAIF offered claimant vocational rehabilitation services from January 1985 through the date of the hearing. Claimant refused three training opportunities that were specifically medically approved for him.

ULTIMATE FINDINGS OF FACT

Claimant is not totally incapacitated from a medical standpoint alone.

Claimant has not made reasonable efforts to secure employment at a suitable, gainful occupation as evidenced by his lack of cooperation with vocational rehabilitation assistance.

It would not be futile for claimant to seek regular, gainful employment.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that, based on the vocational consultant's testimony, there was no job claimant could do without some training. Therefore, he found claimant permanently totally disabled as of the date of hearing. We disagree.

In order to establish permanent total disability, claimant must prove either that: (1) he is completely physically disabled and therefore precluded from gainful employment; or (2) his physical impairment, combined with a number of social and vocational factors, effectively prohibit gainful employment under the "odd-lot" doctrine. Welch v. Banister Pipeline, 70 Or App 699, 701 (1984), rev den 298 Or 470 (1985); Wilson v. Weyerhaeuser, 30 Or App 403 (1977).

Claimant has mild to moderate physical impairment and can lift up to 35 pounds. He should avoid repetitive bending and stooping, and sitting or standing for more than two hours at a time. All the examining physicians, with the exception of former treating chiropractic physician Dr. Peterson, have opined that claimant is capable of performing at least light work.

Although the Board generally gives greater weight to the conclusions of a treating physician, it will not do so 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). In this case, there are persuasive reasons not

to do so. Dr. Peterson's reports consist primarily of a recitation of symptoms without supporting objective findings, and are largely conclusory. Somers v. SAIF, 77 Or App 259, 262 (1986). In contrast, the medical reports of Drs. Brett, Jones, Logan, and Bergquist are well-reasoned and based on complete information. Thus, greater weight will be given to their medical opinions. Id.

Accordingly, we conclude that claimant is not completely physically disabled and not totally precluded from employment on medical grounds alone. We must, therefore, determine whether claimant is permanently and totally disabled under the "odd-lot" doctrine.

The nonmedical factors to be considered in an "odd-lot" analysis include age, education, adaptability to nonphysical labor, mental capacity and emotional condition, as well as the conditions of the labor market. Welch, supra, 70 Or Ap at 701; Livesay v. SAIF, 55 Or App 390, 394 (1981). Because application of an "odd-lot" analysis presupposes some capacity for employment, an injured worker is statutorily required to be willing to work and to make reasonable efforts to find work, although he need not engage in job seeking activities that, in all practicality, would be futile. ORS 656.206; SAIF v. Simpson, 88 Or Ap 638, 641 (1987); Welch, supra.

If claimant is unable to perform any gainful jobs without retraining, he may be found to be permanently totally disabled. The Referee relied on the opinion of Mr. Lenihan, a vocational consultant who testified at hearing regarding claimant's ability to work and his need for retraining. His testimony was inconsistent and contradictory as to whether claimant could perform entry level work with or without retraining. Mr. Lenihan admitted that there might be entry level minimum wage jobs that claimant could perform, yet he also stated that claimant needed retraining. When asked specifically whether claimant could perform an entry level job such as parking lot attendant, he acknowledged that claimant might be able to perform such a job, but that the wages would not be satisfactory to claimant. Considering the equivocal nature of the vocational consultant's testimony, we find that the Referee should not have relied on it in determining that claimant requires training in order to be employable at regular gainful work.

Claimant testified that he is willing to seek work. However, he has engaged in no job search activities, and has refused to contact prospective employers since his injury. Claimant believes that his pain is so debilitating that he is not capable of work or training. However, his own perception of futility, while probative, is not controlling. Objective medical findings do not support claimant's extreme pain behavior. His subjective complaints and pain behavior are exaggerated. Moreover, the record does not establish the presence of any compensable emotional or mental disorder that would limit claimant's ability to seek work or participate in vocational training.

Claimant was 47 years old at the time of the hearing and has a high school education. Vocational tests indicated that he has good reading and math skills and above average learning abilities. All the examining physicians recommended vocational retraining and return to work. Three programs were specifically medically approved for claimant. Claimant cooperated in none of those efforts.

It is possible that claimant's concern about his ability to be trained and obtain and hold employment might have proven accurate. However, claimant has not made a persuasive case as to why he has not made a bonafide attempt at either the job offer or the offered training programs that were within his physical restrictions. Even if claimant needs retraining, he is not entitled to permanent total disability when he unreasonably refuses to undertake or complete

an offered course of vocational rehabilitation. Taylor v. SAIF, 67 Or App 193, 195-96 (1984); Steven E. Puttie, 40 Van Natta 1069, 1072 (1988).

Accordingly, we find that it would not have been futile for claimant to make reasonable efforts to obtain employment by cooperating in vocational assistance efforts. We further conclude that claimant has neither made reasonable efforts to obtain work, nor demonstrated that he is willing to work. Consequently, he is not entitled to an award of permanent total disability.

Claimant makes no argument on review for an increase in his unscheduled permanent partial disability award. SAIF makes no argument for reduction. While we calculate a different degree of unscheduled permanent partial disability than did the Referee, we decline to adjust the award where neither party requests us to do so. Jimmie C. Ward, 42 Van Natta 1265 (1990); Lyndia M. Bristol, 42 Van Natta 1069 (1990).

ORDER

The Referee's order, dated December 16, 1988, is reversed. The Determination Order is reinstated and affirmed.

June 29, 1990 Cite as 42 Van Natta 1370 (1990)

In the Matter of the Compensation of
BUD E. GOLDEN, Claimant
WCB Case No. 88-02483
ORDER ON REVIEW
Roger Rook, Claimant Attorney
Jerome Larkin (Saif), Defense Attorney

Reviewed by Board Members Brittingham and Nichols.

Claimant requests review of Referee Hoguet's order that declined to grant scheduled permanent disability for loss of use or function of the feet. On review, the issue is extent of scheduled permanent partial disability. We reverse.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact", with the exception of the sentence, "He has had no breakdown of his scar tissue since before last seeing Dr. Pulito," in the last paragraph of this section on page 2 of the order. We make the following supplemental findings.

In January 1988 claimant experienced a breakdown of the skin of both feet in the scarred areas. Treating surgeon Pulito treated him with antibiotics, and claimant was absent from work. The irritation occurred because he had worn rubber boots on the job, which chafed his skin and caused his feet to sweat. At present, claimant wears tennis shoes to work because they let his feet breathe. On occasion he will wear rubber boots, but not for a whole day. Claimant had no further skin irritation between Dr. Pulito's final examination in March 1988 and the hearing.

FINDINGS OF ULTIMATE FACT

Claimant has a 10 percent loss of use or function of each foot as a result of his compensable injury.

CONCLUSIONS OF LAW AND OPINION

Claimant argues that he has a loss of use or function in his feet, greater in the right, because of tingling in his feet and the fragility of the scar tissue, which claimant must be aware of and protect. SAIF argues that claimant has not proven a permanent loss of use or function of his feet, because claimant had no loss of range of motion and Dr. Pulito's assessment of "mild" impairment was conclusory. The Referee declined to award scheduled permanent partial disability for injury to claimant's feet because claimant had no problems with skin breakdown between March 1988 and the hearing, and because the Referee was not convinced that the tingling and aching in claimant's feet resulted in any loss of use or function or reached a compensable level of disabling pain. We disagree with the Referee's conclusion.

In his assessment of March 1988, Dr. Pulito, claimant's treating doctor, found claimant had no loss of range of motion. Dr. Pulito reported no sensory loss or pain. However, Pulito found mild impairment because claimant's scar tissue is susceptible to breakdown if rubbed or irritated.

Under the rules applicable in this case, an award is permitted for skin conditions affecting the extremities based on the actual functional loss, rather than the extent of cosmetic or cutaneous involvement. Former OAR 436-65-555(8) & 436-65-530(7). A worker belongs in Class 1 (0-5 percent impairment of the radical) "when (a) signs and symptoms of skin disorder are present; AND (b) with treatment there is minimal limitation in function, although certain physical and/or chemical agents may temporarily increase the extent of functional limitation." Former OAR 436-65-530(7)(a). A worker belongs in Class 2 (15 percent impairment of the radical) "when (a) signs and symptoms of skin disorder are present; AND (b) intermittent treatment is required; AND (c) there is limitation in some of the radical's functions." Former OAR 436-65-530(7)(b).

We are persuaded by Dr. Pulito's report that the scar tissue on claimant's feet is susceptible to breakdown if rubbed or irritated. As a result, claimant is limited in the kind of footwear he can wear, in order to protect his fragile skin. It is true that claimant had no skin breakdown during the year prior to hearing, but he was careful not to wear rubber boots for extended periods.

As we apply the rule, we find claimant's scarred skin is a sign of a skin disorder. With treatment, there is minimal limitation in function, in that he is limited in his footwear. In addition, certain physical and chemical agents (rubbing of boots; sweating) increase the extent of functional limitation. We find claimant to fall between Class 1 and Class 2. Accordingly, we find claimant has a 10 percent loss of use and function of each foot.

ORDER

The Referee's order dated March 29, 1989 is reversed. Claimant is awarded 10 percent (13.5 degrees) scheduled permanent disability for loss of use or function in each foot. Claimant's attorney is allowed an approved fee in the amount of 25 percent of the increased compensation awarded by this order, not exceeding $3,800, payable by the SAIF Corporation directly to claimant's attorney.

In the Matter of the Compensation of
DARCY M. GREENE, Claimant
WCB Case No. 88-14042
ORDER ON REVIEW
Malagon, Moore, et al., Claimant Attorneys
H. Thomas Andersen (Saif), Defense Attorney

Reviewed by Board Members Nichols and Brittingham.

The SAIF Corporation requests review of Referee Howell's order that increased claimant's unscheduled permanent disability award for headache, neck and low back problems from 14 percent (44.8 degrees), as awarded by a Determination Order, to 22 percent (70.4 degrees). The issue on review is extent of unscheduled permanent disability. We modify.

FINDINGS OF FACT

The Board adopts the Findings of Fact of the Referee with the exception of those findings relating to the loss of cervical extension and loss of right lateral cervical flexion referred to in the third full paragraph on page 2 of the order.

CONCLUSIONS OF LAW AND OPINION

SAIF does not dispute the Referee's findings and conclusions on age, education and adaptability as they relate to determining claimant's disability. Therefore, we adopt the Referee's conclusions regarding those factors that contribute to claimant's loss of earning capacity.

SAIF only disputes the rating given to the impairment factor. SAIF contends that the Referee cannot arbitrarily assign a value for pain. The Board has found that pain which results in loss of use or function is a factor which should be considered when determining the value for impairment. Daniel M. Alire, 41 Van Natta 752 (1989). We conclude that the +10 value the Referee awarded for disabling pain is an appropriate measure of claimant's loss of use or function from her low back pain.

SAIF additionally argues that for claimant to receive any value for loss of range of motion, that loss must be verified by medical reports. In this matter, the Referee accepted the credible testimony of claimant and relied on his own observation to support his finding that claimant had lost range of motion of her cervical spine.

The Board has previously held that claimant's testimony can be considered with respect to a determination of degrees of active motion. Linda Young, 41 Van Natta 1070 (1989). The rules which were in effect at the time of this hearing, former OAR 436-35-001 et seq., do not specifically limit the loss of motion to only those measured by a physician. We are not willing, however, to adopt a policy that would allow referees to make range of motion findings based on their observations at hearings. Referees, for the most part, are not trained in how to measure loss of range of motion in degrees, and the consistency and appropriateness of their findings could vary considerably from what a physician may find.

Additionally, this matter differs from Linda Young, supra, in that here there is no medical evidence of loss of cervical extension or right lateral flexion. Rather, the only evidence of reduced motion is claimant's testimony that she had restrictions on her range of motion and her demonstration of that restriction by moving her head and neck at hearing. Unlike Young, claimant's

testimony and demonstration did not substantiate a medically verified loss. For the same reason we are unwilling to accept the Referee's assignment of degrees of loss of motion, we are also unwilling to accept claimant's unsubstantiated testimony as to specific degrees of loss of motion.

Claimant's impairment thus does not include any value for the loss of cervical extension or the loss of right lateral cervical flexion. The remaining loss of motion findings mentioned in the medical reports would equal a 2 percent impairment value, which when combined with the value for disabling pain of 10 percent, equals a total impairment value of 12 percent. This value, when added to the other values that are considered in rating claimant's unscheduled disability results in a total award of 20 percent.

ORDER

The Referee's order dated December 8, 1988 is modified. In lieu of the Referee's award and in addition to the 14 percent (44.8 degrees) unscheduled permanent disability awarded by the Determination Order, claimant is awarded 6 percent (19.2 degrees) unscheduled permanent disability, giving her a total award to date of 20 percent (64 degrees) unscheduled permanent disability for her headache, neck and low back problems.

June 29, 1990 Cite as 42 Van Natta 1373 (1990)

In the Matter of the Compensation of
DORIS L. HICKS, Claimant
WCB Case No. 88-13208
ORDER ON REVIEW
Francesconi & Associates, Claimant Attorneys
Tom Ewing (Saif), Defense Attorney

Reviewed by Board Members Nichols and Brittingham.

Claimant requests review of Referee St. Martin's order that affirmed a Determination Order which made no award of permanent partial disability for her neck, right shoulder, arm or hand. On review, the issue is extent of scheduled and unscheduled permanent partial disability. We reverse in part and affirm in part.

FINDINGS OF FACT

The Board accepts the Referee's "Findings" with the following supplementation.

Claimant was 39 years old at the time of hearing. She has 14 years of education. There is no documentation demonstrating competence in any vocational pursuit. Claimant successfully achieved her highest level of "SVP" proficiency of 5 while working as a patient insurance clerk. She has returned to regular work.

Claimant suffers from disabling pain in her right neck and shoulder which restricts her to 30 minutes of standing, sitting and walking, and from lifting over ten pounds with her right arm. She is also unable to perform housework without taking breaks.

Claimant became medically stationary as of January 25, 1988.

FINDINGS OF ULTIMATE FACT

Claimant has no lost use or function in her right hand and arm as a result of her compensable injury.

Claimant has sustained a 5 percent loss of earning capacity as a result of her compensable neck and right shoulder injury.

CONCLUSIONS OF LAW AND OPINION

The Referee, relying on the opinion of Dr. Larson, the Orthopaedic Consultants and Dr. Pasquesi, held that claimant had not established that she has suffered permanent disability as a result of her industrial injury. We disagree.

If a claimant became medically stationary after January 1, 1988 and his or her claim was closed on or after July 1, 1988, a subsequent determination by a referee or the Board of the claimant's permanent partial disability must be made pursuant to ORS 656.283(7) and 656.295(5), respectively. OAR 438-10-005 and Michelle Griffith, 40 Van Natta 2086 (1988).

For purposes of determining injury-related permanent partial disability, ORS 656.283(7) and 656.295(5) require application of the standards for the evaluation of disabilities adopted by the director pursuant to ORS 656.726(3)(f)(A). Those "standards" in effect on the date of the Determination Order from which the hearing was requested control the evaluation of permanent partial disability. OAR 438-10-010.

In this case, claimant became medically stationary on January 25, 1988 and the Determination Order issued July 27, 1988. Therefore, the "standards" adopted effective July 1, 1988, former OAR 436-35-001 et seq., apply to the rating of claimant's permanent partial disability. Former OAR 436-35-010 through 436-35-260 apply to the rating of scheduled permanent partial disabilities. Former OAR 436-35-010(1). Former OAR 436-35-270 through 436-35-440 apply to the rating of unscheduled permanent partial disabilities. Former OAR 436-35-270(1).

The hearing and Board review of the issue of permanent partial disability continues to be de novo on the hearing record. The underlying facts to which the "standards" are applied need only be established by a preponderance of the evidence.

Scheduled Disability

Claimant argues that she is entitled to an award of scheduled permanent partial disability for loss of use or function of her right arm and hand. She relies on her testimony that she suffers from disabling pain and the findings of Dr. Larson, Dr. Pasquesi and Dr. Long.

Claimant testified that she could not lift a 10-pound weight with her right hand as it had a pulling effect from her neck to her right wrist. She is able to pick up a phone, but with some discomfort. Claimant has to take breaks from housework, whereas before her injury she did not.

Dr. Larson's chart notes of March 27, 1987 through September 17, 1988 document that claimant reported pain in her right arm and hand. Dr. Long reported "[m]yofascial pain involving right pectoral girdle muscle groups, right triceps and right wrist and finger extensors. . ." Dr. Pasquesi found that abduction of claimant's right arm caused pain in her right trapezius region. He

also noted intermittent radiating pain from the neck to the dorsum of the thumb and index fingers.

The record contains no documentation of lost range of motion, loss of sensation, or other objective loss of use or function of the right arm and hand under the "standards." While claimant testified that it hurts to pick up a telephone, she can still perform this function. Although medical reports document arm and hand pain, there are no reports substantiating claimant's contention that the pain in her arm and hand is disabling. In particular, we are not persuaded that claimant's lifting restriction and need to take breaks while performing housework is attributable to her arm and hand pain, as distinct from pain in her neck and shoulder. The latter pain is separately compensated below with an award of unscheduled disability compensation.

We, therefore, conclude that claimant's arm and hand pain has not resulted in a loss of use or function. Former OAR 438-35-010(2)(a). Accordingly, claimant has not established that she has sustained a permanent loss of use or function of her right arm or hand under the standards.

Unscheduled Disability

Claimant argues that she is entitled to an award of unscheduled permanent disability due to her loss of earning capacity as a result of right neck and shoulder impairment.

The determination of unscheduled permanent partial disability under the "standards" is made by determining the appropriate values assigned by the "standards" to the claimant's age, education, adaptability and impairment. Once established, the values for age and education are added and the sum is multiplied by the appropriate value for adaptability. The product of those two figures is then added to the appropriate value for impairment to yield the percentage of unscheduled permanent partial disability. Former OAR 436-35-280.

Impairment

Claimant argues that she is impaired due to her disabling right neck and shoulder pain. As discussed above, she testified that she is unable to lift a 10-pound weight because of pulling from her neck to her wrist, and that she cannot perform housework without frequent breaks, which she did not need prior to her industrial injury.

Claimant has been seen by a number of physicians. Dr. Larson agreed with the Orthopaedic Consultants' opinion that claimant suffers from no impairment of her neck. Dr. Tyner noted right neck and shoulder pain, but was unable to determine whether claimant was impaired. Independent medical examiner Pasquesi believed that claimant is not impaired but noted intermittent radiation of pain from the neck into the shoulder. Dr. Long opined that, after claimant became medically stationary, she was minimally impaired with persisting pain in her right scapula. The Orthopaedic Consultants opined that she could return to work without restrictions. A physical capabilities evaluation on March 24, 1988 revealed that claimant is restricted to not more than 30 minutes of continuous sitting, standing or walking.

Former OAR 436-35-320(1)(a) provides that when pain results in a loss of use or function it is rated based on the amount of lost use or function resulting from the pain. Dr. Long and Dr. Pasquesi both found that claimant suffered from pain in her right neck and shoulder after she was declared medically stationary, and Dr. Long opined that the pain was minimally disabling. These

opinions, along with claimant's testimony, persuade us that claimant has suffered a 5 percent impairment due to disabling pain in her neck and shoulder.

Age, Education, Adaptability

The appropriate value for claimant's age of 30 years is 0. Former OAR 436-35-290.

Former OAR 436-35-300(2)(b) provides that for workers who have returned to their usual and customary work, the factor of education shall be given no value. Former OAR 436-35-310(2)(a) provides that the attending physician's release to usual and customary work shall be proof that a worker is completely adaptable to perform that given job. Claimant argues that she has returned to work in a modified capacity because Dr. Long placed restrictions on sitting, standing and walking. However, claimant's treating physician, Dr. Tyner, released claimant for regular work on January 11, 1988. Further, on August 19, 1988 claimant indicated on a work questionnaire that she had returned to full time regular work. In light of these facts, we find that claimant has returned to regular work. Claimant therefore is allowed no value for education or adaptability.

Computation of Unscheduled Disability

Having determined each value necessary to compute claimant's unscheduled permanent disability under the "standards," we proceed to that calculation. When claimant's age value 0 is added to her education value 0 the sum is 0. When that value is multiplied by claimant's adaptability value 0 the product is 0. When that value is added to claimant's impairment value 5 the result is 5 percent unscheduled permanent partial disability. Former OAR 436-35-280. Claimant's permanent disability under the "standards" is, therefore, 5 percent.

Clear and Convincing Evidence

Claimant argues that because she has returned to a modified position and has restrictions on sitting, standing and walking, she has established by clear and convincing evidence that her disability is more than is indicated by application of the "standards."

Either party may establish that the record, as a whole, constitutes clear and convincing evidence that the degree of permanent partial disability suffered by the claimant is more or less than the entitlement indicated by the "standards." ORS 656.283(7) and 656.295(5). That is, is the record as a whole highly persuasive, free from confusion, fully intelligible and distinct in indicating more or less disability than would be awarded under the standards? See Riley Hill General Contractor Inc. v. Tandy Corp., 303 Or 390, 407 (1987).

In light of the fact that claimant was released for regular work and is currently performing that work, we do not find clear and convincing evidence that claimant's disability is more or less than 5 percent. Claimant is entitled to an award of 5 percent unscheduled permanent partial disability.

ORDER

The Referee's order dated January 20, 1989, is reversed in part and affirmed in part. Claimant is awarded 5 percent (16 degrees) unscheduled permanent partial disability for her neck and shoulder. Claimant's attorney is awarded 25 percent of the increased compensation created by this order, not to exceed $3,800, payable directly to claimant's attorney. The remainder of the order is affirmed.

In the Matter of the Compensation of
DANIEL C. KING, Claimant
WCB Case Nos. 89-02298 & 89-02299
ORDER ON REVIEW
Saif Corporation, Insurance Carrier

Reviewed by Board Members Nichols and Brittingham.

Sea Coast Rental, Inc. (Sea Coast), an employer insured by the SAIF Corporation, requests review of Arbitrator Howell's order that dismissed an arbitration proceeding scheduled pursuant to ORS 656.307 on the grounds that SAIF, as insurer for Sea Coast, had accepted responsibility for claimant's injury claim for his current low back condition. On review, Sea Coast contends that SAIF did not act in Sea Coast's "best interests."

We affirm and adopt the order of the Arbitrator with the following supplementation.

As an "employer", Sea Coast is a party to this proceeding and may request Board review of the Arbitrator's dismissal order. See ORS 656.005(19); Hamid R. Amini, 42 Van Natta 188, 189 (1990). Consequently, we proceed with our review. ORS 656.295.

As the guaranty contract insurer for Sea Coast, SAIF has assumed the obligation to process claimant's injury claim under the Workers' Compensation law. See ORS 656.005(14); 656.419(1). Such obligations necessarily include the acceptance of the claim and the payment of benefits. ORS 656.262; OAR 436-60-140.

Here, SAIF, as Sea Coast's insurer, accepted claimant's injury claim and sought dismissal of the arbitration proceeding. As noted above, such an action is within SAIF's authority as an insurer. Thus, with SAIF's acceptance of the claim and no separate hearing request from claimant, the responsibility issue, as described in the Order Designating a Paying Agent under ORS 656.307, had been resolved. Inasmuch as no issue emanating from the ".307" order remained unresolved, we agree with the Arbitrator's decision to acknowledge SAIF's acceptance of the claim on behalf of Sea Coast and to dismiss the arbitration proceeding.

ORDER

The Arbitrator's order dated April 20, 1989 is affirmed.

In the Matter of the Compensation of
NANCY LUCAS, Claimant
WCB Case No. 88-14961
ORDER ON REVIEW
Merrill Schneider, Claimant Attorney
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

Claimant requests review of Referee Leahy's order that affirmed a Determination Order which did not award unscheduled permanent disability for her functional bowel syndrome condition. Claimant also moves for remand for the

further taking of medical evidence not available at the time of hearing. On review, the issues are unscheduled permanent disability and remand. We affirm.

FINDINGS OF FACT

Claimant was 45 years old at the time of hearing. She has a high school degree but does not have documented competence in a specific vocational pursuit. For the past ten years, claimant has held positions as a real estate sales manager, relocation coordinator, office manager in charge of inventory control, leasing manager, computer software tester and administrative assistant. Claimant has worked for the employer as a legal secretary since February 1987.

In September 1987, one of the partners and his secretary left claimant's law firm. Claimant was asked to perform additional duties and internal personality conflicts and financial problems within the firm increased.

During December 1987, claimant began to experience flu-like symptoms such as chills and loss of appetite. By January and February 1988, claimant was experiencing bowel symptoms, including diarrhea, cramps and constipation.

By March 1988, claimant had lost weight and her doctor diagnosed the condition as irritable bowel syndrome. She began taking medication which controlled her flu-like symptoms. When she stopped taking the medication, her symptoms returned and she began to lose weight.

In May 1988, SAIF accepted claimant's temporary functional bowel syndrome condition. An August 26, 1988 Determination Order awarded her temporary total disability benefits but did not award permanent disability.

Claimant was medically stationary on June 1, 1988. She has been released to work but has not returned to work.

CONCLUSIONS OF LAW AND OPINION

Remand

Claimant requests her case be remanded to the Referee for consideration of medical evidence that was not available at the time of hearing. We may remand a case 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 established that the evidence is relevant to the issues raised in the remand request and was unobtainable with due diligence before the hearing. Kienow's Food Stores v. Lyster, 79 Or App 416 (1986); Delfina P. Lopez, 37 Van Natta 164, 170 (1985).

Here, claimant has submitted documentation of recent hospitalization and subsequent medical reports. Claimant's treating doctor, however, has not changed his opinion about claimant's condition and the medical reports note that she is expected to improve and to be able to work.

Under the circumstances, we conclude that the record has been completely and sufficiently developed. Accordingly, claimant's request for remand is denied.

Unscheduled permanent disability

The Referee found that claimant had not suffered permanent loss of earning capacity and he concluded that she had no permanent disability. We agree with the Referee's finding that claimant has not shown that she is permanently impaired, but we base our conclusion upon the following reasoning.

In the present case, claimant was found medically stationary on June 1, 1988. The Determination Order issued August 26, 1988. Therefore, the "standards" adopted effective July 1, 1988, (former OAR 436-35-001 et seq), as amended by temporary rules effective August 19, 1988, apply to the rating of claimant's permanent partial disability. Former OAR 436-35-270 through 436-35-440 apply to the rating of unscheduled permanent partial disabilities. Former OAR 436-35-270(1).

Claimant argues that she is entitled to an award of permanent disability under former OAR 436-35-420(2). Claimant contends that she is entitled to an award of between 25-35 percent as provided in the standards for a Class 3 colonic or rectal impairment. Former OAR 436-36-420(2) provides that an impairment falls within Class 3 when there is objective evidence of colonic disease, disturbance of bowel habit accompanied by pain, restriction of activity, required special diet and drugs during attacks, and constitutional manifestations, such as weight loss.

Claimant was prescribed Amitriptyline, an anti-depressant, which she is required to take every day. When she attempted to decrease her dosage, her flu-like symptoms recurred. Claimant loses weight when she does not take the medication and she suffers from side effects of drowsiness and dry mouth. It has been recommended that she follow a special diet.

SAIF contends that claimant should not be rated under the standards as no doctor has opined that she is permanently impaired. In March 1988, Dr. Hill, M.D., reported that the results of a claimant's double contrast barium enema test were normal. In March 1988, claimant's treating doctor, Dr. Albaugh, M.D., diagnosed irritable bowel syndrome arising from work-related stress. Dr. Albaugh noted that claimant responded well to medication and he subsequently released her for work.

In April 1988, an independent medical examiner, Dr. Wrigley, M.D., reported that claimant had no more abdominal pain and her bowel movements were normal. He opined that claimant's condition should produce no lasting disability although it could recur with stress. Dr. Wrigley concluded that claimant had no permanent impairment and he reported that no work restrictions were necessary. He opined that claimant could develop symptoms if she was placed under marked stress and was not taking her prescription.

In October 1988, Dr. Albaugh reported that although claimant had irritable bowel syndrome, the condition was rarely disabling. Dr. Albaugh stated that he doubted that claimant's condition would adversely affect her job performance in the future.

Claimant's treating doctor has not opined that her impairment is permanent. Dr. Wrigley has concluded that claimant has no permanent impairment. The medical evidence convinces us that claimant has no permanent impairment and we, therefore, conclude that she is not entitled to an award of permanent disability under the standards.

ORDER

The Referee's order dated December 19, 1988 is affirmed.

In the Matter of the Compensation of
KEVIN L. NEILSEN, Claimant
WCB Case No. 88-15286
ORDER ON REVIEW
Goldberg, et al., Claimant Attorneys
Sharon Schooley (Saif), Defense Attorney

Reviewed by Board Members Nichols and Brittingham.

Claimant requests review of that portion of Referee Mulder's order that upheld the SAIF Corporation's denial of claimant's current post traumatic stress disorder condition. On review, SAIF relies on medical reports included in the record as Exhibits 18 and 20, that the Referee did not expressly admit into the record at hearing. On review, the issues are evidence and compensability. We reverse in part and affirm in part.

FINDINGS OF FACT

Claimant suffered multiple contusions and lacerations on September 27, 1984 when he was assaulted at work with a wire display unit. He was a clerk cashier in the family grocery business. Claimant was taken by ambulance to Emanuel Hospital emergency room, where he was treated and released.

On October 8, 1984, claimant was treated by Dr. Keppel, family practitioner. Claimant did not report any blackout spells to Dr. Keppel at that time. Claimant was next examined by Dr. Keppel on December 26, 1984, at which time he complained of blackout spells and headaches which had been occurring since his injury. An EMG, CT scan, and neurological examination were performed, all of which were normal. Claimant had not had blackout spells or headaches prior to his compensable injury.

The claim was closed by a Determination Order on March 27, 1985. Claimant was awarded temporary disability compensation only.

On June 3, 1986, claimant fell into the river and nearly drowned. Claimant was assaulted in a grocery store parking lot on June 29, 1987. He experienced a superficial injury to the head, chest and arms.

On March 2, 1988, Dr. Gostnell, Ph.D., clinical neuropsychologist, performed a neuropsychological assessment. Dr. Gostnell reported symptoms of dizziness, mild memory loss, reduced emotional control, flash-backs, headaches, chronic depression and suicidal thoughts.

A neuropsychological evaluation was performed at the Northwest Pain Center, on June 2, 1988. The Pain Center concluded that it was unlikely claimant could successfully return to the work force without some form of intervention. It was also recommended that claimant not return to his previous employment.

SAIF issued a denial of claimant's psychological condition and treatment on July 14, 1988. In the denial, SAIF stated that claimant's current need for treatment and his psychological condition were not causally related to his compensable 1984 injury.

FINDINGS OF ULTIMATE FACT

The Referee implicitly admitted Exhibits 18 and 20 into the record by relying on those exhibits in his order.

Claimant's current need for treatment is materially related to his compensable 1984 injury.

CONCLUSIONS OF LAW AND OPINION

Evidence

At the hearing the Referee stated that he would defer his ruling on the admissibility of Exhibits 18 and 20 until the end of the hearing. However, the Referee failed to formally admit these exhibits into evidence. Nevertheless, by relying on Exhibits 18 and 20 in his order, the Referee, in effect, admitted them into the record. Therefore, Exhibits 18 and 20 are properly part of the record and we rely on them in reaching our conclusion.

Compensability

The Referee found that claimant had not proven by a preponderance of the evidence that his psychiatric condition was materially related to his compensable injury. The Referee, in reaching his conclusion, relied on the opinions of Dr. Turco and the Northwest Pain Center, finding them more persuasive than Dr. Leung. We instead find the opinion of Dr. Leung more persuasive.

Dr. Gostnell, who performed a neuropsychological examination and administered the MMPI, opined that the results of the MMPI indicated an overall pattern similar to persons with chronic endogenous or psychotic depression, bipolar affective disorder, schizoid personality and hysterical conversion. Dr. Gostnell concluded that none of these diagnoses necessarily pertained to claimant, and he opined that claimant's subjective history was consistent with a post-concussion syndrome.

The Northwest Pain Center concluded, after examining claimant, that he had a chronic history of interpersonal difficulties and underachievement dating back to grade school. The report indicated that claimant had mild impairment in the area of attention and mental tracking as well as verbal memory and abstract reasoning. It was felt that he had a significant psychopathology. The differential diagnoses included schizophrenia and schizotypal personality disorder. The Pain Center opined that based on the known history it appeared that claimant's emotional behavior difficulties clearly preceded the September 1984 head injury. The Pain Center did not state specifically what part of claimant's "known history" they were referring to; nor did they address whether claimant's injury worsened his emotional problem.

Dr. Turco concurred with the evaluations and opinions of the Northwest Pain Center and Dr. Gostnell. Dr. Turco found that claimant had been a hyperactive child and that his current situation was essentially a continuation of a maladaptive problem. Dr. Turco diagnosed a mixed personality disorder with developmental deficits. Dr. Turco's differential diagnosis was schizotypal personality disorder. Dr. Turco found that claimant's psychopathology was not related to the injury of 1984, as he believed they were the result of claimant's maladaptive childhood. He did not expressly address whether claimant's injury aggravated his psychopathology.

Dr. Leung, Assistant Professor of Psychiatry at Oregon Health Sciences University, reviewed materials and interviewed claimant. Dr. Leung diagnosed chronic post-traumatic stress disorder. Dr. Leung opined that claimant's post-traumatic stress disorder, his inability to confront or to deal with complaints that come from customers, his inability to concentrate on even simple tasks, his impaired memory, and his overwhelming anxieties all affect his ability to work.

Moreover, Dr. Leung found that claimant did suffer from preexisting psychological difficulties which were definitely aggravated by his compensable injury. Dr. Leung, opined that claimant's present condition requires treatment and that claimant's compensable injury definitely contributed to his present difficulties.

We are not persuaded by the opinions of Dr. Turco and the Northwest Pain Center. Dr. Turco and the Northwest Pain Center did not explain why they believed claimant's psychological condition was not related to his compensable 1984 injury other than stating that they thought it was related to his "known history" or his maladaptive childhood. Nor did they comment on Dr. Leung's additional diagnosis of post-traumatic syndrome or otherwise address whether the compensable injury worsened claimant's psychopathology. Consequently, we find that their opinions are not well reasoned.

We, instead defer to Dr. Leung's opinion. Prior to rendering his diagnosis, Dr. Leung performed a complete review of the file and a thorough examination of claimant. In addition, Dr. Leung was aware of the potential contributions from the incidents in 1986 and 1987 (i.e. claimant's 1986 near drowning and his 1987 non-work related assault) but, nevertheless, found a material relationship between the compensable injury and claimant's condition. Moreover, Dr. Leung, while concurring with the diagnosis of preexisting psychological conditions, also diagnosed post-traumatic stress syndrome. This diagnosis is uncontroverted and consistent with claimant's history of increased psychological problems following the compensable injury. Accordingly, we find Dr. Leung's opinion is better reasoned and based upon more complete information. See Weiland v. SAIF, 64 Or App 810, 814 (1983).

Accordingly, we rely on Dr. Leung's opinion and find that claimant has proven by a preponderance of the evidence that his compensable 1984 injury is a material contributing cause to his current psychiatric condition and need for treatment.

ORDER

The Referee's order dated January 18, 1989, as amended February 24, 1989, is reversed in part and affirmed in part. The SAIF Corporation's denial is set aside and the claim is remanded to SAIF for further processing in accordance with the law. The remainder of the order is affirmed. For services at hearing and on review regarding compensability of the aggravation claim, claimant's attorney is awarded an assessed fee of $2,825, payable by SAIF.

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IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Beverly A. Bond, Claimant.

OAK CREST CARE CENTER et al,
Petitioners,

v.

BOND et al,
Respondents.

(WCB 86-17765; CA A61368)

Judicial Review from Workers' Compensation Board.

Argued and submitted January 17, 1990.

Karen O'Kasey, Portland, argued the cause for petitioners. With her on the brief was Schwabe, Williamson & Wyatt, Portland.

Brian R. Whitehead, Salem, waived appearance for respondent Beverly A. Bond.

Jenny A. Ogawa, Salem, argued the cause for respondent Oak Crest Care Center/Crawford Risk Management. With her on the brief was Kevin L. Mannix, P.C., Salem.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

RICHARDSON, P. J.

Reversed and remanded.

RICHARDSON, P. J.

Cigna Ins. Companies (Cigna) seeks review of a Workers' Compensation Board order that found it responsible for claimant's compensable back injury, because it had initially accepted the claim and could not issue a "back-up denial"[1] under *Bauman v. SAIF,* 295 Or 788, 670 P2d 1027 (1983). Cigna contends that *Bauman* should not apply and that Crawford & Company Risk Management (Crawford) is responsible, because it provided coverage at the time of injury. We reverse and remand.

Claimant suffered a back injury on January 5, 1985, while employed as a nurse at employer Oak Crest Care Center. Cigna had provided workers' compensation coverage for employer only until December 31, 1984. However, employer sent the 1985 claim to Cigna which accepted it on January 11, 1985, and began paying benefits.[2] In November, 1986, Cigna

[1] A back-up denial is a retroactive denial of a previously accepted claim. *Ebbtide Enterprises v. Tucker,* 303 Or 459, 461, n 1, 738 P2d 194 (1987).

[2] Claimant subsequently sought benefits for a hip condition that she claimed was compensable as a disability caused by her back injury. Cigna denied compensability for that condition, and the Board upheld the denial. Claimant sought review, and Crawford specifically agreed to assume responsibility to appear on the review. We ultimately upheld the denial. *Bond v. Oak Crest Care Center,* 91 Or App 186, 754 P2d 632 (1988).

discovered that its coverage for employer had terminated before the injury and that Crawford had provided coverage after January 1, 1985. Cigna issued a denial of responsibility on December 10, 1986, and transferred the file to Crawford. Crawford initially paid benefits but subsequently issued a denial based on its conclusion that "[Cigna's] denial of responsibility of December 10, 1986, is ineffective."

At a consolidated hearing on both denials, the referee held that, although a back-up denial is generally inappropriate, Cigna's denial was valid under *D Maintenance Company v. Mischke,* 84 Or App 218, 733 P2d 903, *rev den* 303 Or 483 (1987). He further concluded that Crawford was responsible for the claim, because it was on the risk on the date of the injury. He therefore set aside Crawford's denial and ordered it to accept the claim. The Board reversed the referee's order and ordered Cigna to accept the claim, because its

" 'backup' denial was invalid[.] Therefore, Cigna's acceptance

continued in force and was legally binding, and the duty to pay benefits continued to run. *Georgia[-Pacific v. Piwowar],* 305 Or 494, 502, [753 P2d 948] (1988). Inasmuch as Cigna's denial was invalid, the issue of Crawford's denial is rendered moot."

Cigna seeks review. It first contends that its back-up denial was valid and that Crawford is responsible, because Crawford was on the risk at the time of the injury. The Board relied on *Bauman v. SAIF, supra,* to make Cigna's denial invalid. In *Bauman,* the Supreme Court ruled that an insurer may not deny the compensability of a claim that it has previously accepted, even if the claim in fact arose from a noncompensable cause. That limitation also prohibits an insurer from denying *responsibility* for a claim, even if the claimant's benefits are not affected. *Ebbtide Enterprises v. Tucker,* 303 Or 459, 463, 738 P2d 194 (1987); *see also Jeld-Wen, Inc. v. McGehee,* 72 Or App 12, 695 P2d 92, *rev den* 299 Or 203 (1985). The consequence of those principles is that, once a claim is accepted, an insurer must continue to pay benefits unless and until someone else is determined to be responsible. *Retchless v. Laurelhurst Thriftway,* 72 Or App 729, 696 P2d 1181, *rev den* 299 Or 251 (1985).

Cigna contends its denial was appropriate, given our holding in *D Maintenance Company v. Mischke, supra.* In *Mischke,* the claimant sustained a compensable injury on March 31, 1983, and began receiving benefits from the at risk insurer soon thereafter. The employer subsequently moved its coverage to another carrier that agreed, as part of the policy, to provide retroactive coverage as of March 28. After discovering the new policy, the first insurer issued a denial and attempted to transfer the claim to the new carrier. The new carrier refused, because it concluded that the first insurer could not avoid coverage responsibility after it had accepted the claim.

In our review of the Board order, we explained that *Bauman* protects claimants against vacillation by an employer or an insurance carrier regarding acceptance of com-

pensability or responsibility. *D Maintenance Company v. Mischke, supra,* 84 Or App at 222. However, as between the two carriers, the only question was whether responsibility to provide coverage had shifted to the new carrier. We concluded that the second carrier was responsible for the claimant's

condition, given its agreement to provide coverage as of March 28 and ORS 656.419(1).[3]

Crawford contends that *D Maintenance Company v. Mischke, supra,* is inapplicable, because

> "the second insurer had already entered into a contract *before* the injury arose. Therefore, there was no acceptance of the claim by operation of law, and hence, the issues of compensability and responsibility remained potentially viable and subject to litigation." (Emphasis in original.)

As we made clear in *Mischke, Bauman* protects a claimant from vacillation on issues of compensability and responsibility. In other words, it prohibits denial of the merits of a claim once it has been accepted. In this case, Cigna did not deny compensability of the claim or responsibility of employer. It denied coverage because it did not provide coverage on the date of the injury. *Bauman* does not apply to invalidate such a denial or bind a carrier to a previous acceptance when there is a lack of coverage. *D Maintenance Company v. Mischke, supra.* We do not perceive the Board's efforts to distinguish *Mischke* as having any relevance to this conclusion. Whatever may be the merits of Crawford's denial of the claim, it does not affect the legitimacy of Cigna's denial. *See D Maintenance Company v. Mischke, supra,* 84 Or App at 222, n 3.

We interpret the Board's order to resolve only the issue of whether Cigna could deny the claim under *Bauman.* The Board did not consider the remaining issues raised by Crawford's denial. We remand to allow it to consider those issues.

Reversed and remanded.

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[3] ORS 656.419(1) provides:

> "A guaranty contract issued by an insurer shall provide that the insurer agrees to assume, without monetary limit, the liability of the employer, arising during the period the guaranty contract is in effect, for prompt payment * * *."

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

STATE OF OREGON,
by and through the
STATE ACCIDENT INSURANCE FUND
CORPORATION,
Plaintiff,

v.

BARKMAN et al,
Defendants,

and

BARKMAN et al,
Appellants,

v.

ASSOCIATED OREGON LOGGERS, INC., et al,
Respondents.

(88C-10295; CA A50219)

Appeal from Circuit Court, Marion County.

Greg West, Judge.

Argued and submitted February 12, 1990.

Susan D. Cardoni, Portland, argued the cause for appellants. With her on the brief were John R. Barker, James M. Callahan and Bittner & Barker, P.C., Portland.

William G. Wheatley, Eugene, argued the cause for respondents Associated Oregon Loggers, AOL Services, Inc., and AOL-SAIF Trust. With him on the brief were Denise G. Fjordbeck and Jaqua & Wheatley, P.C., Eugene.

William F. Gary, Eugene, argued the cause for respondents Loggers Assurance Company, Inc. With him on the brief were Sharon A. Rudnick and Harrang, Long, Watkinson, Arnold & Laird, P.C., Eugene.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

RICHARDSON, P. J.

Reversed and remanded.

RICHARDSON, P. J.

Defendants appeal the trial court's summary judgment for third-party defendants (collectively AOL) and the ensuing dismissal of defendants' claims for indemnity and

contribution.[1] SAIF Corporation, the plaintiff in the underlying action, had extensive business dealings with AOL. Defendants are accountants who provided professional services to AOL. SAIF alleges that defendants' negligence and misrepresentations about AOL's business and financial affairs, in conjunction with those services, caused damage to SAIF.[2] Defendants allege that incorrect data was supplied to them and that the misrepresentations were induced by officers of AOL. AOL's supporting evidence for its summary judgment motion was the "settlement agreement" between it and SAIF, in which SAIF agreed, *inter alia,* not to pursue certain claims that it had or could bring against AOL.

Defendants assign error to the summary judgment on their indemnity and contribution claims. Although the order granting summary judgment does not reveal the precise basis for the ruling, AOL defends the judgment on the indemnity claim on two grounds: The settlement agreement eliminates any possible common liability to SAIF and, as between it and defendants, "the obligation ought to be discharged by the latter," as a matter of law. *Ore-Ida Foods v. Indian Head,* 290 Or 909, 920, 627 P2d 469 (1981).

In response to the first argument, defendants rely on *Huff v. Shiomi,* 73 Or App 605, 699 P2d 1178 (1985), where we held that the running of the statute of ultimate repose on the plaintiff's claim against the third-party defendant Kirkman did not defeat the common liability element of the defendant's third-party indemnity action. We explained:

> "[A]ny failure by this plaintiff to bring a timely action against Kirkman has no bearing on whether Kirkman was liable to her *at the time her claim accrued.* For that reason, this case is distinguishable from *Ore-Ida Foods v. Indian Head,* 290 Or 909, 627 P2d 469 (1981), on which Kirkman relies. The court

> held there that an employer which had paid worker's compensation survivor's benefits to the unmarried cohabitant of a deceased worker could not recover indemnity from the person who negligently killed the worker, because the survivor had no right of action against the alleged indemnitor under the Wrongful Death Statute and the latter therefore *never* could have been liable to her." 73 Or App at 610. (Emphasis in original.)

AOL attempts to distinguish *Huff,* by noting that the limitations issue there was a mere "procedural bar," but that the settlement agreement here creates a "substantive bar to suit." We find those labels and that distinction unpersuasive. In both instances, it is at least a question of fact whether the plaintiffs had related claims under which the third-party defendants could be liable to them when the plaintiffs' claims against the defendants accrued. We reject AOL's first ground for upholding the summary judgment on the indemnity claim.

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[1] The judgment was made final pursuant to ORCP 67B.

[2] Our description is of SAIF's third claim, in which it asserts direct injuries to itself. Its first and second claims were brought as AOL's assignee. The parties agree that defendants cannot recover indemnity or contribution from AOL with respect to the assigned claims, and they are not encompassed by our discussion or our remand.

AOL's second argument is that defendants cannot assert that

> "their negligence with regard to the direct (unassigned) claims of SAIF Corporation set forth in SAIF's third cause of action in the original Complaint is merely secondary and passive. That claim alleges that defendant accountants owed duties directly to SAIF to insure that the accounting with regard to an agreement between SAIF and the AOL Companies was properly performed, and that defendants breached that duty by failing to adhere to accepted standards of accountancy and by misrepresenting transactions which took place under that agreement. Defendants had an independent duty to detect errors and illegal or improper activities which could be discovered by the exercise of reasonable professional skill."

Relying on cases from other jurisdictions, AOL contends that, as a matter of law, accountants must be primarily responsible, as between themselves and their clients, for injuries resulting from financial misinformation that the latter provide, because part of the accountant's job is to discern that the information is wrong.

We do not agree that, as a matter of law, an accountant *cannot* claim that his client is more responsible than he for damage resulting from incorrect financial information that the client furnishes. We held in *Becker v. Port Dock Four, Inc.*, 90 Or App 384, 752 P2d 1235 (1988), that an attorney could

assert a comparative fault defense in a client's professional malpractice action, at least to the extent that the client's alleged negligence involves matters as much within his own knowledge as that of the lawyer. The same reasoning applies here, for purposes of determining whether defendants' or AOL's relative involvement can be such that AOL should pay for the injuries to SAIF.

The overriding theme of AOL's argument is that the relationship between defendants and AOL, as professionals and client, *necessarily* means that defendants' responsibility was "primary" and AOL's "secondary" or "passive." AOL also maintains that SAIF's complaint alleges a direct duty from defendants to SAIF and reliance on defendants by SAIF. All of that begs the question. The thrust of the third-party indemnity claim is that AOL's actions *caused* whatever defendants did that resulted in injury to SAIF. The court erred in granting summary judgment on the indemnity claim.

The summary judgment for AOL on defendants' claim for statutory contribution was based on the settlement agreement and on ORS 18.455(1)(b):

> "(1) When a covenant not to sue or not to enforce judgment is given in good faith to one of two or more persons liable in tort for the same injury or the same wrongful death or claimed to be liable in tort for the same injury or the same wrongful death:
>
> "* * * * *
>
> "(b) It discharges the tortfeasor to whom it is given from all liability for contribution to any other tortfeasor."

The issue is whether AOL made the necessary showing, in

support of its motion, that SAIF's covenant was "given in good faith." AOL argues that the agreement itself was evidence of good faith, because:

> "The agreement notes the dispute between the parties and references [*sic*] the litigation underlying the agreement. It further provides for the distribution of real property and other assets, such as contingent claims against others, to SAIF Corporation in exchange for covenants not to sue or enforce judgment against AOL. On its face, the covenant was executed in exchange for valuable consideration by both parties.
>
> "Under the Oregon Rules of Evidence, it is presumed that private transactions have been fair and regular, ORE

> 311(1)(L), that the ordinary course of business has been followed, ORE 311(1)(m) and that the law has been obeyed, ORE 301(1)(x). Under Oregon law, an unrebutted presumption has the force of substantive evidence."

Defendants cite Kirkpatrick, *Oregon Evidence* 59 (1982), and fervently dispute AOL's understanding that an unrefuted presumption is "substantive evidence." Be that as it may, we do not think that the presumptions cited by AOL are relevant to the substantive question of "good faith" under ORS 18.455. That discrete fact, which the statute makes a condition to discharge from liability for contribution, requires more direct proof than the abstract presumptions of obedience to law, fairness and regularity and adherence to the ordinary course of business can supply. *See McCarthy v. Hensel Phelps Const. Co.*, 64 Or App 256, 667 P2d 558 (1983). We are also unable to agree that the settlement agreement itself can furnish an inference that the covenant it contains was given in good faith. Direct evidence of the fact was necessary and was not produced, and the court erred by granting summary judgment on the contribution claim.[3]

Reversed and remanded.

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[3] Our disposition of the case makes it unnecesary for us to reach defendants' remaining asssignment.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Jennifer Matthies, Claimant.

MATTHIES,
Petitioner,

v.

TILLAMOOK COUNTY
CREAMERY ASSOCIATION et al,
Respondents.

(87-11794; CA A50834)

Judicial Review from Workers' Compensation Board.

Argued and submitted September 18, 1989.

Dennis O'Malley, Portland, argued the cause and filed the brief for petitioner.

Jas. Adams, 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 Joseph, Chief Judge, and Newman and Deits, Judges.

NEWMAN, J.

Reversed and remanded for reconsideration.

NEWMAN, J.

A determination order awarded claimant five percent unscheduled permanent partial disability. The referee increased that award to 15 percent. Claimant seeks review of a Board order adopting and affirming the referee's order. We interpret claimant's assignment of error to be that the Board and the referee erred in not giving a reasoned explanation of why the award was increased to only 15 percent.

The Board adopted the findings, reasoning and conclusions of the referee. Claimant is 38 years old and has a high school education. She worked full time in employer's cheese factory as a production worker from 1978 until 1986, when she injured her shoulder at work while pulling a pallet of cheese. She suffered a left trapezius muscle strain with a probable muscle tear. At the time of her injury, her basic hourly wage was $9.37. The injury forced her to stop work at the factory, and she received vocational training as a general office clerk. She obtained a secretarial position, where she worked 36 hours per week at an hourly rate of $5.31, but she anticipated that her hours would be reduced to 26 hours per week after January 1, 1988.

On May 7, 1987, a determination order awarded claimant 5 percent unscheduled permanent partial disability. The referee increased the award to 15 percent. He stated in his opinion and order:

"To prevail on the issue of permanent unscheduled disability a worker must demonstrate, by a preponderance of the evidence, that as a result of his or her industrial injury or disease he or she has sustained a permanent loss of earning capacity. 'Earning capacity' is defined as a worker'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); *Suratt v. Gunderson Bros.*, 259 Or 65, 76-78 [, 485 P2d 410] (1971); and *Jacobs v. Louisiana Pacific*, 59 Or App 1, 3 [, 650 P2d 154] (1982). Though most of us tend to speak in terms of percentages, by statute losses of earning capacity are calculated in 'degrees.' The maximum award allowed in cases such as this is 320 degrees, and workers with less than a 100 percent loss of earning capacity are compensated proportionally. ORS 656.214(5).

"Claimant's testimony, which I find completely credible

and note was corroborated to a large degree by that of her husband, suggests that *she suffers from a rather significant permanent impairment.* This conclusion is substantiated by the facts that she attempted to return to work at the cheese factory but was unable to perform the demands of that job, even on a part-time basis. Moreover, Dr. Munly, claimant's longtime treating physician, has opined that claimant will never be able to return to the 'very strenuous' work at the cheese factory, even with the improvement he anticipates she will experience in the future. Furthermore, Dr. Munly has indicated that claimant cannot even perform the job of a fulltime file clerk because the physical demands of that job worsen the symptons of her trapezius injury. * * * Considering all the evidence, I conclude that claimant has a permanent physical impairment on the upper end of minimal or lower end of mild.

"Claimant's age and education have no significant impact on her loss of earning capacity. *However, the fact that she is now precluded from any form of strenuous labor, and even has difficulty performing the sedentary demands of a bookkeeping position, has very real and hardly insubstantial impact on her loss of earning capacity.* Given this consideration and the degree of her permanent injury-related impairment, I conclude that the Determination Order did not adequately compensate her." (Emphasis supplied).

Claimant asserts that the Board's conclusion that she is entitled to an award of only 15 percent unscheduled permanent partial disability does not rationally follow from the findings. She argues that she should receive an award of at least 50 percent permanent partial disability. *See former* ORS 656.214(5). The Board found that claimant suffers "a rather significant impairment" and that her inability to perform strenuous labor or even to meet the demands of full time sedentary office work has a "very real and hardly insubstantial impact on her loss of earning capacity." It also found that her post-injury earnings were significantly less than her pre-injury earnings. The Board must give a reasoned explanation of why the facts that it found lead to its conclusion that claimant is entitled to a 15 percent permanent partial disability award. *Armstrong v. Asten-Hill Co.*, 90 Or App 200, 206, 752 P2d 312 (1988). It failed to do so.

Reversed and remanded for reconsideration.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Stephen D. McElroy, Claimant.

INTERNATIONAL PAPER CO.,
Petitioner,

v.

McELROY,
Respondent.

(87-13564; CA A60519)

Judicial Review from Workers' Compensation Board.

Argued and submitted January 12, 1990.

Janet M. Schroer, Portland, argued the cause for petitioner. On the brief were Ridgway K. Foley, Jr., and Schwabe, Williamson & Wyatt, Portland.

David L. Johnstone, Portland, argued the cause for respondent. With him on the brief was Bennett, Hartman, Tauman & Reynolds, P.C., Portland.

Before Graber, Presiding Judge, and Rossman and Edmonds, Judges.

ROSSMAN, J.

Affirmed.

Graber, P. J., dissenting.

ROSSMAN, J.

Employer petitions for review in this workers' compensation case. Claimant compensably injured his pelvis in April, 1986. He returned to work, and the claim was closed in September, 1986. Employer laid him off in November; early in 1987, he went to work part-time as a janitor at a different employment. He began to complain of increased pain in March, 1987, and filed an aggravation claim the next month. Employer denied the claim.

After a hearing, the referee affirmed the denial:

> "The only support for claimant's claim for aggravation is the claimant's subjective complaint of increased pain which is not really verified by any of the medical examiners he has seen, including Dr. McLean. I conclude that the claimant believes he could do the work at International Paper and, in fact, wants to be employed there. I did not find claimant to be a credible witness."

The Board reversed, saying:

> "The employer argues that claimant has failed to sustain his burden of proof because the medical opinions are based on claimant's subjective reports and the Referee found claimant not credible. We would agree if we were to accept the Referee's credibility finding; however, we do not.

"The Referee stated without explanation that claimant was not a credible witness. There is no basis for inferring that the Referee's credibility finding is based on demeanor. We find nothing in the record which supports a finding that claimant was not credible. We have no obligation to defer to a credibility finding which is not based on demeanor because we are in as good a position as the Referee to decide credibility based on the record. Accordingly, we find that claimant was credible. We rely on his testimony that his condition has worsened to the point that he cannot do his regular work."

Employer argues that the Board's conclusion that claimant suffered an aggravation is not supported by substantial evidence, because claimant presented no objective evidence and his subjective claims were not credible. It contends that the referee's finding on the issue of credibility should be given great weight, because the referee's opinion implies that the finding is based on claimant's demeanor.

A finding about credibility may rest on demeanor or

on objective evaluation of the substance of a witness' testimony. When the finding is made on the basis of demeanor, deference is given to the referee's determination but, when the determination is not based on demeanor, the referee has no greater advantage than the reviewing body in determining credibility. *Coastal Farm Supply v. Hultberg,* 84 Or App 282, 285, 734 P2d 1 (1987). Here, the referee gave no explanation for his credibility finding.[1] Thus, there was no determination to which the Board, on its *de novo* review, could defer. It was free to make its own determination. The record supports the Board's holding.[2]

Affirmed.

GRABER, P. J., dissenting.

I dissent. The majority holds that "the referee gave no explanation for his credibility finding. Thus, there was no determination to which the Board, on its *de novo* review, could defer." 101 Or App 61 at 64. (Footnote omitted.) Ordinarily, the Board gives great weight to a referee's finding of credibility. The majority's approval of its refusal to do so in this case rests on a misapprehension of the referee's role.

The Supreme Court has established the standard for a referee's findings in an administrative proceeding:

"Where there is evidence in the record both to make more probable and to make less probable the existence of any particular basic fact, a referee need not explain why he or she

[1] We note that the Board's reasoning on credibility does not affect its conclusion that the expert medical evidence supported claimant's aggravation claim. The Board concluded:

"The medical experts agree that claimant's compensable condition has not objectively worsened. *However, they also agree that his subjective complaints have worsened so that he can no longer do his regular work.* A subjective worsening which renders a claimant less able to work is sufficient to prove an aggravation claim." (Emphasis supplied.)

[2] The dissent suggests that, because the Board found "nothing in the *substance* of claimant's testimony to deprive it of credibility," 101 Or App at 66 (emphasis supplied), the referee necessarily based his finding on demeanor. The referee may have based his decision on substantive inconsistencies, demeanor or a combination of those factors.

chose which evidence to believe. Similarly, if from the basic facts found by a referee one could rationally infer a further fact, a referee need not explain the rationale by which the inferred fact is reached.

"On the other hand, where a referee declines to find in accordance with uncontradicted evidence because it comes from a source that the referee finds to be unreliable, a referee should identify the unreliability to serve as an explanation in support of the findings of basic fact or the rationality of an inference the referee may draw from the basic facts. If the evidence is in the form of testimony that a referee does not believe because the referee finds the witness either mistaken or simply to be an untruthful person, the referee should make an express finding of that fact." *Dennis v. Employment Div.*, 302 Or 160, 169, 728 P2d 12 (1986).

That is, a referee is not obliged to state *expressly* that the finding on credibility is based on demeanor.

In affirming employer's denial of the claim here, the referee wrote:

"The only support for claimant's claim for aggravation is the claimant's subjective complaint of increased pain which is not really verified by any of the medical examiners he has seen, including Dr. McLean. I conclude that the claimant believes he could do the work at International Paper and, in fact, wants to be employed there. [Claimant testified that he applied for his old job at International Paper but that he '[didn't] feel capable of doing that kind of work.'] *I did not find claimant to be a credible witness.*" (Emphasis supplied.)

The Board reasoned, however:

"The Referee stated without explanation that claimant was not a credible witness. *There is no basis for inferring that the Referee's credibility finding is based on demeanor.* We find nothing in the record which supports a finding that claimant was not credible. We have no obligation to defer to a credibility finding which is not based on demeanor because we are in as good a position as the Referee to decide credibility based on the record. Accordingly, we find that claimant was credible. We rely on his testimony that his condition has worsened to the point that he cannot do his regular work." (Emphasis supplied.)

Employer contends that the Board's finding of credibility is not supported by substantial evidence and that its reasoning, in rejecting the referee's credibility finding, is irrational or unsound. *See Ledbury v. Montgomery Ward & Co.*, 99 Or App 631, 634-35, 783 P2d 1022 (1989). I agree with the

second argument, because the opinion is internally inconsistent. The Board observed that there was nothing in the *substance* of claimant's testimony to deprive it of credibility. That being so, the only *possible* basis for the referee's express finding that claimant was not a credible witness was subjective, that is, "based on demeanor." *See Coastal Farm Supply v. Hultberg*, 84 Or App 282, 285, 734 P2d 1 (1987). The Board's

statement that "[t]here is no basis for inferring that the Referee's credibility finding is based on demeanor" does not fit logically with the remainder of its own discussion, even if the referee were required to state the basis for a credibility finding in order to be entitled to the Board's deference. Accordingly, the Board has not adequately explained its decision.[1]

On that basis, I would reverse and remand for reconsideration. Therefore, I dissent.

[1] Apparently as an aside, the majority also suggests that "the Board's reasoning on credibility does not affect its conclusion that the expert medical evidence supported claimant's aggravation claim." 101 Or App at 64 n 1. That suggestion ignores the Board's own explanation of its holding:

> "The employer argues that claimant has failed to sustain his burden of proof because the medical opinions are based on claimant's subjective reports and the Referee found claimant not credible. *We would agree if we were to accept the Referee's credibility finding;* however, we do not." (Emphasis supplied.)

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Sammy D. Murphy, Claimant.

FRERES LUMBER COMPANY, INC.,
Petitioner,

v.

MURPHY,
Respondent.

(WCB 85-14939; CA A60369)

Judicial Review from Workers' Compensation Board.

Argued and submitted November 27, 1989.

Jerry K. Brown, McMinnville, argued the cause for petitioner. With him on the brief was Cummins, Brown, Goodman, Fish & Peterson, McMinnville.

David C. Force, Eugene, argued the cause for respondent. On the brief were Kathryn M. Ricciardelli, Randy M. Elmer, and Vick & Gutzler, Salem.

Before Graber, Presiding Judge, and Riggs and Edmonds, Judges.

RIGGS, J.

Reversed and remanded on the issue of frequency of chiropractic treatments; otherwise affirmed.

RIGGS, J.

Employer seeks review in this workers' compensation case. We review for substantial evidence and errors of law, ORS 656.298(6), affirm in part, reverse in part and remand.

Claimant injured his lower back at work on October 5, 1984, when he tripped and fell on a broom. He received weekly chiropractic treatments. On October 25, 1985, the Evaluation Division issued a determination order that awarded claimant temporary total disability only and found him to be medically stationary as of October 2, 1985. In December, 1985, he filed a request for hearing in which he indicated the issues would be temporary total disability and unscheduled permanent partial disability.

Claimant continued to submit weekly chiropractic bills to employer after the issuance of the determination order. Employer did not pay them. On March 7, 1986, employer sent claimant a letter that denied claims for all chiropractic treatments after the date that claimant was declared medically stationary, because it believed that he had fully recovered.

Claimant amended his original request for hearing, adding "medical services ORS 656.245" to the issues to be decided. Employer filed a response in which it "[d]enie[d] * * * [t]he allegations contained in Claimant's Request for Hearing and all other issues raised or raisable."

At the October, 1986, hearing, the referee received evidence on the extent of unscheduled permanent partial disability for claimant's lower back and on employer's denial of chiropractic treatments. She awarded 10 percent unscheduled permanent partial disability. With respect to the medical services issue, she set aside employer's denial in part. She found that two chiropractic treatments per month, after the date claimant became medically stationary, were reasonable and necessary, but that treatment in excess of that frequency was not.

The Board affirmed the award of permanent partial disability,[1] but reversed the referee on the medical services issue, stating in its order on review:

> "[T]he Referee erred in addressing the 'frequency of treatment' issue. The employer's denial was for all further [chiropractic] treatment, not treatment in excess of the guidelines. Furthermore, neither party raised the specific issue of frequency of treatment at hearing. Therefore, we conclude that the Referee's frequency limitation was procedurally improper."

The Board set aside employer's denial in its entirety.

Employer argues that the Board erred as a matter of law when it concluded that neither party had raised the issue of the *frequency* of claimant's chiropractic treatments at the hearing. We agree.

Medical expenses for purely palliative purposes are recoverable if they are necessarily and reasonably incurred in the treatment of an injury for which permanent partial disability has been awarded. ORS 656.245(1); *Wetzel v. Goodwin*

[1] We affirm the award of permanent partial disability without discussion.

Brothers, 50 Or App 101, 108, 622 P2d 750 (1981). However, in *James v. Kemper Ins. Co.,* 81 Or App 80, 84, 724 P2d 856 (1986), we stated:

> "Simply because the Board determines that it is reasonable and necessary for an injured worker to receive *some* chiropractic treatments does not mean that she may expect to be compensated *for any number* of treatments *without showing that the treatments are reasonable and necessary."* (Emphasis supplied.)

In *West v. SAIF,* 74 Or App 317, 320-21, 702 P2d 1148 j1985), we concluded that the claimant had met his burden by showing the need both for chiropractic treatments *and* the frequency with which he received them. A claimant bears the burden of proof, not only as to the reasonableness and necessity of the *type* of medical treatment, but also as to the *frequency* of treatment, if treatment is repetitive. In such cases, frequency is merely one aspect of the determination of whether medical treatment is reasonable and necessary.

Claimant and employer indicated the issues to be raised in the hearing on forms created by the Board. The forms serve the same function as pleadings in civil litigation. After employer denied claims for chiropractic treatments, claimant filed a supplemental request for hearing, adding the issue of "medical services ORS 656.245." In its response, employer denied "[t]he allegations [in claimant's original and

supplemental requests for hearing] * * * *and all other issues raised or raisable."* (Emphasis supplied.) It was logical for the referee to conclude from that statement that employer had denied both elements of the medical services issue, type and frequency.

The Board cited no statute or administrative rule that requires a party to raise frequency as a "specific" issue; claimant has cited none. Moreover, the Board did not indicate what employer should have done, beyond what it did, to raise the question of frequency. Nothing in the record suggests that employer conceded the frequency issue at the hearing or that claimant was surprised or prejudiced in any way.

Claimant argues that the absence of requests, reports and notification contemplated by *former* OAR 436-10-040(2)(a)[2] permitted an assumption that the chiropractic treatments were justified. That assumption, in claimant's view, gave rise to another assumption that frequency was not at issue at the hearing. For the reasons discussed above, we

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[2] *Former* OAR 436-10-040(2)(a) provided:

> "Frequency and extent of treatment shall not be more than the nature of the injury and the process of recovery requires. Insurers have the right to require evidence of the efficacy of treatment. The usual range of the utilization of medical services does not exceed 15 office visits by any and all attending physicians in the first 60 days from the first date of treatment, and two visits a month thereafter. This statement of fact does not constitute authority for an arbitrary limitation of services, but is a guideline to be used concerning requirements of accountability for the services being provided. Physicians requesting reimbursement for visits in excess of this amount must submit upon request a report documenting the need for such services. Insurer shall notify the physician within 30 days of receipt of the report whether or not the report justifies treatment in excess of the guidelines or justification will be assumed."

believe that employer's general denial of claimant's claim for medical services in its response to the supplemental request for hearing eliminated any "assumption" about justification of medical treatment to which *former* OAR 436-10-040(2)(a) may have given rise. *See Kemp v. Workers' Comp. Dept.*, 65 Or App 659, 670, 672 P2d 1343 (1983), *modified* 67 Or App 270, 677 P2d 725, *rev den* 297 Or 227 (1984).

The Board did not consider how many treatments were proper because of its erroneous conclusion that the question was not properly before the referee. Consequently, we remand to the Board so that it may review that aspect of the referee's decision.

Reversed and remanded on the issue of frequency of chiropractic treatments; otherwise affirmed.

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122 April 4, 1990 No. 143

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Toria S. Benson, Claimant.

BENSON,
Petitioner - Cross-Respondent,

v.

MULTNOMAH COUNTY
SCHOOL DISTRICT #1,
Respondent - Cross-Petitioner.

(WCB 85-14056, WCB 84-01712; CA A50780)

Judicial Review from Workers' Compensation Board.

Submitted on record and briefs September 25, 1989.

Toria Sue Benson, Portland, filed the briefs *pro se* for petitioner - cross-respondent.

Jerald P. Keene and Roberts, Reinisch & Klor, P.C., Portland, filed the brief for respondent - cross-petitioner.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

RICHARDSON, P. J.

Affirmed on petition; reversed and remanded for reconsideration on cross-petition.

RICHARDSON, P. J.

Claimant seeks review of an order of the Workers' Compensation Board which affirmed the denial for her chemical sensitivity and stress claims, but overturned the denial for her back and neck conditions. Claimant challenges the denials of her claims; she contends that the Board used an incorrect standard and that the order is not supported by substantial

evidence. Employer cross-petitions for review[1] and challenges the portion of the order which reverses the denials of compensability. It contends that the Board failed to explain its credibility finding which was different than that of the referee and that such reversal is not supported by the record. We affirm on the petition and reverse and remand on the cross-petition.

Claimant was a school teacher for employer between 1965 and 1983. She filed a claim in November, 1983, alleging that, on October 4, 6 and 7, she had been involved in physical confrontations with students that caused compensable injuries to her neck, shoulders and back. She also alleged that these events contributed to her pre-existing psychological disability. She filed a second, unrelated claim in August, 1985, alleging that she had suffered from a chemical sensitivity because of the inhalation of fumes when the school building roof was repaired. Employer denied both claims.

Claimant sought review and, after a consolidated hearing, the referee upheld the denial of both claims. The Board viewed the claims as presenting four potential compensable conditions. It first found that claimant's neck, shoulder and back conditions were caused or worsened by the student confrontations. It also found that those events caused an increase in her pre-existing psychological disability. The Board therefore concluded that she had established a compensable injury with physical and psychological components.[2] The Board then reviewed her alleged chemical sensitivity and psychological stress conditions as they related to her general work activity. It found that neither condition was work related and, therefore, upheld the denial of compensability.

Claimant first contends that the Board used an incorrect standard when it reviewed her chemical sensitivity and psychological stress conditions. We disagree. The Board found that neither condition, which it classified as being occupational disease claims, was compensable, because there was no evidence that her work activity or exposure to the fumes was a major contributing factor in her conditions. That is the correct standard for determining the existence of an occupational disease. ORS 656.802(1); *SAIF v. McCabe,* 74 Or App 195, 199, 702 P2d 436 (1985); *SAIF v. Gygi,* 55 Or App 570, 574, 639 P2d 655, *rev den* 292 Or 825 (1982).

The thrust of claimant's next three assignments is that she proved that her chemical sensitivity and psychological stress conditions are compensable. There was extensive medical evidence presented relating to both conditions that we need not set out. It suffices to say that there is a conflict in the various medical opinions concerning the relationship between claimant's conditions and her work. There is substantial evidence on the basis of countervailing as well as supporting evidence from which a reasonable person could find that her conditions were not compensable.[3]

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[1] Employer is self-insured.

[2] The referee also found that claimant did not timely file a claim for compensation for her increased psychological stress. ORS 656.807(1). The Board reversed, finding that her request was timely. Employer does not challenge that.

[3] Claimant's remaining contentions do not warrant discussion.

Employer cross-petitions and challenges the Board's finding of compensability for claimant's neck, shoulders and back conditions and resulting psychological disability. It contends that the Board necessarily reversed a credibility finding by the referee and that the decision is not properly explained nor supported by the record.

Claimant testified at the hearing about the student confrontations that allegedly caused her condition. The school principal testified that, despite several opportunities, claimant did not inform her of the alleged confrontations. Several of her treating physicians also noted that she did not mention the incidents during physical examinations immediately after the alleged events. There was considerable evidence supporting the referee's implicit finding that her description of the events was not credible. In denying the claim, the referee said:

> "In conjunction with Drs. Rohlfing's and Schoepflin's negative opinions on aggravation of claimant's underlying

> physical condition, the failure of claimant to relate the circumstances of her school injuries to either Dr. Rohlfing or Dr. Schoepflin is of significance. If, as claimant testified, the traumatic events of the October 4, 1983 school week caused tremendous pain, fear and anxiety, one would expect the incidents to have been immediately reported to the school principal and accurately related to the treating doctors. This claimant did not do. Only in reflection did claimant mention the events surrounding any student confrontations. I do not find that claimant has established that her back, shoulders, neck and stress conditions were aggravated in any way by the events involving her students in early October 1983."

Because claimant's testimony was the only direct evidence connecting her condition with her work activity, the Board, in finding compensability, apparently believed her rendition of the events. It did not explain why it disagreed with his disbelief of claimant's testimony.

Affirmed on petition; reversed and remanded for reconsideration on cross-petition.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

ACCIDENT PREVENTION DIVISION,
Respondent,
v.
SURCAMP,
Petitioner.
(SH-88106; CA A60827)

Judicial Review from Workers' Compensation Board.

Argued and submitted January 26, 1990.

George A. Morris, Springfield, argued the cause for petitioner. With him on the brief was Morris & O'Kief, Springfield.

Jas. Adams, 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.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

WARREN, J.

Affirmed as to violations; remanded for reconsideration of penalties.

WARREN, J.

Defendant seeks review of an assessment of penalties of $4,700 pursuant to a citation issued by the Accident Prevention Division (Division). We hold that there is substantial evidence to support the referee's decision to assess penalties but remand to the Board to reconsider the amount of the penalties in accordance with the rules in effect at the time of the violations.

The Board found defendant in violation of OAR 437-80-035(2), OAR 437-80-015(3) and OAR 437-80-015(4), and defendant challenges the findings for all but OAR 437-80-015(4). OAR 437-80-035(2) requires that "employes shall be alert at all times for logs, trees, rootwads, rocks or other objects that could roll or slide towards [*sic*] them or others as a result of any work activity." There was evidence that the log that fatally injured Ronald Pace slid down from an area around or under a landing where defendant's employees had installed a portable tower that was used to haul logs 800 feet up to the landing. Although there was evidence that the log that slid down did not come from the area directly between the work area and the landing, the evidence of snowfall earlier that day plus the location of the tower around or about the area from which the log slid provide substantial evidence to permit an inference that the work activity caused the slide.

The employee who was acting as lookout during much of the operation stated that he was not formally designated as the lookout and that he was starting a fire at the time that the log slid down. No other employee was designated as a lookout. There is substantial evidence on the basis of countervailing as well as supporting evidence from which a reasonable person could find that there was a violation. ORS 183.482(8)(c).

OAR 437-80-015(3) requires monthly safety meetings involving all crew members and documentation of minutes and attendance. It was company procedure for each crew supervisor to conduct the meeting and to turn in the documentation to the bookkeeper. Gilbert, Division's investigator, found complete documentation in the files from one supervisor who had told Gilbert that he had conducted monthly meetings and very little documentation of monthly meetings conducted by any other supervisor. Gilbert spoke with no other supervisor. Because of employer's procedure required

turning the documentation in to the bookkeeper, evidence that there was no documentation of regular monthly meetings by most supervisors was substantial evidence in the whole record of a violation of the safety meetings requirement. The Board reasonably inferred that the monthly meeting requirement was violated.

Defendant also argues that the referee imposed improper penalties for the three violations. Division concedes that errors occurred. We remand to the Board to reconsider the penalties.

Affirmed as to violations; remanded for reconsideration of penalties.

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226 April 4, 1990 No. 158

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Richard T. Bryant, Claimant.

STATE OF OREGON, DEPARTMENT OF JUSTICE,
INMATE INJURY FUND,
Petitioner,

v.

BRYANT,
Respondent.

(87-06139; CA A50496)

Judicial Review from Workers' Compensation Board.

Argued and submitted September 18, 1989.

Ann Kelley, Assistant Attorney General, Salem, argued the cause for petitioner. On the brief were Dave Frohnmayer, Attorney General, Virginia L. Linder, Solicitor General, and Christine Chute, Assistant Attorney General.

Peter E. Baer, Gresham, argued the cause and filed the brief for respondent.

Before Joseph, Chief Judge, and Newman and Deits, Judges.

DEITS, J.

Reversed.

Joseph, C. J., concurring in result.

DEITS, J.

Petitioner seeks review of an order of the Workers Compensation Board holding that claimant's right to benefits was not time-barred, even though his claim was not filed within the 90-day time limit of the applicable statute, ORS 655.520(3). We reverse.[1]

Claimant, an inmate at the Oregon State Penitentiary, injured his back while working at a prison work camp on June 6, 1986. He informed his supervisor of the injury, but was not told to file an accident report or a claim for benefits. On June 23, 1986, claimant was examined by a doctor, who referred him to Dr. Becker, a back specialist. Due to Becker's schedule, claimant's first appointment with him was September 18, 1986, 97 days after the injury. Becker diagnosed claimant's condition as degenerative disk disease and advised him to file a claim for benefits, which he did that same day. Petitioner denied the claim on the ground that it was barred by ORS 655.520(3), because it was filed more than 90 days from the date of the injury.

ORS 655.520(3) provides in pertinent part:

> "The rights to benefits under ORS 655.505 to 655.550 shall be barred unless written claim is filed with the department within 90 days after the date of injury * * *. The requirements of this subsection may be waived by the department on the ground that, for good and sufficient reason, the claim *could not* be filed on time." (Emphasis supplied.)

The Board had two grounds for its conclusion that the claim was not barred by the statute. First, the Board concluded that it has *de novo* review of petitioner's decision that claimant did not have a "good and sufficient reason" for not filing in a timely manner. It held that, in its judgment, claimant did have a "good and sufficient reason," because he reported the injury to his supervisor but was not told to fill out an accident report or that there was any time limit on filing a claim. The Board also based its decision on its conclusion that two of the exceptions to compliance with the time deadlines for filing claims

under the Workers' Compensation Law should be incorporated into ORS 655.520(3). The referee stated: "Although concepts of employer knowledge and prejudice are not discussed directly in ORS 655.520, I see no reason why they should not be incorporated by reference from ORS 656.265(4)(a)." The

[1] The Board also ordered petitioner to pay claimant's attorney fees from the Inmate Injury Fund for legal services performed before the referee and Board. Petitioner assigns error to that portion of the Board's order. However, in view of our disposition of this case, it is unnecessary to address that issue.

Board found that claimant's supervisor was told of claimant's injury and that there was no evidence that petitioner would be prejudiced by the late filing and, therefore, concluded that petitioner's denial of the claim should be set aside.

We first hold that the exceptions in ORS 656.265(4)(a) are not applicable to an inmate injury claim filed under ORS chapter 655. ORS 655.520(3) specifically provides that "rights to benefits under ORS 655.505 to 655.550 *shall be barred*" (emphasis supplied) unless the claim is filed within 90 days, or unless the department waives the time limit on the ground that, "for good and sufficient reason, the claim could not be filed on time." ORS 655.520(1) provides that claims for benefits from the Inmate Injury Fund are to be filed in the manner provided in the Workers' Compensation Laws "to the extent not inconsistent with ORS 655.505 to 655.550." *See Dept. of Justice v. Spear,* 308 Or 594, 783 P2d 998 (1989). The exceptions found in ORS 656.265(4) are inconsistent with ORS 655.520(3). Accordingly, the employer's knowledge of the injury or the lack of prejudice to the employer from the late filing are not relevant considerations in determining if the refusal to waive the time limit was proper.

The remaining question is whether the Board erred in substituting its judgment for petitioner's and concluding that there was "good and sufficient reason" that the claim could not be filed on time. We conclude that the Board does not have authority to review petitioner's decision *de novo,* and it erred in substituting its judgment for that of petitioner. ORS 655.520(3) delegates to petitioner the authority to exercise its discretion to determine if there is "good and sufficient reason" that the claim could not be filed on time and, if there is, to decide whether the time limit should be waived. Petitioner has adopted a written policy that "only physical and mental incapacity will be recognized as good and sufficient reason for failing to file a claim in a timely manner." Oregon Department of Justice, Special Compensation Programs, Inmate Injury Fund, *Policy and Procedures Manuel* at 2. Petitioner determined that, under that policy, there was not a "good and

sufficient reason" why the claim *could not* be filed. *See* ORS 655.525; ORS 656.283(2). The Board made an alternative holding that, even if it were only to review for abuse of discretion, it would overturn the decision not to waive the time limit. Assuming that petitioner's decision was reviewable for abuse of discretion, it did not abuse its discretion. Its denial of the claim was proper. The order of the Board is therefore reversed.

Reversed.

JOSEPH, C. J., concurring in the result.

Assuming that the Workers' Compensation Board has the power to review petitioner's application of ORS 655.520(3), I concur fully with the majority. However, as I read the statute, there does not seem to be any such authority. Petitioner has the discretion to waive the limitation or not. It did not waive the limitation in this instance. I can find nothing in either ORS chapter 655 or ORS chapter 656 that empowers the Board to review the agency's refusal to exercise its discretion in favor of a claimant.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

MONTGOMERY ELEVATOR COMPANY,
Appellant,
v.
TUALITY COMMUNITY HOSPITAL, INC.,
Respondent.
(C880697 CV; CA A50882)

In Banc

Appeal from Circuit Court, Washington County.

Michael J. McElligott, Judge.

Argued and submitted September 19, 1989; resubmitted in banc March 7, 1990.

Thomas M. Christ, Portland, argued the cause for appellant. With him on the briefs was Mitchell, Lang & Smith, Portland.

Lindsey H. Hughes, Portland, argued the cause for respondent. With her on the brief were Molly K. Marcum and Hallmark, Keating & Abbott, Portland.

RIGGS, J.

Reversed and remanded.

Graber, J., dissenting.

RIGGS, J.

In this action for breach of contract, plaintiff appeals a summary judgment for defendant. The issue is whether the exclusive liability provision of the Workers' Compensation Act, ORS 656.018(1), voids an agreement to purchase liability insurance.[1] We conclude that it does not.

Plaintiff contracted with defendant to maintain and repair elevator equipment on defendant's premises. In exchange, defendant agreed to procure comprehensive liability insurance protecting plaintiff from personal injury and property damage claims from all persons, including defendant's employes.[2] Defendant failed to purchase the insurance.

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[1] ORS 656.018(1) provides, in pertinent part:

"(a) The liability of every employer who satisfies the duty required by ORS 656.017(1) [to provide workers' compensation insurance for subject workers] is exclusive and in place of all other liability arising out of compensable injuries to the subject workers * * * specifically including claims for * * * indemnity asserted by third persons from whom damages are sought on account of such injuries * * *.

"* * * * *

"(c) * * * [A]ll agreements or warranties contrary to the provisions of paragraph (a) of this subsection entered into after July 19, 1977, are void."

[2] In a separate provision, the maintenance agreement also included an indemnity clause that required that defendant "indemnify, protect and save harmless Montgomery Elevator Company and its affiliates from and against liabilities, losses and claims * * *." Plaintiff concedes that the indemnity agreement is void insofar as plaintiff's obligations might arise out of compensable injuries to defendant's employees.

One of defendant's employes, injured while using the elevator, sued plaintiff, who settled the claim for $65,000 and incurred $11,470 in defense costs. Plaintiff then demanded that defendant reimburse it. When defendant refused, plaintiff brought this action for breach of contract. On cross-motions for summary judgment, the trial court granted defendant's.

Defendant argues both that the exclusivity of ORS 656.018(1) is comprehensive, and thus precludes any other "liability," and that agreements to purchase insurance are identical to indemnity agreements,[3] which are expressly pro-

hibited by the statute. Consequently, defendant asserts that agreements to purchase insurance are also barred.

Plaintiff counters that agreements to purchase insurance are independent contractual obligations that are not subject to the exclusive liability provision. Plaintiff also argues that agreements to purchase insurance are distinguishable from indemnity agreements and, because insurance agreements are not specifically proscribed by the statute, defendant is liable for damages resulting from its breach of a valid, enforceable contract. We agree with plaintiff.

As a preliminary issue, we address defendant's contentions that we have already decided that insurance and indemnity agreements are one and the same in *Sears, Roebuck & Co. v. Montgomery Elevator,* 63 Or App 769, 772, 665 P2d 1265, 1266-67, *rev den* 295 Or 730 (1983). Defendant misconstrues *Sears.* Interpreting nearly identical contract provisions,[4] we merely stated that "[a] provision in an indemnity agreement that requires the indemnitor to carry liability insurance is *evidence* of the intent of the parties as to the scope of the indemnity obligation."[5] 63 Or App at 772. (Emphasis supplied.) In other words, we implicitly recognized that the two types of agreements are different, but we expressly left the question open.[6]

We turn now to the parties' primary arguments. Under the plain language of ORS 656.018(1), a complying employer's liability is exclusive only for claims "arising out of compensable injuries." The genesis of plaintiff's claim lies in

[3] If the agreements are identical and duplicative, defendant does not explain why Montgomery Elevator would, when negotiating the maintenance contract, "knowingly ask for something which would be of no value to [it]." *Waterway Terminals Co. v. P.S. Lord Mechanical Contractors,* 242 Or 1, 22, 406 P2d 556, 566 (1965).

[4] Both maintenance contracts provided that the hospital and Sears would "maintain comprehensive bodily injury and property damage insurance (naming Montgomery Elevator Company as an additional insured), including bodily injury and property damage caused by the ownership, use or operation of the equipment," as well as a parallel indemnity provision.

[5] For example, a particular claim could be outside the agreed scope of liability, because it was greater than the policy limits or, possibly, because it was not covered by the terms of the policy for other reasons.

[6] We noted:

> "Evidently [Sears] failed to carry such insurance. [Montgomery Elevator] argues that, because this breach of contract by itself directly resulted in defendant's having to defend the original lawsuit and ultimately to pay the settlement sum, [Sears] is now liable to [Montgomery Elevator] for the amounts so expended. Because we dispose of the case on other grounds, we need not address this contention." 63 Or App at 772 n 3.

defendant's failure to keep its part of a bargain by purchasing insurance, not in the infortuitous occurrence of an injury to defendant's employe. The parties' contract was intended to protect the non-employer from liability for tort claims rather than to relieve the employer from its responsibility to provide workers' compensation coverage.

Had plaintiff known before anyone was injured that defendant had not purchased the insurance as it agreed, plaintiff could have sued for specific performance or purchased the insurance itself and then sued defendant for the cost of the policy. Plaintiff's claim against defendant does not fall under the statutory proscription, because it does not "arise out of compensable injuries" but, rather, arises out of a breach of contract.

Defendant's other argument, that indemnity agreements and agreements to procure insurance are identical, is also incorrect. Although there is no Oregon authority for the distinction, plaintiff cites several persuasive decisions in which other jurisdictions have concluded that the two types of agreements are significantly different. *See, e.g., Zettel v. Paschen Contractors, Inc.*, 100 Ill App 3d 614, 427 NE2d 189 (1981); *Pickhover v. Smith's Management Corp.*, 771 P2d 664 (Utah 1989). In *Zettel*, the court stated:

> "[A] promise to obtain insurance is not the same as a promise to indemnify. * * *. Under an indemnity agreement, the promisor agrees to assume all responsibility and liability for any injuries and damages. Under an agreement to obtain insurance, the promisor merely agress to procure the insurance and pay the premium on it. Once the insurance is obtained, the promisor bears no responsibility in the event of injury or damage even if the insurer should breach the insurance agreement through no fault of the promisor." 100 Ill App 3d at 618. (Citations omitted.)

The Utah Court of Appeals noted in *Pickhover:*

> "An agreement to provide insurance merely allocates an economic burden on one party to make a payment to protect another after the parties have ultimately decided 'to shift the risk of loss * * * upon an insurer.' * * * An agreement to purchase insurance does not make the party agreeing to provide the insurance an indemnitor. Rather, an agreement to insure is an agreement to provide both parties with the benefits of insurance." 771 P2d at 669. (Citations omitted.)

Defendant's contention that plaintiff is actually seeking indemnity ignores a critical distinction between the two contracts: under an indemnity contract, payment by the insured is a prerequisite to the insurer's duty of reimbursement; under an insurance contact, the insurer's obligation attaches as soon as liability is established. Payment by the insured is immaterial.[7]

Although, under the facts, damages that plaintiff seeks happen to be the same as if there had been an indemnity agreement, the coincidence of the measure of damages does

not mean that the contract to provide insurance is the equivalent of an indemnity agreement. It is only because an injury intervened between defendant's breach of contract and plaintiff's awareness of that fact that the amount plaintiff seeks is equivalent to the settlement and the defense costs. If, instead, defendant had abided by its agreement and purchased the liability policy for which plaintiff had bargained, then the insurer would have been responsible for any claim that occurred.

Reversed and remanded.

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[7] As one treatise explains:

"Under a liability policy the insurer is required to make payment although the insured has not yet suffered any loss, for by definition the purpose of the liability policy is to shield the insured from being required to make any payment on the claim for which he is liable.

"Under an indemnity contract, by way of contrast, the insurer is only required to indemnify or make whole the insured after he has sustained actual loss, meaning after the insured has paid or been compelled to make a payment, his action against the insurer then being to recover the amount of such loss by way of indemnity." 11 *Couch on Insurance*, 44:4, 187-88, (R. Andersen 2d ed. 1963).

The confusion stems from the fact that plaintiff did sustain an actual loss for which it seeks reimbursement. As a direct consequence of defendant's breach, plaintiff bore the financial burden of discharging the settlement and defense costs of the injury claim. However, unlike under an indemnity agreement, that payment was not a prerequisite to the insurer's obligation under an insurance agreement.

GRABER, J., dissenting.

The foundation of the workers' compensation system is a legislatively-imposed bargain: Employers are liable without fault for all work-related injuries to their employees; in

return, complying employers are insulated from *all* other liability for those injuries. ORS 656.017; ORS 656.018.[1] The majority creates a loophole that eviscerates the bargain. I therefore dissent.

Defendant is a complying employer. It agreed to purchase and "maintain comprehensive bodily injury and property damage insurance (naming [plaintiff] as an additional insured), including bodily injury and property damage caused by the ownership, use or operation of" defendant's elevators. As applied to the claim of a non-employee, the agreement is unexceptional, and defendant should be liable for any damages that result from its failure to carry out its promise. As applied to the claim of one of defendant's employees who is

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[1] ORS 656.018(1) provides, in pertinent part:

"(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.

"* * * * *

"(c) * * * [A]ll agreements or warranties contrary to the provisions of paragraph (a) of this subsection entered into after July 19, 1977, are void."

injured while working, however, the agreement would make defendant liable for a compensable injury beyond its liability for workers' compensation benefits. Accordingly, to that extent the agreement is "void" under ORS 656.018(1)(c).

Partly because of the way that the parties argued the case, much of the majority's opinion deals with tangential issues. The question is not whether an agreement to provide insurance is identical to an indemnity agreement or how to measure the damages if defendant's failure to purchase insurance results in damage to plaintiff. The question is whether the agreement, as it applies in this case, subjects defendant to financial responsibility for an injury to its employee beyond its responsibility for his compensation benefits. If it does, it is void to that extent.

Defendant agreed to buy insurance to protect plaintiff from liability to third parties. If the policy had excluded employee claims, the insurer's risk would have been lower and so, presumably, would have been the premium that defendant

would have paid. Thus, because the agreement required that the insurance cover employees injured while working, part of defendant's cost of complying with the contract would have been attributable to the risk of on-the-job employee injuries. Defendant, however, already had workers' compensation coverage. The agreement with plaintiff effectively would have imposed an extra cost for compensable injuries. Yet defendant's compliance with ORS 656.017 is supposed to be "exclusive and in place of all other liability arising out of compensable injuries to the subject workers[.]" ORS 656.018(1)(a).

In short, defendant's agreement with plaintiff imposed a liability on defendant that the law did not permit it to accept. The fact that the agreement that plaintiff seeks to enforce is one to procure insurance rather than to indemnify is irrelevant. Defendant's liability for its employees' compensable injuries is limited to the cost of complying with ORS 656.017, and no agreement may increase that liability by even a penny or a peppercorn. It does not matter whether the increase is the cost of buying insurance for a third party, damages for failing to purchase that insurance, or any other kind. That is how the legislature has chosen to protect the bargain that is at the heart of the compensation system. The majority fails to enforce the legislature's decision and thereby undercuts the entire system.

I dissent.

Joseph, C. J., and Newman and Edmonds, JJ., join in this dissent.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Beverly J. Martinez, Claimant,
and
In the Matter of the non-complying status of
Shirley Horgen, dba The Lollipop Tree, Employer.
HORGEN,
dba The Lollipop Tree,
Petitioner,
v.
MARTINEZ et al,
Respondents.
(WCB 87-16874; CA A61195)

Judicial Review from Workers' Compensation Board.

Argued and submitted January 22, 1990.

W. Brad Coleman, Salem, argued the case and filed the brief for petitioner.

Richard M. Walsh, Salem, argued the cause for respondent Beverly J. Martinez. With him on the brief was Olson, Rowell & Walsh, Salem.

David L. Runner, 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.

Before Graber, Presiding Judge, and Riggs and Edmonds, Judges.

RIGGS, J.

Reversed and remanded.

RIGGS, J.

Employer seeks review of a Workers' Compensation Board order that concluded that employer cannot challenge the compensability of a claim, because it failed to issue a proper denial. We reverse and remand.

Claimant injured her shoulder in May, 1987, and filed a claim on September 8, 1987. On September 29, 1987, the Workers' Compensation Department issued an order declaring the employer non-complying. By a letter, dated October 18, 1987, the employer requested a hearing, pursuant to ORS 656.283(1),[1] to contest the compensability of "any injury" to claimant. Employer did not send a copy of the letter to claimant.[2] On November 25, SAIF accepted the claim and notified

[1] ORS 656.283(1) provides, in pertinent part:

"Subject to subsection (2) of this section and ORS 656.319, any party or the director may at any time request a hearing on any question concerning a claim."

[2] However, the Hearings Division did send claimant a copy of a letter acknowledging receipt of employer's hearing request. Claimant was also sent copies of several letters that the Hearings Division sent to employer regarding the time, date and various postponements of the hearing.

employer that it could request a hearing on the compensability issue within 60 days. Claimant and her attorney appeared at and participated in the February 26, 1988, hearing, fully litigating the issue of compensability.

The referee found that claimant was not credible and concluded that the claim was not compensable. Claimant appealed to the Board, which, relying on *Derryberry v. Dokey*, 91 Or App 533, 756 P2d 1255, *rev den* 306 Or 661 (1988), concluded that employer could not litigate the issue of compensability, because it had improperly denied the claim. After the Board issued its decision, we expressly disapproved the relevant language in *Derryberry* in *Clark v. Linn*, 98 Or App 393, 779 P2d 203 (1989).

In *Clark*, we held:

> "It is clear that the statutes and administrative rules provide that it is SAIF's responsibility to accept or deny a claim against a non-complying employer. * * * Employer requested a hearing pursuant to ORS 656.283 and is entitled to have the question of compensability determined. Whether or not employer properly denied the claim pursuant to ORS 656.262

> is irrelevant; that was SAIF's responsibility. Her right to litigate the compensability of the claim does not arise from ORS 656.262(8), but from ORS 656.283(1) and OAR 436-80-060(1)(d)." 98 Or App at 396-97.

In the light of *Clark*, the Board erred in concluding that employer could not contest SAIF's acceptance of the claim and litigate the issue of compensability.

Reversed and remanded.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Ralph E. Moen, Claimant.

SAIF CORPORATION et al,
Petitioners,

v.

MOEN,
Respondent.

(86-15963, 87-05149; CA A61588)

Judicial Review from Workers' Compensation Board.

Argued and submitted April 4, 1990.

David L. Runner, Assistant Attorney General, Salem, argued the cause for petitioners. With him on the brief were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

Max Rae, Salem, argued the cause and filed the brief for respondent.

Before Graber, Presiding Judge, and Joseph, Chief Judge, and Edmonds, Judge.

PER CURIAM

Affirmed. *Forshee & Langley Logging v. Peckham*, 100 Or App 717, ___ P2d ___ (1990).

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Earl R. Hall, Claimant.

HALL,
Petitioner - Cross-Respondent,

v.

SILVER EAGLE COMPANY et al,
Respondents - Cross-Petitioners.

(86-02464; CA A60172)

Judicial Review from Workers' Compensation Board.

Argued and submitted January 5, 1990.

Alan M. Scott, Portland, argued the cause for petitioner - cross-respondent. With him on the brief were Gary L. Tyler and Galton, Popick & Scott, Portland.

Jerald P. Keene, Portland, argued the cause for respondents - cross-petitioners. With him on the brief was Roberts, Reinisch & Klor, P.C., Portland.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

DEITS, J.

Affirmed on petition; reversed and remanded for reconsideration on cross-petition.

DEITS, J.

Claimant seeks review of an order of the Worker's Compensation Board increasing his unscheduled permanent disability award for his low back injury to 70 percent and denying his claim for an award of permanent total disability (PTD). He argues that he is entitled to PTD under the odd-lot doctrine and that the Board's order is not supported by substantial evidence. Employer requests review of the Board's refusal to approve its attorneys' supplemental statement of services rendered. We affirm on the petition and reverse and remand on the cross-petition.

In February, 1985, claimant, a truck mechanic, injured his back when he slipped and fell at work. He had back surgery in April, 1985. After the surgery, his treating physician, Dr. Franks, concluded that he could not return to his job as a mechanic but should be retrained for a light duty or sedentary occupation in which he would not have to lift more than 35 pounds or to repetitively bend, lift or lean over. Franks concluded that claimant was employable at a light duty job and could work an eight-hour day but that his back would continue to bother him.

Claimant argues that the Board erred in holding that he is not permanently and totally disabled. To establish PTD, a claimant must prove inability to perform any work at a gainful and suitable occupation. PTD may be established through medical evidence of physical incapacity or under the "odd-lot doctrine." Under that doctrine, a person may establish permanent total disability, even though not completely physically disabled if non-medical factors, such as age, education, adaptability to perform non-physical labor, mental capacity and emotional condition, as well as the conditions of a hypothetically normal market foreclose the person from gainful employment. *Harris v. SAIF,* 292 Or 683, 695, 642 P2d 1147 (1982); *Welch v. Banister Pipeline,* 70 Or App 699, 701, 690 P2d 1080 (1984), *rev den* 298 Or 470 (1985).

Here, the Board did consider non-medical factors that might qualify claimant for PTD. As it stated:

> "We further conclude that when claimant's physical disabilities are combined with his social and vocational factors, he has not established permanent total disability under the

> "odd-lot" doctrine. We are persuaded that he possesses sufficient physical capabilities, work experience, and vocational training to achieve a successful return to the work force.
>
> "Claimant is at the vocationally advanced age of 57 years old. Further, he has limited formal education. However, these negative social and vocational factors, are offset by claimant's extensive experience and knowledge of the mechanic trade."

There is substantial evidence to support those conclusions. Claimant was evaluated by vocational counselors who concluded that he is employable, even considering his impairment, his transferable skills and other socio-economic factors. Both experts had knowledge of the availability in the labor market in claimant's locality of jobs that would be appropriate for claimant.[1]

Pursuant to ORS 656.388, a claim for legal services by an attorney representing a worker or an insurer for services before the Board, must be approved by the Board. Employer requests review of the Board's refusal to address the supplemental statement of legal services that it alleges that its attorneys submitted before the issuance of the Board's order. In December, 1987, the parties completed briefing to the Board in this case. On January 1, 1988, the Board's new administrative rules became effective. The rules changed the procedure for employers' submission to the Board of statements of services in support of defense attorney fees. ORS 656.388(1); OAR 438-15-027(1). In February, 1988, employer's attorneys submitted a statement of services in the amount of $160 for anticipated time spent in monitoring the file pending a decision. It contends that, in February, 1989, it sent a supplemental statement of services, increasing the fees requested to $540 because of the length of time spent waiting for a decision by the Board.

[1] Claimant's other assignments of error are without merit.

On March 10, 1989, the Board issued its order on the merits of the case and approved the $160 fee originally requested, but said nothing about the supplemental fee request. On March 15, employer filed a request for reconsideration of the supplemental request. On March 16, claimant filed a petition for review from the Board's order. On April 4, 1989, the Board issued an order on reconsideration, stating

that it had received the request for a supplemental client-paid fee on March 16, 1989, the same day that claimant filed for judicial review. The Board concluded:

> "We have previously held that, when our prior order has addressed either the carrier's counsel's entitlement to, or the amount of a client-paid fee, our authority to consider requests for attorney fee authorizations is contingent upon our retaining jurisdiction over the order. *See Robert D. Janini,* 40 Van Natta 1127 (1988); *Jane E. Stanley,* 40 Van Natta 831 (1988). Here, our March 10, 1989 order addressed the insurer's counsel entitlement to, as well as the amount of, a client-paid fee. Inasmuch as that our order has been appealed, we lack jurisdiction to address this supplemental request for authorization."

The Board also stated that it recognized that it had the authority to withdraw the order, but that it rarely had done so and would not in this case.

The Board's conclusion that, because claimant filed a petition for review, it no longer had jurisdiction is incorrect. We held in *SAIF v. Fisher,* 100 Or App 288, 785 P2d 1082 (1990), that the Board has the authority to withdraw an order and reconsider its decision until the order becomes final, which, in accordance with ORS 656.295, is 30 days after the order is issued. The fact that a petition for judicial review has been filed during that time does not affect the Board's authority to withdraw its order or to issue a new amended order. It is within its discretion whether to withdraw the order for purposes of reconsideration. Here, the Board held that it would not exercise its authority to withdraw the order in order to consider the supplemental statement of services. However, it appears that its decision not to withdraw the order was based, at least in part, on its conclusion that it lacked jurisdiction because a petition for judicial review had been filed.[2]

Affirmed on petition; reversed and remanded for reconsideration on cross-petition.

[2] The Board's order seems to say that, although the Board did not have jurisdiction to consider the request for attorney fees, it did have jurisdiction to withdraw the order. The Board retained jurisdiction to do both.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Vera C. Terlouw, Claimant.

TERLOUW,
Petitioner,

v.

JESUIT SEMINARY et al,
Respondents.

(WCB 87-03443; CA A61558)

Judicial Review from Workers' Compensation Board.

Argued and submitted January 5, 1990.

Robert Wollheim, Portland, argued the cause for petitioner. With him on the brief was Welch, Bruun and Green, Portland.

David L. Runner, 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.

PER CURIAM

Affirmed.

PER CURIAM

Claimant seeks review of a Workers' Compensation Board order denying her petition for attorney fees. The referee had awarded claimant compensation, and SAIF sought Board review. Before Board consideration, SAIF moved to dismiss its request for review. The Board granted the motion and then denied claimant's petition for attorney fees.

Claimant contends that attorney fees should have been awarded under ORS 656.382(2),[1] because the Board did not reduce or disallow the award. However, the Board dismissed the matter and did not make a decision on the merits. There is, therefore, no authority to award attorney fees under ORS 656.382(2). *Liberty Northwest Ins. Corp. v. McKellips,* 100 Or App 549, 550, 786 P2d 1321 (1990); *Agripac, Inc. v. Kitchel,* 73 Or App 132, 698 P2d 69 (1985).

Affirmed.

[1] ORS 656.382(2) provides, in pertinent part:

"If a request for hearing, request for review, * * * is initiatied 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 * * *." (Emphasis supplied.)

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Theresa L. Howard, Claimant.

HOWARD,
Petitioner,

v.

WILLAMETTE POULTRY et al,
Respondents.

(WCB Case Nos. 87-06763, 86-15767,
86-15861; CA A60173)

Judicial Review from Workers' Compensation Board.

Argued and submitted November 3, 1989.

James L. Edmundson, Eugene, argued the cause for petitioner. On the brief were Christine Jensen and Malagon, Moore & Johnson, Eugene.

John L. Barlow, Corvallis, argued the cause for respondents Liberty Northwest Insurance Corporation and Willamette Poultry. With him on the brief was Fenner, Barnhisel, Willis & Barlow, Corvallis.

Dave Frohnmayer, Attorney General, Virginia L. Linder, Solicitor General, and John A. Reuling, Jr., Assistant Attorney General, Salem, filed the brief for respondent SAIF Corporation.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

NEWMAN, J.

Affirmed.

NEWMAN, J.

Claimant petitions for review of the Workers' Compensation Board's order that denied her an insurer paid attorney fee for services before the Board. We affirm.

Employer hired claimant in March, 1984. At that time, SAIF was employer's insurer. In July, 1984, SAIF accepted claimant's claim for right forearm pain, which was diagnosed as tendonitis. In July, 1985, Liberty Northwest Insurance (Liberty) became the insurer. In 1986, claimant developed carpal tunnel syndrome and filed a claim, but SAIF and Liberty both denied responsibility. An order pursuant to ORS 656.307 designated SAIF as paying agent.

The referee set aside SAIF's denial, and SAIF appealed to the Board. The only issue was responsibility. The Board ruled that Liberty was responsible. Although claimant had filed a brief urging that Liberty was responsible, the Board did not award an insurer paid attorney fee for services

before it.[1] On claimant's motion for reconsideration, the Board affirmed its denial of attorney fees.

Claimant argues[2] that she is entitled to fees from Liberty under ORS 656.386(1).[3] In *Shoulders v. SAIF*, 300 Or 606, 716 P2d 751 (1986), the court held that that section authorizes an award of insurer paid attorney fees if (1) the claimant initiates the review or appeal; (2) the appeal is from an order denying the claim; and (3) the claimant "finally prevails" on the issue of entitlement to compensation. *See*

Short v. SAIF, 305 Or 541, 545, 754 P2d 575 (1988). Here, those three conditions are not met.[4]

Claimant also asserts that she is entitled to attorney fees under ORS 656.382(2).[5] She argues that ORS 656.382(2) does not require that the insurer that initiated Board review be the insurer on whom the Board places responsibility for the fees. She argues that, even though SAIF initiated Board review, the Board may place the responsibility for payment of attorney fees on Liberty. We do not need to reach this question.

ORS 656.382(2) is inapplicable here, regardless of which insurer initiated the appeal to the Board. It authorizes attorney fees when, unlike here, claimant's right to compensation is at risk of disallowance or reduction. *See Anfora v. Liberty Communications*, 88 Or App 30, 744 P2d 265 (1987).[6]

[1] Claimant's temporary total disability benefits will be greater if Liberty is responsible.

[2] Claimant's two assignments of error assert that the Board's "finding" that she was not entitled to fees is not supported by substantial evidence. The issue, however, is one of statutory authority for fees, not substantial evidence.

[3] ORS 656.386(1) provides:

"In all cases involving accidental injuries where a claimant finally prevails in an appeal to the Court of Appeals or petition for review to the Supreme Court from an order or decision denying the claim for compensation, the court shall allow a reasonable attorney fee to the claimant's attorney. In such rejected cases where the claimant prevails finally in a hearing before the referee or in a review by the board itself, then the referee or board shall allow a reasonable attorney fee. In the event a dispute arises as to the amount allowed by the referee or board or appellate court, that amount shall be settled as provided for in ORS 656.388(2). Attorney fees provided for in this section shall be paid by the insurer or self-insured employer."

[4] In *SAIF v. Phipps*, 85 Or App 436, 737 P2d 131 (1987), we allowed attorney fees under ORS 656.386 for services before the Board. The issue was which insurer was responsible. The claimant took a position before the Board on responsibility that would have resulted in increased time loss benefits. *Phipps*, however, does not refer to *Shoulders v. SAIF, supra*, and predates *Short v. SAIF, supra*, 305 Or at 545, which makes it clear that whether a claimant is entitled to an award of attorney fees under ORS 656.386(1) does not depend on the amount of compensation that claimant may receive. *See also Petshow v. Farm Bureau Ins. Co.*, 76 Or App 563, 710 P2d 781 (1985), *rev den* 300 Or 722 (1986).

[5] 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."

[6] In *Dilworth v. Weyerhaeuser Co.*, 95 Or App 85, 767 P2d 484, *rev den* 307 Or 658 (1989), and *SAIF v. Bates*, 94 Or App 666, 767 P2d 87 (1989), attorney fees before the Board were allowed when there was the risk of loss or reduction of compensation to the claimant and the claimant participated in order to avoid that risk.

Here, the issue before the Board was responsibility, and claimant appeared only to argue that Liberty is the responsible insurer. Her right to compensation was never at risk and, therefore, ORS 656.382(2) does not provide a basis for an award of insurer paid attorney fees. *See Hunt v. Garrett Freightliners,* 92 Or App 40, 756 P2d 1275 (1988); *Wilson v. Geddes,* 90 Or App 64, 750 P2d 1182, *rev den* 306 Or 156 (1988).[7]

Affirmed.

[7] One of claimant's arguments is that she should be allowed an attorney fee by analogy to the authority in ORS 656.307(5). That provision, however, allows an award when a claimant is represented in an arbitration proceeding to determine responsibility issues. This proceeding was not an arbitration and there is no statutory basis for attorney fees.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Walter R. Searles, Claimant.

SEARLES,
Petitioner,

v.

JOHNSTON CEMENT et al,
Respondents.

(WCB No. 86-13495; CA A60531)

Judicial Review from Workers' Compensation Board.

Argued and submitted January 5, 1990.

Robert Wollheim, Portland, argued the cause for petitioner. With him on the brief was Welch, Bruun and Green, Portland.

Ann Kelley, 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 Richardson, Presiding Judge, and Newman and Deits, Judges.

NEWMAN, J.

Affirmed.

NEWMAN, J.

Petitioner, widow of claimant, seeks review of a Workers' Compensation Board order that reversed the referee's award of permanent total disability and awarded 35 percent unscheduled permanent partial disability. ORS 656.218(3). We affirm.

The facts are undisputed. Claimant, age 61 at the time of the hearing by the referee, had worked for employer as a manual laborer since 1974. In 1983, he underwent a partial excision of a cancerous colon and had a permanent colostomy. The cancer was not work related. Thereafter, he returned to work with no apparent difficulty. He had had back trouble for about 30 years. On January 17, 1986, he suffered a compensable back injury. At that time, the cancer had not recurred. Employer accepted the back injury claim. Claimant received treatment for his back but was unable to return to work, because the cancer reappeared in the spring of 1986. In July, 1986, his physicians removed another section of his colon and discovered inoperable cancer near his bladder. Beginning in March, 1987, he received chemotherapy.

In September, 1986, a determination order awarded time loss benefits and 30 percent unscheduled permanent partial disability for the back injury. Claimant requested a hearing, which was held in June, 1987.[1] The referee ruled that, although claimant was not medically permanently and totally disabled, he was permanently and totally disabled under the odd lot doctrine by reason of nonmedical factors such as age and education.

The Board found that claimant's preexisting cancer condition was not disabling at the time of the back injury. After excluding from consideration any disability attributable to cancer, the Board ruled that he was not totally and permanently disabled, because the back injury did not prevent him from working at a gainful and suitable occupation. However, it increased the permanent partial disability award to 35 percent.

Petitioner asserts that the Board erred when it

reversed the referee's award of permanent total disability. She argues that, because of claimant's cancer and his back condition, he was medically permanently and totally disabled at the time of the hearing. Petitioner does not argue for the referee's position that claimant was permanently and totally disabled under the odd lot doctrine. Neither does she argue that he was permanently and totally disabled as a result of his back injury alone or that the 35 percent unscheduled permanent partial disability award is an incorrect determination of the permanent partial disability attributable to his back injury.

To determine whether claimant was permanently and totally disabled, the Board must consider any preexisting disability. ORS 656.206(1)(a) provides:

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

[1] Claimant died some time after he requested a hearing, but the record does not disclose the date of death.

Petitioner argues that the Board erred because it failed to consider claimant's cancer condition in determining the extent of his disability at the time of the hearing. She relies on *Weyerhaeuser Company v. Rees,* 85 Or App 325, 328, 736 P2d 213 (1987):

> "In determining whether claimant is permanently and totally disabled, we consider all of her medical impairment, including pre-existing noncompensable disability. *Lohr v. SAIF,* 48 Or App 979, 983, 618 P2d 468 (1980); ORS 656.206(1)(a). The extent of disability is determined from the conditions existing at the time of the hearing. *Gettman v. SAIF,* 289 Or 609, 614, 616 P2d 473 (1980)."

There, the claimant's preexisting disease was disabling at the time of the industrial injury. The referee appropriately considered that disease in determining the extent of her disability at the time of the hearing.

Although extent of disability is determined at the time of the hearing, a noncompensable disability that occurs *after* an industrial injury, but does not exist at the time of the industrial injury, is not relevant in determining the extent of a

App 603, 605, 579 P2d 305 (1978). The recurrence of claimant's cancer in the spring of 1986 was a continuation of his preexisting cancer condition, but that condition was not *disabling* at the time of his back injury.

Affirmed.

598 May 23, 1990 No. 236

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Alva L. Hacke, Claimant.

UAC/KPTV OREGON TV, INC.,
Petitioner,

v.

HACKE et al,
Respondents.

(86-14779, 87-11890, 87-14689, 87-18777;
CA A50305 (Control), A50302)
(Cases Consolidated)

Judicial Review from Workers' Compensation Board.

Argued and submitted September 18, 1989.

Richard Wm. Davis, Portland, argued the cause for petitioner. With him on the brief was Davis & Bostwick, Portland.

John D. Peterson, Hillsboro, argued the cause for respondent Hacke. With him on the brief was Brink, Moore, Brink & Peterson, Hillsboro.

Paul L. Roess, Portland, argued the cause for respondent Liberty Northwest Ins. With him on the brief was Acker, Underwood, Norwood & Hiefield, Portland.

Mildred J. Carmack, Portland, argued the cause for respondent Pacific Indemnity. With her on the brief were Regina Hauser and Schwabe, Williamson & Wyatt, Portland.

David L. Runner, Assistant Attorney General, Salem, argued the cause for respondent SAIF Corporation/KPTV Oregon TV, Inc. On the brief were Dave Frohnmayer, Attorney General, Virginia L. Linder, Solicitor General, and Christine Chute, Assistant Attorney General, Salem.

Before Joseph, Chief Judge, and Newman and Deits, Judges.

DEITS, J.

Affirmed.

Joseph, C. J., dissenting.

DEITS, J.

Underwriters Adjusting Company (UAC) seeks review of a Workers' Compensation Board order holding it responsible for claimant's occupational disease claim. We affirm.

Claimant worked for television station KPTV for 29 years. He spent the first twelve years as a floor director for the news program and worked as a news camera operator for the

last 17 years. As camera operator, he was required to carry heavy camera equipment, often for long distances, up and down stairs and over rough terrain. Claimant did not have any preexisting injuries to his knees when he began employment at KPTV. However, by 1978, after 9 years as a camera operator, he began to complain of pain in both knees. An arthroscopy was performed that year on his left knee and again the following year on the same knee. In December of 1979, claimant suffered an injury to his left knee while covering a news story. Surgery was performed, but he did not file a workers' compensation claim. Another arthroscopy was performed on the left knee early in 1980. In August, 1980, he had surgery on his right knee. In April, 1981, he injured his left knee in a skiing accident. He continued to have problems with his knees and had surgery again in May, 1986. In July, 1986, he was unable to continue working due to pain in both knees. He retired in September, 1986.

During claimant's employment with KPTV, the station's insurer changed a number of times. SAIF was its insurer from the time that claimant began his employment until April, 1983. Liberty Northwest then provided insurance until April, 1985, followed by Pacific Indemnity until February, 1986. UAC was then the insurer until claimant left. In 1987, claimant filed two compensation claims, an occupational disease claim for his bilateral knee condition and a claim for the injury to his left knee that he suffered in 1979. The occupational disease claim was denied by all of the insurers, and SAIF denied the claim for the 1979 injury. The Board concluded that SAIF was responsible for the 1979 left knee injury.[1] It also concluded that the knee condition was an

"occupational disease" and held that, although SAIF was initially responsible for the condition, responsibility shifted to UAC, because claimant's work activities while UAC was on the risk independently contributed to the worsening of his condition.

UAC's first assignment of error is that there was not substantial evidence to support the Board's finding that claimant has an "occupational disease." In order to prove an occupational disease claim, a claimant is required to show by a preponderance of the evidence that work activities were the major contributing cause of the disease. *Dethlefs v. Hyster Company,* 295 Or 298, 310, 667 P2d 487 (1983). Claimant's treating physician stated that claimant's work was "the significant contributing factor to the deterioration and worsening of [his] knee." There was no contrary medical opinion. The evidence showed that claimant's daily work activities were quite strenuous, that his knee progressively got worse and that there were no comparable strenuous off-work activities. Claimant did have a ski accident in 1981, but the medical records show that it did not cause any long term problems, and his treating physician was aware of the accident when he concluded that claimant's work was "the significant contributing factor." The Board's conclusion that claimant's knee condition was an occupational disease was supported by substantial evidence.

[1] SAIF does not contest the Board's holding on the 1979 injury.

In its second assignment of error, UAC argues that there was not substantial evidence to support the Board's conclusion that UAC is responsible for claimant's current condition. Under the last injurious exposure rule, the *last employer* where the work activities independently contributed to a worsening of a claimant's condition, or the last insurer on the risk, is assigned full responsibility for that condition.[2]

Spurlock v. International Paper Co., 89 Or App 461, 465, 749 P2d 611 (1988). UAC argues that there was no evidence that anything occurred during UAC's period of coverage that independently caused his condition to worsen. We disagree. In May, 1986, claimant's treating physician reported that claimant was unable to continue working because of the pain in his knees. The physician also noted that claimant reported that the pain had recently become worse, because employer was pressuring him to push harder, and that he had to carry a new camera and recorder unit that weighed more than the equipment that he had previously been required to carry. Although claimant's work activities throughout his employment undoubtedly contributed to his condition, under the last injurious exposure rule, if the work activities while at the *last employer* independently contributed to the worsening, full responsibility falls on that employer, even if the exposure was very brief. *Runft v. SAIF*, 303 Or 493, 739 P2d 12 (1987). There was substantial evidence to support the Board's conclusion that claimant's work activities while UAC was on the risk independently contributed to a worsening of his condition.

UAC's third assignment of error is that that portion of the Board's order concerning SAIF's responsibility for the occupational disease is unclear. It contends that the Board held SAIF responsible for the occupational disease claim but, nevertheless, ordered UAC to pay the claim. UAC misinterprets the Board's order. The Board did not hold SAIF responsible for the disease claim. The order affirmed SAIF's *de facto* denial of the claim.[3] The Board noted that SAIF was initially responsible for the disease claim until "subsequent work activities independently contributed to a worsening of claimant's condition." However, it went on to hold that claimant's work activities while UAC was on the risk independently

[2] The dissent contends that the last injurious exposure rule is inapplicable here because the case involves successive insurers, but only one employer. However, in *Inkley v. Forest Fiber Products Co.*, 288 Or 337, 605 P2d 1175 (1980), where there was only one employer, the last injurious exposure rule was applied to determine liability as between the employer, who was a direct responsibility employer under *former* ORS 656.017(1), and SAIF, who had previously been on the risk. Moreover, in *Bracke v. Baza'r*, 293 Or 239, 244, 646 P2d 1330 (1982), it was held that the rule applies where "successive employers or insurers" might be liable. It has not been held that the rule does not apply when one employer, but successive insurers, are involved. The dissent asserts that *Garcia v. Boise Cascade Corp.*, 309 Or 292, 787 P2d 884 (1990), *Stovall v. Sally Salmon Seafood*, 306 Or 25, 757 P2d 410 (1988), and *Boise Cascade Corp. v. Starbuck*, 296 Or 238, 675 P2d 1044 (1984), overruled *Inkley* and *Bracke* on this issue. They do not. Furthermore, the reason for the rule, namely to reduce litigation, to remove the burden on claimants, to apportion liability between responsible parties and to provide certainty in the compensation system, apply equally to successive insurers.

[3] Because UAC erroneously thought that the Board's order held SAIF responsible for the occupational disease claim, UAC argued that the Board should have overturned SAIF's denial of that claim and awarded attorney fees to claimant's attorney for overturning that denial. In view of our holding that the Board did not *in fact* hold SAIF responsible for that claim, this argument is without merit.

contributed to the worsening and, therefore, UAC was responsible for the claim.

UAC's last assignment is that the Board erred in not concluding that Liberty Northwest and Pacific Indemnity

should also be responsible for the claim. UAC contends that, if the occupational disease claim can be reassigned to UAC from SAIF, then the two carriers who were on the risk between SAIF and UAC should also share the responsibility. However, Oregon law does not provide for apportionment of responsibility when an occupational disease has worsened over time. As stated in *Runft v. SAIF, supra,* 303 Or at 500:

> "As a rule of assignment of responsibility, the last injurious exposure rule assigns full responsibility to the last employer at which the claimant could have been exposed to the disease-causing substance. This is true no matter how brief or insignificant the possible exposure at the last such employer. * * * For this reason, the rule can be extremely arbitrary in a particular case, but this arbitrariness is mitigated in the long run as responsibility is spread proportionately among employers by operation of the law of averages. *See Bracke v. Baza'r, supra,* 293 Or at 249-50."

As discussed above, the Board's conclusion that claimant's work activities while UAC was on the risk independently contributed to the worsening was supported by substantial evidence and, therefore, full responsibility shifted to UAC.

Affirmed.

JOSEPH, C. J., dissenting.

I dissent, because the majority is confused about the issues and, ultimately, applies an incorrect rule of decision.

It is critical to note certain things about this case that are either misunderstood or overlooked by the majority:

1. UAC disputes the Board's finding that claimant has an occupational disease.

2. UAC disputes its responsibility for claimant's current condition, as between it and SAIF (and other insurers that have been employers' carriers).

3. Only *one* employer is involved.

4. Whatever else UAC and SAIF dispute, they agree that the Board's order is incomplete, unclear and, possibly, contrary to law, insofar as it seems to hold SAIF responsible in some mysterious way for the initial stages of claimant's occupational disease but still holds UAC ultimately responsible.

I agree with the majority that there is substantial evidence to support the Board's conclusion that claimant has an occupational disease. However, given that there is only one employer involved, the majority is wrong in applying the last injurious exposure rule to this case. As the Supreme Court has recently said in *Garcia v. Boise Cascade Corp.,* 309 Or 292, 787 P2d 884 (1990):

> "Finally, claimant has argued before the Board, the Court of Appeals, and this court, for application of the last injurious exposure rule. That rule might render employer, as claimant's last employer, liable for claimant's degenerative back condition if claimant established that the condition was caused by [*sic*] one of two or more places of employment. *See Stovall v. Sally Salmon Seafood,* 306 Or 25, 31, 757 P2d 410 (1988); *Boise Cascade Corp. v. Starbuck,* 296 Or 238, 675 P2d 1044 (1984); *Bracke v. Baza'r,* 293 Or 239, 646 P2d 1330 (1982)." 309 Or at 296.

Stovall and *Starbuck* together put to rest the misunderstanding dragged into the law by *Inkley v. Forest Fiber Products Co.,* 288 Or 337, 605 P2d 1175 (1980), that the last injurious exposure rule has anything to do with the allocation of liability between successive insurers. It has only to do with the liability between different employers. In the single employer case, the allocation rule should be simple: The carrier on the risk when the disease becomes disabling is responsible.

I cannot tell from the Board's order whether it actually applied the last injurious exposure rule, although the words it used indicate that it did. However, that is only one part of a very confusing order. That confusion has contributed to some of the confusion in the briefing in this case and, apparently, to the confusion in the majority opinion. I believe that we should say simply that the Board's reasoning (without saying that we fully understand it) does not lead to its result and remand the matter to the Board for reconsideration.

In fairness to the majority, I must acknowledge that its analysis of UAC's third assignment of error relating to SAIF's responsibility for claimant's condition pretty well tracks in its confusion the confusion of the Board. If UAC was on the risk when claimant's occupational disease became disabling, then UAC is responsible. The trouble is that SAIF had earlier accepted responsibility for claimant's bad knees. The

Board made a mishmash out of the allocation of responsibility. We cannot possibly straighten it out on this substantial evidence review. We can and should remand the matter to the Board.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Newton W. Orr, Claimant.

SAIF CORPORATION et al,
Petitioners,

v.

ORR,
Respondent.

(84-05108; CA A60975)

Judicial Review from Workers' Compensation Board.

Argued and submitted December 8, 1989.

David L. Runner, Assistant Attorney General, Salem, argued the cause for petitioners. With him on the brief were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

Brad G. Garber, Salem, argued the cause for respondent. With him on the brief was Law Office of Michael B. Dye, Salem.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

DEITS, J.

Reversed and remanded for reconsideration.

DEITS, J.

SAIF petitions for review in this workers' compensation case, arguing that claimant should not have received permanent total disability. We reverse and remand.

Claimant is an electrician who worked for employer for 18 years. In June, 1982, he injured his left knee and back in a fall. He received medical treatment and underwent knee surgery in 1983. His claim was closed in April, 1984, and he was awarded 25 percent permanent partial disability (PPD) for his back and 35 percent PPD for his knee. SAIF referred claimant for vocational assistance. Claimant then applied for and began receiving retirement benefits from employer. Claimant obtained a job repairing electronic motors, but he quit after one week because of back pain. He continued to have trouble with his back and had back surgery in June, 1985. SAIF voluntarily reopened his claim at that time.

In July, 1986, the claim was again closed with awards of 45 percent PPD for his back and 45 percent for his knee. Claimant requested a hearing on that order, and a hearing was held in September, 1987. The Board concluded that claimant was permanently and totally disabled. It found that he was no longer physically able to work, that there were no suitable occupations for which he had training and experience and that

he had extremely limited adaptability, slow reactions and no transferable skills. The Board also concluded that, given claimant's physical and nonphysical disabilities, it would be futile for him to seek regular, gainful employment. In its order on reconsideration, the Board specifically addressed SAIF's contention that claimant was not entitled to PTD because he had unreasonably failed to participate in pain therapy and vocational rehabilitation. The Board found that claimant was unable to participate in pain therapy and, therefore, that his refusal to participate was not unreasonable.

SAIF's first assignment of error is that the Board's finding that claimant was unable to participate in pain therapy is not supported by substantial evidence and, therefore, its conclusion that claimant had mitigated his disability was wrong. A claimant who unreasonably fails or refuses to mitigate the extent of his permanent disability is not entitled to compensation for that portion of his disability attributable to the unreasonable failure or refusal. *Nelson v. EBI Companies,*

296 Or 246, 674 P2d 596 (1984). However, the burden of persuasion is on the employer to show that the claimant unreasonably failed to mitigate damages. *Nelson v. EBI Companies,* 296 Or at 251. The court explained the test for whether a claimant has acted unreasonably:

> " '* * * The relevant inquiry is whether, if compensation were not an issue, an ordinarily prudent and reasonable person would submit to the recommended treatment. Such a determination must be based upon all relevant factors, including the worker's present physical and psychological condition, the degree of pain accompanying and following his treatment, the risks posed by the treatment and the likelihood that it would significantly reduce the worker's disability. *Grant v. State Industrial Acc. Com.,* 102 Or at 45; *see* 1 Larson, Workmen's Compensation Law [§ 13.22].' " 296 Or at 251.

The Board considered the relevant factors. It found that claimant has substantial physical problems, that he has experienced significant pain and that treatment is not likely to reduce his disability. Those findings are supported by substantial evidence and support the conclusion that claimant did not unreasonably fail to mitigate his damages.

SAIF also argues that the Board erred because it failed to make an express finding concerning whether claimant is willing to seek regular gainful employment. We agree. Before a claimant is entitled to PTD, a number of prerequisites must be met. First, a claimant must establish that, but for the compensable injury, he or she has made, or would have made, reasonable efforts to obtain employment. A claimant who is so incapacitated that he or she cannot perform regular gainful employment need not establish that such efforts have been made. *See Cutright v. Weyerhaeuser Co.,* 299 Or 290, 702 P2d 403 (1985). Here, this requirement was met. The Board concluded that it would be futile for claimant to seek regular, gainful employment, so it was unnecessary for him to show that he had made such efforts. The Supreme Court has held, however, that a claimant must also establish that, but for the

compensable injury, he or she would be willing to seek regular, gainful employment. It has been held that the Board must make express findings on that issue. *SAIF v. Stephen,* 308 Or 41, 47-48, 774 P2d 1103 (1989). The Board failed to make any

findings concerning that requirement and, therefore, we remand this case for reconsideration.[1]

Reversed and remanded for reconsideration.

[1] SAIF also argues that the Board erred in basing its award of PTD in part on claimant's functional disability. However, the Board found claimant permanently and totally disabled only on the basis of his physical incapacity.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Adolph W. Wende, Claimant.

SCHWABE, WILLIAMSON & WYATT,
Petitioner,

v.

WORKERS' COMPENSATION BOARD,
Respondent,

LIBERTY NORTHWEST INSURANCE et al,
Parties to the Proceeding Below.

(WCB 86-16961; CA A50813)

Judicial Review from Workers' Compensation Board.

Submitted on record and brief February 5, 1990.

Ridgway K. Foley, Jr. and Schwabe, Williamson & Wyatt, Portland, filed the brief for petitioner.

No appearance for respondent.

Before Graber, Presiding Judge pro tempore, and Riggs and Edmonds, Judges.

RIGGS, J.

Reversed and remanded for reconsideration.

RIGGS, J.

Petitioner seeks review of a Workers' Compensation Board order denying its request for attorney fees and assigns error to the Board's allegedly improper and unreasonable retroactive application of its administrative rules. We reverse.

Claimant was injured in September, 1986. Employer denied the claim and claimant requested a hearing, which was held on March 7, 1987. On April 13, the referee issued an opinion and order that upheld the denial, and declined to assess a penalty or attorney fees. On May 1, claimant appealed to the Board. On February 22, 1988, the Board affirmed the referee's order, but did not address the issue of client-paid attorney fees.

On April 22, 1988, employer's attorney filed a statement of services, seeking approval of $2,064 in fees for services rendered on Board review. On December 7, 1988, the Board denied the attorney fees request, because petitioner failed to comply with two rules.[1] First, the statement of services was not accompanied by an executed attorney retainer agreement, as required by OAR 438-15-010(1),[2] and, second, it was untimely, having been filed more than 15 days after the last brief.[3] OAR 438-15-027(1)(d).[4]

Petitioner correctly argues that the Board erred in

retroactively applying the rules. We agree that retroactively applying the 15-day deadline is unreasonable. *Amfac, Inc. v. Garcia-Maciel,* 98 Or App 88, 778 P2d 967 (1989). In *Amfac,* we held that such an application is improper because it

> "would disallow attorney fees to petitioners unless they had performed the impossible—or at least purely fortuitous—act of complying with a rule that did not exist at the time compliance was putatively required. Under the circumstances, that application of the rule 'is unreasonable in its prejudice to petitioners.' " 98 Or App at 92.

The Board further ruled that petitioner failed to comply with OAR 438-15-010(1), because it did not include an executed attorney retainer agreement with its request for attorney fees. Petitioner could have complied with the retainer agreement requirement, because the fee request was not submitted until April 22, 1988, nearly four months after the rule went into effect on January 1. It is not clear from the Board's order how it would treat the fee petition in the light of our ruling in *Amfac, Inc. v. Garcia-Maciel, supra.*

Reversed and remanded for reconsideration.

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[1] The Board also noted that its February 22, 1988, order had become final by operation of law because it was not appealed, abated, stayed or republished.

[2] At the relevant time, OAR 438-15-010(1) provided:

> "Attorney fees for an attorney representing a claimant, insurer or self-insured employer shall be authorized only if an executed attorney retainer agreement has been filed with the referee, Board or Court."

The words "or court" have been deleted from the current version of the rule.

[3] The last brief to the Board was filed on September 18, 1987. Notice of the proposed rulemaking was published on November 15, the rules were adopted December 18, and became effective on January 1, 1988.

[4] At the relevant time, OAR 438-15-027(1)(d) provided:

> "A statement of services for proceedings on Board review of a referee's order shall be filed within 15 days after the filing of the last brief to the Board."

The rule has since been renumbered OAR 438-15-028(1)(c) and currently provides that:

> "A statement of services for Board review of a referee's order shall be submitted to the Board within 15 days of the filing, or expiration of the time for filing, of the last brief."

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Alice C. LaDelle, Claimant.

LaDELLE,
Petitioner,

v.

LIFE CARE CENTER OF OREGON et al,
Respondents.

(WCB 86-00676; CA A60456)

Judicial Review from Workers' Compensation Board.

Argued and submitted December 4, 1989.

David C. Force, Eugene, argued the cause and filed the brief for petitioner.

David L. Runner, 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.

RICHARDSON, P. J.

Affirmed.

RICHARDSON, P. J.

Claimant seeks review of a Workers' Compensation Board order that denied attorney fees for her attorney's representation before the referee. She argues that the Board's ruling is an improper retroactive application of OAR 438-15-010(5). We affirm.

Claimant appealed a denial of her aggravation claim. At the hearing, after stipulations, the referee found that her condition had worsened and granted her additional permanent partial disability. He denied her request for attorney fees paid by SAIF in addition to the compensation award and allowed her attorney a fee paid from the additional benefits awarded. Claimant appealed the attorney fee award to the Board, which held that, because she had prevailed on a denied claim, she was entitled to carrier-paid attorney fees under ORS 656.386 in addition to the fees paid from her compensation. However, the Board said:

> "As previously discussed, claimant's counsel is statutorily entitled to a reasonable, carrier-paid attorney [fee] for services rendered at hearing. *See* ORS 656.386(1). Such a fee is defined as an 'assessed fee.' OAR 438-15-005(2). However, we cannot award 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 awarded."

OAR 438-15-010(5), which went into effect on January 1, 1988, provides that attorney fees shall not be authorized unless a statement of services has been filed by counsel. The referee's order that claimant appealed was issued on June 16, 1987. The Board issued a decision on February 23, 1989, and a decision on reconsideration on March 14, 1989.

Claimant contends that, because the referee's opinion and order was issued before OAR 438-15-010 became effective, the Board could not apply it retroactively to deny her carrier-paid attorney fees. She points out that the statement of services is required to be submitted within 15 days after the record before the referee is closed and she could not now comply with that time limit.

Retroactive application of a rule is not always

improper.[1] In *Amfac, Inc. v. Garcia-Maciel,* 98 Or App 88, 778 P2d 967 (1989), we held that application of the time limits of *former* OAR 438-15-027 to cases already terminated would be improper, because it

> "would disallow attorney fees to petitioners unless they had performed the impossible—or at least purely fortuitous—act of complying with a rule that did not exist at the time compliance was putatively required. Under the circumstances, that application of the rule 'is unreasonable in its prejudice to petitioners.' " 98 Or App at 92.

Here, the Board did not rely on claimant's failure to comply with the time limit; it only required that she file a statement of services in order for the fee to be determined. Application of OAR 438-15-010(5) does not necessarily preclude attorney fees and, under those circumstances, its application is not prejudicial to claimant. In the light of our decision in *Amfac, Inc. v. Garcia-Maciel, supra,* the time limits cannot be applied retroactively.

Claimant also contends that she should have been awarded attorney fees for Board review under ORS 656.386(1), because she sought Board review and increased her award of compensation. The sole issue before the Board was whether the referee correctly rejected her claim for carrier-paid attorney fees. She contends that the Board ruled that she was entitled to carrier-paid fees and, thus, the amount awarded by the referee to be paid out of her compensation was effectively returned to her. Claimant misunderstands the Board's order. It affirmed the referee's award of fees from the increased compensation and held that she was legally entitled to a carrier-paid fee *in addition.* The latter fee was *not* awarded, because claimant had not filed the statement of services. Her compensation was not increased by the Board's action.

Affirmed.

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[1] We accept, for the purposes of discussion, claimant's characterization that the issue is retroactivity.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Donald Davis, Claimant.

Donald DAVIS,
Respondent,

v.

AETNA CASUALTY COMPANY,
Appellant,

and

SAIF CORPORATION and
Liberty Northwest,
Respondents,

and

CHLORIDE BATTERY,
Employer.

(A8901-00118; CA A60425)

Appeal from Circuit Court, Multnomah County.

Anthony L. Casciato, Judge pro tempore.

Argued and submitted April 4, 1990.

Brad R. Scheminske, Portland, argued the cause for appellant. With him on the briefs were Thaddeus J. Hettle and Scheminske & Lyons, Portland.

Robert K. Udziela, Portland, argued the cause for respondent Donald Davis. On the brief were Robert J. Neuberger, David A. Hytowitz and Pozzi, Wilson, Atchison, O'Leary & Conboy, Portland.

Katherine H. Waldo, Assistant Attorney General, Salem, waived appearance for respondent SAIF Corporation.

Kay E. Kinsley, Salem, waived appearance for respondent Liberty Northwest.

Before Graber, Presiding Judge pro tempore, and Joseph, Chief Judge, and Edmonds, Judge.

EDMONDS, J.

Reversed and remanded with instructions to dismiss request for review.

EDMONDS, J.

Aetna appeals from a judgment awarding claimant attorney fees, entered after claimant sought review under ORS 656.388(2)[1] of a decision of the Workers' Compensation Board. Although neither party raises the issue, we reverse the judgment, because the trial court lacked jurisdiction to undertake claimant's request for review.[2] *See Lane Education Service Dist. v. Swanson,* 71 Or App 328, 334, 692 P2d 622 (1984).

During the time that claimant worked for employer, employer was insured at different times by Aetna Casualty Company, Liberty Northwest and SAIF. After claimant suffered a work-related injury, he filed an aggravation claim with Aetna and a new injury claim with SAIF and Liberty. All three insurers denied responsibility. The referee issued an order under ORS 656.307, designating Aetna as the paying agent. The referee found Aetna responsible and awarded claimant an insurer-paid attorney fee for services rendered both before and after issuance of the order. Aetna requested Board review on the questions of responsibility and attorney fees.

The Board affirmed the referee, except that it ruled that the award of attorney fees for services rendered after the issuance of the order under ORS 656.307 was error. It noted that the attorney fees provisions of ORS 656.307(5) were not in effect at the time of the hearing and reasoned that any fees awardable under ORS 656.386(2)[3] were limited to time periods

when compensability was an issue. It reduced claimant's fees accordingly. It also declined to award attorney fees under ORS 656.382(2)[4] for services rendered during Board review, because compensability was not an issue before the Board. Claimant sought review in the circuit court under ORS 656.388(2). The court reinstated the referee's award, awarded claimant attorney fees for services rendered before the Board and entered judgment accordingly.

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[1] ORS 656.388(2) provides:

"If an attorney and the referee or board cannot agree upon the amount of the fee, each forthwith shall submit a written statement of the services rendered to the presiding judge for the circuit court in the county in which the claimant resides. The judge shall, in a summary manner, without the payment of filing, trial or court fees, determine the amount of such fee. This controversy shall be given precedence over other proceedings."

In its 1990 Special Session, the legislature amended ORS 656.388 to delete subsection (2), effective July 1, 1990. Senate Bill 1197 (1990 Special Session), §§ 30, 54, 55.

[2] We reject claimant's argument that *we* lack jurisdiction to review a trial court's determination under ORS 656.388(2). *See SAIF v. Peoples*, 59 Or App 593, 595, 651 P2d 1359 (1982).

[3] ORS 656.386 provides:

"(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. In the event a dispute arises as to the amount allowed by the referee or board or appellate court, that amount shall be settled as provided for in ORS 656.388(2). 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."

[4] 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."

We hold that the trial court was without jurisdiction to award employer-paid attorney fees for services rendered before the Board. The Board denied a request by claimant for fees under ORS 656.382(2). The legislature did not contemplate that a fee controversy arising under ORS 656.382(2) or ORS 656.307 could be litigated under ORS 656.388(2). In *Greenslitt v. City of Lake Oswego,* 305 Or 530, 754 P2d 570 (1988), the court said:

> "ORS 656.382(2) provides for attorney fees to a claimant in an employer-initiated review or appeal where compensation is not reduced or disallowed. * * * Unlike ORS 656.386(1), ORS 656.382(2) makes no reference to ORS 656.388(2).
>
> "* * * * *
>
> "[ORS 656.382(2)] does not provide for circuit court review via ORS 656.388(2)." 305 Or at 535. (Citations omitted.)

The trial court was also without jurisdiction to reinstate the referee's award. ORS 656.388(2) gives the circuit court authority to hear disputes concerning only the *amount*

of fees awarded under ORS 656.386(1). It does not give the court jurisdiction to determine whether the claimant was *entitled* to fees. *See Amfac, Inc. v. Garcia-Maciel,* 98 Or App 88, 91-92, 778 P2d 967 (1989). Because the Board held that claimant was not entitled to any fees after the issuance of the ORS 656.307 order, the circuit court was without authority to hear that dispute.[5]

Reversed and remanded with instructions to dismiss the request for review.

[5] Although the issue is not before us, we note that claimant was not entitled to an award of any fees under ORS 656.386(1), because that statute authorizes an award of attorney fees to a claimant who finally prevails on an appeal of a decision denying compensability of claim. By the time of hearing, there was no issue of compensability; the only issue was responsibility.

No. 287 June 13, 1990 185

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Brenton R. Kusch, Claimant.

Brenton R. KUSCH,
Respondent,

v.

AETNA COMMERCIAL INSURANCE
and U-Haul/Americo,
Appellants,

and

SAIF CORPORATION and
Portland Rent-All,
Respondents.

(8805-02832; CA A50540)

Appeal from Circuit Court, Multnomah County.

Donald H. Londer, Judge.

Argued and submitted May 4, 1990.

Bradley R. Scheminske, Portland, argued the cause for appellants. With him on the brief were Thaddeus J. Hettle and Scheminske & Lyons, Portland.

Robert K. Udziela, Portland, argued the cause for respondent Brenton R. Kusch. With him on the brief were Donald R. Wilson and Pozzi, Wilson, Atchison, O'Leary & Conboy, Portland.

John T. Bagg, Assistant Attorney General, Salem, argued the cause for respondents SAIF Corporation and Portland Rent-All. With him on the brief were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

Before Joseph, Chief Judge, and Riggs and Edmonds, Judges.

PER CURIAM

Reversed and remanded with instructions to dismiss request for review.

PER CURIAM

Appellants[1] appeal from a judgment in favor of claimant for attorney fees awarded by the trial court pursuant to ORS 656.388(2) after a Worker's Compensation Board referee had denied claimant's request.[2] In considering claims for attorney fees pursuant to ORS 656.388(2), the circuit court is without authority to determine *entitlement* to fees under ORS 656.307(5), ORS 656.382(2) or ORS 656.386(1). ORS 656.388(2) gives the court authority only to determine the *amount* of fees awarded by the Board or referee under ORS 656.386(1). *See Davis v. Aetna Casualty Co.,* 102 Or App 132, ___ P2d ___ (1990). Therefore, we reverse the judgment.

Reversed and remanded with instructions to dismiss the request for review.[3]

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[1] The judgment is against Aetna Commercial Insurance only.

[2] ORS 656.388(2) provides:

"If an attorney and the referee or board cannot agree upon the amount of the fee, each forthwith shall submit a written statement of the services rendered to the presiding judge for the circuit court in the county in which the claimant resides. The judge shall, in a summary manner, without the payment of filing, trial or court fees, determine the amount of such fee. This controversy shall be given precedence over other proceedings."

In its 1990 Special Session, the legislature amended ORS 656.388 to delete subsection (2), effective July 1, 1990. Senate Bill 1197 (1990 Special Session), §§ 30, 54, 55.

[3] A similar judgment was entered against SAIF Corporation. Although SAIF has not appealed from that judgment, in its brief it argues that "the appropriate remedy in this case is a return to the circuit court with instructions to find no attorney fees payable against either party." We are without authority to reverse a judgment from which there is no appeal.

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