VAN NATTA'S WORKERS' COMPENSATION REPORTER

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

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CITE AS

42 Van Natta ____ (1990)

In the Matter of the Compensation of
ROLAND L. DAWKINS, Claimant
WCB Case No. 85-11265
SECOND ORDER ON REMAND
Vick & Associates, Claimant Attorneys
Spears, et al., Defense Attorneys

Claimant has requested reconsideration of that portion of our December 11, 1989 Order on Remand that granted claimant's counsel an approved attorney fee equal to 25 percent of the increased compensation created by our order awarding temporary total disability, not to exceed $750. Specifically, claimant contends that he is entitled to a carrier-paid attorney fee for services rendered before every prior forum for finally prevailing against the self-insured employer's denial of his aggravation claim.

Claimant's contention is incorrect. Contrary to his assertion, the issue on remand was his entitlement to temporary total disability benefits, not the compensability of his aggravation claim. The claim had already been reopened for aggravation and closed by Determination Order. The issue was what benefits claimant was entitled to under the accepted claim. See Dawkins v. Pacific Motor Trucking, 308 Or 254 at 256 & 257 (1989); Dawkins v. Pacific Motor Trucking, 91 Or App 562 at 564 (1988). Thus, when we found that claimant had not withdrawn from the workforce and was entitled to temporary total disability compensation, he did not finally prevail against a decision rejecting his claim. See ORS 656.386(1); 656.388(1).

Under such circumstances, we lack authority to award a carrier-paid fee. See Charles L. Smith, 41 Van Natta 75 (1989). Instead, the fee is payable from the increased compensation awarded by our order. See ORS 656.386(2); OAR 438-15-045; former OAR 438-47-030.

Accordingly, our December 11, 1989 order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our December 11, 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
TERESA R. HARMON, Claimant
WCB Case No. 87-16228
ORDER ON RECONSIDERATION
S. David Eves, Claimant Attorney
Dennis Martin (Saif Corp.), Defense Attorney

The SAIF Corporation requests reconsideration of our Order on Review, dated December 5, 1989, which reversed that portion of the Referee's order that failed to award claimant's attorney an approved fee. Specifically, SAIF argues our December 5, 1989, order is "legally indefensible."

This is a difficult case. Both parties present meritorious arguments. SAIF argues that claimant's attorney "could have" requested reconsideration of the Referee's order. The fact is, either party "could have" requested reconsideration by the Referee. However, that was not done and it is not the issue. Nor is the issue that SAIF may have paid all the compensation that the Referee ordered.

We review de novo. Our administrative rules provide that: "[T]he Referee shall approve a fee of 25 percent of the increased compensation * * *." OAR 438-15-040(1); see also ORS 656.386(2). Here, both parties acknowledge that the Referee erred as a matter of law in failing to award claimant's attorney an approved fee. We must address that error.

In doing so, we decline to speculate whether SAIF has or has not paid the compensation ordered by the Referee. Such a finding quite plainly cannot be ascertained from the record. Even if it could, we would not be absolved from addressing the Referee's legal error.

The lack of an approved fee is the issue; not who "could have" requested reconsideration or what, if any, compensation has been paid by SAIF. The Referee erred in not awarding an approved fee. In addressing that legal error, we adhere to the reasoning contained in our order of December 5, 1989.

Accordingly, SAIF's request for reconsideration is granted and our prior order withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our December 5, 1989, 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
ANNETTE PRESTON, Claimant
WCB Case No. 87-13133
ORDER ON REMAND
Pozzi, et al, Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Crider and Nichols.

This matter is before the Board on remand from the Court of Appeals. Preston v. Wonder Bread, 96 Or App 613 (1989). The court reversed the Board's prior order, Annette Preston, 40 Van Natta 589 (1988), with one member dissenting, which had upheld the insurer's denial of claimant's occupational disease claim for an allergy condition. Holding that the Board erred as a matter of law in concluding that claimant's "predisposition" to react to certain allergens was the "condition" to be evaluated, the court has remanded for reconsideration. We proceed to do so.

FINDINGS OF FACT

With the exception of the first sentence in the fourth paragraph of the "Findings of Fact" in our earlier order, we adopt the Board's prior findings with the following supplementation.

Claimant's eye, nose and throat symptoms are due to an allergic rhinitis. The major contributing cause of this condition was claimant's work environment.

CONCLUSIONS OF LAW

To establish a compensable occupational disease, claimant must establish that her work environment was the major contributing cause of either the onset or worsening of her disease. 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, 295 Or at 309-10. Worsening in this context means pathological exacerbation of the underlying condition. See Wheeler v. Boise Cascade Corp., 298 Or 452, 457 (1985); Weller v. Union Carbide Corp., 288 Or 27, 31-35 (1979).

In its previous order, the Board, with one member dissenting, found that claimant's symptoms were due to an atopic diathesis, which was defined as a hereditary predisposition to react to certain allergens, including substances to which she was exposed at work. Concluding that sensitivity to substances found in flour dust was claimant's disease and that her allergic reactions were merely symptoms that did not demonstrate a worsening of her underlying condition, the Board upheld the insurer's denial.

The court reversed, reasoning that the conclusion that claimant's atopic diathesis was the disease or preexisting condition on which compensability should be based was inconsistent with the definition of atopic diathesis as a predisposition to react to certain allergens. The court concluded that a predisposition was "a condition of special susceptibility to a disease, not a disease in and of itself." Preston, supra, 96 Or App at 616 (Citing Stedman's Medical Dictionary 1133 (23rd ed 1976)). Finally, noting that the record indicated that claimant was seeking compensation for an "allergic rhinitis" condition, the court stated as follows:

> "If, on remand, the Board finds that allergic rhinitis is the condition to be evaluated and that claimant's 'eye, nose and throat symptoms' are consistent with that condition, the Board's finding that the major contributing cause of these symptoms is the work environment compels the conclusion that claimant's condition is compensable."

After conducting our reconsideration of the medical and lay evidence, we find that the condition for which claimant is seeking compensation is allergic rhinitis. We base this opinion on the uncontradicted opinion of Dr. O'Hallaren, an allergy specialist. We are further persuaded that claimant's eye, nose and throat symptoms are consistent with, and attributable to, his allergic rhinitis condition. Inasmuch as claimant's work environment was the major contributing cause of the onset or the exacerbation of that condition, we conclude that she has established the compensability of her occupational disease claim.

Accordingly, on reconsideration, we affirm the Referee's order that set aside the insurer's denial of claimant's occupational disease claim. As directed by the Referee's order, the insurer shall process the claim in accordance with law. For services on Board review, claimant's attorney is awarded $545 as a reasonable fee, to be paid by the insurer.

Since claimant has finally prevailed after remand from the court, he is also entitled to an attorney fee for services rendered before every prior forum. See ORS 656.388(1). Yet, we are unable to award such a fee for services at the appellate level unless claimant's counsel submits a statement of services. See OAR 438-15-005(2); 438-15-010(5). Therefore, upon our receipt of such a statement of services, and assuming that we retain jurisdiction over this case, we shall proceed with our determination of a reasonable attorney fee for services at the appellate level.

IT IS SO ORDERED.

In the Matter of the Compensation of
LUCY LINN, Claimant
and in the Matter of the Complying Status of
Lee Ann Clark, dba, SHEAR SUNSHINE, Employer
WCB Case No. 85-07139
ORDER ON REMAND
John J. Lannan, Claimant Attorney
Davis & Bostwick, Defense Attorneys
Les Huntsinger (Saif Corp.), Defense Attorney

This matter is before the Board on remand from the Court of Appeals. Clark v. Linn, 98 Or App 393 (1989). Reversing our prior order which held that claimant was entitled to compensation because the noncomplying employer had not properly denied the claim, the court has remanded with instructions to determine compensability.

FINDINGS OF FACT

In early March 1985, claimant filed an 827 form alleging that she was injured on approximately February 8, 1985, while grooming three large sheep dogs. Shortly thereafter, she changed the date of injury, on an 801 form, to January 11, 1985, the day the three sheep dogs were actually groomed.

Claimant never notified the employer that she had injured her back at work, nor did the employer see any indication of back problems before or after the alleged injury. Claimant continued to groom dogs until March 9, 1985.

Claimant did not file her claim until after she had stopped working for the employer.

Claimant has degenerative disc disease in her lumbar spine.

CONCLUSIONS OF LAW AND OPINION

Based on his observations at hearing, the Referee found claimant to be not credible. Relying on this credibility finding and the lack of medical evidence, the Referee concluded that claimant had failed to establish the compensability of her claim. We agree.

In order to establish the compensability of her claim, claimant has the burden of proving that her work activity was a material contributing cause of her low back 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).

Here, there is no evidence, other than claimant's testimony, that she suffered an industrial injury on January 11, 1985. We concur with the Referee's assessment that claimant's version of events lacked credibility. Specifically, she did not inform the employer of an injury nor did she stop work, as she testified. Rather, she continued to work until March 9, 1985 and subsequently informed her employer that she was thinking of giving up dog grooming.

Considering claimant's noncredible testimony with the fact that all medical evidence supporting a causal relationship between her current condition and the alleged injury was premised on the history provided by claimant, we find

that claimant has not met her burden of proving that her low back disability and treatment is compensable.

We note parenthetically that the court stated that claimant injured her back in January 1985, while working as a dog groomer. Inasmuch as this matter has been remanded to us with instructions to determine compensability, we do not consider such a statement to have been intended as a binding factual finding.

Accordingly, the Referee's order dated November 10, 1986, which set aside the SAIF Corporation's acceptance of claimant's injury claim, is affirmed.

IT IS SO ORDERED.

In the Matter of the Compensation of
RONALD C. EARL, Claimant
WCB Case No. 88-06297
ORDER ON REVIEW
Peter O. Hansen, Claimant Attorney
Kevin L. Mannix, PC, Defense Attorneys

Reviewed by Board Members Myers and Gerner.

The insurer, Argonaut Insurance Company, requests review of those portions of Referee Tenenbaum's order that: (1) set aside its medical services denial; and (2) awarded temporary disability benefits beyond claimant's hospital discharge date of January 26, 1988, through February 26, 1988. Claimant cross-requests review of that portion of the Referee's order that declined to award temporary disability benefits for the periods: (1) June 3, 1987, through November 21, 1987; and (2) after February 26, 1988. On review, the issues are the compensability of medical services and the proper periods of temporary disability benefits. We affirm in part and modify in part.

FINDINGS OF FACT

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

Argonaut's denial, as verbally amended at the hearing, was solely a prospective medical services denial of future treatment by Dr. Colistro, a psychologist.

Since Referee Menashe closed an earlier hearing on March 13, 1987 claimant's psychological condition has not been causally related to the 1981 compensable back injury accepted by Argonaut.

Claimant was not psychologically medically stationary on February 26, 1988, the date Dr. Colistro released him to work.

CONCLUSIONS OF LAW

Medical Services

The Referee set aside Argonaut's medical services denial after concluding that Dr. Colistro's future services were reasonable and necessary. Although we agree that Argonaut's denial must be set aside, we do so for different reasons than those stated by the Referee.

A prospective denial of future medical services is procedurally improper and must be set aside. Evanite Fiber Corp. v. Striplin, 99 Or App 353 (1989). A worker is statutorily entitled to medical services for the duration of his life, which are both materially related to his compensable injury and reasonable and necessary. ORS 656.245(1).

Here, we conclude that Argonaut's denial is an impermissible prospective denial of claimant's future medical treatment. Striplin, supra. There is no dispute among the parties that Argonaut's medical services denial, dated April 12, 1988, denied payment for future treatment from Dr. Colistro. First, the denial itself, denies "further" treatment by Colistro. Second, during closing argument at the hearing below, Argonaut apparently clarified that it was denying Colistro's treatment after the date of the denial. Last, in its brief, Argonaut argues that claimant is not entitled to "continuing" care by Colistro.

Accordingly, for the reasons stated above and different from those stated in the Referee's order, we conclude that Argonaut's denial must be set aside.

Before turning to the remaining issues, we note that the Board held in Ronald C. Earl, 41 Van Natta 530 (1989), that claimant's medical services as of March 13, 1987, were no longer the responsibility of Argonaut. We need not address what res judicata effect, if any, Ronald C. Earl, supra, has on this case. It has none. That is, we are holding in this case that Argonaut's April, 1988, denial must be set aside because it is procedurally improper. An insurer cannot "deny" services for which there have been no claims submitted. Here, claimant never submitted any claims for the future services denied by Argonaut. That narrow procedural issue, has never previously been litigated.

Temporary Disability Benefits

June 3, 1987 to November 21, 1987

We adopt the Referee's opinion on this issue at pages three through five of her order.

After November 21, 1987

The Referee awarded temporary disability benefits from December 1, 1987, through the date of Dr. Colistro's work release of February 26, 1988. On review, the insurer argues that claimant should be awarded benefits from only January 4, 1988, through either January 26, 1988, or February 26, 1988. We modify the Referee's order with respect to the proper effective date of claimant's temporary disability benefits.

Following November 21, 1987, claimant reviewed some of Dr. Maletsky's, treating psychiatrist, chart notes. As a result, he became temporarily totally disabled from work and was briefly hospitalized on two occasions: (1) December 8 through 16, 1987; and (2) January 4 through 26, 1988. The Referee "deemed" that claimant had viewed Maletsky's records on December 1, 1987. We find no support in the record for that finding.

Claimant has not presented any evidence, other than speculation, regarding the date in which he read Dr. Maletsky's chart notes. It is claimant's burden to prove his case. Given the record before us, we can deduce nothing other than that claimant viewed Maletsky's notes no earlier than December 8, 1987, which was the date he was hospitalized.

Accordingly, we modify the Referee's order to reflect the award of temporary disability benefits effective December 8, 1987.

After February 26, 1988

Despite finding that claimant was not psychologically medically stationary on February 26, 1988, the Referee concluded that that was the proper date to terminate claimant's temporary disability benefits. We agree for reasons different than those stated in the Referee's order.

If claimant's psychological condition was compensably related to the 1981 Argonaut claim, then under Fazzolari v. United Beer Distributors, 91 Or App 592, on recon 93 Or App 103, rev den 307 Or 236 (1988), he would be entitled to temporary disability beyond February 26, 1988. That is, there is no dispute that his psychological condition was not medically stationary on that date. Fazzolari requires both a release to regular work and a declaration of medically stationary. 91 Or App at 595.

In Ronald C. Earl, 41 Van Natta 530 (1989), the Board held:

> "We conclude that claimant's current condition is not a continuation of his 1981 exacerbation. The medical record indicates that the latter acute condition had totally resolved by April 1983. This finding is consistent with the fact that claimant's 1981 injury claim was closed with no award for permanent psychiatric disability." 41 Van Natta at 532.

We find no persuasive basis in the record presently before us to conclude that claimant's psychological condition after February 26, 1988, became causally related to the 1981 Argonaut claim. See Liberty Northwest v. Bird, 99 Or App 560 (December 6, 1989). We, therefore, decline to disturb the Referee's termination date based on the medically stationary status of a condition for which, as a matter of law, Argonaut no longer has any responsibility.

ORDER

The Referee's order, dated August 2, 1988, is affirmed in part and modified in part. That portion of the order that set aside Argonaut's denial is affirmed. The Referee's award of temporary disability benefits, however, is modified. In lieu of the Referee's award, claimant is awarded temporary disability benefits from December 8, 1987, through February 26, 1988. The Referee's award of an approved attorney fee shall be reduced accordingly. Claimant's attorney is awarded an assessed fee of $600 for services on Board review concerning the compensability issue. A client-paid fee not to exceed $2,417, payable from the insurer to its counsel, is approved.

In the Matter of the Compensation of
RODNEY E. JONES, Claimant
WCB Case No. 87-12353
ORDER ON REVIEW
Dennis H. Henninger, Claimant Attorney
Kevin L. Mannix, PC, Defense Attorneys

Reviewed by Board Members Gerner and Myers.

Claimant requests review of those portions of Referee Ebner's order that: (1) upheld the insurer's partial denial of claimant's organic brain

syndrome; (2) declined to grant permanent total disability; (3) increased claimant's unscheduled permanent disability award for a back injury from 25 percent (80 degrees) as awarded by a Determination Order, to 35 percent (112 degrees); and (4) admitted, over claimant's objection, several reports from independent medical examiners. On review, the issues are evidence, compensability, and extent of permanent disability, including permanent total disability. We affirm.

The insurer has moved to strike claimant's references to correspondence which it submits are "outside the record." We agree that the aforementioned materials were not admitted as evidence at hearing. However, the materials were submitted with claimant's request for expedited hearing and, as such, are present in the record. Thus, the motion to strike is denied. Although the materials have not been considered for their evidentiary value, they have been considered as a means of reciting the procedural background of the claim.

FINDINGS OF FACT

Claimant is a 45-year-old male with low average intelligence. He did not graduate from high school and has worked as an unskilled laborer for a number of different employers. He currently suffers from organic brain syndrome or dysfunction, more commonly known as dementia. He also suffers from anxiety and possible depression. Vocational rehabilitation was last provided in 1986 and was closed due to noncooperation. Claimant is not motivated to look for work and has not sought work since 1986.

In 1983 claimant suffered an injury to his back for which he underwent surgery in 1984. After being released from the hospital he suffered headaches and noticed leakage from the surgical incision. He was readmitted to the hospital. The leakage was treated and he was diagnosed as having meningitis, an inflammation of the membrane of the brain.

Claimant sustained work-related injuries prior to 1983 for which he received a total of 40 percent unscheduled permanent disability. Of importance to this case is a head injury he suffered in December 1977. Claimant reported severe headaches and memory loss and was off work through January 1978. Brain scans showed a small subdural blood clot which over time was absorbed by the body, leaving no apparent abnormalities or neurological deficit. His employer at that time accepted the injury as disabling but apparently no award was made.

In 1987 claimant was awarded an additional 25 percent unscheduled permanent disability for the 1983 injury.

Claimant, who does not have a regular treating physician, has been examined by a number of doctors since his 1983 injury. The examinations requested by the insurer above the statutorily permitted number were authorized by the Medical Director.

The earliest examination concerning organic brain syndrome is that of June, 1985, when a psychologist, Dr. Charlton, examined claimant at the request of his then physician, Dr. Nash. His report did not mention the 1977 head injury or whether he reviewed the hospital chart notes on meningitis. The next examination took place in December, 1985, when a psychiatrist, Dr. Quan, examined claimant in conjunction with the Orthopaedic Consultants' examination, at which he was present. Dr. Quan did not have access to the hospital chart notes on meningitis.

Another psychologist, Dr. Fleming, examined claimant twice in December 1987 and once in January 1988 and reviewed his medical records. He did

not have records of the 1977 head injury, a December, 1980 injury, nor any of the 1978 medical reports. Dr. Fleming is not a licensed vocational counselor in Oregon.

Dr. Parvaresh, a psychiatrist, examined claimant in 1987 and reviewed claimant's complete medical file and the hospital records concerning the meningitis, as well as a report from a neurologist, Dr. Rosenbaum, which he had requested. The neurologist indicated that normal pressure hydrocephalus syndrome can develop months or years after meningitis, causing dementia. The syndrome's presence can be excluded by an MRI or CT brain scan, which was scheduled for claimant. Claimant did not keep the appointment. In August 1987, upon the suggestion of Dr. Parvaresh, a psychologist, Dr. Reiter, performed a neuropsychological evaluation of claimant.

Organic brain syndrome can be caused by meningitis, alcohol abuse, or a trauma, such as a head injury. In this case, claimant's organic brain syndrome was not caused by his meningitis and his anxiety and possible depression is related to the organic brain syndrome. Claimant's 1983 compensable injury was not a material contributing cause of his organic brain syndrome, or its worsening. As a result of his compensable injury, claimant has sustained permanent impairment in the mild range.

Claimant has not sought work since 1986. Vocational rehabilitation was last provided at that time, but was closed due to claimant's noncooperation. Claimant is not motivated to find work. A work search would not be futile.

CONCLUSIONS OF LAW AND OPINION

The Board adopts the Referee's opinion with the following supplementation.

Claimant objects to the admission of several reports produced by independent medical examiners. Specifically, he maintains that when additional medical examinations are requested from the Medical Director in misleading terms, they should be stricken from the record. Yet, claimant refers us to no authority to support the removal of a medical examination report on such grounds. Furthermore, there is no presumption that the opinions expressed in the examination reports are correct. They could be overcome by appropriate evidence developed by claimant. Norman G. Dyton, 41 Van Natta 860 (1989).

Claimant was provided with vocational rehabilitation in 1986, which he refused, and has not sought work since that time. A worker is required to show reasonable efforts to obtain regular, gainful employment. ORS 656.206 (3). It is not reasonable to require a worker to make efforts to obtain employment if such efforts would be futile. SAIF v. Stephens, 308 Or 41 (1989). However, a finding of futility is reserved for the most extreme situations. Georgia Pacific v. Perry, 92 Or App 56 (1988).

Here, claimant's vocational rehabilitation was closed for noncooperation. Claimant has not actively sought work since 1986. Further, we are unpersuaded that claimant would be unable to obtain and perform regular employment even if his noncompensable psychological problems are considered. Thus, we conclude that claimant has not demonstrated reasonable efforts to obtain regular, gainful employment nor has he shown that a work search would be futile. Therefore, we hold that claimant is not entitled to an award of permanent total disability.

ORDER

The Referee's order, dated June 1, 1988, is affirmed. A client-paid fee, payable from the insurer to its counsel, is approved, not to exceed $1,260.

In the Matter of the Compensation of
JACK K. KYLE, Claimant
WCB Case No. 87-05239
ORDER ON REMAND
PHIL H. RINGLE, JR., Claimant Attorney
ACKER, ET AL, Defense Attorneys

Reviewed by Board Members Brittingham, Nichols and Crider.

This matter is before the Board on remand from the Court of Appeals. Timberline Lodge v. Kyle, 97 Or App 239 (1989). The court has concluded that our prior order, Jack K. Kyle, 40 Van Natta 1230 (1988), did not contain findings necessary to determine if claimant's injury has a "sufficient work relationship." Consequently, the court has remanded "for further findings of fact." We proceed with our reconsideration.

Claimant requests review of Referee Podnar's order that upheld the insurer's denial of claimant's injury claim for his left knee condition. On review, claimant contends that his injury, incurred while participating in a ski race, arose out of and in course of his employment as a ski instructor.

FINDINGS OF FACT

We adopt the "Findings of Fact," as contained in our September 29, 1988 order, with the following supplementation.

Ski instructors with the employer are required to participate in clinics which are designed to improve their skills. Occasionally, ski races are organized in conjunction with these clinics.

The director of the ski school considered racing to be a "good medium for working on skiing skills." However, the director did not encourage instructors to enter ski races. The assistant director and a few of the other certified ski instructors encouraged claimant to race because it "builds your skiing character." Claimant also participated in races because he enjoyed skiing.

On the morning in question, the school's director did not encourage claimant or any other instructor to participate in the ski race. Rather, claimant and at least two other instructors approached the director seeking permission to enter the race. The race was not organized in conjunction with a ski clinic.

In obtaining the director's permission, claimant and the others understood that they would not be paid for the time they were participating in the race. They also were instructed to immediately return to the school following the race in case they were needed for private lessons. Claimant paid his own entry fee.

The employer did not expect claimant or any other ski instructor to participate in ski races that were not organized in conjunction with a ski clinic.

CONCLUSIONS OF LAW

In determining whether the claim is compensable, the issue is whether claimant's injury "arose out of and in the course of employment." ORS 656.005(7)(a). "If the injury has sufficient work relationship, then it arises out of and in the course of employment * * *." Rogers v. SAIF, 289 Or 633, 643 (1980). An on-premises injury has sufficient work relationship if it occurs

while the worker is "on-call" and is involved in an activity that is associated somehow with his/her employment. Clark v. U.S. Plywood, 288 Or 255, 260-61 (1980).

Seven factors have been identified to determine whether an injury is work-related: (1) whether the activity was for the benefit of the employer; (2) whether the activity was contemplated by the employer and employee; (3) whether the activity was an ordinary risk of, and incidental to, the employment; (4) whether the employee was paid for the activity; (5) whether the activity was on the employer's premises; (6) whether the activity was directed by or acquiesced in by the employer; and (7) whether the employee was on a personal mission of his own. Mellis v. McEwen, Hanna, Gisvold, 74 Or App 571, 575, rev den 300 Or 249 (1985). All of the factors may be considered; no one factor is dispositive. Mellis, supra.

In our previous order, we made findings that: (1) claimant was required to remain "on-call" on the employer's premises; (2) permission was requested and given for claimant's participation in the ski race; (3) the ski race occurred on the employer's premises; and (4) claimant was injured while skiing in the race. Based on these findings, we concluded as follows:

> "Thus, when he was injured while skiing, he was engaged in an activity in which the employer expected him to engage, given the requirement that he remain on the employer's premises. We conclude that, under claimant's work conditions, there was sufficient work connection to make the claim compensable."

The court has held that the finding that claimant was required to remain on the premises does not necessarily lead to the conclusion that claimant "was engaged in an activity in which the employer expected him to engage." Timberline v. Kyle, supra, n. 1, p. 242. Reasoning that our prior order did not contain findings necessary to determine if claimant's injury has a "sufficient work relationship," the court has remanded for "further findings of fact" and "reconsideration." Id.

After completing our reconsideration, we make the following conclusions concerning the aforementioned factors.

It is undisputed that claimant was not paid while participating in the ski race. It is likewise apparent that claimant received permission to enter the ski race and was injured while on the employer's premises. Thus, factors 4, 5, and 6 have been addressed.

We turn to the question of whether claimant's participation in a ski race, which was not conducted in conjunction with a ski clinic, was for the benefit of the employer.

The employer could likely receive some intrinsic benefit from claimant's participation in a ski race. Yet, such a benefit would be equally experienced through an instructor's mere appearance on the ski slopes or in the ski lodge. Moreover, the primary thrust in claimant's or any other instructor's participation in a ski race not organized in conjunction with a clinic was the particular instructor's personal initiative in requesting permission to enter the contest.

We conclude that the majority of the benefits derived from claimant's participation in such a ski race were personal in nature. The aforementioned reasoning further persuades us that claimant was engaged in a personal mission while competing in the ski race. These conclusions address factors 1 and 7.

We next address the issue of whether claimant's participation in the race was an activity contemplated or expected by the employer.

Ski instructors were required to participate in clinics, which occasionally included races. Furthermore, races were considered by the employer to be a "good medium" in assisting instructors in improving their skiing skills. Yet, ski instructors were neither required nor expected to participate in races such as the one in which claimant was injured. Rather, as explained by the director of the ski school, participation in races which were not organized in conjunction with clinics was achieved solely through the initiative of the instructors, who sought the employer's permission. If such permission was granted, the instructors "very clearly understood" that they would not be paid for the time they were participating in the race and were also aware of the need to immediately return to the school following the race in case their services were needed.

In short, the employer expected claimant, as well as any ski instructor, to ski while he was "on-call." Thus, skiing was contemplated by the employer and its employees. However, such an understanding does not necessarily lead to the conclusion that the employer also expected claimant or any ski instructor to engage in ski races which were not organized in conjunction with clinics. In fact, the director's testimony, as well as the circumstances surrounding claimant's entry in the ski race, persuade us that there was no such expectation on the part of claimant's employer.

Consequently, we conclude that engaging in ski races, which were not conducted in conjunction with clinics, was neither a contemplated nor expected activity. Based on the aforementioned reasoning, we are also not persuaded that participation in non-clinic ski races was an ordinary risk of, and incidental to, claimant's employment. Thus, the final two factors (2 and 3) have been considered.

Although no one Mellis factor is dispositive, our conclusions concerning these factors, when taken as a whole, lead us to determine that claimant's injury lacks a "sufficient work relationship." Therefore, we are not persuaded that the injury arose out and in the course of claimant's employment.

Accordingly, we affirm the Referee's July 28, 1987 order that upheld the insurer's denial of claimant's injury claim.

IT IS SO ORDERED.

Board Member Crider dissenting:

The majority concludes that a ski instructor's injury while engaging in a competitive event acquiesced in by the employer, on the employer's premises, during a lull in his work activities is not sufficiently work-related to be compensable. Although the majority has addressed each of the factors enumerated in Mellis v. McEwen, Hanna, Gisvold, 74 Or App 571, rev denied 300 Or 249 (1985), in accordance with the Court's instruction, its conclusion is out of line with both Oregon case law and the principles articulated by Larson, The Law of Workmen's Compensation, from whence Oregon derived the unitary work-connection test.

The majority errs by failing to recognize that reasonable activity undertaken under these circumstance is for the benefit of the employer inasmuch as the employer desires, and indeed requires, the worker's continued presence on premises.

The majority also errs by concluding that the employer and employee did not contemplate claimant's participation where, in fact, the employer as a condition of employment provided instructors free lift privileges and permitted them to ski during the shift while not otherwise occupied. By treating the ski race, in which claimant was permitted to participate, as entirely separate from unorganized ski activity, which was clearly contemplated at the time of hire, the majority reaches the artificial conclusion that the particular ski activity which caused the injury was not contemplated by the employer.

The Board finally errs by treating the skiing event as a personal mission of claimant's own simply because claimant participated in the event on his own initiative and "the majority of the benefits derived from claimant's participation in such a ski race were personal in nature." This reasoning effectively renders the factors of employer benefit and personal mission identical. They are not. The majority's analysis is wrong, as is its conclusion.

I. Activity Contemplated by the Employer

The majority, while conceding that claimant's work activities as an instructor from time to time included participation in employer-sponsored races, concludes that the employer did not "contemplate" racing activity for purposes of the Mellis analysis because this particular race was not sponsored by the school and instructor participation was not required or encouraged. Inasmuch as the employer anticipated that claimant would be involved in ski races while instructing (Tr. 65-66) and encouraged skiing during intervals between classes, it cannot fairly be said that racing activity such as claimant engaged in on the date of injury was not contemplated at the time of hire or later. That no one foresaw claimant's participation in this particular race is immaterial. Thus, in Halfman v. SAIF, 49 Or App 23 (1980), the court rejected a contention that the employer did not anticipate the particular route claimant would take during an off-premises break on the date of injury, where the risks associated with off-premises breaks were of the type that was contemplated. So, here, although the particular race could not have been specifically contemplated, it was contemplated that claimant would be exposed to the risks associated not only with skiing activity in general but with racing in particular. This factor, then, should weigh in favor of compensability.

II. Personal Mission

The majority's conclusion that claimant engaged in a personal mission of his own is also misguided. An employee is not involved in a personal mission of his own simply because he initiates the activity and it is primarily for his welfare. A personal mission is "a departure from the employment relationship." See Mellis v. McEwen, Hanna, Gisvold, supra, 49 Or App at 29.

Whether a particular activity, be it playing football or preparing a meal, is incidental to employment or a departure from it (a personal mission) depends on the degree to which claimant's activities are restricted by his employment. Allen v. SAIF, 29 Or App 631, 634 (1977). Thus, whereas preparing a meal is a personal mission unrelated to employment for most workers, it is not where an employee is on 24-hour call at a remote location. Wallace v. Green Thumb, Inc., 296 Or 79 (1983). And whereas social intercourse in a saloon of an evening is a personal mission for most workers, it may be work-related if an employee's recreational options are limited by his work. Rogers v. SAIF, 289 Or 633 (1980).

Similarly, whereas a worker's recreational activities are not work-related generally, they are if they occur during breaktime on employer premises or

during a lull in work activities. Larson, The Law of Workmen's Compensation, sec. 21.74; Velkovitz v. Penasco Independent School District, 633 P 2d 685 (N.M. 1981) (teacher chaperoning ski club to and from ski area hurt while skiing between duty periods); Motto v. Cosmopolitan Tourist Company, 278 App Div 597, 101 NYS 2d 873 (1951) (busdriver for fisherman hurt while fishing during lull in driving duties).

Claimant was very limited in what he could do with the large time periods between classes, given his duty to remain on the premises and readily available to the employer. The activity he was engaging in at the time of injury was of the same type as he engaged in on the job. Thus, he was not engaged in a personal mission of his own.

III. Benefit to the Employer

Claimant's participation in this particular race was of no particular benefit to the employer. However, the majority concedes that his presence skiing on the slopes during lulls in work was to the employer's benefit. Moreover, just as it was to the employer's benefit in Halfman v. SAIF, supra, that a Goodwill Industries collection attendant use off-work restroom facilities thereby putting him at risk for an off-premises injury, it is to the employer's benefit that claimant be limited to break activities in the ski area. Thus, claimant's participation in ski activity, putting him at risk for the injury he suffered, was in the employer's interest. The majority wrongly weighed the factor of benefit to the employer.

IV. Conclusion

All of the Mellis factors, with the exception of the factor of pay, considered in light of the circumstances and location of claimant's employment, weigh in favor of compensability. Moreover, even if I err in concluding that the employer benefits from claimant's skiing activity because the employer has greatly limited claimant's activity during non-instructional time, this limitation of options was decisive in Rogers v. SAIF, 289 Or 633 (1980). Clearly then, consideration of the Mellis factors, while "helpful" (see Halfman v. SAIF, supra at 28), is not exclusive. Nor is it sufficient in this case.

The employer was not entitled to have claimant sit on his hands during non-instructional periods. The risk of reasonable activity undertaken with the consent of the employer during such lulls is work-related. The claim is compensable.

January 4, 1990 Cite as 42 Van Natta 14 (1990)

In the Matter of the Compensation of
HARVEY D. McGAUGH, Claimant
WCB Case No. 88-02644
ORDER ON REVIEW
Black, et al, Claimant Attorneys
Steven D. Hallock, Defense Attorney

Reviewed by Board Members Gerner and Cushing.

Claimant requests review of Referee Mongrain's order which: (1) declined to grant permanent total disability; and (2) increased claimant's unscheduled permanent disability for a low back injury from 40 percent (128 degrees) to 55 percent (176 degrees). The issue on review is extent of permanent disability, including permanent total disability.

We affirm and adopt the Referee's order with the following supplementation.

To establish permanent total disability, claimant must prove that he is unable to perform and 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 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).

Claimant's supporting expert vocational opinion, provided by Mr.\Mihayl, a consultant, is not persuasive. Claimant testified that he was able to sit for 30 minutes, lift up to fifteen pounds, walk six blocks, and stand for 45 minutes. Mr. Mihayl admitted, on cross examination, that relying on these physical limits, rather than those he had used, would cause him to change his earlier opinion that claimant was unable to find work within his limitations. Furthermore, Mr. Mihayl testified he had not performed any local or regional labor market study or analysis in considering claimant's case.

The medical evidence establishes that claimant has suffered permanent impairment. However, such evidence does not support a finding that claimant is permanently incapacitated from regularly performing work at a gainful and suitable occupation. Rather, the medical evidence suggests that claimant's permanent impairment is in the moderate range.

Based on the medical, lay, and vocational evidence, we are persuaded that claimant retains the physical capacity, the education, the intelligence, and the transferable skills to perform jobs of a sedentary nature even considering his age of 63. Thus, we are not persuaded that claimant is permanently incapacitated from regularly performing work at a gainful and suitable occupation.

In the alternative, we would also find claimant had failed to meet his burden of proof under the terms of ORS 656.206(3). The statute states:

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

Claimant is not required to engage in job activities that, for all practical purposes, would be futile. SAIF v. Simpson, 88 Or App 638, 641 (1987).

The consensus of medical opinion is that claimant is moderately disabled but is able to perform modified light or sedentary work. There are vocational opportunities within claimant's limitations such as receptionist, file clerk, and telephone answering service operator. (Ex. 30)

By his own admission, claimant's participation in 15 months of vocational assistance involved sending out "a couple of dozen" resumes and checking want ads. (Tr. 45). There is some indication in the exhibits that the vocational assistance provider had trouble moving forward on the case due to claimant's "continuing complaints." In addition, claimant has not submitted any vocational reports to establish what his involvement in vocational assistance might have been. Outside the vocational assistance program, claimant called two employment agencies who did not call back, contacted the Employment Division and otherwise

limited his efforts to informing friends and acquaintances in the liquid gas industry that he would appreciate if they would contact him if they heard of a job he could do. There is no indication that claimant followed up any of these possible sources of employment beyond an initial contact.

Based on these findings, claimant has not established that he is willing to seek regular employment and has made reasonable efforts to obtain such employment. Consequently, claimant has not established that he is permanently and totally disabled.

Finally, we agree with the Referee that claimant is disabled to a degree beyond that previously awarded. We further concur that an award of 55 percent unscheduled permanent disability appropriately compensates claimant for his permanent loss of earning capacity resulting from his compensable injury.

ORDER

The Referee's order, dated June 9, 1988, is affirmed.

January 4, 1990 **Cite as 42 Van Natta 16 (1990)**

In the Matter of the Compensation of
EDWARD K. MCGUIRE, Claimant
WCB Case Nos. 87-12554, 87-07348, 87-07480, 87-07481 & 87-10318
ORDER ON REVIEW
Bloom, Marandas & Sly, Claimant Attorneys
Norman Cole (Saif Corp.), Defense Attorney
Roberts, et al, Defense Attorneys
Schwabe, et al, Defense Attorneys
Lindsay Hart, et al, Defense Attorneys
Acker, Underwood, et al, Defense Attorneys

Reviewed by Board Members Crider and Nichols.

Lile International Company ("Lile") requests review of those portions of Referee Peterson's order that: (1) declined to bar claimant's claim as untimely; (2) set aside its compensability and responsibility denial of claimant's neck, upper back, and right shoulder conditions; and (3) upheld denials from Chipman Moving and Storage ("Chipman"), Bekins Moving Company ("Bekins"), Eastside Van and Storage ("Eastside"), and Rose City Van and Storage ("Rose City") of the same conditions. On review, the issues are timeliness, compensability, and responsibility. We affirm.

FINDINGS OF FACT

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

In April, 1986, claimant was released to regular work without restriction. The residuals of an earlier 1985 compensable neck and upper back strain had resolved. He returned to work as an on-call furniture mover for several successive employers. The dates he worked for each employer were as follows: (1) Bekins -- April 11, 13, 1986, May 2, 1986, June 18, 1986, and July 9, 1986; (2) Eastside -- April 30, 1986, May 1, 1986, and August 13, 1986; (3) (1) Rose City -- May 4, 1986, June 1, 2, 3, 4, 27, 1986, and July 11, 1986; (4) Lile -- July 2, 10, 11, 12, 18, and 19, 1986; (5) Rose City -- August 16, 1986.

Claimant's work activities, through July, 1986, were the major contributing cause of the onset or worsening of his neck, upper back, and right shoulder conditions, which resulted in his eventual disability and need for surgery.

As a result, he returned to Dr. Crumpacker on August 12, 1986. Crumpacker took him off work, but he continued working as a furniture mover through August 16, 1986. He was hospitalized on September 6, 1986, for a myelogram.

Claimant became disabled on August 12, 1986.

Lile was the last employer for whom claimant performed work, prior to August 12, 1986, of the type that caused the onset or worsening of his neck, upper back and right shoulder conditions.

Claimant's employment after August 12, 1986 did not independently contribute to a worsening of his neck, upper back, and right shoulder conditions.

CONCLUSIONS OF LAW

Timeliness

Although we agree with the Referee's conclusion that claimant's April 23, 1987, claim is not time-barred, we do so for different reasons.

Claimant's worsened back and new right shoulder conditions developed gradually as a result of his work activities between May, 1986, and July, 1986. See e.g., Ex. 30-37. There has never been any allegation of a specific work incident or trauma. Moreover, given the type of work he was engaged in during that period, i.e., heavy lifting, pushing, and pulling, it cannot be said that the gradual development of his back and right shoulder problems were unexpected. We conclude, therefore, that claimant suffered an occupational disease; not an injury. See Valtinson v. SAIF, 56 Or App 184 (1982).

Given our above finding, claimant had 180 days to timely file an occupational disease claim. Former ORS 65.807(1). The 180-day period began to run on the date claimant became disabled or was informed by a physician that he was suffering from an occupational disease, whichever was later. Id. Claimant did not file within 180 days of the date he became disabled, i.e. August 12, 1986. However, as far as we can tell, claimant was never clearly informed by a physician that he was suffering from an occupational disease due to his work activities from May, 1986, through July, 1986. Accordingly, on this record, the 180-day period has never commenced. Victor L. Southwell, 41 Van Natta 234 (1989).

Compensability

Prior to April, 1986, claimant's neck and upper back conditions had resolved. Dr. Crumpacker had released him to regular work without restriction finding no permanent impairment. Claimant returned to work as a furniture mover. Shortly thereafter, he noticed the reonset of pain in his neck and upper shoulder. In addition, he began to experience right shoulder pain.

Dr. Crumpacker was claimant's initial treating physician. He examined and treated claimant on a regular basis from March through September, 1986. According to Crumpacker, claimant's work activities in June and July, 1986, "probably" were the major contributing cause of his disability and resulting need for medical services in late 1986. (Ex. 39). Dr. Walsh, claimant's current treating chiropractor, corroborated Crumpacker's opinion. (Ex. 40). We are persuaded by the collective opinions of treating doctors' Crumpacker and Walsh. See Weiland v. SAIF, 64 Or App 810, 814 (1983).

Under such circumstances, we conclude that claimant has proven that his work activities were the major contributing cause of the onset or worsening of his neck, upper back, and right shoulder conditions. The claim, then, is compensable.

Responsibility

The "last injurious exposure rule" operates in cases such as this, involving an occupational disease that arose over the course of several periods of employment. Boise Cascade Corp. v. Starbuck, 296 Or 238 (1984); Bracke v. Bazar, 293 Or 239 (1982). The rule operates as both a rule of proof and rule of liability assignment. We have already applied the rule of proof in our compensability analysis by not requiring claimant to prove the degree of causation with respect to each and every employer he worked for from April through July, 1986. Runft v. SAIF, 303 Or 493, 500 (1987). Turning to the rule of liability assignment, the Bracke Court stated:

> "Under the last injurious exposure rule of assignment of liability in cases of successive employment, each of which has contributed to the totality of the disease, the potentially causal employer at the time disability occurs is assigned liability for the cumulative whole. If the claimant is not in potentially causal employment when disability occurs, the last such employer is liable." 293 Or at 248. (Emphasis added).

Pursuant to Bracke, we must look to the last "potentially causal employment." The date of disability is the triggering date for that determination. Here, claimant became disabled on August 12, 1986, insofar as Dr. Crumpacker took him off work on that date. Claimant was not working at that time. Consequently, to ascertain the last "potentially causal employment," we must look back to the last period of employment preceeding August 12, 1986. Bracke, 293 Or at 248. Claimant's last period of employment before that date was his employment with Lile on July 19, 1986. Lile, therefore, provided the "potentially causal employment."

Under such circumstances, Lile is the responsible insurer for claimant's current neck, upper back, and right shoulder disabilities unless it is established that claimant's work after August 12, 1989 independently contributed to a worsening of the disability. Spurlock v. International Paper Company, 89 Or App 461 (1988); Alva L. Hacke, 40 Van Natta 1148, 1620 (1988). Inasmuch as we have found, relying on Dr. Crumpacker, that post-August 12 employment with Eastside and Rose City did not contribute to the onset or worsening of the disease, Lile remains responsible.

ORDER

The Referee's order dated March 29, 1988, as reconsidered on April 18, 1988, is affirmed. Claimant's attorney is awarded an assessed fee of $600, to be paid by Lile's insurer, Liberty Northwest Insurance Corporation. The Board approves the following client-paid fees: (1) payable from Lile's insurer, Liberty Northwest, to its attorney, not to exceed $1,488.50; (2) payable from Rose City's insurer, Liberty Northwest, to its attorney, not to exceed $340; (3) payable from Bekins' insurer, Pacific Marine Insurance Company, to its attorney, not to exceed $255; and (4) payable from Eastside's insurer, Safeco Insurance Company, to its attorney, not to exceed $1,240.

In the Matter of the Compensation of
LEONARD F. McSURDY, Claimant
WCB Case No. 86-08066
ORDER ON REVIEW
Stebbins & Coffey, Claimant Attorneys
Saif Corp Legal, Defense Attorney

Reviewed by Board Members Nichols and Crider.

Claimant, pro se, requests review of those portions of Referee Blevins' order that: (1) found claimant was not a subject worker; and (2) found that claimant had not sustained a compensable injury. On review, the issues are subjectivity and compensability. We affirm.

FINDINGS OF FACT

We find as fact the testimony of Mrs. Awain recited as the second paragraph of the Referee's "Summary of Evidence." We further find that Thrift Store Mental and Physically Handicapped Employer, Inc. did not enter into any agreement with claimant whereby he would perform services for remuneration. Rather, the store's manager permitted claimant to come to the store and to help as a volunteer. From time-to-time, she provided claimant with charitable assistance.

CONCLUSIONS OF LAW AND OPINION

We adopt the Referee's "Opinion" with the following supplementation.

ORS 656.005(27) provides that "worker" means any person who engages to furnish services for a remuneration. Here, the Referee found only the employer credible. The employer testified that claimant was a volunteer worker who received no wages. Because claimant received no remuneration for his services, he was not a subject worker within the definition of ORS 656.005(27). See John Dayton, 37 Van Natta 210 (1985).

ORDER

The Referee's order dated December 18, 1987 is affirmed.

In the Matter of the Compensation of
EDWARD R. REUTER, Claimant
Own Motion No. 89-0228M
OWN MOTION DETERMINATION
Saif Corp Legal, Defense Attorney

The SAIF Corporation voluntarily reopened claimant's claim for a worsened condition related to his industrial injury of April 9, 1982. The claim has now been submitted to the Board for closure. We deny SAIF's request for closure for lack of jurisdiction.

ISSUE

Own Motion Jurisdiction. Did claimant file his claim for a worsening of his 1982 industrial injury prior to the expiration of his five-year aggravation rights for that injury?

FINDINGS OF FACT

Claimant, a physical education instructor, compensably strained his left knee on April 9, 1982. He did not leave work due to the injury, but sought conservative treatment a week later. In May, 1982, SAIF formally accepted the claim as a nondisabling injury on the initial claim form.

An arthrogram in June, 1984, revealed a torn medial meniscus in the left knee. On November 15, 1984, claimant underwent sugery to remove the torn meniscus. By letter of November 29, 1984, SAIF advised claimant that it was processing his claim as a disabling injury based on information that he was losing time from work. SAIF began paying claimant temporary disability benefits; however, claimant returned the checks to SAIF, explaining that he did not lose any time from work. Claimant lost no time from work due to surgery because he was not teaching during the fall term. Claimant's claim was closed by Determination Order on March 25, 1985, with awards of temporary total disability from November 15, 1984, through December 17, 1984, and 5 percent scheduled permanent disability for the loss of use or function of the left leg (knee).

Claimant continued to have occasional difficulty with the left knee during the following years. On October 27, 1987, claimant saw Dr. James, an orthopedic surgeon, with severe left knee pain. James diagnosed osteoarthritis and recommended surgery. On November 3, 1987, claimant underwent knee surgery for arthroscopic chondroplasty. By letter of December 28, 1987, SAIF advised claimant that it had reopened his claim for a worsening of the 1982 industrial injury. SAIF ostensibly reopened claimant's claim under the Board's own motion authority.

FINDING OF ULTIMATE FACT

Claimant filed his claim for a worsening of his 1982 industrial injury prior to the expiration of his aggravation rights for that injury.

CONCLUSIONS OF LAW AND OPINION

If claimant's aggravation rights were expired at the time he filed his claim for a worsening of his condition, the Board has own motion jurisdiction of that claim; if not, the Board does not have own motion jurisdiction. ORS 656.273(4), 656.278(1); Miltenberger v. Howard's Plumbing, 93 Or App 475 (1988).

At the time of claimant's 1982 injury, ORS 656.273(4) provided:

> "(a) Except as provided in paragraphs (b) and (c) of this subsection, the claim for aggravation must be filed within five years after the first determination made under ORS 656.268(3).
> "(b) If the injury was nondisabling and no determination was made, the claim for aggravation must be filed within five years after the date of injury.
> "(c) If the injury was disabling but without permanent disability and no determination was made, the claim for aggravation must be filed within five years from the date of the notice of claim closure by the self-insured employer or the employer's insurer."

Or Laws 1981, ch 854, 20 (Emphases added.). Here, claimant's claim was closed and determined by Determination Order on March 25, 1985. Because a determination of claimant's claim was made, paragraphs (b) and (c) of ORS 656.273(4) do not apply here. Hence, under ORS 656.273(4)(a), claimant had five years from the March 25, 1985, Determination Order in which to file his aggravation claim. Because claimant's aggravation rights for the 1982 industrial injury were not expired when claimant filed his claim for a worsening of that injury in 1987, the Board does not have own motion jurisdiction of the claim. See Miltenberger v. Howard's Plumbing, supra. Accordingly, SAIF's request for closure is denied for lack of jurisdiction.

IT IS SO ORDERED.

January 4, 1990 Cite as 42 Van Natta 21 (1990)

In the Matter of the Compensation of
KAREN Y. STUWE (LANE), Claimant
WCB Case No. 88-02164
ORDER ON REVIEW
Roll & Westmoreland, Claimant Attorneys
Tom Sheridan (Saif Corp), Defense Attorney

Reviewed by Board Members Crider and Brittingham.

Claimant requests review of Referee Peterson's order that upheld the insurer's partial denial of claimant's reimbursement claim for travel expenses to and from his treating physician. On review, the issues are entitlement to transportation costs. We reverse.

FINDINGS OF FACT

We adopt the findings of the Referee.

CONCLUSIONS OF LAW AND OPINION

On review, claimant contends that the Referee erred in upholding the insurer's denial of his transportation costs. We agree.

The transportation costs denied by the insurer were incurred by claimant in receiving compensable medical treatment from her established provider after relocating to a new area. The Referee unpheld the insurer's denial of these costs after finding that the insurer had complied with the requirements of OAR 436-60-050(4).

In a decision rendered subsequent to the Referee's order, we have concluded that the limitation on transportation costs authorized by OAR 436-60-050(4) is not applicable in cases such as this. Kenneth D. Salsbury, 41 Van Natta 565 (1989). Accordingly, we reverse.

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 be awarded. See OAR 438-15-010(5).

ORDER

The Referee's order dated July 5, 1988 is reversed. The insurer's February 9, 1988 partial denial of claimant's medical services claim for transportation costs is set aside, and the insurer is directed to process the claim according to law.

In the Matter of the Compensation of
ROSE M. CARRILLO, Claimant
WCB Case No. 87-10962
ORDER ON REVIEW
Quintin B. Estell, Claimant Attorney
Rick Dawson (Saif), Defense Attorney

Reviewed by Board Members Brittingham and Nichols.

The SAIF Corporation requests review of Referee Michael Johnson's order which set aside its denial of claimant's injury claim for a hip and back condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

Claimant, 37 years of age at hearing, sustained an injury on September 4, 1982, while working at a nursing care facility. The injury occurred while she was dealing with an uncooperative and violent patient. Claimant filed a claim for injury to her left hip and back on September 9, 1982, but did not seek immediate medical treatment.

Six days after her injury, claimant experienced a sudden onset of abdominal pain related to an ectopic pregnancy. She was unable to return to work. Surgery was performed by Dr. Schumacker, M.D.

On June 6, 1986, claimant saw Dr. Silva, M.D., complaining of headaches and depression. Claimant did not complain to Silva of any hip or back pain until August 29, 1986. At that time, she sought treatment for right hip and low back pain.

Silva referred claimant to Dr. Gallagher, D.C., who, in October 1986, diagnosed obesity, mild to moderate degenerative disease, L4-L5, and mild stenosis of neuroforamen, L5, right, secondary to arthritis. Claimant's complaints included, but were not limited to, both upper and lower back pain, shoulder pain, and right leg and heel pain.

Claimant's 1982 injury claim was not processed until 1987. SAIF issued a denial of the claim on July 2, 1987.

CONCLUSIONS OF LAW

The Referee acknowledged that the medical evidence failed to establish a compensable injury on September 4, 1982. However, reasoning that the employer was responsible for the lack of contemporaneous medical evidence, the Referee set aside SAIF's denial. We disagree.

To establish the compensability of her condition on an accidental injury theory, claimant has the burden of proving that her episode at work on September 4, 1989 materially contributed to an injury that was disabling or required treatment. See Harris v. Albertson's, Inc., 65 Or App 254, 257 (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).

Here, claimant did not seek medical treatment immediately after the alleged 1982 incident for any back or hip condition. Moreover, six days after the incident, claimant suffered from an ectopic pregnancy, which required hospitalization and surgery.

Given these facts, we conclude that the issue of whether claimant's injury resulted in a condition that was either disabling or required treatment is a complex medical question. Thus, although claimant's and her husband's credible testimony is probative, resolution of this 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).

There is no medical evidence in the record which supports claimant's contention that the episode at work on September 4, 1982 resulted in a compensable injury. There is no medical evidence relating claimant's disabling abdominal pain on September 10, 1982 to the injury. Claimant, herself, related that pain to her ectopic pregnancy. Claimant testified that she informed Schumacker in 1982 that she had problems with her left hip and low back. Claimant also testified that during the two years after the September 1982 incident she saw Dr. Rollings, M.D., complaining of pain in her low back and hip, and then Dr. Dudley, M.D., complaining of excruciating pain. However, there is no medical opinion from these doctor's relating claimant's condition to the September 1982 injury. Moreover, there is no documented treatment for hip and back pain until August 1986. The physicians who subsequently treated claimant, Drs. Silva, M.D., and Gallagher, D.C., did not attribute her condition to the 1982 incident.

We conclude, therefore, that claimant has failed to meet her burden of proving that she sustained a compensable injury on September 4, 1982. We acknowledge that SAIF initially failed to process claimant's injury claim. Nevertheless, the appropriate remedy for a failure to timely process a claim would be a penalty and related assessed attorney fee. Here, claimant did not raise penalties and attorney fees as an issue.

ORDER

The Referee's order, dated January 26, 1988, is reversed. The SAIF Corporation's denial, dated July 2, 1987, is reinstated and upheld.

January 5, 1990 Cite as 42 Van Natta 23 (1990)

In the Matter of the Compensation of
LYNN M. ELLIOTT, Claimant
WCB Case Nos. 87-05171, 86-15343, 86-15352, 87-15114 & 87-15115
ORDER ON RECONSIDERATION
Welch, et al, Claimant Attorneys
Roberts, et al, Defense Attorneys

Claimant has requested reconsideration of our November 15, 1989, Order on Review, which: (1) "set aside" that portion of the insurer's medical services denial that denied causation, but failed to award an assessed attorney fee; (2) reversed the Referee insofar as he declined to reach the issue of extent of unscheduled permanent disability on jurisdictional grounds, but failed to award an assessed attorney fee; and (3) declined to remand for additional evidence on the extent of unscheduled permanent disability issue. In addition, claimant has requested that Member Cushing recuse himself from this case. On December 11, 1989, we issued an Order of Withdrawal indicating that Member Cushing had recused himself and that we would reconsider this case.

After reconsidering this case in light of claimant's request and supporting arguments, we continue to adhere to our November 15, 1989, order.

Assessed Attorney Fee

Medical Services Denial

Claimant asserts that he is entitled to an assessed attorney fee pursuant to ORS 656.386(1), for setting aside that portion of the insurer's medical services denial concerning causation. We disagree.

We acknowledge, however, that we used inartful language in our November 15, 1989, order. That is, we stated: "That portion of the [medical services] denial which denied causation is set aside; the balance of the denial is upheld." (Emphasis added). We should not have stated that a portion of the denial was "set aside." It was not. We intended to uphold the denial in its entirety.

The insurer's denial of claimant's current medical services denied both causation and the need for current treatment. Consequently, to "set aside" the denial, claimant had to prove both causation and that his treatment was reasonable and necessary. He did not. Rather, he only proved causation. He did not prove that his current treatment was reasonable and necessary.

In our view, claimant is confusing elements of proof necessary to prove his medical services case, with prevailing finally against a denial. ORS 656.386(1) states:

> "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 a 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." (Emphasis added).

Here, claimant did not "prevail finally." Prior to the hearing, his current medical services were denied. Neither the Referee's order nor our November 15, 1989, order directed the insurer to accept his claim for current medical services; those services remain denied. Although claimant proved one element of his medical services case, he did not prevail. The instant case is no different from an aggravation situation wherein a worker proves the element of causation, but not the element of a worsened condition. See ORS 656.273(1). In such situations, the worker has plainly not prevailed finally in setting aside an aggravation denial and his attorney is not entitled to a fee.

In support of his case for an assessed fee under ORS 656.386(1), claimant cites Littleton v. Weyerhaeuser, 93 Or App 659 (1988), and Virginia Wolf, 40 Van Natta 1725 (1988). Both of those cases are inapposite to the case at hand. Littleton dealt with the award of an ORS 656.382(2) assessed fee for prevailing against an insurer cross-request for review. Here, the insurer did not cross-request review. Claimant's reliance on Littleton is misplaced. In Virginia Wolf, supra, the insurer's aggravation denial was set aside by the Referee and the Board affirmed. That is not the case here. As we have explained above, here, the insurer's denial stands and has not been set aside.

Accordingly, we decline to award an assessed attorney fee for claimant's attorney's services on the medical services issue. Claimant has not "prevailed finally."

Jurisdictional Issue

At the hearing, the insurer asserted the affirmative defense of lack of jurisdiction. Specifically, it argued that the Referee could not reach the issue of extent of unscheduled permanent disability because claimant had allegedly failed to timely contest a Notice of Closure. The Referee agreed and, therefore, declined to reach the extent of disability issue. On review, we were not persuaded by the insurer's jurisdictional defense. Accordingly, we proceeded to rate the extent of claimant's unscheduled permanent disability.

On reconsideration, claimant cites the same authority as above and argues that his attorney is entitled to an assessed fee for "prevail[ing] on the jurisdictional issue." See ORS 656.386(1), Littleton, supra; Virginia Wolf, supra. Again, however, claimant has not prevailed finally against a denial of a claim for compensation. Rather, he has prevailed against the insurer's affirmative defense of lack of jurisdiction. The statutes do not provide for an assessed fee for defeating an insurer's affirmative defense.

Moreover, the insurer's defense was asserted to avoid reaching the merits of claimant's case for unscheduled permanent disability. It is axiomatic that an insurer need not issue a denial, when a worker files a request for hearing on the issue of extent of disability. In such instances, the worker is contesting either the insurer's Notice of Closure or the Evaluation Section's Determination Order. Inasmuch as no denial was required or issued concerning the extent of disability issue, regardless of whether claimant defeated the insurer's jurisdictional defense, there would be no basis under ORS 656.386(1) to award an assessed fee.

If any fee was awardable on the jurisdictional matter, it would have been an approved fee payable out of claimant's compensation. See ORS 656.386(2). Yet, we declined to award unscheduled permanent disability in our November 15, 1989, order. There was, therefore, no award of compensation in which to award an approved fee.

In sum, we are unable to award an attorney fee to claimant's attorney for defeating the insurer's affirmative defense.

Remand

We adhere to our reasoning in our November 15, 1989, order on the issue of remand.

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our November 15, 1989, order in its entirety. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

January 5, 1990 Cite as 42 Van Natta 25 (1990)

In the Matter of the Compensation of
DAVID E. HORNBUCKLE, Claimant
Own Motion No. 89-0743M
DENIAL OF CONSENT TO ISSUANCE OF ORDER DESIGNATING A PAYING AGENT (ORS 656.307)
Schwabe, et al, Defense Attorneys

The Compliance Division has notified the Board that it is prepared to issue an order designating a paying agent under ORS 656.307 and OAR 436-60-180. Each of the insurers has provided its written acknowledgment that the only issue is responsibility for claimant's otherwise compensable claim. Claimant's aggravation rights under his claim with Employee Benefits Insurance Co. (EBI) have expired. Thus, that claim is subject to ORS 656.278.

Under OAR 438-12-032(3), the Board shall notify the Compliance Division that it consents to the order designating a paying agent if it finds that the claimant would be entitled to own motion relief if the own motion insurer is the party responsible for payment of compensation. The Board may exercise its own motion jurisdiction if there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. ORS 656.278(1)(a). In such cases, the Board may authorize the payment of temporary disability compensation from the time the worker is actually hospitalized or undergoes outpatient surgery until the worker's condition becomes medically stationary, as determined by the Board. Id.

Here, claimant's treatment has been conservative. Therefore, the record fails to establish that there has been a worsening of his compensable injury requiring either inpatient or outpatient surgery or other treatment requiring hospitalization. Consequently, claimant would not be entitled to own motion relief if the own motion insurer is found responsible for his current condition.

Accordingly, the Board is without authority to consent to an order designating a paying agent for purposes of temporary disability compensation. However, since responsibility for claimant's current condition is the only issue in dispute, the Board recommends the issuance of an order designating a paying agent pursuant to ORS 656.307(1)(b) for the payment of claimant's medical services. See OAR 436-60-180(14).

IT IS SO ORDERED.

In the Matter of the Compensation of
SHELDON MOUNT, Claimant
WCB Case No. 89-10510
ORDER DENYING MOTION TO DISMISS
Dwayne R. Murray, Claimant Attorney
Saif Legal, Defense Attorney

Claimant has moved the Board for an order dismissing the request for review filed by the alleged employer on the ground that it did not file an appellant's brief within the time allowed by the briefing schedule. The motion is denied.

FINDINGS OF FACT

The alleged employer requested Board review of the Referee's order within 30 days of its issuance. Copies of the hearing transcript were distributed to the parties on November 22, 1989. At that time, a briefing schedule was implemented.

The employer's appellant's brief was due December 6, 1989. Claimant was advised that its respondent's brief was due 14 days after the date of mailing of the employer's appellant's brief. On December 21, 1989, the Board received claimant's motion to dismiss the employer's request for review.

CONCLUSIONS OF LAW

In essence, claimant contends that we lack jurisdiction to consider the employer's request for review because it failed to timely submit an appellant's brief. Yet, the filing of briefs is not jurisdictional. OAR 438-11-020(1); Bonnie A. Heisler, 39 Van Natta 812 (1987). Accordingly, the motion to dismiss is denied.

Inasmuch as no briefs have been timely submitted, this case shall be docketed for review.

IT IS SO ORDERED.

January 5, 1990 Cite as 42 Van Natta 27 (1990)

In the Matter of the Compensation of
TAMMY PARKE, Claimant
WCB Case No. 88-01412
ORDER ON REVIEW
Merrill Schneider, Claimant Attorney
Carrol Smith (Saif Corp), Defense Attorney

Reviewed by Board Members Howell and Speer.

Claimant requests review of Referee Leahy's order that declined to assess penalties and associated attorney fees for the SAIF Corporation's alleged untimely payment of medical bills and temporary disability benefits. The issue is penalties and attorney fees. We reverse in part.

FINDINGS OF FACT

Claimant was injured in an automobile accident on September 1, 1987. She subsequently filed a workers' compensation claim. The claim was accepted by SAIF on September 16, 1987.

SAIF received notice that claimant was off work as a result of her injury on September 14, 1987. SAIF paid claimant her first installment of temporary disability benefits the following day, September 15, 1987.

On November 25, 1987, SAIF received bills for medical treatment from Clem Eischen, physical therapist, in the amount of $330.03. Sometime thereafter, SAIF requested Mr. Eischen's chart notes. These were received by SAIF on January 9, 1988. The bills were then paid by SAIF on February 4, 1988.

SAIF made adjusted payments of temporary disability benefits on November 10, 1987 and February 16, 1988, following notification of variations in claimant's hours of work.

Between September 1987 and February 1988, SAIF made the following late payments of temporary disability benefits:

Payment	Amount	Days Late
2.	186.68	1
3.	303.35	1
4.	56.00	1
6.	140.01	1
7.	140.01	1
8.	140.01	1
9.	140.01	1
10.	140.01	1
11.	140.01	1
13.	186.68	2

FINDINGS OF ULTIMATE FACT

SAIF's failure to timely pay the medical bills was unreasonable. Further, SAIF's failure to timely make temporary disability payments, except for payments 1, 5 and 12, was unreasonable.

CONCLUSIONS OF LAW AND OPINION

Untimely Paid Medical Bills

Claims for medical services should be paid or denied within 60 days of notice or knowledge of the bill. ORS 656.262(6); Billy J. Eubanks, 35 Van Natta 131 (1983). If the insurer unreasonably fails to pay a bill for medical services within 60 days, then a penalty and associated attorney fee may be assessed. ORS 656.262(10); 656.382(1).

SAIF did not pay the medical bills in question until 71 days after receipt. SAIF contended at hearing that it was not required to pay the medical bills within 60 days of their receipt, but instead was only required to pay the bills within 60 days of receipt of Mr. Eischen's chart notes. SAIF relies upon the provisions of OAR 436-10-090 in support of its argument.

OAR 436-10-090(1) requires that all billings for medical services be fully itemized and services identified. SAIF does not indicate in what way Mr. Eischen's billings failed to satisfy the requirements of OAR 436-10-090(1). Nor does our review of those billings disclose any such deficiency. We, therefore, conclude that the billings were fully itemized and services were identified.

Moreover, OAR 436-10-090(1) does not extend the 60-day period for denying or paying a medical bill. Rather, the rule provides circumstances under which an insurer's failure to timely pay a bill might be reasonable. See Nancy G. Peters, 37 Van Natta 597 (1985) (no unreasonable conduct where employer paid bill with reasonable promptness following receipt of requested itemization). Here, SAIF did not pay the bills until nearly one month following receipt of Mr. Eischen's chart notes. We find that SAIF did not pay the billings with reasonable promptness following receipt of the requested information.

We, therefore, conclude that SAIF unreasonably delayed payment of compensation. Accordingly, claimant is entitled to a penalty and associated attorney fee. We further conclude that, under the circumstances, a penalty of ten percent of the amount of the late paid bills is appropriate.

Untimely Paid Temporary Disability

SAIF made its first payment of temporary disability benefits the day following notification that claimant was off work as a result of her injury. Consequently, the first installment of compensation was timely paid. OAR 436-60-150(3).

Pursuant to OAR 436-60-150(4), all temporary disability payments, after the first payment, are to be paid once every 14 days. In addition, each payment shall include benefits payable for a period ending no more than seven days before the date of payment.

Here, most of SAIF's payments included benefits for a period ending eight days before the date of the payment. As such, they were untimely. Further, an insurer is liable for penalties for any unreasonable delay, no matter how brief. George J. Kovarik, 38 Van Natta 1381 (1986) (penalties assessed where no explanation for two day delay in payment of interim compensa

tion). Therefore, we reject SAIF's argument that a one day delay is too inconsequential to warrant a penalty.

Nor do we find SAIF's explanation for the delay to be reasonable. SAIF's contention in this regard is that payments are made "from" a certain date "to" a certain date. SAIF argues that the "to" date is the date of payment and is not counted as one of the seven days for purposes of OAR 436-10-150(4). However, the rule clearly requires that each payment include benefits payable for a period ending no more than seven days before the date of payment. SAIF's payment method was inconsistent with the clear wording of the rule.

However, two of the payments (payments 5 and 12) reflected adjustments to claimant's temporary disability rate. In each case, SAIF received notification of the need to readjust the rate of payment and promptly did so. We, therefore, conclude that with regard to these two payments SAIF did not unreasonably delay payment.

While the length of the delay does not affect liability for a penalty, it should be considered in setting the percentage factor of the penalty so that the "punishment fits the crime." Kovarik, supra. Considering the fact that none of the unreasonably delayed payments were more than two days late, we find that a five percent penalty appropriately addresses SAIF's conduct. In addition, we shall award an associated attorney fee in accordance with ORS 656.262(10) and 656.382(1).

ORDER

The Referee's order dated April 27, 1988 is reversed in part. The SAIF Corporation shall pay to claimant a penalty equal to 10 percent of the medical bills paid on February 4, 1988. In addition, SAIF shall pay to claimant a penalty equal to five percent of the temporary disability compensation represented by payments 2, 3, 4, 6 through 11, and 13. For services at hearing and on Board review concerning the penalty issue, claimant's attorney is awarded a reasonable fee of $500, to be paid by SAIF.

In the Matter of the Compensation of
RITA L. SHEPHERD, Claimant
WCB Case No. 87-02557
ORDER DENYING RECONSIDERATION
QUINTIN B. ESTELL, Claimant Attorney
RICK DAWSON (Saif), Defense Attorney

Claimant requests reconsideration of that portion of our December 12, 1989 Order on Review that declined to award an assessed fee for services rendered at hearing and on Board review. Claimant is entitled to an assessed fee for successfully prevailing against the SAIF Corporation's denial of her aggravation claim for a cervical-thoracic spine condition. We declined to award an attorney fee because claimant's counsel had not filed a statement of services. On reconsideration, claimant's counsel argues that a statement of services is not required because the services at issue were rendered prior to the effective date of the statement of services requirement under OAR 438-15-010(5).

We disagree. The statement of service requirement applies to all assessed fees awarded after January 1, 1988, the effective date of OAR 438-15-010(5). The date the Board awards the fee is the pivotal date, not the date the attorney renders the service. Here, the assessed fee would be awarded by the Board after

January 1, 1988. As a result, the Board cannot award an assessed fee for services at hearing or on Board review without a statement of services. See Gary Hess, 41 Van Natta 57, 60 (1989).

Accordingly, the request for reconsideration is denied. We adhere to our December 12, 1989 order. The parties' rights of appeal shall continue to run from the date of our December 12, 1989 order.

IT IS SO ORDERED.

January 5, 1990 Cite as 42 Van Natta 30 (1990)

In the Matter of the Compensation of
WILLIAM P. SMITH, Claimant
WCB Case No. 86-04666
ORDER ON REVIEW
Olson et al, Claimant Attorneys
Tom Ewing, Assistant Attorney General (Saif Corp)

Reviewed by Board Members Brittingham and Crider.

The Inmate Injury Fund requests review of those portions of Referee Brown's order that: (1) set aside its denial of claimant's injury claim; and (2) awarded claimant's attorney an assessed fee for services at hearing. We affirm.

FINDINGS OF FACT

The Board adopts the findings of the Referee with the following supplementation.

A written set of work rules was never given to claimant before February 28, 1986. Claimant did not know that he was violating the work rules.

Claimant's counsel requested a copy of the work rules. She was told none existed. Exhibit #5 is a copy of the work rules. It was not included in the Fund's submission of exhibits. It was disclosed on February 5, 1988 to claimant's attorney. Hearing was held February 9, 1988.

CONCLUSIONS OF LAW

The Board adopts the opinion of the Referee with following supplementation.

Although it appears that the Referee may have excluded Exhibit #5 in part on relevance grounds, the evidence is clear that the exhibit was not timely submitted nor timely disclosed as required by former OAR 438-07-015 (3) and (4). The record does not provide evidence of good cause for the late submission. We conclude that the Referee did not abuse his discretion under the rule in excluding the exhibit.

The Department of Justice argues that claimant's injury was the result of a willful violation of work rules and as such claimant is not entitled to benefits from the Inmate Injury Fund. ORS 655.510 (1)(c).

We have found that claimant was not provided with a copy of the work rules nor was he instructed verbally regarding the use of the ladder. Because he was unaware of what the work rules were, he could not willfully violate them.

The Department of Justice argues that there is no statutory authority on which to base an attorney fee payable by the Fund and that without it, the Board may not award attorney fees. The Court has recently held that the Board does have the authority to award such fees. Department of Justice v. Spear, 308 Or 594 (December 12, 1989).

ORDER

The Referee's order, dated March 9, 1988, is affirmed. Claimant's attorney is awarded an assessed fee of $600 for services on Board review, to be paid by the Inmate Injury Fund.

In the Matter of the Compensation of
THERON STIEHL, Claimant
WCB Case No. 87-01138
ORDER DENYING REQUEST
Malagon & Moore, Claimant Attorneys
Chuck Lisle (Saif), Defense Attorney

Claimant seeks reconsideration of that portion of our January 17, 1989 Order on Review that declined to award an insurer-paid attorney fee for services rendered at hearing and on Board review for prevailing against the SAIF Corporation's denial of claimant's transportation expense claim. We declined to award an attorney fee because we had received no statement of services. Contending that his counsel had submitted a statement of services, claimant requests an insurer-paid attorney fee award. The request is denied for lack of jurisdiction.

FINDINGS

On January 17, 1989, the Board issued an Order on Review. Pursuant to that order, the Referee's order, which had upheld SAIF's denial of claimant's transportation expense claim, was reversed. The Board order further stated that since no statement of services had been received from claimant's counsel, no assessed would be awarded. That order has not been appealed, stayed, or republished.

On December 15, 1989, the Board received a letter from claimant's counsel seeking an assessed fee. Enclosed with the request was a copy of a February 6, 1989 letter from claimant's counsel to the Board which also sought an attorney fee award. There is no record of the Board receiving the February 6, 1989 letter until December 15, 1989. Although both of the aforementioned letters refer to a February 22, 1988 statement of services, the Board has not received such a statement.

CONCLUSIONS

Pursuant to our January 17, 1989 order, claimant prevailed against a denial of his compensation. Under such circumstances, we reasoned that he was entitled to an insurer-paid attorney fee. ORS 656.386(1). Yet, because no statement of services had been received, we held that we were unable to do so. See OAR 438-15-010(5).

Inasmuch as our order was neither appealed, abated, stayed, republished nor withdrawn within 30 days of its issuance, it has become final by operation of law. ORS 656.295(8); International Paper Co. v. Wright, 80 Or App 444, 447

(1986). We have previously concluded that we retain jurisdiction to consider a request for an attorney fee even after the order on the merits has become final by operation of law. See Jane E. Stanley, 40 Van Natta 831 (1988), rev'd on other grounds Amfac, Inc. v. Garcia-Maciel, 98 Or App 88 (1989). However, in order to retain jurisdiction over the attorney fee request, our prior order must not have addressed either the entitlement to, or the amount of, an attorney fee. Gabino R. Orozco, 41 Van Natta 599, 775 (1989); Robert D. Janini, 40 Van Natta 1127 (1988).

Here, our January 17, 1989 order addressed claimant's counsel's entitlement to an insurer-paid fee. Since that order has become final by operation of law, we lack jurisdiction to consider the attorney fee request. See Gabino R. Orozco, supra. Accordingly, claimant's request is denied.

In reaching this conclusion, we acknowledge that claimant has submitted a copy of a February 6, 1989 letter, which suggests that his counsel sought an attorney fee award within 30 days of the Board's January 17, 1989 order. Had this request been received while we retained jurisdiction over the case, every effort would have been made to promptly process it. Unfortunately, in this particular instance, the aforementioned submission was not received and the 30-day appeal period to further consider the case elapsed without Board action.

Finally, claimant accurately notes that we have previously approved client-paid fees after the 30-day appeal period has elapsed. However, as previously discussed, such authorizations were given only where: (1) the prior Board order had not addressed either the entitlement to, or the amount of, an attorney fee; and (2) the requesting counsel had established that the statement of services had been timely submitted. See Harry N. Hunsley, 40 Van Natta 972 (1988).

IT IS SO ORDERED.

In the Matter of the Compensation of
JOHN V. STROZYK, Claimant
WCB Case No. 86-07113, 87-09321 & 87-09322
ORDER ON REVIEW
Tooze, Marshall, et al, Claimant Attorneys
Merrily McCabe (Saif), Defense Attorney

Reviewed by Board Members Brittingham and Nichols.

Claimant requests review of that portion of Referee Fink's order that: (1) declined to grant permanent total disability; and (2) increased claimant's unscheduled permanent disability for an abdominal condition, from 30 percent (96 degrees), as awarded by a prior Determination Order, to 75 percent (240 degrees). The issue on review is extent of permanent disability, including permanent total disability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following supplemental findings.

Claimant, 58 years of age at hearing, compensably injured his abdomen in an industrial accident in June, 1982. He had had prior surgeries for vascular tumors which resulted in muscular wall adhesions. Following the 1982 injury,

claimant suffered continuing pain in the region of these adhesions, radiating into his low back. He was hospitalized for treatment and returned to work. He continued to work as a shingle sawyer after this injury until being laid off in 1984. Claimant's pain complaints have increased since he stopped working.

Claimant suffered from disabling hypertension and high blood pressure prior to his compensable injury. After the injury, these conditions continued to limit some of his activities and occasionally required treatment.

Claimant has been employed in the manufacture of shingles for the past 20 years. He completed the 11th grade in school. He has limited transferable skills, and is restricted in lifting, standing, carrying, and walking. He is physically capable of doing only light to sedentary work.

The geographical area where claimant resides is depressed economically and has limited jobs available. Claimant is further limited in vocational rehabilitation efforts by the prior loss of the tips of two fingers on his right hand, although claimant is left handed. Claimant was cooperative with two different vocational rehabilitation efforts, both unsuccessful.

FINDINGS OF ULTIMATE FACT

As a result of his compensable injury, claimant has suffered permanent impairment in the mild to mildly moderate range.

Claimant has made reasonable efforts to find work.

Claimant is not precluded from regularly performing work at a gainful and suitable occupation as a result of his compensable injury, preexisting disabilities, and other social and vocational factors.

CONCLUSIONS OF LAW AND OPINION

Permanent Total Disability

The Referee found that claimant was not willing to relocate to a more populous and more prosperous region of the state and, therefore, found that he was not permanently totally disabled. We affirm on a different basis.

In order to prove 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); Wilson v. Weyerhaeuser, 30 Or App 403 (1977). The standard used is whether claimant is currently able to sell his services on a regular basis in a hypothetically normal labor market. Harris v. SAIF, 292 Or 683 (1982).

Claimant must also prove that he is willing to seek regular gainful employment, and that he has made reasonable efforts to obtain such employment. ORS 656.206(3). The Referee found that claimant was not willing to relocate and, therefore, had not proved that he had made reasonable efforts to obtain employment. We disagree.

Claimant lives in a small town on the Oregon coast. He is restricted by Dr. Van der Waal, his treating physician, to sedentary-light jobs. He has few transferable job skills and is not a good candidate for retraining because of his age and other physical conditions. Claimant sought work within a thirty mile radius of his home for such jobs as a security guard and gate tender. We consider claimant's efforts to obtain employment to have been reasonable.

However, we affirm the Referee's order because we find that claimant's compensable injury, combined with his other medical and nonmedical disabilities, has not caused him to be permanently and totally disabled. See ORS 656.206(1)(a).

Claimant may prove permanent total disability by medical evidence that he is completely physically disabled. Wilson v. Weyerhaeuser, supra. We find that claimant is not completely physically disabled. He continued to work at his regular employment for about two years after his compensable injury, at which time the job ended. After the job ended, his condition worsened and an aggravation claim was opened and subsequently closed. Further, his treating physician has released him for light-sedentary work.

Claimant may also prove permanent total disability under the "odd lot" doctrine. Wilson v. Weyerhaueser, supra. Here, claimant must show that a combination of medical and nonmedical disabilities effectively foreclose him from gainful employment. Welch v. Bannister Pipeline, 70 Or App 699 (1984). We find that claimant has not proved that he is permanently and totally disabled under the "odd lot" doctrine.

Dr. Van der Waal opined that claimant was permanently and totally disabled because he would be unable to find employment in his community. When a physician renders an opinion based more on social and vocational factors than medical considerations, we decline to substitute his judgment in such matters for our own. Keith K. Evans, 34 Van Natta 1035 (1982), aff'd mem 63 Or App 255 (1983).

In the context of permanent total disability, we also consider the extent of claimant's total impairment, including that caused by preexisting disabilities. ORS 656.206(1). Here, claimant suffered from disabling hypertension and high blood pressure prior to the compensable injury. In addition, he lost the tips of two fingers on his right hand in a prior industrial accident. However, because he is left handed the effect of this loss is not as great as if it had been his dominant hand.

In August 1985, claimant suffered an accidental overdose of narcotic analgesics. He was hospitalized overnight. In January 1986, he was admitted to a pain center and temporarily taken off narcotics. However, he then returned to the use of codeine. Some of claimant's physical condition is the result of extended use of narcotics.

At the pain center referenced above, claimant was given a placebo spinal injection. He reported immediate relief and one entire day free of pain. His physical condition improved when he used the exercise and relaxation techniques demonstrated at the pain center. His condition returned to its prior state when he returned home and ceased doing the exercises.

Claimant worked for about two years after his compensable injury, despite reporting pain in his back. His stated goals are to open his own business in the sporting goods area or to be self-employed in a fern-gathering business. The medical evidence establishes that these goals are within his physical limitations.

Having considered the combination of claimant's preexisting disabling conditions, his impairment from the compensable injury, and the other factors discussed above, we conclude that the evidence does not establish that claimant is permanently precluded from performing gainful and suitable work on a regular basis. We, therefore, find that claimant is not permanently totally disabled.

Permanent Partial Disability

The criteria for rating the extent of claimant's unscheduled permanent partial disability is the permanent loss of earning capacity due to the compensable injury. ORS 656.214(5). To determine claimant's permanent loss of earning capacity, we consider his physical impairment as reflected in the medical record, the testimony at hearing, and all of the relevant social and vocational factors set forth in OAR 436-30-380, et seq. We apply these rules as guidelines, not as restrictive mechanical formulas. See Harwell v. Argonaut Insurance, 296 Or 505, 510 (1984).

The medical evidence indicates claimant's injury-related impairment is in the mild-mildly moderate range. He has been released for sedentary-light work. Claimant was 58 years old at the time of the hearing. After reviewing the relevant factors, we agree with the Referee that an award of 75 percent unscheduled permanent disability appropriately compensates claimant for his permanent loss of earning capacity.

ORDER

The Referee's order dated September 25, 1987 is affirmed.

In the Matter of the Compensation of
DAVID L. HOWARD, Claimant
WCB Case Nos. 86-06254 & 86-16541
ORDER ON REVIEW
Roll, et al, Claimant Attorneys
Schwenn, Bradley, et al., Defense Attorneys
Thomas Johnson (Saif), Defense Attorney

Reviewed by Board Members Brittingham and Nichols.

Claimant requests review of those portions of Referee Knapp's order that: (1) upheld the SAIF Corporation's partial denial, on behalf of Pacific West Motel, of claimant's psychological condition; (2) upheld SAIF's denial, on behalf of F.C. Jones, for the same condition; (3) upheld SAIF's denial, on behalf of Pacific West Motel, of claimant's aggravation claim for a cervical back condition; and (4) upheld SAIF's denial, on behalf of F. C. Jones, for a "new injury" claim for the same condition; (5) declined to direct payment of Dr. Sherman's medical bills amounting to $837.50; and (6) declined to assess penalties and related attorney fees for an alleged untimely denial of claimant's aggravation claim. On review, the issues are: (1) compensability of the psychological condition; (2) compensability of, and responsibility for, the cervical back condition; (3) payment of $837.50 in outstanding medical bills; and (4) penalties and related attorney fees. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact as supplemented.

On April 23, 1986, claimant experienced a temporary increase of neck pain and stiffness. This temporary exacerbation was not pathological in nature. These increased symptoms were not related to his accepted cervical back condition.

We also find that claimant's work activities at F. D. Jones did not contribute independently to a worsening of claimant's cervical back condition.

The February 1986 Disputed Claim Settlement between Claimant, SAIF (Pacific West Motel), and EBI dismissed with prejudice claimant's psychological condition, which was diagnosed as an "adjustment disorder with depression." This condition was a result of claimant's personality flaws and how he dealt with the accumulated burdens of life. It was unrelated to the 1981 compensable injury. Claimant suffered no new psychological disability arising from a new condition, a worsened condition, or increased symptomology after the Disputed Claim Settlement.

Claimant's employment at F.C. Jones did not contribute in a material way to claimant's psychological disability.

The $837.50 in unpaid medical bills were for palliative chiropractic treatment resulting from the 1981 cervical back injury.

Claimant filed an aggravation claim on April 23, 1986. SAIF had notice of the claim on April 28, 1986, but did not deny the claim until August 1, 1986.

CONCLUSIONS OF LAW

Cervical back condition

The Referee declined to find claimant's cervical back condition compensable either as an aggravation of the 1981 Pacific West Motel compensable injury, or as a "new injury" resulting from the F. C. Jones employment. We agree.

To establish a claim for aggravation, claimant must show "worsened conditions resulting from the original injury." ORS 656.273(1). Claimant may establish an aggravation by showing that claimant's condition has exacerbated either pathologically or symptomatically to the extent that claimant is more disabled than at the time of the last arrangement of compensation. Smith v. SAIF, 302 Or at 396, 399-401 (1986).

On June 22, 1982, the Orthopaedic Consultants found claimant to be suffering from chronic recurrent cervical strain. They rated claimant's permanent disability for this condition as mild. They further stated claimant was able to return to work with limitations. As a result, the July 16, 1982 Determination Order issued.

Subsequent to this closure, claimant had another work-related claim which was filed with EBI for his neck and upper back. That claim was accepted and closed with no award for permanent disability in March 1984. It was later agreed in the February 1986 disputed settlement agreement that claimant's condition had returned to its pre-July 1983 status.

The aggravation claim with Pacific West Motel at issue here is based on the April 23, 1986 report of Dr. Sherman, claimant's treating chiropractor. Dr. Sherman indicated that claimant was not medically stationary and that claimant was unable to work. Sherman also authorized time loss in excess of 14 days.

The Orthopaedic Consultants examined claimant on July 18, 1986. They found claimant medically stationary with no objective findings related to the compensable injury, and no worsening since last claim closure of March 21, 1984. No additional treatment was recommended. They further indicated that claimant was able to return to his prior occupation.

Claimant was reexamined by the Orthopaedic Consultants on January 27, 1987. Their conclusions were similar to those rendered in their July 1986 report. They continued to find no objective basis for claimant's subjective complaints, and no need for chiropractic care. They viewed the September 1986 exacerbation as an "over-use syndrome on a mild temporary basis." The Consultants considered claimant's problem as psychiatric, not orthopedic or neurologic. The conclusions of the Orthopaedic Consultants are further supported by Dr. Nelson, osteopathic neurologist, who found no objective reason for claimant's continuing symptoms of pain, as well as that of Dr. Kappes, rheumatologist, who reached a similar conclusion.

We find the conclusions and opinions of the Orthopaedic Consultants, Dr. Nelson, and Dr. Kappes more persuasive than that of Dr. Sherman, claimant's treating chiropractor. Dr. Sherman based his views on the opinion that there exists an underlying objective basis for claimant's current condition. Consequently, Dr. Sherman considers claimant's subjective complaints essentially accurate, if somewhat exaggerated. This opinion is refuted by every other physician who has examined claimant. Inasmuch as we consider the opinions of the Orthopaedic Consultants, Dr. Nelson, and Dr. Kappes to be more well-reasoned, they are given greater weight in our deliberations. Somers v. SAIF, 77 Or App 259 (1986).

In conclusion, we are not persuaded that claimant has experienced either a pathological or a symptomatic exacerbation of his 1981 compensable chronic cervical back condition which resulted in reduced earning capacity. Accordingly, claimant has failed to establish an aggravation claim.

Furthermore, we find no evidence that claimant has sustained a "new injury" while employed at F. C. Jones. The preponderance of the medical and lay evidence establishes that claimant's work activities at F. C. Jones did not independently contribute to the causation of a disabling condition, i. e., to a worsening of claimant's underlying cervical back condition. See Hensel Phelps Const. v. Mirich, 81 Or App 290 (1986).

Psychological condition

The Referee concluded that claimant did not establish a compensable psychological condition. He found that the February 1986 Disputed Claim Settlement barred claimant from bringing this psychological claim against SAIF, on behalf of Pacific West Motel. In the alternative, the Referee also found that claimant failed to prove a compensable claim on the merits. We agree with the Referee's conclusion that the claim is not compensable, but on different grounds.

Claimant is not barred from bringing a later psychological claim because an earlier mental stress claim had been dismissed with prejudice under the terms of a Disputed Claim Settlement. See generally Patricia M. Emery, 41 Van Natta 892 (1989). To prove compensability of a psychological claim resulting from a compensable injury, claimant must establish that, after the Disputed Claim Settlement, he has developed a new psychological condition and/or disability related to his compensable injury. Proctor v. SAIF, 68 Or App 333, 335 (1984).

Furthermore, to prove the compensability of the psychological condition claimant must establish that the compensable injury was a material contributing cause of the condition, or, if the claimant's mental condition predated the injury, that the injury worsened that preexisting condition. Jeld-Wen v. Page, 73 Or App 136 (1985). In this regard, the claim is compensable even if the underlying psychological condition is not worsened. It is sufficient that the

injury precipitated symptoms so as to require medical treatment. Grace v. SAIF, 76 Or App 511 (1985);

Prior to the February 1986 Disputed Claim Settlement, claimant had been examined by psychiatrist, Dr. Colbach, in September 1985. Dr. Colbach diagnosed "adjustment disorder with depression" and opined that causation was primarily due to "personality flaws and the accumulated burdens of life." He considered the work injury of 1981 with SAIF (Pacific West Motel) to be unrelated to claimant's psychological condition.

Claimant was reexamined by Dr. Colbach in January 1987. He opined that claimant was medically stationary with respect to his psychological condition. He saw no significant change since the September 1985 examination, or from the date of the Disputed Claim Settlement in February 1986.

Dr. Erkkila, psychiatrist, also examined claimant in January, and again in March 1987. Similarly to Dr. Colbach's diagnosis, she opined that claimant suffered from "depression with generalized anxiety." Dr. Erkkila did not find greater disability due to this psychological condition than that already identified by Dr. Colbach in September 1985.

It was also Dr. Erkkila's opinion that the 1981 compensable injury materially contributed to the claimant's psychological condition. However, we consider the opinion of Dr. Colbach to be well-reasoned and based on a thorough examination of both claimant and the medical record. Therefore, we find the medical opinion of Dr. Colbach more persuasive with respect to medical causation than that of Dr. Erkkila, and give it greater weight. Somers v. SAIF, supra.

Accordingly, we find no evidence of either a new disorder, a worsened condition, or increased symptomology of claimant's noncompensable psychological condition resulting in disability causally related to the 1981 compensable injury.

We also find the "new injury" claim for claimant's psychological condition against SAIF, on behalf of F. C. Jones, is not compensable due to the lack of material contribution to increased symptomology or worsening of claimant's noncompensable psychological condition, or to causation of a new condition resulting in disability. Claimant's psychological condition is not compensable.

Payment of Dr. Sherman's medical bills

The Referee found that Dr. Sherman's medical bills were due and owing, and that SAIF had not paid the outstanding bills as of the date of hearing. Implicit in this decision is the finding that the medical bills were compensable medical services for the 1981 compensable injury. Accordingly, the Referee found that SAIF's conduct in failing to pay the bills in a timely fashion was unreasonable and would support a penalty and related attorney fee to be paid by SAIF. However, the Referee failed to order payment of the $837.50 in unpaid bills.

The medical billings in question are for treatments rendered by Dr. Sherman, consisting mostly of spinal adjustments, traction, hot or cold packs, and x-rays for the cervical back from March 26, 1986 to July 14, 1986. As such, these treatments are designed to provide claimant palliative care related to the 1981 compensable injury. Therefore, Dr. Sherman's medical bills are compensable as medical services. See ORS 656.245. Inasmuch as we agree with the Referee's findings, we direct SAIF, on behalf of Pacific West Motel, to pay the $837.50 in unpaid medical bills.

Penalty and attorney fee for late denial

Although raised in claimant's request for hearing, and also raised in claimant's closing argument at hearing, the Referee failed to make a finding regarding SAIF's late denial, on behalf of Pacific West Motel, of claimant's aggravation claim for his cervical back condition resulting from the 1981 compensable injury. On April 23, 1986, claimant's counsel filed an aggravation claim based on Dr. Sherman's Form 829 dated March 19, 1986, and also on a Form 827 dated April 23, 1986. The April 23, 1986, medical report indicated that claimant was not medically stationary and was unable to work. SAIF had notice of the claim on April 28, 1986, and therefore, had 60 days from the date of the notice in which to accept or deny the aggravation claim. ORS 656.262(6). SAIF denied the claim on August 1, 1986, in excess of the required 60 days. It has offered no explanation for its delay in acceptance or denial. Therefore, SAIF's late denial was unreasonable, and failure to deny the aggravation in a timely fashion will support a penalty and attorney fee. ORS 656.262(10); 656.382(1). Accordingly, claimant is entitled to a penalty as well as a related attorney fee. However, inasmuch as we are affirming that portion of the Referee's order that assessed the maximum penalty for another violation, no further penalty is awarded.

ORDER

The Referee's order, dated November 19, 1987, is reversed in part and affirmed in part. The SAIF Corporation, on behalf of Pacific West Motel, is directed to pay Dr. Sherman's outstanding medical bills in the amount of $837.50. Claimant's counsel is awarded an assessed fee of $500 to be paid by SAIF for prevailing on the unreasonable untimely denial issue. The remainder of the order is affirmed. Claimant's counsel is awarded an assessed attorney fee of $500 for prevailing on Board review on the unpaid medical bills issue. This fee should be paid by SAIF, on behalf of Pacific West Motel. A client-paid fee is approved, payable by SAIF, on behalf of F. C. Jones, to their outside counsel, not to exceed $586.50.

In the Matter of the Compensation of
NANCY J. PETTY, Claimant
WCB Case No. 85-02087
ORDER ON REVIEW
Peter O. Hansen, Claimant Attorney
Rankin, et al, Defense Attorneys

Reviewed by Board Members Gerner and Myers.

The insurer requests review of that portion of Referee Thye's order which set aside that portion of the insurer's denial that denied treatment for a psychological condition. On review, the issue is compensability of the treatment for the psychological condition. We affirm.

FINDINGS OF FACT

Claimant compensably injured her left knee in 1981. There have been indications of psychological factors affecting this claim throughout the course of the claim.

Claimant has a preexisting histrionic personality. That condition was neither caused by nor altered by the compensable injury; however, the compens

able injury precipitated the psychiatric symptoms from which claimant now suffers. The histrionic personality has complicated claimant's recovery from the compensable injury. Treatment of the histrionic personality is reasonable and necessary treatment to help claimant's physical recovery from the compensable injury.

CONCLUSIONS AND OPINION

In order to prove the compensability of the psychological treatment, claimant must prove by a preponderance of the evidence that her compensable injury is a material cause of the need for treatment. In Grace v. SAIF, 76 Or App 511 (1985), the Court of Appeals held that even though a compensable injury did not worsen the underlying psychological condition, if it precipitated the symptoms, then that renders the condition compensable. Id at 517.

In this case, Dr. Parvaresh, an independent psychiatric examiner, testified persuasively that the compensable injury did not change claimant's underlying psychiatric condition. Nevertheless, he conceded that the injury precipitated claimant's symptoms. He also testified that it is reasonable to treat the psychiatric condition to indirectly help claimant's recovery from the compensable injury. We agree with the Referee that this evidence is sufficient to render treatment for the psychiatric condition compensable.

ORDER

The Referee's order, dated July 21, 1988, is affirmed. Claimant's attorney is awarded an assessed fee of $600, to be paid by the insurer. The Board approves a client-paid fee, payable from the insurer to its counsel, not to exceed $1,674.50.

January 9, 1990 Cite as 42 Van Natta 40 (1990)

In the Matter of the Compensation of
LAURA BASL, Claimant
WCB Case No. 87-17697
ORDER ON REVIEW
Emmons, et al., Claimant Attorneys
Williams, et al., Defense Attorneys

Reviewed by Board Members Howell and Speer.

The self-insured employer requests review of Referee Higashi's order that set aside its partial denial of claimant's chiropractic treatments for her low back condition. On review the issue is medical services.

We review de novo and for reasons different from those stated in the Referee's order, affirm.

The employer's November 5, 1987 denial denied claimant's "current need for chiropractic treatment." No evidence was produced at hearing that any claims for chiropractic treatments rendered prior to the date of the denial had not been paid.

Without evidence of the denial of rendered chiropractic treatments, a denial of current chiropractic treatment must be presumed to be a denial of future treatments. Such a denial is prospective and invalid. See Evanite Fiber Corp. v. Striplin, 99 Or App 353 (1989).

Accordingly, we conclude that the employer's denial should be set aside as an invalid prospective denial.

ORDER

The Referee's order, dated June 10, 1988, is affirmed. Claimant's attorney is awarded an assessed fee of $900, payable by the self-insured employer. The Board approves a client-paid fee, payable by the insurer to its counsel, not to exceed $2,227.50.

January 9, 1990 Cite as 42 Van Natta 41 (1990)

In the Matter of the Compensation of
DAREIL D. BENNETT, Claimant
WCB Case No. 85-00272
ORDER ON REVIEW
Quintin B. Estell, Claimant Attorney
Gail Gage (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

The SAIF Corporation requests review of Referee Quillinan's order which granted claimant permanent total disability in lieu of prior awards and arrangements of compensation totaling 92 percent (294.4 degrees) unscheduled permanent disability for a low back injury and 20 percent (30 degrees) scheduled permanent left knee disability. On review, SAIF contends that claimant is not permanently and totally disabled. We reverse.

FINDINGS OF FACT

Claimant, 52 years of age at hearing, attended school through the seventh grade. He has very low level reading and writing skills. His work experience includes heavy machine operator, farm hand, truck and bus driver, security guard, groundskeeper and custodian.

Prior to his compensable low back injury in March 1978, claimant underwent three back surgeries. He had a fourth surgery in November, 1978. Claimant was awarded a total of 50 percent unscheduled permanent disability in 1979.

In 1980, claimant secured a job as part-time bus driver and part-time groundskeeper for a high school. Dr. Ferguson, his treating physician, approved of this job. After working three months, claimant had a heart attack and eventually underwent by-pass surgery. Claimant has had several subsequent heart attacks, and has undergone heart surgery a total of three times.

Claimant subsequently filed an aggravation claim and was awarded, by Stipulated Order in October, 1983, an additional 42 percent unscheduled permanent disability, for a total award of 92 percent permanent partial disability.

In September, 1983, claimant sustained a left knee injury which was found, by Referee's order, to be related to his compensable back injury. He subsequently underwent surgery to repair a torn meniscus. He was awarded 20 percent scheduled permanent disability by Determination Order dated December 7, 1984.

Claimant has not held a job since his 1980 heart attack. He has worked with vocational counselors, but with little success. Claimant, in

February, 1986, was cleared by his treating doctor to do modified security guard work. However, the doctor subsequently retracted his release due to an increase in claimant's angina. Claimant is restricted from lifting over 20 pounds. He can sit for one hour at a time. Claimant is capable of performing sedentary/light work. Excluding consideration of claimant's heart condition, he is capable of performing bench assembly jobs, small engine repair, locksmithing and certain types of security guard jobs. However, his poor fine, manual dexterity precludes electronics assembly and optician apprentice work.

CONCLUSIONS OF LAW AND OPINION

In order to prove entitlement to permanent total disability benefits, claimant must prove that he is permanently incapacitated from regularly performing work at a gainful and suitable occupation. ORS 656.206(1)(a). Permanent total disability may result from less than total physical incapacity, when combined with nonmedical conditions, including "age, training, aptitude, adaptability to nonphysical labor, mental capacity, emotional condition, as well as the condition of the labor market." Wilson v. Weyerhaeuser, 30 Or App 403, 409 (1977). Unless claimant's physical incapacity in conjunction with his nonmedical disabilities renders work search futile, SAIF v. Scholl, 92 Or App 594, 597 (1988), he must also establish that he is willing to seek regular gainful employment and that he has made reasonable efforts to obtain such employment. ORS 656.206(3).

For purposes of determining eligibility for permanent total disability benefits, preexisting disabilities are taken into consideration. However, disabilities which develop subsequent to the compensable injury, and which are not causally related to the injury, are not considered. See ORS 656.206(a). In this case, claimant's heart problem occurred after he had returned to work following his compensable low back injury. Further, no evidence was presented that claimant's heart condition is causally related to his back injury. Therefore, it is not a factor that may be considered when determining whether claimant is permanently and totally disabled.

The medical evidence does not support a conclusion that claimant's compensable physical condition alone prevents him from working. Dr. Ferguson, his treating physician, has stated more than once that claimant could work at light/sedentary jobs but for his heart condition. Moreover, he refused to release claimant for a sedentary job in a modified security guard position because of his angina.

We find that claimant was not totally physically incapacitated by his low back and knee injuries so as to warrant an award of permanent total disability.

Because claimant has not proved that he is totally disabled based solely on his physical condition, he must prove by a preponderance of the evidence that, because of a combination of his physical condition and social and vocational factors, he is precluded from regular gainful employment. He has not sustained that burden of proof.

Claimant's low education level, his lack of transferable skills, and his restrictions against performing heavy or medium physical labor, partly due to his compensable injuries and partly because of his noncompensable heart condition, combine to greatly limit the types of jobs that he is capable of performing. However, as previously discussed, limitations resulting from claimant's heart condition are not considered. In this regard, two vocational counselors, Ms. Grape and Ms. Branch, who worked extensively with claimant, were able to identify certain jobs that would be suitable for him. These included

bench assembly jobs and small motor repair. The counselors also ruled out jobs such as locksmithing and certain security guard jobs solely because of claimant's heart condition.

One other vocational counselor, Mr. McNaught, interviewed the claimant and reviewed his file, but did not provide any vocational services. We are not persuaded by Mr. McNaught's conclusion that claimant is not capable of any employment. Instead, we rely upon the opinion of the two vocational counselors who worked with claimant over an extended period of time.

We find that, at the very least, the evidence establishes that claimant could obtain and hold some gainful, suitable work on either a full or part-time basis. Given that evidence we do not consider it futile for claimant to seek work. He has made no such efforts on his own since 1980. Efforts to return claimant to work through vocational assistance were apparently suspended pending the outcome of his claim of permanent total disability. We conclude that claimant has not established that he is unable to obtain and hold gainful suitable employment.

Accordingly, claimant has failed to establish his entitlement to an award of permanent total disability.

ORDER

The Referee's order dated May 8, 1987 is reversed. The December 7, 1984 Determination Order is affirmed.

January 9, 1990 Cite as 42 Van Natta 43 (1990

In the Matter of the Compensation of
LESTER K. COMSTOCK, Claimant
WCB Case No. 87-06359, 87-06358 & 86-07985
ORDER ON RECONSIDERATION
Peter O. Hansen, Claimant Attorney
Cummins et al, Defense Attorneys

The self-insured employer has requested reconsideration of our December 29, 1989 Order on Review. Specifically, the employer contends that we erred in finding: (1) that claimant had made a valid aggravation claim for a low back injury in January 1983; and (2) that claimant had sustained a compensable aggravation of a low back injury in January 1983. After considering the employer's motion and memorandum in support, we grant the request in order to clarify our prior order.

With regard to its first contention, the employer submits that Dr. Keizer's letter of January 23, 1983, was not sufficient to trigger a duty to pay interim compensation. Although we disagree, we find the contention to be moot in light of our finding that claimant had sustained a compensable aggravation of his low back condition in January 1983. Given this finding, it follows that claimant is substantively entitled to temporary disability benefits from January 10, 1983, the date of his disability. See Sandra L. Berkey, 41 Van Natta 944 (1989).

With regard to the employer's second contention, we conclude that our order adequately addresses this issue and we decline to discuss the issue further.

Accordingly, our December 29, 1989 order is withdrawn. On reconsideration, as supplemented and clarified herein, we adhere to and republish our former 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
PAUL E. DENUE, Claimant
WCB Case No. 87-10257
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Dennis Martin (Saif), Defense Attorney

Reviewed by Board Members Crider and Nichols.

Claimant requests review of Referee Higashi's order that: (1) declined to grant him permanent total disability; and (2) affirmed Determination Orders awarding 60 percent (90 degrees) scheduled permanent partial disability for the loss of use or function of the left leg. On review, the issue is extent of scheduled permanent disability, including permanent total disability. We affirm.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact with these exceptions and additions: We find that claimant lacks 90 degrees, rather than 60 degrees, of flexion. We do not find that claimant lacks transferable skills from his years of logging activities. Rather, we find that his experience as a log truck driver coupled with his truck driver course enables him to perform some truck driving jobs.

Claimant lacks 5 degrees of dorsiflexion in the left ankle compared to the right.

FINDINGS OF ULTIMATE FACT

Claimant has suffered a 60 percent loss of use or function of the left leg due to the compensable injury.

CONCLUSIONS OF LAW AND OPINION

We adopt the Referee's Conclusions and Opinion.

Claimant requests that we rate his left leg disability in accordance with his loss of earning capacity. We decline to do so. Disability of the extremities, including the leg, is rated in accordance with loss of use or function of the member due to the compensable injury. ORS 656.214(2)(c). Claimant did not specify unscheduled disability, which is rated based on loss of earning capacity, as an issue at hearing. He may not raise it now.

Claimant apparently contends that the 1987 amendments to ORS 656.726 require that all permanent disability, scheduled as well as unscheduled, be rated based on loss of earning capacity. That is incorrect. The requirement that the Director develop standards for evaluation of disabilities under ORS 656.214(5) in light of "impairment as modified by the factors of age, education, and adaptability to perform a given job" has no bearing on this case. Disability to the leg is a disability under ORS 656.214(2), not 656.214(5). Nothing in the 1987 amendments to chapter 656 alters the fact that disability to scheduled body parts is rated based on loss of use or function only.

ORDER

The Referee's order dated July 25, 1988, is affirmed.

In the Matter of the Compensation of
EDNA R. FORD, Claimant
WCB Case No. 87-15999
Order on Review
Francesconi & Associates, Defense Attorneys
Terrall and Miller, Defense Attorneys

Reviewed by Board Members Crider and Brittingham.

Claimant requests review of Referee Mulder's order that: (1) declined to grant her permanent total disability; and (2) increased her unscheduled permanent partial disability award for her low back condition from 35 percent (112 degrees), as awarded by Determination Order, to 70 percent (224 degrees). We conclude that claimant is permanently and totally disabled.

ISSUE

Extent of permanent disability for claimant's low back condition, including permanent total disability.

FINDINGS OF FACT

Claimant injured her jaw, low back and the left side of her rib cage on May 16, 1986 when she slipped and fell in the course of her employment as a cook. She was treated by Dr. Eubanks, an osteopath, and returned to regular work on June 3, 1986. Claimant compensably injured her low back a second time in late July 1986 when she pulled on a heavy refrigerator drawer full of meat. She resumed treatment with Dr. Eubanks and was off work until August 24, 1986, when she returned to half-time work. Her back pain subsequently increased and she left work again on September 3, 1986.

After claimant left work in September 1986, Dr. Eubanks referred her to Dr. Cruickshank, a neurosurgeon. Dr. Cruickshank ordered a CT scan and myelogram which revealed a herniated disc at L4-5. Dr. Cruickshank proposed surgical treatment and discussed with claimant the risks and potential benefits of such treatment. Claimant had a similar discussion with Dr. Eubanks, in which Eubanks told her that there was about a 50 percent chance that surgery would improve her condition. She ultimately declined surgery because she was afraid that it would not improve her condition and might worsen it.

Dr. Eubanks declared claimant medically stationary on June 26, 1987 and referred her to another osteopath, Dr. Howell, for a rating of her impairment. Dr. Howell noted decreased reflexes in claimant's right leg, but otherwise found no objective evidence of impairment. He rated the impairment due to claimant's herniated disc at 5 percent and that due to her right leg symptoms at 18 percent. He recommended that claimant be limited to light work. Claimant's claim was closed by Determination Order in October 1987 with a 35 percent unscheduled award for her low back and a 5 percent scheduled award for her right leg.

After claim closure, claimant participated in vocational assistance. Dr. Eubanks completed a physical capacities assessment which restricted claimant to sedentary work for a total of 2 hours per day. (See Ex. 35-2). In testimony at the hearing, Dr. Eubanks stated that he would release claimant for sedentary work for a total of four hours per day on a trial basis. At the time of the hearing, claimant was anticipating, but had not yet received, an offer of half-time employment as a hostess with the employer. She is willing to attempt this work.

Claimant was 61 years old at the time of the hearing. She dropped out of school after the eighth grade. She experiences persistent pain in her low back, right hip and right leg which increases with prolonged sitting, standing or walking. Since claim closure, claimant has applied for employment with at least ten restaurants or other businesses. No job offers have resulted from these applications.

FINDINGS OF ULTIMATE FACT

Claimant's refusal of surgery was reasonable. Her low back impairment is mild. Her right leg impairment is mildly moderate. She is willing to seek regular gainful employment and has made reasonable efforts in that direction. She is permanently incapacitated from performing work at a gainful and suitable occupation.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant's decision not to undergo surgery was reasonable and does not justify reducing her permanent disability award. See Clemons v. Roseburg Lumber Co., 34 Or App 135 (1978). We agree with this conclusion. The Referee further concluded, however, that claimant was capable of gainful part-time employment and thus was not permanently and totally disabled. He did not explain the reasoning underlying this conclusion, but apparently it was based upon the prospect of a job offer for claimant from the employer.

Assuming that to be the basis of the Referee's decision, we must reject it. The determination of permanent total disability status turns on whether the claimant is currently employable or able to sell her services on a regular basis in a hypothetically normal labor market. Harris v. SAIF, 292 Or 683, 695 (1982). This determination must be based upon conditions existing at the time of the decision, not upon a speculative future change in the claimant's employment status. Gettman v. SAIF, 289 Or 609, 614 (1980). The essence of the determination is the probable dependability with which claimant can sell her services in a competitive labor market, undistorted by such factors as business booms, sympathy of a particular employer or friends, temporary good luck, or superhuman efforts by the claimant. Harris v. SAIF, supra, 292 Or at 695. If the injured worker has some capacity for employment, she is statutorily required to make reasonable efforts to find work, unless those efforts would be futile. ORS 656.206(3).

Under these rules, we conclude that claimant is permanently and totally disabled. She is significantly impaired from a physical standpoint and is limited to light or sedentary work. She has made reasonable efforts to find work. Her lack of education and advanced age further diminish her employability to an extent that, as a practical matter, she is incapable of selling her services in a competitive labor market.

The fact that the employer may offer her a job does not alter this conclusion. In the first place, the employer had not actually made an offer at the time of the hearing. Any reduction of claimant's award on that basis, therefore, would require consideration of a speculative future change in her employment status. In addition, based upon the record as developed, we must conclude that the prospect of a job offer for claimant did not result from claimant's ability to sell her services in a competitive labor market, but rather from sympathy or some other such motive. Even if the employer had offered claimant a job before the date of the hearing, therefore, that action would not have affected our ultimate conclusion. Finally, the prospect that

claimant may be released by Dr. Eubanks to attempt a job does not persuade us that she will in fact be capable of performing it.

We thus conclude that claimant is entitled to an award of permanent total disability as of June 26, 1987, the date that Dr. Eubanks declared her medically stationary. The employer will be authorized to offset any temporary or permanent disability compensation paid to claimant after that date against the permanent total disability award. See Pacific Motor Trucking Co. v. Yeager, 64 Or App 28, 32 (1983); Paul D. Rasmussen, 38 Van Natta 1310 (1986).

ORDER

The Referee's order dated February 17, 1988 is reversed. In lieu of all prior awards, claimant is awarded permanent total disability effective June 26, 1987. The employer is authorized to offset any temporary or permanent disability compensation paid to claimant after that date against her award of permanent total disability. Claimant's attorney is awarded 25 percent of claimant's increased compensation, provided that the total of fees awarded by the Referee and the Board shall not exceed $6,000. The Board approves a client-paid fee, not to exceed $556.

January 9, 1990 Cite as 42 Van Natta 47 (1990)

In the Matter of the Compensation of
STEPHANIE A. GEE, Claimant
WCB Case No. 89-09625
SECOND ORDER DENYING MOTION TO INTERVENE
Roll & Westmoreland, Claimant Attorneys
Roberts, et al, Defense Attorneys
David C. Force, Attorney

Dr. Buttler, claimant's attending chiropractor, seeks reconsideration of our December 13, 1989 interim order which denied his request to intervene as a party to these proceedings. In addition to reiterating his prior contentions, Dr. Buttler seeks a finding as to whether he has an interest in the outcome of this proceeding.

Dr. Buttler contends that he has an interest in the outcome of the proceeding and should be allowed to intervene as a party. For purposes of the Workers' Compensation Act, "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). In addition, we have held that an attending physician is not a party. See Karen K. Van Santen, 40 Van Natta 63 (1988).

Dr. Buttler argues that the applicable statute in this instance is ORS 183.310(6)(c), which defines a party as:

> "Any person requesting to participate before the agency as a party or in a limited party status which the agency determines either has an interest in the outcome of the agency's proceeding or represents a public interest in such result. The agency's determination is subject to review in the manner provided by ORS 183.482 after the agency has issued its final order in the proceedings." ORS 183.310(6)(c)

Dr. Buttler argues that, in order to deny his motion to intervene, the Board is required to make a finding that he is not an interested party as defined in the statute.

We disagree with Dr. Buttler's contention. It is a maxim of administrative law that in the absence of evidence of contrary intent, a specific statute controls over a general statute. See, e.g. South Benton Educ. Ass'n v. Monroe Union High School Dist. No. 1, 83 Or App 425, rev den 303 Or 331 (1987); Skinner v. Keeley, 47 Or App 751 (1980).

We conclude that the Workers' Compensation statute defining a "party" for purposes of participating in a proceeding, is the more specific statute and it therefore precludes Dr. Buttler from intervening in this matter. However, this finding does not cause us to recede from our prior conclusion that the jurisdictional issue which he seeks to advance can be considered without his intervention into these proceedings at this time.

Accordingly, on reconsideration, we continue to deny the motion to intervene. We retain jurisdiction over this matter; consequently, this order is interim and will be incorporated into our final, appealable order. The parties' briefing schedule shall be revised as follows. Claimant's appellant's brief shall be due 14 days from the date of this order. The employer'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 the employer's brief. Thereafter, this case shall be docketed for review.

IT IS SO ORDERED.

January 9,1990 Cite as 42 Van Natta 48 (1990)

In the Matter of the Compensation of
CAROL J. HOPKINSON, Claimant
WCB Case No. 87-17743
ORDER ON REVIEW
Black, Chapman & Webber, Claimant Attorneys
Cowling & Heysell, Defense Attorneys
Ronald Pomeroy (Saif), Defense Attorney
Carl M. Davis, Assistant Attorney General

Reviewed by Board Members Brittingham and Crider.

The noncomplying employer requests review of Referee Brown's order dismissing its request for hearing for lack of jurisdiction. On review, the issues are jurisdiction and compensability. We affirm.

FINDINGS OF FACT AND ULTIMATE FACT

Claimant filed a claim for bilateral carpal tunnel syndrome on July 1, 1987 with the employer, Sweet's General Store. Because the employer was not insured, the Department of Insurance and Finance investigated. On August 7, 1987, the Department issued a Notice of Proposed and Final Order declaring Sweet's to be a noncomplying employer from July 1, 1986 to July 21, 1987. By letter dated August 6, 1987 and received by the SAIF Corporation on August 10, 1987, claimant's claim was referred to SAIF for processing under ORS 656.054.

On September 28, 1987, SAIF accepted the claim for bilateral carpal tunnel syndrome. SAIF notified the noncomplying employer of the acceptance and

of the employer's right to contest compensability of the claim by requesting a hearing.

The employer requested a hearing on November 18, 1987 to contest the acceptance "on the grounds that claimant did not sustain a compensable injury during the course and scope of her employment . . .."

At hearing, counsel for the employer stated that the employer sought the hearing to establish that the claim was not compensable. However, he also stated that the employer did not contest claimant's entitlement to benefits pursuant to SAIF's acceptance but only sought to protect the employer in the event recovery should be sought from the employer. (Tr. 2-7). He stated that the dispute is:

> "utterly and totally irrelevant to any interests that the claimant has. She has her accepted claim with SAIF Corporation. We don't dispute that. We just say SAIF Corporation accepted and SAIF Corporation should pay without the right to recover from my client . . .."

The Referee dismissed the request for hearing for lack of jurisdiction.

CONCLUSIONS OF LAW AND OPINION

The Referee dismissed the request for hearing on the grounds that the employer sought to litigate an issue which is not a question concerning a claim within the meaning of ORS 656.283(1) and 656.708(3). The employer, on review, argues that the Hearings Division has jurisdiction of its dispute with SAIF pursuant to that portion of ORS 656.708(3) which provides that the division's authority extends beyond matters concerning a claim to "such other hearings and proceedings as may be prescribed by law." The employer asks us to read ORS 656.054 to create a right to hearing, under ORS 656.708(3), on an abstract question of compensability. That is, for the purpose not of determining claimant's right to compensation, but of determining the right of the employer vis-a-vis SAIF in a civil proceeding to recover costs from the employer. We do not read ORS 656.054 to direct the Hearings Division to conduct such a hearing.

The employer's right to contest the compensability of the claim arises under ORS 656.283(1), which provides that any party may request a hearing on a matter concerning a claim. Clark v. Linn, 98 Or App 393 (1989). The employer's right to a hearing under this provision is the right to put in issue claimant's entitlement to compensation. We, therefore, agree with the Referee that a request for hearing does not constitute a matter concerning a claim, under ORS 656.283(1), unless it affects claimant's right to compensation or the amount thereof. Hayden v. Workers' Compensation Department, 77 Or App 328 (1986).

Moreover, ORS 656.054 does not create an independent right to a hearing regarding recovery of the costs of a claim from the employer. Although the employer argues this case as if it concerned the right of SAIF to recover from the employer, it is in fact the Director of the Department of Insurance and Finance who is responsible for the costs of claims processed by SAIF, and it is the Director who recovers costs from the employer. OAR 436-80-070. ORS 656.054(3) provides that the costs of a claim filed by a worker employed by a noncomplying employer, and processed by SAIF on referral from the Director, shall be recovered by the Director from the noncomplying employer in a civil proceeding. The statute appears to equate what is recoverable from the employer with what SAIF paid out in a compensable claim. Therefore, as long as the claim remains compensable as between SAIF and the worker, the employer remains liable for the cost. The employer, then, must protect his pocketbook by acting to relieve SAIF of the duty to pay by requesting a hearing regarding compensability under ORS 656.283. The employer cannot establish that the claim was not compensable as an

abstract proposition, so as to strip the Director of the authority to recover claim costs, while leaving the Director to reimburse SAIF for those costs.

Even if we did not construe ORS 656.054 to require the Director to recover all of SAIF's claim costs without regard to compensability in the abstract, we would still affirm the Referee's decision. The provision does not direct the Hearings Division to conduct hearings related to the right to recover costs from the employer. Rather, it contemplates that the recovery action shall be undertaken in a civil proceeding in a court of law. Only issues of noncompliance, associated civil penalties and matters concerning a claim are litigated initially before the Hearings Division. Compare ORS 656.054(3) with ORS 656.740(3) and (4).

Accordingly, we conclude that nothing in the law authorizes the Hearings Division to conduct hearings concerning the dispute the employer wishes us to decide. For that reason, the Referee correctly dismissed the request for hearing for lack of jurisdiction.

ORDER

The Referee's order dated March 28, 1988 is affirmed.

January 9, 1990 42 Van Natta 50 (1990)

In the Matter of the Compensation of
STEPHEN J. JACOBS, Claimant
WCB Case No. TP-89038
THIRD PARTY DISTRIBUTION ORDER
Joanne Reisman, Claimant Attorney
James E. Griffin, Assistant Attorney General

The SAIF Corporation, as a paying agency, has petitioned the Board for resolution of a conflict concerning the "just and proper" distribution of proceeds from a third party settlement. See ORS 656.593(3). Specifically, the dispute pertains to SAIF's contention that it is entitled to recover an additional $115 from the settlement proceeds as reimbursement for legal expenses advanced to claimant. We conclude that SAIF is entitled to be reimbursed for the aforementioned advanced expenses.

FINDINGS OF FACT

Claimant sustained a compensable injury for which SAIF provided benefits. He also engaged legal counsel to explore the possibility of bringing suit for his compensable injury against a third party.

In May 1988 claimant's counsel, Ms. Reisman, advised Ms. Blair, a third party claims examiner for SAIF, that a complaint had been prepared which sought damages from the third party. Blair was further told that the complaint could not be filed because claimant lacked the funds for filing and service fees. Requesting that the necessary costs to satisfy such fees be advanced, Reisman assured Blair that the expenses would be added to SAIF's "subrogation interests."

In June 1988 Blair responded that SAIF did not wish to advance costs. Noting that the statute of limitations would soon run on claimant's cause of action, Blair requested that Reisman notify SAIF immediately if claimant did not choose to pursue settlement of the third party action.

Shortly thereafter, Reisman contacted Blair's supervisor, again seeking the advancement of costs. Over Blair's objections, the supervisor agreed to provide the advance.

In September 1988 Blair notified Reisman that SAIF would contribute a maximum of $120 toward claimant's legal costs. In return for the advancement, Blair stated that:

> "It is understood that should a recovery be made that SAIF will be reimbursed its contribution at the same level in the statutory distribution as all other legal costs are paid."

Thereafter, Reisman provided receipts for filing and service fees totalling $115. Reisman assured Blair that SAIF would be "reimbursed for these costs out of any settlement reached."

In July 1989 Reisman contacted Blair by telephone. Although a significant judgment was anticipated if a trial ensued, Reisman advised that there was only $5,000 of insurance coverage. Because the third party was otherwise without assets, Reisman suggested that recovery of any judgment beyond the insurance coverage would be unlikely.

Concluding that claimant's attorney fee from a judgment exceeding $5,000 under such circumstances would likely consume SAIF's share of the recoverable portion of the recovery, Reisman recommended that SAIF approve a $5,000 settlement. The settlement was approved.

In August 1989 Reisman forwarded to Blair $1,062.22, representing "full payment" of its share of the settlement proceeds. In so doing, Reisman noted that "you agreed to assume the $115 in litigation costs expended by [claimant] in view of the fact that we settled for the insurance limits instead of pursuing more costly litigation."

Shortly thereafter, Blair responded to Reisman's letter. Insisting that she had never agreed to waive reimbursement for the advanced legal costs, Blair sought recovery of the $115.

FINDINGS OF ULTIMATE FACT

Reimbursement of the $115 in advanced legal costs to SAIF is a "just and proper" distribution of the third party settlement proceeds.

CONCLUSIONS OF LAW

If a worker settles a 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 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).

When an agency represents the amount of its claimed lien to a worker, knowing that the worker is in the process of negotiating a third party settlement, the agency may not claim as its "just and proper" share of the settlement any more than the originally asserted lien, even if the total amount claimed is not in excess of the lien authorized by ORS 656.593(1) and (2). Estate of Troy Vance v. Williams, supra, at page 621. When either a worker or an agency makes a representation to the other which could affect the other's

position on the amount of the settlement, the other is entitled to rely on that representation. Id. at page 620.

Here, claimant contends that Blair, on behalf of SAIF, represented that reimbursement of the $115 in advanced costs would be waived. In support of this contention, claimant relies on an affidavit from her counsel, Reisman, who describes her recollection of her July 1989 conversation with Blair. Reisman also includes her notes of that conversation. Reisman states that Blair agreed to waive the $115 reimbursement in return for claimant's agreement to absorb a $130 deposition bill.

In response, Blair also testified by means of affidavit. Blair insists that she neither discussed nor agreed to the waiver of the $115 in legal cost reimbursement. Blair has a "very clear memory" of her conversation with Reisman because she had previously refused to provide advanced costs to claimant on two occasions. That advancement was eventually obtained, at Blair's objection, after Reisman "went over [Blair's] head" to a SAIF supervisor. Finally, Blair asserted that she had no authority to waive recovery of third party liens without supervisor approval.

We are not persuaded that SAIF agreed to waive its recovery of the $115 in advanced legal costs. In reaching this conclusion, we are particularly persuaded by Blair's personal interest in the matter as well as her representation that she lacked the authority to waive such a reimbursement without supervisor approval. This representation of limited authority is supported by Reisman's previous dealings with Blair regarding the advancement of costs for claimant's filing and service fees. We note that the authorization for such an advancement only materialized after Reisman had contacted Blair's superior.

Blair's representation is further supported by a review of the written correspondence between her and Reisman. Throughout their negotiations leading to the filing of claimant's complaint and, eventually, the approval of the third party settlement, their correspondence consistently confirmed the existence of SAIF's lien for the advanced costs and claimant's concession that it would be honored.

The first indication that SAIF would not recover its advanced legal costs appeared in Reisman's August 1989 letter confirming the third party settlement. This correspondence was preceded by Reisman's notes, which suggest that Blair agreed to waive recovery of the advanced costs in return for claimant's agreement to pay for a $130 deposition bill. While that may have been Reisman's understanding, we find this evidence unpersuasive for several reasons.

To begin, despite its prior arrangement to provide advanced costs, SAIF was under no obligation to pay for the deposition in any event. Since the deposition bill was a litigation expense, claimant was statutorily entitled to recover the cost before application of SAIF's lien. See ORS 656.593(3); 656.593(1)(a). Moreover, because the settlement totalled $5,000 and the costs involved in the third party case were minimal ($115 and $130), a recovery of SAIF's entire lien ($1,177.22), following distributions for claimant's attorney fees and statutory share, would appear to be assured.

Thus, the reason for SAIF to accede to such an offer is not readily apparent. Finally, considering that the parties' respective recollections of their conversation are so diametrically opposed, we do not find it particularly noteworthy that one party's notes concerning the conversation would correspond with that party's recollection of events.

Accordingly, we hold that SAIF is entitled to an additional $115 from the remaining balance of proceeds from the third party settlement. Consequently, claimant's attorney is directed to disburse $115 from the settlement proceeds as a "just and proper" distribution. See ORS 656.593(3); 656.593(1)(a).

IT IS SO ORDERED.

In the Matter of the Compensation of
JERRY E. JAMES, Claimant
WCB Case No. 88-01452
ORDER ON REVIEW
Robert J. Guarrasi, Claimant Attorney
Roberts, et al, Defense Attorneys
Coons & Cole, Attorneys

Reviewed by Board Members Gerner and Cushing.

Claimant requests review of Referee Fink's order that: (1) upheld the self-insured employer's denial of claimant's medical services claim for acupuncture treatments; and (2) declined to assess penalties and attorney fees for an alleged untimely denial. The employer cross-requests review, contending the Referee erred in awarding a carrier-paid fee for prevailing against a portion of the aforementioned denial. On review, the issues are medical services, penalties and attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

The Board adopts the Referee's "Findings."

ULTIMATE FINDINGS OF FACT

The employer's denial issued more than 60 days after claimant's counsel asked the employer to respond to claimant's physician's report supporting the need for acupuncture treatments. At the time of the denial, there was no compensation then due. The employer did not unreasonably resist the payment of compensation. Claimant did not finally prevail in a hearing from a denial of compensation.

CONCLUSIONS OF LAW AND OPINION

The Board adopts those portions of the Referee's "Opinion" which pertain to claimant's lack of credibility and the denial of acupuncture treatment.

Penalties and Attorney Fees

The Referee did not consider Dr. Lee's letter of December 5, 1987 to be a claim, reasoning that the letter only reiterated the same position that Dr. Lee had expressed in June of 1987. The Referee concluded that this issue had been resolved by the Stipulation and Order of October 12, 1987 and that the employer was entitled to rely on the agreement. We disagree with the Referee's analysis, but agree that no penalties or attorney fees are assessable.

Citing ORS 656.273(3), claimant contends that the Referee erred in finding that neither Dr. Lee's December 5, 1987 letter (Ex 65) nor claimant's attorney's December 29, 1987 letter was a claim. Claimant asserts that penalties and an associated fee should be assessed for a late denial. A "claim" is "a written request for compensation from a subject worker or someone on the workers' behalf, or any compensable injury of which a subject employer has notice or knowledge." ORS 656.006.

We agree that Dr. Lee's letter itself, or in conjunction with claimant's counsel's letter, constitutes a "claim." However, considering the parties' October 1987 stipulation, which stated that the employer was not responsible for Dr. Lee's acupuncture treatments, we do not find the employer's conduct

unreasonable, particularly when it issued its denial within 30 days of receiving Dr. Lee's bill for services. Moreover, even assuming that the "claim" was made, the denial was untimely, and the employer's conduct was unreasonable, no amount of compensation was owed to claimant at the time of the employer's denial. Consequently, there was no amount "then due" upon which to assess the penalty. Ellis v McCall Insulation, 308 Or 74 (1989).

Regarding attorney fees, the basis for an award of attorney fees, unlike the basis for an award of a penalty is not hinged to "amounts then due." Instead, ORS 656.262(10) provides that attorney fees are to be assessed under ORS 656.382. ORS 656.382, in turn, is keyed to unreasonably resisting the payment of compensation. Lloyd L. Cripe, 41 Van Natta 1774 (1989). Here, the employer did not unreasonably resist the payment of compensation where the parties had previously stipulated that claimant was not authorized any acupuncture treatments and the current claim is not compensable.

ASSESSED ATTORNEY FEE

The Referee awarded claimant's attorney a $1000 assessed fee for prevailing on the issue of Dr. Lee's treatment. The Referee reasoned that the insurer had denied all treatment provided by Dr. Lee. We disagree.

Taken in its entirety, the denial did not attempt to deny all treatment provided by Dr. Lee. Rather, as one of three bases for denial of claimant's acupuncture treatments, the employer contended that Dr. Lee was claimant's sixth treating physician. The Referee correctly concluded that, because the employer had not complied with OAR 436-10-060(4)(a), the "sixth treating physician" ground was not valid. Yet, a carrier-paid fee is appropriate only where counsel has caused a denial to be overturned and has obtained compensation for his client. ORS 656.386(1).

In the instant case, only one "basis" of denial, that Dr.\Lee was the "sixth physician", has been rejected, not the denial itself. The Referee's award of a carrier-paid fee is reversed.

ORDER

The Referee's order, dated May 11, 1988, is reversed in part and affirmed in part. The Referee's award of an assessed fee to claimant's counsel is reversed. The remainder of the Referee's order is affirmed. A client-paid fee, payable from the employer to its counsel, is approved, not to exceed $1,147.50.

In the Matter of the Compensation of
GLORIA SERNA, Claimant
WCB Case No. 85-11974
ORDER ON RECONSIDERATION
Myrick, et al, Claimant Attorneys
Schwabe, et al, Defense Attorneys

The self-insured employer has requested reconsideration of our October 10, 1989, Order on Review. On November 2, 1989, we abated our order to consider the employer's request. After doing so, we issue the following Order on Reconsideration.

Claimant requests review of those portions of Referee Blevins' order that: (1) upheld the employer's June 25, 1986, medical services denial; (2) upheld the

employer's February 18, 1987, aggravation denial; and (3) declined to award additional unscheduled permanent disability for her back condition, beyond a Determination Order that had awarded 15 percent (48 degrees). The employer cross-requests review of that portion of the Referee's order that set aside its November 22, 1985, denial, which denied the compensability of claimant's psychiatric condition and all of her then current medical services, save for psychiatric services from Drs. Kirkpatrick and Nitzberg that it had previously agreed to pay. On review, the issues are compensability, medical services, aggravation, and extent of unscheduled permanent disability. We affirm.

FINDINGS OF FACT

Claimant, 29 at the hearing, sustained a compensable mid-and-low back strain in October, 1984, while employed as a food service worker. She was treated conservatively by Dr. Samuel, a chiropractor. Several other medical experts examined claimant over the next few months. Diagnostic studies revealed no objective pathology. Consequently, in June, 1985, she was referred to the Southern Oregon Pain Center for evaluation and treatment. She successfully completed a three-week program at the Center.

In August, 1985, claimant was examined by Dr. Howell, an osteopath. Shortly thereafter, she was examined jointly by the Orthopaedic Consultants and Dr. Parvaresh, a psychiatrist. On September 13, 1985, her claim was closed by a Determination Order, which awarded a period of temporary disability and 15 percent unscheduled permanent disability. That same day, she was examined by Dr. Kirkpatrick, a psychiatrist. On September 16, 1985, Samuel completed a Physical Capacities Analysis. Apparently due to the September, 1985, reports from Kirkpatrick and Samuel, the Evaluation Division issued another Determination Order on October 11, 1985, which affirmed the earlier Determination Order. A few days later, claimant was examined by Dr. Hennings, a psychologist.

The employer issued a partial denial in November, 1985, which denied the compensability of claimant's psychiatric condition and her then current medical services.

In February, 1986, claimant was involved in a non-work related automobile accident. The accident resulted in injuries to her entire back, as well as her left upper extremity. She sought immediate treatment from Samuel for those injuries.

The employer issued a second partial denial in June, 1986, which denied claimant's current medical services.

Claimant was examined by Dr. Garcia, M.D., in September, 1986. In a letter, dated September 9, 1986, Garcia indicated that claimant's claim should be reopened. The employer received Garcia's letter on October 7, 1986, and commenced the payment of temporary disability compensation. Ex. 112. In February, 1987, the employer issued a formal aggravation denial.

Claimant has not returned to work since the injury of October, 1984. Samuel released her to light work as a playground aide in August, 1985, but she declined to pursue that position. She also declined vocational services. Ex. 77-1. As a result, those services were terminated. Claimant is educated through the eleventh grade. Her employment experience includes work as a cafeteria worker, sales clerk, dental lab assistant, and waitress.

Claimant suffered a preexisting personality disorder. As a material result of the compensable October, 1984, injury, claimant suffered increased psy

chiatric symptoms. Those symptoms required medical services in the form of psychiatric evaluation and treatment.

The compensable injury of October, 1984, was a material contributing cause of her need for medical services -- for both her psychiatric and back conditions -- at the time of the insurer's November, 1985, denial.

The motor vehicle accident was a superseding cause, which broke the material causal connection between the October, 1984, injury and claimant's need for medical services for her back condition.

Claimant does not have a permanent loss of earning capacity due to the October, 1984, injury, in excess of the 15 percent previously awarded by Determination Order.

CONCLUSIONS OF LAW

1. November 22, 1985, Denial

a. Compensability of Psychiatric Condition

The Referee concluded that claimant had proven the compensability of her psychiatric condition and need for then current medical services. He, therefore, set aside the employer's psychiatric and medical services denial of November, 1985. We agree and comment as follows.

Claimant must prove that the compensable October, 1984, back injury was a material contributing cause of her existing psychiatric condition. Jeld-Wen, Inc. v. Page, 73 Or App 136 (1985); Harris v. Albertson's, Inc., 65 Or App 254 (1983). We find that this compensability issue presents a complex medical causation question. See Uris v. Compensation Department, 247 Or 420 (1967). Consequently, although claimant's testimony is probative, this issue is largely resolved by the weight of expert medical opinion. When the medical opinions are divided, as here, we must choose the correct medical hypothesis. McClendon v. Nabisco Brands, Inc., 77 Or App 412, 417 (1986).

Here, Howell reported in August, 1985, that claimant suffered from a psychogenic pain disorder. According to Howell, that disorder was "non-work related." Parvaresh essentially concurred with Howell, concluding that claimant's psychiatric disorder "predated" and was, therefore, "independent" of her October, 1984, injury.

In contrast to the opinions of Howell and Parvaresh, are those of Kirkpatrick and Hennings. Kirkpatrick examined claimant in September, 1985, and concluded that her psychiatric condition had been "aggravated" by the October, 1984, injury. Hennings, who had examined claimant on three occasions, reached a similar conclusion. Accordingly, Hennings opined:

> "Following [claimant's] accidental injury, she clearly did present with symptoms of adjustment disorder related to her injury, yet one month following Pain Center treatment there was significant improvement in this psychiatric condition. * * * The complaints would appear related to her accidental injury. Her continued somatization and excessive pain behavior would appear to suggest that her accidental injury was exacerbated and made materially worse an underlying personality disposition towards somatization of anxiety."

We are persuaded by the collective opinions of Hennings and Kirkpatrick. First, both Hennings and Kirkpatrick examined claimant on several occasions. Exs. 35, 51, 75, 82, & 85. Neither Howell nor Parvaresh did so. Second, in our view, Hennings offered the most complete and well-reasoned opinion. Ex. 82. In doing so, he persuasively rebutted the contrary opinion of Parvaresh. Last, Howell is an osteopath. While he is certainly qualified to render an opinion, we accord greater weight to the opinions of those experts who specialize in the mental health profession.

b. Then Current Medical Services

The Referee found that the employer had issued an impermissible prospective denial of claimant's future medical services. To be sure, a prospective denial is improper and must be set aside. Evanite Fiber Corp. v. Striplin, 99 Or App 353 (1989). Here, however, the employer did not issue a prospective denial. Nothing in the November, 1985, denial directly or indirectly suggests that the employer prospectively denied claimant's right to medical services under ORS 656.245(1). In fact, the employer limited its denial of chiropractic services to treatments "at this time." With respect to the psychiatric services, claimant did not have an accepted psychiatric condition under ORS 656.245(1) at the time of the November, 1985, denial. The employer did nothing more than to deny the compensability of that condition and the resulting psychiatric treatments from Kirkpatrick and Nitzberg.

Accordingly, we disagree with the Referee insofar as he concluded that the November, 1985, denial was an impermissible prospective denial of claimant's medical services under ORS 656.245(1).

Regarding the merits of the then current medical services denied by the November, 1985, denial, we have found above that claimant's psychiatric condition was compensable. We are, therefore, persuaded that her then current psychiatric treatments were compensably related to the October, 1984, injury. Likewise, we are persuaded that her then current chiropractic treatments were compensable. At the time of the November, 1985, denial, claimant was receiving chiropractic treatment from Samuel for her back condition. Regardless of the precise physical or psychiatric etiology of her complaints, she was continuing to experience back pain. Nothing in the reports of the mental health experts leads us to conclude that Samuel's chiropractic treatments at that time were not reasonable and necessary. Moreover, Samuel's chart notes at that time indicate that he was providing reasonable and necessary treatment, while simultaneously encouraging claimant to undergo psychotherapy. Ex. 76-1.

Under such circumstances, we agree with the Referee's ultimate conclusion that the employer's denial of November, 1985, should be set aside.

2. June 25, 1986, Denial

The Referee upheld the employer's June, 1986, denial. We agree.

a. Current treatment for Back Condition

In August, 1985, Samuel declared claimant medically stationary and released her to light work. Exs. 72 & 73. He continued, however, to provide reasonable and necessary treatment. Ex. 76. In February, 1986, claimant sustained multiple injuries to her back and left upper extremity in a non-industrial automobile accident. She sought treatment from Samuel for those injuries. Samuel diagnosed a "[s]pinal axis strain/sprain" and treated conservatively. He acknowledged that separating the residuals of the October, 1984, and February, 1986, injuries, would be "difficult." Ex. 90-1. Claimant continued to treat

with Samuel for the residuals of her automobile accident, through mid-August, 1986. Ex. 107. In a report, dated August 17, 1986, Samuel opined:

> "The 2-18-86 [automobile] injury exacerbated a spinal condition which was stationary at that time. Any treatment for the 1984 [industrial] injury was only as needed. She was seen four times in December 1985, three times in January 1986 and two times in February 1986, prior to the 2-18-86 MVA. She has developed cervical cephalalgia that was not evident prior to the 2-18-86 MVA."

Viewing Samuel's reports as a whole, we find no persuasive basis to conclude that claimant's current chiropractic treatments remain causally related to the October, 1984, injury. In sum, the weight of the evidence indicates that the February, 1986, automobile accident was a superseding cause, which broke the chain of causation between the October, 1984, industrial injury and claimant's current chiropractic treatments.

b. Current Treatment for Psychiatric Condition

Likewise, we find no persuasive basis in the record to conclude that claimant's psychiatric treatments after November 22, 1985, if any, are compensable. The last psychiatric report in the record is a report from Hennings, dated October 18, 1985. Ex. 82. Hennings suggested a follow-up examination. We are unable to ascertain whether Hennings provided any further treatment. We are able to ascertain, however, that Samuel repeatedly encouraged claimant to obtain psychotherapy from Kirkpatrick. Ex. 76. Yet, Kirkpatrick last examined claimant on September 13, 1985. Ex. 75.

The employer denied all current medical services in June, 1986. The record reveals no psychiatric care beyond Hennings' evaluation of October 18, 1985. Given the eight month absence of psychiatric care thereafter, coupled with no expert opinion supporting the need for current psychiatric services, we conclude that claimant has not proven her case.

Accordingly, we agree with the Referee that the employer's June, 1986, denial of current medical services should be upheld.

3. February, 1987, Aggravation Denial

At the hearing, claimant withdrew his request for hearing concerning the February, 1987, aggravation denial, save for that portion denying current medical services. Tr. 3 & 9-12. Claimant conceded that the aggravation issue was "moot." Tr. 3. The parties understood that disposition of the June, 1986, denial would take care of claimant's concern regarding entitlement to current medical services. Tr. 9-12.

In light of the parties' agreement, and our above disposition of the June, 1986, denial, we decline to address the merits of the employer's February, 1987, aggravation denial.

4. Unscheduled Permanent Disability

Claimant is entitled to an award of unscheduled permanent disability for a permanent loss of earning capacity due to the compensable injury of October, 1984. ORS 656.214(5).

The Determination Order at issue issued in October, 1985. Ex. 81. After that date and before the date of the hearing, claimant was involved in the February, 1986, automobile accident. We have found above that that accident was a superseding cause, which broke the causal chain between her current back condition and the October, 1984, injury. We are mindful of the well settled principle that a worker's permanent disability is evaluated at the time of the hearing. Gettman v. SAIF, 289 Or 609 (1980). However, on these facts, claimant's physical complaints as expressed at the hearing in July, 1987, were not due to the October, 1984, injury. Accordingly, in determining the extent of her unscheduled permanent disability, we look to her physical condition as it existed immediately before the superseding automobile accident of February, 1986.

Drs. Samuel and Garcia indicated that claimant's back condition had become stationary prior to the automobile accident of February, 1986. Exs. 94A & 108B. Claimant was, however, continuing to experience some chronic pain. She was also continuing to treat with Samuel on an as needed basis. There is little physical basis in the record to support her pre-February, 1986, complaints of pain. Her continued pain complaints were largely of a psychiatric origin. Henning persuasively opined that claimant's psychiatric condition was not disabling and had not resulted in any impairment.

Claimant is relatively young at 29. Although she has a limited educational background, she has a diverse employment history in light to medium fields of labor. Her compensable back strain largely resolved prior to the February, 1986, automobile accident. Although she had chronic pain, it was largely attributable to her compensable psychiatric condition. The persuasive expert opinion is that her psychiatric condition was not disabling and without permanent impairment.

Under such circumstances, we conclude that claimant has not proven more than a 15 percent loss of permanent earning capacity due to the October, 1984, injury.

Accordingly, our October 10, 1989, order is withdrawn. On reconsideration, as supplemented herein, we affirm the Referee's order, dated September 18, 1987. The Board approves a client-paid fee, payable from the employer to its attorney, not to exceed $1,793.43. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
ADELBERT P. SHEPPARD, Claimant
WCB Case Nos. 85-01687, 85-01769 & 85-01770
ORDER DENYING RECONSIDERATION
Pozzi, et al, Claimant Attorneys
Schwabe, et al, Defense Attorneys
Roberts, et al, Defense Attorneys
Lindsay, et al, Defense Attorneys

Farmers Insurance Group seeks reconsideration of our November 13, 1989 Order on Review (Remanding) that vacated a Referee's order and remanded "with instructions to address and resolve the issue of whether claimant obstructed AIAC's right to speak ex parte with Milligan at, and before, the time of the original dismissal order dated August 11, 1986, not subsequent thereto."

Farmers seeks "clarification" of that portion of our order which directed the Referee to "decide the obstruction issue after a record has been opened and evidence submitted . . . in any manner that will achieve substantial, as determined by the Referee, after considering the respective positions of the parties."

Our order issued November 13, 1989. Since that date, the order has neither been appealed, abated, stayed, withdrawn, nor republished. Under such circumstances, it has become final by operation of law. ORS 656.295(8); International Paper Co. v. Wright, 80 Or App 444, 447 (1986). Thus, we lack jurisdiction to address Farmers' reconsideration request. Accordingly, the request is denied.

IT IS SO ORDERED.

In the Matter of the Compensation of
ALICE F. SNELSON, Claimant
WCB Case No. 87-19707
ORDER ON REVIEW
Daryll E. Klein, Defense Attorney

Reviewed by Board Members Cushing and Myers

Claimant, pro se, requests review of that portion of Referee Tuhy's order which upheld the insurer's partial denial of claimant's eye condition. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

Claimant compensably injured her left elbow and lower back when she slipped and fell at work on September 25, 1984. Dr. Bump, M.D., claimant's treating physician, prescribed various pain medications, including Percodan, Dalmane, Elavil.

Claimant had no vision problems prior to February, 1987, when she was prescribed Desipramine in 50 milligram quantities. Dr. Bump's medical records show that prescription being filled on May 22, 1987, for a quantity of one hundred. That same month, Dr. Paulsen, M.D. recommended increasing the dosage to 150 milligrams.

On June 4, 1987, Dr. Barcus, optometrist, reported that claimant experienced blurring of vision and itchy eyes. Eyeglasses were prescribed. Claimant sought reimbursement for her purchase of glasses, contending that her need for corrective lens was related to the compensable medication.

On September 21, 1987, the insurer issued a denial. This denial was based on the assertion that claimant's need for glasses was not caused by any medication being taken as a result of the compensable injury.

CONCLUSIONS OF LAW

The Referee found that claimant had not proven that her need for benefits regarding the eye condition were causally related to the 1984 compensable injury. We agree.

To establish compensability of her eye condition, claimant must show, by a preponderance of the evidence, that the 1984 compensable injury is a material

contributing cause to her current disability or need for medical treatment. Hutcheson v. Weyerhaeuser, 288 Or 51, 56 (1979). The issue of whether claimant's need for medical services is causally related to the 1984 compensable injury is a complex medical question. Thus, while 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).

On February 3, 1988, Dr. Shenk, an eye surgeon, found signs of possible early glaucomatous field defect (OD). Dr. Shenk concluded that this condition had no relationship to claimant's medication or her back injury.

Dr. Singer, ophthalmologist examined claimant on February 16, 1988. He reported that all external structures were normal, the corners were clear, and that the intraocular pressure was normal in both eyes. Dr. Singer opined that claimant showed early presbyopia which was not uncommon in a 41 year old person. He concluded that there were no findings to support the assertion that claimant's need for glasses arose out of her accident or the medication.

Dr. Barcus, optometrist, examined claimant on March 7, 1988, three weeks after she stopped taking medication. Since claimant's vision had cleared up, Dr. Barcus opined that the medication could have aggravated her vision problems. Noting a rise in claimant's intraocular pressure over the past eight months, Dr. Barcus reasoned that the Norpromin probably elevated the pressure slightly and aided in the discovery of the possible glaucomatous field defect in the right eye. Finally, Barcus concluded that the disappearance of symptoms following the cessation of the medication for claimant's back and hip injuries created a causal relationship between the compensable injury and the visual problems.

In response, Dr. Singer, ophthalmologist, asserted that the pressure reading on claimant's right eye was slightly above normal, but that it was not exaggerated. Likewise, he opined there was not enough evidence from either Drs. Barcus's or Shenk's examination to make a diagnosis of glaucoma. In any event, Dr. Singer reasoned that the medication could have aggravated a preexisting condition of glaucoma, but would not have created such a condition. However, Dr. Singer could find no organic disease in claimant's eyes to attribute to the accident or the medicine she was taking.

Dr. Singer, an eye specialist, explained his opinion that claimant's eye condition was neither caused nor worsened by the compensable medication. Singer's opinion was well reasoned and provides an accurate review of claimant's eye history. See Somers v. SAIF, 77 Or App 259,263 (1986). Under such circumstances we find it persuasive. See Kenneth L. Jessie, 40 Van Natta 1592, 1595 (1988).

Moreover, portions of the medical opinion rendered by Dr. Barcus suggest that claimant's vision difficulties could have have been caused by the compensable medical treatments. Yet, claimant is required to prove a relationship between the compensable medical treatment and the vision complaints to a reasonable medical probability. A statement of a physician of a mere possibility or speculation does not meet that requirement. Gormley v. SAIF, 52 Or App 1055 (1981). Consequently, claimant has failed to prove, to a reasonable medical probability, a material relationship between the compensable medical treatment and her ensuing vision complaints. Accordingly, her eye condition is not compensable.

ORDER

The Referee's order, dated June 15, 1988, is affirmed. A client-paid fee, not to exceed $288, payable from the insurer to its counsel, is approved.

In the Matter of the Compensation of
CHARLEY F. STRINGER, Claimant
Own Motion No. 89-0621M
OWN MOTION ORDER
Bischoff & Strooband, Claimant Attorneys

The insurer has submitted to the Board claimant's claim for an alleged worsening of his August 2, 1982 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.

Following our review of this record, we are persuaded that claimant's compensable injury has worsened requiring surgery. In addition, claimant has submitted an affidavit listing employers he contacted in 1989 while seeking employment. Accordingly, claimant's claim is reopened with temporary disability benefits to commence the date he is hospitalized for the proposed surgery. The insurer 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. Finally, claimant's counsel is entitled to a reasonable attorney fee, payable out of the increased compensation awarded by this order. However, we cannot approve a fee unless claimant's attorney files a retainer agreement. See OAR 438-15-010(1). Because no retainer agreement has been received to date, an attorney fee shall not be approved. Reimbursement from the Reopened Claims Reserve is authorized to the extent allowed under ORS 656.625 and OAR 436, Division 45. When appropriate, the claim shall be closed by the insurer pursuant to OAR 438-12-055.

IT IS SO ORDERED.

In the Matter of the Compensation of
ELIZABETH A. THOMPSON, Claimant
WCB Case No. 87-19173
ORDER ON REVIEW
Drakulich & Carlson, Claimant Attorneys
Roberts, et al, Defense Attorneys

Reviewed by Board Members Myers and Gerner.

The insurer requests review of Referee Davis's order which: (1) found that the insurer had not been prejudiced by the untimeliness of claimant's neck injury claim, and (2) set aside the insurer's denial of the claim. On review, the insurer contends that claimant has not established the compensability of her claim. We reverse.

FINDINGS OF FACT

In 1986, claimant was examined and treated by Dr. Strom, D.O. Claimant reported arm, neck, and shoulder pain, in addition to headaches and arm weakness.

On July 7, 1987, claimant was working as a housekeeper for the insured, a motel. Claimant was standing on a laundry bin attempting to prod open a laundry shoot. A co-worker grabbed claimant's legs, causing claimant to fall into an adjacent laundry bin.

On September 11, 1987, claimant was examined by Dr. Morgan, M.D. She complained of pain on the right side of her neck, and numbness and tingling that radiated from her shoulder to her fingertips.

None of the physicians who rendered an opinion concerning the existence of a causal relationship between claimant's current complaints and the July 1987 incident were aware of claimant's 1986 treatments for the same complaints.

On October 29, 1987, the insurer denied claimant's injury claim.

CONCLUSIONS OF LAW

The Referee chose not to speculate on what the physicians might have said had they known of claimant's prior medical treatment for roughly the same complaints. Primarily relying upon claimant's and her co-worker's testimony, the Referee found the claim compensable. We disagree.

Medical and legal causation are requirements for every workers' compensation claim. Legal causation requires the existence of an on-the-job injury. Medical causation requires evidence connecting the accidental injury and the condition for which medical benefits are being claimed. Claimant carries the burden to establish each of these elements by a preponderance of the evidence. Hutcheson v. Weyerhaeuser Co., 288 Or 51 (1979).

Here, claimant has proven legal causation. On July 7, 1987 a co-worker grabbed her causing her to fall. That incident occurred. The difficult question, is whether claimant has proven medical causation. To do so she must establish that the July, 1987, injury materially contributed to the causation of her neck condition, for which she sought treatment in September, 1987.

Drs. Moore, Misko, and Wiebe all found that claimant was suffering from a neck injury. Moreover, Dr. Wiebe found that claimant's work injury had contributed to her present condition. Dr. Wiebe had a history of claimant falling into a linen bed on September 10, 1987, even though the first medical report indicated the incident had occurred on July 7, 1987. In addition, neither Dr. Wiebe, Dr. Moore, Nor Dr. Misko knew about the 1986 medical treatment. Inasmuch as these medical opinions were not based on a complete and accurate history, they are not persuasive. See Miller v. Granite Construction Co., 28 Or App 473, 476 (1977).

In addition, claimant's testimony is contradictory and irreconcilable. She initially testified that she had not been treated for her neck and upper right extremity before the July, 1987 incident. On cross examination, however, she admitted having been treated by Dr. Strom for these complaints in February 1986. Likewise, claimant admitted that she never told Dr. Misko or Dr. Wiebe of this previous medical treatment. Such admissions prompt us to question claimant's reliability.

Considering the incomplete medical histories supplied by claimant to the various physicians, we conclude that the July, 1987, incident did not materially contribute to the causation of neck condition for which she did not seek treatment until two-months later.

ORDER

The Referee's order, dated April 6, 1988, is reversed. Liberty Northwest's denial is reinstated and upheld. A client-paid fee, not to exceed $1,300 payable from the insurer to its counsel, is approved.

In the Matter of the Compensation
OLIVER JEFFRIES, Claimant
WCB Case No. 87-17901
ORDER ON REVIEW
Peter O. Hansen, Claimant Attorney
Roberts, et al, Defense Attorneys

Reviewed by Board Members Cushing and Gerner.

The insurer requests review of that portion of Referee Tenenbaum's order that set aside its denial of claimant's occupational disease claim for his psychological condition. Claimant cross-requests review of that portion of the Referee's order that declined to award temporary disability. On review, the issues are compensability and temporary total disability. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following supplementation:

Claimant worked in several capacities for the employer's silicon wafer manufacturing company. His primary position was as a reactor operator, but when the work load fluctuated he was routinely rotated to other assignments in the department. Claimant's position required him to make precise calculations and to carefully process and handle the product.

Between 1985 and 1987, claimant received a total of three informal warnings regarding job performance and attendance. Beginning in 1986, claimant began to experience symptoms of depression, irritability, headaches and sleep disturbance.

On August 21, 1987, claimant was temporarily reassigned to a different position, due to a manpower shortage. On the same day, claimant tendered his resignation and the employer refused to rehire him when he later asked to have his job back. After his resignation and the employer's refusal to rehire him, claimant's depression symptoms increased significantly. On November 9, 1987, claimant filed a stress claim with the insurer. The insurer denied the claim on November 19, 1987.

CONCLUSIONS OF LAW AND OPINION

1. Compensability.

The Referee found that claimant's stress claim was compensable since work conditions were the major contributing cause of his mental stress 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 condi

tions, are the major contributing cause of claimant's mental disorder. McGarrah v. SAIF, 296 Or 145, 166 (1983). Although the work events must be real and capable of producing stress, their medical effect on claimant is measured by his actual reaction. Duran v. SAIF, 87 Or App 509 (1987); Leary v. Pacific Northwest Bell, 67 Or App 766 (1984).

The Referee found that some of the events claimant contended to have caused stress were misperceptions or were not real events or conditions of employment. However, the Referee also noted that claimant had been subjected to increased pressure to properly process orders and had been temporarily reassigned to a position for which he had been trained but did not ordinarily perform. The Referee concluded that claimant's working conditions and the real events of his employment were capable of causing stress.

The insurer argues that claimant's condition is not compensable, since his stress arose from fictional events, rather than real events or conditions of work. In Leary v. Pacific Northwest Bell, supra, a mental stress claim was found not compensable even though some of the stress-causing conditions were real and others were imagined.

As examples of fictional events or misperceptions, the insurer points out claimant's belief that he was given the most difficult assignments, his fear that he would be suspended for a single mistake and his perception that his new transfer required him to deal with more than 40 new procedures. The insurer also notes that the Referee found that claimant had quit his job and was not terminated by the employer, as claimant originally contended.

The issue of whether claimant's work activities were the major cause of his stress condition is a complex medical question. Thus, although claimant's testimony is 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., 75 Or App 105, 109 (1985).

Claimant's treating psychologist, Dr. Colistro, opined that claimant had experienced job stressors such as the employer's demand for high productivity, claimant's fear of being "written up" and terminated for a single error and claimant's lack of familiarity with new procedures. Dr. Colistro noted that claimant's symptoms and condition had worsened since his termination in August 1987. Dr. Colistro concluded that claimant's depression was the direct result of work-related stressors.

Dr. Turco, an examining psychiatrist, noted that claimant's employment records contradicted the history he had related during his examination. In Dr. Turco's opinion, claimant was experiencing problems associated with his job difficulties and with being unemployed. Dr. Turco also noted that claimant's termination and the employer's subsequent refusal to rehire him was a very strong emotional issue for him. Dr. Turco concluded that it was difficult to know whether claimant's psychological condition occurred as a result of his employment or as a result of his personality problems.

Under the circumstances, we do not find Dr. Colistro's opinion to be persuasive in supporting claimant's contention that employment conditions were the major contributing cause of his mental stress condition. Many of the events that Dr. Colistro relied upon in forming his opinion were events that the Referee found, and we agree, were fictional. See Miller v. Granite Construction Co., 28 Or App 473, 476 (1977) (Medical opinions based on inaccurate histories are not persuasive).

More importantly, both doctors noted that claimant's symptoms had worsened since his termination. In fact, it was not until after his termination that claimant sought medical treatment or became disabled. Specifically, the evidence preponderates that the employer's failure to rehire claimant was a very significant factor to his debilitated condition. In short, claimant was troubled by his unemployed status.

Yet, under Elwood v. SAIF, 298 Or 429 (1984), illness resulting from the stress of actual or anticipated unemployment, as distinct from stressful work events leading to unemployment, is not compensable. Here, in arriving at his opinion, Dr. Colistro failed to separate claimant's work-related stress from stress arising from his unemployment. Because of this factor and the inaccurate history relied upon by Dr. Colistro, we find that claimant has failed to establish that objectively existing stressful work conditions, as opposed to unrelated stress from actual or anticipated unemployment, were the major contributing cause of his psychological condition.

2. Temporary Total Disability

Since we have not found claimant's condition to be compensable, the issue of temporary total disability is moot.

ORDER

The Referee's order, dated April 4, 1988, is reversed. The insurer's denial is reinstated and upheld. A client-paid fee, payable from the insurer to its counsel, not to exceed $1,152, is approved.

January 10, 1990 Cite as 42 Van Natta 66 (1990)

In the Matter of the Compensation of
GARY A. KOCH, Claimant
WCB Case Nos. 84-08835 & 87-10187
ORDER ON REVIEW
Pozzi, Wilson, et al., Claimant Attorneys
Beers, Zimmerman & Rice, Defense Attorneys
Dennis Ulsted (Saif), Defense Attorney

Reviewed by Board Members Crider and Nichols.

The SAIF Corporation requests review of those portions of Referee Daron's order that: (1) set aside its denial of claimant's aggravation claim for his low back; (2) upheld EBI Company's "new injury" denial for the same condition; and (3) awarded claimant an assessed attorney fee payable by SAIF. Claimant cross-requests review, joining SAIF in its assertion that EBI is the responsible insurer. Claimant also asserts that EBI, rather than SAIF, should be responsible for payment of his attorney fees. In its brief, EBI requests that we strike claimant's cross-request for failure to timely file a brief on review. EBI also requests that we enter an order limiting claimant's entitlement to temporary disability compensation. We reject EBI's requests and reverse the Referee's assignment of responsibility to SAIF.

ISSUES

1. Motion to strike.

2. Temporary Disability.

3. Compensability.

4. Responsibility.

5. Attorney Fees.

FINDINGS OF FACT

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

Claimant experienced a work-related injury on April 30, 1987 while employed by EBI's insured which resulted in a herniated lumbar disc requiring medical services and resulting in disability.

CONCLUSIONS OF LAW AND OPINION

Motion to Strike

Claimant filed a formal cross-request for review of the Referee's order. EBI requested in its brief that we strike claimant's cross-request for failure to timely file a brief. Subsequent to that request, claimant submitted his cross-appellant's/respondent's brief. That brief was timely submitted. See OAR 438-11-020. Moreover, filing of a brief is not jurisdictional. Id. Therefore, EBI's motion is without merit.

Temporary Disability

In its brief, EBI also requests an order of the Board finding that claimant is not entitled to temporary disability benefits beyond a certain date. This issue was not raised at hearing. In addition, it raises a question relating to the proper processing of the claim upon acceptance. We decline to address the issue at this time. See Randy L. Johnson, 39 Van Natta 463 (1987).

Compensability and Responsibility

The Referee found that claimant had failed to establish that a "new injury" had occurred while he was employed by EBI's insured. The Referee noted in this regard that claimant had testified that he told his supervisor about the April 30, 1987 incident shortly thereafter. The supervisor denied that claimant made such a statement. Implicit in the Referee's order is an acceptance of the supervisor's testimony and rejection of claimant's testimony.

We do not agree that claimant has failed to establish the occurrence of an April 30, 1987 work injury. To the contrary, Dr. Campagna, who performed lumbar surgery on claimant before April 30, 1987 and who reexamined claimant after that date, has unequivocally opined that claimant experienced a new injury dating to April 30, 1987. Moreover, Dr. Campagna noted that, whereas claimant's previous injury was to the L5-S1 disc, on April 30, 1987 claimant sustained an injury to the L4 disc. In addition, there is no evidence in the record suggesting an off-work explanation for claimant's post-April 30, 1987 condition. Further, claimant was forced to leave work a week after the incident due to increased pain. These facts lead us to conclude that claimant credibly testified to the occurence of an April 30, 1987 work-related incident, which independently contributed to a worsening of his underlying condition resulting in medical services and disability. Accordingly, EBI is the responsible insurer for claimant's post-April 30, 1987 condition. See Hensel Phelps Construction v. Mirich, 81 Or App 290 (1986).

Attorney Fees

As a result of our decision finding EBI to be the responsible insurer, EBI is also responsible for payment of the assessed attorney fee as awarded by the Referee.

ORDER

The Referee's order dated December 2, 1987 is reversed. The SAIF Corporation's aggravation denial is reinstated and upheld. EBI Company's "new injury" denial is set aside and the claim is remanded to EBI for acceptance and processing. EBI, rather than SAIF, shall be responsible for payment of the $1,000 assessed fee awarded to claimant at hearing. In addition, claimant's attorney is awarded an assessed fee of $840 for services on Board review, to be paid by EBI.

In the Matter of the Compensation of
GLEN D. ROLES, Claimant
WCB Case No. 88-02747
ORDER ON REVIEW
Welch, et al, Claimant Attorneys
Jeff Gerner (Saif), Defense Attorney

Reviewed by Board Members Nichols and Crider.

Claimant requests review of that portion of Referee Michael Johnson's order that awarded him 60 percent (90 degrees) scheduled permanent disability for loss of use of the left forearm in lieu of prior awards totalling 55 percent (82.5 degrees). Claimant contends that he is entitled to an increased award for his left forearm, as well as a separate award for loss of use or function of his left arm. The SAIF Corporation cross-requests review of that portion of the Referee's order that found that claimant's claim was prematurely closed by Determination Orders dated February 8, 1984, February 16, 1984, April 26, 1985, and November 18, 1986. SAIF argues that claimant was medically stationary as of those dates, and, in any event, that the Referee lacked jurisdiction to consider the merits of the premature closure issue. Claimant requests that we strike that portion of SAIF's cross-reply brief discussing the merits of the premature closure issue. The motion to strike is denied. We reverse with regard to the premature closure issue and affirm with regard to the permanent disability issue.

ISSUES

1. Whether, as the result of a prior Order of Dismissal, the Determination Orders at issue had become final prior to the date of claimant's most recent hearing request?
2. If the prior Determination Orders had not become final by operation of law, whether claimant was medically stationary at the time of the prior Determination Orders?
3. Extent of Permanent Disability.

FINDINGS OF FACT

On June 3, 1980, claimant compensably injured his left wrist while employed by SAIF's insured. His claim was accepted by SAIF and benefits were paid.

On September 15, 1981, Dr. Cronk, orthopedic surgeon, performed a wrist fusion involving insertion of a plate and screws. A March 10, 1982 Determination Order awarded claimant 30 percent scheduled permanent disability for loss of use of his left forearm. On August 12, 1982, the permanent disability award was increased by Stipulation to 45 percent.

On September 6, 1983, the plate and screws were removed from claimant's wrist. Claimant subsequently experienced increased pain. Dr. Cronk referred claimant to Dr. Nathan, a hand specialist. Dr. Nathan had x-rays exposed which revealed an incomplete fusion. Dr. Nathan also found evidence of underlying carpal tunnel disease.

Claimant's claim was closed by Determination Orders dated February 8, 1984 and February 16, 1984 on reconsideration. Pursuant to these orders, claimant was awarded an additional 10 percent permanent disability. Claimant timely requested a hearing on these Determination Orders listing premature claim closure as one of the issues. His hearing request was assigned WCB Case No. 84-13214.

Claimant continued to experience constant wrist pain which worsened with activity. In September 1984, Dr. Cronk referred claimant to Dr. Ellison, a hand surgeon, for consultation. On October 29, 1984, Dr. Ellison performed a refusion of the wrist, along with a decompression of the left carpal tunnel. Immediately following this surgery, claimant's preoperative pain occasioned by movement in the wrist disappeared.

Claimant's claim was again closed by a Determination Order dated April 26, 1985. This Determination Order awarded no additional permanent disability. Claimant requested a hearing, again listing premature closure as one of the issues. This request was consolidated with WCB Case No. 84-13214.

Claimant commenced an on-the-job training program in July 1985 as an engine assembler. The training program ended in October 1986. Claimant's claim was again closed by a Determination Order dated November 18, 1986, which awarded no additional permanent disability. This Determination Order was also appealed, partly on the basis of premature closure, and was consolidated with WCB Case No. 84-13214. The consolidated requests were set for hearing on October 22, 1987.

In January 1987, claimant was diagnosed as suffering from arthritis of the ulnar joint. Dr. Ellison subsequently performed surgical fusion of claimant's distal radial ulnar joint. Claimant's claim was again reopened for the surgery.

The claim was still open as of September 1987. Claimant's attorney and the SAIF claims examiner discussed the situation by telephone on September 15, 1987. Claimant's attorney subsequently contacted the Hearings Division requesting that his pending hearing requests be dismissed without prejudice. On September 25, 1987, an Order of Dismissal was entered by a Referee in WCB Case No. 84-13214. The order stated:

> "The request for hearing filed in the captioned-matter has been withdrawn by claimant; therefore,
> "THE MATTER IS DISMISSED WITHOUT PREJUDICE."

The Order of Dismissal did not include a statement of the parties' appeal rights under ORS 656.289(3). Neither party requested Board review of the dismissal order within 30 days of its issuance.

On February 17, 1988, the claim was again closed by a Determination Order. On February 24, 1988, claimant requested a hearing on the Determination Order raising as issues temporary total disability for the period August 12, 1982 through September 6, 1983, as well as extent of scheduled permanent disability. At hearing, temporary disability during the period January 13, 1984 through October 28, 1984 was also raised by claimant as an issue.

The parties stipulate that the November 18, 1986 Determination Order should be amended to award temporary total disability compensation from January 15, 1986 through March 3, 1986.

Claimant experiences constant pain in his left wrist which worsens with activity. He is able to manipulate objects with the fingers of his left hand, but he is unable to lift objects with his left hand due to wrist pain. He has greatly reduced grip strength with the left hand. His wrist is fused in the neutral position.

FINDINGS OF ULTIMATE FACT

The February 8, 1984, February 16, 1984, April 26, 1985 and November 18, 1986 Determination Orders were all mailed more than one year prior to claimant's February 24, 1988 request for hearing.

Claimant's injury-related symptoms are confined to his forearm. He experiences no symptoms above his forearm.

CONCLUSIONS OF LAW AND OPINION

Whether the February 8, 1984, February 16, 1984, April 26, 1985 and November 18, 1986 Determination Orders have become final by operation of law.

We reject SAIF's argument that the Referee did not have jurisdiction to consider claimant's request for hearing on the Determination Orders in question. The Hearings Division has jurisdiction over any question concerning a claim. ORS 656.283(1) and 656.726(2). Whether the Determination Orders properly closed claimant's claim was a question concerning a claim. Therefore, the Referee had jurisdiction to determine whether litigation of the Determination Orders was barred because they had become final by operation of law. However, we disagree with his ruling on this issue.

Pursuant to former ORS 656.319(4), a request for review of a Determination Order must be filed within one year after mailing of the Determination Order to the parties. (ORS 656.319(4) currently requires filing within 180 days. However, the former provision is applicable here.) If an appeal is not perfected within one year, the statute of limitation runs and the Determination Order becomes final by operation of law.

Here, claimant timely filed requests for hearings on the Determination Orders dated February 8, 1984, February 16, 1984, April 26, 1985 and November 18, 1986. These hearing requests were consolidated. However, claimant's claim was repeatedly reopened for further surgery and vocational training so that no hearing was held on the hearing requests for several years.

Following claimant's appeal of the November 18, 1986 Determination Order, the consolidated hearing requests were set for hearing on October 22, 1987. However, prior to that hearing date, claimant's claim was reopened yet again for surgery.

Claimant's hearing requests were subsequently dismissed without prejudice pursuant to the Order of Dismissal dated September 25, 1987. Because claimant's prior, timely requests for hearing were dismissed, and because more than one year had transpired between issuance of any of the Determination Orders and claimant's current hearing request, SAIF contended at hearing that the one-year limitations period had run and that claimant was precluded from obtaining review of all issues intrinsic to those orders.

Claimant argued that, at the time of the order of dismissal, it was the intent of the parties that claimant be allowed to preserve his right to challenge the Determination Orders. Claimant relied, in part, upon the Board's decision in Robert L. Murphy, 40 Van Natta 442 (1988), in support of his position. The Referee agreed that the parties intended that claimant's right to contest the Determination Orders would survive the Order of Dismissal. Relying upon the Board's decision in Murphy, the Referee concluded that the Order of Dismissal would not be given effect. We disagree with the Referee's reasoning.

In Murphy, claimant timely requested a hearing on a Determination Order. Upon reopening of the claim for surgery, claimant's attorney wrote the Hearings Division, requesting that the hearing request be dismissed "with the right to preserve all issues until this claim has been closed and is ready to proceed to hearing." Two weeks later, the Presiding Referee entered an order of dismissal, noting that the hearing request had been withdrawn. The order did not specify whether the dismissal was "with" or "without" prejudice. At the time of the dismissal order, more than one year had transpired since issuance of the Determination Order.

The claimant in Murphy then filed a timely request for Board review of the dismissal order. Claimant was concerned that, as a result of the running of the one-year statute of limitation, the dismissal order would have the effect of precluding him from later contesting the Determination Order. Claimant requested that the dismissal order be modified to read that it was issued "without prejudice."

The Board in Murphy declined to modify the dismissal order, but granted claimant other relief. The Board declined to modify the dismissal order for two reasons. First, we noted our policy to interpret any dismissal order issued by the Hearings Division as an order of "dismissal without prejudice," unless the order states otherwise. More fundamentally, we noted that the modification requested by claimant would not serve the purpose for which it was requested. This conclusion resulted from our determination that a dismissal "without prejudice" would only allow future timely requests for hearing on the Determination Order, and would not toll the running of the one-year limitation period. Consequently, any subsequent hearing request on the Determination Order would be untimely.

Having so found, we then concluded in Murphy that claimant's letter to the Hearings Division was not intended as a request for an order of dismissal "without prejudice." Rather, claimant intended to have his case placed in inactive status. We, therefore, reversed the Referee's order of dismissal, reinstated claimant's hearing request, and remanded to the Hearings Division for further action consistent with our order.

SAIF argues that the Referee misapplied Murphy to the facts of this case. SAIF argues that, properly interpreted, Murphy requires the opposite conclusion to that reached by the Referee. That is, SAIF contends that Murphy supports the conclusion that an uncontested dismissal order, even if entered "without prejudice," has no effect upon the one-year limitation period; if the

period has run, then litigation of the Determination Order is forever barred. The intent of the parties is irrelevant.

SAIF asserts that the Board in Murphy afforded relief to claimant only because claimant timely requested review of the dismissal order itself. Since the dismissal in Murphy was not final, and it was brought before the Board, the Board could exercise its jurisdiction and, under its general policy, change the situation to prevent the statute of limitations from barring litigation of the Determination Order. By contrast, here SAIF argues that the dismissal order is final. Therefore, SAIF contends the provisions of former ORS 656.319(4) bar review of the Determination Orders.

SAIF's interpretation of Murphy is correct. We granted relief in that case because the claimant filed a timely request for review of the dismissal order. There was no timely request for review of the dismissal order at issue in the present case. Moreover, at the time of the dismissal order, the period of limitations for requesting a new hearing on the Determination Orders had expired, so that further litigation is barred. Under these circumstances, the intent of the parties is irrelevant.

Claimant contends that the order of dismissal here was not final because it failed to contain a notice of appeal rights. In this regard, ORS 656.289(3) provides that:

> "(3) The order is final unless, within 30 days after the date on which a copy of the order is mailed to the parties, one of the parties requests a review by the board under ORS 656.295. When one party requests a review by the board, the other party or parties shall have the remainder of the 30-day period and in no case less than 10 days in which to request board review in the same manner. The 10-day requirement may carry the period of time allowed for requests for board reviews beyond the 30th day. The order shall contain a statement explaining the rights of the parties under this subsection and ORS 656.295."

We conclude that an order does not depend upon notice of appeal rights to be final. Rather, to be a final order, an order must leave no issue unresolved, i.e., no further questions can arise before the Referee hearing the matter. See Lindamood v. SAIF, 78 Or App 15, 18 (1986). That is clearly the case with an order of dismissal. Pursuant to such an order, nothing remains to be done.

Therefore, the dismissal order at issue here was final under ORS 656.295(3) "unless, within 30 days after the date on which a copy of the order [was] mailed to the parties, one of the parties request[ed] review by the board under ORS 656.295." Neither party requested review of the dismissal order within 30 days. The fact that the order did not include a notice of appeal right did not void the order or stop the running of the 30-day appeal period.

Therefore, we conclude that the September 25, 1987 dismissal order was final despite the absence of appeal rights. Further, because more than one year transpired between issuance of the February 8, 1984, February 16, 1984, April 26, 1985 and November 18, 1986 Determination Orders and claimant's most recent request for hearing, those orders had become final by operation of law prior to the hearing.

Extent of Scheduled Permanent Disability

(a) Forearm

The Board adopts the Referee's discussion of this issue found on pages 4 through 5 and 7 through 8 of his order.

(b) Arm

On review, claimant requests an additional award for loss of use of his left arm. In support of his request, claimant replies upon a January 18, 1988 report from Dr. Nye, a hand surgeon who performed an independent medical examination. In his report, Dr. Nye stated:

> "I think the patient is medically stationary at the present time. I would award him a 30% impairment for ankylosis of the wrist and a 10% impairment of the upper extremity on the basis of chronic discomfort."

SAIF argues that Dr. Nye was not indicating entitlement to a separate award for claimant's upper arm, but that instead he was simply indicating that claimant suffers from chronic pain which causes additional impairment to his injured wrist. Alternatively, SAIF argues that Dr. Nye was converting his wrist findings to a finding for the entire arm. SAIF argues that such a conversion is improper because claimant has suffered no injury-related impairment to his arm. We agree. Claimant testified that his symptoms are restricted to the area from his mid-forearm towards his hand. There is no indication of involvement above the forearm. Consequently, claimant is not entitled to a separate award for the arm.

ORDER

The Referee's order dated August 26, 1988, as reconsidered October 17, 1988, is affirmed in part and reversed in part. That portion of the Referee's order that set aside the February 8, 1984, February 16, 1984, April 26, 1985 and November 18, 1986 Determination Orders is reversed. The Determination Orders are reinstated and affirmed subject to amendment, by stipulation, of the November 18, 1986 Determination Order to award temporary total disability compensation from January 15, 1986 through March 3, 1986. The remainder of the Referee's order is affirmed.

January 10, 1990 Cite as 42 Van Natta 73 (1990)

In the Matter of the Compensation of
GLEN D. ROLES, Claimant
WCB Case No. 88-19267
ORDER ON REVIEW
Welch, et al, Claimant Attorneys
Jeff Gerner (Saif) Defense Attorney

Reviewed by Board Members Nichols and Crider.

This is a consolidated review of WCB Case Nos. 88-19267 and 89-06314. In WCB Case No. 88-19267, the SAIF Corporation requests review of Referee Harri's order that: (1) awarded temporary total disability benefits pursuant to a prior order issued by Referee Michael Johnson; and (2) assessed penalties and an associated attorney fee for a failure to comply with the afore

mentioned order. In WCB Case No. 89-06314, SAIF requests review of Referee Emerson's order that assessed penalties and an associated attorney fee for a failure to comply with Referee Harri's enforcement order.

On review, SAIF argues that Referee Johnson lacked jurisdiction to enter his order; and therefore that his order is void. In addition, SAIF contends that the amounts awarded by Referee Johnson were not "compensation" payable pending appeal. See ORS 656.313(1) & 656.005(8). Moreover, SAIF contends that penalties and associated attorney fees are not assessable because SAIF had a legitimate doubt as to its duty to pay the amounts awarded by Referee Johnson. For these reasons, SAIF contends that Referee Harri erred in enforcing Referee Johnson's order and, in turn, that Referee Emerson erred in assessing penalties and a related fee for SAIF's failure to comply with Referee Harri's order.

We reverse the penalty assessments and affirm the remainder of the orders in both cases.

WCB Case No. 88-19267

ISSUES

1. Enforcement of prior order awarding temporary disability benefits.

2. Entitlement to penalties and related attorney fees.

3. Amount of the penalty-related attorney fee.

FINDINGS OF FACT AND ULTIMATE FACT

The Board adopts the Referee's Findings of Fact and Ultimate Facts with the following addition.

By Order on Review of this date in WCB Case No. 88-02747, the Board has reversed those portions of Referee Michael Johnson's August 26, 1988 order, as reconsidered October 17, 1988, which set aside four Determination Orders as premature and ordered SAIF to pay various amounts of temporary total disability compensation. Glen D. Roles, 42 Van Natta 68 (Issued this date).

CONCLUSIONS OF LAW AND OPINION

SAIF argues that it reasonably believed that its refusal to comply with Referee Johnson's order was legally supported. It, therefore, contends that no penalty should be assessed. However, failure to pay compensation in the face of a clear order to do so is an unreasonable refusal to pay compensation and exposes an employer or insurer to liability for penalties. ORS 656.262(10). SAIF could not have been uncertain as to its duties under Referee Johnson's order. Compare Irene M. Gonzalez, 38 Van Natta 954 (1986) (ambiguous order may give rise to reasonable uncertainty as to obligations). SAIF's duties under Referee Johnson's order were clear. SAIF chose not to comply with that order. We conclude, therefore, that SAIF's conduct was unreasonable.

We further conclude, however, that penalties are nevertheless not assessable. In this regard, ORS 656.262(10) provides for a penalty on "amounts then due." The import of this statutory language was addressed by the Supreme Court in Georgia-Pacific v. Hughes, 305 Or 286 (1988). In Hughes, the employer failed to pay interim compensation to claimant between the time claimant filed his occupational disease claim and the date the employer denied the claim. A

referee determined that claimant was entitled to compensation during this period. The employer requested Board review and refused to pay the awarded interim compensation pending that review. Claimant requested a hearing on the employer's refusal to pay. A second referee concluded that the employer should have paid the award pending appeal. The referee awarded claimant penalties and attorney fees based upon the interim compensation awarded.

On Board review of the first referee's decision, citing the Supreme Court's decision in Bono v. SAIF, 298 Or 406 (1984), we reduced the award of interim compensation. On review of the second referee's enforcement decision, we correspondingly reduced the penalty assessed against the employer to conform to the modified interim compensation award. On judicial review with regard to the penalty issue, the Court of Appeals reinstated the entire penalty levied by the referee on the ground that Bono reflected a change in the law so that at the time the interim compensation was awarded, it was "then due" within the meaning of ORS 656.262(10). The employer requested Supreme Court review.

The Supreme Court found that the Board properly reduced the penalty to reflect the reduction in interim compensation that was mandated by Bono. The Court explained as follows (305 Or App 294):

> "The flaw in the [Court of Appeal's] reasoning is the statement that Bono changed the law regarding interim compensation. In fact, Bono merely clarified a point that is implicit in the statutes and in Jones [v. Emanuel Hospital, 280 Or 147 (1977)] * * *. That part of the referee's award of unpaid interim compensation, compensating claimant during a period when he was working, was never due. Consequently, Georgia-Pacific cannot be penalized for not having paid it."

We conclude that the Court's reasoning as expressed in Georgia-Pacific v. Hughes controls our decision here. In this regard, pursuant to our decision on the merits in WCB Case No. 88-02747, the temporary disability compensation ordered paid by Referee Michael Johnson was "never due." Consequently, SAIF cannot be penalized for not having paid it. In sum, although SAIF refused to comply with an unambiguous order of a referee to pay compensation, we are constrained from assessing a penalty for that conduct. Therefore, despite the adverse policy implications of such a conclusion (see Oscar L. Drew, 38 Van Natta 934, 936 (1986)), we find that the Referee's award of a penalty must be reversed.

The Referee also awarded claimant's attorney a penalty-related attorney fee of $3,000 for services at hearing. A penalty-related attorney fee may be assessed under ORS 656.382(1) whether or not there are "amounts then due" so long as there is "unreasonable resistance to the payment of compensation". Ellis v. McCall Insulation, 308 Or 74 (1989); Lloyd L. Cripe, 41 Van Natta 1774 (1989). We have previously determined that SAIF's conduct was unreasonable. Furthermore, a fee may be assessed under 656.382(1) if an employer "refuses to pay compensation due under an order of a referee..." Here, the temporary disability benefits awarded pursuant to Referee Johnson's order were clearly "compensation" despite the fact that, in light of our decision in WCB Case No. 88-02747, those benefits were not "then due." We therefore conclude that the Referee's award of a penalty-related fee was appropriate.

SAIF has also challenged the amount of the penalty-related attorney fee awarded by the Referee. In determining the reasonableness of attorney fees, several factors must be considered: (1) the time devoted to the case; (2) the

complexity of the issue(s) involved; (3) the value of the interest involved; (4) the skill of the attorneys; (5) the nature of the proceedings; (6) the benefit secured for the represented party; (7) the risk in a particular case that an attorney's efforts may go uncompensated; and (8) the assertion of frivolous issues or defenses. OAR 438-15-010(6). Our review of the record, in light of the above factors, suggests that the attorney fee award made by the Referee was appropriate and should be affirmed.

Subject to the foregoing discussion, we adopt the Referee's opinion regarding SAIF's contentions as found in his Opinion and Order and his Order on Reconsideration.

WCB Case No. 89-06314

We adopt the Referee's factual findings. On the merits, our analysis above is equally applicable to this case. Therefore, we adopt the Referee's Conclusions and Law so long as they are not inconsistent with the above analysis. Consequently, we conclude that the Referee's award of a penalty must be reversed given our reversal of the underlying order; however, the penalty-related attorney fee award was proper.

Because attorney fees are not "compensation" within the meaning of ORS 656.382(2), claimant is not entitled to attorney fees for successfully defending those awards on Board review. See Saxton v. SAIF, 80 Or App 631, rev den 302 Or 159 (1986); Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

In WCB Case No. 88-19267, the Referee's order dated February 27, 1989, as reconsidered March 16, 1989, is affirmed in part and reversed in part. That portion of the Referee's order that assessed a 25 percent penalty against the SAIF Corporation is reversed. The remainder of the order is affirmed. Claimant's attorney is awarded an assessed fee of $500 for prevailing on the temporary disability compensation issue, to be paid by SAIF. In WCB Case No. 89-06314, the Referee's order dated May 16, 1989 is affirmed in part and reversed in part. That portion of the Referee's order that assessed an additional 25 percent penalty against SAIF is reversed. The Referee's attorney fee award is affirmed.

In the Matter of the Compensation of
RICHARD F. TAYLOR, Claimant
WCB Case Nos. 87-11524 & 87-14282
ORDER ON REVIEW
Peter O. Hansen, Claimant Attorney
Stafford Hazelett, Defense Attorney
Judy Johnson (Saif), Defense Attorney

Reviewed by Board Members Crider and Nichols.

Liberty Northwest Insurance Corporation requests review of Referee Daughtry's order which: (1) set aside its denial of claimant's aggravation claim for an upper back condition; and (2) upheld the SAIF Corporation's denial of claimant's aggravation claim for the same condition. On review, the issue is responsibility. We affirm.

FINDINGS OF FACT

Claimant suffered low back and leg injuries in December, 1978, while he was working for SAIF's insured. A laminectomy was performed at L2-3 in May, 1979. The claim was accepted by SAIF, and subsequently closed by Determination Order issued April 9, 1982, which awarded 20 percent unscheduled permanent disability. By stipulation dated July 24, 1984, this award was increased to 27.5 percent unscheduled permanent disability and claimant was also awarded 12.5 percent scheduled permanent disability for the left leg and 17.5 percent scheduled permanent disability for the right leg.

Claimant returned to work as a school custodian.

On April 22, 1985, claimant suffered a mid-low back strain while moving a ladder at work. He returned to regular work without limitations in October, 1985. A claim for that injury was accepted by Liberty Northwest, and subsequently closed on March 12, 1986 by Determination Order, which awarded temporary disability only.

In November, 1986, claimant suffered a recurrence of upper leg and low back pain which became increasingly more severe. He returned to his family doctor, Dr. Eubanks, seeking additional treatment. Claimant was unable to return to work commencing February 11, 1987.

Investigation by Dr. Johnson, neurosurgeon, established that claimant's condition had worsened. Claimant had suffered a herniated disc at L3-4. A laminectomy was performed on August 4, 1987.

In July, 1987, Liberty Northwest denied compensability of claimant's current low back condition. In September, 1987, SAIF denied responsibility for claimant's aggravation claim and payment for medical treatment, contending that claimant's work activities with Liberty Northwest had independently contributed to the need for surgery. No .307 order issued.

FINDINGS OF ULTIMATE FACT

The April 22, 1985 injury independently contributed to the causation of claimant's worsened back condition.

CONCLUSIONS OF LAW

The Referee found Liberty Northwest responsible for claimant's current condition. We adopt the Referee's opinion on this issue, subject to the following supplementation.

In cases involving successive work-related injuries, responsibility rests with the carrier at risk at the time of the most recent injury that independently contributed to a worsening of the claimant's condition. Hensel Phelps Construction v. Mirich, 81 Or App 290 (1986); Smith v. Ed's Pancake House, 27 Or App 361 (1976). Where successive injuries are to the same body part, a rebuttable presumption exists that the last accepted injury contributed to the worsened condition and that the insurer at that time is responsible. That insurer can then rebut the presumption by showing that its accepted injury caused only symptoms or involved a different condition affecting the same body part. Industrial Indemnity Co. v. Kearns, 70 Or App 583 (1984).

The condition in the present case is a low back condition. Claimant's recurrent low back condition occurred after two claims, one accepted by SAIF, and one accepted by Liberty Northwest. Liberty Northwest was on the risk at the

time of the last accepted claim. Accordingly, it has the burden of proving that claimant's April, 1985 injury did not independently contribute to a worsening of claimant's current low back condition. See Kearns, supra.

The Referee determined that the weight of the medical evidence established that the 1985 injury did independently contribute to claimant's condition, and therefore set aside Liberty Northwest's denial. We agree.

Where there is a dispute between medical experts, more weight is given to those medical opinions which are both well-reasoned and based on complete information. Somers v. SAIF, 77 Or App 259, 263 (1986); see Miller v. Granite Construction Co., 28 Or App 473, 476 (1977).

Dr. Johnson, the treating neurosurgeon for both laminectomies, and claimant's treating physician both prior to and following the 1985 injury, concluded that claimant's need for surgery in 1987 was related to the 1978 injury. However, he further opined that all of claimant's intervening injuries since 1978 impacted claimant's current condition. Therefore, it was Johnson's opinion that claimant's low back injury claim with Liberty Northwest did independently contribute to claimant's current low back condition.

Dr. Pasquesi, an orthopedic surgeon who examined claimant after the second laminectomy, opined that the 1978 low back injury was the largest contributor to claimant's need for treatment in 1987. Yet, Pasquesi concluded that every exposure in claimant's life since then has contributed incrementally to the worsening. Logically, claimant's 1985 injury with Liberty Northwest would be included within such exposures.

Liberty Northwest argues that the 1985 back strain and the 1978 residuals are separate injuries, relying solely on the opinion of Dr. Rosenbaum, neurosurgeon, who evaluated claimant in September, 1985. Based on an evaluation of claimant after the 1985 incident and past medical records, Rosenbaum opined that claimant suffered a "separate injury on April 22, 1985." We are not persuaded by Dr. Rosenbaum's opinion.

Claimant was treated by Dr. Johnson on many occasions, including prior to and after both injuries. On the other hand, Rosenbaum did not examine claimant until after the 1985 injury, and based his opinion on his independent evaluation and a review of claimant's past medical records. Inasmuch as the treating surgeon had the opportunity to examine and treat claimant at relevant times in the history of claimant's condition, we find the opinion of Johnson more persuasive and give it more weight. Kienow Food Stores v. Lyster, 79 Or App 416, 421 (1986); see David W. Huntley, 40 Van Natta 2012, 2013 (1988). We further conclude that Johnson's opinion that claimant's low back injury claim with Liberty Northwest did independently contribute to claimant's current low back condition is both well reasoned and based on complete information. See Somers, supra.

Therefore, we hold that Liberty Northwest has failed to rebut the presumption that the April 1985 injury, which it accepted, independently contributed to claimant's worsened condition. Consequently, we agree with the Referee that responsibility for claimant's current upper back condition should be assigned to Liberty Northwest.

Finally, a claimant's attorney is entitled to a reasonable fee when a carrier initiates Board review and the Board determines that "the compensation awarded to [the] claimant should not be disallowed or reduced." ORS 656.382(2).

Here, Liberty Northwest requested review and sought to shift responsibility for claimant's claim to SAIF. No order designating a paying agent pursuant to ORS 656.307 has issued. Consequently, claimant's entitlement to receive compensation remains at risk. See Thomas W. Williamson, 39 Van Natta 1147 (1987). Claimant's counsel participated on Board review and contended that the Referee's responsibility finding should be affirmed.

Under these circumstances, we conclude that claimant's attorney is entitled to a fee for services on review under ORS 656.382(2), payable by Liberty Northwest, the insurer who initiated Board review.

ORDER

The Referee's order, dated June 8, 1988, is affirmed. For services on Board review, claimant's attorney is awarded $600, payable by Liberty Northwest Insurance Corporation.

In the Matter of the Compensation of
RANDALL P. ADAMS, Claimant
WCB Case Nos. 88-07914 & 88-08615
ORDER ON REVIEW
Wilbur C. Smith, Jr., Claimant Attorney
Randolph Harris (Saif), Defense Attorney

Reviewed by Board Members Nichols and Crider.

The SAIF Corporation requests review of that portion of Referee Knapp's order that set aside its denial of claimant's occupational disease claim for a mental disorder. The issue is compensability.

The Board affirms and adopts the order of the Referee with the following additional findings and conclusions.

Claimant has a depressive mental disorder. Objectively stressful conditions at the workplace are the major contributing cause of that disorder.

The Referee concluded that the 1987 amendments to ORS 656.802 did not apply to this case. We agree.

We have held that the 1987 amendments do not apply to cases in which the last injurious exposure occurred prior to the effective date of the amendments. Donna E. Aschbacher, 41 Van Natta 1242 (1989). See Johnson v. SAIF, 78 Or App 143, 146-48, rev den 301 Or 240 (1986).

Claimant's mental disorder is chronic. He first sought treatment for it in May, 1985 when he was hospitalized for one day. Since then he has taken various anti-depressant medications. In 1987, if not before, he missed work due to his depression. Therefore, claimant was disabled by the mental disorder no later than 1987. Thus, the last exposure which could have caused this disability occurred prior to January 1, 1988. Consequently, for purposes of ORS 656.202, claimant's injury occurred before that date. The 1987 amendments, which became effective January 1, 1988, do not apply.

Because SAIF requested review on the issue of compensability and we are affirming the Referee's order, claimant's attorney normally would be entitled to a fee payable by SAIF under ORS 656.382(2). Claimant's attorney, however, filed no brief and has submitted no statement of services rendered on Board review. No fee, therefore, may be awarded. See Shirley M. Brown, 40 Van Natta 879, 881-83 (1988); OAR 438-15-010(5).

ORDER

The Referee's order dated December 7, 1988 is affirmed.

In the Matter of the Compensation of
JOHN E. HEADRICK, Claimant
WCB Case No. TP-89039
THIRD PARTY FINAL DISTRIBUTION ORDER
Scheminske & Lyons, Attorneys

Reviewed by Board Members Myers and Cushing.

On September 10, 1988, we issued a Third Party Partial Distribution Order, as corrected September 16, 1989 and reconsidered October 17, 1989. John E. Headrick, 40 Van Natta 1153, 1641 (1988). Pursuant to our order, the third party insurer was directed to disburse a portion of the proceeds from a third party settlement to the unrepresented claimant and the paying agency. We further directed that the remaining balance of the proceeds be held by the third party insurer's counsel in trust, pending a final determination concerning the extent of claimant's permanent disability.

Contending that, in effect, a final determination regarding the extent of claimant's permanent disability has been rendered, the third party insurer seeks permission to distribute the remaining balance of settlement proceeds. We agree that a final distribution can be made. In reaching our conclusions, we have also considered the record as developed in the prior case.

FINDINGS OF FACT

We adopt the findings of fact as set forth in our previous orders with the following supplementation.

Claimant's February 1987 injury claim was accepted as nondisabling. As of November 9, 1989, claimant had neither objected to the classification of his claim nor had his claim been submitted to the Evaluation Section for closure. The paying agency has not objected to a determination concerning a final distribution of the $934.64 remaining balance from the third party settlement proceeds.

CONCLUSIONS OF LAW

Noting that there is no record with the Department that claimant's February 1987 nondisabling injury claim has been closed, the third party insurer contends that, in effect, a final determination concerning the extent of claimant's permanent disability has been made. Inasmuch as the time within which to object to the nondisabling classification of the claim has long since elapsed and because the paying agency does not indicate that permanent disability has been or will be awarded to claimant, we concur. See ORS 656.262(12); 656.268(3). Consequently, we proceed to a determination of the paying agency's entitlement to a lien for future claim expenditures.

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).

Any conflict as to the amount of the balance which may be retained by the paying agency shall be resolved by the Board. ORS 656.593(1)(d). To support its lien for anticipated future expenditures, the paying agency must establish that it is reasonably certain to incur such expenditures. Donald P. Bond, 40 Van Natta 361, 480 (1988); Leonard Henderson, 40 Van Natta 31 (1988).

Here, the paying agency has asserted its entitlement to the remaining balance of proceeds from the third party settlement. Specifically, it has contended that claimant will require monthly chiropractic treatments for the next 3 years. At $44 per visit, the agency projects claim costs totalling $1,584, which would exceed the $934.64 remaining balance.

The aforementioned projections are based upon the billings and opinion offered by claimant's treating chiropractor, Dr. Saalfield. In response to a question posed by a senior claims examiner for the paying agency, Saalfield concurred with the statement that claimant came in for treatment approximately once per month "as long as he is involved in heavy work activities."

We consider the paying agency's projections to be unpersuasive. To begin, Dr. Saalfield has conceded that claimant has been instructed to return for treatment on an "as needed basis." Moreover, Saalfield has previously opined that claimant's complaints "could go on for several months, or it may stop - - I have no idea." Finally, Dr. Saalfield's concurrence with the monthly treatment projection was expressly conditioned upon claimant's involvement in heavy work activities. Yet, as stated in claimant's affidavit, claimant's work duties have been altered to accommodate his condition. Thus, he no longer engages in such strenuous endeavors.

In sum, Saalfield's opinion provides no persuasive support for the paying agency's contention that claimant's need for chiropractic treatment will continue for 3 years. Furthermore, the basis for Saalfield's conclusion that claimant would require monthly treatments has been eliminated. i.e., claimant's work activities are no longer heavy and strenuous. Consequently the paying agency has not established to a reasonable certainty that monthly chiropractic treatments for the next 3 years will occur.

Because we are not persuaded that it is reasonably certain that the paying agency will incur future expenditures concerning claimant's nondisabling injury claim, we conclude that the paying agency is not entitled to a share of the remaining balance of settlement proceeds. Accordingly, the third party's counsel is directed to distribute the remaining balance of the settlement proceeds to claimant. See ORS 656.593(1)(d).

IT IS SO ORDERED.

January 11, 1990 Cite as 42 Van Natta 81 (1990)

In the Matter of the Compensation of
MAXINE V. McINNIS, Claimant
WCB Case No. 88-04256
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Bullard, et al, Defense Attorneys

Reviewed by Board Members Cushing and Gerner.

Claimant requests review of Referee Podnar's order that upheld the self-insured employer's denial of claimant's request for housekeeping services. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

Claimant sustained a compensable low back injury in 1986. The employer processed the claim as a nondisabling injury. After undergoing back surgery in 1986, claimant developed psychological overlay.

In 1987, claimant's treating doctor, Dr. Ordonez, M.D., prescribed home cleaning assistance for her. The employer initially accepted the claim for housekeeping services, but in 1988, issued its denial of housecleaning services.

CONCLUSIONS OF LAW AND OPINION

The Referee upheld the employer's denial of claimant's claim for housekeeping services on the grounds that such services did not constitute medical services under ORS 656.245(1). We agree with the Referee's conclusion, but we base our decision upon the following reasoning.

Rather than contending that housekeeping services are not reasonable and necessary in claimant's case, the employer instead argues that housekeeping services are not medical services within the definition of ORS 656.245(1). The statute provides in part:

> "Such medical services shall include medical, surgical, hospital, nursing, ambulances and other related services, and drugs, medicine, crutches and prosthetic appliances, braces and supports, and where necessary, physical restorative services." ORS 656.245(1).

Claimant asserts that housekeeping assistance constitutes restorative services which are therefore compensable medical services. Dr. Burns, claimant's treating psychologist, opined that her depression and anxiety were caused, to a substantial extent, by her performing household services which were formerly provided for by housekeepers. Dr. Larsen, M.D., reported that claimant was medically unable to perform housework duties and was in need of a housekeeper two days a week.

We agree with the employer that housekeeping services do not fall within the definition of ORS 656.245(1). In Lorenzen v. SAIF, 79 Or App 751 (1986), the court held that child care services were not "other related services" within the meaning of the statute. Lorenzen v. SAIF, 79 Or App 751 (1986). The rule of statutory construction known as ejusdem generis led the court to the conclusion that the legislature did not intend to include those services because they were not of the same kind or class as those services specifically enumerated in the statute. Id.

In accordance with Lorenzen, we decline to broadly construe the statute and instead conclude that housekeeping services are not of the same kind or class as the services enumerated in ORS 656.245(1).

ORDER

The Referee's order, dated June 28, 1988, is affirmed. A client-paid fee, not to exceed $200, is approved.

In the Matter of the Compensation of
CRAIG A. MULLEN, Claimant
WCB Case No. 86-13221
ORDER ON REVIEW
Peter O. Hansen, Claimant Attorney
Stafford J. Hazelett, Defense Attorney

Reviewed by Board Members Cushing and Gerner.

The insurer requests review of that portion of Referee Schultz's order, which set aside its partial denial insofar as it denied compensability of a mid-back and low back condition. Claimant cross-requests review of those portions of the order that reduced the rate of his temporary disability benefits and did not award an insurer-paid fee for his attorney's services in prevailing against the insurer's partial denial. On review, the issues are compensability, temporary total disability rate and attorney fees. We reverse.

FINDINGS OF FACT

Claimant is a musician who compensably injured his right knee on March 5, 1986. His medical history includes prior knee problems, including left knee surgery in 1974 and a 1982 surgery on the right knee. The 1986 compensable injury resulted in surgery by Dr. Weintraub.

Dr. Weintraub authorized temporary disability. Rather than basing the rate of claimant's temporary disability on his wages at the time of the injury, the insurer calculated claimant's rate by averaging his total wages from various jobs.

On August 22, 1987 a Determination Order issued, awarding 5 percent scheduled permanent disability for the right knee.

Nine months after the compensable knee surgery, on January 12, 1988, claimant returned to Dr. Weintraub complaining of pain in his knees and his back. Dr. Weintraub again operated on claimant's right knee. An MRI scan revealed no disc herniation.

Claimant was next examined by the Orthopaedic Consultants, who diagnosed preexisting chronic lumbosacral strain. Thereafter, the insurer denied claimant's back condition

CONCLUSIONS OF LAW AND OPINION

Compensability

Regarding claimant's back pain, Dr. Weintraub stated that he could not determine if claimant's back problem was related to his knee. Dr. Weintraub suspected something "fishy" and suggested an independent examination. Dr. Pasquesi, an independent medical examiner, felt that claimant's knee condition had probably caused increased stress in his back. Dr. Weintraub, in response to an inquiry from claimant's attorney, then stated that he knew of no other factors contributing to claimant's back problem other than his continuing right knee problem from the March 5, 1986 injury. Dr. McVay, of the Orthopaedic Consultants, felt that claimant's back problems were unrelated to his knee problem.

Based on his observation, the Referee held that claimant's testimony that his back problems were caused by his knee was credible. The Referee concluded that Dr. Weintraub's statement that he knew of no other factors contributing to

claimant's back problems other than his continuing knee problems, coupled with the opinion of Dr. Pasquesi and claimant's testimony, was sufficient to carry claimant's burden of proving that his back problems are related to his knee injury. We disagree.

Claimant bears the burden of proving by a preponderance of the evidence that the industrial injury materially contributed to his disability and the need for medical treatment. Hutcheson v. Weyerhaeuser, 288 Or 51, 56-57 (1979); Milburn v. Weyerhaeuser Company, 88 Or App 375, 378 (1987). The issue of whether claimant's back condition is causally related to the 1986 compensable knee injury is a complex medical issue. Thus, although claimant's credible testimony is probative, the resolution of this causal relationship issue largely turns on an analysis of the medical evidence. Uris v Compensation Dept, 247 Or 240 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985).

Unlike the Referee, we find Dr. Weintraub's opinion to be unpersuasive. At first, Dr. Weintraub considered claimant's back complaints to be unrelated to his knee problems. He reported the back complaints as a separate condition. When confronted with the issue of causation, Dr. Weintraub stated that it was "virtually impossible" to determine whether claimant's knee problems were causally related to his back condition. Yet, without explanation for the change in his opinion, Dr. Weintraub then opined that claimant's knee problems were causally related to his back complaints. The inconsistencies and conclusory nature of this opinion prompts us to give it little weight. See Somers v. SAIF, 77 Or App 259 (1986); Moe v Ceiling Systems, 44 Or App 429 (1980).

We also find Dr. Pasquesi's opinion to be unpersuasive. Dr. Pasquesi reported that claimant's favoring of the right knee probably affected his back. Yet, Pasquesi's opinion contains no explanation of how this could occur. Lacking a reasoned explanation, we give this conclusory opinion little weight. Id.

On the other hand, in her testimony, Dr. McVay gave a detailed explanation of how knee injuries could produce low or midback injuries. This is the only medical opinion in the record which provides an explanation concerning the mechanism by which an injured knee can cause a back injury. Consequently, we give Dr. McVay's opinion great weight. Somers v. SAIF, supra. After describing the aforementioned mechanism, McVay opines that claimant's back condition was unrelated to the compensable knee injury. Accordingly, we conclude that claimant has failed to sustain his burden of establishing a causal nexus between his compensable right knee injury and his current back conditions.

Inasmuch as the denial has been reinstated and upheld, claimant is not entitled to an insurer-paid attorney fee. ORS 656.386(1). Therefore, it is unnecessary to address the attorney fee issue raised by claimant's cross-request.

Time Loss Rate

Reasoning that claimant's work history represented a series of "regular employments," the Referee concluded that claimant's average daily wage should be determined by dividing his gross remuneration for all jobs between December 10, 1985 and March 22, 1986 by the total number of days worked.

Claimant contends that he is entitled to be paid temporary disability based on his remuneration from the job he was doing at the time he was injured, rather than on the average of his various jobs as a musician. We agree.

ORS 656.210 provides that when a claimant's disability is temporary, he shall receive compensation equal to 66-2/3 percent of wages. For purposes of the statute, the weekly wage is ascertained by use of a multiplier reflecting

the daily wage the "regularly employed" worker was receiving at the time of the injury. As used in the statute, "'regularly employed' means actual employment or availability for such employment."

After reviewing the circumstances of claimant's employment, we find that he was "regularly employed" under ORS 656.210. The concept of "regular" employment is not a static one; whether or not a worker was regularly employed at the time of his injury will vary, depending on the circumstances. In Saiville v EBI Companies, 81 Or App 469 (1986), for example, the court found a worker "regularly employed", despite his being an "on call" employee who did not work regular hours for an hourly wage. The fact that the claimant had worked five of the six days between the date of his hiring and the date of his injury was sufficient, in the court's opinion, to find the worker regularly employed. Id. at 472.

Here, claimant worked for three days for the employer on whose premises he was injured. In our view, claimant was "regularly employed" at the time of his injury and his compensation should have been calculated based on the wage he was receiving at the time of his injury.

ORDER

The Referee's order, dated June 16, 1988, is reversed. The insurer's denial is reinstated and upheld in its entirety. The insurer is directed to calculate claimant's temporary disability rate based on the wage he earned at the time of his compensable injury. Claimant's attorney is allowed 25 percent of the increased compensation created by this order, not to exceed $3,000.

In the Matter of the Compensation of
SHIRLEY A. PATTERSON, Claimant
WCB Case No. 84-08978
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
Art Stevens (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

Claimant requests review of that portion of Referee Brown's order that awarded 5 percent (16 degrees) unscheduled permanent partial disability for her contact dermatitis condition, whereas a Determination Order had awarded no permanent disability. The issue on review is extent of unscheduled permanent disability. We affirm.

FINDINGS OF FACT

The Board adopts the Referee's factual findings appearing on page 5 of his order. In addition, the Board makes the following finding.

Claimant's exposure to Captan 5 in March 1984 did not result in either the onset of sensitivity to Captan 5 or an increase in a preexisting sensitivity to the chemical.

CONCLUSIONS OF LAW AND OPINION

On review, claimant notes that the Referee's conclusion as to whether claimant experienced irritant dermatitis or allergic dermatitis as a re

sult of her March 1984 exposure to Captan 5 is unclear. We agree. In his "Findings" the Referee states that test results were consistent with a diagnosis of irritant dermatitis rather than allergic dermatitis. However, in his "Opinion" on page 6 of his order, the Referee states that claimant cannot work with Captan "due to this allergy."

We are persuaded on this point by the reports from the Contact Dermatitis Clinic at the Oregon Health Sciences University. When patch tested with the worksite formulation of Captan, claimant experienced a late-developing urticarial reaction. (Ex. 39). According to the Clinic physicians, such a response is consistent with an irritant condition rather than an allergic condition. (Ex. 38) Dr. Wagner, a toxicologist and specialist in pesticides, also opined that claimant experienced an irritant dermatitis condition. While Drs. Otaski and Naversen opined otherwise, their reports were not apparently based upon patch tests involving worksite formulations of Captan. We conclude in this regard that claimant has experienced irritant dermatitis rather than allergic dermatitis.

We further conclude that regardless of whether claimant experienced irritant dermatitis or allergic dermatitis, she has failed to establish entitlement to an increased permanent disability award. In this regard, Dr. Wagner's opinion is that claimant is not sensitized to any chemicals as a result of her exposure to Captan. While Dr. Otaski felt that claimant had developed a permanent sensitization to Captan, he was unable to relate that sensitization to claimant's exposure to Captan in March 1984. In addition, Dr. Otaski was unaware that claimant had used an antibiotic which could be a skin irritant just prior to the development of her rash in March 1984. Moreover, Dr. Otaski was unaware that claimant was previously exposed to Captan as a result of her husband's potato farming activities. We, therefore, find Dr. Wagner's opinion to be the more persuasive. See Somers v. SAIF, 77 Or App 259 (1986). In conclusion, the record does not persuade us that claimant has either experienced the onset of a permanent sensitivity to Captan or has developed increased sensitivity to Captan as a result of her March 1984 workplace exposure.

The Referee awarded claimant 5 percent permanent disability. Our conclusion is that claimant has failed to establish that she sustained any permanent disability. However, because SAIF has not requested a reduction in the Referee's award, the award will not be disturbed.

ORDER

The Referee's order dated April 11, 1988, as amended on April 28, 1988, is affirmed.

January 11, 1990 Cite as 42 Van Natta 86 (1990)

In the Matter of the Compensation of
LINDA A. STEVENSON, Claimant
WCB Case Nos. 87-07020 & 86-15450
ORDER ON REVIEW
Schouboe, Marvin, et al, Claimant Attorneys
Norman Cole (Saif), Defense Attorney

Reviewed by Board Members Brittingham and Nichols.

Claimant requests review of those portions of Referee Bennett's order that: (1) found that the SAIF Corporation's denial of claimant's tendinitis condition was not an invalid "backup" denial; (2) found that claimant's tendin

itis and psychological conditions were not compensable, and declined to award unscheduled permanent disability for those conditions; (3) found that an October 1986 Determination Order did not prematurely close her 1986 claim; (4) found that an April 1987 Determination Order did not prematurely close her 1985 claim and, therefore, declined to award temporary disability benefits on the 1985 claim after August 27, 1986; (5) awarded 10 percent (15 degrees) scheduled permanent disability for loss of use or function of each of her hands, whereas a Determination Order had awarded 5 percent (7.5 degrees) for each hand; and (6) awarded a penalty-associated attorney fee of $300 for unreasonable processing of the 1985 claim. On review, claimant requests that the Board modify the April 1987 Determination Order to reflect the Referee's ruling that claimant is entitled to additional interim compensation under the 1985 claim for the period August 11, 1985 through August 13, 1985. Claimant also requests penalties and attorney fees for SAIF's failure to timely accept or deny his 1986 claim for the tendinitis condition. Claimant further requests interim compensation under that claim.

On review, the issues are: (1) whether SAIF's denial of claimant's tendinitis condition is an invalid "backup" denial; (2) compensability of claimant's tendinitis condition; (3) compensability of claimant's psychological condition; (4) premature closure; (5) temporary disability benefits; (6) extent of permanent disability; and (7) penalties and attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's "Findings" with the following supplementation. In November, 1984, claimant began working for the employer as a staple clerk; she became a file clerk after six months. Subsequently, claimant began exhibiting a rash, red sores, itchiness, and bumps on her hands.

On October 3, 1985, she submitted an 801 Form regarding the rash and open sores on her hands. The claim referenced an August 10, 1985 date of injury or diagnosis. Dr. Cook, claimant's treating osteopath, diagnosed the condition as irritant contact dermatitis. In December 1985, SAIF accepted the claim. On May 17, 1986, claimant was released to work.

Due to the dermatitis, claimant could no longer handle file room papers. Consequently, she transferred to the reporting desk, where she worked on a CRT and a typewriter. After three weeks, claimant experienced pain in her left elbow from typing. Claimant's dermatitis also continued.

On May 21, 1986, claimant filed a claim for aching in her left hand, arm and shoulder, and red spots and a rash on her left hand, dating back to May 15, 1986. The 801 Form listed claimant's injury or disease as tendinitis. On June 6, 1986, SAIF indicated on the 801 that the claim had been accepted. On that same date, 1986, SAIF sent a notice of claim acceptance to claimant for a condition of "cellulitis/eczema; contact dermatitis."

On September 19, 1986, Dr. Won, D.O., became claimant's attending physician. Claimant complained of a painful neck and shoulder, elbow, and wrist (mostly on the left side). Dr. Won found chronic strain and sprain of the cervical spine, left shoulder and hand.

On October 17, 1986, a Determination Order was issued on the 1986 claim. The medically stationary date under this claim was set at August 27, 1986.

Another Determination Order was issued on April 29, 1987. This order referred to the 1985 claim. The medically stationary date under this claim was set at February 12, 1987.

In March 1987, claimant returned to light duty work on a part-time basis. She experienced increased left hand pain and left work. Claimant's dermatitis condition also remained symptomatic.

Some portion of claimant's tendinitis and dermatitis conditions are attributable to emotional and functional factors.

On June 22, 1987, SAIF issued a denial regarding claimant's request for reopening of her claim for "irritant contact dermatitis" and "cellulitis/eczema; contact dermatitis" sustained by you on August 10, 1985, and May 15, 1987, respectively . . . "

ULTIMATE FINDINGS OF FACT

We adopt the ultimate findings included in the "Opinion" portion of the Referee's order. We make the following additional findings.

On this record, we are not persuaded that claimant's dermititis condition was medically stationary at the time the October 1986 and April 1987 Determination Orders issued.

The issues of penalties and attorney fees for failure to accept the 1986 tendinitis claim and entitlement to interim compensation on that claim were not raised at the hearing.

CONCLUSIONS OF LAW

We adopt those portions of the Referee's order which pertain to the issues of: "backup" denial; compensability of claimant's tendinitis and psychological conditions; extent of unscheduled permanent disability for those conditions; and penalty associated attorney fees on the 1985 claim.

Premature Closure

We disagree with the Referee's ruling that claimant's 1985 and 1986 claims were not prematurely closed. In reaching this decision, we do not consider claimant's noncompensable tendinitis condition. We base our analysis solely on the compensable dermatitis condition.

The 1985 and 1986 claims were prematurely closed if claimant's dermatitis condition was not medically stationary at the time these claims were closed by Determination Order. "Medically stationary" means that no further medical improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). It is claimant's burden to prove that her claim was prematurely closed. Austin v. SAIF, 48 Or App 7 (1980). In determining whether a claim has been properly closed, a determination of whether a claimant was medically stationary on the date of closure must be made, without considering subsequent changes in his or her condition. Sullivan v. Argonaut Inc. Co., 73 Or App 694 (1985); Alvarez v. GAB Business Services, 72 Or App 524 (1985).

We first address the 1986 claim, which was closed by the October 17, 1986 Determination Order. That Determination Order found that claimant was medically stationary on August 27, 1986, the date Dr. Button, the hand surgeon, found claimant to be medically stationary. However, Dr. Button was not evaluating claimant for her dermatitis condition, but only for her noncompensable tendinitis condition.

The October 7, 1986 report from treating physician Winslow is unpersuasive for much the same reason. He reported that claimant had developed a real

fixation with her arm. He opined that her return to work might need to be deferred until this problem was resolved. It is unclear if Dr. Winslow was addressing claimant's dermatitis condition or the noncompensable tendinitis condition.

The only other medical opinion addressing this issue is from treating dermatologist Storr. Based on his examination of claimant on January 12, 1987, he opined in a report dated January 28, 1987 that claimant would be medically stationary in one month. We give little weight to Dr. Storr's opinion because it is a mere prediction of claimant's future status rather than an assessment of her current condition. See Carol K. Matthews, 41 Van Natta 1032, 1034 (1989).

Based on this record, we are persuaded that claimant's dermititis condition was not medically stationary when her 1986 claim was closed by the October 1986 Determination Order. We, therefore, conclude that the Determination Order prematurely closed the 1986 claim, and reverse the Referee on this issue. In turn, the Referee's finding that SAIF was entitled to a credit for an overpayment of temporary disability based on the closure of the 1986 claim is reversed.

We turn to the April 1987 Determination Order, which closed the 1985 claim. The medical records do not make any clear distinction between the dermatitis conditions under the 1985 and 1986 claims. We conclude that the condition which arose in 1985 is the same condition referenced in the 1986 claim and treated by Dr. Storr in January 1987. As discussed above, there is no persuasive evidence in the record that this condition has ever become medically stationary. Accordingly, we are not persuaded that claimant's dermititis condition was medically stationary when her 1985 claim was closed by the April 1987 Determination Order. We, therefore, conclude that the Determination Order prematurely closed the 1985 claim, and we reverse the Referee on this issue.

Temporary Disability Compensation

In light of our conclusion that the 1985 claim was prematurely closed, we also reverse the Referee's ruling that claimant is not entitled to additional temporary disability compensation after August 28, 1986.

Claimant also contends that the Referee failed to modify the April 1987 Determination Order to reflect his additional award of interim compensation. We disagree. The "Order" Section of the Referee's opinion and order reads: "IT IS FURTHER ORDERED that claimant is awarded temporary disability from August 11 through August 13, 1985." That language effectively modifies the April 1987 Determination Order.

Extent of Scheduled Permanent Disability

As noted above, there is no persuasive evidence in the record that claimant's dermititis condition has ever become medically stationary. A determination regarding the extent of her permanent disability from that condition would, therefore, be premature. Consequently, we decline to address that issue at this time.

Penalties and Attorney Fees

Claimant seeks penalties and attorney fees for SAIF's failure to timely process claimant's 1986 tendinitis claim. Claimant also requests interim compensation on that claim. However, these issues were not raised at hearing. Under these circumstances, it would not be proper for the Board to address them on review. Mavis v. SAIF, 45 Or App 1059, 1062-63 (1980); Richard C. Centeno, 41 Van Natta 619, 620 (1989).

ORDER

The Referee's order dated May 10, 1988 is affirmed in part and reversed in part. The October 17, 1986 and April 29, 1987 Determination Orders are set aside. The claims are remanded to the insurer for processing according to law. Pursuant to the Referee's order, the insurer shall pay claimant interim compensation under the 1985 claim for the period August 11, 1985 through August 13, 1985. The Referee's authorization to offset is reversed. The Referee's award of permanent partial scheduled disability is set aside. In accordance with claimant's retainer agreement, her attorney is awarded 25 percent of the increased temporary disability compensation created by this order, not to exceed $750. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
MARION TABOR, Claimant
Own Motion No. 89-0549M
CONSENT TO ISSUANCE OF ORDER DESIGNATING A PAYING AGENT (ORS 656.307)
Malagon, et al, Claimant Attorneys

The Compliance Division has notified the Board that it is prepared to issue an order designating a paying agent under ORS 656.307 and OAR 436-60-180. Each of the insurers has provided its written acknowledgment that the only issue is responsibility for claimant's otherwise compensable claim. Claimant's aggravation rights under his claim with Industrial Indemnity have expired. Thus, that claim is subject to ORS 656.278.

Under OAR 438-12-032(3), the Board shall notify the Compliance Division that it consents to the order designating a paying agent if it finds that the claimant would be entitled to own motion relief if the own motion insurer is the party responsible for payment of compensation. The Board may exercise its own motion jurisdiction if there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. ORS 656.278(1)(a). In such cases, the Board may authorize the payment of temporary disability compensation from the time the worker was actually hospitalized or undergoes outpatient surgery until the worker's condition becomes medically stationary, as determined by the Board. Id.

The record establishes that there has been a worsening of claimant's compensable injury requiring either inpatient or outpatient surgery or other treatment requiring hospitalization. Inasmuch as claimant would be entitled to own motion relief if the own motion insurer is found responsible for claimant's current condition, the Board consents to the order designating a paying agent for temporary disability benefits commencing the date claimant was hospitalized for surgery. Furthermore, for the purposes of ORS 656.625 and OAR 436, Division 45, this consent constitutes an order reopening a claim under ORS 656.278 and the Board's rules if the designated paying agent is an own motion insurer. See OAR 438-12-032(3).

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fixation with her arm. He opined that her return to work might need to be deferred until this problem was resolved. It is unclear if Dr. Winslow was addressing claimant's dermatitis condition or the noncompensable tendinitis condition.

The only other medical opinion addressing this issue is from treating dermatologist Storr. Based on his examination of claimant on January 12, 1987, he opined in a report dated January 28, 1987 that claimant would be medically stationary in one month. We give little weight to Dr. Storr's opinion because it is a mere prediction of claimant's future status rather than an assessment of her current condition. See Carol K. Matthews, 41 Van Natta 1032, 1034 (1989).

Based on this record, we are persuaded that claimant's dermititis condition was not medically stationary when her 1986 claim was closed by the October 1986 Determination Order. We, therefore, conclude that the Determination Order prematurely closed the 1986 claim, and reverse the Referee on this issue. In turn, the Referee's finding that SAIF was entitled to a credit for an overpayment of temporary disability based on the closure of the 1986 claim is reversed.

We turn to the April 1987 Determination Order, which closed the 1985 claim. The medical records do not make any clear distinction between the dermatitis conditions under the 1985 and 1986 claims. We conclude that the condition which arose in 1985 is the same condition referenced in the 1986 claim and treated by Dr. Storr in January 1987. As discussed above, there is no persuasive evidence in the record that this condition has ever become medically stationary. Accordingly, we are not persuaded that claimant's dermititis condition was medically stationary when her 1985 claim was closed by the April 1987 Determination Order. We, therefore, conclude that the Determination Order prematurely closed the 1985 claim, and we reverse the Referee on this issue.

Temporary Disability Compensation

In light of our conclusion that the 1985 claim was prematurely closed, we also reverse the Referee's ruling that claimant is not entitled to additional temporary disability compensation after August 28, 1986.

Claimant also contends that the Referee failed to modify the April 1987 Determination Order to reflect his additional award of interim compensation. We disagree. The "Order" Section of the Referee's opinion and order reads: "IT IS FURTHER ORDERED that claimant is awarded temporary disability from August 11 through August 13, 1985." That language effectively modifies the April 1987 Determination Order.

Extent of Scheduled Permanent Disability

As noted above, there is no persuasive evidence in the record that claimant's dermititis condition has ever become medically stationary. A determination regarding the extent of her permanent disability from that condition would, therefore, be premature. Consequently, we decline to address that issue at this time.

Penalties and Attorney Fees

Claimant seeks penalties and attorney fees for SAIF's failure to timely process claimant's 1986 tendinitis claim. Claimant also requests interim compensation on that claim. However, these issues were not raised at hearing. Under these circumstances, it would not be proper for the Board to address them on review. Mavis v. SAIF, 45 Or App 1059, 1062-63 (1980); Richard C. Centeno, 41 Van Natta 619, 620 (1989).

ORDER

The Referee's order dated May 10, 1988 is affirmed in part and reversed in part. The October 17, 1986 and April 29, 1987 Determination Orders are set aside. The claims are remanded to the insurer for processing according to law. Pursuant to the Referee's order, the insurer shall pay claimant interim compensation under the 1985 claim for the period August 11, 1985 through August 13, 1985. The Referee's authorization to offset is reversed. The Referee's award of permanent partial scheduled disability is set aside. In accordance with claimant's retainer agreement, her attorney is awarded 25 percent of the increased temporary disability compensation created by this order, not to exceed $750. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
MARION TABOR, Claimant
Own Motion No. 89-0549M
CONSENT TO ISSUANCE OF ORDER DESIGNATING A PAYING AGENT (ORS 656.307)
Malagon, et al, Claimant Attorneys

The Compliance Division has notified the Board that it is prepared to issue an order designating a paying agent under ORS 656.307 and OAR 436-60-180. Each of the insurers has provided its written acknowledgment that the only issue is responsibility for claimant's otherwise compensable claim. Claimant's aggravation rights under his claim with Industrial Indemnity have expired. Thus, that claim is subject to ORS 656.278.

Under OAR 438-12-032(3), the Board shall notify the Compliance Division that it consents to the order designating a paying agent if it finds that the claimant would be entitled to own motion relief if the own motion insurer is the party responsible for payment of compensation. The Board may exercise its own motion jurisdiction if there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. ORS 656.278(1)(a). In such cases, the Board may authorize the payment of temporary disability compensation from the time the worker was actually hospitalized or undergoes outpatient surgery until the worker's condition becomes medically stationary, as determined by the Board. Id.

The record establishes that there has been a worsening of claimant's compensable injury requiring either inpatient or outpatient surgery or other treatment requiring hospitalization. Inasmuch as claimant would be entitled to own motion relief if the own motion insurer is found responsible for claimant's current condition, the Board consents to the order designating a paying agent for temporary disability benefits commencing the date claimant was hospitalized for surgery. Furthermore, for the purposes of ORS 656.625 and OAR 436, Division 45, this consent constitutes an order reopening a claim under ORS 656.278 and the Board's rules if the designated paying agent is an own motion insurer. See OAR 438-12-032(3).

In the Matter of the Compensation of
DORN P. THOMPSON, Claimant
WCB Case Nos. 88-03046, 87-17636 & 88-04302
ORDER ON REVIEW
Patrick Lavis, Claimant Attorney
Roy Miller (Saif), Defense Attorney
Stafford Hazelett, Defense Attorney
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Nichols and Brittingham.

Claimant requests review of Referee Leahy's order that: (1) upheld Liberty Northwest Insurance Corporation's denial of claimant's "new injury" claim for a low back condition; (2) upheld Aetna's denial of claimant's aggravation and medical services claim for the same condition; (3) declined to assess penalties and attorney fees against Aetna for an alleged unreasonable denial; and (4) affirmed a Determination Order that declined to award unscheduled permanent disability. On review, the issues are compensability, responsibility, aggravation, medical services, extent of permanent disability, and penalties and attorney fees. We affirm.

FINDINGS OF FACT

On February 25, 1987, claimant injured his low back refinishing doors while employed by Aetna's insured. He began treating with Dr. Sears, a chiropractor, who diagnosed an acute lumbar sprain/strain and took him off.

On April 26, 1987, claimant fell down five or six stairs at home, bruising his low back. He was taken by ambulance to the emergency room, where his back was x-rayed. He was seen the next day by Dr. Sears, who characterized the incident as an injury and referred claimant to Dr. Borman, an orthopedist. Dr. Borman diagnosed chronic paravertebral muscle strain and recent low back reinjury.

On May 12, 1987, Dr. Sears reported that claimant had been missing appointments and providing misleading information about his condition. Suspecting that claimant was malingering, Dr. Sears noted that he had information that claimant was performing activities inconsistent with the symptoms he presented. Dr. Sears found claimant medically stationary as of this date.

The claim was closed by Determination Order in June, 1987 with an award of temporary disability from February 25, 1987 through May 8, 1987 and without an award of permanent disability. A hearing was requested on the question of the extent of claimant's permanent disability.

Claimant went to work for another employer approximately one month after the Determination Order was issued and he worked there about one week. Some weeks later he began work on a gill net boat, helping to prepare it for the fishing season. He worked on the gill net boat about three weeks, but after working a couple of nights actually fishing he quit due to back pain.

Two weeks later, claimant went to work for Liberty Northwest's insured, a seafood company. He worked for two days, during which time he sprained his thumb. On September 9, 1987 he quit this job, telling the employer that he had a scheduled back surgery for a previous on-the-job injury. While these two days of work made his back sore, claimant did not hurt his back. Although he continued to take prescription medication for his back pain, claimant had not sought medical treatments since May 8, 1987.

On October 20, 1987 claimant began treating with Dr. Johnson, a chiropractor. He gave Dr. Johnson a history of having been on time loss until July 1, 1987 and having been employed by Liberty Northwest's insured a week prior to the examination. There is no indication that Dr. Johnson was ever informed of the April 1987 fall. On November 19, 1987, Dr. Johnson referred claimant to Dr. Nelson, a neurologist, to determine "whether a true physiological problem exists" that could be related to the February, 1987 compensable injury. Claimant did not attend the appointment made with Dr. Nelson and did not return to Dr. Johnson.

On November 19, 1987, Aetna issued a denial of aggravation of claimant's low back condition, alleging a new intervening injury in April, 1987. On March 7, 1988, claimant filed an 801 claim form with Liberty Northwest's insured. A date of injury of February 25, 1987 was given and the accident was described as a "caring (sic) injury from a previous job." Liberty Northwest issued a denial of compensability on March 10, 1988.

CONCLUSIONS OF LAW AND OPINION

Liberty Northwest's Denial

No medical opinion links claimant's employment of two days duration at Liberty Northwest's insured with his alleged need for treatment in October, 1987. Claimant's own testimony was that his back was not injured while he was at this job. In his brief, claimant concedes that there is no evidence linking Liberty Northwest's insured with his alleged need for treatment, but requests that we address this issue independently. Aetna, in its brief, maintains that claimant has not produced evidence against either insurer, but wants the last injurious exposure rule applied against Liberty Northwest should we find claimant's current need for treatment to be compensable.

We agree with the Referee's conclusion that claimant's two day period of employment at Liberty Northwest's insured did not contribute in any way to his alleged current need for treatment or worsening of his low back condition.

Aetna's Denial

To establish a compensable aggravation, claimant must prove that: (1) his condition has worsened since the last award of compensation, so that he is more disabled, either temporarily or permanently; and (2) his compensable injury was a material contributing cause of the worsened condition. ORS 656.273(1); Grable v. Weyerhaeuser Company, 291 Or 387, 400-01 (1981); Smith v. SAIF, 302 Or 396, 399 (1986). If the claim involves an unscheduled body part, "more disabled" means increased loss of earning capacity. See Smith v. SAIF, supra.

Expert medical evidence is generally not required to prove an aggravation claim. A claimant's own testimony may be sufficient. Garbutt v. SAIF, 297 Or 148 (1984). The evidence in this case demonstrates that claimant has misled or provided inaccurate histories to his treating chiropractors and is suspected by at least one of his doctors of malingering. Claimant was not truthful with his last employer about his reason for leaving his employment. The Referee found the claimant to be not credible. We agree and place no reliance on his testimony.

Turning to the medical evidence, we find that only Dr. Johnson has provided an opinion which links claimant's current need for treatment in October and November, 1987 to his compensable low back injury of February, 1987. Yet, claimant provided an inaccurate history to Dr. Johnson and failed to inform him of the April, 1987 fall. Medical opinion that is not based on a complete and

accurate history is not persuasive. See Miller v. Granite Construction Co., 28 Or App 473, 476 (1977).

Claimant has failed to produce any credible testimony or persuasive medical opinion that his condition is causally related to the February, 1987 compensable injury with Aetna. Consequently, claimant has failed to meet his burden of proof.

Penalties and Attorney Fees

Claimant advances the argument that Aetna's compensability denial was unreasonable because it relies on medical reports which were in existence prior to the closing of the claim in June 1987, rather than reports on claimant's current condition. Claimant contends that Aetna should be estopped from using these medical reports as the basis of a later denial. Claimant provides no authority for his contention. Moreover, the Court of Appeals has specifically held that once a claim is accepted as compensable, an employer may not later deny responsibility for the claim prior to its closure. The court went on to state that this holding "does [not] affect employer's post-closure right to deny claims for specific medical treatments or for aggravation on the ground that they do not 'result from the injury.'" Roller v. Weyerhaeuser Company, 67 Or App 583 (1984), at 587.

Here, the claim was properly closed. Claimant had stopped medical treatments on his own prior to claim closure. The denial was properly issued after claims for medical benefits were made following Dr. Johnson's treatments in October 1987. Accordingly penalties and attorney fees are not warranted.

In the alternative, claimant argues that Aetna's denial was unreasonable because claimant is entitled to continuing medical treatment under ORS 656.245. Claimant maintains that even though his testimony was not found to be credible, the opinion of Dr. Johnson linking the treatment to his compensable injury is unrefuted. In view of our finding that Dr. Johnson's opinion is unpersuasive, this argument is without merit.

Extent of Disability

Claimant contends that he is entitled to unscheduled permanent partial disability as a result of his February, 1987 injury with Aetna. Claimant's argument is based entirely on his own testimony, which we have found not credible. The only medical opinion which addresses this question is contained in a May 29, 1987 report by Dr. Sears, claimant's treating chiropractor at the time of claim closure. Dr. Sears concluded that claimant had no permanent impairment. We agree with the Referee that claimant has failed to establish that his February, 1987 compensable injury with Aetna resulted in permanent impairment. Accordingly, claimant is not entitled to an award of unscheduled permanent disability.

ORDER

The Referee's order, dated May 17, 1988, is affirmed. A client paid fee, payable from Aetna to its counsel, not to exceed $1,347, is approved.

In the Matter of the Compensation
SUSAN G. TWIGGER, Claimant
WCB Case No. 86-16798
ORDER ON REVIEW
Robert E. Nelson, Claimant Attorney
Roberts et al, Defense Attorneys

Reviewed by Board Members Brittingham and Nichols.

The insurer requests review of that portion of Referee Lipton's order that set aside its denial of claimant's occupational disease claim for mental stress. The issue on review is compensability. We reverse.

FINDINGS OF FACT

Claimant was employed as a salesperson for the employer for about seven years. She worked 40-hour weeks, while some of her coworkers were permanent part-time employees who worked 20 to 32 hour weeks. Claimant operated a cash register terminal and assisted in stocking the department.

Claimant was an average employee. She was informally disciplined once in seven years for returning late from a break. Lunch hours were scheduled, but breaks were arranged informally for all employees. When one part of the department store was busy, management and other personnel were called to assist.

In May, 1986, claimant's oldest son was assaulted in a parking lot and rendered unconscious. He suffered severe head injuries and was hospitalized for a week. He was then taken to claimant's home for recuperation but his condition worsened and he was rehospitalized for brain surgery. At one point, it was feared he would lose the sight in one eye. After surgery, he returned to claimant's home for a few weeks for rehabilitation.

On June 11, 1986, claimant arranged her department for a sale to take place the following day. When she arrived for work on June 12, she found the store director and store manager had rearranged the department to allow greater foot traffic. She worked throughout the day with the store director. That evening she became distraught and anxious and was hospitalized.

She was thereafter treated by Dr. Anderson, psychiatrist, for a dysthymic disorder.

ULTIMATE FINDINGS OF FACT

The work events complained of by claimant were both real and nonreal events.

Stressors related to real work events were not the major contributing cause of her current psychiatric condition.

CONCLUSIONS OF LAW AND OPINION

The Referee found the employer's store director to be a credible witness. He did not make credibility findings regarding claimant. In the absence of express credibility findings by the Referee, we make the necessary credibility findings based on the substance of the witnesses' testimony and not on demeanor. See Coastal Farm Supply v. Hultberg, 84 Or App 282 (1987).

The insurer argues that claimant failed to prove that the real conditions and events of her employment, when viewed objectively, could cause stress. The

insurer alternatively argues that any stress resulting from claimant's employment is outweighed by the non-work related stress, including that resulting from an assault on her son. Accordingly, the insurer contends that work conditions and events are not the major contributing cause of her psychiatric condition. We agree with the latter contention.

In order to establish the compensability of a mental disorder, claimant must prove that: (1) the real events or conditions of her work, when viewed objectively, were capable of producing stress; and (2) the actual stressful conditions of her employment were the major contributing cause of her mental disorder. McGarrah v. SAIF, 296 Or 145 (1983); Barbara T. Chilla, 39 Van Natta 284 (1987), aff'd mem 90 Or App 193 (1988).

The stressful conditions must be objective in that they must be real. However, the medical effect of stressful conditions on the worker is measured by the worker's actual reaction to them, rather than by an objective standard of whether the conditions would have caused disability in the average worker. Petersen v. SAIF, 78 Or App 167 (1986). Stated another way, we factually determine what were the actual conditions of employment. If these conditions could cause stress, we weigh their contribution to claimant's condition against the contribution from other stressors in claimant's life.

Conditions of Employment

Claimant testified that she did not have enough assistance and did not promptly receive help when she called. She testified that several coworkers took long breaks and long lunches. Credible testimony to the contrary by the store manager and store director showed that employees must punch in and out for lunch periods, and that employees must limit lunch periods to that time allotted. The store director testified that when one department became busy, managers and other employees were directed to assist that department. However, it is not always possible to get relief help immediately when assistance was requested.

Claimant testified that a coworker in the stock department would leave items in her department in the aisle. Credible testimony by store management established that this is store policy and that claimant was expected to stock items left by the stock person. Claimant's testimony revealed that she had a personality conflict with this coworker for some time.

Claimant found a bag of bloody matter in the store. Investigation revealed the items to be chicken parts. She testified that coworkers would thereafter make "clucking" noises as they passed her department. She could identify no coworker who made such noises. No other witness heard employees make "clucking noises" as they passed claimant's department.

The Referee found that the "final straw" event which precipitated claimant's disability was the rearrangement of part of claimant's department by store management during the night preceding the sale. The store director testified that claimant appeared surprised at first at the new arrangement, but said nothing and worked all day without incident. The actual rearranging of the display was minor and pertained to only one area, plastics.

We find that claimant's testimony is inconsistent with some testimony found credible by the Referee. Claimant's testimony exaggerates the actual stressful conditions of employment and the number of stressful incidents. However, we find that at least some of the real conditions of claimant's employment could cause stress. She had successfully performed the job for a number of years and was considered an average employee. It is apparent from claimant's

testimony that times when her department was extremely busy were stressful, and the preparations for promotional sales were also stressful. We consider the conditions of employment, that were determined to be real as opposed to perceived, to be a stressor and proceed to weigh it against the other stressors in claimant's life.

Work Activities Compared To Non-work Activities

The next step in our analysis is to determine whether claimant has established that her work activities were the major contributing cause of her disability. McGarrah v. SAIF, supra. We find they were not.

Dr. Anderson opined that claimant's work activities were a major contributing cause of her condition.

Dr. Wheeler, claimant's family physician, opined that claimant's work activities contributed to her condition, along with other factors.

Dr. Parvaresh, psychiatrist, opined that claimant's concern for the condition of her son was the major contributing cause of her need for treatment and disability. He described claimant's stress from job-related activities as moderate and her stress from her son's condition as severe.

Both Dr. Anderson and Dr. Parvaresh based their opinions on job conditions as related by claimant. We have found not all of these events or conditions to be real. In addition, Dr. Parvaresh had the benefit of investigative reports showing actual conditions on the job. He also had complete information regarding the condition of claimant's son which claimant said was "hard on the family."

Dr. Parvaresh discussed the effect of the son's hospitalization, surgery, and subsequent need for rehabilitation on claimant and described this as severe. He opined that, even if one believed claimant's version of her work activities, such conditions would not result in claimant's current condition. He noted that claimant still suffered significant disability four months after leaving the job. He felt any job-related stress would have resolved by this time.

Dr. Anderson's reports and testimony do not address the other stressors in claimant's life nor compare them to employment stressors. Moreover, we are unable to determine from Dr. Anderson's testimony whether he was ever aware of the condition of claimant's son and how that affected the claimant and her family. Consequently, we give less weight to this medical opinion, which does not address nonemployment stressors. See Betty A Wilcox, 39 Van Natta 828 (1987).

Dr. Parvaresh evaluated the major stressors in claimant's life and concluded that claimant's concern for her son's condition was the major contributing cause of her current condition. We agree and rely on Dr. Parvaresh's opinion. His report and deposition are based on a more complete history and more thoroughly discuss the various stressors in claimant's life. We find his opinion persuasive and choose to rely on it. See Somers v. SAIF, 77 Or App 259 (1986). We, therefore, conclude that the real events and conditions which claimant encountered at work and which she felt were the cause of her depression were not the major contributing cause of her current condition.

Accordingly, we conclude that claimant has not proven that her work activities were the major contributing cause of her current condition and has, therefore, not proven the compensability of her claim.

ORDER

The Referee's order, dated January 15, 1988, is reversed. The insurer's denial is reinstated and upheld. A client-paid fee, not to exceed $1,854.50, is approved.

In the Matter of the Compensation of
ANN L. WAGENIUS, Claimant
WCB Case No. 87-18846
ORDER ON RECONSIDERATION
Malagon, et al, Claimant Attorneys
Beers, et al, Defense Attorneys

Claimant has requested reconsideration of the Board's Order on Review dated December 21, 1989, which affirmed a Referee's order that upheld the insurer's denial of claimant's aggravation claim for an allegedly worsened low back condition. Specifically, claimant, (1) requests that we reconsider whether the Referee found claimant credible; and (2) remand for the taking of additional evidence concerning the alleged worsening of claimant's low back condition.

The Referee held as follows:

> "After hearing and observing claimant, I am inclined to question her credibility. I do feel she has a tendency to exaggerate her situation--at least when comparing her situation now with what it was prior to December, 1983."

Claimant argues that these statements do not rise to the level that we could determine that the Referee found claimant not credible and that by doing so the Board was exaggerating the Referee's credibility finding which, claimant agrees, was based on claimant's demeanor.

Although the Referee did not specifically say that he found claimant "not credible," we find that the Referee's statements, taken as a whole, make a finding that claimant was not credible as a witness concerning whether her compensable condition had worsened. Assuming for the sake of argument that we found claimant's testimony to be credible, we would still give it little weight because we agree with the Referee's assessment that claimant tended to exaggerate her complaint.

We turn to the remand issue. We may remand a case to the Referee for further evidence taking if we determine that the case has been "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(5). Remand 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).

Here, to substantiate her testimony at hearing that her condition had worsened, claimant requests remand so that she may submit into evidence, medical records and post-operative records relative to her surgery on September 30, 1988. The surgery occurred some seven months after the hearing and eight months after the expiration of claimant's aggravation rights.

As we stated in our Order on Review, claimant must establish that her condition worsened prior to the expiration of her aggravation rights. Perry v. SAIF, 93 Or App 631 (1988), rev'd on other grounds 307 Or App 654, on remand 99 Or App 52, n.2 (1989). Claimant's aggravation rights expired on January 13, 1988. Inasmuch as the post-hearing submission concerns September 30, 1988 surgical records, we question the material's relevance regarding the question of whether claimant's compensable condition worsened prior to the expiration of her aggravation rights. Moreover, such information does not indicate that the present record concerning the aforementioned question has been insufficiently developed. Consequently, claimant's request for remand is denied.

Accordingly, our December 21, 1989 order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our December 21, 1989 order in its entirety. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
TERRANCE A. BENBOE, Claimant
WCB Case No. 87-19767
ORDER ON REVIEW
Max Rae, Claimant Attorney
Rick Dawson (Saif), Defense Attorney

Reviewed by Board Members Nichols and Crider.

Claimant requests review of the portion of Referee Myers' order that dismissed claimant's hearing request insofar as it challenged the SAIF Corporation's denial of reimbursement to claimant's doctor for prescribed vitamins. SAIF cross-requests review of the portion of the order that awarded claimant's attorney an assessed fee. On review the issues are jurisdiction and attorney fees. We affirm.

We adopt the Referee's findings of fact.

We adopt the Referee's conclusions of law with the following supplement on the issue of attorney fees.

SAIF argues that the Referee erred in awarding an attorney fee when he set aside the denial of December 28, 1987. SAIF contends the second denial issued on January 22, 1988 rescinded the first denial and therefore there is no basis for an attorney fee. Contrary to counsel's argument, SAIF's second denial did not rescind the compensability denial that was raised in the first denial. It did not concede compensability. Instead, the second denial specifically stated that SAIF took no position on the compensability of the vitamin therapy. It was not until the hearing that SAIF conceded actual compensability. Since the question of compensability of the vitamin therapy remained in doubt until the hearing, an attorney fee to be paid by the insurer was appropriate.

Given the facts of this case, we do not decide the issue SAIF raises in its brief: Whether a claimant is entitled to a carrier-paid fee where a denial is rescinded and compensability conceded prior to hearing.

Inasmuch as attorney fees are not "compensation" within the meaning of ORS 656.382(2), claimant is not entitled to an attorney fee award for successfully defending against SAIF's cross-request. See Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The Referee's order dated June 13, 1988, as reconsidered June 27, 1988, is affirmed.

In the Matter of the Compensation of
LARRY H. ERBS, Claimant
WCB Case No. 88-01764
ORDER ON REVIEW
Haugh, et al, Claimant Attorneys
Breathouwer, et al, Defense Attorneys

Reviewed by Board Members Myers and Gerner.

The self-insured employer requests review of Referee Tuhy's order, which set aside its denial of claimant's aggravation claim for a right leg/knee condition. On review the sole issue is aggravation. We reverse.

FINDINGS OF FACT

Claimant compensably injured his right knee on March 5, 1986. Following surgery, claimant became medically stationary in July, 1986. A Determination Order of July 31, 1987 closed the claim with an award for 5 percent scheduled disability to the right leg. Claimant requested a hearing to protest the Determination Order. The employer also issued a partial denial of an anterior cruciate tear of the right knee. Claimant requested a hearing to protest that denial.

On December 9, 1987, before the hearing on the Determination Order and the partial denial, claimant saw Dr. Cook. Dr. Cook's chart note for this date indicated that claimant's symptoms continued and a brace was suggested.

The hearing on the Determination Order and the partial denial was held before Referee Irving on December 23, 1987. The evidentiary record closed on that date.

On January 18, 1988, Dr. Cook reported that claimant had been unable to work since December 9, 1987 due to his compensable knee injury. The insurer received the report on January 21, 1987.

On January 20, 1988, Referee Irving issued her Opinion and Order. She set aside the partial denial regarding the anterior cruciate tear of the right knee and increased claimant's award of scheduled disability for the right knee to 10 percent.

On March 17, 1988, an outpatient arthroscopic surgery and resection of medial plica was performed on claimant's right knee.

ULTIMATE FINDINGS OF FACT

The December 9, 1987 chart note from Dr. Cook did not indicate a need for further medical services or additional compensation.

The last arrangement of compensation is the December 23, 1987 hearing.

Claimant's compensable condition has not worsened to the point of making him more disabled than at the time of the December 23, 1987 hearing.

CONCLUSIONS OF LAW AND OPINION

The Referee held that Dr. Cook's December 9, 1987 chart note substantiated claimant's claim that his condition had worsened as of December 9, 1987. Therefore, the Referee reasoned that the last award of compensation upon which to base claimant's aggravation claim was the Determination Order of July 31, 1987 rather than the December 23, 1987 hearing. We disagree.

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 resulting from the compensable injury. ORS 656.273(3); Haret v. SAIF, 72 Or App 668 (1985).

As the court noted in Haret, the purpose of subsection (3) is to allow an aggravation claim to be made by a physician's report requesting additional services. However, "additional services" must be read together with ORS 656.273(1). In reading the two provisions together it is clear that the additional medical services referred to are for "worsened conditions." Here, the chart note does not need to prove that claimant's condition has worsened, but it must put the insurer on notice that treatment for more than continuing conditions is 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. Cook's brief December 9, 1987, chart note stated that claimant's knee problem "continues" and that, "...it would be worthwhile to get him an ACL brace. I also re-emphasized the importance of exercise." Dr. Cook's chart note does not indicate that claimant's knee condition has changed or worsened. Rather, the chart note merely indicates that application of a brace might relieve the continuing knee problems, problems which have persisted since the last award of compensation. Krajacic, 84 Or App at 130. Hence, we find that Dr. Cook's December 9, 1987 chart note does not constitute a claim for aggravation.

On January 21, 1988, the employer received a January 18, 1987 note from Dr. Cook stating that claimant had been unable to work since December 9, 1987, "and continues to be disabled due to his knee injury of 2/15/86..." This note constitutes a claim for aggravation. Thus, the question becomes from which date to determine whether claimant's condition has worsened.

As we held in Joseph R. Klinsky, 35 Van Natta 332, aff'd mem 66 Or App 193 (1983), the logical point from which to measure the worsening is the date of the extent hearing because: (1) Board and judicial review of a claimant's extent of disability is based on the record made at the hearing; and (2) Board and judicial decisions about extent of disability are decisions about disability as of the time of the hearing, e.g. Gary A. Freier, 34 Van Natta 543 (1982).

Here, in accordance with Klinsky, the appropriate time from which to review this claim for aggravation is the December 23, 1987, extent of disability hearing. It was at this point that claimant had his last opportunity to be heard with respect to his condition.

We turn to the merits of the aggravation claim. ORS 656.273 allows a claimant additional compensation where the claimant has demonstrated worsened conditions resulting from the original injury since the last award of compensation. In order to demonstrate a compensable aggravation (worsened condition) of his knee/leg condition, claimant must demonstrate that he has experienced increased loss of use or function of his leg/knee since the last award of compensation. International Paper Co. v. Turner, 304 Or 354 (1987), on rem 91 Or App 91 (1988). The increased loss of use or function must be greater than any future periods of increased disability, that is, increased loss of use or function, contemplated by the last award. Id.

Here, the January 20, 1988 order issued by Referee Irving after the December 23, 1987 hearing, awarded claimant an additional 5 percent scheduled disability to his right knee. That hearing afforded claimant the opportunity to present all evidence of his current right knee/leg conditions, such as Dr. Cook's December 9, 1987 chart note, which reported claimant's continued symptoms and suggested the use of a knee brace. We note that Referee Irving considered Dr. Cook's hypothesis, in a report not related to the December 9, 1987 chart note, that claimant's continued problems may be due to ongoing degeneration of the knee which had led to damage of the anterior cruciate ligament. Based on

this contemplation of future periods of claimant's loss of use of function of his right knee/leg, claimant was awarded the additional 5 percent disability.

We are not persuaded that claimant has suffered an increased loss of use or functioning of his right leg/knee greater than what was anticipated at the time of the December 23, 1987 hearing. As was anticipated, claimant lost time from work for his compensable, March 17, 1988 diagnostic arthroscopic surgery. Claimant was not an inpatient for this surgery. Thereafter, he returned to the work force as a cement truck driver and had not missed time from work since due to knee pain. (Tr 15 & 16).

ORDER

The Referee's order, dated June 3, 1988, is reversed. The self-insured employer's denial of claimant's aggravation claim is reinstated and upheld. The Board approves a client-paid fee, payable from the employer to its counsel, not to exceed $960.

January 16, 1990 Cite as 42 Van Natta 101 (1990)

In the Matter of the Compensation of
PHILIP M. GORRINGE, Claimant
WCB Case No. 86-04066
ORDER ON REVIEW
Chelsea Mohnike (Saif), Defense Attorney

Reviewed by Board Members Crider and Nichols.

Claimant requests review of Referee Neal's order which: (1) found that claimant was not a subject worker for the SAIF Corporation's insured; and (2) upheld SAIF's denials of claimant's stress and heart condition claim. On review the issues are whether claimant was a subject worker for SAIF's insured and compensability.

The Board affirms with the following supplementation.

FINDINGS OF FACT

The Board adopts the Referee's Findings of Fact. In addition, we find that claimant was neither promised nor paid wages for work performed at the training site.

CONCLUSIONS OF LAW AND OPINION

With the exception of the third paragraph, the Board adopts the Referee's Opinion with the following supplementation.

The Referee held that claimant was not an employee of Portland Security, the employer at claimant's training site. Consequently, the Referee reasoned that SAIF, the training site's insurer, was not responsible and SAIF's denial should be upheld.

Neither a vocational rehabilitation organization nor a training-site employer is required to provide compensation coverage for a trainee placed in a nonremunerative, on-the-job training program, because the trainee is not a "worker" within the meaning of ORS 656.005(27). Firkus v. Alder, 48 Or App 251 (1980). The claimant in Firkus appealed the Board's affirmance of the insurer's denial of responsibility for a "new" injury to his right elbow which claimant

sustained while engaged in an authorized vocational rehabilitation program necessitated by a compensable right elbow injury. The court, citing Wood v. SAIF, 30 Or App 1103, 1110 (1977), rev den 282 Or 189 (1978), held that rather than the carrier for the training site, the carrier responsible for the original compensable injury was responsible for the new injury.

As claimant was involved in nonremunerative training activity when he was allegedly injured, we agree with the Referee that claimant was not employed by SAIF's insured. SAIF's denial must be upheld. Claimant's claim should have been submitted to the employer responsible for claimant's compensable back injury rather than to the training-site employer.

ORDER

The Referee's order dated March 1, 1988 is affirmed.

January 16, 1990 Cite as 42 Van Natta 102 (1990)

In the Matter of the Compensation of
CHAE S. HUGHES, Claimant
Own Motion No. 89-0707M
OWN MOTION ORDER
Saif Legal, Defense Attorney

The SAIF Corporation has submitted to the Board claimant's claim for an alleged worsening of her November 1, 1979 industrial injury. Claimant's aggravation rights have expired. SAIF has accepted responsibility for the surgery but opposes reopening of her 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.

Following our review of this record, we are persuaded that claimant's compensable injury has worsened requiring surgery. In addition, claimant has submitted tax records for the years 1987 and 1988 confirming she is self-employed, and a release from work that states she has not been able to work since April 29, 1989. Accordingly, claimant's claim is reopened with temporary disability benefits to commence October 3, 1989, the date she 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.

In the Matter of the Compensation of
THEODORE L. NOMELAND, Claimant
WCB Case No. 88-01084
ORDER ON RECONSIDERATION
Charles Robinowitz, Claimant Attorney
David Jorling, Defense Attorney
Garrett, et al, Attorneys

Claimant requested reconsideration of that portion of our December 8, 1989 Order on Review which reinstated the Determination Order award of 16.16 percent (31.03 degrees) permanent scheduled disability for binaural hearing loss. In order to fully consider the matter, we abated our prior order and granted the employer an opportunity to respond. After receiving the employer's response, and further considering the matter, we make the following conclusions.

Claimant contends that we erred in reinstating the Determination Order as the portion of the Referee's order which did not allow a deduction for presbycusis was not appealed by the employer. The employer concurs with claimant's contention and we agree.

The only issue on appeal was whether the Referee erred in not allowing a deduction for claimant's pre-employment baseline hearing loss. That portion of the Referee's order which did not allow for a deduction of claimant's presbycusis was not appealed. Although our review is not limited to issues specifically raised by the parties, we conclude in this instance that it would not be appropriate to reach the issue of the presbycusis deduction. See ORS 656.295(6); Destael v. Nicolai Co., 80 Or App 596 (1986).

We therefore reverse the Referee's decision only to the extent that it did not deduct the pre-employment base line hearing loss. In lieu of the Determination Order, claimant is granted 24.84 percent (47.69 degrees) scheduled permanent disability for binaural hearing loss.

Accordingly, as modified herein, we adhere to and republish our December 8, 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
LYRIS J. REAM, Claimant
WCB Case No. 87-15387
ORDER ON REVIEW
Welch, Bruun & Green, Claimant Attorneys
Ruth Cinniger (Saif), Defense Attorney

Reviewed by Board Members Crider and Nichols.

The SAIF Corporation requests review of Referee Neal's order that granted claimant permanent and total disability, whereas Determination Orders awarded 40 percent (128 degrees) unscheduled permanent disability for a low back injury. On review, the issue is permanent and total disability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the exception of the finding that claimant was diagnosed with depression at the Callahan Center in 1980.

We additionally find that due to the combination of claimant's compensable psychological condition, her compensable back condition and her preexisting disability, claimant is permanently incapacitated from regularly performing work at a gainful and suitable occupation. Any effort to find work would be futile.

CONCLUSIONS OF LAW AND OPINION

We adopt the Referee's opinion with the exception of that portion of the opinion that holds that, because this claim has been previously closed, claimant must establish that her condition has worsened since the last arrangement of compensation -- that is, since the January, 1982 hearing on appeal from the 1980 Determination Order.

When this claim was last closed, and at the time of the January, 1982 hearing, the claim was solely one for a back condition. Claimant's psychological condition had not been accepted. Since that time, SAIF accepted the psychological condition as nondisabling and, then, pursuant to final order of Referee Shebley, accepted the condition as disabling. Claimant was entitled to a rating of her permanent disability due to the psychological condition. There having been no prior rating of that condition, Stepp v. SAIF, 304 Or 375 (1987), does not apply. Claimant is not obliged to show that her psychological condition has permanently worsened since the prior closure of the back claim as a prerequisite to rating of the psychological condition.

Inasmuch as SAIF does not argue that claimant is in fact able to work in view of her compensable conditions and her preexisting disability, and inasmuch as the record establishes that she is not able to work, we conclude that the Referee correctly awarded permanent and total disability.

If, however, we err in holding that claimant need not establish a worsening, we would find that claimant's psychological condition has, in fact, worsened since the last arrangement of compensation. Whereas claimant's emotional problems were described as minimal after examination at the Callahan Center in 1980, claimant, according to Dr. Flemming, was suffering from severe depression in 1985. On that basis, we would rerate claimant's permanent disability even had the psychological condition been considered at the time of the last arrangement of compensation.

ORDER

The Referee's order dated June 9, 1988 is affirmed. Claimant's attorney is awarded an assessed fee of $1,200 for services on Board review.

January 17, 1990 Cite as 42 Van Natta 104 (1990)

In the Matter of the Compensation of
DANNY E. HUNT, Claimant
WCB Case No. 88-03543
ORDER ON REVIEW
Donald L. Dickerson, Claimant Attorney
Breathouwer, et al, Defense Attorneys

Reviewed by Board Members Gerner, Cushing and Myers.

Claimant requests review of Referee Nichols' order which dismissed his request for hearing from the self-insured employer's denial of an aggravation claim as untimely filed without good cause. On review, the issue is whether claimant established "good cause" for his untimely hearing request. We affirm.

FINDINGS OF FACT

Claimant compensably injured his back in January, 1985, and a Determination Order issued in December, 1985 closing the claim. In January, 1987, the parties stipulated to awarding claimant 10 percent unscheduled permanent partial disability for his upper back condition.

Claimant continued to be treated by his chiropractor, Dr. McCrory, frequently. In May, 1987, two other chiropractors, Duncan and Fladoos, examined claimant and found his condition to be resolved with no permanent impairment and that continued treatment was unnecessary.

In November, 1987, McCrory reported that claimant had exacerbated his condition and authorized work release. The insurer denied claimant's aggravation claim on November 27, 1987.

Claimant's wife signed for the denial on November 27, 1987. No copy of this denial was sent to an attorney representing claimant. Upon receipt of the denial, claimant phoned his attorney several times, but never spoke directly to him. Claimant took no further action. Claimant's attorney had no record of such phone calls or attempted contact and had no knowledge of the insurer's denial until March, 1988, at which time the request for hearing was filed and a new retainer agreement was signed.

On March 15, 1988, the Board received claimant's request for a hearing.

The January, 1987 stipulation litigated all prior claims initiated by claimant. Eleven months elapsed between the time of the January, 1987 stipulation and the November, 1987 denial. The insurer had no knowledge that claimant was represented by counsel in November, 1987. There had been no contact by an attorney, representing claimant, with the insurance company since February, 1987.

CONCLUSIONS OF LAW

We adopt the conclusions of law as set forth in the "Opinion and Conclusions" section of the Referee's order, with the following supplementation.

Claimant has 60 days to request a hearing on a denial, or 180 days if good cause for the failure to request within the 60 days is shown. ORS 656.319(1).

The test for determining if good cause exists has been equated to the standard of "mistake, inadvertence, surprise or excusable neglect", recognized under ORCP 71(B)(1). 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).

Claimant argues "excusable neglect", in that the insurer violated ORS 656.331(1)(b). The statute provides that:

> "An insurer . . . shall not contact the worker without giving prior or simultaneous written notice to the worker's attorney if the contact affects the denial, reduction or termination of the worker's benefits."

Claimant argues that he relied on his attorney to file a request for a hearing after the attorney's receipt of a copy of the denial. As a consequence

of the alleged statutory violation, and his reliance on his attorney, claimant argues that the insurer's denial should be set aside as "null and void", and that "good cause" has been established for his untimely request for hearing.

We reject claimant's assertion that he has established "good cause" based on "excusable neglect".

Where claimant shows that he had reasonably expected that the carrier would notify his attorney if there was any significant action to be taken on a claim, excusable neglect may be established. Cowart v. SAIF, 94 Or App 288 (1988). In Cowart, claimant proved that he had instructed the carrier to keep in contact with his attorney, and that claimant left instructions with his attorney to challenge all denials. The present case is distinguishable.

After conducting our de novo review, the record fails to establish that: (1) the carrier should have known that claimant's attorney in January, 1987, was still his attorney in November, 1987; (2) claimant had left his attorney with instructions to appeal all denials; or (3) claimant relied on his attorney to appeal all matters. In reaching these conclusions, we note that claimant had not been in contact with his attorney for approximately 11 months, when he notified his counsel after the denial, some four months after its issuance. Furthermore, at that time, they entered into a new retainer agreement.

We therefore agree with the Referee that claimant has failed to prove "good cause" for his failure to file a hearing request within 60 days after receiving notice of the denial.

Inasmuch as the Referee did not consider the "null and void" issue, we proceed to do so. We find no legal basis for claimant's contention that an insurer's failure to give proper notice to a claimant's attorney renders a previously issued denial "null and void". In doing so, we note that sanctions for such conduct are available. Specifically, when such conduct is established, civil penalties may be imposed against carriers for statutory violations. See OAR 436-60-015(2). Such sanctions do not include rendering a denial "null and void".

ORDER

The Referee's order, dated June 15, 1988, is affirmed. A client-paid fee, not to exceed $984, is approved.

Board Member Myers dissenting.

I respectfully dissent from that portion of the majority's opinion which excuses the employer from giving claimant's attorney notice of the denial.

The majority notes correctly that ORS 656.331(1)(b) requires a carrier to give a claimant's attorney prior or simultaneous notice of a denial. The majority, however, apparently excuses the employer's failure to give such notice in this case because the last time the attorney had been involved with the claim was eleven months previously at the time a stipulation was signed.

The claims examiner testified that she had not provided a copy of the denial to the attorney because "I didn't feel that there were any litigated issues and the file was in litigation at that time."

The employer was fully aware that claimant was represented by the attorney. The attorney had signed the stipulation. There is no indication that the attorney and claimant had severed their relationship or that either had informed the employer that the attorney no longer represented claimant. Thus, as far as the employer knew, the attorney continued to represent claimant.

Nonetheless, the employer ignored the express requirement of the statute that it give the attorney notice of the denial because it had somehow concluded that the attorney no longer represented claimant. While it is true that claimant's attorney had not been involved in the claim since the stipulation was approved in January 1987; it is equally true that between January 1987 and November 1987 when the denial was issued, there were no disputes between claimant and the employer. In other words, during that eleven month interval there was no reason for the attorney to be involved with the claim.

The mere passage of time accompanied by no disputes requiring the attention of an attorney should not be sufficient to excuse the employer from complying with the express requirement of the statute that it give claimant's attorney notice of the denial.

Because I conclude that the employer should have given the attorney notice of the denial, I would consider its failure to do so as a factor mitigating in favor of a finding of good cause for claimant's late appeal of the denial. I express no opinion whether that factor would be sufficient to establish good cause given the other facts in this case.

January 17, 1990 Cite as 42 Van Natta 107 (1990)

In the Matter of the Compensation of
JOE C. LINDSEY, Claimant
WCB Case No. 87-03469
ORDER ON REVIEW
Gastineau & Smith, Claimant Attorneys
Art Stevens (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

Claimant requests review of Referee Melum's order that: (1) upheld the SAIF Corporation's denial of his aggravation claim relating to his upper back, neck and right shoulder; (2) held that he was not entitled to interim compensation; (3) rejected his request for an associated penalty and attorney fee; (4) upheld SAIF's denial of medical services pursuant to ORS 656.245(3); and (5) rejected his request for an associated penalty and attorney fee. On review, the issues are aggravation, interim compensation, medical services, and penalties and attorney fees.

The Board adopts the Referee's findings of fact and conclusions of law with the exception of the conclusion of law on the medical services issue. Even assuming that the jurisdiction of the Hearings Division and the Director regarding controversies arising under ORS 656.245(3) is concurrent, SAIF referred the controversy in the present case to the Director. The Hearings Division, therefore, should refrain from addressing the issue, unless or until a request for hearing is filed from an order or action of the Director or there are actual claims for medical services in dispute. See 2 Am Jur 2d Administrative Law 786 (1962).

ORDER

The Referee's order dated March 31, 1988 is vacated in part. That portion of the Referee's order which upheld the SAIF Corporation's denial of

medical services pursuant to ORS 656.245(3) is vacated on jurisdictional grounds. The remainder of the order is affirmed.

In the Matter of the Compensation of
LEONARD M. SAARI, Claimant
WCB Case No. 88-02728
ORDER ON REVIEW
Goldberg, et al, Claimant Attorneys
David Horne, Defense Attorney

Reviewed by Board Members Gerner and Cushing.

The insurer request review of those portions of Referee St.\Martin's order that: (1) set aside its partial denial of claimant's claim for a left shoulder condition; and (2) awarded claimant's counsel $3,750 for efforts in setting aside the denial and $1,000 for efforts in obtaining a penalty against it for an unreasonable denial. On review, the issues are compensability and attorney fees. We affirm in part and modify in part.

FINDINGS OF FACT

In November 1986, claimant began work for the employer as a heavy equipment operator. He was laid off in January 1987. On September 23, 1987, claimant returned to work for the employer as a D-9 bulldozer operator. During that day, while dismounting from the bulldozer, claimant fell to the ground landing on his knees and hands. Claimant sustained lacerations on his face and left knee and experienced pain in his left shoulder. The incident was witnessed by the foreman and drill crew.

Claimant sought treatment the following day at an emergency care clinic. He was then referred to Dr. Switlyk, an orthopedist. Claimant's condition was diagnosed as a left shoulder strain. In December 1987, an arthrogram revealed degenerative disease in the left shoulder. In January 1988, the insurer accepted claimant's claim as a nondisabling left shoulder strain and abrasions. In February 1988, the insurer issued a denial of claimant's left shoulder condition on the basis it was not caused or aggravated by the September 1987 incident.

Claimant has preexisting arthritis in both shoulders. This condition was not disabling prior to the September 1987 incident.

FINDINGS OF ULTIMATE FACT

The September 1987 incident caused claimant's preexisting arthritis condition in the left shoulder to become symptomatic.

CONCLUSIONS OF LAW

Compensability

The Referee concluded that the compensable September 1987 injury caused claimant's underlying left shoulder arthritic condition to become symptomatic. We agree.

At the outset, we note that in the penalty section of his order, the Referee concluded that the insurer's denial was a "back-up" denial and violated Bauman v. SAIF, 295 Or 788 (1989). Although the penalty issue is not on review, we find it necessary to address the application of Bauman to the facts of this case.

The insurer originally accepted claimant's claim as a nondisabling left shoulder strain and abrasions on the face and left knee. Subsequent medical evidence revealed that claimant had a preexisting arthritic condition as well as atrophy in the left shoulder. The insurer's denial, although inartfully worded, denies claimant's left shoulder injury only insofar as the September 1987 incident did not cause or aggravate claimant's preexisting left shoulder condition. Under these circumstances, we conclude that the insurer's denial does not deny a previously accepted left shoulder strain and abrasions and is therefore valid. See Johnson v. Spectra Physics, 303 Or 49 (1987). We now turn to the merits.

In an injury case, a worker must prove by a preponderance of the evidence that the industrial injury was a material contributing cause of his existing disability or need for medical treatment. Harris v. Albertson's Inc., 65 Or App 254 (1983). A worker need not, however, prove the worsening of his underlying condition. Jameson v. SAIF, 63 Or App 553 (1983).

Dr. Switlyk, claimant's treating orthopedist, reported that claimant had experienced some stiffness in his left shoulder prior to the September 1987 injury, but had been able to use his left arm overhead. Switlyk opined that the September 1987 injury rendered claimant's preexisting arthritis condition more symptomatic. Dr. Puziss, orthopedist, felt that it was unlikely that the September 1987 injury pathologically worsened claimant's left shoulder arthritic condition, but agreed that the incident did cause claimant's left shoulder symptoms to increase.

We find these opinions persuasive and conclude that claimant has sustained his burden of proving that the September 1987 compensable incident caused claimant's preexisting left shoulder arthritic condition to become symptomatic. Accordingly, we agree with the Referee that the left shoulder arthritis symptoms are compensably related to claimant's September 1987 injury.

Attorney Fees

The Referee awarded claimant's counsel $1,000 for efforts in obtaining a penalty against the insurer for an unreasonable denial. We agree with this award and adopt the Referee's conclusions and reasoning with regard to the penalty-related attorney fee.

The Referee also awarded claimant's counsel $3,750 for efforts in regard to setting aside the insurer's denial. We modify.

After review of claimant's counsel's statement of services and the retainer agreement, and considering the factors set forth in OAR 436-15-010(6), we conclude that an attorney fee award of $3,000 reasonably compensates claimant's counsel for services rendered regarding the compensability issue. See Weyerhaeuser Co. v. Fillmore, 98 Or App 567, 571 (1989).

ORDER

The Referee's order, dated July 13, 1988, is affirmed in part and modified in part. In lieu of the Referee's attorney award, claimant's attorney is awarded $3,000 for services rendered at hearing in setting aside the insurer's denial. The remainder of the Referee's order is affirmed. Claimant's attorney is awarded a reasonable assessed fee of $600 for services on Board review concerning the compensability issue.

In the Matter of the Compensation of
VERL W. SHIELDS, Claimant
WCB Case No. 87-16189
ORDER ON REVIEW
Nichols & Bogardus, Claimant Attorneys
Ronald Pomeroy (Saif), Defense Attorney

Reviewed by Board Members Perry and Howell.

The SAIF Corporation requests review of that portion of Referee Brown's order that granted claimant an award of permanent total disability, whereas a Determination Order awarded 40 percent (128 degrees) unscheduled permanent disability for claimant's low back injury and 10 percent (15 degrees) scheduled permanent disability for loss of use of the left leg. On review, the issue is permanent total disability.

The Board affirms the order of the Referee.

FINDINGS OF FACT

Claimant, 47 years of age, sustained an industrial injury to his low back in 1973, while working as a millwright. As a result, he underwent a laminectomy and a fusion. The latter procedure was performed by Dr. Gilsdorf, his treating physician. In August, 1976, Gilsdorf performed a closing examination and released claimant to light duty work. Claimant returned to Gilsdorf in November, 1978, with complaints of right leg pain and difficulty ambulating. He sought no further treatment until he reinjured his low back in August, 1986, while employed as a truck driver/road builder for the employer in this matter. At that time, he returned to Gilsdorf who eventually diagnosed a "permanently symptomatic state" due to an exacerbation of post-surgical changes in the lumbar canal and spine areas.

In January, 1987, Gilsdorf performed a second closing examination finding that claimant was restricted to minimal ambulatory activities and was "essentially unemployable." Claimant returned to Gilsdorf the following month with complaints of increased mid-and-lower back pain. Upon examination, he was unable to stand erect and walked with a list to his left. Gilsdorf recommended hospitalization, but claimant declined.

Vocational rehabilitation services were commenced in February, 1987. After discussing claimant's physical restrictions with Dr. Gilsdorf, vocational counselor, Mr. Bogart, understood that claimant was physically capable of performing sedentary work. (Ex. 37-9). Claimant's at-injury employer felt that claimant was a good worker and was interested in moving him into a sedentary or light duty job. No such job was identified or offered, however.

In March, 1987, claimant moved to Reno, Nevada, due to the warmer climate, job opportunities for his wife, and proximity to his daughter. As a result, his vocational file was closed.

While in Nevada, claimant was examined by a panel of physicians at the Washoe Medical Center. Diagnostic studies were consistent with a diagnosis of chronic left lumbar radicular irritation. In addition, psychological testing indicated a mixed personality disorder. Based on their examination findings, the Washoe physicians opined that claimant could return to light work with no stooping, squatting, or repetitive bending.

Dr. Gilsdorf agreed with the Washoe physicians' exam findings, but disagreed with their conclusion. In Gilsdorf's view, claimant's prognosis for any return to gainful employment was "extremely improbable."

In July, 1987, SAIF referred claimant to Mr. Bollman, vocational expert, for a vocational evaluation. Bollman identified the following six sedentary jobs, which he believed claimant was capable of performing: service clerk, maintenance service dispatcher, police radio dispatcher, telephone answering service operator, color matcher, and fast food clerk.

A Determination Order closed claimant's claim in August, 1987, awarding 40 percent unscheduled permanent disability for his low back condition and 10 percent scheduled permanent disability for the loss of use or function in his left leg.

A few months later, claimant was examined by Dr. Atcheson, an orthopedist. Atcheson opined that claimant was unable to perform any activity that required more than a few minutes at a time in the supine position.

Claimant has severe permanent physical impairment due to his compensable injury of August, 1986. As a result, he may only occasionally lift up to 10 pounds, crouch, kneel, walk, climb stairs, and reach above shoulder level. He may, however, repetitively operate foot controls as well as repetitively use his hands for simple grasping.

Claimant has an eighth grade education and fourth grade verbal skills. He claims to have worked as a "millwright" for nine years, but his description of that job indicates a lower skill level. He has been self-employed as a firewood cutter and service station manager. Neither of those two jobs, however, required him to exceed his tested seventh grade math skills. He has also worked as a jailer and truck driver. Until his injury of August, 1986, he was steadily employed.

CONCLUSIONS OF LAW

A worker may establish permanent total disability based solely on his physical incapacity or in combination with his age, education, adaptability to nonphysical labor, and emotional adjustment. Clark v. Boise Cascade Co., 72 Or App 397 (1985). Unless it would have been futile, however, a worker must show that he made reasonable efforts to obtain regular gainful employment. ORS 656.206(3); Butcher v. SAIF, 45 Or App 318 (1983).

While we agree with the Referee's ultimate conclusion that claimant has proven entitlement to an award of permanent total disability, we do not agree with his apparent finding that claimant did so based solely on his physical incapacity. Rather, in our view, claimant is permanently totally disabled by way of the "odd-lot" doctrine.

Although claimant has extremely limited physical capacities, especially the limitation that he avoid anything outside of the supine postion for more than a few minutes, neither Dr. Gilsdorf, the Washoe physicians, nor the vocational experts, opined that his physical incapacity alone rendered him unemployable. In particular, Gilsdorf plainly stated that it was a combination of claimant's physical and nonphysical limitations that led him to conclude that claimant was permanently totally disabled. (Ex. 56). Accordingly, on this record, claimant has not proven permanent total disability based solely on his physical incapacity.

We turn to the "odd-lot" doctrine. As we found above, claimant has severe permanent physical impairment and must remain in the supine position for all but a few minutes at at time. At 47, his age is a slight impediment to reentering the work force. His eighth grade education and fourth grade verbal skills are more significant impediments. His work experience has been almost exclusively in heavy duty occupations and he has no training in lighter occupations.

The more persuasive vocational evidence is that claimant is permanently totally disabled. Mr. Mihyl, claimant's vocational expert, testified that it would have been "an exercise in futility" for claimant to have sought work in his hometown of Lakeview, Oregon, and that there was only a "minimal probability" of obtaining a sedentary job in Reno. (Tr. 51). Likewise, Mr. Potocki, SAIF's vocational expert, testified, inter alia:

> "If we're to assume that [claimant] will have to recline on a half-time basis during an eight-hour work day, I would say that his employment possibilities are very limited. Based on an eight-hour work day." (Tr. 91).

Although Mr. Bollman identified six prospective sedentary jobs, absent from his July, 1987, report, is any indication that he was aware of claimant's limited tolerance to maintain an upright position. The report's sole reference to claimant's physical disability is a statement by Bollman that claimant had been denied SSDI benefits "due to the administrative judge[']s ruling that he is capable of doing sedentary work." (Ex. 55-1). Moreover, given claimant's physical limitations, we find it stretches credulity to conclude that he can perform work such as a food order clerk. In sum, we are not persuaded by Bollman's opinion.

Regarding the statutory "seek work" requirement of ORS 656.206(3), we find that it would have been futile for claimant to have sought regular gainful employment in the light of his severe permanent physical impairment, his lack of work experience outside of heavy occupations, his poor education and verbal skills, and his limited transferable skills.

Accordingly, after our de novo review, we agree with the Referee's conclusion that claimant is permanently totally disabled.

Claimant's attorney is entitled to an assessed fee for his services on Board review. However, inasmuch as he has not submitted a Statement of Services to date, we cannot award such a fee. OAR 438-15-010(5).

ORDER

The Referee's order dated January 15, 1988, as amended February 10, 1988, is affirmed.

In the Matter of the Compensation of
JAMES D. TATE, Claimant
WCB Case No. 86-18044
SECOND ORDER ON RECONSIDERATION
Charles Maier, Claimant Attorney
Rick Dawson (Saif), Defense Attorney

The SAIF Corporation has submitted a second request for reconsideration of that portion of our December 7, 1989, Order on Review that, inter alia, affirmed the Referee's award of an assessed attorney fee for its unreasonable late acceptance of claimant's low back condition. On December 27, 1989, we issued an Order on Reconsideration responding to SAIF's first request for reconsideration. We adhere to our reasoning in that order with the following comment.

SAIF argues that the Board incorrectly declined to consider its "new legal theory," which it advanced in its initial request for reconsideration. Not so. SAIF is confusing legal theory with substantive issue. SAIF did not raise or argue the issue of claimant's entitlement to an assessed attorney fee for its unreasonableness under ORS 656.262(10), until after the Board's December 7, 1989, order. We decline to entertain issues raised in the first instance on reconsideration.

Here, SAIF could have identified the Referee's award of an assessed fee as an issue either in its request for Board review, its briefs, or by way of a brief supplemental letter noting recent case law developments. It did not do so. In Betty L. Juneau, 38 Van Natta 553, 556 (1986), we specifically approved the practice of allowing parties to bring to our attention recent developments in the case law after completion of the briefing schedule. SAIF did not follow that practice. Rather, it read the Board's December 7, 1989, order and decided, for the first time, to raise the issue of claimant's entitlement to an assessed fee by way of a request for reconsideration.

Finally, SAIF argues that: "[U]ntil now the Board has always applied new appellate decisions on its own initiative * * *." In fact, the Board did so with respect to the only issue raised by the request for review and SAIF's appellate brief. It applied the recent case of Eastmoreland v. Reeves, 94 Or App 698 (1989), "on its own initiative" to the issue raised and argued by SAIF; i.e., the Referee's assessment of a penalty under ORS 656.262(10).

Our prior orders are withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our prior orders in their entirety. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

January 17, 1990 Cite as 42 Van Natta 113 (1990)

In the Matter of the Compensation
DANETTE A. WILLINGHAM, Claimant
WCB Case No. 87-03093
ORDER ON REVIEW
Willner & Associates., Claimant Attorneys
Schwabe, et al, Defense Attorneys

Reviewed by Board Members Myers and Gerner.

The insurer requests review of Referee Black's order that set aside its denial of claimant's medical services claim for mastopexy surgery. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

Claimant, 30 years old at time of hearing, worked for a year and a half as a production line assistant. In 1983, she began to experience symptoms of pain in her neck, shoulder and arm. Her occupational disease claim for thoracic outlet compression was accepted. Claimant underwent carpal tunnel surgery in 1983 and a rib resection in 1985. Her symptoms of tingling, numbness and heaviness returned, however, in 1986.

Claimant's request for a mastopexy (breast lift surgery) was denied by the insurer in October 1987 on the grounds that the need for the surgery was neither related to, nor necessary treatment for, claimant's 1983 compensable condition.

CONCLUSIONS OF LAW AND OPINION

The Referee found claimant's proposed mastopexy surgery to be compensable as a reasonable and necessary medical service under ORS 656.245. We disagree.

The insurer argues that claimant has not proven by a preponderance of the evidence that her mastopexy surgery is reasonable and necessary. Claimant is entitled to all reasonable medical services, curative or palliative, so long as they are necessitated by the compensable injury. ORS 656.245(1); West v. SAIF, 74 Or App 317 (1985). It is claimant's burden to prove the reasonableness and necessity of treatment. McGarry v. SAIF, 24 Or App 1083 (1976).

Claimant's doctors concluded that her thoracic outlet symptoms were exacerbated by her bra strap as it crossed the clavicle. The doctors who examined claimant provided three options which would significantly reduce her symptoms. Claimant could wear a strapless bra, not wear any bra or she could undergo mastopexy surgery.

In May 1987, Dr. Bascom, M.D., noted that claimant was still experiencing some discomfort, but was obtaining relief by wearing a strapless bra. Dr. Bascom and Dr. Korn, M.D., both reported that when claimant went braless or utilized a strapless bra, her symptoms almost completely disappeared. Dr. Korn also stated that the proposed surgery was not breast reduction but was a breast lift operation, or mastopexy. He later opined that the surgery would not affect the underlying pathology of claimant's condition. Finally, Dr. Gripekoven, orthopedic surgeon, stated that it was questionable whether plastic surgery would affect claimant's condition.

The Referee found that claimant credibly testified that she did not feel it was comfortable or socially acceptable to go without a bra. Claimant complained that a strapless bra was uncomfortable and inconvenient and required constant readjustment.

We find that claimant has failed to show that the proposed surgery is reasonable and necessary treatment. Both Dr. Korn and Dr. Gripekoven have opined that the results of such surgery on claimant's underlying condition are questionable. See Art Prouty, 40 Van Natta 1250 (1988) (Upholding denial of rib resection surgery even though the compensable injury was causally related and a material contributing factor to claimant's upper extremity condition. Denial is proper where the requested surgery would not reasonably be expected to result in any material improvement in claimant's condition; such surgery is not reasonable and necessary medical treatment. Id.)

Even if we did agree with those of claimant's doctors who believe the mastopexy surgery would be reasonable, claimant has nonetheless failed to prove that the surgery is necessary. Claimant's doctors report that the surgery is "desired by the patient due to the inconvenience of wearing a strapless bra," and claimant has testified that she experiences instances of social disapproval when she goes without a bra. Under the circumstances, however, we do not find such occurrences to amount to a showing that mastopexy surgery is necessary. Claimant's reports and the medical opinions show that by using a strapless bra, claimant is provided with a reasonable means by which she can alleviate her thoracic outlet symptoms.

ORDER

The Referee's order, dated April 11, 1988, is reversed. The insurer's denial is reinstated and upheld. A client-paid fee, not to exceed $1,414, is approved.

In the Matter of the Compensation of
LINDA L. WISE, Claimant
WCB Case Nos. 88-06851 & 88-03817
ORDER ON REVIEW
Vick & Gutzler, Claimant Attorneys
Bottini, et al, Defense Attorneys
Schwabe, et al, Defense Attorneys

Reviewed by Board Members Gerner, Myers and Crider.

The Safeco Insurance Company requests review of Referee Podnar's order which: (1) set aside its denial of claimant's "new injury" claim for a right shoulder condition; and (2) upheld Liberty Northwest Insurance Corporation's denial of claimant's aggravation claim for the same condition. On review, the issue is responsibility. We reverse.

FINDINGS OF FACT

Claimant compensably injured her neck and right shoulder in November 1984, while employed by Liberty Northwest's insured. This claim was closed by a March 1986 Determination Order which awarded claimant 20 percent unscheduled permanent disability. A later Stipulation gave claimant an additional 5 percent unscheduled permanent disability.

In January 1987, claimant began working for Safeco's insured. Initially she was doing light janitorial work, however, in mid-1987 she was assigned to do heavier work including wet mopping, lifting full mop buckets and dumping trash bags into a dumpster at a level over her head. Following these activities, claimant began to experience increased shoulder pain and she occasionally dropped things. She sought treatment in November 1987 from Dr. Sabatowicz, a chiropractor.

Liberty Northwest denied responsibility for claimant's current right shoulder condition in February 1988. Safeco denied responsibility for the same condition in April 1988.

CONCLUSIONS OF LAW

The Referee concluded that claimant's work at Safeco's insured caused a worsening of her underlying right shoulder condition. We disagree.

Claimant experienced increased pain following a period of heavier work while at Safeco's insured. Her treating chiropractor, Dr. Sabatowicz, opined that she had sustained a gradual material worsening. He next described claimant's condition as an exacerbation of the 1984 industrial injury. He later described her current condition as partially being caused by the work activities at Safeco's insured, but that the primary contributor was the 1984 industrial injury. He further opined that it was medically probable that her work exposure at Safeco's insured was an independent material contributor to her current condition, but again qualified his opinion by stating that the 1984 industrial injury was the primary cause of the current condition.

Western Medical Consultants opined that claimant's work activities at Safeco's insured was a material contributing factor to her exacerbation, but said it would be difficult to speculate whether her condition had worsened. Dr. Duncan, chiropractor, opined that her work at Safeco's insured did not contribute to her current condition and noted that there were no objective findings to support a finding that her condition had worsened. Finally, Independent Chiropractic Consultants opined that her current condition had not worsened, based on the history given to them.

After reviewing the evidence we are unable to determine whether claimant's underlying right shoulder condition was worsened by her work activities while at Safeco's insured, or whether she sustained 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.

In Donald D. Davis, 40 Van Natta 2000 (1988), we stated that in responsibility cases where the evidence was in equipoise, the second carrier had the burden of proving a lack of contribution to a worsening of the underlying condition. In reaching this conclusion, we relied on the court's decision in Champion International v. Castilleja, 91 Or App 556 (1988).

After further consideration, however, we do not believe that our ruling in Davis is supported by the court's decision in Castilleja.

After reviewing the decisions of the Court of Appeals and the Supreme Court, we conclude that there are essentially three types of responsibility cases. We recognize that individual cases may involve combinations and permutations of these three types, but these are the basic factual situations in responsibility cases.

The first type involves the situation in which claimant has a series of employments, any one of which may have caused disability. In that type of case, claimant must first establish that his employments caused the occupational disease. Responsibility is then assigned to the last employment which at the time of the onset of disability could have contributed to the occupational disease. In the absence of disability, responsibility is assigned to the employer/insurer on the risk at the time of the first medical treatment for the occupational disease. This is the classic "last injurious exposure" rule case. The rule operates both to relieve claimant of the burden of proving which of several potential employments caused the disability and to arbitrarily assign liability to one of the potentially liable employer/insurers. See Bracke v. Baza'r, 293 Or 239 (1982).

The second major type of responsibility case involves the situation in which there are a series of work related injuries. This is the "successive injury" case, referred to by the Supreme Court in Boise Cascade v. Starbuck, 296 Or 238, 244 (1984). In this type of responsibility case, where there is a dispute over responsibility for a period of disability during or after the later employment, once the later incident is accepted as a compensable injury or the evidence establishes that the later incident is a work related injury, there is a rebuttable presumption that responsibility lies with the last employer/insurer at the time of the last work-related injury. See Boise Cascade v. Starbuck, supra; Industrial Indemnity v. Kearns, 70 Or App 583 (1984).

In Kearns, the second injury was an accepted injury. The court, there, applied the successive injury rule from Starbuck and stated that there was a rebuttable presumption that the employer at the time of the second accepted injury was responsible. Where the second injury is not accepted, then the burden of persuasion is on either the claimant or the first employer/insurer to prove that there was a work-related injury with the second employer/insurer. Crowe v. Jeld-Wen, 77 Or App 81, 86 (1985). Once that has been done, the burden shifts to the second employer/insurer to prove that the later work-related injury did not independently contribute to the disability in issue.

The third major type of responsibility case is the type where there is an accepted compensable injury or occupational disease followed by an increase in disability during or after employment with a later employer/insurer. Starbuck was such a case. In these cases, 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, supra; Fred Meyer v. Benjamin Franklin Savings & Loan, 73 Or App 795 (1985); see Hensel Phelps v. Mirich, 81 Or App 290 (1986). In Spurlock, Crowe and Fred Meyer, the court left responsibility with the first employer because the evidence did not preponderate that the later employment contributed to a worsening of the disability. It is apparent that the court placed the burden on the first employer to shift responsibility.[1]

As can be seen, this third category of cases is distinct and differently treated than those involving successive injuries because only one accepted compensable injury is involved. The Supreme Court emphasized that distinction in Starbuck by first noting that the "last injurious exposure" rule did not apply to the facts before it. Starbuck, supra at 243. To more clearly demonstrate the distinction, the court cited examples of cases in which the rule did apply. One such example was successive work-related injury cases. Starbuck, supra at 244.[2]

We conclude that Castilleja, supra falls within the second category of case. In Castilleja, the claimant had an accepted low back injury and an accepted groin injury. The court found that the evidence was inconclusive as to which accepted injury was the cause of a disc problem. Consequently, it assigned responsibility to the last accepted injury employer. In other words, it applied the Kearns' rebuttable presumption without specifically so stating.

Because Castilleja is a case involving successive injuries, we do not believe it is applicable to the third type of responsibility case, in which there is only one work-related injury. Crowe v. Jeld-Wen, supra. Where there is an accepted claim and then a later employment which could have independently contributed to a pathological worsening of the accepted condition, the burden of proof is on the party seeking to shift responsibility. That burden must be carried by proving that the later employment actually contributed to a pathological worsening of the accepted condition.

We conclude that our holding in Davis, which required an employer/insurer to prove an absence of contribution to a claim for which another employer/insurer was already responsible, was incorrect. Accordingly, to the extent that our decision in Donald D. Davis, supra, places the burden of proof on the second carrier, which has no accepted claim and no work-related injury, we hereby disavow the decision.

Because we have concluded that the evidence in this case is in equipoise as to whether the second employment independently contributed to a pathological worsening of claimant's accepted condition, responsibility remains with Liberty.

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[1] The court stated in Spurlock "To assert the last injurious exposure rule as a defense...[The employer previously determined to be responsible] must prove that claimant's underlying disease has worsened and that her subsequent employment caused the worsening." Spurlock, supra at 465.

[2] The dissent, as did the appellant in Crowe, fails to make this distinction. In Crowe the court stated that for the last injurious exposure rule to apply under the employer's successive injury theory, there must be evidence of a second injury which contributed to claimant's disability. Crowe, supra at 87.

ORDER

The Referee's order, dated June 7, 1988, is reversed. That portion which upheld the Liberty Northwest Insurance Corporation's denial is reversed. Liberty Northwest's denial is set aside and the claim is remanded to it for processing according to law. That portion which set aside the Safeco Insurance Company's denial is reversed. Safeco's denial is reinstated and upheld. Liberty Northwest, rather than Safeco, is responsible for the Referee's award of an insurer-paid attorney fee. A client-paid fee not to exceed $776, is approved, payable from Safeco to it's counsel. A client-paid fee not to exceed $1,548.75, is approved, payable by Liberty Northwest to its counsel.

Board Member Crider, dissenting.

The Board, in Donald D. Davis, 40 Van Natta 2000 (1988), overruled its prior decision in Eva L. (Doner) Staley, 38 Van Natta 1280 (1986). In so doing, we recognized that where compensability is established but causation is unclear, responsibility is assigned to the last employer whose employment could have caused the disability. This result was compelled by the discussion of the equipoise problem in Boise Cascade v. Starbuck, 296 Or 238, 244 (1984), as interpreted in Champion International v. Castilleja, 91 Or App 556 (1988).[1] The Board now misconstrues Castilleja and embraces again the (Doner) Staley view. Therefore, I dissent.

As I understand the majority opinion, it posits three categories of responsibility cases. For two categories the opinion recognizes that the case law compels application of the last injurious exposure rule where the evidence regarding causation is in equipoise; for the third it does not. That is the difficulty.

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1 "In a procedural context, if a worker presents substantial evidence of successive work-related injuries causing disability, a prima facie case for recovery from the last employer is made out. Either or any employer against whom a claim is made still can present evidence to prove that the cause of the worker's disability is another employment or a cause unrelated to the employment. In such a case, the trier of fact decides the case on the basis of the evidence presented. If the trier of fact is convinced that the disability was caused by successive work-related injuries but is unconvinced that any one employment is the more likely cause of the disability, the finding is for the worker against the last employer whose employment may have caused the disability. On the other hand, if the trier of fact is convinced that the disability was caused by an earlier injury, or was not work related, such a finding may be made.

"True there is evidence in this case that straining and lifting at the later employment concurred with the first injury to cause the disability. Had the trier of fact made that finding, the second employer would be liable. But the trier of fact (in this case, the Court of Appeals) concluded otherwise, and we are bound by that finding."

Boise Cascade v. Starbuck, 296 Or 238, 244-245 (1984).

The first of the majority's categories is comprised of cases involving initial assignment of responsibility for an occupational disease. In such cases, responsibility is assigned to the last employment prior to the onset of disability which could have contributed to causation of the disease. I agree, with the proviso that even in such a case the last employer may escape responsibility by proving that a prior employment was in fact the sole cause of the disability[2] or that it is impossible that the last employment caused the disability.[3] Where the last employer does not meet this burden, it is responsible. See FMC Corp. v. Liberty Mutual Ins. Co., 70 Or App 370 (1984), modified, 73 Or App 223 (1985).

The majority posits a second category which it, unfortunately, calls the "successive injury case." In this category, I understand the majority to include two very different types of cases--cases involving the fact pattern of Industrial Indemnity v. Kearns, 70 Or App 583 (1984) and cases in which "there is a work-related injury with the second employer/insurer." In both these types of cases, the majority would assign responsibility to the second employer, unless that employer proves that the second injury did not independently contribute to the disability.

A Kearns case, of course, is one in which claimant suffers two compensable injuries to the same body part followed by a new period of disability. The new period of disability is concededly compensable and no one contends that a new injury has occurred. The sole question is whether the worsening was caused by the first or the second injury. The court held that in such cases, the aggravation is the responsibility of the second employer in the absence of persuasive evidence that the second injury did not independently contribute to the causation of the worsened condition.

I am more perplexed as I seek to understand what facts define the second type of case in this category. It appears to me, however, that the second type of category two case is distinguished from a category three case as follows: A category two case involves an accepted injury followed by a period of increased disability caused by an identifiable traumatic incident (an "injury") whereas a category three case involves an accepted injury followed by a period of increased disability withouy identifiable traumatic incident. The majority suggests that where there is a second traumatic incident, the last employer is responsible unless the evidence establishes that its employment did not independently contribute to the worsened disability; where, however, there is no second traumatic incident, the employer that accepted the first injury remains responsible unless the evidence establishes that later employment independently contributed to the worsened condition. In short, absent a second traumatic incident, if the evidence is in equipoise, the first employer is responsible.

This is precisely the doctrine--once articulated by the Court of Appeals in Boise Cascade v. Starbuck, 61 Or App 631, 638 (1983)--which is now obsolete. The Court of Appeals, in Starbuck, declined to assign responsibility to the last employer because there was no traumatic incident during that employment that contributed independently to causation of the disability. The Supreme Court's analysis, however, gave no weight to lack of traumatic incident. Instead, because the evidence established that the second employment played no part in causation of the disability, the first employer was held responsible. Boise Cascade v. Starbuck, supra, 296 Or at 243. Since that time, the Court of Appeals has applied the same rule of responsibility whether or not a second

2. Boise Cascade v. Starbuck, 296 Or 238, 244 n.3 (1984)
3. Fossum v. SAIF, 293 Or 252, 256 n.1 (1982)

traumatic event occurred precipitating the disability. See Hensel Phelps Construction v. Mirich, 81 Or App 290, 293-294 (1986); Home Ins. v. EBI Companies, 76 Or App 112, 118 (1985). Therefore, we err if we rely on the absence of traumatic event to assign the burden of proof to the first rather than the last employer in responsibility cases.

Although the Supreme Court, in Starbuck, announced a rule governing assignment of responsibility where the evidence is in equipoise, the Court did not apply the rule in that case because the evidence was not in equipoise. Similarly, responsibility "remained" with the first employer in each of the cases cited by the majority at page 4 of this order not because they were category three cases in which the evidence on causation was in equipoise, but because the facts established that the second employment played no part in causation of the disability. In short, in these cases, the second employer escaped liability under the rule first articulated in the occupational disease context in Fossum v. SAIF, supra: The second employer escaped liability because that employer proved, as a matter of fact, its employment played no part in causation of the disability.

There are two court decisions that actually did turn on burden of proof. They are Kearns and Castilleja. The majority disposes of them by treating Kearns as if it were governed by a rule entirely different from that applicable to responsibility cases generally. I submit that Kearns explains how the general rule applies given that particular fact pattern.

The majority disposes of Castilleja by reading it to be a Kearns case. But Castilleja was not a Kearns case. While it involved a worker who had suffered two accepted injuries, the question was not whether the period of worsened back disability was an aggravation of Champion's accepted back injury or of Cascade's accepted groin injury. Rather, the question was whether it was an aggravation of the accepted back injury or a new injury caused by claimant's heavy work activity for Cascade. Thus, it was a category three case, to use the majority's parlance. The referee found that "work activities at Cascade are the cause of his low back problem, because of their day by day heavy nature." Thus, he found that there was a "new injury" and assigned responsibility to Cascade. Victorio R. Castilleja, WCB Case Nos. 84-00697 and 84-05900 (Opinions of Raymond S. Danner, January 25, 1985 and March 28, 1985). The Board was not persuaded that the evidence enabled it to determine which employment was the more likely cause of claimant's disability. Thus, finding that "conditions of claimant's second employment with Cascade may have caused claimant's disability," the Board affirmed assignment of responsibility to Cascade. Victorio R. Castilleja, 37 Van Natta 1605 (1985). On reconsideration, however, the Board reversed. Relying on Eva L. (Doner) Staley, supra, the Board held that where the evidence on causation is in equipoise, liability remains with the first employer. The Court of Appeals reversed, applying the general rule governing successive injuries articulated in Starbuck.

The majority indicates that the court found that "the evidence was inconclusive as to which accepted injury was the cause of the disc problem." However, claimant's right leg and hip pain--the symptoms of the disc herniation--appeared three months before the lifting incident which caused the groin injury. And the court found the evidence inconclusive not as to which accepted injury caused the disc herniation but as to which employment caused it. The court did not hold Cascade liable for the back condition because it had accepted the second of two traumatic injuries. It held Cascade liable because claimant's work exposure at Cascade could have contributed to the disability and Cascade had failed to prove that it did not:

> "Where, as here, the trier of fact is convinced that the disability was caused by successive work exposures but is unconvinced that any one employment is the more likely cause of the disability, the rule operates to place liability on the last employer."

Champion International v. Castilleja, supra, 91 Or App at 560 (1988).

In short, the Supreme Court, in Starbuck, enunciated a rule governing cases in which it cannot be determined what employment caused a disability. The Court told us that the rule applied to both injuries and diseases. The Court of Appeals, in Castilleja, applied the rule in a case involving an injury followed by a period of increased disability. In so doing, the Court reversed a Board decision resting on a contrary understanding of the burden of proof. The Board, here, clings to that contrary understanding.

Assuming that the majority's findings are correct, and that the evidence is indeed in equipoise, the Referee correctly assigned responsibility to Safeco.

January 18, 1990 Cite as 42 Van Natta 121 (1990)

In the Matter of the Compensation of
ROGER A. BANKSTON, Claimant
WCB Case No. 87-19186
ORDER ON REVIEW
Charles D. Maier, Claimant Attorney
Bottini, et al, Defense Attorneys

Reviewed by Board Members Myers and Gerner.

The self-insured employer requests review of those portions of Referee Emerson's order which set aside its denial of claimant's industrial injury claim. On review the issue is compensability.

We adopt the Referee's Findings of Fact with the following supplementation: Claimant's injury occurred while he was within the course and scope of his employment. Claimant was not engaged in a prohibited activity when the injury occurred.

We adopt the Referee's Conclusions and Opinion except the portion which assigns the burden of proof to the employer to prove that claimant was not within the course and scope of his employment. Claimant has the burden of proving compensability, including that he was within the course and scope of his employment when the injury occurred. We conclude that claimant's credible testimony establishes that he was within the course and scope of his employment and that he was not engaged in a prohibited activity when the injury occurred.

ORDER

The Referee's order, dated September 8, 1988, is affirmed. Claimant's attorney is awarded an assessed fee of $600, to be paid by the employer.

January 18, 1990 Cite as 42 Van Natta 121 (1990)

In the Matter of the Compensation of
STEVEN P. BURG, Claimant
WCB Case Nos. 87-18456, 87-16403, 88-02046 & 88-02047
ORDER ON REVIEW
Welch, et al, Claimant Attorneys
Edward C. Olson, Defense Attorney
Sharon Schooley (Saif), Defense Attorney

Reviewed by Board Members Crider and Nichols.

The SAIF Corporation requests review of those portions of Referee Bennett's order that:

(1) set aside its denial of claimant's "new injury" claim for his low back condition; and (2) upheld North Pacific Insurance Company's denial of claimant's aggravation claim for the same condition. On review the issues are compensability and responsibility.

FINDINGS OF FACT

We adopt the Referee's findings of fact except that we find that the book sale rather than the "book store" was in the basement of the Chapel.

CONCLUSIONS OF LAW AND OPINION

We adopt the Referee's conclusions and opinion with the following comment.

SAIF argues that claimant's injury bears no relationship to his employment. SAIF relies on the factors outlined in Mellis v. McEwen, Hanna, Grisvold, 74 Or App 571 (1985). We disagree with SAIF's contention.

In Mellis the court outlined seven factors for determining whether an injury is work-related. The first is whether the activity was for the benefit of the employer. In the present case, although the book sale attended by claimant resulted in no funds paid directly to the employer, it was sponsored by its student affairs office. It was a sale which allowed its students and others to buy books on a discounted basis. This benefited the employer's student body and thus benefited the employer.

The second Mellis factor is whether the activity was contemplated by the employer and employee either at the time of hiring or later. Here, the manager of the book store was aware that claimant would be selling books at the book sale, and did so himself.

The next factor is whether the activity was an ordinary risk of, and incidental to, the employment. Pursuant to his job duties, claimant did various tasks around campus. He placed advertisements for the book store in mail boxes in the basement of the chapel where he was injured. Thus, entering the basement of the chapel where the book sale was held was incidental to claimant's employment.

The next factor is whether the employee was paid for the activity. Here, claimant was a salaried employee on his employer's time when the accident occurred.

The next factor is whether the activity was on the employer's premises. In this case, claimant's accident occurred on the campus of his employer.

The next factor is whether the activity was directed by or acquiesced in by the employer. Claimant's manager knew that claimant was going to participate in the book sale. Moreover, as previously noted, the manager himself also participated in the book sale.

The last Mellis factor is whether the employee was on a personal mission of his own. Here, claimant arguably was on a personal mission; however, we consider this activity to be too similar with his employment activity to find claimant had made a departure from the employment activity. Claimant was not clearly on a personal mission.

After weighing all the factors, we conclude that claimant has established that his injury is work related.

Finally, claimant asserted at hearing that under Bauman v. SAIF, 295 Or 788 (1983), the insurers are estopped by their responsibility denials from denying compensability. SAIF did initially indicate that its denial was solely pertaining to responsibility. However, prior to the issuance of a ".307" order, SAIF announced that its denial was on compensability grounds also. Inasmuch as this clarification occurred prior to the issuance of the ".307" order, Bauman is not applicable. See Judy Witham, 40 Van Natta (1988).

ORDER

The Referee's order dated May 11, 1988 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $750, to be paid by the SAIF Corporation.

In the Matter of the Compensation of
DAVID A. BUSWELL, Claimant
WCB Case No. 87-03623
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
Terrall & Miller, Defense Attorneys

Reviewed by Board Members Nichols and Crider.

Claimant requests review of those portions of Referee Daron's order that: (1) declined to admit into evidence a certain medical report from his treating chiropractor; (2) upheld the insurer's aggravation denial of his low back condition; and (3) alternatively, affirmed a Determination Order that did not award unscheduled permanent disability for his back injury. On review, the issues are evidence, aggravation, and extent of unscheduled permanent disability. We affirm on the evidence issue and reverse the Referee's aggravation ruling.

FINDINGS OF FACT

The Board adopts the Referee's findings and makes the following additional findings with respect to the evidentiary issue.

At the beginning of the hearing, claimant offered a medical report, Exhibit 31, from his treating chiropractor, Dr. Schubert. Claimant had submitted the report to the Hearings Division nine days prior to the hearing. Counsel for the insurer received a hand-delivered copy the next day, eight days before the hearing. The Referee declined to admit the report pursuant to then existing former OAR 438-07-005(3)(b). That rule required claimant to submit additional evidence not less than 10 days before the hearing.

CONCLUSIONS OF LAW AND OPINION

Evidentiary Issue

Claimant argues that the Referee abused his discretion in declining to admit Exhibit 31. We disagree.

Pursuant to the rules in effect at the time of the hearing, the Referee had discretion to admit a late document upon a showing of good cause. Former OAR 438-07-005(4). Claimant argues that he attempted to timely submit Exhibit 31, and that, in any event, the Referee could have cured any prejudice to the insurer by allowing it to either cross-examine the report's author or to obtain a responsive report from its own expert. Claimant offered the testimony of Ms. Pavelek, a clerical worker at his attorney's office, that the report had been hand delivered to the Board on the 10th day before the hearing. Pavelek conceded, however, that no one was at the main desk to accept delivery and that she left the report on the desk for processing. The report was not date stamped "received" until the following day; i.e, nine days prior to the hearing. Opposing counsel did not receive the document until eight days pre-hearing when it was hand delivered to his office. The rule in effect at the time of filing re

quired filing ten days before hearing and service at the time of filing. In this matter service was accomplished at the time of delivery eight days prior to hearing.

Under such circumstances, we agree with the Referee that claimant has not proven good cause to excuse her late submission of Exhibit 31. We, therefore, find no basis to conclude that the Referee abused his discretion in declining to admit the report.

Aggravation

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 exacerbations, 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 Referee concluded that claimant's condition had not worsened since the last arrangement of compensation. We disagree.

The last arrangement of compensation was the February 24, 1987 Determination Order. On March 6, 1987, Dr. Schubert reported that claimant was medically stationary and that he could begin light work. Consequently, claimant began working as a shipping and packaging clerk. After working approximately one week, he experienced increased pain while packaging and lifting some buckets. He returned to Schubert. By way of a "check-the-box" report of March 21, 1987, Schubert informed claimant's employer that he would not be able to return to work for an indefinite period of "weeks." (Ex. 28). The record contains no subsequent medical opinion, either agreeing or disagreeing with Schubert's report of March 21, 1987.

Although Dr. Schubert's March, 1987, "check-the-box" report is conclusory, it nonetheless indicates that he was of the opinion that claimant was no longer able to work. Moreover, his report is unrebutted; that is, there are no subsequent medical opinions in the record. Although the record contains other medical opinions issued prior to the February, 1987 Determination Order, those opinions understandably do not address factual events that occurred after their issuance, such as claimant's release from work in March, 1987.

Given this record, we conclude that claimant experienced a symptomatic exacerbation resulting in diminished earning capacity since the last arrangement of compensation. Given that the February, 1987 Determination Order did not award permanent disability, we further conclude that the order did not contemplate future exacerbations accompanied by diminished earning capacity. Consequently, the temporary reduction in claimant's ability to work establishes a compensable worsening.

Accordingly, we conclude that claimant has proven a compensable aggravation. We reverse the Referee on this issue and set aside the insurer's aggravation denial.

Unscheduled Disability

Claimant has proven an aggravation of this condition and there is nothing in the record to persuade us that claimant's condition has become medically stationary. We, therefore, defer ruling on the issue of extent.

ORDER

The Referee's order, dated August 24, 1987, is affirmed in part and reversed in part. That portion of the order dealing with the evidentiary issue is affirmed. The insurer's "defacto" denial of aggravation is set aside and the claim is remanded to the insurer for processing according to law. For services at hearing and on Board Review, claimant's attorney is awarded an assessed fee of $2,000 to be paid by the insurer. We authorize a client-paid fee, not to exceed $176.

January 18, 1990 Cite as 42 Van Natta 125 (1990)

In the Matter of the Compensation of
PEGGY S. CHARPILLOZ, Claimant
WCB Case No. 86-04089
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
John Motley (Saif), Defense Attorney

Reviewed by Board Members Perry and Howell.

Claimant requests review of those portions of Referee Black's order that: (1) declined to grant permanent total disability; and (2) increased claimant's unscheduled permanent disability for a low back condition from 55 percent (176 degrees), as previously awarded, to 80 percent (256 degrees). We reverse and award permanent total disability benefits.

ISSUES

1. Whether claimant is permanently totally disabled.

2. If so, then the effective date for her award.

FINDINGS OF FACT

Claimant, 69 years of age at hearing, injured her low back in 1980 while employed as a nurse's aide by the SAIF Corporation's insured. The injury occurred when claimant attempted to prevent a patient from falling. Claimant subsequently underwent lumbar laminectomies in 1980 and 1985, and additional exploratory surgery in 1986.

Claimant received a 35 percent unscheduled permanent disability award by Determination Order dated July 16, 1981. Claimant received an additional award of 20 percent unscheduled permanent disability in October 1981 pursuant to stipulation between the parties. No additional permanent disability was awarded following her 1985 and 1986 surgeries.

SAIF referred claimant for vocational assistance in June 1986. Her vocational assistance file was closed in October 1986, when it appeared that continuing medical problems prohibited claimant from participating in return-to-work activities.

Claimant was again referred by SAIF for vocational assistance in August 1987. Her file was closed on November 7, 1987 after the expiration of 120 days without progress having been made toward finding employment. Claimant has not returned to any remunerative employment since the date of her injury.

Claimant occasionally serves as a volunteer food preparer at a bible college. She performs this work on a sporadic basis when she feels physically capable of working. She works, at most, for a few hours on those days when she volunteers her services.

Claimant experiences constant low back pain with radiating pain into her left hip and leg. She also experiences periodic giveway of her left leg causing her to fall unexpectedly. She utilizes a TNS unit and takes pain medication, including Tylenol 3, as needed. Claimant is capable of standing, walking or sitting for one-half hour continuously. She is restricted from bending, twisting, kneeling or crawling. She must frequently alternate between standing, sitting and walking. She needs to lie down several times during the day for an hour or more each time. She is restricted from lifting any weight from ground level.

Claimant has an eighth grade education. She was employed as a nurse's aide for seventeen years until her injury. Previously, she was employed as a bartender and in canneries. As a result of her compensable injury, she is unable to perform any of these prior jobs.

It would be futile for claimant to seek regular gainful employment.

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). The Referee concluded, and claimant concedes, that she is not totally incapacitated on a physical or medical basis alone. Consequently, claimant can prevail only by proving that she falls within 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 be futile. See Butcher v. SAIF, 45 Or App 318 (1983).

We first address the question whether claimant has proven a willingness to seek regular gainful employment and has made reasonable efforts to obtain such employment. The Referee concluded that claimant had failed to carry her burden of proof on these issues. With regard to the latter requirement, the Referee found that claimant had refused to cooperate with vocational rehabilitation and placement efforts.

We agree that claimant's willingness to seek and efforts to obtain work were minimal at best. We nevertheless conclude that claimant is excused from making efforts to obtain work because they would be futile. We first note in this regard claimant's substantial physical limitations. She is capable of standing, walking or sitting for only one-half hour at a time. In addition, she must continually alternate between sitting, standing and walking. She cannot lift any weight from ground level. She cannot bend, twist, or kneel. She must lie down several times during the day for an hour or more each time. She is prone to unexpected falls due to periodic giveway of her leg.

Thus, considering these physical limitations alone, claimant's employment options are severely restricted. Dr. Collada opined in this regard that claimant could be employed "if there is a regular job that gives her the same options that the voluntary work force provides her ***." (Ex. 59). However, the record discloses that claimant's volunteer activities are very sporadic, with several weeks sometimes transpiring between volunteer appearances. Further, when claimant does volunteer, such activities last no more than a couple of hours during any particular day.

While Dr. Collada felt claimant was physically capable of performing only very limited work, Dr. Danner went further and opined that claimant was unable to participate in any gainful employment. However, to the extent that Dr. Danner's opinion reflects vocational considerations in addition to medical considerations, we look to the vocational evidence for guidance.

A conflict exists between the vocational experts as to claimant's employability. Janet Chandler, claimant's vocational counselor from August 1987 through November 1987, met with claimant once and spoke with her on the telephone several times. She testified that claimant was capable of employment on a part-time basis. Chandler identified several jobs for which she felt claimant was vocationally and physically qualified. These included various office clerking positions, counter attendant, food preparation worker, teacher's aide, hotel desk clerk, switchboard operator, child care worker, timekeeping clerk, and home health aide. Chandler testified that these positions were available on a part-time basis.

By contrast, claimant's vocational consultant at hearing, Byron McNaught, opined that claimant is unemployable. McNaught discussed the employment possibilities listed by Chandler. He acknowledged that, other than the teacher's aide position, claimant is vocationally qualified to perform the entry level positions identified by Chandler. He opined, however, that claimant's physical limitations preclude many of the proposed employments. In particular, he opined that claimant was prohibited from performing the office clerk jobs because of her bending and lifting limitations. With regard to possible employment as a home health aide, McNaught noted that claimant was severely limited in terms of performing her own daily living activities; consequently, it was doubtful that claimant would be able to perform such services on a regular basis for someone else. Moreover, McNaught questioned the availability of part-time employment among the potential jobs mentioned by Chandler.

We accept the testimony of McNaught over that of Chandler. McNaught's opinion regarding the preclusive effect of claimant's age and physical limitations on her job-seeking activities is more persuasive than that of Chandler. In addition, Chandler's opinion that claimant is employable rests, in part, upon her belief that claimant would be able to find part-time employment on as limited a basis as one-to-two hours per week. Such frequency is similar to that she currently undertakes in her volunteer work. However, we are unwilling to find that employment in an entry-level position, at a frequency of one-to-two hours per week, qualifies as "regular gainful" employment under ORS 656.206(1) or (4).

In sum, considering claimant's age, lack of education, paucity of transferable skills and significant physical limitations, we conclude that claimant would be unable to obtain gainful and suitable employment regardless of her motivation or job seeking efforts. We, therefore, find that claimant is entitled to an award of permanent total disability benefits.

It remains for us to determine the effective date for claimant's award. In this regard, the effective date of a retroactive permanent total dis

ability award under the "odd-lot" doctrine is the earliest date that the disability is proved to exist and is based upon all relevant medical, social and vocational factors. Adams v. Edwards Heavy Equipment, Inc., 90 Or App 365, 370-71 (1988). We find that claimant's second unsuccessful participation in return-to-work assistance demonstrated that she was not employable on even a part-time basis. As a result, we conclude that her award should be effective on the date her return-to-work assistance was terminated. Accordingly, we make claimant's award effective as of November 7, 1987, the date her job search assistance ended.

ORDER

The Referee's order dated March 21, 1988 is reversed. Claimant is granted permanent total disability as of November 7, 1987. The SAIF Corporation is authorized to offset the permanent partial disability benefits paid pursuant to the Referee's order against the permanent total disability award. Claimant's attorney is awarded an approved fee of 25 percent of the increased compensation created by this order. However, the total of fees approved by the Referee and the Board shall not exceed $6,000.

January 18, 1990 Cite as 42 Van Natta 128 (1990)

In the Matter of the Compensation of
NORMAN F. EVANS, Claimant
WCB Case No. 86-13011
ORDER ON REVIEW
Charles D. Maier, Claimant Attorney
Cliff, Snarskis, et al, Defense Attorneys

Reviewed by Board Members Brittingham and Crider.

The insurer requests review of those portions of Referee Michael Johnson's order that: (1) increased claimant's scheduled permanent disability award for loss of use or function of the right leg from 5 percent (7.5 degrees), as awarded by a Determination Order, to 10 percent (15 degrees); (2) 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); and (3) assessed a penalty and related attorney fee for the insurer's unreasonable claims processing. On review the issues are extent of disability, scheduled and unscheduled, and penalties and attorney fees.

We affirm and adopt the Referee's order with the following supplement.

We disavow the statement made by the Referee on page 6 of the Opinion and Order indicating that he based the penalty for delaying claim closure in part on the insurer's failure to "follow up with the Evaluation Division rather than waiting for some response to issue therefrom." We do not believe a carrier has a duty to prod Evaluation; if the insurer timely requests closure and timely provides the information necessary for closure, that is sufficient. In this case, however, Evaluation requested the insurer to get an independent medical examination (IME) on May 20. The insurer did not notify claimant that an appointment had been made until July 14. The appointment was scheduled for August 13th. This delay in scheduling the IME unreasonably delayed claim closure. For that reason, we affirm.

ORDER

The Referee's order, dated June 23, 1987, is affirmed. Claimant's attorney is awarded an assessed fee of $800, to be paid by the insurer.

In the Matter of the Compensation of
GENE J. HUGHES, Claimant
Own Motion No. 89-0655M
ORDER POSTPONING ACTION ON OWN MOTION REQUEST
Hollis Ransom, Claimant Attorney
Saif Legal, Defense Attorney

The SAIF Corporation has submitted to the Board claimant's claim for an alleged worsening of his August 19, 1969 industrial injury. Claimant's aggravation rights have expired. SAIF issued a denial of responsibility for claimant's current condition which claimant has appealed to the Hearings Division. (WCB Case No. 89-19971).

It is the Board's policy to postpone action regarding own motion relief until such time as pending litigation on related issues has been resolved. Therefore, we delay action on this request for own motion relief and request that the Referee who conducts the hearing in WCB Case No. 89-19971 submit a copy of his/her order to the Board. After issuance of that order, the parties should advise the Board of their respective positions regarding own motion relief.

IT IS SO ORDERED.

In the Matter of the Compensation of
KURT E. KRAAL, Claimant
WCB Case No. 88-01075
ORDER ON REVIEW
David J. Hollander & Associates, Claimant Attorneys
Davis & Bostwick, Defense Attorneys

Reviewed by Board Members Myers and Cushing.

The insurer requests review of Referee Knapp's order which set aside its denial of an aggravation claim. Claimant cross-requests review of those portions of the Referee's order which: (1) concluded that a Determination Order did not prematurely close the claim; (2) affirmed the Determination Order award of 10 percent (32 degrees) unscheduled permanent disability; (3) declined to assess a penalty for an alleged unreasonable denial; (4) declined to award interim compensation; and (5) declined to assess a penalty for failure to pay interim compensation.

ISSUES

The first issue is whether the Determination Order prematurely closed the claim.

The second issue is whether claimant is entitled to a greater award for unscheduled permanent disability than the 10 percent awarded by Determination Order.

The third issue is whether claimant has sustained a compensable aggravation.

The fourth issue is whether the insurer's denial of the aggravation claim was unreasonable.

The fifth issue is whether claimant is entitled to interim compensation.

The last issue is whether the insurer unreasonably failed to pay interim compensation.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following supplementation:

Claimant compensably injured his back on February 16, 1987. By August 3, 1987, claimant's condition was not reasonably expected to improve by further treatment or the passage of time. At that time claimant had minimal permanent impairment from the compensable injury.

During 1987 claimant moved to California where he worked for about three weeks. Claimant sustained no injury while working for the California employer. Claimant developed increased symptoms which caused him to be totally unable to work for over 14 days. Claimant's compensable injury was a material cause of the symptomatic worsening.

CONCLUSIONS AND OPINION

We adopt the Referee's opinion on all issues except the aggravation issue.

The insurer argues that because claimant's increased symptoms developed while claimant was working in California and because claimant did not file a workers' compensation claim in California, that it is not responsible for an aggravation of claimant's back condition. It relies on Olson v. EBI Companies, 78 Or App 261 (1985). In Olson, the Court of Appeals held that where a claimant sustains a discrete injury with an out-of-state employer and does not file a workers' compensation claim with the out-of-state employer, then the Oregon employer is relieved of responsibility if the out-of-state injury independently contributed to a worsening of claimant's underlying condition. Id at 264. In this case, there was no discrete event.

We need not decide whether Olson extends to the situation where an Oregon injury is followed by a period of work exposure with an out-of-state employer because we conclude that claimant has sustained a compensable aggravation of his compensable condition and that the insurer has failed to prove that the California employment independently contributed to a worsening of claimant's underlying condition. Thus, whether we apply the standard enunciated in Olson or the material cause standard adopted in Grable v. Weyerhaueser, 291 Or 387 (1981), the insurer remains liable.

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 compensation anticipated future periods of increased symptoms or exacerbation of the physical condition accompanied by a diminished earning capacity, claimant must also prove that his earning capacity was diminished longer or in greater degree than was anticipated or that his earning capacity was diminished to the extent of total disability and resulted in 14 consecutive days of total disability or inpatient hospitalization. Edward D. Lucas, 41 Van Natta 2272 (1989).

The medical evidence establishes that: (1) claimant sustained a symptomatic exacerbation; (2) claimant's compensable injury is a material cause of his increased symptoms; and (3) as a result of the increased symptoms, claimant became totally disabled for more than 14 days. Thus, whether or not

the 10 percent unscheduled disability award contemplated periodic exacerbations, claimant has established an aggravation claim under Lucas.

Furthermore, as previously noted, there is no evidence that the California employment independently contributed to a worsening of claimant's underlying compensable condition.

ORDER

The Referee's order, dated August 16, 1988, is affirmed. Claimant's attorney is awarded an assessed fee of $400, to be paid by the insurer. The Board approves a client-paid fee, not to exceed $1,557.

January 18, 1990 Cite as 42 Van Natta 131 (1990)

In the Matter of the Compensation of
CHARLES R. LIES, Claimant
WCB Case No. 86-10833
ORDER ON REVIEW
Phillip H. Garrow, Claimant Attorney
Richard Barber (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

The SAIF Corporation requests review of that portion of Referee Nichols' order that set aside its denial of claimant's medical services claim for sclerotherapy (prolotherapy). The issue is compensability of medical services.

We affirm and adopt those portions of the Referee's order dealing with the compensability of denied medical services, with the following supplementation. The Referee recited the testimony of several witnesses. With the exception of claimant, we expressly find those witnesses to have been credible and find their testimony to have been fact.

SAIF argues that prolotherapy is not approved and taught by accredited institutions of medical training and that it is, therefore, not compensable. See former OAR 436-10-040(9). However, beginning effective January 1, 1986, former OAR 436-10-040 recognized the compensability of prolotherapy. Subsections (11) and (13) provided:

> "(11) Prolotherapy is not reimbursable without prior authorization by insurer.
> * * * *
> "(13) A written request for authorization for prolotherapy or thermography shall be answered within 14 working days of receipt by insurer or approval will be assumed."

Former OAR 436-10-040(11) & (13) remain essentially unchanged in their current versions. (See current OAR 436-10-040(9) & (11)).

It is clear from the specific provisions of OAR 436-10-040 that prolotherapy may be found compensable. In this case the Referee found such treatment to be reasonable and necessary. We agree. We do not therefore, address the effect, under OAR 436-10-040(13), of SAIF's delay in denying the claim for prolotherapy -- which it received June 9, 1986 -- until August 4, 1986.

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 be awarded. See OAR 438-15-010(5).

ORDER

The Referee's order dated March 2, 1987 is affirmed.

January 18, 1990 Cite as 42 Van Natta 132 (1990)

In the Matter of the Compensation of
NORRIS C. MONTEITH, Claimant
Own Motion No. 89-0619M
OWN MOTION ORDER ON RECONSIDERATION
Malagon, et al, Claimant Attorneys

Claimant requests reconsideration of our December 19, 1989 Own Motion Order that denied temporary disability benefits on the ground that he has withdrawn from the work force. Submitting additional materials that previously were not in the record, claimant contends that he has not withdrawn from the work force.

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 428-12-065(3). The new evidence consists of a handwritten list from claimant indicating what work he has applied for and copies of invoices documenting five days work between August 23 and September 29, 1989. After reviewing the new evidence, we do not find that the additional evidence submitted by claimant was previously unobtainable with due diligence.

Accordingly, claimant's request for reconsideration is denied. The parties' rights of reconsideration and appeal shall run from the date of our December 19, 1989 order.

January 18, 1990 Cite as 42 Van Natta 132 (1990)

In the Matter of the Compensation of
ELVA M. PIERCE, Claimant
WCB Case No. 88-03058
ORDER ON REVIEW
Charles Maier, Claimant Attorney
Williams, et al., Defense Attorneys

Reviewed by Board Members Howell and Speer.

Liberty Northwest Insurance Corporation requests review, and claimant cross-requests review, of Referee Michael Johnson's order that: (1) declined to grant permanent total disability; (2) increased claimant's unscheduled permanent disability award for a neck and left shoulder injury from 20 percent (64 degrees), as awarded by a Determination Order, to 60 percent (192 degrees); (3) increased claimant's scheduled permanent disability award for loss of use or function of the left hand from 5 percent (7.5 degrees), as awarded by

a Determination Order, to 30 percent (45 degrees); and (4) awarded claimant's attorney a fee payable out of compensation in an amount not to exceed $2,000. We reverse the Referee's unscheduled and scheduled permanent disability awards.

ISSUES

1. Whether claimant is permanently totally disabled.

2. If not, the extent of claimant's scheduled and unscheduled permanent partial disability.

3. Whether claimant's attorney is limited to the maximum attorney fee provided for in his fee agreement with claimant; or instead whether he may recover a fee up to the maximum provided in the current administrative rules.

FINDINGS OF FACT

Claimant compensably injured her left shoulder and upper spine on December 10, 1981, while assisting a patient from a wheelchair into the patient's automobile. The SAIF Corporation accepted the claim.

Claimant subsequently underwent a C5-6 diskectomy and fusion. Claimant had a good recovery from surgery, but still had pain, tingling, and numbness in her thumb and fingers, muscle spasms in her shoulder and headaches.

On October 1, 1984, Liberty Northwest assumed the employer's Workers' Compensation coverage.

An April 29, 1985 Determination Order granted claimant 20 percent unscheduled permanent partial disability and 5 percent scheduled permanent partial disability for loss of the left hand.

Claimant returned to light work in the fall of 1984. The light work lasted only a few weeks and then no work was available until March 1985, at which time claimant returned to full-time employment as a nurse's aide on the medical floor. This employment required that claimant engage in heavy lifting. During the following year, claimant missed work on a number of occasions. However, she missed only one day of work due to her injury-related condition.

Claimant voluntarily resigned her position by letter dated April 14, 1986. Her letter of resignation indicated that she could not work the night shift, that she was unable to sleep well during the day, and that she had personal and family problems.

Claimant was 56 years of age at hearing. She did not graduate from high school, however she obtained a GED. She has received training as a nurse's aide and an LPN. Her work history has included only work as a nurse's aide, except for a short stint when she "moon-lighted" as a dress shop clerk.

Procedural History

In 1986, claimant filed an aggravation claim with SAIF and a "new injury" claim with Liberty Northwest. Both claims were denied on responsibility grounds alone. Claimant requested a hearing on the denials. An order pursuant to ORS 656.307 subsequently issued, designating SAIF as the paying agent. Following hearing on the issue of responsibility, Referee Michael Johnson found that Liberty Northwest was responsible for claimant's then-current cervical and shoulder conditions. Liberty Northwest requested Board review of the Referee's order.

A Determination Order issued on June 10, 1987 which reclosed the claim with an award of additional temporary disability benefits but no additional permanent disability beyond that awarded by the April 29, 1985 Determination Order. Claimant requested a hearing, alleging entitlement to additional permanent disability benefits, including benefits for permanent total disability. By Notice of Hearing, both Liberty Northwest and SAIF were notified of the date of hearing.

A hearing on the extent of claimant's permanent disability was held on December 14, 1987, before Referee Michael Johnson. Liberty Northwest, which had previously been found responsible by the Referee, appeared at the hearing. SAIF did not appear. By order dated March 9, 1988, as republished and amended on April 22, 1988, Referee Johnson increased claimant's scheduled and unscheduled permanent disability awards. Liberty Northwest and claimant both requested Board review of the Referee's order.

Subsequently, on November 3, 1989, the Board issued an Order on Review which reversed the Referee's prior responsibility finding. The Board held that SAIF, rather than Liberty Northwest, was the responsible insurer. Elva M. Pierce, 41 Van Natta 1975 (1989).

CONCLUSIONS OF LAW AND OPINION

Permanent Disability

We adopt the Referee's Opinion with regard to the issue of permanent total disability. However, we reverse the Referee's award of additional permanent partial disability for the following reasons.

The Referee concluded that claimant has injury-related impairment of the left arm in the mild range and neck and shoulder impairment in the mildly moderate range. The Referee based these conclusions primarily upon claimant's statements regarding the nature and severity of her symptoms. On review, Liberty Northwest argues that claimant's subjective symptom complaints are unreliable and exaggerated. Consequently, it argues, claimant has failed to establish entitlement to disability beyond that awarded by the prior Determination Orders.

In this regard, Dr. Shaw, claimant's treating physician, opined that claimant "exaggerates" her symptoms "quite a bit", although he also added that he did not have the impression that claimant was malingering or lying about her symptoms. He based this statement regarding "exaggeration" upon a lack of objective evidence to support her complaints. Similarly, Dr. Moore, an independent medical examiner, stated that "psychological factors account for virtually all of her functional limitations."

Claimant contends that the psychological component of her claim is properly taken into consideration in rating the extent of her permanent disability, including permanent total disability. Liberty Noryhwest disagrees, arguing that claimant has failed to causally link her psychological problems to her compensable injury.

The fact that claimant's symptoms are largely functional rather than organic does not mean that they are per se not compensable. See Barrett v. Coast Range Plywood, 294 Or 641 (1983). Rather, disability caused by a functional element resulting from a compensable injury is no less compensable than disability resulting from pathological causes. Mesa v. Barker Manufacturing, 66 Or App 161 (1983) (emphasis added).

In this regard, the only opinion from a psychological expert came from Dr. Davies, a clinical psychologist, who opined that claimant's psychological problems are primarily due to her "premorbid" character and were not caused by her injury. The question whether the psychological aspects of her claim are causally related to the compensable injury is a complex medical question. Therefore, claimant must have some medical opinion linking her psychological problems (which the evidence establishes caused her functional disability) to the compensable injury. Uris v. Compensation Department, 247 Or 420, 424 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105 (1985). Such evidence is lacking here. Consequently, claimant has failed to establish that the "functional" aspects of her claim are compensable.

The Referee awarded increased permanent disability. The Referee reasoned that claimant was a "competent witness" as to the level of her impaired physical ability. However, we have concluded that claimant exaggerates her symptoms for reasons unrelated to her compensable injury. Given the fact that claimant exaggerates her symptoms as the result of noncompensable psychological factors, and considering the other evidence in the record, we conclude that claimant has failed to establish entitlement to additional permanent disability beyond that awarded by the prior Determination Orders.

Attorney Fees

Our decision with regard to the extent of claimant's permanent disability renders the attorney fee issue moot.

ORDER

The Referee's order dated March 9, 1988, as amended and republished April 22, 1988, is affirmed in part and reversed in part. That portion of the Referee's order that declined to award permanent total disability is affirmed. That portion of the Referee's order that increased claimant's scheduled and unscheduled permanent disability awards is reversed. The prior Determination Orders are reinstated and affirmed. The Board approves a client-paid fee, not to exceed $2,377.50.

January 18, 1990 Cite as 42 Van Natta 135 (1990)

In the Matter of the Compensation
DONALD E. SIMPSON, Claimant
Own Motion No. 89-0616M
OWN MOTION ORDER ON RECONSIDERATION
Emmons, et al, Claimant Attorneys
EBI Companies, Insurance Carrier

The insurer requests reconsideration of the Board's December 19, 1989 Own Motion Order that did not address the issue of recovery of an overpayment from any and all future compensation that may be awarded on claimant claim.

An offset of overpaid temporary disability benefits is appropriate only against awards of permanent disability benefits, but not against awards of temporary disability compensation. See Buddy Tillman, 41 Van Natta 239 (1989). Since there is no authority which would allow the Board to grant claimant an increased award for permanent disability. Orville D. Shipman, 40 Van Natta 537 (1988). We deny the insurer's request for an offset authorization.

IT IS SO ORDERED.

In the Matter of the Compensation of
KENNETH J. THUNDERBIRD, Claimant
WCB Case No. 88-00428
ORDER ON REVIEW
Parker & Bush, Claimant Attorneys
Edward C. Olson, Defense Attorney

Reviewed by Board Members Cushing and Gerner.

Claimant requests review of those portions of Referee Schultz's order which: (1) found that claimant was not entitled to be reimbursed for mileage to his physician's office; and (2) declined to assess a penalty or related attorney fee for alleged unreasonable failure to reimburse claimant for the aforementioned mileage. In his brief, claimant further contends that he is entitled to a new hearing on the basis that the insurer attached a prior statement by claimant to its written closing argument that was not previously submitted to the Referee. We treat such a request as a request for remand. See Judy A. Britton, 37 Van Natta 1262 (1985). On review, the issues are mileage reimbursement, penalties and attorney fees, and remand.

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

We may remand to the the Referee should we find that the record has been "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(5).

Claimant contends that the Referee improperly considered his prior statement that was submitted with the insurer's closing argument. We disagree. Nothing in the the Referee's order suggests that he admitted or considered the submission, nor is it listed as an exhibit. Under these circumstances, we conclude that remand is not warranted.

ORDER

The Referee's order, dated July 26, 1988, is affirmed.

In the Matter of the Compensation of
DARRELL R. ZWICKER, Claimant
WCB Case No. 86-01392
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
Brian L. Pocock, Defense Attorney

Reviewed by Board Members Cushing and Gerner.

Claimant requests review of Referee McCullough's order that: (1) affirmed a Determination Order that awarded 10 percent (32 degrees) unscheduled permanent disability for a right shoulder injury; and (2) granted the self-insured employer's request to offset overpaid temporary disability against future permanent disability awards. On review, the issues are extent of unscheduled permanent disability and offset.

We affirm and adopt the Referee's order with the following comment.

In his brief, claimant raises for the first time the question of the date he became medically stationary. Such issues must be raised at hearing or they will be considered waived. See Mavis v. SAIF, 45 Or App 1059 (1980); Gunther H. Jacobi, 41 Van Natta 1031 (1989). Therefore , we will not consider this issue on review.

ORDER

The Referee's order, dated June 2, 1988, is affirmed. The Board approves a client-paid fee, payable by the self-insured employer to its counsel, not to exceed $400.

In the Matter of the Compensation of
ROBIN A. ARNOLD, Claimant
WCB Case No. 88-11286
ORDER ON REVIEW
Black, et al, Claimant Attorneys
Stafford J. Hazelett, Defense Attorney

Reviewed by Board Members Gerner and Myers.

The insurer requests review of Referee Brown's order which set aside its denial of claimant's industrial injury claim. On review the issue is whether claimant's injury occurred within the course and scope of her employment. We reverse.

FINDINGS OF FACT

On June 9, 1988 after claimant's shift ended, she hitched a ride to her car on a company owned hyster. The employer has a rule prohibiting passengers on hysters. Claimant was aware of the rule against passengers.

Claimant fell off the hyster onto the blacktop of the employer's parking lot and fractured her skull.

CONCLUSIONS OF LAW AND OPINION

To be compensable, an injury must arise out of and in the course of employment. ORS 656.005(7)(a). "If the injury has sufficient work relationship, then it arises out of and in the course of employment...." Rogers v. SAIF, 289 Or 633,643 (1980). An on-premises injury has sufficient work relationship if it occurs while the employe is leaving work, unless the employe engaged in conduct not expressly or impliedly allowed by the employer. Clark v. U.S. Plywood, 288 Or 255 (1980); Agripac v. Zimmerman, 97 Or App 512 (1989).

The Referee concluded that claimant's riding the hyster was conduct impliedly allowed by the employer. Therefore, he concluded that claimant's conduct was within the course of employment. We disagree.

In this case, there was an employment rule that claimant was aware of, which expressly disallowed claimant's conduct. The Referee found, however that the employer, by its conduct, acquiesced in the non-enforcement of the rule, thus impliedly negating it. We conclude that the employer did not so acquiesce.

In finding that the employer had acquiesced in enforcing it's rule, the Referee appeared to rely upon claimant's statement that she saw other persons

violating the rule. The record contains no evidence that the employer was aware of these instances, nor that it would have let them go unpunished if it had been aware of them. The evidence establishes that four hyster drivers did not allow passengers. Further, the employer disciplined the hyster driver involved in this incident for violating the work rule.

We conclude from these facts that claimant has failed to prove by a preponderance of the evidence that the employer acquiesced in non-enforcement of the rule against employees riding on hysters.

Claimant's conduct of riding the hyster, in violation of an express and known work rule, was not within the course and scope of her employment. The injury is, therefore, not compensable. Zimmerman, supra.

ORDER

The Referee's order, dated September 30, 1988, is reversed. The insurer's denial is reinstated and upheld.

January 19, 1990 Cite as 42 Van Natta 138 (1990)

In the Matter of the Compensation
IOLA CARR, Claimant
Own Motion No. 89-0730M
OWN MOTION ORDER
Peter O. Hansen, Claimant Attorney
Fireman's Fund, Insurance Carrier

The insurer has submitted to the Board claimant's claim for an alleged worsening of her April 10, 1977 industrial injury. Claimant's aggravation rights have expired. The insurer has accepted responsibility for the claimant's condition. However, it opposes reopening of her claim for payment of temporary total disability benefits, contending that claimant has removed herself 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.

Following our review of this record, we are persuaded that claimant's compensable injury has worsened requiring surgery. In addition, claimant submitted an affidavit that she looked for work in 1987 and 1988 and worked from November 1, 1988 through November 19, 1989. Accordingly, claimant's claim is reopened with temporary disability benefits to commence November 11, 1989, the date she was hospitalized for surgery. The insurer 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. Finally, claimant's counsel is entitled to a reasonable attorney fee, payable out of the increased compensation awarded by this order. However, we cannot approve a fee unless claimant's attorney files a retainer agreement. See OAR 438-15-010(1). Because no retainer agreement has been received to date, an attorney fee shall not be approved. 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.

In the Matter of the Compensation of
RONALD C. EARL, Claimant
WCB Case No. 87-19461
ORDER OF ABATEMENT
Peter O. Hansen, Claimant Attorney
Kevin L. Mannix, Defense Attorney

The insurer has requested reconsideration of our January 4, 1990, Order on Review (Remanding) that remanded this case to the Referee for clarification of whether he correctly understood that the December, 1987, denial, rather than the June, 1987 denial, was at issue. Specifically, the insurer argues that "it is clear from the hearing transcript" that the denial at issue was the December, 1987, denial.

In order to allow sufficient time to consider the motion, our prior order is abated and withdrawn. The employer is requested to file a response to the motion within ten days from the date of this order. Thereafter, we shall take this matter under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
SUSAN L. EASTBURN, Claimant
WCB Case No. 87-0497M
OWN MOTION ORDER
Pozzi, et al, Claimant Attorneys
Meyers and Radler, Defense Attorneys

Reviewed by Board Members Cushing and Gerner.

Claimant requested that the Board exercise its Own Motion authority and reopen her 1979 claim for an alleged worsening of her back condition. Claimant's aggravation rights have expired. On September 13, 1987, we referred claimant's request to the Hearings Division for consolidation with WCB Case Nos. 87-05518 and 85-05401. The Referee was instructed to issue a recommendation to the Board concerning the request for Own Motion relief. On May 3, 1988, the Referee found that claimant's current back condition was compensably related to the 1979 injury. In addition, the Referee recommended that claimant's claim be reopened as an aggravation.

This date, we have affirmed the Referee's order. We turn to claimant's petition for Own Motion relief.

All requests for compensation under the Board's Own Motion authority pending on January 1, 1988, but not reopened as of that date, shall be processed by the Board under the law in effect subsequent to January 1, 1988. OAR 438-12-018. Here, claimant's request was submitted in 1987, but remained pending on and after January 1, 1988. Therefore, the request shall be processed under the current version of ORS 656.278(1)(a). See OAR 438-12-018; Susan A. Bagwell, 40 Van Natta 99 (1988).

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

tion commencing from the time the worker is actually hospitalized or undergoes outpatient surgery. ORS 656.278(1)(a).

There is no indication that claimant's current treatment involves hospitalization or surgery. We conclude, therefore, that we are without authority to grant the relief claimant seeks. The request for Own Motion relief is hereby denied.

IT IS SO ORDERED.

In the Matter of the Compensation of
BRENDA M. HUNTLEY, Claimant
WCB Case Nos. 87-06324 & 87-02044
ORDER ON RECONSIDERATION
Coons & Cole, Claimant Attorneys
Acker, et al, Defense Attorneys

The self-insured employer has requested reconsideration of our Order on Review, dated December 13, 1989, that affirmed the Referee's order setting aside its denial of claimant's cervical condition and bilateral carpal tunnel syndrome. In order to fully consider the matter, we abated our prior order and granted claimant an opportunity to respond. After receiving claimant's response, and after further consideration of the matter, we issue the following order.

FINDINGS OF FACT

In mid-1981, claimant sought treatment for non-work-related upper back pain. Her condition was diagnosed as significant thoracolumbar scoliosis. In October 1981, claimant underwent a Harrington instrumentation and fusion surgery for this condition. In 1983, claimant sought treatment for increased discomfort and upper back pain. These symptoms resolved after a few months. Claimant again experienced upper back symptoms in 1985.

In November 1986, claimant began working for the employer as a tree grader. As a tree grader, claimant repeatedly removed trees from a belt in order to inspect the tree, separate its roots and remove dirt before preparing five-pound bundles of twenty trees which were place in a packing belt directly behind her. It was sometimes necessary for claimant to slide the 2' trees up the belt to keep the machinery clear. This work required constant movement and twisting of the upper body as well as flexion and extension of the hands.

Between November 17, 1986 and December 19, 1986, she worked eight, eight hour shifts and four, four to six hour shifts. Following a two week hiatus, claimant worked six hours on January 7, 1987. During the course of her work, claimant began gradually experiencing pain in her left shoulder, neck and wrists. She had swelling in her wrists at night, and was occasionally awakened when her arms and wrists became numb. On January 8, 1987, claimant sought treatment with complaints of left shoulder, left and right arm pain.

In April 1987, the employer denied claimant's cervical strain and bilateral carpal tunnel syndrome. In June 1987, the results of a cervical myelogram were normal. In September 1987, claimant sought treatment for a motorcycle accident which resulted in a herniated lumbar disc and increased her cervical and wrist symptoms.

FINDINGS OF ULTIMATE FACT

Claimant had not experienced carpal tunnel symptoms in her wrists prior to her work with the employer.

Claimant's work activities were the major contributing cause of her bilateral carpal tunnel syndrome.

CONCLUSIONS OF LAW

The Referee concluded that claimant's work activities for the employer were the major contributing cause of her cervical sprain and bilateral carpal tunnel syndrome. We disagree with regard to the cervical condition and affirm with regard to the bilateral carpal tunnel syndrome.

In order to prevail on an occupational disease claim, claimant must show that the work activity either caused the condition, or in the case of a preexisting condition, that the work activity caused a worsening of the underlying condition. Wheeler v. Boise Cascade, 298 Or 452 (1985). In addition, claimant must prove that the work activities were the major cause of the the condition or its worsening. Roseburg Lumber Co. v. Killmer, 72 Or App 626 (1985).

Bilateral Carpal Tunnel Syndrome

Dr. Campagna's initial report indicates EMG results showed bilateral median nerve latency in both wrists. He opined that this condition and need for treatment was causally related to claimant's work activities. Dr. Langston reported that he could find no objective signs of carpal tunnel syndrome.

We note that "magic words" are not required if the physician's opinion supports compensability and is accompanied by other persuasive evidence. McClendon v. Nabisco Brands, Inc., 77 Or App 412 (1986). Although Campagna's opinion is conclusory, it is supported by objective findings. Further, claimant had not experienced carpal tunnel symptoms prior to her work with the employer. Dr. Campagna's opinion and the objective nerve latency findings, in conjunction with the fact that claimant had not experienced carpal tunnel syndrome prior to her work with the employer, leads to the conclusion that claimant's work activities were the major contributing cause of her bilateral carpal tunnel syndrome. Accordingly, the condition is compensable.

Cervical Condition

Dr. Campagna also opined that claimant's cervical condition was causally related to her work activities. Dr. Langston opined that claimant had no objective signs of a cervical condition. Under these circumstances, we conclude that claimant has not established that her work activities were the major contributing cause of her cervical condition.

Although Dr. Campagna's conclusory opinion supports a causal relationship, he does not explain what effect claimant's preexisting scoliosis and surgery may have had on claimant's current cervical condition. We again note that although "magic words" are not required if a physician's opinion supports compensability, the opinion must be accompanied by other persuasive evidence. McClendon, supra. Under these circumstances we find no other persuasive evidence to support Dr. Campagna's opinion with regard to the cervical condition.

ORDER

Our December 13, 1989 order is withdrawn. The Referee's order dated April 4, 1988, as amended July 15, 1988, is reversed in part, modified in part, and affirmed in part. That portion which set aside the employer's denial of claimant's cervical condition is reversed. The employer's denial, insofar as it relates to claimant's cervical condition, is reinstated and upheld. Claimant's counsel's attorney fee for services rendered at hearing is modified. In lieu of the Referee's award, claimant's counsel is awarded a reasonable assessed fee of $900, for services rendered at hearing concerning the bilateral carpal tunnel syndrome issue. The remainder of the order is affirmed. For services on review, concerning the carpal tunnel syndrome issue, claimant's counsel is awarded a reasonable assessed fee of $500. The Board approves a client-paid fee, payable from the employer to its attorney, not to exceed $612.

January 19, 1990 Cite as 42 Van Natta 142 (1990)

In the Matter of the Compensation of
ASHANTI HUSAIN, Claimant
WCB Case No. 89-12516
ORDER OF DISMISSAL
Jerome Larkin (Saif), Defense Attorney

Claimant has requested Board review of a Referee's November 13, 1989 order. We have reviewed the request to determine whether we have jurisdiction to consider the matter. Because we conclude that we lack jurisdiction, the request is dismissed.

FINDINGS

The Referee's order issued November 13, 1989. On January 4, 1990, the Board received claimant's request for review of the order. Acknowledging that his request was submitted more than 30 days after the Referee's order, claimant asked the Board to take into consideration his inability to contact his attorney and the fact that he resided in another state.

ULTIMATE FINDINGS

Claimant's request for Board review was received by the Board more than 30 days after the issuance of the Referee's order.

CONCLUSIONS

A Referee's order is final unless, within 30 days after the date on which a copy of the order is mailed to the parties, one of the parties requests Board review under ORS 656.295. ORS 656.289(3). Requests for Board review shall be mailed to the Board and copies of the request shall be mailed to all parties to the proceeding before the Referee. ORS 656.295(2). Compliance with ORS 656.295 requires that statutory notice of the request for review be mailed or actual notice be received within the statutory period. Argonaut Insurance Co. v. King, 63 Or App 847, 852 (1983).

Here, the 30th day after the Referee's November 13, 1989 order was December 13, 1989. Since claimant's request was received by the Board on January 4, 1990, it is untimely. See ORS 656.289(3); ORS 656.295(1).

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 stated in the Referee's order. Moreover, with his request claimant has included a copy of a December 4, 1989 letter he received from his former attorney advising him of the need to appeal the Referee's order within 30 days of its issuance. Finally, 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.

January 19, 1990 Cite as 42 Van Natta 143 (1990)

In the Matter of the Compensation of
BRIAN L. LEIS, Claimant
WCB Case No. 88-03457
ORDER ON REVIEW
Roll, et al, Claimant Attorneys
Roberts, et al, Defense Attorneys

Reviewed by Board Members Myers and Gerner.

Claimant requests review of those portions of Referee Podnar's order which: (1) upheld the insurer's denial of a claim for a low back strain resulting from either an industrial injury or an occupational disease; and (2) declined to assess penalties and attorney fees for an allegedly unreasonable denial. On review the issues are compensability and penalty and attorney fees. We affirm.

FINDINGS OF FACT

In November 1987 claimant began working for the employer as a clean up man. The job required claimant to lift heavy barrels of glass waste and aluminum. Claimant complained of a sore back sometime shortly after starting work with the employer.

On December 10, 1987 claimant played hackey sack with fellow employees during the lunch break. At that time he showed no indication that his back was bothering him or that his movements were impeded in any way.

The morning of December 11, 1987 claimant reported to his supervisor that he had fallen and injured his back in the shower that morning.

Claimant's treating doctor does not mention the shower incident in his opinion on the causation of claimant's low back problems.

CONCLUSIONS AND OPINION

Claimant has the burden of proving his case by a preponderance of the evidence. This is true whether claimant seeks to prove compensability of an industrial injury or an occupational disease. We conclude that claimant has failed to sustain his burden of proof.

We are unsure whether claimant is claiming an industrial injury or an occupational disease. He testified that his back began hurting while performing

a specific activity, lifting barrels of glass and aluminum; however, he also testified that the back pain developed gradually.

If this case is viewed as an industrial injury, claimant has failed to prove his case. To prove compensability of an industrial injury, claimant must prove by a preponderance of the evidence that an injury at work is a material cause of the need for treatment or of disability.

Claimant is not really able to point to a specific injury. Furthermore, despite some earlier mention of back pain, his need for treatment arose on December 11, 1987, the day after he had been playing hackey sack with no apparent problems.

Furthermore, there is an intervening incident. The morning he first saw the chiropractor, claimant had some incident in his shower. He told his supervisor that he fell in the shower. A co-worker heard that conversation. At hearing, claimant attempted to explain that he had not fallen in the shower, but had merely bent over and his back had "exploded." The inconsistency between what claimant told the supervisor and his later testimony renders his testimony suspect. We conclude that it is more likely than not that claimant actually fell in the shower as he originally reported. Because of this inconsistency, we give claimant's testimony little weight. His testimony alone is not sufficient to prove that he sustained an industrial injury.

If this case is viewed as an occupational disease case, compensability rests on the opinion of claimant's treating chiropractor, Dr. Buttler. To prove an occupational disease claim, claimant must prove by a preponderance of the evidence that his work activity was the major cause of his back condition. Dr. Buttler opined:

> "[Claimant] did not give me any other history of low back injury other than his lifting activities at work. As you know, [claimant] had been lifting barrells (sic) of heavy glass waste material into dumpsters at work and his back had become progressively worse to the point where he entered our clinic seeking treatment."
>
> "It is my considered opinion that [claimant's] work activity, as listed above, is the major factor which caused the development of his lumbosacral sprain and myalgia with concurrent intervertebral disc derangement and sciatica."

We give Dr. Buttler's opinion little weight because his opinion is premised on the belief that there was nothing else which could have caused the low back problem. He does not consider the fall in the shower. Consequently, we do not find Dr. Buttler's opinion sufficient to establish the compensability of an occupational disease.

The fact that claimant reported falling in the shower the morning he reported a back injury is sufficient basis for the denial. We do not find it unreasonable.

ORDER

The Referee's order, dated June 20, 1988, is affirmed. The Board approves a client-paid fee, not to exceed $961.50.

In the Matter of the Compensation of
CLAUDE E. OVER, Claimant
WCB Case No. 88-06603
ORDER ON REVIEW
Quintin B. Estell, Claimant Attorney
Stafford Hazelett, Defense Attorney

Reviewed by Board Members Gerner and Myers.

Claimant requests review of Referee Nichols' order which upheld the insurer's denial of claimant's industrial injury claim. On review the issue is whether claimant was in the course and scope of his employment when he was injured in a motor vehicle accident. We reverse.

FINDINGS OF FACT

Claimant is a heavy equipment operator for the employer, a paving company. The job requires claimant to work on various construction projects. He travels from his home to each day's project by his private automobile. Claimant carries special tools and safety equipment used on the job in his automobile. Approximately one to two times per week, the crew, including claimant, must leave one job site and travel to a different job site. The employer does not provide transportation between job sites. Claimant travels between job sites in his private automobile. The other crew members do the same. The employer pays claimant mileage for travel between job sites.

On February 22, 1988, claimant left home in his private automobile to travel to a job site in Tigard. He was involved in a motor vehicle and was injured.

ULTIMATE FINDING OF FACT

The employer implicitly required claimant to supply his automobile as transportation between job sites.

CONCLUSIONS AND OPINION

As a general rule, workers are not within the course and scope of employment when traveling to or from work. Adamson v. The Dalles Cherry Growers, Inc., 54 Or App 52 (1981). There are exceptions to the general rule. We conclude that claimant's case fits the following exception:

> "If an employee, as a part of his job, is required to bring his own car to work for use during his working day, his trip to and from work is, by that fact alone, embraced within the course of employment." Jenkins v. Tandy Corp., 86 Or App 133, 138 (1987).

The Referee concluded that there was not sufficient evidence to establish that claimant was required by the employer to bring his automobile to work so that he could transport himself between job sites. We disagree.

It is true that the employer did not specifically order claimant to bring his own car. Nevertheless, the requirement was implicit in the way the job was arranged. The unrebutted evidence is that the crew had to move between job sites during the work day approximately one or two times per week. Furthermore, the

employer's representative admitted that the employer did not provide sufficient transportation to move all crew members between sites. The fact that the employer reimbursed claimant for mileage and did not provide alternative transportation, indicates that the employer expected claimant to provide transportation between job sites. We conclude that these facts are sufficient to establish an implicit requirement that claimant provide a vehicle for transportation between job sites during the work day. Consequently, we conclude that claimant's injury was within the course and scope of his employment.

ORDER

The Referee's orders dated August 11, 1988 and September 7, 1988 are reversed. The denial is set aside and the claim is remanded to the insurer for further processing. Claimant's attorney is awarded an assessed fee of $350, for services on Board review and $1,200 for services at hearing to be paid by the insurer.

January 19, 1990 Cite as 42 Van Natta 146 (1990)

In the Matter of the Compensation of
THOMAS C. REENTS, Claimant
WCB Case Nos. 87-07222 & 87-07221
ORDER ON REVIEW
MALAGON & MOORE, Claimant Attorneys
ROBERTS et al, Defense Attorneys

Reviewed by Board Members Crider and Nichols.

The self-insured employer requests review of that portion of Referee Huffman's order which found that claimant's back injury claim had been prematurely closed. On review, the issues are premature closure and, alternatively, aggravation or extent of permanent disability. We reverse.

FINDINGS OF FACT

In March, 1986, claimant sustained a compensable back injury. The diagnosis was thoracic strain and subluxation complex with secondary cervical strain and subluxation. A September 4, 1986 Determination Order closed the claim awarding claimant 15 percent (48 degrees) unscheduled permanent disability.

As of September 4, 1986, claimant was back to work on a light-duty basis with the only restriction that he not lift over 20 pounds. On October 17, 1986 he was released to perform his regular work for two hours a day. This was increased to four hours a day on October 27, 1986. On November 19, 1986, claimant reported that he had pulled the left side of his neck while at work. Complaining of headaches and neck pain, claimant was on and off work until Dr. Gorman, D.C., released him to regular work, 8 hours per day, on January 15, 1987. Complaining of headaches and neck pain, claimant worked a total of 11 days in March and four days in April, 1987. (Tr. 65).

On April 14, 1987, claimant was examined by the Orthopaedic Consultants.

Dr. Gorman released claimant from work as of May 15, 1987. Claimant had not returned to regular work at the time of hearing.

The claim was reopened and closed again by Determination Order, issued May 20, 1987, terminating temporary disability as of April 19, 1987. No additional

permanent disability was awarded. On June 26, 1987, the employer denied claimant's aggravation claim for his thoracic and cervical spine.

Claimant, 34 years old, completed 12 years of high school. As a result of his compensable injury, claimant has sustained permanent impairment in the minimal range.

FINDINGS OF ULTIMATE FACT

Claimant was medically stationary on May 20, 1987, the date of claim closure.

Claimant has suffered a 15 percent loss of earning capacity due to the compensable injury.

CONCLUSIONS OF LAW AND OPINION

Premature Closure

The Orthopaedic Consultants opined that claimant was medically stationary on April 14, 1987. The Referee conceded that the Orthopaedic Consultants may have been correct. However, basing her conclusion on evidence subsequent to the May 20, 1987 Determination Order, and claimant's work release history, the Referee held that the claim was closed prematurely. We disagree.

It is claimant's burden to prove that his claim was prematurely closed. Austin v. SAIF, 48 Or App 7 (1980). The propriety of the closure turns on whether claimant was medically stationary at the time of the May 20, 1987 Determination Order considering claimant's condition at the time of closure and not of subsequent developments. Sullivan v. Argonaut Ins. Co., 73 Or App 694 (1985); Alvarez v. GAB Business Services, 72 Or App 524 (1985). "Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). Medical reports authored after closure may be considered where there has been no post-closure change in claimant's condition and the only question is whether claimant was stationary at the time of closure. Wojick v. Weyerhaeuser Co., 89 Or App 561 (1987); Scheuning v. J.R. Simplot & Co., 84 Or App 622 (1987). They may also be considered where they clearly address claimant's condition at the time of claim closure.

In support of his contention that the claim was prematurely closed, claimant relies on Dr. Gorman's October 21, 1987 letter. In that letter, Dr. Gorman states, "The patient, [claimant], is not medically stationary at this time." (Emphasis added).

We are not persuaded that Dr. Gorman's opinion establishes claimant was not stationary on May 20, 1987. To begin, Dr. Gorman seems to equate time off work with not being stationary. However, inability to work does not mean improvement is anticipated. Further, Dr. Gorman's October 1987 opinion does not address claimant's condition as of the May 20, 1987 Determination Order. Therefore, we conclude that claimant has not carried his burden of proving his claim was closed prematurely by the May 20, 1987 Determination Order.

Aggravation

As a general rule, in an unscheduled disability case, a claimant is entitled to have his claim reopened under ORS 656.273 when, as a result of either a pathological or symptomatic exacerbation of his compensable condition, he is less able to work than at the time of the last award or arrangement of compensation. Smith v. SAIF, 302 Or 396 (1986). This worsening may be either temporary or permanent.

A worsening need not be substantial to require reopening, Clark v. SAIF, 70 Or App 150 (1984), and a showing of increased symptoms may establish an aggravation claim Smith v. SAIF, 302 Or at 399; Consolidated Freightways v. Foushee, 78 Or App 509 (1986). Assuming claimant's aggravation rights continued under ORS 656.273(4), the first inquiry is whether, as a factual matter, claimant's physical condition or symptoms became exacerbated. If not, the inquiry is ended. See Edward D. Lucas, 41 Van Natta 2272 (1989).

The findings regarding claimant's back condition in Dr. Gorman's October 21, 1987 letter, are similar to the findings in the April 14, 1987 Orthopaedic Consultants' report. We conclude that the medical evidence does not establish that claimant's compensable condition or its symptoms exacerbated since the last award of compensation by the May 1987 Determination Order.

Claimant's own testimony may be sufficient to prove an aggravation. Garbutt v. SAIF, 297 Or 148 (1984). Here, claimant's testimony regarding his condition is vague, contradictory and not persuasive. Claimant stated that after May 20, 1987, his neck pains and headaches had increased, that he lost more time from work and suffered shoulder problems. (Tr. 16, 18, 19). However, claimant has not shown a causal relationship between his neck pain and headaches and his compensable back condition. ORS 656.273(1); Stepp v. SAIF, 78 Or App 438 (1986).

In conclusion, neither claimant's testimony nor the medical evidence substantiates a pathological or symptomatic exacerbation of claimant's compensable condition since the last award of compensation. Consequently, we conclude that claimant has not established a compensable aggravation claim.

Extent of Permanent Disability

The extent of claimant's unscheduled permanent disability is measured by the permanent loss of earning capacity attributable to his compensable back injury. ORS 656.214(5). Disability is rated at the time of hearing. See Gettman v. SAIF, 289 Or 609, 614 (1980).

The criterion for rating unscheduled permanent disability is the permanent loss of earning capacity due to the compensable injury. In determining loss of earning capacity, we consider medical and lay evidence of physical impairment resulting from the compensable injury and all of the relevant social and vocational factors set forth in former OAR 436-30-380 et seq. We apply these rules as guidelines, not as restrictive mechanical formulas. See Harwell v. Argonaut Insurance Co., 296 Or 505, 510 (1984).

Based upon claimant's minimal impairment, his capacity to return to the same occupation, his relatively young age, his high school education, and other relevant social and vocational factors, we conclude that the 15 percent (48 degrees) unscheduled permanent disability award previously granted claimant adequately and appropriately compensates him for the loss of earning capacity due to his compensable injury.

ORDER

The Referee's order, dated February 23, 1988, is reversed. The Determination Order of May 20, 1987 is reinstated and affirmed. The self-insured employer's denial of claimant's aggravation claim is reinstated and upheld. The Board approves a client-paid fee, not to exceed $1,255.

In the Matter of the Compensation of
STEVEN L. STRYKER, Claimant
WCB Case Nos. 88-05480 & 88-05481
ORDER ON REVIEW
Merrill Schneider, Claimant Attorney
Stafford J. Hazelett, Defense Attorney

Reviewed by Board Members Cushing and Gerner.

The insurer requests review of those portions of Referee Fink's order which: (1) set aside its denial of claimant's claim for mid-back, lower back and neck injury; and (2) assessed a penalty and attorney fee for late denial and for late payment of interim compensation. We reverse in part and affirm in part.

FINDINGS OF FACT

Claimant worked as a shipping and receiving clerk for the employer. Don Kroll was the employer's truck driver. The two men developed animosity towards each other over several months because their job duties overlapped and each thought he should be in charge of the other. The two men had been reprimanded by supervisors for their attitude towards each other.

On the morning of January 19, 1988, claimant and Kroll had been yelling at each other over their work. Claimant retreated into his office where he could not be heard, but could be seen speaking and gesturing in an angry manner. Kroll went into the office and asked claimant to step outside. Both men left the office and went into the warehouse area. They argued for a time and then Kroll knocked claimant's hat off. Claimant perceived Kroll's knocking his hat off as an attempt to strike claimant. Claimant then pushed Kroll away and the two men wrestled around until Kroll slugged claimant. Claimant was injured in the fray.

Claimant filed a claim on January 20, 1988. The insurer denied the claim on April 15, 1988. The insurer paid no interim compensation despite the fact that claimant's treating physician reported that claimant was unable to work.

CONCLUSIONS AND OPINION

The Referee concluded that claimant was not an active participant because he was attempting to protect himself from Kroll's aggression. We disagree.

ORS 656.005(7(a)(A) excludes from the definition of compensable injury:

> "Injury to any active participant in assaults or combats which are not connected to the job assignment and which amount to a deviation from customary duties."

In Kessen v. Boise Cascade Corp., 71 Or App 545 (1984), the Court of Appeals held that this statute contemplates a four part test:

> "In order to be barred from receiving compensation, (1) the claimant must be an active participant, (2) in assaults or combats, (3) which must not be connected to the job assignment and (4) which must amount to a deviation from customary duties." Id at 548.

In the present case, claimant and Kroll were on less than friendly terms prior to the altercation. They had a heated verbal exchange on the morning of the incident, after which claimant retreated to the office and could be seen yelling and gesturing. When Kroll invited claimant outside, claimant followed and continued the argument which eventually lead to the physical confrontation, in which both actively participated. Under these circumstances, we find that claimant was an "active participant" as that phrase is used in ORS 656.005(7)(a)(A).

Accordingly, we conclude that claimant's injury is excluded from being a compensable injury under ORS 656.005(7)(a)(A).

Penalties and Attorney Fees

We adopt the Referee's conclusions and reasoning concerning the penalty and attorney fee issue with the following supplementation.

The insurer argues that the penalty should only have been based on interim compensation due up to one week before the denial--in effect it argues that the last week's interim compensation was not due because it was within a 7-day grace period for paying that installment of interim compensation. We have held that no such grace period exists under the administrative rule cited by the insurer. Arlene Marshall, 40 Van Natta 1828 (1988). Accordingly, the Referee was correct in basing the penalty on all interim compensation due up to the date of the denial.

Claimant has successfully defended the referee's assessment of a penalty and attorney fee. However, because a penalty and related attorney fee do not constitute "compensation" within the meaning of ORS 656.382 (2), claimant is not entitled to an attorney fee for such efforts. Saxton v. SAIF, 80 Or App 631 (1986); Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The Referee's order dated July 20, 1988 is reversed in part and affirmed in part. That portion which set aside the insurer's denial and awarded an assessed fee for such services is reversed. The denial is reinstated and upheld. The remainder of the order is affirmed.

In the Matter of the Compensation of
RAYMOND M. HAMMER, Claimant
WCB Case No. 87-12211
CORRECTED ORDER ON REVIEW
Ormsbee & Corrigall, Claimant Attorneys
Acker, et al., Defense Attorneys

Reviewed by Board members Perry and Howell.

The self-insured employer requests review of that portion of Referee Blevins' order which set aside its partial denial of claimant's low back condition. Claimant cross-requests review of that portion of the order which upheld the employer's denial of claimant's chiropractic treatment in excess of the Director's guidelines. On review the issues are compensability of claimant's low back condition and the propriety of the employer's prospective denial.

The Board affirms that portion of the order setting aside the employer's denial of claimant's low back injury with supplementation, and reverses that portion of the order upholding the employer's denial of future chiropractic care in excess of two treatments a month.

FINDINGS OF FACT

We adopt the facts contained within the Referee's Summary of Evidence with the following supplementation.

Claimant sustained a compensable upper back injury on October 10, 1986. Claimant sustained a lower back injury while doing exercises prescribed by, performed under the supervision of, and on a machine of Dr. Meece for the purpose of enhancing claimant's overall body condition as treatment of his compensable upper back condition.

On July 30, 1987, prior to closure of the claim, the employer denied chiropractic care in excess of two office visits per month in accordance with OAR 436-10-040. This denial pertained solely to prospective chiropractic treatment.

CONCLUSIONS OF LAW AND OPINION

DENIAL OF LOW BACK CONDITION

The Referee concluded that claimant's low back condition was compensable since he sustained it while doing exercises at the direction, and under the supervision of the treating chiropractor. We agree.

The adverse effects of medical examination or treatment associated with a compensable injury are themselves compensable. Vickie L. Cox, 40 Van Natta 904 (1988); Terry L. Link, 40 Van Natta 17, 19 (1988). Furthermore, it has been established that the insurer is liable for the consequences flowing from the injury and treatment, even where such consequences are damaging rather than curative. William v. Gates McDonald & Co., 300 Or 278, 281 (1985) citing McDonough v. National Hospital Assn., 134 Or 451 (1930). See 1 Larson, The Law of Workmen's Compensation, 13.21, at 3-415 (1985).

Here, but for the compensable upper back injury, claimant would not have been in the chiropractor's office performing exercises to enhance the overall treatment of his upper back condition. Therefore, claimant's low back condition is a direct and natural consequence of the original compensable upper back injury.

PROSPECTIVE DENIAL OF CHIROPRACTIC TREATMENT

The Referee decided that the employer's denial of July 20, 1987, regarding future chiropractic treatment in excess of two a month was valid and not a denial of all treatment in the future. The Referee reasoned that the employer had provided examinations by orthopaedic physicians and by a neurologist subsequent to the issuance of its denial.

However, a denial must be addressed to a claim for medical services. ORS 656.245(2). Furthermore, the employer may not prospectively deny medical services claims, but rather must deny only current claims for medical services (if the medical services are not reasonable and necessary and attributable to the compensable injury). Evanite Fiber Corp. v. Striplin, 99 Or App 353 (1989).

Here, the employer's denial is void because it improperly denies prospective treatment rather than existing chiropractic claims.

ORDER

The Referee's order dated February 19, 1988, is affirmed in part and reversed in part. The self-insured employer's prospective denial of chiropractic treatments is set aside. For services at hearing and on review concerning this issue, claimant's attorney is awarded a reasonable fee of $750, to be paid by the employer. For services on review concerning the low back partial denial, claimant's attorney is awarded a reasonable fee of $500, to be paid by the employer. The Board approves a client-paid fee, not to exceed $425.

In the Matter of the Compensation of
BONNIE V. BARKER, Claimant
WCB Case Nos. 87-11496 & 87-11495
ORDER ON REVIEW
Karen Werner, Claimant Attorney
Acker, et al, Defense Attorneys
Schwabe, et al, Defense Attorneys

Reviewed by Board Members Cushing and Gerner.

Claimant requests review of Referee Mulder's order that upheld Liberty Northwest's and Aetna Insurance's denials of her claim for post labyrinthine concussion syndrome, right ulnar neuropathy, right knee joint irritability, inner ear and psychological condition. On review the issues are compensability and responsibility.

The Board affirms and adopts the order of the Referee with the following supplementation.

FINDINGS OF FACT

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

On February 7, 1985, claimant sustained an injury to her neck and upper back while employed by Aetna's insured. The claim was closed January 2, 1986 by Determination Order awarding claimant 5 percent unscheduled permanent disability. Pursuant to an August 28, 1986 Settlement, claimant was granted an additional 5 percent unscheduled permanent disability. An August 28, 1986, Disputed Claim Settlement disposed of a denied psychiatric condition.

On April 24, 1987, while working for Liberty Northwest's insured, claimant sustained another back injury, diagnosed as a cervical, mid thoracic and lumbosacral strain. A ".307" order was issued on August 10, 1987 appointing Liberty as the responsible carrier for the April 24, 1987 injury. Liberty rescinded its July 20, 1987 denial on September 28, 1987.

Within the September 28, 1987 rescission letter, Liberty partially denied claimant's claim for post labyrinthine concussion syndrome, right ulnar neuropathy, right knee joint irritability and psychological and stress conditions. Liberty asserted that these conditions were not related to the April 24, 1987, compensable injury.

On February 19, 1988, Aetna denied claimant's claim for an inner ear condition.

The post labyrinthine concussion syndrome denied by Liberty is the same condition subject to Aetna's denial for the inner ear condition. (Tr. 9, 10, 11)

CONCLUSIONS OF LAW AND OPINION

The Referee found claimant not credible, unreliable and evasive. Noting that medical reports indicated that physicians had difficulties with claimant's inconsistencies during examinations, the Referee concluded that the medical evidence did not establish a causal relationship between the labyrinthine concussion syndrome (inner ear condition), right ulnar neuropathy, right knee joint irritability, and psychological condition with either compensable injury. We agree.

An injured worker is entitled to reasonable and necessary medical services necessitated by a compensable injury. ORS 656.245. The question here is whether claimant's current conditions are causally related to either one or both of her compensable injuries. The etiology of claimant's current conditions is a complex medical question, the resolution of which largely turns on an analysis of the medical evidence. Uris v. Compensation Dept., 247 Or 420 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985).

Where there is no persuasive reasons to do otherwise, the claimant's treating doctor's opinion is generally afforded great weight. Weiland v. SAIF, 64 Or App 810 (1983). Here, claimant relies on the medical reports of her treating physician Dr. Grimm, a neurologist, and Dr. Black, a neuro-otologist, to establish causation. Yet, neither of these doctors first examined claimant until well after the second, April, 1987, injury. Lacking this familiarity with claimant's condition coinciding with her compensable injuries, we do not accord these opinions the weight generally reserved for treating physicians.

Moreover, medical opinion which is based on inaccurate or incomplete information deserves little weight. Foley v. SAIF, 29 Or App 151 (1977). Because claimant's rendition of her physical conditions critically affects the medical opinions submitted, claimant's noted lack of credibility and reliability is a crucial factor that the Referee correctly considered in weighing the medical evidence. See Bush v. SAIF, 68 Or App 230 (1984). Inasmuch as the opinions authored by Grimm and Black are dependent on claimant's history, the physicians' opinions are not persuasive.

After considering the medical evidence, we are more persuaded by Dr. Seres, M.D., Director of Northwest Pain Center. Seres provided a well-reasoned and thorough opinion persuasively explaining that there is no causal relationship between claimant's alleged conditions and either compensable injury. See Somers v. SAIF, 77 Or App 259 (1986).

We conclude that the weight of the persuasive evidence does not support claimant's burden of proving that her alleged conditions are causally related to the compensable February, 1985 and/or the April, 1987 injury. Accordingly, claimant has not shown that the current post labyrinthine concussion syndrome, right ulnar neuropathy, right knee joint irritability, inner ear or psychological condition are compensable.

ORDER

The Referee's order dated July 19, 1988, is affirmed. The Board approves a client-paid fee, not to exceed $357, payable from Liberty Northwest to its counsel, and a client-paid fee, not to exceed $1,628, payable from Aetna/CIGNA to its counsel, is approved.

In the Matter of the Compensation of
CARL S. BETHELL, Claimant
WCB Case Nos. 87-02710 & 87-02709
ORDER ON RECONSIDERATION
FRANCESCONI & ASSOCIATES, Claimant Attorneys
ROBERTS, et al, Defense Attorneys
SCHEMINSKE & LYONS, Defense Attorneys

Claimant has requested reconsideration of that portion of our December 21, 1989 Order on Review that declined to award an assessed fee for services on review. In that order, we affirmed those portions of Referee Bethlahmy's order that assigned AIAC responsibility for claimant's cervical back condition and a perilymph fistula and hydrops condition. Claimant contends that he is entitled to an assessed attorney fee for prevailing against AIAC's request for review.

Under ORS 656.382(2), a claimant's attorney is entitled to a reasonable assessed fee when a carrier initiates Board review and the Board determines that "the compensation awarded to [the] claimant should not be disallowed or reduced." AIAC initiated Board review in this case and sought to shift responsibility to Scott Wetzel Services. Claimant participated on Board review and argued the prevailing position that AIAC was the responsible carrier. However, there is no evidence in the record that claimant will receive a higher rate of temporary disability compensation because AIAC was assigned responsibility. We are, therefore, unable to find that his compensation was "not disallowed or reduced" within the meaning of ORS 656.382(2). See Rhonda L. Bilodeau, 41 Van Natta 11 (1989). Therefore, we are not authorized to award an assessed fee.

Accordingly, our December 21, 1989 Order on Review is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our December 21, 1989 order in its entirety. The parties' rights of appeal shall run from the date of this order.

In the Matter of the Compensation of
JUDITH L. KEELER, Claimant
WCB Case No. 87-15543
ORDER ON REVIEW
Roll, et al, Claimant Attorneys
Acker, et al., Defense Attorneys

Reviewed by Board Members Myers and Gerner.

The insurer requests review of that portion of Referee Podnar's order that affirmed a Determination Order award of temporary total disability benefits from June 1, 1987, through October 16, 1987. On review, the issue is temporary total disability. We affirm.

FINDINGS OF FACT

Claimant sustained a compensable injury on May 1, 1987, while working as a cannery laborer. An independent medical examiner advised her to change occupations and avoid work involving repetitive shoulder use. On September 28, 1987, claimant enrolled in a community college business course as a full-time student. A December 1987 Determination Order awarded her 10 percent (32 degrees) unscheduled permanent disability and temporary total disability from June 1, 1987, through October 16, 1987.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant was entitled to temporary total disability benefits as she had not withdrawn from the labor force. We agree, but we base our conclusion upon the following reasoning.

The insurer contends that when claimant enrolled as a full-time student, she effectively withdrew from the work force and is therefore not entitled to temporary disability benefits. The insurer argues that once claimant began school, she had no expectation of earning a wage and no incentive to obtain employment. The insurer relies upon Cutright v. Weyerhaeuser Company, 299 Or 290 (1985), for the proposition that temporary total disability is awarded to replace lost wages, and a person who has withdrawn from the work force has not lost wages.

We do not find Cutright to be applicable in the present case. Cutright involved the processing of an aggravation claim. In that case, at the inception of his claim for aggravation, the claimant had permanently withdrawn from the work force. He was, therefore, no longer "engaged to furnish services for remuneration, subject to the direction and control of an employer." See ORS 656.005(27). Since the claimant in Cutright was no longer a "worker," he was not entitled to temporary disability benefits, regardless of the reason for his prior withdrawal from the work force.

In contrast, claimant in this case had not withdrawn from the work force at the inception of her injury claim. Rather, she left work as a direct result of the disabling effects of her compensable injury. Consequently, at the time of her departure from the work force, claimant was a "worker" for purposes of ORS 656.005(27). Once such status is established, it should continue throughout the processing of the initial claim. See Charles P. Kepford, 41 Van Natta 573 (1989).

In prior decisions, we have held that under Cutright, once a claim is closed and the claimant permanently withdraws from the work force, for whatever reason, he is no longer considered a "worker" and is therefore not entitled to temporary total disability benefits should his condition worsen. See Ted W. Peckham, 41 Van Natta 609 (1989). However, the analysis does not apply in situations such as the present one, where the claim has not been previously closed. We conclude that in such cases, the reason for the worker's total disability is the compensable injury and claimant remains entitled to such benefits for the period coinciding with that disability. ORS 656.210(1); former ORS 656.268(2).

ORDER

The Referee's order dated July 28, 1988, is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $300, to be paid by the insurer. A client-paid fee, payable from the insurer to its counsel, is approved, not to exceed $391.

In the Matter of the Compensation of
DONALD B. KARSTETTER, Claimant
Own Motion No. 89-0772M
OWN MOTION ORDER
Saif Legal, Defense Attorney

SAIF has submitted to the Board claimant's claim for additional medical benefits related to his 1928 injury. Claimant's aggravation rights have expired. Claimant is requesting reopening of his 1928 injury claim for the Visiting Nurse Association bill and reimbursement for pain medication, travel expenses, parking permits, building permits and a wheelchair ramp. SAIF recommends reopening of the claim to provide payment for the Visiting Nurse Association bill.

In cases involving pre-1966 injury claims, as here, we may exercise our "own motion" authority to reopen a claim for payment of further medical benefits. ORS 656.278(1)(b). No worsening is required. Nevertheless, lifetime medical care for pre-1966 injuries is entirely within the discretion of the Board. We reserve our discretion in these pre-1966 claims for circumstances in which a claimant's need for service, the expense of the service or other factors warrant reopening. For example, we generally do not reopen to authorize ongoing pain medication, travel expenses, parking permits and miscellaneous expenses.

After review of the record, we conclude that claimant's claim should be reopened for the payment of the Visiting Nurse Association bill for services rendered April 17 through April 30, 1989 and, if the wheelchair ramp has passed final city inspection, the cost of the building materials and building permits. 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
FREDRICK D. OXFORD, Claimant
Own Motion No. 89-0672M
OWN MOTION ORDER
Malagon, et al, Claimant Attorneys
Saif Legal, Defense Attorney

The SAIF Corporation has submitted to the Board claimant's claim for an alleged worsening of his November 20, 1978 industrial injury. Claimant's aggravation rights have expired. SAIF has accepted responsibility for the hospitalization and recommends that claimant's claim be reopened for the payment of temporary disability benefits. Claimant requests that the Board exercise its own motion authority to assess a penalty and attorney fee for unreasonable claims processing.

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.

Following our review of this record, we are persuaded that claimant's compensable condition has worsened requiring hospitalization. Accordingly, claimant's claim is reopened with temporary disability benefits to commence June 8, 1989, the date he was hospitalized for chemical dependency. 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.

An employer or insurer may be assessed with a penalty and related attorney fee when it unreasonably delays the payment of compensation, or unreasonably delays acceptance or denial of a claim. ORS 656.262(10), 656.382(1). Here, the record shows that SAIF received claimant's request for reopening on October 17, 1989. SAIF submitted its recommendation on claimant's request to the Board by letter dated December 15, 1989. Because SAIF apparently mailed its recommendation within 60 days after receipt of claimant's request, we do not find that SAIF unreasonably delayed the payment of compensation. See OAR 438-12-025(2). No penalty or attorney fee is appropriate. Finally, claimant's counsel is entitled to a reasonable attorney fee payable out of the increased compensation awarded by this order. However, we cannot approve a fee unless claimant's attorney files a retainer agreement. See OAR 438-15-010(1). Because no retainer agreement has been received to date, an attorney fee shall not be approved.

IT IS SO ORDERED.

In the Matter of the Compensation of
RENEE A. ANDERSON, Claimant
WCB Case Nos. 87-12035 & 86-04852
ORDER DENYING REQUEST
Francesconi, et al., Claimant Attorneys
Mark Bronstein (Saif), Defense Attorney
Schwabe, et al., Defense Attorneys

Claimant seeks reconsideration of that portion of our December 11, 1989 Order on Review that did not award an insurer-paid attorney fee for services rendered at hearing and on Board review for prevailing against the SAIF Corporation's denial of claimant's "new injury" claim for a neck, left shoulder, and upper back condition. Enclosing statements of services, claimant requests an insurer-paid attorney fee award for both levels. The request is denied.

FINDINGS

On December 11, 1989, the Board issued an Order on Review. Pursuant to that order, the Referee's order, which had upheld SAIF's denial of claimant's "new injury" claim and set aside a self-insured employer's "de facto" denial of claimant's aggravation claim, was reversed. The Board order did not address the amount of, or the entitlement to, an assessed fee. That order has not been appealed, stayed, or republished.

On January 11, 1990, claimant's counsel mailed, by certified mail, a request for reconsideration of our December 11, 1989 order. Statements of services for both the hearing and review levels were enclosed. The request was received by the Board on January 16, 1990.

CONCLUSIONS

Inasmuch as our December 11, 1989 order was neither appealed, abated, stayed, republished nor withdrawn within 30 days of its issuance, it has become final by operation of law. ORS 656.295(8); International Paper Co. v. Wright, 80 Or App 444, 447 (1986). We have previously concluded that we retain jurisdiction to consider a request for an attorney fee even after the order on the merits has become final by operation of law. See Jane E. Stanley, 40 Van Natta 831 (1988), rev'd on other grounds Amfac, Inc. v. Garcia-Maciel, 98 Or App 88 (1989). In order to retain jurisdiction over the attorney fee request, our prior order must not have addressed either the entitlement to, or the amount of, an attorney fee. Gabino R. Orozco, 41 Van Natta 599, 775 (1989); Robert D. Janini, 40 Van Natta 1127 (1988).

Our December 11, 1989 order did not address claimant's counsel's entitlement to or the amount of an insurer-paid fee. Thus, we conclude that we retain jurisdiction to consider claimant's attorney fee request.

Although we have jurisdiction to entertain the attorney fee issue, we must turn to our rules to determine whether the request is properly before us. We hold that it is not.

The last brief was filed in this case in June 1988. At that time, OAR 438-15-027(1)(d) (amended and renumbered OAR 438-15-028(1)(c), WCB Admin. Order 2-1989, April 1, 1989), provided that a statement of services for Board review shall be filed within 15 days after the filing of the last brief to the Board.

Here, claimant's statements of service were not submitted within 15 days of the filing of the last brief on review. Rather, the statements were received by the Board more than 30 days after the issuance of our December 11, 1989 order. We have previously proceeded to address attorney fee requests when a statement of services has been untimely submitted. See Marie C. Walsh, 41 Van Natta 777 (1989). However, in order to do so, we have emphasized that we must retain jurisdiction over the merits of the case. Id.

Inasmuch as our order on the merits of this case has become final by operation of law and since the statements of services have been untimely submitted, we deny claimant's request for an assessed fee for services at the hearing and review level.

IT IS SO ORDERED.

In the Matter of the Compensation of
JOHN G. BARRON, Claimant
WCB Case Nos. 88-03911 & 87-19363
ORDER ON REVIEW
John D. McLeod, Claimant Attorney
Roberts, et al, Defense Attorneys
Mitchell, et al, Defense Attorneys

Reviewed by Board Members Gerner and Myers.

Crawford & Company requests review of Referee Mulder's order that: (1) set aside its denial of claimant's "new injury" claim for his current right knee condition; and (2) upheld Scott Wetzel Services' denial of claimant's aggravation claim for the same condition. On review, the issues are compensability and responsibility.

FINDINGS OF FACT

Claimant sustained a compensable right knee injury in October 1979 while working as a meat packer for a prior employer. He had surgery on his right knee. The claim was closed in August 1980 by a Determination Order which awarded 10 percent (32 degrees) scheduled permanent disability. X-rays at that time showed claimant had degenerative arthritis in both knees. He retired from butchering.

In August 1982, after experiencing left knee pain, claimant and the prior employer entered into a Disputed Claim Settlement, stipulating that claimant's left knee and bilateral osteoarthritic knee conditions were not due to the 1979 right knee injury.

In May 1985 claimant began working as a security person for the present employer. In December 1985 claimant compensably injured his left knee. Scott Wetzel Services, who was on the risk at this time, accepted the injury claim.

In early 1986 Dr. Manley, an orthopedist, noted some right knee swelling while treating claimant's left knee.

On July 1, 1987, insurance coverage for the employer passed to Crawford & Company. On July 7, 1987, claimant complained to Dr. Manley of increased pain in his right knee. No new traumatic event led to the increased pain. Dr. Manley suggested a total knee replacement on the right knee.

In April 1988, claimant saw Dr. Thompson for an independent medical examination. Both Crawford & Company and Scott Wetzel denied compensability and responsibility. Claimant's condition requiring treatment was degenerative osteoarthritis of the right knee.

CONCLUSIONS OF LAW AND OPINION

The Referee found that the opinion of Dr. Manley was more persuasive than that of Dr. Thompson and that claimant had established by a preponderance of the evidence that his knee condition was due to his work activities after July 1, 1987. As a result, the Referee assigned responsibility to Crawford & Company. We disagree.

Compensability

To establish a compensable claim against Crawford & Company, claimant must establish that his work as a security guard after July 1, 1987 was the major contributing cause of the worsening of his underlying degenerative arthritic condition. Weller v. Union Carbide, 288 Or 27 (1979). We usually defer to the opinion of the treating physician, unless significant reasons exist to do otherwise. Taylor v. SAIF, 75 Or App 583, 585 (1985).

Here, we find there are reasons to do otherwise. We find Dr. Manley to be unpersuasive, because his opinion is based on incomplete or inaccurate information. See Moe v. Ceiling Systems, 44 Or App 429 (1980). Manley admitted that he had no information about the condition of claimant's right knee in 1979, although he suggested that it was the underlying problem for his 1987 right knee difficulty. He also assumed that claimant's job entailed a great deal of walking and going up and down stairs. In contrast, claimant testified that ten percent or less of his time was spent in walking and that he used elevators and escalators, not stairs. From this, we conclude that Dr. Manley had insufficient information from which to offer a persuasive medical opinion regarding the causation of claimant's current condition. Furthermore, as discussed below,

Manley changed his mind so frequently about causation that we find him unpersuasive.

We are thus left with Dr. Thompson's opinion, which we find to be more persuasive because it is well-reasoned and based on complete information. See Somers v. SAIF, 77 Or App 259, 262 (1986). Dr. Thompson examined claimant and reviewed a series of x-rays of both of claimant's knees taken in 1979 and 1980. He opined that claimant's current right knee problem was due to the natural progression of his degenerative arthritis, which had probably been accelerated by the 1979 injury and resulting surgery. He also stated that claimant's employment as a security guard was not the major contributing cause of his right knee condition.

We conclude that claimant has not established that his work was the major contributing cause of the worsening of his degenerative arthritic condition.

To establish compensability against Scott Wetzel of his 1987 right knee condition, claimant must show, by a preponderance of the evidence, that the 1985 left knee compensable injury with Scott Wetzel was a material contributing cause of his 1987 right knee disability or need for medical treatment. Hutcheson v. Weyerhaeuser, 288 Or 51, 56 (1979). ORS 656.005(7)(a). The issue of whether claimant's 1987 right knee condition was causally related to the 1985 left knee injury is a complex medical question. Thus, the resolution of this issue largely turns on an analysis of the medical evidence. Uris v. Compensation Dept., 247 Or 420 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105 (1985).

The only medical evidence supporting the Referee's opinion was provided by Dr. Manley. Initially, he indicated that claimant's right knee problems were directly related to the degenerative changes in claimant's left knee and the walking required by his work as a security guard. Next, he stated that claimant's right knee problem was directly related to his 1979 injury. Then, he opined that claimant's present work was a material cause of his right knee problem. Finally, he stated he could find no direct relationship between claimant's right knee problem and his left knee injury.

We find Dr. Manley to be unpersuasive because he changed his opinion three times before he finally stated that he could find no direct relationship between claimant's 1987 right knee problem and his 1985 left knee injury. As a result, claimant has not met his burden to prove that his 1987 right knee problem was materially related to his 1985 left knee injury.

Responsibility

Because claimant failed to establish that his 1987 right knee problem was materially related to his 1985 left knee injury with Scott Wetzel or that his work as a security guard while Crawford and Company was on the risk was the major contributing cause of the worsening of his arthritic condition, we conclude that the claim is not compensable against either carrier.

ORDER

The Referee's order, dated July 13, 1988, is affirmed in part and reversed in part. Crawford & Company's denial is reinstated and upheld. The Referee's attorney fee award to claimant is reversed. The remainder of the Referee's order is affirmed. A client-paid fee, not to exceed $1,411, payable frm Crawford & Company to its counsel, is approved.

In the Matter of the Compensation of
MARY G. CHARD, Claimant
WCB Case Nos. 87-05726 & 87-05725
ORDER ON REVIEW
Michael B. Dye, Claimant Attorneys
Terrall & Miller, Defense Attorneys
Marshall J. Yager, Defense Attorney

Reviewed by Board Members Gerner and Cushing.

Claimant requests review of those portions of Referee Higashi's order that: (1) declined to grant an award of permanent total disability, beyond a prior Determination Order that awarded 5 percent (9.6 degrees) scheduled permanent disability for each arm; (2) awarded 40 percent (128 degrees) unscheduled permanent disability for her neck, upper back and bilateral shoulder conditions, beyond a prior Determination Order that did not award unscheduled permanent disability; and (3) declined to award additional scheduled permanent disability for her bilateral arm condition, beyond the 5 percent (9.6 degrees) previously awarded for each arm.

We modify the Referee's award of unscheduled permanent disability.

ISSUES

1. Whether claimant is permanently and totally disabled.

2. The extent of claimant's unscheduled and scheduled permanent disability.

FINDINGS OF FACT

Claimant, 68 at the hearing, began working for the employer in 1980 as a cherry sorter. Shortly thereafter, she began to experience pain in her neck, back, shoulders, arms, and wrists. She sought medical treatment and was diagnosed as having bilateral carpal tunnel syndrome. In December, 1984, she filed an occupational disease claim with the employer, who at that time was insured by Industrial Indemnity. The claim was accepted. In May, 1985, carpal tunnel release surgery was performed on each of claimant's wrists. She eventually received a total award of 30 percent scheduled permanent disability for each wrist.

In April, 1985, the employer changed insurers and began coverage with Lumbermen's Underwriting Alliance. Claimant returned to work for the employer in August, 1985, and worked through April, 1986. Because her work was seasonal, she did not resume her work until August, 1986. Shortly thereafter, she noticed a recurrence of her upper extremity pain and symptoms. She sought treatment from Dr. Moore, a chiropractor. Moore took her off work. Later that month, claimant filed another workers' compensation claim with her employer for her "arms." Both Industrial Indemnity and Lumbermen's Underwriting denied the claim.

In October, 1986, claimant began to treat with Dr. Akita, a chiropractor. Akita diagnosed her upper neck, upper back, and bilateral shoulder conditions as a myofascial syndrome.

An ORS 656.307 Order issued in March, 1987. Shortly thereafter, Industrial Indemnity and Lumbermen's Underwriting denied responsibility for claimant's neck, upper back, and bilateral shoulder conditions. Claimant proceeded to hearing before Referee Quillinan. Quillinan found that Lumbermen's Underwriting was the responsible insurer for claimant's neck, back, and bilateral shoulder conditions.

In August, 1987, a Determination Order closed claimant's claim with Lumbermen's Underwriting and awarded her 5 percent scheduled permanent disability for each arm. That Determination Order was amended by two subsequent orders without any additional award of scheduled permanent disability.

ULTIMATE FINDING OF FACT

Claimant is capable of performing suitable and gainful employment and has moderate disability.

CONCLUSIONS OF LAW

Permanent Total Disability

A worker may prove that she is permanently totally disabled from the medical evidence alone or from a combination of physical, social, and vocational factors under the "odd-lot" doctrine. Wilson v. Weyerhaeuser, 30 Or App 403 (1977); ORS 656.206(1)(a). In addition, she must prove that she is willing to seek regular gainful employment and that she made reasonable efforts to obtain such employment, unless to do so would be futile. SAIF v. Scholl, 92 Or App 594, 597 (1988); ORS 656.206(3).

Here, claimant is not permanently totally disabled based solely on her physical or medical condition. Moore did not restrict her from performing sedentary work. Moreover, Akita opined that she could return to light duty work.

Turning to the "odd-lot" doctrine, viewing the medical experts' evaluation of claimant's permanent impairment together with her testimony, we assess her impairment as moderate. See e.g., Exs. 62A & 62B-4; Tr. 30-40. In addition, her bilateral carpal tunnel syndrome is a "preexisting disability" under ORS 656.206(1)(a). We, therefore, include that condition in deciding whether she is permanently totally disabled.

Claimant is 68 years of age. Although she has a GED certificate, she has no formal education or training beyond 10th grade. She has worked on an assembly line, as a cannery worker, and as a nurse's aide. Based on that employment history, the following suitable employment was identified by vocational counselor Riddle: (1) belt worker cherry sorter; (2) drill press operator; (3) goods packager; (4) furniture repair finisher; (5) food packager; and (6) nurse's aide, supra. We are persuaded by Riddle's expert opinion.

Claimant's expert, McNaught, also testified at hearing. There is nothing in his testimony that would persuade us that claimant is permanently and totally disabled. Riddle identified jobs within claimant's capabilities and so did McNaught. McNaught did not persuasively rule out these jobs as being within claimant's capabilities.

Accordingly, on this record, claimant has not proven that her physical condition combined with the various social/vocational factors, permanently precludes her from regularly performing work at a gainful and suitable occupation. We, therefore, agree with the Referee insofar as he concluded that claimant had not proven entitlement to an award of permanent total disability.

Extent of Unscheduled and Scheduled Disability

The test for determining the extent of a worker's unscheduled permanent disability is the permanent loss of earning capacity due to the compensable injury. ORS 656.214(5); see also former OAR 436-30-380 et seq.

Here, claimant has moderate permanent physical impairment in her neck, upper back, and bilateral shoulder areas. Moreover, her advanced age of 68 years detracts from her earning capacity, as does her limited education and employment history. Despite her existing transferable skills identified by Riddle, we conclude that she has permanently lost 80 percent of her earning capacity due to her compensable neck, upper back, and bilateral shoulder conditions.

A worker's extent of scheduled permanent disability is determined by the degree of loss of use or function of the injured member. ORS 656.214(2). Viewing claimant's testimony together with the evaluation of her physical capacities, we assess her permanent degree of loss of use or function of each arm as no greater than the 30 percent total award that she has already received. See ORS 656.222. Accordingly, we agree with the Referee insofar as he concluded that claimant was not entitled to an additional award of scheduled permanent disability.

ORDER

The Referee's order dated March 4, 1988, as amended on March 25, 1988, is reversed in part, modified in part, and affirmed in part. We modify that portion of his order that awarded 40 percent unscheduled permanent disability. In lieu of the Referee's award, claimant is awarded 80 percent (256 degrees) unscheduled permanent disability. We affirm all remaining portions of the Referee's order. Claimant's attorney is awarded an approved attorney fee equal to 25 percent of the increased permanent disability compensation awarded by this order, provided that the total of fees approved by the Referee and the Board do not exceed $3,800. The Board approves a client-paid fee, payable from Lumbermen's Underwriting to its attorney, not to exceed $1,225.

January 24, 1990 Cite as 42 Van Natta 163 (1990)

In the Matter of the Compensation of
THERESA A. DOUGLASS, Claimant
WCB Case No. 86-14368
ORDER ON REVIEW
Peter O. Hansen, Claimant Attorney
Schwabe, et al, Defense Attorneys

Reviewed by Board Members Cushing and Gerner.

The self-insured employer requests, and claimant cross-requests, review of Referee Shebley's order that: (1) set aside its denial of claimant's occupational disease claim for her neck, right shoulder, arm, head, and consequent depression; (2) awarded interim compensation; and (3) assessed a penalty and attorney fee for an alleged failure to pay interim compensation. On review, the issues are compensability, interim compensation, and penalties and fees. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact with supplementation.

Claimant has had recurring periods of depression and attendant somatization prior to her employment and alleged occupational disease.

Claimant's range of shoulder motion decreased during the period of time she was released from work and receiving treatment for her condition.

CONCLUSIONS OF LAW AND OPINION

To prevail on her occupational disease claim, claimant must demonstrate by a preponderance of the evidence that her work activities and exposures, when compared to nonwork activities and exposures, were the major contributing cause of the onset or worsening of her condition resulting in disability or requiring medical services. See former ORS 656.802(1)(a); Dethlefs v. Hyster Co., 295 Or 298, 310 (1983); Devereaux v. North Pacific Ins. Co., 74 Or App 388 (1985).

The Referee found claimant to be unreliable in her testimony. We agree. Claimant has had occasion to be seen by a number of physicians in the course of her treatment. Medical opinion regarding the diagnosis and cause of claimant's condition is varied and contradictory.

Claimant last worked on March 29, 1985. She reported that she had been experiencing an onset of right arm pain for an undetermined period prior to this date. She initially began receiving long term disability payments under private health care coverage provided by her employer. A form 801 was first filed on September 12, 1986.

Claimant's complaints have been subjective and her examinations have been characterized by normal physical findings. X-rays, EMG, and other laboratory studies have all proven negative.

Claimant's primary source of supporting medical opinion comes from Dr. Rusch, an orthopedist. Dr. Rusch advanced contradictory opinions as to whether claimant's employment was responsible for a worsening of her underlying condition, which he defined as myofascitis that preexisted her employment. As late as June 1987, Dr. Rusch was reporting that claimant's work had only worsened her symptoms and not her underlying condition. However, in a December 1987 deposition Dr. Rusch modified his earlier opinion by saying that, in his opinion, the symptoms of myofascitis were the condition. Dr. Rusch went on to say that the causes of myofascitis were multifactorial and could result from mechanical, psychological, and disease processes. He acknowledged that claimant's daily activities of housekeeping and recreation would have a worsening effect on her condition and that somatization was also a potential cause of the worsening.

Claimant began treating with Dr, Watkins, a psychiatrist, on December 3, 1986. At that time, Dr. Watkins took a history of periods of depression with somatic manifestations. His initial findings included an Axis 3 diagnosis of vague somatic complaints of pain in the right shoulder. In an April 1, 1987 report, he opined that claimant's need for psychiatric treatment was related to the stress resulting from her injury and attendant disability. Watkins indicated that this opinion was based on a history provided to him by claimant that her right shoulder problems preceded her depression. Yet, we note that in a prior history claimant provided to Dr. Schoepflin, a rheumatologist, on the first occasion she sought treatment for her condition, she reported that she was experiencing depression with crying.

Claimant was seen twice by the Orthopaedic Consultants. She was first seen in July 1985. Her examination was essentially normal and the diagnosis was recurring right shoulder pain, secondary to overuse. She reported that she was asymptomatic and free of subjective complaints. The Consultants saw claimant again in November 1986. At this time she reported her condition had worsened in the intervening 16 months. The objective findings of her examination were basically normal except for a loss of range of motion in her right shoulder. She was noted to have severely interfered with the examination and to have exhibited an inconsistent range of neck motion.

The Consultants diagnosed psychiatric depression and right shoulder pain without organic findings. In connection with the Consultant's examination, claimant was also seen by Dr. Parvaresh, a psychiatrist. He also reviewed claimant's past medical and psychiatric records including those of Dr. Watkins. Dr. Parvaresh opined that claimant had underlying psychological problems which predated her employment and which were periodically manifested in various somatic disorders. He found claimant's complex of right shoulder symptoms was the most recent somatic manifestation.

We are unpersuaded by the opinions offered by Drs. Rusch and Watkins. Dr. Rusch's inconsistency in rendering his medical opinion regarding whether or not claimant's employment had caused a worsening of her underlying condition weakens the persuasiveness of that opinion. Furthermore, there is no explanation of the reported worsening of claimant's subjective complaints during the more than two years she had been off work and under treatment for her condition.

Dr. Watkins initially diagnosed claimant's right shoulder pain as being somatic in origin. He related her need for psychiatric care to her shoulder based on her history. Yet, we have found claimant to be unreliable and noted that her complaints of depression are contemporaneous with her first complaints about shoulder pain to Dr. Schoepflin and her subsequent release from work. Medical opinion based on an incomplete or unreliable history is not persuasive. See Miller v. Granite Construction Co., 28 Or App 473, 476 (1977).

We are most persuaded by the medical opinions of the Orthopaedic Consultants and Dr. Parvaresh. We acknowledge that the Consultants' initial opinion of July 1985 is somewhat at odds with their opinion of November 1986. However, this earlier opinion was based on the report of claimant that her condition had become asymptomatic under Dr. Rusch's treatment. Moreover, they were presented with the appearance of a program which was resolving claimant's complaints at a time prior to reports of a psychiatric component to claimant's condition.

The Orthopaedic Consultants' November 1986 examination was similar to the earlier examination in its lack of objective findings, but was dealing with a claimant who had been in an additional sixteen months of treatment with a marked increase of subjective complaints. Their examination was done in conjunction with the examination of Dr. Parvaresh, which added a dimension of medical expertise and inquiry which was not present at the first examination. For these reasons, we find the Consultants' later opinion persuasive. Consequently, we find that claimant's right arm, shoulder, neck, and head complaints are a somatic manifestation of her preexisting psychological condition and that her work activities were not the major cause of a worsening of this condition.

Even if we were to accept the diagnosis of preexisting myofascitis, we would still find that claimant has failed to establish that her employment was the major cause of a worsening of her preexisting condition. Dr. Rusch has acknowledged that myofascitis can be caused by somatization. He has stated, in his deposition, that activities such as housekeeping and sports activities, which claimant continued to participate in after her release from work, could have caused or worsened her condition. Her subjective symptoms, which Dr. Rusch now describes as claimant's condition, have worsened during a two-year period of treatment and release from the alleged harmful influence of her employment. Claimant has failed to establish the compensability of her condition.

On the question of the Referee's award of interim compensation and the assessment of a penalty and attorney fee for the employer's failure to pay interim compensation, we affirm and adopt the reasoning and conclusions contained in the last five paragraphs in the Conclusions of Law and Opinion section of the Referee's order.

ORDER

The Referee's order, dated June 9, 1988, is reversed in part and affirmed in part. The self-insured employer's denial is reinstated and upheld. The Referee's award of an assessed fee to claimant's attorney for prevailing on the issue of compensability is reversed. The remainder of the Referee's order is affirmed. For services on review concerning the interim compensation issue, claimant's attorney is awarded $350, to be paid by the self-insured employer. The Board approves a client-paid fee, payable by the employer to its counsel, not to exceed $2,658.50.

January 24, 1990 Cite as 42 Van Natta 166 (1990)

In the Matter of the Compensation of
JACK D. EASLEY, Claimant
WCB Case No. 87-08913
ORDER ON REVIEW
Philip H. Garrow, Claimant Attorney
Cummins, et al, Defense Attorneys

Reviewed by Board Members Cushing and Gerner.

The insurer requests review of those portions of Referee Howell's order that: (1) set aside its denial of current medical services; and (2) granted claimant an award of permanent total disability, beyond a Determination Order that awarded 20 percent (64 degrees) unscheduled permanent disability for a low back condition. On review, the issue is permanent total disability and medical services. We affirm in part and reverse in part.

FINDINGS OF FACT

Claimant, 44 at the hearing, sustained compensable back injuries in 1969 and 1985. In 1969, he worked as a laborer, operating a welding machine and painting water tanks. As a result of the 1969 injury, he underwent a lumbar discectomy and fusion performed by Dr. Kendrick, an orthopedic surgeon. His recovery was slow. He developed pseudarthritis at L4-5 and treated conservatively with Kendrick.

Between 1970 and mid-1972, claimant received social security benefits. In 1973 he briefly returned to work, before experiencing increased pain. Attempts were made to reinstate his social security benefits. In 1974, he was examined by Dr. Johnson, for the Social Security Administration. Diagnostic studies revealed no evidence of nerve root impression. Claimant's pain complaints were pyschogenic in origin.

Later that year, he successfully returned to work. He performed various heavy labor jobs over the next 11 years. Those jobs included work as a ranch hand, feed lot worker, heavy equipment mechanic, autobody worker, and heavy equipment operator. During that 11-year period, he experienced some minor intermittent low back and left leg symptoms. Those symptoms did not prevent him from working, however, and did not result in medical treatment.

In August, 1985, claimant compensably injured his low back while working as a "cat" operator. He treated conservatively with Dr. Reilly, an osteopath. A CT scan revealed marked degenerative joint disease in the lumbar spine. Claimant also began to display consistently high blood pressure. Despite Reilly's advice to the contrary, he briefly returned to work in September, 1985. He was unable to continue, however, due to pain.

Claimant was examined by Dr. Kendrick, a neurosurgeon, in October, 1985. Kendrick performed diagnostic studies and recommended weight loss.

Shortly thereafter, claimant began to developed epigastric difficulties, urinary incontinence, hypertriglyceridemia, and mild reactive depression. His back and leg conditions remained unchanged, however.

Claimant was examined by Dr. Misko, a neurosurgeon, in August, 1986. Misko recommended massive weight loss (70 pounds) as a condition precedent to effective treatment. At that time, claimant was 6 feet tall and weighed 266 pounds. The insurer proposed a dietary and exercise program. Reilly rejected the program as unrealistic and inappropriate. Nevertheless, claimant did participate, to some extent, in an exercise and dietary program suggested by the insurer's nurse.

Vocational services were commenced in December, 1986. It became readily apparent, however, that claimant had adopted the view that he was permanently and totally disabled. Although he was careful not to refuse vocational services -- because of concern that he would lose his worker's compensation benefits -- he preferred to be left alone.

In February, 1987, claimant underwent a work tolerance test. He was able to lift five pounds, stand for up to five minutes, and sit for up to 47 minutes. At the end of the 3-1/2 hour test, a palpable muscle knot was present in his low back. Two months later, he was examined by Dr. Flanagan, M.D.

In June, 1987, claimant's claim was closed by a Determination Order, awarding a period of temporary disability and 20 percent unscheduled permanent disability for his low back.

Claimant was provided vocational services until mid-1987, when he went to Missouri for two months. At the time of the hearing, he weighed 248 pounds. He had begun a diet program, but did not consider himself significantly overweight. He experiences constant low back and left leg pain, as well as periodic muscle spasms. He can walk less than a city block. He can drive a car for less than an hour.

CONCLUSIONS OF LAW

Medical Services

We adopt that portion the Referee's conclusions on the medical services issue, under subheading "B)" at page eight of his order.

Permanent Total Disability

A worker may prove permanent total disability based solely on his physical condition, which includes any preexisting "disabilities," or in combination with nonphysical factors such as his age, education, training, adaptability to lighter occupations, mental capacity, emotional condition, and the labor market. ORS 656.206(1)(a); Wilson v. Weyerhaeuser, 30 Or App 403 (1977). Additionally, the worker must prove that he was willing to seek work and that he made reasonable efforts to do so, unless such efforts would have been futile. ORS 656.206(3); SAIF v. Scholl, 92 Or App 594 (1988).

The Referee considered claimant's preexisting back, left leg, obesity, and psychological profile, in addition to any impairment due to the 1985 injury, in concluding that claimant was permanently totally disabled. We disagree.

It is well settled that preexisting disabilities under ORS 656.206(1)(a) are considered as they exist at the time of the worker's injury. John D. Kreutzer, 36 Van Natta 285, aff'd mem 71 Or App 355 (1984). The trier of fact does not consider any subsequent worsening of the worker's preexisting disabilities in deciding whether he has proven permanent total disability. Id. It follows, therefore, that the proper date on which to determine whether a worker has a preexisting disability, as opposed to a mere preexisting condition, is the date of injury.

Here, claimant sustained a disabling industrial injury to his back and left leg in 1969. Surgery was required. His recovery was slow and he developed a psychogenic pain disorder. In 1974, however, he returned to heavy labor work. Thereafter, he successfully continued to perform such work for 11 years without either time loss or medical treatment for his back, left leg, obesity, or psychogenic disorder. Accordingly, those conditions were not a disability during that 11-year period.

Under such circumstances, we conclude that at the time of claimant's 1985 injury, he was not suffering from any preexisting disabilities under ORS 656.206(1)(a).

Regarding claimant's obesity, the Referee found that that condition was a consequence of Reilly's treatment and, therefore, compensably related to the 1985 injury. We disagree.

This case does not present a factual situation involving the development of an injured worker's obesity following and as a material result of a compensable injury. Both Kendrick and Misko opined that claimant's obesity preexisted the 1985 injury. Exs. 57B & 57C. We find no persuasive evidence in the record to the contrary. Moreover, Reilly's treatment had little or nothing to do with the onset of claimant's obesity. Reilly inexplicably did not encourage claimant to reduce his weight. While such treatment, or lack thereof, may have contributed to the continuation of claimant's preexisting obesity, it did not contribute to the cause or any worsening of that condition. Claimant's obesity is, therefore, not a compensable consequence of Reilly's treatment.

We, therefore, look to claimant's 1985 injury in combination with the appropriate social/vocational factors. Wilson, supra. The insurer accepted claimant's 1985 claim for a "hurt back." No other body parts were accepted by the insurer. An employer takes a worker as he finds him. Senters v. SAIF, 91 Or App 704 (1988). Although claimant did not have a preexisting back disability under ORS 656.206(1)(a) at the time of the 1985 injury, he did have a preexisting back condition. That preexisting condition became symptomatic as a material result of the 1985 injury. Accordingly, it is appropriate for us to consider claimant's total back disability resulting from the 1985 injury. Claimant need not prove a worsening of his preexisting back condition. Harris v. Albertson's, Inc., 65 Or App 254 (1983).

There is little medical evidence of physical pathology to explain claimant's continuing back pain. Moreover, the medical experts have almost uniformly blurred claimant's many conditions-- all of which, save for the back, are not compensable-- in assessing his physical limitations and ability to return to work. It is claimant's burden to prove his case. Hutcheson v. Weyerhaeuser, 288 Or 51 (1979).

In February, 1987, Dr. Howell opined that claimant was medically stationary with no injury-related impairment. A few months later, Misko reached an identical conclusion. In September, 1987, Kendrick reported that, based on his last examination, claimant was not permanently totally disabled.

On the other hand, Flanagan examined claimant in May, 1987, and opined that his back pain, obesity, and lack of aerobic conditioning all contributed to render claimant unable to work. We are not persuaded by Flanagan's opinion. He did not explain whether he attributed claimant's back pain to the 1985 injury. More damaging, is that his opinion was partially premised on consideration of claimant's obesity and lack of conditioning. Those conditions, however, are not compensably related to the 1985 injury. Inasmuch as Reilly "concur[red]" with Flanagan, his opinion suffers from the same defects.

In sum, we are persuaded by the collective opinions of Howell, Misko, and Kendrick. In particular, that of Howell, inasmuch as he persuasively explained his opinion at the hearing. We, therefore, conclude that claimant has minimal physical impairment due to the 1985 injury.

Turning to the "odd-lot" factors, claimant is relatively young at 44. His age is not an impediment to obtaining work. His 11th grade education, work experience in heavy labor occupations, and lack of transferable skills, however, are all impediments to reentering the work force. Nonetheless, assuming a hypothetically normal labor market, we are not persuaded that such impediments combined with claimant's relatively young age and minimally impaired back, are so great as to permanently preclude gainful and suitable employment.

Accordingly, claimant has not proven entitlement to an award of permanent total disability.

We proceed to rate claimant's unscheduled permanent disability. The test we apply is the permanent loss of earning capacity claimant has suffered as a result of the 1985 injury. ORS 656.214(5); former 436-30-380 et seq. Given claimant's limited education, training, work experience, and transferable skills, weighed against his minimally impaired back and relatively young age, we conclude that he has suffered a 30 percent loss in permanent earning capacity.

ORDER

The Referee's order, dated December 31, 1987, as amended on March 16, 1988, is affirmed in part and reversed in part. That portion of his order that set aside the insurer's medical services denial is upheld. That portion that awarded permanent total disability is reversed. In lieu of the Referee's award of permanent total disability, claimant is awarded an additional 10 percent (32 degrees) unscheduled permanent disability for his back condition, for a total award to date of 30 percent (96 degrees). The Board awards claimant's attorney a reasonable assessed fee of $500 for services on review, which pertained to the medical services issue. A client-paid fee, payable from the insurer to its attorney, not to exceed $5,959.30 is approved.

January 24, 1990 Cite as 42 Van Natta 169 (1990)

In the Matter of the Compensation of
GAIL M. LOVELACE, Claimant
WCB Case No. 88-06478
ORDER ON REVIEW
Merrill Schneider, Claimant Attorney
Schwabe, et al, Defense Attorneys

Reviewed by Board Members Cushing and Gerner.

The insurer requests review of Referee Knapp's order that set aside its denial of claimant's aggravation claim for a low back condition. On review, the

insurer contends that claimant's current condition is not related to her compensable injury. We agree and reverse.

FINDINGS OF FACT

Claimant sustained a compensable low back injury in March, 1985. Dr. King, a chiropractor, diagnosed lumbosacral disc syndrome. The claim was closed by Determination Order in October, 1985 with an award of temporary total disability and no permanent disability.

Claimant had an onset of soreness of her back in February, 1988 after she slipped and fell in a girlfriend's yard. Then she had an acute onset of pain after lifting a stereo speaker into her car on March 8, 1988. Three days later she returned to Dr. King, but he was unable to treat her because her back pain was too severe. She then sought treatment from Dr. Ordonez, who performed surgery to correct a herniated L4-5 disc.

Dr. King was not claimant's treating physician because he saw her only once after 1986.

CONCLUSIONS OF LAW AND OPINION

The Referee found that the opinion of Dr. King, combined with claimant's credible testimony, demonstrated that claimant had established by a preponderance of the evidence that her compensable injury of March, 1985 was a material contributing cause of her March, 1988 low back treatment and surgery. We disagree.

To establish compensability of her 1988 back condition, claimant must show, by a preponderance of the evidence, that the 1985 compensable injury remained a material contributing cause of her 1988 disability or need for medical treatment. Hutcheson v. Weyerhaeuser, 288 Or 51, 56 (1979). The issue of whether claimant's 1988 back condition was causally related to the 1985 compensable injury 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.

Dr. King reasoned that because claimant's symptoms in 1985 and 1988 were in the same place, the lower back, her 1988 back problems and subsequent surgery must be directly and causally related to her 1985 injury. Yet, there is no evidence that King was aware of claimant's February and March 1988 injuries leading to the acute onset of her back problems and ensuing surgery. Therefore, we find his opinion unpersuasive. See Miller v. Granite Construction Co., 28 Or App 473, 476 (1977).

Moreover, Dr. Ordonez, claimant's surgeon, concluded that in light of claimant's injury three days prior to her admission to the hospital, he could not tell whether the compensable injury was responsible for her 1988 back condition. Considering this first-hand exposure to claimant's current condition, which included an accurate history, we find Dr. Ordonez's well-reasoned opinion to be persuasive. See Argonaut Insurance Company v. Mageske, 93 Or App 698 (1988); Somers v. SAIF, 77 Or App 259 (1986).

Claimant has the burden of proving that her 1988 back problems and ensuing surgery are due to her compensable injury. She has failed to carry her burden of proof. Based on the foregoing reasoning, we are unpersuaded that claimant's compensable injury was a material cause of her need for medical treatment and surgery.

ORDER

The Referee's order, dated July 27, 1988, is reversed. The insurer's denial is reinstated and upheld. A client-paid fee, payable from the insurer to its counsel, is approved, not to exceed $3,427.50.

January 24, 1990 Cite as 42 Van Natta 171 (1990)

In the Matter of the Compensation of
DEBBY NORMAN, Claimant
WCB Case No. 88-01345
ORDER ON REVIEW
Roll, et al., Claimant Attorneys
Julia Philbrook (Saif), Defense Attorney

Reviewed by Board Members Perry and Howell.

The SAIF Corporation requests review of that portion of Referee Schultz's order that set aside its denial of claimant's injury claim for her right hip condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

Claimant was involved in a car accident in 1973 and, as a result, underwent a total right hip replacement. From 1974 through 1987, claimant did not seek follow-up treatment for her 1973 hip replacement. Prior to her injury, claimant had participated in low-impact exercises and had not experienced symptoms in her right hip.

In October 1987, claimant was working as a night staff person for SAIF's insured, a group home. Her duties at the group home included the care and supervision of the children at the facility. Claimant's injury occurred as she arose to check on the children in the sleeping area. Claimant got up with a stumble, heard a crack in her right hip and felt intense pain. After her shift was complete, claimant received treatment for a fracture of her right femur. On December 4, 1987, SAIF denied claimant's claim for her hip and leg injury.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant had proven that her injury arose out of and in the course of her employment. We disagree.

Claimant's treating orthopedic surgeon, Dr. Stewart, diagnosed her fracture and opined that it was job-related, although she had preexisting problems due to her earlier hip replacement. Claimant also treated with Dr. Wells, M.D., who referred her to Dr. Zimmerman. Zimmerman eventually performed claimant's second total hip replacement.

Dr. Weintraub, an orthopedist, examined claimant for SAIF and concluded that claimant's accident was not job-related, but instead, her problems had occurred spontaneously. He found that claimant had gross loosening of her prosthesis prior to the time she arose from her chair at work. Dr. Weintraub believed that if claimant had been examined earlier, he would have recommended that she have a revision of the artificial hip in order to prevent fractures such as the one that occurred.

In a "check-the-box" letter, Drs. Stewart and Wells concurred with Dr. Weintraub. Dr. Zimmerman stated that claimant had a preexisting loosening, but that she had also had severe pain that occurred at work.

SAIF contends that claimant's femur broke as she stood up and the injury was due to degenerative changes in her hip which would not have occurred if she had returned to her doctor over the years. SAIF also claims that the condition is not compensable because the stumble is unexplained and claimant did not eliminate idiopathic causes.

To establish compensability of her claim, claimant must prove by a preponderance of the evidence that the industrial injury was a material contributing cause of her existing disability or need for medical treatment. Harris v. Albertson's Inc., 65 Or 254 (1983). The issue of whether claimant's current need for medical services is causally related to her injury of October 1987, is a complex medical question. Thus, although claimant's testimony is 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).

Dr. Weintraub opined that claimant's injury was not work-related, and Dr. Wells concurred with that opinion. Only Dr. Stewart found claimant's injury to be related to her work. We are not persuaded by Dr. Stewart's opinion, however, as we find the opinion to be conclusory and devoid of any explanation as to how claimant's injury was caused by her work activity (i.e. was it due to rising to her feet, to an unexplained stumble or to some other cause). See Karen L. Kerekes, 41 Van Natta 954 (1989).

Additionally, although Dr. Stewart was claimant's treating doctor, his examinations of claimant were limited to emergency room treatment and one follow-up visit. When the medical evidence is divided, we have tended to give greater weight to the conclusions of a claimant's treating physician, absent persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810 (1983). Dr. Stewart subsequently concurred with Dr. Weintraub that claimant's injury was not work-related. Because of Dr. Stewart's inconsistency and the absence of any explanation for his first opinion as to the immediate cause of claimant's injury, we do not defer to his conclusion in this case.

Even though we agree with the Referee that claimant credibly testified regarding the circumstances of her injury, such testimony is insufficient to establish the necessary causal relationship in this medically complex case. See James A. Ross, 41 Van Natta 250 (1989). We, therefore, conclude that claimant has not proven by a preponderance of the evidence that conditions arising from her employment were a material contributing cause of her existing disability or need for medical treatment since the October 1987 incident.

ORDER

The Referee's order, dated May 4, 1988, is reversed. The SAIF Corporation's denial is reinstated and upheld.

In the Matter of the Compensation of
GEORGE K. O'KELLEY, Claimant
WCB Case Nos. 87-16162 & 87-16163
ORDER ON REVIEW
Malagon, et al, Claimant Attorneys
Employers Defense Counsel, Defense Attorney
H. Thomas Andersen (Saif), Defense Attorney

Reviewed by Board Members Nichols and Brittingham.

Claimant requests review of the portions of Referee Huffman's order and Referee Gruber's orders that declined to award claimant's attorney an assessed fee for services rendered at hearing on a responsibility issue. The SAIF Corporation cross-requests review of the portions of the orders that: (1) set aside SAIF's denial of responsibility for claimant's aggravation claim for a low back condition; and (2) upheld Liberty Northwest Insurance Corporation's denial of claimant's "new injury" claim for the same condition. The issues on review are responsibility and attorney fees. We affirm.

FINDINGS OF FACT AND ULTIMATE FACT

The Board adopts the findings of the Referee with the following supplementation:

Claimant's attorney requested a hearing on the denials issued by SAIF and Liberty, was present and participated at the hearing, attended the post hearing deposition of Dr. Hart but asked no questions, and did not take a position on which insurer was responsible at the time of the hearing.

CONCLUSIONS OF LAW AND OPINION

We adopt the conclusions of law and opinion of the Referee with the following supplementation on the issue of attorney fees. Claimant argued his right to an assessed attorney fee based on ORS 656.307(5). This provision did not become effective until January 1, 1988 and is not applicable in this matter. Rhonda L. Bilodeau, 41 Van Natta 11 (1989).

Under the law which was applicable at the time of this hearing, claimant's attorney would be entitled to an assessed attorney fee only if he "actively litigated" the responsibility issue. Mercer Industries v. Rose, 100 Or App 252 (January 17, 1990). Here, claimant's attorney did not take a position on which carrier was responsible. Under these circumstances, he did not actively litigate the responsibility issue and is not entitled to an assessed fee.

Finally, claimant is not entitled to an attorney fee for services on review. The record indicates that claimant's temporary disability rate is the same regardless of which insurer is found responsible. Inasmuch as his compensation would not have been disallowed or reduced had SAIF prevailed on its cross-request, claimant is not entitled to a carrier-paid fee for services on review. ORS 656.382(2).

ORDER

The Referee's order, dated May 9, 1988, as reconsidered July 28, 1988, is affirmed. The Board approves a client-paid fee, not to exceed $744, payable from Liberty Northwest Insurance Corporation to its counsel.

In the Matter of the Compensation of
RINALDO F. SINCLAIR, Claimant
WCB Case No. 86-09427
ORDER ON REVIEW
Emmons, Kropp, et al, Claimant Attorneys
Brian L. Pocock, Defense Attorney

Reviewed by Board Members Perry and Howell.

The self-insured employer requests review of Referee Myers' order that: (1) set aside its denial of claimant's aggravation claim; and (2) granted claimant an award of permanent total disability in lieu of previous awards totalling 70 percent (224 degrees) unscheduled permanent partial disability for his low back and 10 percent (15 degrees) scheduled permanent partial disability for his left leg. In addition, if the Board affirms the Referee's award of permanent total disability, the employer requests authorization to offset all previously paid permanent partial disability compensation against the award. We affirm the Referee's order.

FINDINGS OF FACT

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

During the course of this claim, claimant has overtly resisted efforts at physical rehabilitation and treatment, as well as vocational assistance. Claimant's actions were prompted, at least in part, by longstanding personality disorders. Additionally, a significant portion of claimant's physical complaints have been psychological in origin and related to his personality disorder.

By Opinion and Order dated September 14, 1984, claimant was found to have 50 percent injury-related permanent partial disability. That is the last award or arrangement of compensation in this case. Since then, claimant's psychological condition and resulting elaboration of physical complaints has worsened.

The worsening of claimant's psychological condition was materially contributed to by his compensable injury.

CONCLUSIONS OF LAW AND OPINION

Permanent Total Disability

We agree with and adopt that portion of the Referee's Opinion and Order labeled "Conclusions", with the following supplementation.

The Referee found that claimant's physical condition had not worsened since September 1984. We agree. He also found, and we agree, that claimant's psychological condition has worsened.

Claimant has been diagnosed by psychologists Martin and Ackerman and by psychiatrist Kuttner as suffering from a personality disorder or disorders. Drs. Ackerman and Kuttner related a worsening of those disorders, in material part, to claimant's compensable injury. Dr. Martin offered no opinion on that question.

A preponderance of the evidence indicates that claimant's injury materially contributed to a worsening of his psychological disorder(s). Those disorders, in turn, were partially responsible for claimant's resistance to rehabilitation efforts and for his exaggerated physical complaints. Those

consequences are, therefore, appropriately considered in determining whether claimant is able to regularly perform work at a gainful and suitable occupation.

Offset

In the event that we affirm the Referee's permanent total disability award, the employer has requested that we authorize an offset against that award "for all permanent partial disability previously granted." We decline to grant the employer authority for an offset as this issue was not raised at hearing. See Elsie L. Hobkirk, 40 Van Natta 778, modified on other grounds 40 Van Natta 1947 (1988). Moreover, even if the employer had timely requested authority for an offset, we would nevertheless limit that offset to those permanent partial disability benefits which were paid subsequent to the effective date of the permanent total disability award. See Pacific Motor Trucking Co. v. Yeager, 64 Or App 28 (1983).

Claimant's attorney is entitled to an assessed fee for services on Board review, but has not submitted a statement of services in accordance with OAR 438-15-010(5). No assessed fee, therefore, can be awarded at this time.

ORDER

The Referee's order dated March 16, 1988 is affirmed. A client-paid fee of up to $575 is approved.

January 24, 1990 Cite as 42 Van Natta 175 (1990)

In the Matter of the Compensation of
RODNEY L. STAEHLE, Claimant
WCB Case No. 87-19053
ORDER ON REVIEW
William H. Skalak, Claimant Attorney
Mark Bronstein (Saif), Defense Attorney

Reviewed by Board Members Speer and Howell.

Claimant requests review of those portions of Referee Galloway's order that: (1) declined to award interim compensation; and (2) declined to assess penalties and attorney fees against the SAIF Corporation for its alleged unreasonable failure to pay interim compensation. On review, the issues are interim compensation and penalties and attorney fees. We affirm.

FINDINGS OF FACT

Claimant underwent spinal fusion in November, 1986 for a compensable injury. He was followed by his treating physician, Dr. Baum, thereafter. A June 16, 1987 Determination Order closed the claim and claimant requested a hearing. By letter dated June 30, 1987 and received by SAIF July 14, 1987, Dr. Baum asserted an aggravation claim on claimant's behalf. Claimant was thought to have a possible pseudo-arthrosis. He was reported to have experienced worsened symptoms beginning in April, two months earlier. Claimant was not considered medically stationary or able to work. (Ex. 33) Both claimant and SAIF treated that report as an aggravation claim. (Exs. 36A & 43) SAIF denied the claim on August 17, 1987. (Ex. 43). Claimant amended his earlier hearing request to include the denial.

Claimant sought emergency room treatment for acute increases of his chronic low back pain on July 21, 1987 (Ex. 37), July 23, 1987 (Ex. 39), August 7, 1987 (Ex. 42), August 29, 1987 (Ex. 48), September 7, 1987 (Ex. 50), September 13, 1987 (Ex. 51), September 29, 1987 (Ex. 56), October 2, 1987 (Ex.

58), October 4, 1987 (Ex. 59) and October 6, 1987 (Ex. 60). Notes from the July 23, 1987 treatment indicated that there had been something wrong since claimant's pain increased in April. SAIF received that note by August 27, 1987. (Ex. 39)

In an October 12, 1987 chart note Dr. Sirounian again reported a worsening of claimant's condition since April 1987. He felt that claimant might have a pseudo-arthrosis and that further treatment was necessary. SAIF received that note on October 14, 1987. (Ex. 61) It did not pay interim compensation nor accept or deny the October 12, 1987 chart note as an aggravation claim. (Tr. 6)

On October 28, 1987 a settlement was approved which resolved all issues raised or raisable at that time.

CONCLUSIONS OF LAW AND OPINION

Claimant maintains that Dr. Sirounian's October 12, 1987 chart note to SAIF constituted a new aggravation claim under ORS 656.273(3) and that the first installment of interim compensation was due 14 days later. Claimant does not dispute the Referee's upholding of the denial of the "aggravation claim", but only the interim compensation issue.

The October 12, 1987 chart note was not a new aggravation claim as is assumed by the parties. Dr. Baum filed an aggravation claim on claimant's behalf by his June 30, 1987 letter. Claimant's attorney confirmed that claim. An emergency room report of July 23, 1987 also noted the claim of worsening since April 1987. SAIF denied the aggravation claim. In September, 1987 Dr. Sirounian reasserted facts supporting the earlier aggravation claim, indicating that claimant's condition had definitely worsened since April. Finally, in his October 12, 1987 chart note, Dr. Sirounian repeated once again his opinion in support of the earlier aggravation. He noted, as had Dr. Baum in June, 1987, that claimant's condition had worsened in April, 1987, that claimant might have a pseudo-arthrosis and that claimant should have been on time loss.

The September and October 1987 chart notes supporting an aggravation related to the claim first asserted by Dr. Baum in June, 1987. SAIF denied that claim in August, 1987 and claimant requested a hearing on the denial. It had no obligation to deny it again in October, 1987, when additional support for the same claim was proffered. Vandehey v. Pumilite Glass & Building Co., 35 Or App 187, 192-93 (1978). Neither was it obligated to pay interim compensation after its denial simply because the claimant, through a doctor's chart notes, re-asserted that he had suffered an aggravation in April. On October 28, 1987, a settlement was approved which resolved any request for hearing by claimant from SAIF's denial of his aggravation claim. Claimant had no further rights based upon that claim for aggravation.

Accordingly, claimant is neither entitled to interim compensation nor to penalties and attorney fees for alleged failure to pay interim compensation.

ORDER

The Referee's order dated May 2, 1988 is affirmed.

In the Matter of the Compensation of
DONALD E. TYSON, Claimant
WCB Case No. 88-01596
ORDER ON REVIEW
Peter O. Hansen, Claimant Attorney
Norman Cole (Saif), Defense Attorney

Reviewed by Board Members Perry and Howell.

The SAIF Corporation requests review of Referee Galton's order which: (1) awarded claimant permanent total disability in lieu of prior awards and arrangements of compensation totaling 60 percent (192 degrees) unscheduled permanent disability for low back injuries; (2) found claimant to be medically stationary on December 3, 1987; and (3) declined to authorize recalculation of claimant's temporary total disability rate. SAIF filed a motion to remand for acceptance of additional evidence. On review, the issues are remand, extent of unscheduled permanent disability, including permanent total disability, premature closure, and rate of temporary disability. We affirm in part and reverse in part.

After the Referee's order, SAIF received a closing report from Stonebridge Rehabilitation Association. SAIF submitted a Motion to Remand so that the closing report from Stonebridge could be admitted into evidence. To merit remand for consideration of additional evidence, it must be shown that the record was improperly, incompletely, or otherwise insufficiently developed. ORS 656.295(5). Here, we find that the numerous exhibits already in the record were sufficient to completely, sufficiently, and adequately develop the record. See ORS 656.295(5). Thus, the motion to remand is denied.

FINDINGS OF FACT

The Board adopts the Referee's Findings of Fact through the first full paragraph on page 4 of the Opinion and Order, and adds the following supplementation.

Claimant was mildly to moderately impaired by his low back injury. Claimant was released to light duty work or vocational rehabilitation on December 3, 1987.

Claimant was medically stationary on December 3, 1987.

Claimant has many transferable skills and several jobs were identified that he could perform.

Claimant worked an average of 27.43 hours per week for the nearly four weeks he worked for the employer. His schedule was arranged so that claimant filled in as needed at work.

CONCLUSIONS OF LAW AND OPINION

Permanent Total Disability

In order to prove entitlement to permanent total disability benefits, claimant must prove that he is permanently incapacitated from regularly performing work at a gainful and suitable occupation. ORS 656.206(1)(a). Permanent total disability may result from less than total physical incapacity, when combined with nonmedical conditions, including "age, training, aptitude, adaptability to nonphysical labor, mental capacity, emotional condition, as well as the condition of the labor market." Wilson v. Weyerhaeuser, 30 Or App 403, 409 (1977). Unless claimant's physical incapacity in conjunction with his nonmedical disabilities renders work search futile, SAIF v. Scholl, 92 Or App 594,

597 (1988), he must also establish that he is willing to seek regular gainful employment and that he has made reasonable efforts to obtain such employment. ORS 656.206(3).

Here, the evidence does not support the Referee's conclusion that claimant's compensable physical condition prevents him from working. Dr. Berselli, his treating physician, released claimant to light duty work and has stated that claimant is mildly to moderately permanently impaired. At least two independent medical examinations found the same amount of impairment and opined that claimant could return to light work. We are persuaded by the consistent medical evidence that claimant is not totally disabled from a purely physical standpoint.

Because claimant has not proved that he is totally disabled based solely on his physical condition, he must prove by a preponderance of the evidence that, because of a combination of his physical condition and social and vocational factors, he is precluded from regular gainful employment. He has not sustained that burden of proof.

Claimant was evaluated by two vocational services providers. They found that he had numerous transferable skills and were able to identify certain jobs that would be suitable. Although some of the jobs required retraining, claimant has not expressed an interest in such.

A claimant's attitude toward returning to work may be relevant in determining whether the claimant "is excluded from employment by his or her own will rather than by that of employers." Wilson v. Weyerhaeuser, 30 Or App at 412. Here, the evidence from the vocational reports is that claimant is not motivated to return to work. His sporadic work history tends to support our conclusion that claimant lacks motivation to return to work. We conclude that claimant has not established that he is willing to seek regular, gainful employment, nor that it is futile to do so.

Accordingly, claimant has failed to establish his entitlement to an award of permanent total disability.

Extent of 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 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).

Considering claimant's mild to moderate permanent low back impairment, his age of 52 years, and his prior work experience in the auto parts field, along with the other relevant factors, we conclude that the January 11, 1988 Determination Order adequately and appropriately compensates claimant for his compensable injury.

Premature Closure

The Referee stated that SAIF has the burden of proving that claimant was medically stationary on a date earlier than that found by the Determination Order. SAIF argues that claimant has the burden on this issue. The Referee is

correct; the proponent of an earlier medically stationary date has the burden of persuasion. David L. Wall, 40 Van Natta 861 (1988).

Dr. Berselli released claimant to work on December 3, 1987, after prescribing physical therapy on November 19. We find that Dr. Berselli's prescription of further treatment indicates that he believed further material improvement might occur from that treatment. Thus, we find that claimant was medically stationary on December 3, 1987, the same date that the Determination Order found claimant medically stationary.

Rate of Temporary Total Disability

Former OAR 436-60-020(4) provides a method of computing temporary total disability for workers employed less than 4 weeks at the time of injury. The rule states that intent at time of hire, as confirmed by the employer and worker, controls. Claimant argued that the intent at the time of hire was for him to work 5 days per week, 8 hours per day. However, the employer disagreed and claimant never did work that many hours per week, during the less than four weeks before his injury. When there is a dispute as to intent at time of hire, the best evidence of intent is claimant's actual work history. Perry S. Seagrove, 38 Van Natta 1420 (1986).

Here, the record shows that claimant actually did work less than 40 hours per week. His work record is consistent with the employer's understanding of the terms of his employment. Thus, we find that the initial computation of temporary total disability was incorrect and should be calculated based on the agreed upon summary of claimant's actual work hours. Ex. 66-1.

Claimant's counsel is statutorily entitled to a reasonable, insurer-paid attorney fee for services rendered on Board review regarding SAIF's challenge to the medically stationary date. Such a fee is defined as an "assessed fee." See OAR 438-15-005(2). However, we cannot award an assessed fee to claimant for services on Board review 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 June 3, 1988 is affirmed in part and reversed in part. That portion of the Referee's order awarding permanent total disability is reversed. The January 11, 1988 Determination Order award of permanent partial disability is reinstated and affirmed. That portion of the order which found that claimant's temporary total disability benefits were to be based on employment of 40 hours per week is reversed and the SAIF Corporation is authorized to recalculate claimant's temporary total disability benefits based on the agreed upon summary of claimant's actual work hours. To the extent this recalculation results in an overpayment, and except for any temporary disability compensation paid pending this review, SAIF is authorized to offset the overpayment against any unpaid or future awards of permanent disability compensation. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
HUGH M. WILLIAMS, Claimant
WCB Case No. 87-19180
ORDER ON REVIEW
Pozzi, et al, Claimant Attorneys
Roberts, et al, Defense Attorneys

Reviewed by Board Members Gerner and Cushing.

The self-insured employer requests review of Referee G. Peterson's order that set aside its compensability denial of claimant's industrial injury claim for a heart condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

Claimant is a 52-year old corrections officer. On October 12, 1987, he and another officer physically restrained a combative inmate for approximately five minutes. Immediately thereafter, he felt slightly dizzy, began sweating, and experienced some abdominal pain. After resting a few minutes, his symptoms completely resolved and he felt "pretty good." Although he finished his shift, his symptoms briefly returned on two occasions without exertion and then completely resolved. Thereafter, he experienced a similar brief onset of symptoms nearly every day, with complete resolution after each episode.

On October 26, 1987, claimant was examined by Dr. Rich, M.D., for follow-up of sleep apnea and narcolepsy conditions. He complained of general nausea and chest pain, which appeared at night during rest. Shortly thereafter, Dr. Shepherd, M.D., began to treat claimant's heart complaints. Diagnostic studies revealed coronary atherosclerotic heart disease with a recent myocardial infarction. As a result, claimant underwent a coronary bypass operation in November, 1987.

Prior to the hearing, Dr. Rogers, a cardiologist, reviewed claimant's medical file. Rogers' testified at the hearing as an expert witness called by claimant.

CONCLUSIONS OF LAW

A worker must prove that the work incident was both the legal and medical cause of his heart condition. Bush v. SAIF, 68 Or App 230, 232 (1984). Complex medical causation cases are largely resolved by the weight of the expert medical opinion. See Uris v. Compensation Dept., 247 Or 420 (1967).

Here, the expert medical opinions are divided between Shepherd and Rogers. Shepherd examined and treated claimant on several occasions. On October 31, 1987, he performed an angiogram. Following claimant's surgeries in November, 1987, he continued to monitor claimant's recovery. After doing so, he opined that the incident of October 12, 1987, was not a material contributing cause of claimant's myocardial infarction. Rogers, on the other hand, testified to the contrary. In Rogers' view, claimant's myocardial infarction was caused by the physical and emotional stress of the October 12, 1987, incident. Key to his opinion was his understanding that claimant suffered continuous symptoms after October 12, 1987, and before his myocardial infarction.

We are not persuaded by Rogers' opinion. First, there is little persuasive evidence of either physical or emotional stress surrounding the incident of October 12, 1987. The incident involved a handcuffed inmate. Claimant was assisted by another corrections officer, who frisked the inmate. The entire event lasted no more than a few minutes. After experiencing some minor dizzi

ness and sweating, claimant felt "pretty good" and quickly returned to work. Second, claimant experienced only intermittent and brief episodes of dizziness and sweating thereafter. Last, Rogers never observed or examined claimant. His entire opinion is based on a brief review of certain medical records that were furnished to him by claimant's attorney shortly before the hearing.

In sum, we are persuaded by the opinion of treating doctor Shepherd, over that of Rogers. See Weiland v. SAIF, 63 Or App 810, 814 (1984). Claimant has not proven, by a preponderance of the evidence, that his heart condition was materially caused by the incident of October 12, 1987.

ORDER

The Referee's order, dated March 7, 1988, is reversed. The employer's denial is reinstated and upheld. The Board approves a client-paid fee, payable from the employer to its attorney, not to exceed $1,296.

January 25, 1990 Cite as 42 Van Natta 181 (1990)

In the Matter of the Compensation of
RANDALL P. ADAMS, Claimant
WCB Case Nos. 88-08615 & 88-07914
ORDER OF ABATEMENT
Wilbur C. Smith, Jr., Claimant Attorney
Randolph Harris (Saif), Defense Attorney

The Board issued an Order on Review in the above-captioned matter on January 11, 1990. Claimant now requests that the Board rescind its order on the ground that the SAIF Corporation has withdrawn its request for review.

In order to allow sufficient time to consider claimant's request, the January 11, 1990 order is abated and withdrawn. SAIF is requested to file a response to the motion within ten days. Thereafter, this matter shall be taken under advisement.

IT IS SO ORDERED.

January 25, 1990 Cite as 42 Van Natta 181 (1990)

In the Matter of the Compensation of
DALE R. GREENEP, Claimant
WCB Case No. 87-16042 & 87-16041
ORDER ON REVIEW
Eichsteadt, et al, Claimant Attorneys
Scheminske & Lyons, Defense Attorneys
Roberts, et al, Defense Attorneys
Schwabe, et al, Defense Attorneys

Reviewed by Board Members Myers and Gerner.

Liberty Northwest, as insurer for General Foods Corporation, requests review of Referee Hayduke's order, which found it responsible for claimant's low back condition.

ISSUES

The issue is whether Liberty Northwest as insurer for General Foods (hereafter referred to as General Foods) or Liberty Northwest as insurer for

Agripac (hereafter referred to as Agripac) is responsible for claimant's low back condition.

General Foods contends that the later employment with Agripac independently contributed to claimant's low back condition.

Agripac contends that current ORS 656.307 rather than former ORS 656.307 applies to this case; consequently, it argues that the Board's review is limited to determining whether the Referee committed any errors of law.

FINDINGS OF FACT

Claimant filed a claim, on July 31, 1986, for a pulled muscle in his low back. General Foods accepted the claim.

On July 10, 1987, while working for Agripac, claimant injured his low back while lifting 40 pound boxes. General Foods denied that the injury at Agripac constituted an aggravation of its July, 1986, accepted injury. Agripac denied that claimant had sustained a new injury. The Workers' Compensation Division issued an order under former ORS 656.307 on November 4, 1987. The Hearings Division received that order on November 5, 1987. The hearing took place on January 28, 1988.

The incident at Agripac constitutes a new and distinct injury to claimant's low back. The incident at Agripac independently contributed to a worsening of claimant's low back condition.

CONCLUSIONS AND OPINION

Agripac argues that current ORS 656.307 applies to this case because the hearing took place after January 1, 1988 when that statute became effective. We have previously held that the significant date for determining which version of ORS 656.307 applies is the date the Hearings Division received the ".307" order, not the date of hearing. Timothy R. Schroeder, 41 Van Natta 568, 570 (1989). The Hearings Division received the ".307" order before the effective date of current ORS 656.307. Consequently, we conclude that former ORS 656.307 applies to this case.

Responsibility for claimant's low back condition shifts from General Foods to Agripac if the incident at Agripac independently contributed to a worsening of claimant's low back condition. The Referee concluded that it did not. We disagree.

The medical evidence is overwhelming that the incident at Agripac independently contributed. Dr. Stevens saw claimant in August 1987. He characterized the incident with Agripac as a new injury. He also considers the two injuries as independent. Dr. Asper also believes that the Agripac incident independently contributed.

The Referee acknowledged that the medical evidence supported a finding that the Agripac incident independently contributed; nonetheless, he concluded that it did not independently contribute because claimant's testimony seemed to be contrary. Although claimant's testimony is entitled to some weight, we view this as a complex medical question. Therefore, we accord more weight to the expert evidence. Accordingly, we conclude that the injury at Agripac independently contributed and hold Agripac responsible.

ORDER

The Referee's order, dated July 21, 1988, is reversed. The denial issued by Liberty Northwest, as insurer for Agripac, is set aside and Liberty Northwest is directed to process the claim according to law. The denial issued by Liberty Northwest, as insurer for General Foods, is reinstated and upheld. The Board approves a client-paid fee, not to exceed $478 to Liberty Northwest/Agripac's current attorney. The Board approves a client-paid fee, not to exceed $1,182, to Liberty Northwest/Agripac's former attorneys. The Board approves a client-paid fee, not to exceed $2,852.50 to Liberty Northwest/General Foods' attorneys.

January 25, 1990 Cite as 42 Van Natta 183 (1990)

In the Matter of the Compensation of
CURTIS R. KEYS, Claimant
WCB Case No. 88-04595 & 87-17677
ORDER ON REVIEW
Callahan, et al, Claimant Attorneys
Stafford J. Hazelett, Defense Attorney
Mitchell, et al, Defense Attorneys

Reviewed by Board Members Nichols and Crider.

Liberty Northwest Insurance Corporation requests review of those portions of Referee Seymour's order which: (1) set aside its denial of claimant's hand, bilateral elbow and right shoulder conditions; and (2) upheld Mission Insurance Company's denial of the same conditions. On review, the issue is responsibility. We affirm.

FINDINGS OF FACT AND ULTIMATE FACT

Claimant worked as a truck driver for JB Sod and its successor, JB Express, for fifteen years, hauling agricultural products. His duties for the employer included driving, tarping trucks and throwing binders and straps over trucks.

As of May, 1983, and until June 30, 1985, the employer was insured by Mission. Thereafter, the employer was insured by Liberty Northwest.

Claimant was compensably injured in May, 1983, while working for Mission's insured. He suffered a left hip fracture and left elbow injury. Surgery was required. Mission accepted the claim for injury to the left hip and elbow. The claim was closed by Determination Order in January, 1984, awarding claimant temporary disability only. Claimant requested a hearing.

In December, 1983, claimant sought and received medical treatment from Dr. Shaw, orthopedic surgeon, for right shoulder and right elbow pain. On December 19, 1983, Mission denied compensability of claimant's shoulder and right arm conditions. Mission asserted in its denial that the condition was not related to claimant's 1983 industrial injury and indicated that it had in its possession documentation which established that claimant's right shoulder complaints commenced in June, 1980. Claimant requested a hearing.

Claimant continued to treat with Drs. Shaw, Mayhall and Boyd for the right shoulder and elbow conditions, through early 1984. This treatment was for bursitis and osteomyelitis (bone infection) of the shoulder and degenerative joint disease in the elbow. He was hospitalized for the treatment in 1983. The condition limited claimant's ability to move the shoulder. Claimant sought no treatment from 1985 through January, 1987 although the shoulder pain persisted.

In August, 1984, claimant was awarded 42.67 percent scheduled permanent disability for his left leg by stipulation. The stipulation allowed the denial of the shoulder and right arm conditions to stand. The requests for hearing were dismissed.

Claimant's shoulder pain and disability increased noticeably in mid-1986. In January, 1987, claimant sought medical treatment from Dr. Stevens, M.D., for bilateral elbow and right shoulder pain. On examination, bilateral carpal tunnel syndrome was also identified. By March 8, 1988, claimant was no longer able to perform his truck driving job due to the shoulder condition.

Claimant suffers from bilateral carpal tunnel syndrome. The syndrome is related to his work as a truck driver. The condition has not interfered with claimant's ability to work. However, he first sought treatment for the condition in 1987, while Liberty Northwest was on the risk.

Claimant has suffered from bilateral radial extensor tendinitis in both elbows since at least 1979. His work as a truck driver has worsened the tendinitis condition. Work activities while Liberty Northwest was on the risk have independently contributed to a worsening of the tendinitis condition.

Claimant suffers from a right shoulder condition of primarily infectious origin. The increased symptoms of the condition as well as claimant's increased shoulder disability are related to his truck driving activities.

In January, 1988, claimant filed an occupational disease claim for his bilateral hand, elbow, and shoulder conditions. On March 10, 1988, Mission denied responsibility for the conditions and requested the designation of a paying agent pursuant to ORS 656.307. On March 28, 1988, Liberty Northwest denied responsibility for the same conditions.

The insurers conceded compensability; and, in May, 1988, a .307 order issued designating Liberty Northwest as paying agent. Mission's weekly temporary total disability payment was $355.04, while Liberty Northwest's weekly temporary total disability payment was $288.13.

CONCLUSIONS OF LAW

The Referee set aside Liberty Northwest's denial and upheld Mission's denial of claimant's hand, elbow and shoulder conditions. We agree with the Referee's order, but for different reasons than articulated by the Referee.

By entering into a .307 order, the carriers conceded compensability of claimant's hand, elbow and shoulder conditions. Therefore, the only remaining issue is responsibility.

Mission accepted responsibility for a prior injury to claimant's left elbow. Consequently, responsibility initially rests with Mission. But it can transfer responsibility to Liberty Northwest if claimant's later employment independently contributed to a worsening of the condition. Hensel Phelps Const. v. Mirich, 81 Or App 290 (1986).

Responsibility for claimant's right elbow, right shoulder and bilateral carpal tunnel conditions is initially assigned to the last employment which, at the time of the onset of disability, could have contributed to those conditions. Bracke v. Baza'r, Inc., 293 Or 239, 246 (1982). See also Boise Cascade Corp. v. Starbuck, 296 Or 238, 243 (1984). The carrier at risk during that employment can then shift responsibility to an earlier insurer by demonstrating that conditions at the earlier employment were the

sole cause of the condition, or that it was impossible for conditions at the later employment to have caused the condition. See FMC Corp. v. Liberty Mutual Insurance Co., 70 Or App 370 (1984), modified 73 Or App 223 (1985). The date of disability is the date upon which the claimant is disabled by the condition, or, if not disabled, first receives medical services for his medical condition. Bracke, supra at 248 & n.4; United Pacific Insurance Co. v. Harris, 63 Or App 256,260, rev den 295 Or 730 (1983).

In the present case, claimant's bilateral carpal tunnel syndrome became disabling in January, 1987, when claimant sought and obtained medical treatment for his hands from Dr. Stevens. Therefore, Liberty Northwest was on the risk at the time of disability. Dr. Stevens has related the development of the carpal tunnel syndrome to repetitive work and indicated that claimant's work activity while Liberty Northwest was on the risk was capable of causing the condition. Inasmuch as Dr. Stevens does not distinguish between work activity before and after Liberty Northwest came on the risk, we are unable to find that work activity before that time was the sole cause of the disability. Nor are we persuaded that the employment with Liberty Northwest did not contribute to the condition. Therefore, responsibility must be assigned to Liberty Northwest.

Dr. Stevens reported that claimant suffered from radial extensor tendinitis in both elbows, noting that a "particular diagnosis is not directly related to the 11 May, 1983 injury, but is related to continued, hard heavy work with the upper extremities, lifting tarps, etc., i.e., either in the form of aggravation or worsening." The elbow tendinitis condition was first noted and treated prior to the 1983 injury.

We first analyze the right elbow condition. We are unable to determine whether or not it ever interfered with claimant's ability to work. Nevertheless, it continued to worsen throughout his truck driving employment and worsened as a consequence of that employment. Therefore, we find, based on Dr. Stevens' testimony by deposition, that even if claimant's right elbow tendinitis condition became disabling before Liberty Northwest came on the risk the condition has worsened since that time. Accordingly, Liberty Northwest is responsible for the condition.

We turn to the left elbow condition. Inasmuch as Dr. Stevens did not distinguish between work activities before and after Liberty Northwest came on the risk, and inasmuch as those work activities were virtually identical, we find that work activities while Liberty Northwest was on the risk independently contributed to a worsening of claimant's elbow condition. Accordingly, Liberty Northwest is responsible for the left elbow tendinitis.

Finally, claimant suffers from a longstanding, disabling right shoulder condition. It caused him to miss work in December, 1983. A right shoulder condition was denied by Mission in 1983. Inasmuch as the parties have conceded the compensability of the current right shoulder condition, we conclude that they have necessarily conceded that: the current right shoulder condition is different from the condition as it stood in 1983; and that the current condition is related to claimant's work activities. The shoulder condition did become increasingly disabling until claimant sought medical services, after a lengthy period without treatment, in January, 1987. By March 8, 1988, claimant was no longer able to work as a truck driver; and he was taken off work by Dr. Stevens due to the right shoulder condition. Therefore, we conclude that claimant became disabled due to his current right shoulder condition while Liberty Northwest was on the risk, and that this employment could have contributed to the condition. Liberty Northwest has not established that work activities while Mission was on the

risk were the sole cause of the disability. Nor has Liberty Northwest established that conditions while it was on the risk did not contribute to the condition. Therefore, Liberty Northwest is responsible for the shoulder condition. FMC Corp. v. Liberty Mutual Ins. Co., supra.

Attorney Fees

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).

Mission's weekly temporary total disability rate is approximately $70 more than that of Liberty Northwest. The amount of claimant's compensation was not at risk on Board review because the party that sought Board review, Liberty Northwest, had the lower temporary disability rate. Had it prevailed in establishing that Mission was responsible, claimant's compensation would have been increased, not decreased. Under these circumstances, claimant's attorney is not entitled to a carrier-paid fee for services on Board review.

ORDER

The Referee's order, dated July 13, 1988, is affirmed. A client-paid fee, not to exceed $1,224, payable from Mission Insurance Company to its counsel, is approved.

In the Matter of the Compensation of
RAY J. LANZ, Claimant
Own Motion No. 86-0506M
OWN MOTION ORDER ON RECONSIDERATION
Emmons, et al, Claimant Attorneys
Saif Legal, Defense Attorney

Claimant has requested reconsideration of our December 12, 1989, Own Motion Determination that granted him additional awards of temporary total and permanent partial disability benefits. Claimant specifically requested that this matter be referred for a fact-finding hearing regarding the extent of his permanent physical impairment due to the compensable injury. In order to allow sufficient time to consider claimant's motion, we abated and withdrew our determination order on January 9, 1990.

Our determination of the extent of claimant's permanent disability was based in part on eyewitnesses' statements submitted by the SAIF Corporation concerning claimant's recent physical activities. Claimant now contends that he should be afforded an opportunity to cross-examine those eyewitnesses and to present witnesses of his own. We disagree. SAIF apparently sent claimant a copy of the eyewitnesses' statements in late November, 1989. Thereafter, claimant had at least two weeks until issuance of our determination in which to submit an affidavit specifically responding to the eyewitnesses' statements and/or request referral for a hearing, yet he failed to do either. Claimant has offered no explanation for his apparent lack of diligence. Under these circumstances, we conclude that the record was sufficiently developed for our determination and deny claimant's request for referral to hearing.

On reconsideration, we adhere to and republish our December 12, 1989, order. The parties' rights of appeal and reconsideration shall run from the date of this order

IT IS SO ORDERED.

January 25, 1990 Cite as 42 Van Natta 187 (1990)

In the Matter of the Compensation of
AUDREY L. YAKES, Claimant
Own Motion No. 89-0503M
OWN MOTION ORDER
Doblie & Associates, Claimant Attorneys
Roberts, et al, Defense Attorneys

The insurer has submitted to the Board claimant's claim for an alleged worsening of her February 14, 1980 industrial injury. Claimant's aggravation rights have expired. The insurer has accepted responsibility for the claimant's condition. However, it opposes reopening of her claim for payment of temporary total disability benefits, contending that claimant has removed herself from the work force.

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

Nevertheless, claimant is not entitled to additional temporary total disability compensation unless the worsening has resulted in lost wages. Cutright v. Weyerhaeuser Company, 229 Or 290 (1985). Claimant contends that, at the time of her worsening, she was a member of the work force because she was a foster parent for the Oregon Children's Services Division (CSD). We disagree. Foster parenting is not wage-earning employment. Although claimant received payments from CSD, those payments do not represent compensation for services rendered by claimant under a contract of hiring. Rather, they are maintenance payments provided solely for the care and support of the foster children. We conclude, therefore, that claimant was not receiving wages. See ORS 656.005(26). Because there is no evidence that claimant was working or making reasonable efforts to find work at the time of her worsening, we find that claimant has withdrawn from the work force and did not lose any wages due to the worsening. See Dawkins v. Pacific Motor Trucking, 308 Or 254, 258 (1989). We deny claimant's request for own motion relief.

Entitlement to medical expenses pursuant to ORS 656.245 is not affected by this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
HAMID R. AMINI, Claimant
WCB Case No. 89-06149
ORDER DENYING MOTION TO DISMISS
Goldberg, et al., Claimant Attorneys
William Hoelscher, Attorney
Mark Braverman (Saif), Defense Attorney

Claimant has moved the Board for an order dismissing the alleged employer's request for review of a Referee's order which: (1) found that claimant was a subject worker; and (2) set aside a denial of claimant's injury claim, issued on the employer's behalf by its insurer, the SAIF Corporation. Noting that SAIF has withdrawn its request for review and accepted the claim, claimant seeks dismissal of the employer's separate request for review. We conclude that we have jurisdiction to consider the employer's request for review and deny the motion to dismiss.

FINDINGS OF FACT

In March 1989 claimant submitted a hearing request concerning SAIF's February 1989 denial of his injury claim. SAIF had issued the denial on behalf of its insured, the employer. At hearing, claimant, SAIF, and the alleged employer were each represented by counsel. The issue primarily concerned whether claimant was an independent contractor or a subject worker.

On October 2, 1989, the Referee issued an Opinion and Order, finding that claimant was a subject worker. Consequently, SAIF's denial was set aside and the claim was remanded to SAIF for processing.

On October 6, 1989, the Board received the alleged employer's request for review of the Referee's order. The request included a certificate of personal service by mail upon claimant and SAIF. On October 23, 1989, the Board received SAIF's request for review of the Referee's order. That request also included a certificate of personal service by mail upon claimant and the employer.

A transcript was obtained and a briefing schedule established. Following an extension of the schedule, the employer submitted its appellant's brief. Thereafter, claimant moved for dismissal, enclosing a copy of a December 21, 1989 letter from SAIF's counsel to the Board. The letter indicated that SAIF was withdrawing its request for review.

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 alleged employer's request for review was received by the Board and copies of the request were mailed to the parties each within 30 days of the Referee's order. Thus, we have jurisdiction to consider this case. See ORS 656.289(3); 656.295(2).

Claimant seeks dismissal of the employer's request, asserting that SAIF's withdrawal of its request for review renders the employer's request "moot." We disagree with claimant's contention.

The employer is a party to this proceeding. See ORS 656.005(19). Because the employer timely requested Board review, the Referee's order has not become final. ORS 656.289(3). Furthermore, after conducting our review, we are authorized to affirm, reverse, modify or supplement the Referee's order, as well as make such disposition of the case as we determine to be appropriate. ORS 656.295(6). Thus, despite the withdrawal of SAIF's request for review, the issue of whether claimant was a subject worker remains viable.

Claimant asserts that to permit review under these circumstances simultaneously places this claim "in both an accepted and denied status." Again, we disagree.

We disagree with claimant's characterization of SAIF's withdrawal of its request for review as "acceptance of the claim", particularly when SAIF is aware that another party's timely request for review concerning the Referee's order remains pending on the compensability issue.

Moreover, pursuant to the Referee's order and in accordance with its statutory obligations, SAIF is required to process the claim and provide compensation. See ORS 656.313(1). Yet, at the same time, as a party to the proceeding, the employer is availing itself of its statutory right to request review of the Referee's order. ORS 656.289(3); 656.295(6).

The fact that subsequent actions have been lawfully taken in response to an appealed Referee's order does not resolve the question of whether the conclusions reached in that order were appropriate in the first instance. Instead, in accordance with a party's timely request for Board review, that question remains subject to our jurisdiction. See ORS 656.289(3), 656.295(6).

Accordingly, the motion to dismiss is denied. As a result of this order, it will be necessary to revise the briefing schedule. Claimant's respondent's brief shall be due 14 days from the date of this order. The employer's reply brief shall be due seven days from the date of mailing of claimant's brief. Thereafter, the case will be docketed for review.

IT IS SO ORDERED.

January 26, 1990 Cite as 42 Van Natta 189 (1990)

In the Matter of the Compensation of
MARK V. ANDERSON, Claimant, and
In the Matter of the Complying Status of
Ernest Perasso, a Noncomplying Employer
WCB Case Nos. 88-02539 & 88-02538
ORDER ON REVIEW
Gerald C. Doblie, Claimant Attorney
Norman Cole (Saif), Defense Attorney
Carl M. Davis, Assistant Attorney General

Reviewed by Board Members Nichols and Brittingham.

The noncomplying employer requests review of Referee Menashe's order which affirmed a Proposed and Final Order of non compliance and declined to address the issue of the compensability of claimant's injury claim on the merits. On

review the issues are subjectivity and compensability. We agree that the employer is noncomplying, but conclude that the compensability issue should be addressed.

We adopt the findings of the Referee.

We adopt the conclusions of the Referee with the following supplementation. The Referee refused to address compensability of claimant's claim, on the merits relying on Derryberry v. Dokey, 91 Or App 533 (1988), which held that claimant was entitled to compensation because the noncomplying employer had not properly denied a claim which the SAIF Corporation had accepted. Those facts are the same in the instant matter. However, the court has since issued Clark v. Linn, 98 Or App 393 (1989), which held that a noncomplying employer could request a hearing on SAIF's acceptance of a claim if it contested compensability.

In this matter the Referee took evidence on the issue of compensability and made an advisory finding that claimant was credible and that he had sustained a compensable injury while working for this noncomplying employer. We agree.

ORDER

The Referee's order dated July 22, 1988 is affirmed, as supplemented herein. The SAIF Corporation's acceptance of the claim is upheld.

January 26, 1990 Cite as 42 Van Natta 190 (1990)

In the Matter of the Compensation of
JAMES A. GREEN, Claimant
WCB Case Nos. 86-12037, 87-12369, 87-12370 & 87-13402
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
David Smith (Saif), Defense Attorney
Beers, et al., Defense Attorneys
Kevin Mannix, Defense Attorney

Reviewed by Board Members Howell and Perry.

United Pacific Insurance Company requests review of Referee Neal's order that set aside its denial of responsibility for claimant's upper back condition. The issue is responsibility.

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

This is a case in which a compensable condition with one insurer was followed by a period of increased disability while a subsequent insurer was at risk. The burden of proving a shift of responsibility was on EBI Companies, the insurer on the risk at the time of claimant's original injury. Linda L. Wise, 42 Van Natta 115 (1990). The Referee correctly found that claimant's subsequent work activity had worsened his underlying condition and assigned responsibility to United Pacific on that basis.

ORDER

The Referee's order dated April 21, 1988 is affirmed. A client-paid fee, payable from United Pacific to its counsel, is approved, not to exceed $1,400.

In the Matter of the Compensation of
JEFFREY A. GUILD, Claimant
WCB Case No. 87-08712
ORDER ON REVIEW
Coons & Cole, Claimant Attorneys
Karen M. Werner, Attorney
Brian L. Pocock, Defense Attorney
William J. Blitz (Saif), Defense Attorney

Reviewed by Board Members Howell and Perry.

The SAIF Corporation requests review, and claimant cross-requests review, of Referee Huffman's order which: (1) increased claimant's unscheduled permanent disability award for a low back condition from 5 percent (16 degrees), as awarded by Determination Order, to 15 percent (48 degrees); (2) upheld SAIF's denial of claimant's medical services claim for a home Jacuzzi spa; (3) set aside SAIF's denial of claimant's medical services claims for prescription drugs; (4) assessed penalties and associated attorney fees for alleged unreasonable claims processing; and (5) awarded an attorney fee, to be paid by the employer to claimant's attorney, for prevailing against the employer's cross-request for hearing. The employer filed a brief on its own behalf on Board review. Claimant submitted a motion to dismiss the employer's request. The issues on review are dismissal, extent of unscheduled permanent disability, medical services and penalties and attorney fees. We affirm.

Claimant moved to dismiss all issues raised in the employer's brief because it had not filed a formal request for review. We have previously held that we have the authority to consider issues which are not raised via formal cross-requests for review. Kenneth Privatsky, 38 Van Natta 1015 (1986). Claimant's motion to dismiss is denied.

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" with the following comment.

When a claimant requests a hearing asking for an additional award of permanent disability compensation, and a carrier cross-requests a hearing seeking a reduction of the award, if claimant prevails against the cross-request for hearing, claimant is entitled to an assessed (insurer-paid) attorney fee. Our holding to the contrary in Frances Gentry, 40 Van Natta 1697 (1988) has been rejected by the Supreme Court. Kordon v. Mercer Industries, 308 Or 290 (1989).

ORDER

The Referee's order dated March 1, 1988 is affirmed. The Board approves a client-paid fee, not to exceed $372.50, payable by the employer to its outside counsel.

In the Matter of the Compensation of
GEORGE F. HOOVER, Claimant
WCB Case No. 89-10930
ORDER OF DISMISSAL
Malagon, et al, Claimant Attorneys
Dennis Ulsted (Saif), Defense Attorney

Reviewed by Board Members Brittingham and Nichols.

Claimant has requested Board review of an October 10, 1989 Stipulation and Order. We have reviewed the request to determine whether we have jurisdiction to consider the matter. Because we conclude that we lack jurisdiction, the request is dismissed.

FINDINGS

The Stipulation and Order was issued October 10, 1989. On December 29, 1989, the Board received claimant's letter. Claimant stated that he was "request[ing] a hearing concerning the Order of Dismissal."

On January 10, 1990, the Board mailed a computer-generated letter to the parties acknowledging a request for review.

ULTIMATE FINDINGS

Claimant did not request Board review of the Referee's stipulated order.

CONCLUSIONS

A request for review by the Board of a Referee's order need only state that the party requests a review of the order. ORS 656.295(1). While no "magic words" are required for compliance, the statute contemplates a modicum of information sufficient to clearly identify a document as a party's request for Board review of a Referee's order. Gerardo V. Soto, Jr., 35 Van Natta 1801, 1803 (1983). Where a party has not expressly requested Board review, but their intention to do so is both clear and unmistakable, we have concluded that we have jurisdiction pursuant to ORS 656.295. See Rochelle M. Gordon, 40 Van Natta 1808 (1988).

Here, claimant did not expressly request Board review of the Referee's stipulated order. Indeed, his intentions seem clear and unmistakable, i.e., he was requesting a hearing concerning the dismissal order.

Under such circumstances, we conclude that claimant did not request Board review of the Referee's stipulated order. Rather, he requested a hearing. Accordingly, the request for review is dismissed.

Even assuming that claimant requested Board review, he did so more than 30 days after the order. Therefore, it is untimely. ORS 656.289(3).

In reaching this conclusion, we note that claimant's letter has also been processed as a request for hearing. The matter remains pending before the Hearings Division and is undisturbed by this order. WCB Case No. 90-00316.

IT IS SO ORDERED.

In the Matter of the Compensation of
JAMES M. SWANSON (Deceased), Claimant
WCB Case No. TP-89032
THIRD PARTY DISTRIBUTION ORDER
Charles J. Merten, Claimant Attorney
James E. Griffin, Assistant Attorney General

The SAIF Corporation, as a paying agency, has petitioned the Board for resolution of a conflict concerning the "just and proper" distribution of proceeds from a third party settlement. See ORS 656.593(3). Specifically, the dispute concerns SAIF's asserted lien against the surviving spouse's share of the deceased worker's third party settlement. We conclude that SAIF has established its entitlement to the remaining balance of the surviving spouse's share of the settlement proceeds.

FINDINGS OF FACT

We adopt the findings of fact as set forth in our July 5, 1988 Third Party Order of Dismissal. James M. Swanson, (Deceased), 40 Van Natta 780 (1988). At the parties' request, the record as developed in the prior case has been considered in this review. We make the following supplemental findings of fact.

At the time of its initial petition for relief, SAIF requested that we find that its lien applied to the remaining balance of settlement proceeds from the decedent's wrongful death lawsuit before the proceeds had been distributed to the decedent's heirs, some of whom were not "beneficiaries" under the Workers' Compensation Law. In response, the surviving spouse (claimant), in her capacity as Personal Representative for the estate, moved for dismissal of the petition, contending that SAIF was barred from seeking further relief because the Circuit Court for Umatilla County had already decreed that SAIF's lien would only attach to the surviving spouse's share of the settlement proceeds ($43,030.52). Reasoning that the court had already addressed and resolved the identical issue, we dismissed SAIF's petition.

SAIF appealed our dismissal order. Thereafter, SAIF withdrew its appeal of the circuit court's order, as well as our dismissal order. When SAIF sought a portion of the surviving spouse's share of the settlement proceeds, she declined.

SAIF asserts a "third party" lien of $49,730.12, which is composed of actual incurred medical and death benefits. Noting that its lien would exceed its share of the remaining balance of the surviving spouse's portion of the settlement proceeds after deduction of the spouse's statutory 1/3 share, SAIF seeks recovery of that remaining balance, i.e., $28,687.01. Claimant does not contest the amount of SAIF's asserted lien or its projection of the remaining balance. Instead, she argues that SAIF is precluded from bringing its petition by virtue of our prior dismissal order.

FINDINGS OF ULTIMATE FACT

Reimbursement of the remaining balance of claimant's share of the third party settlement proceeds to SAIF is "just and proper."

CONCLUSIONS OF LAW

If a worker receives a compensable injury in the course of employment due to the negligence or wrong of a third person, entitling the worker under ORS 656.154 to seek a remedy against such third person, such worker or, if

death results from the injury, the other beneficiaries shall elect whether to recover damages from such third person. ORS 656.578. The proceeds of any damages recovered from a third person by the worker or beneficiaries shall be subject to a lien of the paying agency for its share of the proceeds. ORS 656.593. The paying agency's lien applies only to those portions of a third party recovery which pertain to the shares allotted to the worker or beneficiaries. Scarino v. SAIF, 91 Or App 350 (1988).

If the worker or beneficiaries settle 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 or beneficiaries receive at least the amount to which he or they are 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). ORS 656.593(1) provides in exact detail how, and in what order, the proceeds of any damages shall be distributed.

Pursuant to ORS 656.593(1)(a), costs and attorney fees incurred shall be initially disbursed. Then, the worker or beneficiaries shall receive at least 33-1/3 percent of the balance of the recovery. ORS 656.593(1)(b). The paying agency shall be paid and retain the balance of the recovery to the extent it is compensated for its expenditures for compensation, first aid or other medical, surgical or hospital service, and for the present value of its reasonably to be expected future expenditures for compensation and other costs of the worker's claim under ORS 656.001 to 656.794. See ORS 656.593(1)(c).

Here, claimant contends that our prior dismissal of SAIF's petition precludes it from bringing the current request for relief. Specifically, she argues that the withdrawal of SAIF's appeal of our dismissal order and the probate court order results in the waiver of its right to assert a lien against her share of the settlement as surviving spouse. We disagree.

The issue presented to us for resolution in SAIF's prior petition was its contention that its "third party" lien extended to the settlement proceeds prior to their distribution to the decedent's heirs, some of whom were not "beneficiaries" under the Workers' Compensation Law. In response, claimant moved for dismissal of the petition, contending that the determination of this allocation question had already been addressed and resolved by the probate court. Specifically, claimant argued that:

> "Thus, SAIF's petition is premature and there is no subject matter jurisdiction because, as of yet, no Chapter 656 beneficiary has received any damages from any third party. The Personal Representative, who is not a Chapter 656 beneficiary, has received such damages and has a fiduciary obligation to hold such funds until apportionment by the probate court."

We agreed with claimant's argument, reasoning that the probate court decree was conclusive regarding the dispute between the parties and that we were obligated to honor it. Consequently, SAIF's petition was dismissed.

Claimant submits that our previous dismissal order precludes SAIF from its current attempt to recover its lien from her portion of the settlement. Asserting that SAIF has already had a full and fair opportunity to litigate its right to a portion of the entire settlement proceeds, claimant contends that SAIF should not be permitted to reassert its lien against a reduced portion of the settlement at this time.

We disagree with claimant's arguments in several respects. To begin, as claimant noted in her response to SAIF's initial petition for relief, the party to that proceeding was the estate of the deceased worker. To be sure, claimant participated in the prior proceeding. However, her participation was as the personal representative for the estate, not as a party in her own individual capacity. Inasmuch as the prior proceeding did not involve the same parties, we do not agree that SAIF is now precluded from seeking reimbursement from claimant.

Moreover, as previously discussed, the prior proceeding pertained to the issue of whether SAIF was entitled to assert its lien against the settlement proceeds attributable to the estate of the deceased worker before distribution to the decedent's heirs. This issue was pivotal because several of the heirs were not "beneficiaries" under the Workers' Compensation Law and, as such, their eventual shares of the proceeds would not be subject to SAIF's third party lien. At no time during this proceeding was there a dispute regarding whether SAIF's lien applied to claimant's eventual share of the settlement as the surviving spouse. Rather, the dispute involved the question of whether the lien, in effect, reduced the shares of the "non-beneficiaries."

Because claimant did not contest the fact that SAIF was entitled to her eventual share of the settlement, that question was not ripe for litigation during the prior proceeding. Since this issue only materialized after our dismissal order, SAIF is not barred from seeking resolution of this dispute at this time.

Inasmuch as SAIF is not precluded from seeking recovery of its lien against the remaining balance of claimant's share of the third party settlement, we proceed to a determination of a "just and proper" distribution. ORS 656.593(3). As previously noted, claimant neither objects to the amount of SAIF's asserted lien nor to SAIF's contention that its lien exceeds the remaining balance from claimant's share of the settlement proceeds. Under such circumstances, we conclude that SAIF's recovery of the remaining balance, $28,687.01, would be "just and proper." ORS 656.593(3).

Accordingly, claimant is directed to distribute $28,687.01 to the SAIF Corporation as its "just and proper" share of the third party settlement.

IT IS SO ORDERED.

In the Matter of the Compensation of
MARK A. WIITALA, Claimant
WCB Case No. 88-12436
ORDER ON REVIEW (REMANDING)
Merrill Schneider & Associates, Claimant Attorneys
Roberts, et al, Defense Attorneys

Reviewed by Board Members Cushing and Myers.

Claimant requests review of Referee Leahy's order which dismissed claimant's request for hearing for failure to appear. On review the issue is whether the Referee should have dismissed the request for hearing. We remand.

FINDINGS OF FACT

Claimant requested a hearing on July 20, 1988. Hearing was scheduled for August 18, 1988. Claimant did not appear at hearing; however, his attorney and the insurer's attorney did appear at hearing. Claimant's attorney represented at hearing that claimant had moved since filing his request for hearing, that he had not received the notice of hearing, that claimant had only learned of the hearing on the day before the hearing and that claimant had not been able to get time off work to attend the hearing on that short notice. The Referee denied a motion to postpone and granted the insurer's motion to dismiss.

CONCLUSIONS AND OPINION

The Referee apparently relied on former OAR 438-06-071 which provides authority for a Referee to dismiss for failure to appear. This rule does not provide authority for dismissal for failure of a claimant to appear at hearing if claimant's attorney does appear at hearing. Williams v. SAIF, 99 Or App 367 (1989); Denette D. Dale, 41 Van Natta 2179 (1989). Accordingly, the Referee was without authority to dismiss.

The Referee was correct in first deciding claimant's motion to postpone. See Mark R. Luthy, 41 Van Natta 2132 (1989). We agree with the Referee that on the facts as represented by claimant's attorney, claimant failed to establish extraordinary circumstances which would justify a postponement under either former OAR 438-06-081 or former 438-13-035.[1] Claimant had provided an address to the hearings division and had not informed it of a change of address when he moved. He was aware of the hearing by the day before the hearing was scheduled. He did not appear because of his work schedule. Former OAR 438-06-081(2) provides that business conflicts are not sufficient to 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 to the Referee for a hearing. At hearing the Referee shall not allow claimant to testify, but otherwise may hear testimonial evidence. He shall make whatever evidentiary rulings are appropriate and shall decide the case without benefit of claimant's testimony. A client-paid fee, not to exceed $1,300, payable from the insurer to its counsel, is approved.

IT IS SO ORDERED.

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[1] In his brief, claimant's attorney refers to an affidavit which recites these same facts. No such affidavit is in this record. Nevertheless, because claimant's attorney represented similar facts to the Referee at hearing, we accept that representation for purposes of deciding the correctness of the Referee's ruling on the motion to postpone.

In the Matter of the Compensation of
RONALD J. COLE, Claimant
WCB Case No. 88-08293
ORDER ON REVIEW
Andrew H. Josephson, Claimant Attorney
Roberts, et al, Defense Attorneys

Reviewed by Board Members Myers and Gerner.

Claimant requests review of Referee Podnar's order which upheld the self-insured employer's denial of an industrial injury claim. On review, the issues are: (1) whether claimant established good cause for requesting a hearing more than 60 days after the denial; and (2) if so, 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.

The insurer's denial letter included appeal rights. In March 1988, claimant's chiropractor informed him that his bills were not being paid by the insurer. Claimant's request for hearing was not filed until May 18, 1988.

FINDINGS OF ULTIMATE FACT

Claimant's hearing request was not filed within 60 days of the denial. He did not have good cause for the delay in filing the request.

CONCLUSIONS OF LAW

The adopt the conclusions and reasoning as set forth in the "Conclusions" section of the Referee's order with the following supplementation.

Claimant had the responsibility to pursue his claim with due diligence. Here, claimant was told that in order for the denial to be reconsidered, he had to submit the questionnaire. Claimant was not advised that the denial would be rescinded or that he should not appeal the denial. Hence claimant had no reasonable basis for believing he did not have to appeal the denial. Furthermore, the denial letter contained a prominent description of his appeal rights as well as the limitations of those rights. Under these circumstances, claimant has not established good cause. See Leonard Trigg, 41 Van Natta 1264 (1989).

Assuming arguendo that claimant had a reasonable basis for believing that the denial would be rescinded, he did not exercise due diligence in filing his request for hearing. Claimant's chiropractor informed him that his bills were not being paid in March 1988. However, claimant waited until May 18, 1988 to file his hearing request. Assuming that March 1988 was the first time claimant realized that his claim was in denied status, claimant is not excused from waiting until May 18, 1988 to file his hearing request. See Cogswell v. SAIF, 74 Or App 234, 237 (1985).

ORDER

The Referee's order, dated August 31, 1988, is affirmed. A client-paid fee, not to exceed $1,022.50, payable from the self-insured employer to its counsel, is approved.

In the Matter of the Compensation of
ROBERT R. ESCOBAR, Claimant
WCB Case No. 88-07919
ORDER ON REVIEW
James D. Church, Claimant Attorney
Schwabe, et al, Defense Attorneys

Reviewed by Board Members Myers and Gerner.

The insurer requests review of that portion of Referee McGeorge's order which set aside its partial denial of claimant's mid-back condition. Claimant has moved the Board to dismiss the insurer's request for review on the grounds that the issue raised by the request has been rendered moot by events subsequent to the issuance of the Referee's order. On review, the issues are jurisdiction and compensability. We deny the motion and reverse.

FINDINGS OF FACT

On December 20, 1985, claimant suffered a compensable left shoulder and left ankle injury. His claim for those conditions was accepted on January 27, 1986.

On January 14, 1986, claimant received conservative treatment from Dr. Campbell, orthopedist, for "back, left shoulder and left leg pain." Campbell diagnosed "sprain cervical spine and left shoulder, contusion, left elbow."

Seven months later, in August, 1986, claimant received conservative treatment from Dr. Achterman, orthopedist, for a mid-back condition. Claimant sought no further medical treatment until May, 1987.

Claimant had ceased working for this insured in February, 1987.

On May 4, 1987, claimant returned to Achterman for "continuing midthoracic back pain." At that time, x-rays were taken and Achterman diagnosed "anterior wedging of midthoracic level at two or three levels," and treated claimant conservatively with anti-inflammatories.

In late May, 1987, claimant became employed with a tire company. In early June, 1987, claimant suffered a low back injury related to that work. Achterman treated claimant's low back condition, prescribing pain medication. He was released from work.

The insurer issued a partial denial on April 13, 1988 of claimant's mid- and low-back conditions, indicating that the conditions were not related to his October, 1985 industrial injury. Claimant requested a hearing on the denial.

CONCLUSIONS OF LAW

Preliminary Matter

The Referee set aside the insurer's denial of claimant's mid-back condition and remanded that portion of claimant's claim for processing. In compliance with the Referee's order, the insurer issued a form 1502, indicating that it was processing the claim for claimant's mid-back condition.

Claimant moves for dismissal of the insured's request for review, contending that the insurer's subsequent acceptance of claimant's mid-back condition bars the Board from reviewing the Referee's order. We deny the motion.

The Referee set aside the insurer's denial of claimant's mid-back claim and remanded the claim for processing. As a result, the insurer issued a form 1502, stating that the claim was "now accepted as nondisabling as no comp due, per opinion and order."

Claimant contends that the insurer's subsequent issuance of of a 1502 form for claimant's mid-back condition after the Referee's order directing it to process the claim constitutes an official acceptance. As such, claimant asserts that the Board lacks jurisdiction to consider the issue of compensability of claimant's mid-back condition. Claimant relies upon Bauman v. SAIF, 295 Or 788 (1983). We disagree.

Because the insurer timely requested Board review, the Referee's order has not become final. See ORS 656.289(3). After conducting our review, we are authorized to affirm, reverse, modify or supplement the Referee's order, as well as make such disposition of the case as we determine to be appropriate. ORS 656.295(4).

Despite its appeal, the insurer is required to comply with the Referee's order. ORS 656.313(1); Weyerhaeuser Company v. McCullough, 92 Or App 204 (1988); Theodore W. Lincicum, 40 Van Natta 1953 (1988), aff'd mem Aetna Casualty v. Lincicum, 100 Or App 261 (January 17, 1990). Thus, the subsequent actions taken in response to the Referee's directions to process the claim do not deprive the insurer the right to appeal. See Loren Callihan, 41 Van Natta 1449 (1989).

Furthermore, claimant's reliance on Bauman is misplaced. Bauman provides, that "if the insurer officially notifies claimant that the claim has been accepted, the insurer may not, after 60 days have elapsed, deny the compensability of the claim unless there is a showing of fraud, misrepresentation or other illegal activity. Bauman, supra, at 794. Here, claimant did receive notice of the 1502, accepting his mid-back condition. However, the issuance of a 1502 does not constitute official notice of acceptance. EBI v. CNA Insurance, 95 Or App 448 (1989). See also Knapp v. Weyerhaeuser, 93 Or App 670 (1988).

Therefore, the motion to dismiss is denied.

Compensability

The Referee set aside the insurer's partial denial of claimant's mid-back condition, reasoning that claimant had met his burden of proving that his mid-back symptoms are a result of his compensable injury of December 20, 1985. We disagree.

To establish the compensability of his mid-back condition, claimant has the burden of proving that the work incident 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).

Although lay testimony concerning causation is probative, it may not be persuasive when the claim involves a complex medical question. See Uris v. Compensation Department, 247 Or 420, 424 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985).

Considering that claimant has suffered two injuries involving his back and since his back complaints are chronic in nature, we conclude that the issue of

whether claimant's current mid-back condition is causally related to his December, 1985 injury is a complex medical question. Thus, although claimant's testimony that he has suffered mid-back pain since the 1985 incident is credible, resolution of this issue turns largely on an analysis of the medical evidence. Uris, supra; Kassahn, supra.

The medical record reflects that claimant did not complain of "mid back" pain, nor seek treatment for such a condition, until August, 1986, eight months after the initial injury. At that time, claimant reported to Dr. Achterman, orthopedist, that he suffered from mid-back pain, which he began to experience "over the last several months." Achterman noted that claimant's "symptoms are primarily the basis of chronic, mild muscular strain."

Claimant did not again complain or seek medical treatment for his mid-back condition until May 4, 1987, approximately nine months later. Achterman ordered x-rays and conservatively treated claimant with anti-inflammatories. Achterman noted that the x-rays were "normal", noted an "anterior wedging of midthoracic level at two or three levels", and concluded that claimant was medically stationary. He also concluded, after a comparison to x-rays taken a year prior, that claimant's back condition was unchanged. Achterman did not relate claimant's current mid-back condition to his December, 1985 injury.

In January, 1988, Achterman reported that in August, 1986, claimant "was complaining of pain involving his mid back. The x-ray changes in the mid portion of his thoracic spine were noted at that time. It is this area that is still giving the patient symptoms."

In March, 1988, claimant was evaluated, at the request of the insurer, by Dr. Hardiman, orthopedist and independent medical examiner. Based on a complete review of all of claimant's prior medical reports, and an independent examination, Hardiman reported that claimant "has residual symptoms in his mid back, but no physical findings to support them." He concluded that no further treatment was needed. Hardiman did not relate claimant's mid-back condition to his December, 1985 injury.

Finally, in April, 1988, Achterman, in response to Hardiman's evaluation, reported that claimant's mid-back condition was "specifically not related to his previous work injuries and is probably developmental in nature." This conclusion suggests that claimant's current complaints of mid-back pain overlap an ongoing chronic back condition which has been determined to be unrelated to his 1985 compensable injury.

As previously discussed, there is no medical evidence to support claimant's contention that his current mid-back condition is causally related to his 1985 injury. We conclude, therefore, that claimant has failed to meet his burden of proving that his 1985 work incident was a material contributing cause of his current mid-back condition.

ORDER

The Referee's order, dated August 23, 1988, is reversed. The insurer's denial of claimant's mid-back condition is reinstated and upheld. A client-paid fee, not to exceed $2,442, payable from the insurer to its counsel, is approved.

In the Matter of the Compensation
GARY D. EVERETT, Claimant
WCB Case No. 88-06351
ORDER ON REVIEW
Bottini, et al, Claimant Attorneys
Schwabe, et al, Defense Attorneys

Reviewed by Board Members Gerner and Myers.

Claimant requests review of those portions of Referee Mulder's order which: (1) found that claimant's low back injury claim was not prematurely closed; and (2) affirmed a Determination Order that awarded claimant 10 percent (32 degrees) unscheduled permanent disability for a low back injury. On review, the issues are premature closure and extent of unscheduled permanent disability. We reverse.

FINDINGS OF FACT

Claimant sustained a compensable low back injury in August 1987. Thereafter, he sought treatment from Dr. Noall, an orthopedist, who prescribed pain medication and physical therapy. In mid-February 1988, claimant underwent a work hardening evaluation. Claimant last treated with Dr. Noall on March 14, 1988. On April 8, 1988, claimant began treating with Dr. Johnson, chiropractor. Between March 14, 1988 and April 8, 1988, claimant's experienced the same pain symptoms he had prior to Dr. Noall's last treatment on the former date.

Claimant's claim was closed by a Determination Order dated April 12, 1988. The Determination Order awarded temporary disability benefits through March 14, 1988 as well as 10 percent unscheduled permanent disability.

FINDINGS OF ULTIMATE FACT

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

CONCLUSIONS OF LAW

The Referee found that claimant's claim had not been prematurely closed by the April 12, 1988, Determination Order. We disagree.

"Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). In determining whether a claim has been properly closed, a determination of whether claimant was medically stationary on the date of closure must be made, without considering subsequent changes in his or her condition. Sullivan v. Argonaut Ins. Co., 73 Or App 694 (1985). However, medical reports authored after closure may be considered where there has been no post-closure change in claimant's condition and the only question is whether claimant was stationary at the time of closure. Scheuning v. J.R. Simplot & Co., 84 Or App 622 (1987).

On March 14, 1988, Dr. Noall reported that claimant was markedly sore following the work-hardening evaluation. He further reported that claimant was medically stationary as it appeared that he had reached maximal improvement and needed no further treatment. Dr. Noall did not see claimant after March 14, 1988. On April 8, 1988, claimant was first seen by Dr. Johnson. In a July 5, 1988 letter, he reported that claimant had made substantial progress since April 8, 1988.

We conclude that claimant was not medically stationary at the time his claim was closed by Determination Order. Claimant's condition remained the same from the time he last saw Dr. Noall until the time he sought treatment from Dr. Johnson on April 8, 1988. Further, Dr. Johnson offered a new form of treatment with the purpose of improving claimant's low back condition. Johnson offered this treatment with a reasonable hope of further medical improvement. Under these circumstances, claimant's claim was prematurely closed. Scheuning, supra at 626.

As we have found claimant's claim to be prematurely closed, we do not reach the issue of extent of permanent disability.

ORDER

The Referee's order, dated August 11, 1988, is reversed. The Determination Order is set aside as premature and the claim is remanded to the self-insured employer for processing according to law. Claimant's attorney is awarded 25 percent of the increased compensation created by this order, not to exceed $3,800. A client-paid fee, not to exceed $1,216, is approved.

In the Matter of the Compensation of
ARTHUR M. JENSEN, Claimant
WCB Case Nos. 88-05343, 88-17696, 88-17697 & 88-19148
ORDER DENYING MOTION TO DISMISS
Rasmussen & Henry, Claimant Attorneys
Saif Legal, Defense Attorney
Beers, et al, Defense Attorneys

EBI Companies has moved for an order dismissing it as a party to this proceeding on the ground that claimant has only requested review of that portion of the Referee's order which pertained to the extent of his permanent disability attributable to his claim with the SAIF Corporation. The motion is denied.

FINDINGS

The Referee's order issued October 11, 1989. Pursuant to that order, SAIF's denial of claimant's medical services claim was set aside and EBI's denial was upheld. In addition, Determination Orders under the SAIF claim, which did not award permanent disability, were affirmed.

On November 9, 1989, claimant mailed, by certified mail, his request for Board review of the Referee's order. Copies of the request were mailed to all parties to the proceeding.

Following the implementation of the briefing schedule, claimant timely submitted his appellant's brief. Claimant contended that the Referee had erred in refusing to award permanent disability under the SAIF claim.

CONCLUSIONS

The request for review by the Board of a Referee's order need only state that the party requests a review of the order. ORS 656.295(1). The Board may affirm, reverse, modify or supplement the order of the Referee and make such disposition of the case as it determines to be appropriate. ORS 656.295(6).

In accordance with our de novo review authority, such actions may be taken notwithstanding a party's failure to raise an issue or the lack of a cross-request. See Destael v. Nicolai Co., 80 Or App 596 (1986); Kenneth Privatsky, 38 Van Natta 1015 (1986). Moreover, although a Referee's conclusions and opinions in consolidated cases may be separately stated, if the Referee's decisions are contained in one final order, we retain jurisdiction to consider all matters contained therein. William E. Wood, 40 Van Natta 999 (1988).

Here, EBI accurately notes that the only issue raised in claimant's appellant's brief is the Referee's refusal to award permanent disability under the SAIF claim. Yet, such circumstances do not justify the dismissal of EBI as a party to this proceeding. Inasmuch as the Referee's decisions regarding the other issues raised at hearing are contained in one final order and since that order has been timely appealed, we retain jurisdiction to consider all matters contained therein. Wood, supra.

Accordingly, the motion to dismiss is denied. As a result of this order it will be necessary to revise the briefing schedule. EBI has advised that it will not be filing a respondent's brief. Therefore, SAIF's respondent's brief shall be due 14 days from the date of this order. Claimant's reply shall be due 7 days from the date of mailing of SAIF's brief. If SAIF raises the responsibility issue in its brief, EBI shall be permitted to submit a reply brief, which will be due 7 days from the date of mailing of SAIF's brief. Thereafter, the case will be docketed for review.

IT IS SO ORDERED.

January 29, 1990 Cite as 42 Van Natta 203 (1990)

In the Matter of the Compensation of
DENISE A. LANTER, Claimant
WCB Case Nos. 88-01730 & 88-00953
ORDER ON REVIEW
Francesconi & Associates, Claimant Attorneys
Mitchell, et al, Defense Attorneys
Roberts, et al, Defense Attorneys

Reviewed by Board Members Gerner and Myers.

Crawford & Company requests review of that portion of Referee Shebley's order that set aside its denial of claimant's claim for hives and a depressive disorder. Kemper Insurance Company cross-requests review of that portion of the Referee's order that set aside its denial of claimant's syncopal episode and skull fracture claim. On review the issues are compensability and responsibility.

The Board affirms in part and reverses in part.

FINDINGS OF FACT

The Board adopts the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Hives Condition

The Referee held that the weight of the evidence supported a finding that claimant's work exposure was the major contributing cause of her urticaria (hives condition). We disagree.

In order that her urticaria be found compensable, claimant must prove, by a preponderance of the evidence, that her work activities and exposures were the major contributing cause of her urticaria. Former ORS 656.802(1)(a); Blakely v. SAIF, 89 Or App 653 (1988); Dethlefs v. Hyster Company, 295 Or 298 (1983).

The causation of claimant's condition is of sufficient medical complexity tht we cannot decide it without expert opinion. See Kassahn v. Publishers Paper, 76 Or App 105 (1985). Absent persuasive reasons not to do so, we ordinarily defer to the opinion of the treating physician. Weiland v. SAIF, 64 Or App 810 (1983). Dr. Kazmierowski, the treating dermatologist and allergist, stated that twenty percent of urticaria conditions are caused by allergic reactions to causative agents, forty percent are caused by disease and forty percent are caused by unknown factors. He ruled out an allergic reaction and disease as cause of claimant's hives and placed claimant in the unknown category. Of the unknown category, between only three to five percent of urticaria cases are caused by stress. He concluded, "I would put her in the unknown category because I don't feel it's due to stress."

The Referee concluded that the opinion of Dr. Kazmierowski lacked persuasiveness because claimant, when she first sought Dr. Kazmierowski's assistance for her hives, did not mention to him the stress she felt from her employment; and therefore the doctor did not work from the perspective that stress could have caused claimant's urticaria. However, after becoming aware that claimant attributed her condition to job stress, Dr. Kazmierowski continued to opine that stress was not the cause of her hives.

Moreover, other medical opinions on the cause of claimant's hives condition only speculated that her hives could possibly be stress related. See Gormley v. SAIF, 52 Or App 1055 (1981). Still others related it to a nonwork-related toxic condition.

Given Dr. Kazmierowski's opinion that her hives were not stress-related, and the absence of persuasive medical opinion to the contrary, we conclude that claimant has not established, by a preponderance of the medical evidence, that her work activity and exposures were the major contributing cause of her urticaria.

Skull Fracture

Claimant alleges that the medication she was taking for her hives condition caused her to fall unconscious and fracture her skull in December, 1986. The Referee found the urticaria compensable and thus the skull fracture compensable. Because we do not find claimant's urticaria compensable, it follows that the skull fracture, caused by an unconscious fall which may or may not have been caused by the medication claimant was taking for her urticaria, has also not been shown to be compensable.

Depressive Disorder

The Referee held that claimant's depressive disorder was compensable because her work was stressful and caused her emotional problems. We agree that claimant's psychiatric condition is compensable.

In determining the compensability of a mental stress claim, there are four relevant questions: (1) What were the "real" events and conditions of claimant's employment? (2) Were those real events and conditions capable of producing stress when viewed "objectively," even though an average worker might not have responded adversely to them? (3) Did claimant suffer a mental dis order? (4) Were the real stressful events and conditions the major contributing cause of claimant's mental disorder? McGarrah v. SAIF, 296 Or 145 (1983).

Claimant's employment became stressful for her after her department was transferred to a new company in early 1986. A new labor contract was signed in August, 1986, which increased claimant's work load and decreased her salary. Shortly after the new labor contract went into effect, a co-worker was off work for an extended period of time and claimant had to fill in for her as well as perform her own recently enlarged tasks. We view these facts as constituting "real" conditions capable of producing stress even though another worker might not have responded in the same manner claimant has.

The next question to answer is whether claimant actually suffers from a mental disorder. Dr. Beavers, D.O., neuropsychiatrist, on January 6, 1988, diagnosed claimant's psychological condition as a major depressive disorder with anxious feature, single episode. He noted that there was no personality disorder and that the level of psychosocial stressors at that time were moderate to severe. (EX. 5c-5). We conclude that claimant has sustained a mental disorder in the form of a depressive condition.

The causation of claimant's depressive condition is of sufficient medical complexity that we cannot decide it without expert opinion. Kassahn v. Publishers Paper, 76 Or App 105 (1985). Dr. Beavers opined that claimant's work activities constituted the major source of claimant's depressive condition and need for treatment. He reported that there were no other psychosocial stress-related difficulties or personal problems contributing to claimant's depressive symptoms. He further reported that the doubling of the claimant's work duties was the major contributing factor in regard to work-related pressures for the claimant.

Crawford argues that Dr. Beavers suggests that claimant's psychological disorder may be linked to the December, 1986, skull fracture. In this regard, in response to a question regarding his recommendations for treatment of claimant, Dr. Beavers speculates that there may be an additional component to claimant's condition, i.e. an organic component stemming from the skull fracture that can complicate his therapy. However, he ultimately concludes that claimant's work-related stress was the major cause of her depressive condition. The fact that he considers other hypotheses, before reaching this conclusion, renders his opinion more persuasive rather than less persuasive.

Accordingly, we conclude that the weight of the evidence demonstrates that claimant's work activities were the major contributing cause of claimant's depressive disorder.

RESPONSIBILITY

Responsibility for occupational diseases is governed by the "last injurious exposure rule." Bracke v. Baza'r Inc., 293 Or 239, 246 (1982). The carrier on the risk when the condition becomes disabling is initially responsible if that work activity could have cnstributed to the condition. Id. at 248. "That carrier can then shift responsibility by proving that employment while it was on the risk did not contribute to the condition, or that a later employment independently contributed to the condition." Where the disease has not resulted in time loss, the date claimant first sought medical treatment is relevant in determining which employer is the "last potentially causal employer". SAIF v. Carey, 63 Or App 68 (1983).

Here, claimant was taken off work several times. However, these periods of time loss were due to her hives condition, which, each time, claimant claimed to be caused by stress on the job. Because we have concluded that there isn't enough evidence to prove that her hives condition was caused by her stressful working conditions, we must look to a disability date where we can distinguish

between the hives condition and the diagnosed depressive disorder. Dr. Beavers noted on January 6, 1988, when he first examined claimant for her psychological condition, that she was currently on disability leave. However, the "801" form for that disability leave indicates that described her condition as "hiave do [sic] to stress on the job." (Ex. 4f) There is insufficient evidence to conclude that claimant lost time fromwork as a result of her depressive condition. Consequently, we look to the date tht claimant first sought medical treatment. Carey, supra.

Claimant first sought treatment for her emotional condition on January 6, 1988. The employer became self-insured on April 1, 1987. Crawford & Company was its claims administrator. Therefore, Crawford & Company was on risk at the time claimant first sought medical treatment for her emotional condition and the Referee was correct to assign responsibility to Crawford & Company for claimant's depressive disorder.

Claimant's counsel is statutorily entitled to a reasonable, insurer-paid attorney fee for services rendered on Board review with regard to claimant's depressive disorder to be paid by Crawford & Company. 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 rendered regarding claimant's depressive disorder. 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 April 20, 1988, is affirmed in part and reversed in part. Crawford & Company's denial of claimant's claim for her hives condition is reinstated and upheld. Kemper's denial of claimant's claim for the syncopal episode and the skull fracture is reinstated and upheld. The Referee's attorney fee award concerning Kemper's denial is reversed. The remainder of the Referee's order, including the $700 carrier-paid fee to be paid by Crawford & Company, is affirmed. The Board approves a client-paid fee, payable from Kemper to its counsel, not to exceed $744. The Board approves a client-paid fee, payable from the self-insured employer to its counsel, not to exceed $3,079.50.

In the Matter of the Compensation of
ELBERT B. McQUEEN, Claimant
WCB Case No. 87-19288
ORDER ON REVIEW
Wilbur C. Smith, Jr., Claimant Attorney
Rankin, et al, Defense Attorneys

Reviewed by Board Members Cushing and Gerner.

The self-insured employer has requested review of those portions of Referee Menashe's order which: (1) set aside the Director's order and found claimant entitled to vocational assistance; and (2) granted claimant's counsel an assessed fee of $3,500 for services rendered in setting aside the aforementioned Director's order. On review, the issues are vocational assistance and attorney fees. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the findings of fact as set forth in the "Facts" section of the Referee's order.

CONCLUSIONS OF LAW

Vocational Assistance

We adopt the conclusions and reasoning regarding the vocational assistance issue as set forth in the Referee's order.

Attorney Fees

The Referee concluded that claimant's counsel was entitled to an assessed fee for services rendered in setting aside the Director's order. We disagree.

Subsequent to the Referee's order, we issued our decision in Nyall W. Bacon, 41 Van Natta 2046 (1989), wherein we held that entitlement to vocational assistance was a question of extent of benefits, therefore an "assessed" attorney fee is not available under ORS 656.386(1). We find our reasoning in Bacon, supra to be wholly applicable to the instant case. Therefore, we conclude that claimant's counsel is not statutorily entitled to the carrier-paid fee awarded by the Referee.

ORDER

The Referee's order, dated August 17, 1988, is reversed in part and affirmed in part. That portion which awarded claimant's counsel an assessed fee of $3,500, is reversed. The remainder of the order is affirmed. For services on review concerning the vocational assistance issue, claimant's counsel is awarded a reasonable assessed fee of $1,000, payable by the self-insured employer. A client-paid fee, not to exceed $1,598, is approved.

Board Member Myers specially concurring.

I agree with the majority that ORS 656.386(1) does not provide authority to award an assessed fee for prevailing on a Director's order in which a claimant is not eligible for vocational assistance. I write to express my concern for the practical effect that this loophole will have on the Workers' Compensation system. I believe this decision and Nyall Bacon, 41 Van Natta 2046 (1989) will assure that claimants will not be represented by attorneys in vocational assistance questions.

While it is possible there may be some temporary disability benefits flowing from a decision in which a claimant is eligible for vocational assistance, that possibility is remote. Thus, it is unlikely that a claimant's attorney would even be entitled to a fee out of claimant's compensation under ORS 656.386(2).

One of the major goals of the Workers' Compensation Act is to return injured workers to work as quickly as possible. If this were done, it would benefit individual claimants and the system as a whole. Injured workers should not be left without assistance to figure out a system which rivals the system for obtaining other benefits in its complexity.

If attorneys are unlikely to get paid for helping to obtain vocational assistance, they are unlikely to be willing to spend time and energy to obtain vocational assistance for their clients. Claimants will be left to their own devices to obtain a significant benefit of the Workers' Compensation system. This is bad policy.

In the Matter of the Compensation
COLLIN M. OWENS, Claimant
WCB Case No. 88-07311
ORDER ON REVIEW
Malagon, et al, Claimant Attorneys
Breathouwer, et al, Defense Attorneys

Reviewed by Board Members Cushing and Gerner.

The self-insured employer requests review of that portion of Referee Emerson's order which set aside its denial of claimant's injury claim for cervical, thoracic, and lumbosacral conditions. In his respondent's brief, claimant contends that the Referee erred in declining to assess penalties and attorney fees for an unreasonable denial. On review, the issues are compensability, penalties and attorney fees. We reverse in part and affirm in part.

FINDINGS OF FACT

Claimant was 22 years of age at the time of the hearing. As of February 26, 1988, claimant had worked as a veneer patcher for four months.

On December 28, 1987, while at home, claimant fell through his coffee table. As a result of this fall, he received ten stitches for a laceration to the right lower back.

On February 26, 1988, claimant had difficulty with his machine clogging with broken patches. He removed the glove from his right hand and pushed the debris down and out with his middle finger. The machine then activated, almost crushing claimant's finger. The finger was held in place. Claimant twisted and turned trying to get his finger out. After two or three minutes of twisting and turning, he managed to free his finger. Claimant went to the hospital. There it was found that claimant had a laceration of the middle right finger. Claimant filed a claim that day for "laceration on finger." (Ex. 8).

Claimant did not experience back discomfort on the date of the finger injury. His finger remained painful for several days, and was splinted and bandaged for three weeks.

On March 7, 1988, claimant experienced sharp back pain after getting off a couch at home to answer a door bell. On March 8, 1988, claimant was examined by Dr. Taylor, treating chiropractor. Claimant complained of headaches, neck pain, finger pain, and low back pain.

On April 25, 1988, the insurer accepted claimant's right middle finger injury as being compensable. However, claimant's cervical, thoracic and lumbosacral spine conditions were denied.

CONCLUSIONS OF LAW

The Referee found that claimant's claim for medical services for his low and mid back condition was compensable. The Referee reasoned that claimant's back condition was derived from the abnormal spinal movement associated with trying to free his finger from the machine. We disagree.

The burden of proof is on claimant to show that the February 26, 1988, incident is a material contributing cause of his back condition. Hutchenson v. Weyerhaeuser, 288 Or 51, 56 (1979); James v. Kemper Ins. Co., 81 Or App 80, 81 (1986). The causation of claimant's back condition is a complex medical question. Thus, while his 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 his burden.

On March 22, 1988, Dr. Taylor opined that claimant had sustained muscular ligamentous injury to his neck, mid and low back. He reasoned that, "the original incident which fractured the finger could very easily cause a response that could additionally injure that patient's arm and upper back." (Ex. 17-1)(Emphasis added). Claimant is required to prove a relationship between the work incident and the need for medical treatment to a reasonable probability. A statement of a mere possibility does not meet that requirement. Gormley v. SAIF, 52 Or App 1055 (1981). Dr. Taylor's opinion is insufficient to establish a medical probability of a causal connection between the work injury and his back conditions.

Furthermore, Dr. Taylor based his opinion on an inaccurate medical history. Claimant testified that the back pain developed 2 or 3 days after the accident, whereas Taylor indicated that claimant experienced "midback pain since his finger was fractured." (Tr. 24)(Ex. 17-1). Because Taylor had an inaccurate history, we find his opinion unpersuasive. Miller v. Granite Construction Co., 28 Or App 473, 476 (1977).

On the other hand, Dr. Utterback, M.D., orthopedist, examined claimant and reasoned there was no way a lumbar strain could be caused by a smashed finger. (Ex. 18-2). Dr. Utterback also addressed the alternative causes of claimant's back condition. He reasoned that the more probable cause of claimant's back condition was the December, 1987, "coffee table" fall or the March 1988, "couch" incident. In this case we find the well reasoned opinion of orthopedic specialist, Dr. Utterback, persuasive. Somers v. SAIF, 77 Or App 259, 264 (1986). Consequently, we find that claimant has failed to establish that the February, 1988, incident was a material contributing cause of his back condition.

Considering our reasoning concerning the compensability issue, we do not consider the employer's denial to be unreasonable.

ORDER

The Referee's order, dated August 17, 1988, is reversed in part and affirmed in part. The self-insured employer's April 25, 1988 denial for claimant's cervical, thoracic, and lumbosacral conditions is reinstated and upheld. The Referee's attorney fee award is reversed. The remainder of the order is affirmed. A client-paid fee, not to exceed $1,392, payable from the self-insured employer to its counsel, is approved.

January 29, 1990 Cite as 42 Van Natta 209 (1990)

In the Matter of the Compensation
WILLIAM O. PADGETT, Claimant
WCB Case No. 86-18007
ORDER ON REVIEW
Cash R. Perrine, Claimant Attorney
Joseph T. McNaught (Saif), Defense Attorney

Reviewed by Board Members Brittingham and Crider.

The SAIF Corporation requests review of Referee Michael Johnson's order that set aside the Director's Review and Order terminating claimant's vocational rehabilitation benefits. The issue on review is whether the Director abused his discretion in terminating claimant's benefits. We reverse.

FINDINGS OF FACT AND ULTIMATE FACT

We adopt the Referee's Findings of Fact, excluding the first full paragraph on page two, with the following supplementation.

Claimant's compensable back injury occurred on January 18, 1985. Claimant was involved in a car accident on December 5, 1985.

Following the December 5, 1985 car accident, claimant's willingness to cooperate with the vocational rehabilitation program steadily waned although he received three letters from SAIF (January 24, February 12, and April 2, 1986) warning him that vocational assistance would be terminated due to his lack of participation. Claimant's follow through on rehabilitation assignments was sporadic, and he failed to maintain contact with his vocational rehabilitation counselor. Pursuant to former OAR 436-120-090(9), claimant's vocational file was subsequently closed, effective April 26, 1986, for failure to follow through with vocational activities and failure to stay in touch with his counselor.

Dr. Altrocchi did not begin treating claimant until June 10, 1986, six weeks after claimant's vocational assistance had been terminated.

Claimant appealed the April 1986 vocational assistance termination to the Director on September 17, 1986. In support of his position, claimant relied on reports and chart notes written by Dr. Altrocchi in June and July 1986.

The Director concluded in his December 11, 1986 order that Dr. Altrocchi's June 1986 report came "after-the-fact" and could not be considered as evidence of justification for claimant's failure to participate in vocational rehabilitation efforts. The Director also concluded that there was no evidence that claimant was incapable of calling his counselor on a regular basis, taking part in his vocational rehabilitation program, and looking for light/sedentary work between December 5, 1985 and April 26, 1986.

CONCLUSIONS OF LAW AND OPINION

Under former ORS 656.283(2), the Director's decision can only be modified if it violated a statute or rule, exceeded the statutory authority of the agency, was made under unlawful procedure, or was characterized by abuse of discretion. The Referee set aside the Director's order, finding that the Director's refusal to consider the report chart notes of Dr. Altrocchi was an abuse of discretion.

Under former ORS 656.283(2), the standard for review is limited. However, the statute does not preclude examination and scrutiny of the underlying facts upon which the Director's decision is based. See generally Daniel T. Cobbin, 41 Van Natta 326 (1989). Accordingly, we proceed to review, as a factual matter, the basis of the Director's decision in terms of former ORS 656.283(2).

The Director denied continued vocational assistance under former OAR 436-120-090(9) (now OAR 463-120-050). The former rule provided: "The eligibility of a worker for vocational assistance will end if . . . the worker has failed, after written warning, to cooperate in the development of a return-to-work plan."

There is no persuasive medical evidence in the record to demonstrate that claimant was justified in his lack of participation and cooperation with the vocational services up until the closure date of April 26, 1986. At best, the medical evidence shows that participation in vocational efforts would have been difficult. Nevertheless, claimant was physically capable of doing some light work. Moreover, the record shows that claimant was continually encouraged by his vocational counselor to maintain contact and to participate in the rehabilitation program; and he was warned that his lack of participation would result in termination of services. On this record, we conclude that claimant knowingly and willingly refused to cooperate in his vocational rehabilitation.

The report and chart notes of Dr. Altrocchi are not relevant to this issue. Dr. Altrocchi did not examine claimant until June 10, 1986. His June and July chart notes and report address his condition at the time of examination, not his condition at the time claimant was receiving vocational services. In any event, while the July 1 report indicates claimant was unable to return to work at that time, it does not address his ability to participate in vocational services. Therefore, the Director did not abuse his discretion in declining to consider those reports and chart notes.

Accordingly, we conclude that the Director properly terminated claimant's vocational services, and we reverse the Referee's order.

ORDER

The Referee's order, dated August 11, 1987, is reversed. The Director's Review and Order is reinstated and affirmed.

January 29, 1990 Cite as 42 Van Natta 211 (1990)

In the Matter of the Compensation of
GARY L. REDDEN, Claimant
WCB Case No. 87-02914
ORDER ON REVIEW (REMANDING)
Black, et al, Claimant Attorneys
Parks & Ratliff, Attorneys
Saif Legal, Defense Attorney

Reviewed by Board Members Crider and Nichols.

Terry Kuhlman, an alleged noncomplying employer, requests review of Referee Mongrain's order that dismissed Kuhlman's request for hearing on the issue of subjectivity for lack of jurisdiction. The issues on review are jurisdiction and subjectivity. We reverse.

FINDINGS OF FACT AND ULTIMATE FACT

Claimant was injured while working on December 23, 1986, for Terry Kuhlman, a sole proprietor. On January 19, 1987, claimant submitted a Form 801 to Kuhlman. On February 23, 1987, claimant requested a hearing regarding Kuhlman's failure to pay interim compensation benefits. Kuhlman neither accepted nor denied the claim. Claimant filed a supplemental Request for Hearing on February 26, 1987, putting in issue the compensability of the claim on a "de facto" denial theory.

On May 4, 1987, the Compliance Division issued a Notice of Proposed and Final Order finding claimant to be a subject employee and the employer to be a subject employer. The order further held that the employer was noncomplying. The notice was mailed to Donald Crane, an attorney who had previously contacted Compliance on behalf of the employer. It was not mailed to the employer personally. The employer did not request a hearing on the noncompliance issue.

By letter dated May 4, 1987, the Compliance Division forwarded the claim to the SAIF Corporation for processing pursuant to ORS 656.054(1). SAIF accepted the claim for a fractured right hip and femur. On July 1, 1987, SAIF notified the employer that it had accepted claimant's claim.

In a letter to the Board dated August 14, 1987, attorney Crane, acting as counsel for the employer, requested a hearing, objecting to SAIF's acceptance of the claim on the ground that claimant was not the employer's employee. As far as the record reveals, no copy of the request was sent to the Director, to SAIF or to claimant.

Hearing convened on November 9, 1987. Claimant no longer had any issues he wished to pursue as SAIF had accepted the claim. The employer, however, contended that SAIF's acceptance should be set aside on the ground that: (1) claimant was not an employee but rather was an independent contractor; and (2) the employer was not noncomplying because he had no employees.

CONCLUSIONS OF LAW AND OPINION

The only issue any party sought to raise before the Referee at the November 9, 1987 hearing was whether or not SAIF's acceptance should be set aside given Kuhlman's contention that he was not a subject employer and claimant was not a subject employee. The Referee dismissed the request for hearing on the ground that the subjectivity issues were disposed of by the Notice of Proposed and Final Order, the order was not appealed timely, and thus the argument was precluded.

The employer contends that he is not precluded from litigating the subjectivity issues because he was not personally served with a copy of the Notice of Proposed and Final Order and thus, in effect, the Order is not final.

Former OAR 436-80-050 provided that notices be served by one of two methods: "(1) By delivering a copy to the employer in the manner provided by ORS 15.080; or (2) By sending a copy of the document to the employer by certified mail with instructions to deliver to the addressee only, return receipt requested. If the employer is a corporation the certified mail may be addressed to any one of the persons named in ORS 15.080(1)."

ORS 15.080, referred to in the Rule, was repealed in 1979. It was replaced by Rule 7D of the Oregon Rules of Civil Procedure.

In light of the repeal, OAR 436-80-050 could be read any of three ways: (a) to allow service only in accordance with subsection 2 of the Rule; (b) to allow service as described in the repealed statute as well as pursuant to subsection 2; or (c) to allow service as described in Rule 7D as well as pursuant to subsection 2.

The Notice of Proposed and Final Order was not mailed to the employer. Consequently, service was not made in accordance with subsection 2 of the Rule. Nor was service made in accordance with ORS 15.080 or Rule 7D. Former ORS 15.080(8) required that service of a summons on a person be made personally or to a family member over 14 years old at the person's home. Rule 7D(3)(a)(i) of the Oregon Rules of Civil Procedure provides that service be made on an individual personally or on his authorized agent. Neither provides for service of summons on an attorney. Therefore, no matter which construction we should adopt, service was not made on Kuhlman by serving attorney Crane.

The Referee held, nevertheless, that because the employer was "reasonably apprised of the contents of the proposed and final Order and what was happening as a result thereof" (Tr. 39), service was sufficient to trigger the running of the 20-day period for requesting a hearing on the order. We disagree.

The employer is entitled to personal service under the rule. Actual notice is not sufficient to bring him within the jurisdiction of the Director. See Jordan v. Wiser, 302 Or 50 (1986). Not having been properly served, he is not precluded from arguing that he is not a subject employer or that claimant is not a subject employee.

Therefore, we reverse the Referee's order and remand this claim to Referee Mongrain for further proceedings. The matter shall be reset for hearing for a date that will allow the Director to properly serve the Notice of Proposed and

Final Order should he choose to do so, and that will allow Kuhlman time to request a hearing thereon. Should the matter of Kuhlman's noncomplying status come properly before the Hearings Division, it shall be consolidated with Kuhlman's August 14, 1987 request for hearing on SAIF's acceptance of the claim.

ORDER

The Referee's Order, dated December 2, 1987, is reversed. The case is remanded to Referee Mongrain for further proceedings consistent with this order.

In the Matter of the Compensation
DARLENE K. SIMS , Claimant
WCB Case No. 87-16940
ORDER ON REVIEW
Peter O. Hansen, Claimant Attorney
Roberts, et al, Defense Attorneys

Reviewed by Board Members Crider and Brittingham.

Claimant requests review of Referee Hoguet's order that affirmed a Director's Review and Order denying retroactive temporary disability benefits and expenses related to an educational program. On review, the issue is entitlement to educational expenses and related temporary disability compensation. We affirm.

FINDINGS OF FACT AND ULTIMATE 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.

While we agree with the Referee's ultimate ruling, we do not agree with that portion of his analysis that suggests that pre-authorization of educational services must be by "administrative approval", i.e., approval by the Department. Although the rules applicable to this case required administrative approval of certain expenditures, that does not mean that all expenditures must be approved by the Department.

Under former OAR 436-61-151(1), an authorized training program (ATP) shall be provided when the vocational assistance server believes such is necessary to achieve employability. The rule does not require administrative approval except for: training in excess of one year (former OAR 436-61-151(5)); extension of a training program for more than 90 days (former OAR 436-61-151(9)); and participation in more than one training program (former OAR 436-61-151(10)). Thus, the vocational assistance server may authorize training programs except in the limited circumstances noted above.

Here, claimant's attendance at Northwest College of Art was not pre-authorized by either the insurer or the Field Service Division. Accordingly, we agree with the Referee's ruling that retroactive payment of time loss benefits and expenses is not appropriate for any portion of the Northwest College of Art program.

ORDER

The Referee's order dated March 9, 1988 is affirmed. A client-paid fee, not to exceed $1,084, payable by the insurer to its counsel, is approved.

In the Matter of the Compensation of
JULIA ZAVALA, Claimant
WCB Case No. 88-08603
ORDER ON REVIEW
Charles E. Woods, 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 set aside its partial denial of claimant's current mid-back, neck, and arm conditions. The issue on review is compensability. We reverse.

FINDINGS OF FACT

Claimant is a 25-year-old former kitchen aide for the employer. On June 13, 1987, claimant lifted a rack of coffee cups and felt a tear around her umbilicus. That afternoon she lifted a heavy pan and again felt pain in that area.

Claimant sought treatment for abdominal pain that night at the Salem Hospital. An 827 form was filed by the hospital reporting only complaints of abdominal wall pain. Four days later, claimant started treating with Dr. Gary Jansen, a chiropractor. Claimant's only complaints were to her low back and left leg.

No 801 form was filed by claimant. The insurer accepted the claim as a nondisabling lumbar strain/sprain on August 3, 1987.

Jansen continued to treat claimant until October 28, 1987. During Jansen's treatment, there were no complaints of, or treatment for, any injury to claimant's mid-back, neck, or arm attributable to her injury of June 13, 1987. After muscle testing at a rehabilitation center, claimant did complain of incidental neck stiffness. These complaints were not related to her injury of June 13, 1987, or its sequela.

On May 6, 1988, claimant switched treatment to Dr. Thomas McFie, a chiropractor. At that time claimant was first treated for her complaints to her upper back, neck, and arm. Claimant filed her first 801 on May 9, 1988.

The insurer denied compensability of claimant's upper-back, neck, and arm conditions on May 9, 1988. Claimant timely appealed.

Claimant was seen by Western Medical Consultants on July 11, 1988.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant's mid-back, neck, and arm conditions had all been accepted as part of her original June 6, 1987 injury claim. The Referee then found that the claimant had sustained an aggravation of those previously accepted conditions. In so finding, the referee found Dr. McFie's opinion persuasive. We disagree.

Before addressing the compensability issue, it is first necessary to decide whether or not the insurer had ever accepted claimant's mid-back, neck, and arm conditions as part of the original compensable claim. We conclude that the insurer did not.

The claimant never filed an 801 in this claim until she filed her aggravation claim. The original claim was filed based on an 827 indicating an abdominal wall strain. The insurer formally accepted the claim by a notice of acceptance dated August 5, 1987. This was after a subsequent 827 indicated that the low back and leg were also involved. The insurer specifically accepted a lumbar strain/sprain. The acceptance does not make mention of the mid-back, neck, and arm conditions. Accordingly, we conclude that those conditions have not been accepted. See Georgia Pacific v. Piwowar, 305 Or 494 (1988).

To establish compensability of her current mid-back, neck, and arm conditions, claimant must show, by a preponderance of the evidence, that her 1987 compensable injury is a material contributing cause of her disability or need for medical treatment. Hutcheson v. Weyerhaeuser, 288 Or 51, 56 (1979). The issue of whether claimant's mid-back, neck, and arm conditions are causally related to the 1987 compensable injury is a complex medical question. Thus, although claimant's testimony is probative, the resolution 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 106, 109 (1985).

McFie is the only physician who relates the medical causation of claimant's mid-back, neck, and arm conditions to her 1987 compensable injury. His conclusion is based solely on claimant's history that she sustained an injury to those body parts at the time of the original injury; that she reported these complaints to her then treating physician contemporaneously with her original injury; and that she received treatment to these parts of her body from very early on in the claim. We find this history to be inaccurate.

McFie did not see claimant until eleven months after the injury. Claimant was treated by Jansen prior to that time. Jansen does not have any record of injury, complaints, or treatment to the body parts in question throughout his treatment course. There is a mention of neck stiffness following muscle testing at Northwood Rehabilitation, but Jansen believed that this did not represent an injury or problem related to claimant's 1987 injury or its sequela. Further, the medical records prior to McFie's treatment do not indicate any injury, complaints, or treatment regarding the mid-back, neck, and arm. These medical records are the more persuasive and reliable indicators of claimant's injuries, complaints, and treatment during the eleven months following her compensable injury.

Claimant's history is inaccurate and therefore unreliable. Since McFie relied on this inaccurate history in reaching his conclusion, his opinion is unpersuasive. See Moe v. Ceiling Systems, 44 Or App 429 (1980).

There is no other medical evidence that supports a medical causal connection of claimant's current mid-back, neck, and arm conditions to her compensable 1987 injury. Claimant has failed to prove that these current conditions are compensable.

ORDER

The Referee's order, dated September 14, 1988, is reversed. The insurer's denial dated May 20, 1988 is reinstated and upheld. A client-paid fee, not to exceed $1,331, payable from the insurer to its counsel, is approved.

In the Matter of the Compensation of
JOHN H. BOGLE, Claimant
Own Motion No. 89-0361M
OWN MOTION ORDER ON RECONSIDERATION
Industrial Indemnity, Insurance Carrier

Claimant requests reconsideration of our January 2, 1990, Own Motion Order that denied his request for reopening of the above-captioned claim for temporary disability benefits. We denied his request based on findings that claimant had withdrawn from the work force and, therefore, did not lose any wages due to the worsening of his condition. Claimant now submits additional evidence to prove that he has not withdrawn from the work force.

The medical evidence submitted by claimant is Dr. Douglass's letter of December 11, 1989, stating that claimant is "unemployable at the present time because of his previous [industrial] injury." That letter is not enough, however, because it merely addresses claimant's work capacity after the worsening of his condition. To receive temporary disability benefits upon a worsening of his compensable injury, claimant must be in the work force at the time of the worsening. See Dawkins v. Pacific Motor Trucking, 308 Or 254, 258 (1989). In determining whether claimant was in the work force at the time of the worsening, we look to claimant's employment status immediately before the worsening. Claimant's low back condition worsened in April, 1989. At that time, hospital records described claimant as a "retired" ironworker. There is no evidence that claimant either worked or looked for work immediately prior to the worsening. Moreover, there is no evidence that, prior to the worsening, claimant was unable to work due to the compensable injury. We do not find, therefore, that reasonable efforts to seek work would have been futile. Finally, there is no indication in the record that claimant was willing to work at any time prior to the worsening of his condition. Given this record, we are not persuaded that claimant was in the work force at the time of his worsening. See Dawkins v. Pacific Motor Trucking, supra. Claimant is not entitled to temporary disability benefits.

On reconsideration, we adhere to and republish our January 2, 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
SHEILA A. CRESS, Claimant
WCB Case No. 88-08042
ORDER ON REVIEW
Malagon, et al, Claimant Attorneys
Acker, Underwood, et al, Defense Attorneys

Reviewed by Board Members Howell and Speer.

Claimant request review of Referee Myers' order which declined to award temporary disability compensation for the periods June 20, 1986, through August 2, 1986, and August 12, 1987, through March 10, 1988. On review, the issue is claimant's entitlement to temporary disability compensation. We affirm in part and reverse in part.

FINDINGS OF FACTS

Claimant began working for the self-insured employer as a laborer in its saw mill on June 10, 1986. On June 17, 1986, she compensably injured her left wrist. She continued working but with difficulty and limitations in the use of her injured wrist. Some of the duties to which she was assigned involved very heavy lifting and pulling. After her shift on June 19, 1986, claimant was discharged by the employer for an unsatisfactory attitude and work performance.

Claimant's left wrist condition worsened following her discharge. On June 23, 1986, she sought treatment for her injury from Dr. Hercher. He released claimant for light work, but he did not consider her able to perform her regular work. Claimant was later referred to Dr. Jones, an orthopedic surgeon, and first seen in February, 1987. Dr. Jones agreed that claimant was unable to perform mill work when he first began treating her.

In August, 1986, claimant began working for another employer as a bartender. She was unable to use her injured wrist to pull heavy tables across the floor or to carry pitchers of beer.

ULTIMATE FINDINGS

During the periods June 23, 1986, through August 2, 1986, and August 12, 1987, through March 10, 1988, claimant was unable to perform her regular work for the employer because of her compensable left wrist injury.

CONCLUSIONS OF LAW

Claimant asserts entitlement to temporary disability compensation for a compensable injury during a period prior to closure of the claim for that injury. Both the Referee and the parties focus their arguments on the reason claimant left work. The Referee found that claimant left work because she was fired. He concluded that claimant was not entitled to temporary disability compensation thereafter.

We agree that if claimant was off work thereafter for reasons unrelated to her compensable injury, then she is not entitled to temporary disability compensation. Noffsinger v. Yoncalla Timber Products, 88 Or App 118 (1987); Nix v. SAIF, 80 Or App 656 (1986). In this regard, the court in Noffsinger found as fact that claimant had never been disabled from work as a result of his compensable injury.

On the other hand, if claimant can establish that she was subsequently temporarily disabled from performing her regular work as a result of her compensable injury, then she is entitled to temporary disability. Gray v. SAIF, 70 Or App 313 (1984); Michael J. Harvey, 41 Van Natta 980 (1989); cf. Safeway Stores v. Owsley, 91 Or App 475 (1988) (claimant disabled from "regular" work, but returns to modified work at a wage equal to or exceeding her at-injury wage).

We are persuaded by claimant's testimony, which was found credible, and by the uncontradicted opinion of claimant's treating physicians that by June 23, 1986, and during the relevant periods thereafter, she was unable to perform her regular work as a consequence of her wrist injury. She is therefore entitled to temporary disability compensation for those periods. Because she had no other income during the periods in question, she is entitled to temporary total disability compensation.

We find, however, that claimant has failed to establish entitlement to temporary disability compensation for the period June 19, 1986, through June 22, 1986.

ORDER

The Referee's order dated September 2, 1988, is reversed in part and affirmed in part. Claimant is entitled to temporary total disability compensation for the periods June 23, 1986, through August 2, 1986, and August 12, 1987, through March 10, 1988. The Referee's order is otherwise affirmed. Claimant's agreement with her attorney is approved for payment of 25 percent of the increased compensation as a reasonable attorney fee, not to exceed $3,800. A client-paid fee, payable by the employer to its attorney, is approved in an amount not to exceed $425.

In the Matter of the Compensation of
LINDA S. GETTE, Claimant,
and, In the Matter of Complying Status of
BOSSIO'S INN, Employer
WCB Case No. 87-14516
ORDER ON REVIEW (REMANDING)
Burton Bennett, Attorney
Mark Bronstein (Saif), Defense Attorney
Carl Davis, Assistant Attorney General

Reviewed by Board Members Howell and Speer.

The noncomplying employer requests review of Referee Foster's order which dismissed its Request for Hearing. On review, the issue is dismissal. We remand.

FINDINGS OF FACT

The SAIF Corporation accepted claimant's claim on July 31, 1986. The noncomplying employer requested a hearing on the compensability of the claim. The Referee found that a denial meeting the requirements of ORS 656.262 had not been issued by the noncomplying employer and, thus, dismissed the Request for Hearing.

CONCLUSIONS OF LAW AND OPINION

The Referee dismissed the employer's hearing request, citing Derryberry v. Dokey, 91 Or App 533 (1988), and stating that the claim had been accepted by SAIF and had not been denied by the employer. However, since the issuance of the Referee's order, that portion of Derryberry that suggests it is a noncomplying employer's responsibility to accept or deny a claim has been disavowed. Clark v. Linn, 98 Or App 393 (1989). In Clark, the court held that an alleged noncomplying employer which requests a hearing on compensability is entitled to such a determination whether or not the employer denied the claim pursuant to ORS 656.262. Accordingly, the Referee's dismissal was in error.

ORDER

The Referee's order dated August 31, 1988 is vacated. This case is remanded to the Presiding Referee with instructions to assign this case to a Referee for further proceedings consistent with this order.

In the Matter of the Compensation of
EDWARD K. McGUIRE, Claimant
WCB Case Nos. 87-12554, 87-07348, 87-07480, 87-07481 & 87-10318
ORDER OF ABATEMENT
Bloom, Marandas & Sly, Claimant Attorneys
Norman Cole (Saif), Defense Attorney
Roberts, et al, Defense Attorneys
Schwabe, et al, Defense Attorneys
Lindsay, Hart, et al, Defense Attorneys
Acker, Underwood, et al, Defense Attorneys

The Board has received the insurer's motion for reconsideration of our Order on Review, issued January 4, 1990. In order to allow sufficient time to consider the motion, the above noted order is abated and withdrawn. The parties are 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
GRANT W. NAIRN, Claimant
Own Motion No. 87-0635M
OWN MOTION ORDER
Allen, et al, Claimant Attorneys
Daryll E. Klein, Defense Attorney

The insurer has submitted to the Board claimant's claim for an alleged worsening of his March 3, 1979, industrial injury. Claimant's aggravation rights have expired. The Board initially postponed action on claimant's request for own motion relief pending resolution of his request for hearing on the insurer's denial of his current low back condition (WCB Case No. 87-12276). By Opinion and Order dated February 10, 1988, the Referee in WCB Case 87-12276 upheld the insurer's denial. By Order on Review dated March 13, 1989, the Board reversed the Referee's order and set aside the insurer's denial. The Board's order was appealed to the Court of Appeals and affirmed without opinion September 27, 1989. Although the insurer subsequently authorized claimant's low back surgery, it continues to oppose 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. Although we are persuaded that claimant's compensable injury has worsened requiring surgery, we decline to reopen his claim for temporary disability benefits because claimant was not in the work force at the time of his worsening.

Following his industrial injury in March, 1979, claimant was diagnosed with a low back strain and taken off work for a couple of weeks. He was treated conservatively and returned to regular work until the employer's business closed in December, 1979. Claimant has neither worked nor looked for work since 1979. Claimant's claim was closed by Determination Order on July 19, 1979, with no permanent disability award. In 1984 claimant sought treatment for continuing low back pain with some radiating symptoms in the right leg. He was diagnosed with chronic lumbosacral pain secondary to disc disease. Claimant did

not seek treatment again until April, 1987, when he was diagnosed with a herniated disc at L4-5. There is no evidence of when the disc herniation occurred.

It is undisputed that claimant has been disabled from work due to the disc herniation since April, 1987, and that subsequent efforts to seek work would have been futile. The question remains, however, whether reasonable efforts to find work were futile during the seven-year period preceding the discovery of the herniation in 1987. Because there is no evidence establishing when the disc herniation occurred, there is no basis for finding that claimant was disabled due to the herniation prior to 1987. Indeed, there is no persuasive medical evidence that claimant was disabled from work anytime between 1979 and 1987. Although claimant testified at hearing in WCB Case No. 87-12276 to the persistence of low back and right leg symptoms during those years, that testimony alone does not persuade us that he was totally disabled from work for which he was qualifed. Hence, we do not find that reasonable efforts by claimant to obtain work would have been futile due to the compensable injury. We conclude, therefore, that claimant had withdrawn from the work force when his low back condition worsened requiring surgery. See Dawkins v. Pacific Motor Trucking, 308 Or 254, 258 (1989). Because claimant was not in the work force at the time of his worsening, he is not entitled to temporary disability benefits. See Cutright v. Weyerhaeuser, 299 Or 290 (1985). Accordingly, claimant's request for own motion relief is denied.

IT IS SO ORDERED.

January 30, 1990 Cite as 42 Van Natta 220 (1990)

In the Matter of the Compensation of
RAY E. SCHLICHTING, Claimant
WCB Case Nos. 87-14245 & 87-14246
ORDER ON REVIEW
Borneman & Rossi, Claimant Attorneys
Joe McNaught (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

The SAIF Corporation requests review of that portion of Referee Thye's order which set aside its denial insofar as it denied compensability of the increased symptoms of claimant's underlying bilateral arthritic wrist condition. The issue on review is compensability. We affirm in part and reverse in part.

FINDINGS OF FACT

The Board adopts the Referee's "Findings."

CONCLUSIONS OF LAW AND OPINION

The Board adopts the "Conclusions" of the Referee insofar as he upheld SAIF's denial of the compensability of claimant's underlying bilateral arthritic wrist condition. However, we do not agree with his holding that SAIF is responsible for increased symptoms of the arthritic condition.

In reaching his decision as to the compensability of claimant's increased wrist symptoms, the Referee relied on a previous Board case which held that when a compensable injury makes a preexisting, underlying disease temporarily symptomatic without causing or worsening that disease, the carrier is

responsible for payment of benefits resulting from the temporary symptomatic increase, even though there is no liability for the underlying condition per se. Donald L. Call, 39 Van Natta 672 (1987). The Referee was in error in relying on that case because it applies to compensable injuries, whereas this case involves the asserted contribution of claimant's work activities and exposures to the underlying arthritis condition, i.e., an occupational disease theory.

To establish the compensability of his condition on an occupational disease theory, claimant has the burden of proving that his work activities and exposures were the major contributing cause of either the onset or a worsening of his arthritis 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., 295 Or 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).

Here, claimant has not shown a pathological worsening of his arthritic condition as a result of his work activities. Dr. Forman, a rheumatologist to whom claimant was referred by his treating surgeon, stated only that claimant's work activity caused the underlying arthritis to become more symptomatic. Consequently, claimant has failed to establish compensability of either his underlying arthritic condition or its symptoms.

ORDER

The Referee's order dated April 21, 1988, is affirmed in part and reversed in part. That portion of the order that held SAIF responsible for the symptomatic exacerbation of the arthritic condition and awarded an assessed attorney fee is reversed. SAIF's denial is reinstated and upheld in its entirety. The remainder of the Referee's order is affirmed.

January 30, 1990 Cite as 42 Van Natta 221 (1990)

In the Matter of the Compensation of
JOY SHELBY, Claimant
WCB Case No. 88-03892
ORDER ON REVIEW
Peter O. Hansen, Claimant Attorney
David B. Smith (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

Claimant requests review of those portions of Referee Mulder's order which: (1) increased claimant's scheduled permanent disability award for loss of use or function of the left foot from 5 percent (6.75 degrees) as awarded by Determination Order to 15 percent (20.25 degrees); and (2) awarded 10 percent (32 degrees) unscheduled permanent disability for circulatory problems, whereas a Determination Order had awarded no permanent disability. The issues on review are extent of scheduled and unscheduled disability. We modify the award of scheduled disability.

FINDINGS OF FACT

The Board adopts the Referee's "Findings" through the last full paragraph on page two of the Opinion and Order.

CONCLUSIONS OF LAW AND OPINION

Unscheduled Permanent Disability

Claimant argues that the unscheduled permanent disability award for her vascular problem should be increased. SAIF argues that claimant is not entitled to an unscheduled disability award for her vascular problem because the problem is limited to her leg. See Shaw v. Portland Laundry/Dry Cleaning, 47 Or App 1041, 1045 (1980). However, claimant's treating physician, Dr. De'ak, has opined that the Coumadin medication claimant must take for her circulatory problem puts claimant at risk for increased bleeding and bruising over her entire body, not just her leg. Therefore, to the extent claimant's use of Coumadin results in permanent impairment, she is entitled to an award of unscheduled permanent disability. Shaw, supra.

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 has returned to work with her original employer, but has not been doing home visitations because of the possibility of encountering hazardous conditions at homes she visits. Considering the fact that she has retained her job, with some modifications, and other social and vocational factors, we conclude that 10 percent (32 degrees) permanent disability, as awarded by the Referee, appropriately compensates claimant for her permanent loss of earning capacity.

Scheduled Permanent Disability

Extent of scheduled permanent partial disability is\measured\by the permanent loss of use or function of the injured member due to the industrial injury. ORS 656.214(2). In determining loss of use or function, we consider the medical and lay evidence in light of the rules as 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, 337-38, rev den 294 Or 749 (1983); Isabel Aparicio, 38 Van Natta 421, 421-22 (1986). Loss of use or function does not necessarily correlate with mechanical impairment, although mechanical impairment is usually an important consideration. See Boyce v. Sambo's Restaurant, 44 Or App 305, 308 (1980).

Here, we are persuaded that claimant has shown that she has suffered permanent impairment of her left foot as a result of her compensable injury. She is unable to walk two blocks without discomfort. She must elevate her leg as much as possible, and she has moderate disabling pain.

Following our de novo review of the medical and lay evidence we conclude that an award of 30 percent (40.50 degrees) adequately and appropriately compensates claimant for the permanent loss of use or function of her left foot.

ORDER

The Referee's order dated June 20, 1988 is affirmed in part and modified in part. That portion awarding unscheduled permanent disability of 10 percent (32 degrees) is affirmed. Claimant is awarded an additional 15 percent

(20.25 degrees) scheduled permanent disability, for a total of 30 percent (40.50 degrees). Claimant's attorney is entitled to an approved fee equal to 25 percent of the increased compensation awarded by this order, however, the total attorney fee approved by the Referee's order and this order shall not exceed $3,000 payable from this compensation.

January 30, 1990 Cite as 42 Van Natta 223 (1990)

In the Matter of the Compensation of
JOANNE TORREZ, Claimant
WCB Case Nos. 87-02095 & 88-02062
ORDER ON REVIEW
Miller, et al, Defense Attorneys
Cummins, et al, Defense Attorneys

Reviewed by Board Members Howell and Speer.

Claimant, pro se, requests review of Referee Hettle's order that upheld the self-insured employer's denials of claimant's chiropractic 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 with the following supplementation.

The employer's January 12, 1987, denial reads:

> "In a recent review of the medical information in your file, we find that your need for ongoing chiropractic care is no longer reasonable or necessary. Therefore, [the employer], must respectfully deny further chiropractic care." (Emphasis supplied).

CONCLUSIONS OF LAW AND OPINION

The Referee, in upholding the employer's denials of chiropractic treatment, found claimant's condition as of January 12, 1987 was no longer related to her 1985 compensable injuries. While we agree with the Referee's reasoning and conclusions, we must still reverse his decision with regard to the January 12, 1987 denial.

The January 12, 1987 denial is a denial of further chiropractic care. As such, it is a prospective denial of future entitlement to benefits and is therefore invalid. See Evanite Fiber Corp. v. Striplin, 99 Or App 353 (1989).

The record reflects that the employer stopped making payments on claimant's chiropractic bills following the January 12, 1987 denial. These bills remained unpaid on October 6, 1987 the date of the employer's second denial, which denied claimant's current condition and medical treatment. We uphold the October 6, 1987 denial and adopt the Referee's findings and conclusions as applied to this denial.

ORDER

The Referee's order, dated May 16, 1988, is reversed in part and affirmed in part. The self-insured employer's January 12, 1987 denial is set aside. All remaining portions of the Referee's order are affirmed. The Board approves a client-paid fee, payable by Adjustco to its counsel, not to exceed $957.

In the Matter of the Compensation of
MARYANNE CHAMPAGNE, Claimant
WCB Case No. 88-06773
ORDER ON REVIEW
Roll, et al, Claimant Attorneys
Saif Legal, Defense Attorney

Reviewed by Board Members Crider and Brittingham.

Claimant requests review of Referee Neal's order affirming a Determination Order that awarded 25 percent (80 degrees) unscheduled permanent disability for the low back and 5 percent (7.5 degrees) scheduled permanent disability for the right leg. The issue on review is extent of permanent disability. We affirm.

FINDINGS OF FACT

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

Claimant is able to perform light work. She can no longer work as a convenience store clerk, her job at injury, or any other retail position involving substantial bending. She would be able to perform assembly work such as the position she held for ten years.

Claimant has declined vocational services.

Claimant's decision not to undergo surgery was based on Dr. Parsons' advice that she had a 75 percent chance of improvement, a 20 percent chance that her condition would neither be improved nor worsened, and a 5 percent chance that her condition would worsen with surgery. It was also based on her understanding that a lot of back surgeries do not work. Her decision not to undergo surgery was reasonable.

FINDINGS OF ULTIMATE FACT

Claimant has lost 5 percent of the use or function of her right leg and 25 percent of her earning capacity as a result of the compensable injury.

CONCLUSIONS OF LAW AND OPINION

We adopt the first and final paragraphs of the Referee's Opinion. Unlike the Referee, however, we do not find that claimant's decision not to undergo surgery for her herniated disc condition was unreasonable. As the Referee acknowledged, although the question is whether a reasonably prudent person would undergo recommended treatment given all the relevant factors including the risks of the treatment and the likelihood of improvement in the claimant's condition, compensation may not be reduced for failure to take advantage of recommended therapy unless the insurer establishes that the worker's choice was unreasonable from the worker's perspective.

In this case, claimant consulted Dr. Parsons, a neurosurgeon, who recommended surgery for the herniated disc at L5-S1. Although he advised claimant that the surgery had a 75 percent chance of success, he also advised her that it might be unsuccessful or even cause a worsening of her condition. When she declined surgery he did not press her. We believe, like the court in Clemons v. Roseburg Lumber Co., 34 Or App 134 (1978), that this worker is entitled to choose not to undertake the risks of surgery. This is especially so where, as here, there is a risk that the surgery will actually worsen the condition and an even more significant risk that it will have no beneficial result.

We have not assumed that claimant would have been less disabled had she undergone surgery. Moreover, inasmuch as we have found that claimant's conduct was not unreasonable, we have not reduced her award due to her refusal of treatment.

Nevertheless, we conclude that given claimant's residual abilities, her youth and her prior work experience, as well as the other factors noted by the Referee, the award granted by Determination Order was sufficient.

ORDER

The Referee's order, dated July 27, 1988, is affirmed.

January 31, 1990 Cite as 42 Van Natta 225 (1990)

In the Matter of the Compensation of
CAROLE J. DAMM, Claimant
WCB Case No. 88-05479
ORDER ON REVIEW
Vick & Gutzler, Claimant Attorneys
Nelson, et al, Defense Attorneys

Reviewed by Board Members Howell and Speer.

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

FINDINGS OF FACT

The Board adopts the Referee's findings of fact as set forth in the "Findings" section of the order.

ULTIMATE FINDING OF FACT

Claimant's work activities and exposures until February 1988 were a material contributing cause of a worsening of her underlying condition. Claimant's worsened condition required medical treatment and resulted in physical disability.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant's claim was one for an occupational disease. He concluded that claimant had shown that her work activities were the major contributing cause of her condition or, if the condition preexisted her employment, that it was the major contributing cause of an aggravation or worsening of her condition. We agree that claimant's condition is compensable, but we base our conclusion upon the following reasoning.

Claimant experienced symptoms of numbness and sought treatment in February 1988. A new occupational disease law became effective January 1, 1988 and ORS 656.202(2) provides that:

> "Except as otherwise provided by law, payment of benefits for injuries or deaths under ORS 656.001 to 656.794 shall be continued as authorized, and in the amounts provided for, by the law in force at the time the injury giving rise to the right to compensation occurred."

The court has held that an "injury" resulting from an occupational disease occurs on the date of last exposure. Johnson v. SAIF, 78 Or App 143, 148, rev den 301 Or 240 (1986). In the present case, the injurious exposures alleged by claimant were the impacts sustained each time her bus hit a hole or rough spot in the road. Claimant was exposed to the work activity until she sought treatment and was taken off work by her doctor in February 1988. The new occupational disease law therefore applies to claimant's case.

To be compensable under the new law, claimant's occupational disease must fall within one of the subsections of ORS 656.802(1) which defines 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."

The insurer argues that claimant's occupational disease falls within the definition of ORS 656.802(1)(a). However, in a recent case, we held that an occupational disease claim for a degenerative bone spur and low back condition fell within ORS 656.802(1)(c). Donna E. Aschbacher, 41 Van Natta 1242 (1989).

In Aschbacher, the claimant's work activities included hours of standing on her feet and walking, which her doctor related to her increased symptoms. In the present case, claimant was subjected to 19 years of exposure to a series of impacts as a result of driving a school bus. Those impacts constituted a "series of traumatic events or occurrences." Claimant's case should therefore be analyzed under subsection (c) of ORS 656.802(1).

In Dethlefs v. Hyster Co., 295 Or 298 (1983), the Court held, relying upon statutory language contained in former ORS 656.802(1)(a), that in order to establish compensability, a claimant must prove that her work exposure is the major cause of a disease. In Aschbacher, we noted that the statutory language relied upon by the Court in Dethlefs, supra, had not been retained in current ORS 656.802(1)(b) or (c). We therefore concluded that a claimant whose occupational disease falls within subsections (b) or (c) is no longer required to prove by a preponderance of the evidence that her 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 her work exposure was a material cause of her condition.

Using the rationale applied in Aschbacher, we find that claimant in this case has proven that her work exposure was a material contributing cause of a worsening of her underlying condition. That worsening required medical treat

ment and resulted in physical disability. Claimant has therefore established a compensable claim for her low back condition.

Claimant did not submit a brief on Board review. Moreover, the record does not disclose other evidence of legal representation by claimant's attorney on Board review. Accordingly, we conclude that claimant's counsel is not entitled to an award of an insurer-paid attorney fee on review. See Shirley M. Brown, 40 Van Natta 879 (1988).

ORDER

The Referee's order dated August 5, 1988 is affirmed.

January 31, 1990 Cite as 42 Van Natta 227 (1990)

In the Matter of the Compensation of
SHANNON M. EVANS, Claimant
WCB Case No. 87-19423
ORDER ON REVIEW
Malagon, et al, Claimant Attorneys
Joseph McNaught (Saif), Defense Attorney

Reviewed by Board Members Perry and Howell.

Claimant requests review of those portions of Referee Peterson's order which: (1) awarded 5 percent (16 degrees) unscheduled permanent disability for a back injury, whereas a Determination Order awarded no permanent disability; (2) upheld the SAIF Corporation's partial denial of claimant's thoraco cervical tension myalgia; and (3) declined to assess penalties and attorney fees for an alleged unreasonable denial. On review, the issues are the extent of permanent disability, the propriety of SAIF's "partial denial", and penalties and attorney fees. We affirm in part, and reverse in part.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact, subject to the following exception and additions.

We disagree with the finding that claimant's back claim was closed by Determination Order on January 20, 1987. We, instead, find that claimant's back injury claim was initially closed by Determination Order dated November 19, 1987. This Determination Order was subsequently appealed and affirmed on January 20, 1988.

Claimant has not made a claim for a thoraco cervical tension myalgia condition.

CONCLUSIONS OF LAW

We adopt the Referee's Conclusions of Law with respect to the issue of claimant's entitlement to permanent disability. However, with respect to the issue of the partial denial, we disagree for the following reasons.

Partial Denial

The Referee upheld SAIF's "partial denial" of claimant's thoraco cervical tension myalgia, concluding that she failed to meet her burden of proving the compensability of her condition. After a de novo review of the record,

we find that the issue as presented by claimant is not whether the denied condition was compensable, but whether the issuance of the denial was proper in the first instance.

Claimant asserts that the partial denial issued by SAIF is null and void because no "claim" had been filed, thus no claim existed upon which SAIF could issue a denial. SAIF argues that its partial denial is proper, in that "a carrier may, at any time, deny, in whole or in part, claims for medical expenses or disability on the ground that they are unrelated to the injury claim theretofore accepted." Johnson v. Spectra Physics, 303 Or 49, 58 (1987). We find that the issuance of SAIF's partial denial was improper under the circumstances of this case.

Claimant filed a claim for a "back" injury in March 1987. That claim was accepted and closed by Determination Order. Thereafter, during an independent medical evaluation resulting from claimant's appeal of the Determination Order, Western Medical Consultants diagnosed, for the first time, thoraco cervical tension myalgia. Claimant did not file a claim for the thoraco cervical tension myalgia, nor is there any evidence to show that claimant filed medical expense claims resulting from such condition. Ultimately, SAIF issued a "partial denial" of the condition on the grounds that it was unrelated to claimant's injury claim.

This case is substantially similar to that of Alvin H. Despain, 40 Van Natta 1823 (1988). In Despain, the employer issued a denial of certain upper extremity conditions on the grounds that they were not related to claimant's employment. The denial was issued in response to an independent medical report which diagnosed the conditions in the course of evaluating claimant's compensable bilateral forearm arthritis. Further, the employer did not have notice of a claim for the conditions which it denied, and the record in that case did not demonstrate that any treatment was planned or required for any of the denied conditions. Accordingly, the Board affirmed the Referee, who had set aside the denial as "premature."

In Sidney M. Brooks, 38 Van Natta 925, 926 (1986), we held that "precautionary denials" are appropriate to avoid the appearance of having accepted an unrelated condition. However, in Brooks, the claimant's physicians were investigating an unrelated condition at the same time they were treating an accepted condition. Here, the report which evoked SAIF's denial was not generated by any treatment of an accepted condition. Rather, the denial issued in response to a diagnosis contained in an independent medical evaluation. Inasmuch as no claim for disability or medical services concerning this diagnosis had been made, we consider the denial of such a diagnosis to be "premature", and thus, invalid.

Accordingly, the denial is set aside as premature.

Penalties and Attorney Fees

The Referee failed to address claimant's contention that the "partial denial" was unreasonable. Therefore, we discuss it 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).

We find that under these circumstances, SAIF 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 May 15, 1988, is affirmed in part, and reversed in part. The SAIF Corporation's partial denial is set aside as premature. For services at hearing and on review concerning the denial issue, claimant's attorney is awarded $1,750, to be paid by SAIF. The remainder of the order is affirmed.

January 31, 1990 Cite as 42 Van Natta 229 (1990)

In the Matter of the Compensation of
DARA A. GERVELIS, Claimant
WCB Case Nos. 86-05758, 86-01021, 86-04797, 86-04798 & 86-01862
ORDER ON REVIEW
Bottini, et al, Claimant Attorneys
Saif Legal, Defense Attorney
Roberts, et al, Defense Attorneys
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Nichols and Brittingham.

Claimant requests review of Referee Podnar's order which upheld several denials of the compensability of claimant's low back condition: the SAIF Corporation's August 13, 1985 denial; Fred S. James & Company's October 17, 1985 denial; Aetna's February 3, 1986 denial; Fred S. James & Company's April 2, 1986 denial; and SAIF's April 4, 1986 denial. The issues on review are: (1) timeliness of claimant's hearing requests on the August 1985 and October 1985 denials; and (2) compensability of claimant's low back condition for which she had surgery in November 1985. We affirm.

FINDINGS OF FACT

Claimant has a preexisting degenerative disc condition at L5-S1. In 1974, claimant was involved in a motor vehicle accident and injured several parts of her body, including her low back. After a period of treatment she experienced no further back problems until 1981.

In June 1981, claimant saw Dr. Berland, an internist, and Dr. Kayser, an orthopedic surgeon, for complaints of low back and right leg pain. She gave a history of the onset of said complaints while shopping. She subsequently received conservative treatment for what was described by Dr. Kayser as a lumbar disc syndrome (Ex. 2 and Ex. 41). At the time of this occurrence of low back and right leg pain claimant was employed as a nurse at St. Vincent's Hospital. She was off work for about three months because of her symptoms.

In the fall of 1981 claimant began working as a nurse in the oncology ward at Meridian Park Hospital. She has held the same job since then. Her work requires lifting, turning, and otherwise assisting terminally ill patients. At the time she began her employment at Meridian Park Hospital in 1981 she was having no problems with her low back.

In the spring of 1984 claimant experienced low back and right leg pain after bending and twisting at work. Claimant has not filed a claim regarding this symptomatic exacerbation. She received conservative medical treatment from Dr. Kayser (Ex. 7). No workers' compensation claim was filed. Claimant was also seen in consultation by Dr. Tanabe, a neurosurgeon. A CT scan was performed and showed a central L5-S1 disc herniation, but no nerve root impingement. No surgery was recommended (Exs. 9 and 13).

Claimant experienced no further back problems until May 1985. She saw Dr. Kayser on May 23, 1985 after recently straining her back at work lifting a patient. She was off work 2-3 days and received conservative treatment (Ex. 15). A workers' compensation claim was filed and the claim was accepted by Meridian Park's insurer, SAIF (Tr. Page 6 lines 4-5). Claimant fully recovered regarding her low back within a short time after the May 1985 injury (Ex. 24, Ex. 25, & Tr. Page 53 lines 5-14).

On July 1, 1985, Meridian Park Hospital became self-insured and Fred S. James & Company became its insurance adjuster.

On July 18, 1985 claimant hurt her low back at work again while turning a patient. Once again she saw Dr. Kayser and was treated conservatively for a brief period of time. She was off work for about a week. She then returned to her regular nursing duties. She recovered from the July 1985 injury without permanent disability or any need for further treatment after August 1985 (Exs. 17, 18, 19, 20, 24 & 25).

Claimant filed a worker's compensation claim regarding the July 1985 injury (Ex. 16). The claim was denied by SAIF on August 13, 1985 on the ground that SAIF was no longer Meridian Park's insurer (Ex. 21). Claimant received and read SAIF's denial in August 1985 and because her condition was better she decided at that time not to appeal the denial (Tr. Page 57 lines 7-14). On March 13, 1986 claimant filed an appeal of SAIF's August 1985 denial.

Claimant's July 18, 1985 injury claim was denied by Fred S. James & Company on October 17, 1985 (Ex. 26). Claimant received and read this denial and did not appeal it within 60 days. She decided not to appeal the denial for the same reason she had decided not to appeal SAIF's denial: she felt all right regarding her back and was not worried about it (Tr. Page 45 lines 6-11, Page 57 lines 7-14, Page 66 lines 7-25 & Page 67 lines 1-4). On April 7, 1986 claimant filed an appeal of Fred S. James' October 1985 denial.

Claimant returned to see Dr. Kayser, on November 15, 1985, regarding a recurrence of low back pain. She also had lower extremity symptoms at that time. Dr. Kayser prescribed bed rest (Ex. 27). Claimant saw Dr. Tanabe on November 18, 1985. Claimant had a myelogram on November 19. The myelogram showed a right L5-S1 disc herniation (Ex. 28, Ex. 29, and Ex. 30 Page 1). Claimant was scheduled for surgery. However, before the surgical date arrived claimant experienced a sudden onset of excruciating pain and this prompted an emergency hospital admission on November 21, 1985 (Ex. 30, Page 1). Dr. Tanabe performed surgery on November 23: a right L5-S1 microlaminectomy and discectomy. A very large free fragment of herniated disc material was removed (Ex. 31).

Claimant returned to work in January 1986 and has remained employed at Meridian Park Hospital since then (Ex. 37 and Tr. Page 47 lines 13-16).

On January 16, 1986 claimant filed a workers' compensation claim with St. Vincent's Hospital alleging an injury to her low back in June 1980 from lifting patients (Ex. 1). St. Vincent's insurer, Aetna, denied the claim on February 3, 1986 (Ex. 38). Claimant filed a timely request for review of that denial.

On January 16, 1986, claimant filed an occupational disease claim with Meridian Park Hospital regarding her low back for the period of 1982-September 1985 (Ex. 10). On April 2, 1986, Fred S. James & Company denied the claim with respect to its period of coverage (Ex. 45). On April 4, 1986 SAIF denied the claim with respect to its period of coverage (Ex. 46). Claimant made timely request for hearing on those denials.

Dr. Kayser authored a report on March 18, 1986 that is sufficient to establish an aggravation claim based on the accepted May 1985 injury. SAIF has never responded to that claim.

FINDINGS OF ULTIMATE FACT

Claimant's requests for hearing on SAIF's August 13, 1985 denial and Aetna's October 17, 1985 denials were not received within 60 days, nor did claimant show good cause for her failure to file timely requests for hearing.

Claimant's work at Meridian Park Hospital, either before or subsequent to July 1, 1985, was not the major contributing cause of her disc herniation and resultant surgery in November 1985.

Claimant sustained no specific work injury at St. Vincent's Hospital in 1980 or 1981. Claimant's work at St. Vincent's was not a material contributing cause of her November 1985 disc herniation and resultant surgery.

Claimant's May 1985 work injury was not a material contributing cause of her November 1985 disc herniation and resultant surgery.

Claimant suffered no specific traumatic work injury to her low back in November 1985.

CONCLUSIONS OF LAW AND OPINION

The issue in these cases is whether claimant's low back condition that required surgery in 1985 is compensable on either an occupational disease basis or with respect to a compensable specific work injury. The occupational disease theory of compensability will be addressed first. Claimant must establish by a preponderance of the evidence that her work at Meridian Park Hospital, when compared with nonwork activities, was the major contributing cause of the low back condition that required surgery in November 1985. See Devereaux v. North Pacific Insurance Co., 74 Or App 388, 391 (1985). Where there is evidence of a natural progression of an underlying disease, claimant must show that her work, compared with nonwork activity, was the major contributing cause of an acceleration of the natural progression process.

We consider this to be the kind of complex case where the resolution of the compensability issue requires expert medical opinion evidence. Dr. Kayser has not addressed the occupational disease theory in his reports. The only physicians who have done so are Dr. Tanabe, a consulting neurosurgeon, and Dr. Thompson, an orthopedic surgeon who has reviewed the pertinent records and who testified at the hearing.

Dr. Thompson opined that claimant's daily work in the oncology ward after July 1, 1985 was not the major contributing cause of her degenerative disc disease and herniated disc in November 1985 (Tr. Pages 75 & 776). Rather, he believes that the herniated disc requiring surgery in November 1985 was attributable to the natural progression of claimant's longstanding degenerative disc disease (Tr. Page 83 lines 17-21 and Page 885 lines 19-24). The most that Dr. Thompson would say regarding compensability on an occupational disease basis was that the work claimant was doing from July 1985 to November 1985 was the type that "could" cause or contribute to the condition that required surgery (Tr. Page 79). We construe this to be simply an expression of a possibility, and this is insufficient to establish compensability. Gormley v. SAIF, 52 Or App 1055, 1060 (1981). We find nothing in Dr. Thompson's testimonial that supports, in terms of medical probability, a finding that claimant's work accelerated the natural progression of her disc disease.

Some of Dr. Tanabe's comments in his February 18, 1986 report seem to address the occupational disease theory of compensability (Ex. 40). Therein he opined that claimant's 1985 injury[1] was most probably the cause of claimant's ruptured disc and that said ruptured disc was significantly aggravated by claimant's "later work activity". We do not find Dr. Tanabe's opinion persuasive because it is not well explained. Although his other reports in the record show that he was aware that claimant worked as a nurse, none of his reports persuade us that he was aware of the specific nature of claimant's nursing duties in late 1985. Further, Dr. Tanabe has not indicated whether he feels that claimant's daily work activity from 1982 to November 1985 was the major contributing cause of her condition or simply a material contributing factor.

We conclude that the medical evidence in the record does not support the compensability, on an occupational disease basis, of claimant's disc herniation and consequent surgery in November 1985.

The remaining question is whether claimant's November 1985 disc herniation was materially attributable to any specific compensable injury. We first determine whether claimant's current condition is related to a work injury at St. Vincent's Hospital. We are not persuaded that claimant suffered any specific work injury to her low back while employed at St. Vincent's Hospital. Although claimant's January 16, 1986 claim form identifies an injury in June 1980, there is nothing in the medical record or in claimant's testimony that identifies a work injury in 1980. Claimant testified that she suffered a specific work injury at St. Vincent's in 1981. She stated that she hurt her back turning a patient. She testified that this occurred shortly before she saw Dr. Berland and Dr.Kayser in June 1981 (Tr. Pages 29 and 31). However, nothing is mentioned in Dr. Kayser's June 16, 1981 report about any work incident. The only history reported by Dr. Kayser is that claimant experienced low back pain when shopping, first in January 1981 and then again in June 1981 (Ex. 2). Dr. Berland reported the same history (Ex. 41). We note that claimant did not neglect to tell Dr. Kayser about the work relatedness of her low back problem in May 1985 and July 1985 (Ex. 15 and 18). We find it likely that if anything had happened at work with respect to her low back in June 1981 claimant would have so advised Dr. Kayser.

Finally, even if claimant's back problem in mid-1981 was caused by a work injury, the evidence in the record does not causally connect claimant's low back condition that required surgery in November 1985 for a disc herniation to her low back condition in 1981. In this regard we note that in his March 1986 report Dr. Kayser referred to all of claimant's on-the-job injuries having aggravated her underlying disc condition (Ex. 42). However, Dr. Kayser could not have been referring to the 1981 occurrence because he was not aware that claimant was contending that said occurrence involved any work injury.

In addition to the lack of medical opinion evidence linking the 1985 disc herniation to the 1981 low back occurrence, the evidence in the record shows that claimant recovered from the effects of her 1981 problem and went about three years without seeing any physicians regarding her low back. We conclude that claimant's November 1985 disc herniation and surgery is not related to a work injury at St. Vincent's Hospital.

We next consider whether claimant's condition is compensable as the residual of a work injury in 1984. The evidence in the record shows that claimant experienced low back symptoms in early 1984 following a work incident, and that she subsequently received conservative treatment and had a CT scan

1. Dr. Tanabe's other reports in the record (Exs. 50a,51, and 52) indicate tht he was probably referring to the July 1985 injury.

(Exs. 7, 8, 9 and 13). However, we are without authority to find the 1985 condition compensable on this basis, as the record does not establish that claimant has ever filed a workers' compensation claim for this occurrence.

We turn to claimant's work injury in May 1985. The record shows that a claim was filed and SAIF accepted it (Ex. 15 and Tr. Page 6 lines 4-5). There is no evidence in this record that the claimant specifically filed an aggravation claim against the May 1985 injury. There is no evidence to show that the May 1985 claim has indeed been closed. Dr. Kayser's report of March 18, 1986 would be sufficient to give SAIF notice that he felt the May 1985 injury was causally related to some extent to claimant's condition in November 1985. SAIF's failure to respond in 60 days places the claim in a "de facto" denial status thus making it appropriate to address the issue of causal relationship to the 1985 injury.

The only medical opinion in the record that implicates the May 1985 work injury as a contributing cause of claimant's November 1985 disc herniation is from Dr. Kayser, as expressed in his March 18, 1986 letter and April 1, 1986 chart note (Ex. 42 and Ex. 44). Therein, Dr. Kayser included the May 1985 injury as one of several contributing factors regarding claimant's November 1985 disc rupture. However, Dr. Kayser gave no explanation for this opinion. Further, said opinion is not consistent with other evidence in the record, including Dr. Kayser's previous reports that claimant suffered only a minor sprain and had completely recovered. In October 1985, Dr. Kayser advised Fred S. James & Company that claimant became medically stationary after the May 1985 injury and before July 1985 and that her status was "o.k." (Exs. 24 and 25). His initial description of the May 1985 injury was simply a strain. He reported that claimant had no leg symptoms and no neurological findings (Ex. 15). Claimant testified that she only missed about two days of work after the May 1985 injury (Tr. Page 52 lines 21-25 and Page 53 lines 1-2). She also indicated in her testimony that she fully recovered from the May 1985 injury prior to July 1985 (Tr. Page 45 Lines 6-11 and Page 53 lines 5-14). For the above reasons, we do not find Dr. Kayser's opinion persuasive.

Rather, we find persuasive the opinion of Dr. Thompson that the May 1985 injury was not a material contributing cause of claimant's November 1985 disc herniation and surgery. The reason given by Dr. Thompson for his opinion was that the records show that claimant's May 1985 injury involved no leg pain and only a short period of back pain after which claimant recovered (Tr. Page 73 lines 21-25, Page 74 lines 1-10, Page 83, lines 7-25, and Page 84 lines 1-15). We are persuaded by this rationale. Accordingly, we conclude that claimant has not established that the May 1985 work injury was a material contributing factor regarding her November 1985 disc herniation and surgery.

We turn to the July 18, 1985 injury. Both SAIF and Fred S. James issued denials after a claim was made for the July injury. Claimant did not request a hearing on either of those denials within 60 days and has failed to show good cause for that late filing. Claimant did not request a hearing because she felt better and decided to let it go. We do not find this to be good cause. The referee dismissed the request for hearing as to these denials because they were untimely. We agree and therefore do not reach the merits of the causal relationship to the July 1985 injury.

Finally, we consider whether claimant's herniated disc is materially related to an injury in November 1985. At the hearing, claimant testified that her low back/lower extremity symptoms in November 1985 were precipitated by her work. She testified that she could not recall specifically what happened, but she was "doing something, assisting a patient and something". She said she walked out of the room and had a lot of leg pain and told her friend about it

(Tr. Page 46 lines 11-223). We do not find claimant's assertion believable. There is no evidence in the record that claimant ever filed a claim regarding this alleged specific work injury. Claimant certainly knew how to file a workers' compensation claim as shown by the one she filed in July 1985 (Ex. 16). Most significantly, there is nothing regarding this alleged specific work injury in Dr. Kayser's November 15, 1985 chart note (Ex. 27). In fact, Dr. Kayser reported at that time, and again in his April 1, 1986 chart note (Ex. 44), that there was no injury in November 1985. Claimant had advised Dr. Kayser about the work relatedness of her May and July 1985 injuries, and Dr. Kayser had put such a history in his reports (Exs. 15 and 18). We are persuaded that if there had been a specific traumatic incident at work in November 1985 it would have appeared in Dr. Kayser's November 15, 1985 history. Further, we note that Dr. Tanabe reported no history of any specific traumatic work incident in November 1985 (Ex. 28, Ex. 30, Page 1, and Ex. 34). The weight of the evidence supports a finding that there was no specific work injury to claimant's low back in November 1985.

In sum, based upon the evidence presented and for the forgoing reasons, we conclude that claimant's November 1985 disc herniation and resultant disability and medical services, including surgery, are not compensable on an occupational disease basis, nor in connection with any compensable accidental injury.

ORDER

The Referee's order, dated July 22, 1987, is affirmed. We authorize a supplemental client-paid fee for counsel for Fred S. James & Company, not to exceed $150.

January 31, 1990 Cite as 42 Van Natta 234 (1990)

In the Matter of the Compensation of
GORDON C. GREEN, Claimant
WCB Case No. 86-09604
ORDER ON REVIEW
Green, et al, Claimant Attorneys
Randolph Harris (Saif), Defense Attorney

Reviewed by Board Members Howell and Perry.

The SAIF Corporation requests review of Referee Bethlahmy's order that granted claimant an award of permanent total disability in lieu of an award by Determination Order of 30 percent (45 degrees) scheduled permanent partial disability for loss of use of his right leg. On review, the issue is extent of permanent disability, including permanent total disability. We reverse.

FINDINGS OF FACT

Claimant compensably injured his right knee in September 1982. He was 60 years old at the time of the injury. Dr. Manley, an orthopedic surgeon, performed a partial meniscectomy by arthroscope in January 1983. Claimant continued to experience pain and swelling and Manley performed a second arthroscopic operation in June 1983. The same problems continued after that operation and Manley diagnosed degenerative osteoarthritis.

In September 1984, Dr. Manley performed another operation called a valgus osteotomy. Claimant's recovery after this operation was complicated by a delayed union at the site of the osteotomy.

In January 1986, SAIF referred claimant to Richard Ross, a vocational consultant, for an evaluation of claimant's employment potential. Claimant's physician, Dr. Manley, stated that he did not think that vocational rehabilitation would be "cost effective" given the fact that claimant was then 64 years old and would reach retirement age in just one year. Claimant told Ross that he did not see any point in vocational rehabilitation because he was going to retire from the labor market on December 26, 1986, his 65th birthday.

Claimant's claim was closed by Determination Order dated June 19, 1986 with a 30 percent scheduled permanent disability award for loss of use of his right leg.

In December 1986, SAIF referred claimant to Mr. Ross for an updated vocational evaluation. Claimant told Ross that he would like to return to work but that he did not consider himself employable. He also told Ross that he had applied for and was about to begin receiving Social Security disability benefits.

Claimant was released by his physician to return to sedentary work on April 13, 1987.

Also in April 1987, claimant began to experience chest pain and was treated for a heart ailment. After this development, claimant expressed additional reservations about proceeding with vocational rehabilitation. Claimant's entitlement to vocational assistance was terminated effective April 28, 1987 on the ground that his "lack of suitable employment [could not] be resolved by currently providing vocational assistance." Claimant did not protest this action.

Claimant was 66 years of age at the time of the hearing. He completed 11 years of formal education and worked his entire adult life in residential and commercial construction. Besides Social Security benefits, claimant receives a pension from the carpenter's union. Continuation of the union pension is contingent upon claimant not working in a construction-related occupation. He has not worked or looked for work of any kind since the first surgery on his knee.

Because of the industrial injury and the subsequent surgeries, flexion of claimant's right knee joint is limited to 110 degrees and he experiences pain, weakness and some instability in the knee with prolonged standing, walking or climbing. He cannot comfortably kneel, crouch or crawl. He is able to lift up to 20 pounds from waist to shoulder level on an occasional basis. He is able to lift up to 10 pounds from knee level to overhead on an occasional basis.

Claimant has disabilities to his left hand and right shoulder which preexisted the industrial injury to his knee. He injured his left hand in a work-related automobile accident in September 1977. The claim for that injury was closed by Determination Order in April 1980 with an award of 10 percent (19.2 degrees) scheduled permanent partial disability. He injured his right shoulder in April 1979. That injury required two surgeries for repair of a torn rotator cuff. The claim for that injury was closed by Determination Order in August 1980 with an award of 20 percent (38.4 degrees) scheduled permanent partial disability.

ULTIMATE FINDINGS OF FACT

Claimant is capable of performing work of a sedentary nature. He withdrew from the labor market on December 26, 1986 and remained withdrawn as of the date of the hearing.

CONCLUSIONS OF LAW

In order to prove entitlement to permanent total disability benefits, claimant must prove that he is permanently incapacitated from regularly performing work at a gainful and suitable occupation. ORS 656.206(1)(a). Permanent total disability may result from less than total physical incapacity, when combined with non-medical factors, including "age, training, aptitude, adaptability to nonphysical labor, mental capacity, emotional condition, as well as the condition of the labor market". Wilson v. Weyerhaeuser, 30 Or App 403, 409 (1977). Unless claimant's physical incapacity in conjunction with his non-medical disabilities renders work search futile, SAIF v. Scholl, 92 Or App 594 (1988), he must also establish that he is willing to seek regular gainful employment and that he has made reasonable efforts to obtain such employment. ORS 656.206(3).

The Referee concluded that claimant was permanently and totally disabled based upon his knee impairment, his preexisting disabilities, his advanced age and his narrow work history. She noted the arguments by SAIF that claimant was capable of sedentary work and that claimant had failed to demonstrate a willingness to seek such work or to make reasonable efforts to obtain such work, but held, without explanation, that any effort by claimant to obtain such employment would be futile.

We agree that claimant is capable of at least sedentary work. We next address the question whether claimant has made reasonable efforts to obtain regular gainful employment. We note that claimant has testified that he had no intention of retiring. However, claimant has stated that he does not consider himself to be employable. Claimant was released to work by his treating physician. Physicians at the Orthopaedic Consultants believe that claimant can return to light/sedentary work. However, he has not looked for work since his physician released him. If he does return to work in the construction-related field, he will lose his carpenter's union pension. For all of the abovementioned reasons, we are not persuaded that claimant has made reasonable efforts to obtain regular gainful employment.

Nor are we persuaded that it would be futile for claimant to seek work. Ross Associates conducted at least two vocational evaluations of claimant, each time arriving at a list of jobs that claimant could perform, albeit with modifications in some cases. Ross has stated that he has valuable transferable skills related to the construction field where he has worked his entire working life.

After our de novo review of the record in this case, we conclude that claimant has failed to prove that he is or would be willing to seek regular gainful employment but for his compensable injury, or that it would be futile for him to do so. See Butcher v. SAIF, 45 Or App 313 (1980). Accordingly, claimant is not entitled to an award of permanent total disability.

Because we reverse the Referee's award of permanent total disability, we address the issue raised at hearing concerning extent of scheduled permanent disability for loss of use or function of claimant's right leg.

Extent of scheduled permanent partial disability is measured by the permanent loss of use or function of the injured member due to the industrial injury. ORS 656.214(2). In determining loss of use or function, we consider the medical and lay evidence in light of the rules as 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, 337-38, rev den 294 Or 749 (1983); Isabel Aparicio, 38 Van Natta 421, 421-22 (1986).

After de novo review of the pertinent evidence, we conclude that 30 percent (45 degrees) scheduled permanent disability appropriately compensates claimant for loss of use or function of his right leg.

ORDER

The Referee's order dated March 25, 1988 is reversed. The Determination Order dated June 19, 1986 awarding 30 percent (45 degrees) scheduled permanent disability for claimant's right leg is reinstated and affirmed.

In the Matter of the Compensation of
TERESA R. HARMON, Claimant
WCB Case No. 87-16228
SECOND ORDER ON RECONSIDERATION
S. David Eves, Claimant Attorney
Dennis Martin (Saif), Defense Attorney

The SAIF Corporation requests further reconsideration of our December 5, 1989 Order on Review, as reconsidered January 2, 1990, which reversed that portion of the Referee's order that failed to award claimant's attorney an approved fee. Specifically, SAIF asks that we resolve an alleged ambiguity between our two orders. In the interests of clarification, we grant SAIF's request.

We reiterate our previous conclusion that claimant's attorney is awarded an attorney fee equal to 25 percent of the increased permanent disability award granted by the Referee's order, not to exceed $2,800. Consequently, SAIF is directed to pay the aforementioned attorney fee.

In the event that the permanent disability award granted by the Referee has already been paid, our directive will have created an overpayment of compensation, equal to the attorney fee awarded by our order. Should those circumstances exist, SAIF is authorized to recover the overpayment created by our order against claimant's future awards of permanent disability. To the extent that statements in our prior orders suggest a decision or rationale contrary to that reached in this order, those statements are disavowed.

Accordingly, our prior orders are withdrawn. On reconsideration, as clarified herein, we adhere to and republish our prior orders, 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
JAMES R. JONES, JR., Claimant
WCB Case No. 87-08450
ORDER ON REVIEW
Malagon, et al, Claimant Attorneys
Saif Legal, Defense Attorney

Reviewed by Board Members Brittingham and Crider.

The SAIF Corporation requests review of Referee Michael Johnson's order that: (1) set aside its denial of responsibility for payment of temporary total disability compensation while claimant was incarcerated; (2) assessed a 10 percent penalty and an associated attorney fee against SAIF for its alleged unreasonable failure to pay temporary total disability compensation; and (3) awarded claimant's attorney an assessed fee for prevailing against SAIF's denial. We affirm in part and reverse in part.

ISSUES

(1) Whether the insurer properly refused to pay claimant temporary disability benefits for the period during which he was incarcerated; and

(2) penalties and attorney fees.

FINDINGS OF FACT AND ULTIMATE FACT

We adopt the Referee's findings.

CONCLUSIONS OF LAW AND OPINION

Entitlement to Temporary Disability Compensation

We affirm the Referee's ruling on this issue. The Referee concluded that SAIF's failure to pay the temporary disability benefits in question was procedurally improper. We agree with the Referee's disposition of this issue on procedural grounds. SAIF's failure to pay benefits for the period of claimant's incarceration was, in effect, an improper unilateral termination of benefits. Donny R. Rule, 41 Van Natta 73 (1989).

Penalties and Associated Attorney Fees

We affirm the Referee's opinion on this issue.

Attorney Fee for Services at Hearing

The Referee awarded claimant an assessed fee for prevailing on the temporary disability compensation issue. We, instead, conclude that claimant is entitled to an approved fee, payable out of increased compensation.

Claimant is entitled to an assessed fee under ORS 656.386(1) if he prevailed at hearing over a denial of a claim for compensation. Within this context, a "denial of a claim for compensation" is a denial of the compensability of a condition or a medical service, as opposed to a denial concerning the amount of benefits paid. Here, SAIF's denial concerned the amount of temporary disability compensation to be paid. Accordingly, claimant is not entitled to an assessed fee for prevailing against the denial. Rather, his fee is payable out of his increased compensation. ORS 656.386(2).

Parenthetically, we note that the term "denial of a claim for compensation" has the same meaning under ORS 656.262 as under ORS 656.386(1). Consequently, the 60-day filing deadline under ORS 656.262 for requesting a hearing on a denial would not apply to the denial of temporary disability compensation at issue in this case.

ORDER

The Referee's order, issued October 15, 1987, is affirmed in part and reversed in part. In lieu of the assessed attorney fee awarded by the Referee for services at hearing, we approve a fee in the amount of 25 percent of the additional compensation paid under the Referee's order, not to exceed $1,050. Claimant is awarded a $600 assessed fee for prevailing against the SAIF Corporation's request for Board review on the temporary total disability issue, to be paid by SAIF.

In the Matter of the Compensation of
RILEY E. LOTT, JR., Claimant
WCB Case Nos. 89-23291, 89-14700, 89-14699, 89-14698, 89-14697 & 89-12184
ORDER DENYING MOTION TO DISMISS
BENNETT, HARTMAN, ET AL, Claimant Attorneys
KEVIN L. MANNIX, Defense Attorney
SCHWABE, ET AL, Defense Attorneys
H. THOMAS ANDERSEN (Saif), Defense Attorney
DAVID HORNE, Defense Attorney
ROBERTS, ET AL, Defense Attorneys

Liberty Northwest Insurance Corporation has moved for an order dismissing it as a party to this proceeding on the ground that all issues concerning it have been settled, withdrawn and dismissed. The motion is denied.

FINDINGS

The Referee's order issued November 30, 1989. Pursuant to that order, CNA Insurance's denial of claimant's hearing loss claim was set aside. The Referee also upheld denials of claims for claimant's condition which had been issued by Wausau Insurance Company on behalf of its insureds, Pacific Steel Fabricators and Oregon Boiler Works. Finally, the Referee dismissed claimant's hearing requests concerning denials issued by the SAIF Corporation, Cigna Insurance Company, and Liberty Northwest. The Referee noted Liberty Northwest's stipulation that it would pay claimant a $100 assessed fee for its untimely denial.

On December 18, 1989, CNA mailed, by certified mail, its request for Board review of the Referee's order. Copies of the request were mailed to all parties to the proceeding.

CONCLUSIONS

The request for review by the Board of a Referee's order need only state that the party requests a review of the order. ORS 656.295(1). Although a Referee's conclusions and opinions in consolidated cases may be separately stated, if the Referee's decisions are contained in one final order, we retain jurisdiction to consider all matters contained therein. William E. Wood, 40 Van Natta 999 (1988).

Here, Liberty Northwest accurately notes that the Referee's order states that claimant withdrew his hearing request from Liberty Northwest's denial, apparently in return for its agreement to pay a $100 assessed fee for a late denial. Moreover, the Referee's order concludes that claimant's hearing request regarding Liberty Northwest's denial is dismissed.

Yet, such events do not justify the dismissal of Liberty Northwest as a party to this proceeding. Because Liberty Northwest was a party to the Referee's order and because its dismissal as a party is contained in that order, it must remain a party on review. See Zurich Ins. Co. v. Diversified Risk Management, 300 Or 47 (1985); Rual E. Tigner, 40 Van Natta 1789 (1988); James G. Adams, 38 Van Natta 1318 (1986); Wood, supra. Of course, considering these circumstances, Liberty Northwest's further participation in this case will likely be nominal. Adams, supra.

In reaching this conclusion, we acknowledge that our decision would appear to be contrary to that reached in Michael J. Moreno, 39 Van Natta 667 (1987). In Moreno, we dismissed a portion of a request for Board review insofar as it pertained to issues raised in a particular case number because those issues had been settled by the parties prior to the hearing. Inasmuch as it is unclear whether the settlement and dismissal of those issues were contained in the appealed Referee's order, it is unclear whether the Moreno holding directly conflicts with this decision. In any event, to the extent that Moreno can be interpreted as contrary to our conclusion, it is expressly disavowed.

Accordingly, the motion to dismiss is denied. Upon receipt of a hearing transcript, copies will be provided to the parties. Thereafter, a briefing schedule will be implemented.

IT IS SO ORDERED.

January 31, 1990 Cite as 42 Van Natta 240 (1990)

In the Matter of the Compensation of
EUGENE P. NELSON, Claimant
WCB Case No. 87-06253
ORDER ON REVIEW
Emmons, et al, Claimant Attorneys
Stafford J. Hazelett, Defense Attorney

Reviewed by Board Members Crider and Brittingham.

Claimant requests review of Referee Seifert's order which: (1) found that claimant's neck and upper back injury claim was not prematurely closed; (2) affirmed the Determination Order that awarded him no permanent disability; (3) upheld the insurer's denial of his medical services claim for neck and upper back symptoms following an off-the-job incident; and (4) declined to assess a penalty and attorney fee for the insurer's allegedly unreasonable denial. Claimant also seeks a penalty and attorney fee for the insurer's allegedly unreasonable closure of his claim. We affirm in part and reverse in part.

ISSUES

1. Premature claim closure. Was claimant medically stationary when his claim was closed by Determination Order on April 3, 1987?

2. Extent of unscheduled permanent partial disability. If claimant's claim was properly closed, how much permanent loss of earning capacity did claimant sustain due to the compensable injury?

3. Compensability of medical services for neck and upper back symptoms. Did the compensable injury materially contribute to claimant's need for neck and upper back treatment following an off-the-job incident on March 7, 1987?

4. Penalty and attorney fee for the insurer's allegedly unreasonable denial. Was the insurer's denial of medical services for claimant's neck and upper back condition unreasonable?

5. Penalty and attorney fee for the insurer's allegedly unreasonable closure of claimant's claim. Was the insurer's administrative closure of claimant's claim unreasonable?

We reverse on the issues of premature claim closure and compensability, and affirm on the remaining issues.

FINDINGS OF FACT

Claimant compensably strained his cervicothoracic spine on July 8, 1986. The claim was initially denied, but ultimately accepted by way of a stipulated settlement in early 1987. Claimant treated with Dr. Clifford, who became the treating chiropractor and continued in that role throughout the period at issue. Claimant was released to modified work on August 18, 1986, and returned to regular work without restrictions on September 15, 1986.

On November 11, 1986, claimant experienced a severe symptomatic flareup as a result of working a double shift. The frequency of treatment was increased, and claimant returned to regular work, again without restrictions.

The insurer closed claimant's claim by Notice of Closure on February 20, 1987, with an award of temporary disability benefits for the period ending September 6, 1986. The Evaluation Division subsequently issued a Determination Order on April 3, 1987. That order modified the closure notice to award additional temporary disability benefits through September 14, 1986. On March 7, 1987, almost a month before issuance of the Determination Order, claimant exacerbated his neck and upper back condition off-the-job while assisting a friend in moving a dresser into his home. He was taken off work and treated more frequently. Claimant's symptoms following the March, 1987 incident were similar in nature and location to those following the compensable injury. On May 20, 1987 the insurer denied the compensability of medical services for claimant's neck and upper back condition following the March, 1987, incident, contending that the services were the result of the intervening injury and not related to the compensable injury.

FINDINGS OF ULTIMATE FACT

1. Claimant was not medically stationary when his claim was closed by Determination Order on April 3, 1987.

2. The compensable injury materially contributed to claimant's need for neck and upper back treatment following the off-the-job lifting incident on March 7, 1987.

3. We do not find that the insurer's denial of medical services for claimant's neck and upper back condition was unreasonable.

4. We do not find that the insurer's administrative closure of claimant's claim was unreasonable.

CONCLUSIONS OF LAW

Premature Closure

The Referee apparently concluded without explanation that claimant's neck and upper back injury claim was properly closed. Claimant asserts that his

claim was prematurely closed because he was not medically stationary when the Determination Order issued on April 3, 1987. We agree and set aside that determination.

An injured worker's claim may not be closed if his condition has not become medically stationary. ORS 656.268(1). If the worker's condition is not medically stationary when his claim is closed by Determination Order, the Determination Order is premature and must be set aside. See Brown v. Jeld-Wen, Inc., 52 Or App 191, 196 (1981). "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 has the burden of proving that his claim was prematurely closed. Austin v. SAIF, 48 Or App 7, 12 (1980).

Dr. Clifford declared claimant's neck and upper back condition medically stationary as of January 5, 1987. The insurer subsequently closed claimant's claim by Notice of Closure on February 20, 1987, awarding him temporary disability benefits only. The Evaluation Division reviewed the closure notice pursuant to former ORS 656.268(3) and, on April 3, 1987, issued a Determination Order modifying the notice to award additional temporary disability benefits. On March 7, 1987, before issuance of the Determination Order, claimant exacerbated his neck and upper back condition during an off-the-job lifting incident, causing disability and requiring more frequent treatments. On review, the insurer argues that claim closure was proper because claimant was medically stationary on February 20, 1987, the date the Notice of Closure issued. We disagree with that analysis.

Former ORS 656.268(3) permitted the insurer to close an injured worker's claim by Notice of Closure, without the issuance of a Determination Order, when the worker's condition became medically stationary and the insurer determined that the claim is disabling, but without permanent disability. However, the worker was entitled to a Determination Order if requested within one year of the date of the Notice of Closure. Former ORS 656.268(3). Our review of former ORS 656.268 persuades us that a Determination Order, issued pursuant to paragraph (3) of that subsection, superseded the prior Notice of Closure. Specifically, if the Evaluation Division concluded, following its review of the worker's claim and the Notice of Closure, that claim closure was appropriate and issued a Determination Order that either affirms or modifies the closure notice, the date of issuance of the Determination Order becomes the effective date of claim closure. Because the worker's claim may not be closed unless he is medically stationary, see ORS 656.268(1), it follows that the Determination Order may not issue under former ORS 656.268(3) unless claimant is medically stationary. See Brown v. Jeld-Wen, Inc., supra. Therefore, in order for claimant to establish that his claim was prematurely closed, he must prove that he was not medically stationary due to the compensable injury when the Determination Order issued on April 3, 1987.

Dr. Clifford indicated that, following the March 7, 1987, lifting incident, claimant was no longer medically stationary and opined that the compensable injury of July 8, 1986 remained the "primary material contributing factor" in claimant's worsened neck and upper back condition (Exs 36, 43). Clifford based his opinion on the finding that the nature and location of claimant's symptoms following the compensable injury were almost identical to those following the March, 1987 incident. Dr. Duncan, a chiropractor who performed an independent medical examination (IME) in May, 1987, opined that the original compensable injury had resolved without impairment and that claimant's then-current complaints were related solely to the March, 1987 incident (Ex 34). After reviewing the conflicting opinions, we are most persuaded by Clifford's opinion. As treating physician since July, 1986, Clifford had the best opportunity to evaluate claimant's condition and its relationship to the compensable injury.

See Weiland v.SAIF, 64 Or App 810, 814 (1983). Moreover, unlike Duncan, Clifford examined claimant before and after the March, 1987 incident. See Kienow's Food Stores v. Lyster, 79 Or App 416, 421 (1986). We find, therefore, that the compensable injury remained a material contributing cause of claimant's worsened condition following the March, 1987 incident and that further material improvement was expected from chiropractic treatments and the passage of time. We find that claimant was not medically stationary due to the compensable injury when the Determination Order issued on April 3, 1987. Hence, we conclude that the Determination Order prematurely closed claimant's claim and must be set aside.

Extent of Permanent Disability

We decline to reach the extent of disability issue, because our disposition of the premature closure issue requires that we set aside the April 3, 1987 Determination Order.

Compensability of Medical Services

The Referee upheld the insurer's May 20, 1987 denial of medical services for claimant's neck and upper back condition, reasoning that the off-the-job lifting incident had intervened so as to preclude a finding of compensability. We disagree.

In disposing of the premature closure issue, we found that the compensable injury materially contributed to claimant's worsened neck and upper back condition following the off-the-job lifting incident on March 7, 1987. Because claimant's subsequent need for medical services was clearly occasioned by the worsened condition, we necessarily find that the compensable injury materially contributed to claimant's need for neck and upper back treatment. Hence, claimant's medical services claim for the neck and upper back condition is compensable. See Van Blokland v. Oregon Health Sciences University, 87 Or App 694, 697-98 (1987); Jordan v. SAIF, 86 Or App 29, 32 (1987).

Penalties and Attorney Fees

1. Denial of May 20, 1987

Claimant argues that the insurer's partial denial was unreasonable. We disagree. At the time of the denial, the insurer had in its possession Dr. Duncan's IME report (Ex 34). Duncan opined that claimant's compensable injury had resolved and that his then-current condition and resulting need for treatment was related to the off-the-job lifting incident. Based on that report, we find that the insurer had a legitimate doubt of its liability for claimant's medical services following the off-the-job incident. Therefore, we decline to assess a penalty or attorney fee based on that partial denial. See Brown v. Argonaut Insurance Company, 93 Or App 588 (1988); Peterson v. SAIF, 78 Or App 167, 172, rev den 301 Or 193 (1986).

2. Administrative Claim Closure

Claimant also argues that the insurer unreasonably closed his claim by Notice of Closure on February 20, 1987. We disagree. At the time of the insurer's administrative closure, there was uncontroverted medical evidence in its possession that claimant became medically stationary as of January 5, 1987 (Ex 23). Although chart notes submitted after the administrative closure indicated the need for further curative treatment, the insurer was clearly justified in closing the claim at the time that it did so. No penalty or attorney fee is appropriate here.

ORDER

The Referee's order dated October 2, 1987 is reversed in part and affirmed in part. The portions of the Referee's order that affirmed the Determination Order of April 3, 1987 and upheld the insurer's denial of May 20, 1987 are reversed. The Determination Order is set aside and claimant's neck and upper back injury claim is remanded to the insurer for further processing to closure. Claimant's attorney is allowed an attorney fee of 25 percent of any increased compensation created by this order, not to exceed $3,800. The insurer's denial is set aside and claimant's medical services claim is remanded to the insurer for processing according to law. For prevailing from the insurer's denial at hearing and on review, claimant's attorney is awarded an assessed fee of $2,000, to be paid by the insurer. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
JERRY S. PARKER, Claimant
WCB Case No. 88-03850 & 88-03849
ORDER ON REVIEW
Black, et al, Claimant Attorneys
Schwabe, et al, Defense Attorneys
Ronald Pomeroy (Saif), Defense Attorney

Reviewed by Board Members Perry and Howell.

United Employers Insurance Company requests review of Arbitrator Myers' order which: (1) set aside its "back up" denial of claimant's aggravation claim for a right elbow condition; and (2) upheld the SAIF Corporation's denial of claimant's "new injury" claim for the same condition. On review, the issue is responsibility. We affirm.

FINDINGS OF FACT

We adopt the Arbitrator's "Findings of Fact".

CONCLUSIONS OF LAW

We adopt the conclusions of law and reasoning set forth in the "Conclusion" section of the Arbitrator's order, with the following supplementation.

In that the order which issued pursuant to ORS 656.307 was received by the Board on March 11, 1988, our review is limited to questions of law only. ORS 656.307(2); Timothy R. Schroeder, 41 Van Natta 568 (1989).

United argued at hearing that SAIF waived its right to contest United's denial as a "back up" denial, in that it failed to raise the retroactiveness of the denial prior to the hearing. The Arbitrator did not address this issue.

Assuming that SAIF's affirmative defense was an "issue", United provides no authority or support for its contention that SAIF waived this Bauman issue merely because it was not expressly identified until the date of the hearing. Former OAR 438-06-031 provided that issues could be presented before, at or during a hearing. United's contention that SAIF waived their right to assert the "back up" denial as a defense is without merit.

With respect to the issue of responsibility, we agree with the Arbitrator that "back up" denials of responsibility are prohibited, absent fraud, misrepresentation, or other illegal activities. Ebbtide Enterprises v. Tucker, 303 Or 459 (1987). Inasmuch as United's acceptance of claimant's aggravation claim was not shown to have been based on fraud, misrepresentation, or other illegal activity, its "back up" denial is prohibited. Ebbtide Enterprises v. Tucker, supra; Bauman v. SAIF, 295 Or 788, 790 (1983).

ORDER

The Arbitrator's order, dated June 21, 1988, is affirmed. A client-paid fee, payable from United Employers Insurance Company to its counsel, not to exceed $1,318, is approved.

In the Matter of the Compensation of
STEVEN E. PUTTIE, Claimant
WCB Case No. 87-09775
ORDER ON REVIEW
Peter O. Hansen, Claimant Attorney
Saif Legal, Defense Attorney

Reviewed by Board Members Nichols and Crider.

The SAIF Corporation requests review of Referee Menashe's order that denied its request for authorization to suspend payment of claimant's permanent total disability benefits while he is incarcerated. On review, the issue is suspension of permanent total disability benefits.

The Board affirms the order of the Referee as supplemented by the following additional findings of fact and reasoning.

FINDINGS OF FACT

Claimant became entitled to permanent total disability benefits as of March 23, 1987. Claimant was incarcerated April 10, 1987.

CONCLUSIONS OF LAW AND OPINION

SAIF argues that claimant is not entitled to permanent and total disability benefits because he did not experience lost wages during his incarceration. SAIF relies on the Supreme Court's decision in Cutright v. Weyerhaeuser Co., 299 Or 290 (1985). In Cutright, the Court found that claimants who have voluntarily withdrawn from the labor market are not entitled to temporary total disability benefits for subsequent aggravations because they have not experienced lost wages.

Claimant argues that the Cutright doctrine is not applicable to permanent total disability benefits, citing the Board's decision in Everett S. Stanley, 39 Van Natta 486 (1987). The Board based its decision in Stanley on the theory that permanent disability is not based on wage replacement, so that the rationale in Cutright does not apply. The Supreme Court has since concluded otherwise in its decision in SAIF v. Stephen, 308 Or 41 (1989) (where the Court applied Cutright doctrine to permanent total disability benefits after ruling that permanent total disability is based on wage replacement).

Nevertheless, we conclude that Stephen is not applicable to the present case. In Stephen, the Court held that a claimant voluntarily withdrawing from the labor market prior to a finding of permanent total disability must establish that he or she, but for the compensable injury, is or would be willing to seek regular gainful employment in order to be entitled to an award of permanent total disability. The Court was concerned with initial entitlement to such benefits. Here, claimant had established his entitlement to a permanent total disability award prior to his incarceration. The issue in the present case is not whether claimant is entitled to permanent total disability, but whether these benefits can be suspended during his incarceration.

We conclude that, without a showing of an improvement in the physical, mental, social and vocational factors which resulted in claimant's permanent total disability award, justifying adjustment of the award pursuant to ORS 656.325(3), his benefits may not be suspended during incarceration. Accordingly, we agree with the Referee's refusal to authorize suspension of benefits. We note that the Referee's ruling is consistent with the Board's holding in Ralph E. Moen, 41 Van Natta 1231 (1989). In Moen, the Board concluded that a claimant was substantively entitled to payment of temporary disability benefits during incarceration. In support of that position, the Board reasoned that an incarcerated claimant who is medically unable to work has lost wages within the meaning of Cutright, and is therefore entitled to continued payment of temporary total disability benefits during incarceration. See also Ted W. Peckham, 41 Van Natta 609 (1989). We conclude that this reasoning is equally applicable to continued payment of permanent total disability benefits during incarceration.

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 be awarded.

ORDER

The Referee's order, dated February 1, 1988, is affirmed.

In the Matter of the Compensation of
MERLE L. ROHRICH, Claimant
WCB Case Nos. 88-22038, 88-18297 & 88-22039
ORDER DENYING MOTION TO DISMISS
Malagon, et al., Claimant Attorneys
Nancy Marque (Saif), Defense Attorney

Liberty Northwest has moved the Board for an order dismissing claimant's 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 November 30, 1989. Claimant's request for Board review of the Referee's order was received by the Board on December 15, 1989. The request did not indicate that a copy had been provided to the employer or its representatives. Neither the employer, Liberty Northwest, nor its counsel received a copy of claimant's request for review.

On December 20, 1989 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, claimant filed his request for Board review of the Referee's November 30, 1989 order on December 15, 1989. Thus, the request is timely. See ORS 656.289(3).

The other parties to the proceeding did not receive copies of claimant's request for review. However, computer-generated letters acknowledging the request were mailed to all parties to the proceeding on December 20, 1989. Since the Board's acknowledgment letter was mailed to all parties to the hearing within 20 days after the Referee's order, we conclude that it is more probable than not that the other parties received actual notice of claimant's request for review within the statutory 30-day period. See John M. Carranza, 40 Van Natta 773 (1988); John D. Francisco, 39 Van Natta 332 (1987); ORS 40.135(1)(q).

Accordingly, Liberty Northwest'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.

January 31, 1990 Cite as 42 Van Natta 247 (1990)

In the Matter of the Compensation of
MITCHELL W. SHUCK, Claimant
WCB Case Nos. 88-00202, 88-00201, 87-13744 & 88-05038
ORDER ON REVIEW
Emmons, et al, Claimant Attorneys
Dennis S. Martin (Saif), Defense Attorney
Atherly, et al, Defense Attorneys
Garrett, et al, Defense Attorneys
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Nichols and Brittingham.

Alexsis Risk Management requests review of Referee Higashi's order which: (1) set aside its denial of claimant's aggravation claim a for low back condition; (2) upheld the SAIF Corporation's denial, issued on behalf of Pat's Tavern, of claimant's "new injury" claim for the same condition; (3) upheld Northwest Farm Bureau's denial of claimant's "new injury" claim for the same condition; and (4) upheld SAIF's denial, issued on behalf of Ammon Brothers, of claimant's "new injury" claim for the same condition. On review, the issue is responsibility.

We affirm and adopt the Referee's order with the following supplementation.

FINDINGS OF FACT

The microtissue damage did not worsen the underlying condition caused by the initial injury.

CONCLUSIONS OF LAW

In successive injury cases, the second employer is responsible if the second period of employment independently contributes to the causation of the disabling condition. Hensel Phelps Const. v. Mirich, 81 Or App 290 (1986). In this case, Dr. Saboe, the treating physician, rationally explained his opinions regarding claimant's present condition being an exacerbation of the initial injury at Tiline. The microtissue damage discussed by Dr. Saboe and accepted as fact by the Referee was not shown to be a contribution to the causation of the disabling condition. The mere fact that a microscopic examination might show some tissue damage that did not exist prior to the exacerbation is not proof that the underlying condition is worsened.

ORDER

The Referee's order, dated June 10, 1988, is affirmed. Claimant's attorney is awarded an assessed fee of $1,250, to be paid by Alexsis Risk Management. The Board approves client-paid fees not to exceed the following amounts from each of the following insurers: (1) $1,738.50, Alexsis Risk Management to its counsel; (2) $221, payable from the SAIF Corporation to its outside counsel; and (3) $711.50, payable from Northwest Farm Bureau to its counsel.

January 31, 1990 Cite as 42 Van Natta 248 (1990)

In the Matter of the Compensation of
JACKIE L. SHUTTS, Claimant
WCB Case Nos. 87-06260 & 87-15413
ORDER ON REVIEW
Olson Law Firm, Claimant Attorney
Rick Dawson (Saif), Defense Attorney

Reviewed by Board Members Nichols and Brittingham.

The SAIF Corporation requests review of Referee Myzak's order which: (1) set aside its denial of claimant's aggravation claim for her current low back condition; (2) set aside its partial denial of claimant's current cervical and right arm complaints; and (3) set aside its denial of claimant's occupational disease claim for right carpal tunnel syndrome. The issues on review are aggravation and compensability.

We affirm those portions of the Referee's order that set aside the denials of claimant's current cervical and right arm complaints and right carpal tunnel syndrome. We reverse that portion which set aside the denial of claimant's aggravation claim for her low back condition. In light of this decision, we modify the Referee's attorney fee award.

FINDINGS OF FACT

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

On March 11, 1987, Dr. Akita, claimant's treating chiropractor, reported that claimant was "taken off work as of February 10, 1987 to the present due to her aggravation of her right carpal tunnel syndrome." (Ex. 27).

ULTIMATE FINDINGS OF FACT

Claimant was rendered less able to work by either a pathological or symptomatic worsening of her low back condition.

Claimant's current exacerbation is not greater in degree or duration than was anticipated by the July 10, 1985 Opinion and Order.

Claimant was not totally disabled for 14 consecutive days due to her low back condition.

CONCLUSIONS OF LAW AND OPINION

The Referee noted that, as a result of low back pain, claimant had additional restrictions placed on her activities beyond those present at the time of her last award of compensation. From this the Referee concluded that her low back condition had worsened, at least temporarily, and therefore an aggravation of her condition had occurred.

To establish a compensable aggravation, claimant must prove that: (1) her condition has worsened since the last award of compensation, so that she is more disabled, either temporarily or permanently; and (2) her compensable injury was a material contributing cause of the worsened condition. ORS 656.273(1); Grable v. Weyerhaeuser Company, 291 Or 387, 400-01 (1981); Smith v. SAIF, 302 Or 396, 399 (1986). If the claim involves an unscheduled body part, "more disabled" means increased loss of earning capacity. See Smith v. SAIF, supra.

Here, claimant began treating with Dr. Akita in January, 1987, with complaints of constant low back pain which she attributed to her compensable low back injury of June, 1983. Later in the course of treatment, claimant began complaining of neck, shoulders, and right arm problems. On February 10, 1987, Dr. Akita took claimant off work "due to an on-the-job injury suffered at Diane's Foods." This statement was later clarified by Dr. Akita to refer to claimant's carpal tunnel syndrome.

We note that on March 11, 1987, the same date that Dr. Akita sent the report to SAIF which attributed claimant's need to be released from work to her carpal tunnel syndrome, another short letter was sent by Dr. Akita to SAIF. (Ex. 27 & 28). In this letter, Dr. Akita notified SAIF that he had been treating claimant for "an aggravation of her previous on-the-job injury of 6/83." Claimant's date of injury for her low back is November 15, 1983. The initial diagnosis of claimant's carpal tunnel syndrome, which is cited in Dr. Akita's other report, was reported by Dr. Bolin on June 30, 1984.

We are persuaded by the unambiguous statement made by Dr. Akita in Exhibit 27, that claimant's release from work was necessitated by her carpal tunnel syndrome, and conclude that the "6/83" date contained in Exhibit 28 is a typographical error and should read "6/84." We further conclude that claimant's release from work was not attributable to a worsening of her low back condition.

Claimant's last award or arrangement of compensation was Referee Johnson's July 10, 1985 order, which awarded her 20 percent unscheduled permanent partial disability for her low back.

The Referee is correct in noting that claimant had increased restrictions placed on her activities by Dr. Akita as a result of her low back pain. In January 1987 these consisted of sitting and standing for no longer than 15 minutes intervals. By October 1987 claimant was allowed "to change positions from sitting to standing as needed or frequently." Ex. 45. Yet, these restrictions did not cause claimant to be released from work. However, we are persuaded that claimant's increased low back symptoms resulted in a diminishment of her earning capacity beyond the level fixed at the time of her last award or arrangement of compensation.

In those cases in which the last award or arrangement of unscheduled permanent partial disability compensation anticipated future exacerbations, accompanied by a diminished earning capacity, the claimant must also prove that her earning capacity was diminished longer or in greater degree than was anticipated, or that her exacerbation resulted in 14 consecutive days of total disability or inpatient hospitalization. Edward D. Lucas, 41 Van Natta 2272 (1989)

Prior to the last award, some of the medical reports state that claimant can be expected to have periodic exacerbations. Since July 1985, claimant has had flare ups of her low back problem. In her testimony, when asked if the symptoms in her low back changed in late 86 or early 87, claimant replied "it started swelling again," "like it always had." Claimant further acknowledged that she continued to work after her low back exacerbated until she was taken off work because of her arm complaints.

Based on the medical reports of expected exacerbations and claimant's testimony that her symptoms were similar to what they had been, we find that the exacerbation did not exceed what had been anticipated. Since claimant's exacerbation in January 1987 did not exceed what was anticipated in the last award of compensation, and the record is devoid of evidence which would show she was totally disabled for 14 consecutive days, due to her low back condition, claimant has failed to prove an aggravation.

Concerning the compensability issue for claimant's current cervical and right arm conditions and occupational disease claim for right carpal tunnel syndrome, we adopt the Referee's conclusions and opinion as our own.

Claimant's counsel is statutorily entitled to a reasonable, insurer-paid attorney fee for services rendered on Board review concerning the partial denial and occupational disease issues. 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 May 13, 1988 is reversed in part, modified in part and affirmed in part. That portion of SAIF's denial of April 14, 1987 which denied claimant's claim for aggravation of her low back condition is reinstated and upheld. In lieu of the Referee's attorney fee award concerning this denial, claimant's attorney is awarded $750, to be paid by SAIF. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
THERESA SIEFER, Claimant
WCB Case No. 88-07428
ORDER ON REVIEW
Roll, et al, Claimant Attorneys
Mark Bronstein (Saif), Defense Attorney

Reviewed by Board Members Crider and Brittingham.

Claimant requests review of Referee Neal's order which: (1) increased her scheduled permanent disability award for the loss of use or function of the left arm from 5 percent (9.6 degrees), as awarded by Determination Order, to 10 percent (19.2 degrees); (2) affirmed the Determination Order award of 10 percent (19.2 degrees) scheduled permanent disability for the loss of use or function of the right arm; (3) declined to direct the SAIF Corporation to reimburse her for medical and mileage expenses; (4) declined to assess a penalty and attorney fee for SAIF's allegedly unreasonable refusal to reimburse her for medical and mileage expenses. On review, the issues are extent of scheduled permanent partial disability, penalties and attorney fees, and medical services.

The Board affirms and adopts the Referee's order with the following additional findings and conclusions.

Claimant contends on review that, contrary to the Referee's findings, she established that SAIF has received certain requests for reimbursement of medical and travel expenses and thus is entitled to an order requiring reimbursement and penalties and attorney fees. She relies on the mailing presumption.

We agree that claimant may rely on a rebuttable presumption of receipt of a document if she establishes that she has properly addressed a letter enclosing the document and deposited it in the mails. In this case, however, claimant's testimony concerning the method of mailing, the identity of the documents mailed and the services for which she sought reimbursement is too imprecise to allow us to make findings permitting us to conclude that the expenses are compensable and to order them paid. This does not preclude her, however, from seeking reimbursement of them from SAIF in the future.

ORDER

The Referee's order dated August 2, 1988, is affirmed.

In the Matter of the Compensation of
JEFFREY K. STAFFORD, Claimant
WCB Case No. 87-09052
ORDER ON REVIEW
Gatti, et al, Claimant Attorneys
Harold M. Sliger, Attorney
Sharon Schooley (Saif), Defense Attorney
Carl M. Davis, Assistant Attorney General

Reviewed by Board Members Howell and Speer.

Claimant requests review of Referee McGeorge's order which set aside the SAIF Corporation's acceptance of his back injury claim, issued on behalf of

the alleged noncomplying employer. On review, the issues are compensability, jurisdiction and compliance. We affirm.

FINDINGS OF FACT

Claimant was hired by Walter Summerton, in February 1987, to assist Summerton in installing natural gas pipe in a restaurant. Claimant was hired by Summerton as an individual, not by Summerton's business, Adept Mechanical Specialists.

It was anticipated that the job would take only two days to complete. Claimant was to earn no less than $5 per hour. He was actually paid a total of $90.

Claimant worked with Summerton on Friday February 20, 1987, making preparations to begin the job. On Saturday February 21, 1987, claimant and Summerton worked installing pipe. Neither worked on Sunday February 22, 1987.

Claimant asserted that he was injured on February 22, 1987. On March 20, 1987, he filed a workers' compensation claim. On April 22, 1987, the Compliance Division found Walter Summerton, dba Adept Mechanical Specialists, to be a non-complying employer, and that claimant was a subject employee of Adept Mechanical Specialists on the date of his alleged injury. SAIF accepted claimant's claim, as processing agent, on June 1, 1987.

ULTIMATE FINDINGS

Claimant was not injured on the job while working with Summerton installing gas pipe.

Claimant's employment with Summerton was casual and Summerton did not employ any other subject employees. Summerton was not a subject employer.

CONCLUSIONS OF LAW AND OPINION

Prior to SAIF's acceptance of the claim, both Summerton and his attorney wrote letters to the Workers' Compensation Department (Workers' Compensation Division) requesting a hearing to contest compensability. The Referee subsequently found that, because of many inconsistencies in claimant's testimony, he had not injured his back at work and, thus, denied compensability of the claim.

On review, claimant argues, citing Derryberry v. Dokey, 91 Or App 533 (1988), that his claim had not originally been properly denied because those letters were not mailed to him and did not meet the requirements of ORS 656.262; and, as a result of SAIF's acceptance, he was entitled to compensation. However, that portion of Derryberry that suggests it is a noncomplying employer's responsibility to accept or deny a claim has been disavowed. Clark v. Linn, 98 Or App 393 (1989). In Clark v. Linn, the court held that an alleged noncomplying employer which requests a hearing on compensability is entitled to such a determination whether or not the employer properly denied the claim pursuant to ORS 656.262.

Claimant next argues that the Referee did not have jurisdiction to hear the issue of compensability because the employer requested a hearing on the issue before SAIF had accepted the claim. Nevertheless, 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. Thomas v. SAIF, 64 Or App

193 (1983). Here, claimant did not object at hearing and the issue was fully litigated. The Referee, therefore, had jurisdiction to hear the issue.

In her Opinion and Order, the Referee stated that because she had found the claim to be noncompensable, the issue of noncompliance was rendered moot. We disagree. The request for hearing challenging the Proposed and Final Order of the Compliance Division cannot be ignored. Because the record was adequately developed and because the request for hearing must be disposed of, on de novo review we consider the issue of noncompliance of Mr. Summerton. See Destael v. Nicolai Company, 80 Or App 596, 600-01 (1986).

In order to be a noncomplying employer, the employer must first be a subject employer; i.e., employ one or more subject workers in the state. ORS 656.023. "Subject worker" is defined by ORS 656.027. All workers are subject workers except those expressly designated as nonsubject. Subsection (3) of ORS 656.027 applies in the present case and designates a nonsubject worker as:

> "(3)(a) A worker whose employment is casual and either:
>
> "(A) The employment is not in the course of the trade, business or profession of the employer; or
>
> "(B) The employment is in the course of the trade, business or profession of a nonsubject employer."

Casual employment refers to those "employments where the work in any 30-day period, without regard to the number of workers employed, involves a total labor cost of less than $200."

Claimant's employment was "casual" under either subsection (A) or (B). He was hired to work at most two days, and was to be paid $5 per hour. The actual amount paid claimant by Mr. Summerton was $90. The evidence indicates that Summerton, as an individual, employed no other workers.

Accordingly, we conclude that claimant's employment was casual and that Mr. Summerton did not employ any other subject workers. Mr. Summerton was not a subject employer within the meaning of ORS 656.023 and thus, was not a noncomplying employer.

ORDER

The Referee's order dated June 7, 1988 is affirmed. The Department's April 22, 1987 Proposed and Final Order finding the employer to be noncomplying is set aside.

January 31, 1990 Cite as 42 Van Natta 253 (1990)

In the Matter of the Compensation of
DENNIS WILLIAMS, Claimant
WCB Case Nos. 87-17220 & 88-03048
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Employers Defense Counsel, Defense Attorneys
Ronald Pomeroy (Saif), Defense Attorney

Reviewed by Board Members Brittingham and Crider.

The SAIF Corporation requests review of Referee Mongrain's order which found that claimant was a subject worker of SAIF's insured at the time of injury. On review, the sole issue is subjectivity. We affirm and adopt the order of the Referee with the following additional findings.

At the time Dan Hutchison and his crew signed up for the Canyon Mountain fire, Hutchison asked what the men would be paid for firefighting work. The man who signed them up quoted hourly rates which varied depending on the nature of the work performed.

Claimant was employed by the State Department of Forestry at the time he was injured.

ORDER

The Referee's order dated July 26, 1988, is affirmed. Claimant's attorney is awarded an assessed fee of $425, to be paid by the SAIF Corporation. The Board approves a client-paid fee, not to exceed $858, for services of counsel for Liberty Northwest.

In the Matter of the Compensation of
R. J. WILLIS, Claimant
WCB Case No. 87-15112
ORDER ON REVIEW
Stebbins & Coffey, Claimant Attorneys
Saif Legal, Defense Attorney

Reviewed by Board Members Crider and Nichols.

The SAIF Corporation requests review of the portion of Referee Mongrain's order that granted claimant permanent total disability. On review, the sole issue is permanent total disability.

We affirm and adopt the Referee's order with the following supplementation and exception.

FINDING OF ULTIMATE FACT

Claimant cannot regularly perform any work at a gainful and suitable occupation.

CONCLUSIONS OF LAW AND OPINION

To establish his entitlement to permanent total disability (PTD), claimant must prove that he cannot regularly perform any work at a gainful and suitable occupation. ORS 656.206(1)(a); Harris v. SAIF, 292 Or 683, 695 (1982). Claimant does not contend that he is physically incapacitated; therefore, he can prevail only if he proves that he is PTD under the so-called "odd-lot" doctrine. Under that doctrine, an injured worker, capable of performing work of some kind, may still be permanently and totally disabled due to a combination of his physical condition and certain nonmedical factors, such as age, education, work experience, adaptability to nonphysical labor, mental capacity and emotional conditions. Clark v. Boise Cascade Corp., 72 Or App 397, 399 (1985).

We agree with the Referee's conclusion that at least a portion of claimant's current disability due to Parkinson's Disease preexisted the industrial accident and, therefore, may be considered in determining claimant's PTD status. See ORS 656.206(1)(a). However, in the last paragraph of page three of his order, the Referee apparently considered claimant's tremors due to Parkinson's Disease as they appeared at hearing. That is error. There is persuasive evidence that the Parkinson's Disease and related tremors have worsened since the industrial accident (Ex 34); therefore, the post-accident worsening of claimant's tremors should not be considered in the PTD analysis. Bob G. O'Neal, 37 Van Natta 255 (1985), aff'd mem O'Neal v. Borden, Inc., 77 Or App 194 (1985). Nevertheless, after considering claimant's preexisting disability due to Parkinson's Disease and his current disability due to the neck injury, as well as nonmedical factors of age, education and prior work experience, we conclude that claimant has established his entitlement to PTD under the odd-lot doctrine.

ORDER

The Referee's order, dated February 5, 1988, is affirmed. Claimant's attorney is awarded an assessed fee of $1,000, to be paid by the SAIF Corporation.

In the Matter of the Compensation of
JESSE L. COLBERT, Claimant
WCB Case No. 88-03550
ORDER ON REVIEW
Emmons, Kyle, et al, Claimant Attorneys
Jeff Gerner (Saif), Defense Attorney

Reviewed by Board Members Brittingham and Nichols.

Claimant requests review of those portions of Referee Brazeau's order that: (1) declined to grant permanent total disability, and (2) increased claimant's unscheduled permanent disability award for a low back injury from 40 percent (128 degrees), as awarded by Determination Order, to 85 percent (272 degrees). On review, the issue is extent of permanent disability, including permanent total disability.

We affirm and adopt the Referee's order with the following supplement.

CONCLUSIONS OF LAW AND OPINION

The treating physician's failure to release claimant to return to work coupled with his statement that claimant could do certain sedentary jobs creates an ambiguity. That ambiguity works in claimant's disfavor when assessing whether it is futile for him to seek work. See Smith v. Brooks-Scanlon, Inc., 54 Or App 730 (1981).

ORDER

The Referee's order dated July 1, 1988, is affirmed.

In the Matter of the Compensation of
LANCE O. GLOVER, Claimant
WCB Case No. 88-01364
ORDER ON REVIEW
Welch, et al, Claimant Attorneys
Roberts, et al, Defense Attorneys

Reviewed by Board Members Gerner and Cushing.

The self-insured employer requests review of that portion of Referee McGeorge's order which set aside its denial of claimant's aggravation claim, and claimant cross-appeals Referee McGeorge's failure to assess penalties and associated attorney fees for the insurer's alleged failure to provide documents. On review, the issues are aggravation and penalties and associated attorney fees. We affirm.

FINDINGS OF FACT

Claimant compensably injured the cervical and lumbar regions of his back on May 21, 1986, while employed as a prefitter for a door company. The claim was subsequently closed by Determination Order, dated August 26, 1986, which awarded temporary disability only.

Shortly thereafter, claimant's condition worsened and the claim was reopened. The claim was closed by Determination Order, dated April 3, 1987, awarding temporary disability only.

Claimant requested a hearing from these Determination Orders. Pursuant to an October 13, 1987 stipulation, claimant was awarded 2 percent permanent unscheduled disability.

From February 1987 until December 1987, claimant received no medical treatment for his back condition. He did not return to work. Sometime in late November or early December 1987, claimant began collecting unemployment compensation.

In early December, 1987, while playing basketball with his son, claimant exacerbated his underlying back condition. He received chiropractic treatment from Dr. Ferrante, who authorized a release from work for approximately two weeks.

On December 29, 1987, the employer denied claimant's aggravation claim, indicating that, "it does not appear that your condition was worsened by or arose out of and in the course of your employment." Claimant requested a hearing.

In March, 1988, Ferrante reported that claimant should not return to his previous employment as a glazer, and should avoid heavy lifting and awkward positions. In April, 1988, Dr. Grossenbacher, independent medical examiner, reported that claimant was capable of returning to modified employment.

CONCLUSIONS OF LAW

The Referee set aside the self-insured employer's denial of claimant's aggravation claim, reasoning that claimant established an aggravation by proving that the symptomatology of his condition was more disabling than at the time of the last arrangement of compensation. Further, the Referee concluded that claimant's increased pain made him less able to work than at the time of the

last arrangement of compensation, and thus he had established an aggravation claim. We agree, but with different reasoning.

Aggravation

As a general rule, in an unscheduled disability case a claimant is entitled to have his claim reopened under ORS 656.273 when, as a result of a symptomatic worsening of his compensable condition, he is less able to work than at the time of the last arrangement of compensation. Smith v. SAIF, 302 Or 396 (1986). The worsening may be either temporary or permanent.

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 periods of increased symptoms or exacerbation of the physical condition, 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 earning capacity was diminished to the extent of total disability, and resulted in 14 consecutive days of total disability or inpatient hospitalization. Edward D. Lucas, 41 Van Natta 2272 (1989).

After a de novo review of the record, we find that claimant has established a symptomatic exacerbation of his back condition.

As a result of claimant's increased symptoms in December, 1987, Drs. Ferrante, chiropractor, and Grossenbacher, M.D., reported that claimant had suffered a worsening of his underlying condition. At that time, Ferrante authorized time loss and found claimant not medically stationary due to the worsening. In a letter to claimant's attorney, Ferrante noted that claimant should not return to his "previous work as a glazer", and he should stay away from heavy lifting and awkward positions. Grossenbacher, in his second independent medical examination of claimant, concluded that, "it appears that [claimant] has sustained a temporary, material worsening of his condition related to his 21 May 1986 injury."

We also find that as a result of the exacerbation, claimant's earning capacity was diminished below the level fixed at the time of the last arrangement of compensation.

Not every exacerbation of a physical condition or symptoms results in a diminished earning capacity. Whether claimant suffered a diminished earning capacity is a question of fact. Perry v. SAIF, 307 Or 654 (1989). If claimant's earning capacity was diminished, even temporarily, below the level fixed at the time of the last award or arrangement of compensation, the worker's condition will generally have worsened and he or she will be entitled to additional compensation under ORS 656.273(1). Smith, supra.

With respect to claimant's diminished earning capacity, it is well established that claimant's back condition at the time of the last arrangement of compensation was resolved. He was authorized to return to regular work by two physicians, Grossenbacher and Reynolds, M.D. In May 1987, Dr. Graham noted that claimant suffered from "minimal impairment", but indicated specifically that claimant was "fully employable", with no limitations. Moreover, claimant testified that at the time of the last arrangement of compensation, he was in good physical health, capable of working at a regular job, with no limitations.

Claimant suffered the exacerbation in December, 1987. His treating chiropractor, Ferrante, authorized a release from work for approximately two weeks.

Ferrante noted that claimant should not return to his regular work as a glazer, and that he should avoid heavy lifting and awkward positions.

In April 1988, Grossenbacher, in his second independent medical examination, reported that claimant was still complaining of back pain. Although Grossenbacher reported that claimant's condition was unchanged from his previous examination in September 1986, he noted that claimant was capable of returning only to "modified employment."

Because we find that at the last arrangement of compensation claimant was capable of returning to regular employment without limitations and that, as a result of his December 1987 exacerbation, he was able to return to only modified work, with limitations of no heavy lifting and working in awkward positions, we find that claimant has proven that his worsened condition resulted in a diminished earning capacity.

Claimant must also establish whether the last arrangement of compensation anticipated future periods of increased symptoms or exacerbations of the physical condition, resulting in diminished earning capacity, in order to establish entitlement to additional compensation. Lucas, supra.

The record contains medical reports documenting the original injury, and a subsequent aggravation of that injury in August 1986. The August 1986 aggravation resulted in total disability for approximately one week. In May 1987, claimant's physician, Graham, reported that claimant did suffer from "minimal impairment", but he did specifically note that claimant was "fully employable" with no limitations. Other than the one aggravation, there is nothing in the record to suggest that the parties anticipated future flare-ups of claimant's back condition. In light of the fact that claimant had suffered from only one aggravation, and that claimant had not seen a physician for approximately ten months prior to the time of the last arrangement of compensation, we conclude that the October 1987 stipulation did not contemplate future periods of increased back symptoms accompanied by diminished earning capacity.

Because we find that the last arrangement of compensation did\not anticipate future periods of increased symptoms, or exacerbation of the physical condition, accompanied by a diminished earning capacity, we conclude that claimant's diminished earning capacity in December 1987 constitutes an aggravation within the meaning of ORS 656.273.

Penalties and Attorney Fees

We adopt that portion of the Referee's "Conclusions of Law" which discusses penalties and attorney fees for an alleged failure to provide information.

ORDER

The Referee's order, dated June 8, 1988, is affirmed. For services on Board review, concerning the aggravation issue, claimant's attorney is awarded $850, to be paid by the self-insured employer. A client-paid fee, not to exceed $1,679.50, is approved, payable from the self-insured employer to its counsel.

In the Matter of the Compensation of
EDWIN A. STEINBORN, Claimant
WCB Case No. 87-03249
INTERIM ORDER OF REMAND
Emmons, Kyle, et al, Claimant Attorneys
Williams, et al, Defense Attorneys

Claimant requests review of Referee Daron's order that upheld the self-insured employer's denial of claimant's claim for coronary artery disease, peptic ulcer disease, gastritis, diabetes and obesity. We remand.

Should we determine that a case has been improperly, incompletely, or otherwise insufficiently developed, we may remand to the Referee for further evidence taking, correction, or other necessary action. See ORS 656.295(5). Considering the circumstances of this case, we conclude that remand is an appropriate action.

Claimant is an asthmatic who began working for the employer in 1969. He subsequently experienced periods of increased asthma symptoms. Reports of claimant's treating physician, Dr. Bardana, noted claimant's work exposure as the only complicating factor in his asthma. However, it appears that Bardana did not tell claimant that he had an occupational asthma problem.

In 1971, claimant was first prescribed prednisone to control his asthma. Prednisone is a steroid which causes numerous side-effects. Beginning in 1974, claimant was diagnosed with numerous other conditions, including coronary artery disease, a peptic ulcer, gastritis, diabetes and obesity. Claimant's asthma condition worsened further in 1986, and Bardana took him off work. This was claimant's first notice that his work exposure might have contributed to his asthma condition. He filed a claim for respiratory difficulty, and the employer concedes that it accepted the claim. The acceptance is not in the file.

The record indicates that claimant's prednisone use contributed to his current conditions. Claimant contends that the employer accepted an occupational aggravation of asthma dating back to 1971, so that it is responsible for the consequences of the prednisone use. The employer contends that it accepted only the 1986 worsening and is, therefore, not responsible for side effects of the prednisone use. If the employer's acceptance is clearly very broad, we would conclude that it accepted the asthma condition dating back to 1971. In that event, the employer will be responsible for claimant's current conditions. If it is narrower, we may need to make additional findings in order to resolve the compensability issues before us.

As a copy of the acceptance is not included in the record, we conclude that this case has been improperly, incompletely or otherwise insufficiently developed. Accordingly, this matter is remanded to Referee Daron with instructions to include the acceptance in the record. Referee Daron should then issue an interim order on remand discussing the effect, if any, the acceptance has upon his prior order. We retain jurisdiction over this matter. Upon receipt of Referee Daron's order, we shall proceed with our review.

IT IS SO ORDERED.

In the Matter of the Compensation of
EVELYN M. STRAYER, Claimant
WCB Case No. 87-17586
ORDER ON REVIEW
Victor Calzaretta, Claimant Attorney
Roberts, et al, Defense Attorneys

Reviewed by Board Members Cushing and Gerner.

Claimant requests review of those portions of Referee Bennett's order which: (1) upheld the self-insured employer's denial of claimant's claim for a low back condition; (2) declined to assess penalties and attorney fees for alleged unreasonable denial; and (3) refused to admit into evidence the testimony of the treating chiropractor. On review the issues are compensability, evidence, penalties and attorney fees. We affirm.

FINDINGS OF FACT

Claimant was a phlebotomist for the employer for almost nine years. She drew blood from approximately 65 patients per day. To do so, claimant would bend over a table for one to two minutes per patient. Claimant experienced intermittent lower back pain for three or four years prior to July 30, 1987. She had not missed work or seen a physician for her back pain prior to July 30, 1987.

During the morning of July 30, 1987, claimant drew blood from a couple of patients. Around mid-morning, claimant's back started to bother her. She told a co-worker that it was hurting her back to put away supplies. The next day, claimant's back discomfort was worse.

On August 3, 1987, Dr. O'Leary, M.D. examined claimant. Claimant reported that the cause of her back condition was the repetitive act of bending over low tables. On August 6, 1987, claimant filed her 801 form noting that, "I was bent over drawing blood & felt a 'twinge' in my back." (Ex. 1). The employer first had knowledge of the claim on August 4, 1987.

On August 28, 1987, Dr. O'Leary reported that claimant was medically stationary. Dr. Zivin, M.D., neurologist, noted that claimant returned to work on September 1, 1987.

In October, 1987 claimant's back condition worsened. She experienced a recurrence of low back pain, and for the first time felt radicular symptoms into the left lower extremity.

On October 26, 1987, Dr. Fish, chiropractor, examined claimant. Fish reported that claimant experienced left leg and gluteal pain.

Shortly thereafter, Dr. Wayson, M.D., microneurosurgeon, reported that claimant's MRI scan showed a disc herniation at L3-4 with inferior migration.

On November 2, 1987, the employer denied claimant's back strain claim.

Four days later, Dr. Wayson performed surgery for a herniated disc. Claimant's disc herniation was caused by degenerative disc disease which was neither caused nor worsened by either a work incident or her work activities.

At hearing, the Referee excluded the testimony of Dr. Fish due to claimant's failure to timely disclose Fish as an expert witness.

CONCLUSIONS OF LAW

Claimant objects to the Referee's decision to omit Dr. Fish's testimony at hearing. We conclude that the decision was within the discretion of the Referee.

Parties are required by OAR 438-07-016 to disclose beforehand the appearance of expert witnesses. Failure to comply with this rule may be a ground for exclusion of expert testimony upon motion. Here, the employer was not informed of Dr. Fish's live testimony before the hearing. Considering such circumstances, we conclude that it was within the Referee's discretion to omit Dr. Fish's testimony.

We adopt the "opinion" section of the Referee's order.

ORDER

The Referee's order, dated August 16, 1988, is affirmed. A client-paid fee, not to exceed $1,434, payable from the self-insured employer to its counsel, is approved.

February 2, 1990 Cite as 42 Van Natta 261 (1990)

In the Matter of the Compensation of
BRIAN J. BROWN, Claimant
WCB Case No. 88-01397
ORDER ON REVIEW
Black, et al, Claimant Attorneys
Garrett, et al, Defense Attorneys

Reviewed by Board Members Cushing and Myers.

Claimant requests review of Referee Thye's order which: (1) upheld the insurer's denial of an industrial injury claim; and (2) declined to assess a penalty and attorney fee for an allegedly unreasonable denial. On review the issues are compensability and the reasonableness of the denial. We affirm.

FINDINGS OF FACT

On January 18, 1988, claimant was working as a cook for the employer. On that morning, claimant slipped on some bacon grease and fell to the floor of the kitchen, injuring himself. The fall was witnessed.

Claimant was angry at the employer on that morning and told a fellow employee that he intended to slip in some bacon grease and fall while somebody was watching. The floor of the kitchen had been cleaned the night before. The bacon grease appeared to have been placed on the floor in a solid form, rather than spilled while still in a hot liquid form.

Claimant deliberately caused the fall and injury.

CONCLUSIONS AND OPINION

If a worker intentionally causes his own injury, that injury is not covered under the Workers' Compensation Act. ORS 656.156(1). The Referee concluded, and we agree, that the testimony that claimant deliberately caused the slip and fall on the bacon grease is more persuasive than claimant's testimony

to the contrary. Consequently, we conclude that claimant intentionally caused his own injury and that it is, therefore, not compensable.

In view of the facts, the denial was reasonable.

ORDER

The Referee's order, dated May 31, 1988, is affirmed. The Board approves a client-paid fee, payable from the insurer to its counsel, not to exceed $1,112.50.

February 2, 1990 Cite as 42 Van Natta 262 (1990)

In the Matter of the Compensation of
LINDA A. STEVENSON, Claimant
WCB Case Nos. 87-07020 & 86-15450
ORDER ON RECONSIDERATION
Schouboe, Marvin, et al, Claimant Attorneys
Norman Cole (Saif), Defense Attorney

Claimant requests reconsideration of those portions of our January 11, 1990 Order on Review that declined to address certain arguments raised by claimant on review because they had not been presented at the hearing. Enclosing an amended specification of issues and referring to a portion of the hearing transcript, claimant asserts that the issues of interim compensation, penalties and attorneys fees pertaining to the 1986 tendinitis claim were raised at hearing.

The amended specification of issues contains a "x" beside "Penalties & Attorney Fees." In addition, the document lists "unreasonable delay in acceptance or denial" concerning a "6/22/87" denial. However, the Referee's order identified and addressed 17 issues, several of which pertained to penalties and attorney fees. Moreover, the parties spent a significant period of time at hearing clarifying the issues to be addressed. Yet, interim compensation, penalties and attorney fees in regards to a 1986 tendinitis claim were neither mentioned at hearing nor in the Referee's order.

Claimant admits that a "long list of issues was dealt with off the record." She also suggests that a transcript reference to "late denial" in regards to the "6/22/87" denial encompasses the aforementioned issues. Considering that the issues to be resolved by the Referee were discussed by the parties prior to the beginning of the testimony and since 17 issues were identified and addressed by the Referee's order (none of which concerned interim compensation, penalties, and attorney fees concerning a 1986 tendinitis claim), we continue to be unpersuaded that the aforementioned issues were raised at hearing.

Accordingly, our January 11, 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.

In the Matter of the Compensation of
WILBUR E. GUNDERSON, Claimant
WCB Case No. 88-00166
CORRECTED ORDER ON REVIEW
Myrick, et al, Claimant Attorneys
Cowling & Heysell, Defense Attorneys

Reviewed by Board Members Brittingham and Nichols.

The insurer requests review of those portions of Referee Mills' order that: (1) found that claimant's May 1987 compensable back injury claim was prematurely closed; and (2) awarded claimant 25 percent (80 degrees) unscheduled permanent disability for the May 1987 back injury, whereas a Determination Order awarded no permanent disability. On review, the issues are premature closure, jurisdiction and, alternatively, unscheduled permanent disability. We affirm on the issue of premature closure. Inasmuch as we find that the Referee lacked jurisdiction to make an initial determination of the extent of claimant's permanent disability, we reverse the Referee's award as premature and remand to the insurer for processing to closure.

FINDINGS OF FACT

The Board adopts the Referee's Findings of Fact.

FINDINGS OF ULTIMATE FACT

At the time of the December 28, 1987 Determination Order, further improvement in claimant's condition would reasonably be expected from medical treatment or the passage of time.

CONCLUSIONS OF LAW AND OPINION

The Board adopts the Referee's reasoning and conclusion on the premature closure issue. However, we find that the Referee had no authority to close the claim and rate the extent of disability.

This was a first closure of a claim for a "new injury" of the same body part. The parties stipulated at the hearing to have the Referee rate extent, provided that he found claimant to be medically stationary on a date prior to the hearing. The Referee so found and proceeded to rate the extent of claimant's permanent disability. We conclude that the Referee lacked authority to make the first determination in this claim.

At the time of claimant's 1987 injury, a Notice of Closure or Determination Order was necessary to effect an initial claim closure. See ORS 656.268. In Woodward v. C & B Logging, 82 Or App 274 (1986) the court held that in the 1979 version of ORS 656.268(2), a Determination Order was a condition precedent to claim closure. In the case at bar, the insurer did not issue a Notice of Closure. A Determination Order issued, but was set aside as premature. Because the Determination Order no longer existed, there was in effect no claim closure. Under the applicable statute and the analysis used by the court in Woodward, supra, the claim could not be closed by Referee order. Rather, the claim must be remanded to the insurer for proper closure by issuance of a Determination Order or a Notice of Closure.

This procedure assures that claimant's aggravation rights are established by the first determination under ORS 656.268 as set forth in ORS 656.273(4). The Referee had no jurisdiction to close the claim and to rate the extent of unscheduled permanent disability. We remand the claim to the insurer for processing.

Claimant is entitled to an attorney fee for prevailing on the premature closure issue. ORS 656.382(2). However, because no statement of services has presently been submitted, no fee can be awarded. See OAR 438-15-010(5).

ORDER

The Referee's order, dated May 13, 1988, is affirmed in part and reversed in part. The Referee's permanent disability award is reversed as premature. The claim is remanded to the insurer for further processing according to law. 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 $513.

In the Matter of the Compensation of
MELTON J. JACKSON, JR., Claimant
WCB Case No. 87-07304
CORRECTED ORDER ON REVIEW
Saif Legal, Defense Attorney

Reviewed by Board Members Crider and Brittingham.

Claimant, pro se, requests review of those portions of Referee Michael Johnson's order which: (1) upheld the SAIF Corporation's partial denial of claimant's right carpal tunnel syndrome and low back injury claim; (2) awarded 5 percent (16 degrees) unscheduled permanent disability for a neck injury, whereas a Determination Order awarded no permanent disability; and (3) declined to assess penalties and attorney fees for alleged unreasonable claims processing. Claimant has also moved for remand to the Referee for the taking of additional evidence. On review, the issues are remand, compensability, extent, penalties and attorney fees. We deny the motion and affirm.

FINDINGS OF FACT AND ULTIMATE FACT

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

Claimant commenced modified work, at regular wages, the day following the September 17, 1986 incident. At that time, SAIF's insured had sufficient facts to reasonably conclude that workers' compensation liability was a possibility. Claimant did not report to work on September 19, 25 and 26, 1986, for unknown reasons. He left work again on September 29, 1986, to conduct personal business, and he never returned. He did not seek medical treatment for the alleged injury until October 13, 1986. Claimant filed his claim the next day.

The record was not improperly, incompletely or otherwise insufficiently developed.

CONCLUSIONS OF LAW AND OPINION

Remand

After the hearing, claimant, pro se, submitted additional medical chart notes and requested that the case be remanded to the Referee for the taking of that evidence. The chart notes dated September 14 and 17 were obtainable with due diligence prior to the date of the hearing. The chart notes dated May 12, June 6, 10 and 23, 1988 represent claimant's medical condition subsequent to the date of the hearing.

Claimant requests that the Board consider this "new evidence", which he contends was unobtainable at the time of hearing. We deny the motion.

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 clearly be 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. Osborn, 37 Van Natta 1054, 1055 (1985), aff'd mem, 80 Or App 152 (1986).

We are not persuaded that the record concerning the compensability issue has been improperly, incompletely or otherwise insufficiently developed. We acknowledge that four of the chart notes were not obtainable at the time of the hearing, since they represent post-hearing medical reports. However, these particular chart notes do not pertain to claimant's condition at the time of, or prior to, the hearing. Therefore, they are irrelevant.

With respect to the remaining two chart notes, dated prior to the date of the hearing, there has been no showing by claimant that this evidence was not obtainable prior to, or at the time of, the hearing. In any event, we find them to be cumulative. Consequently, we conclude that remand is not warranted.

Compensability and Extent of Permanent Disability

We adopt the Referee's opinion on these issues.

Penalties and Attorney Fees

The Referee found that the employer did not have knowledge of the claim until the date of its filing, October 14, 1986, because the injury was not of the type which would ordinarily give an employer notice that a potential claim existed. The Referee concluded, therefore, that the first payment of disability, made on October 28, 1986, was timely made. We agree with that result, but for different reasons.

ORS 656.262(4) requires that the first payment of compensation be made no later than 14 days after the employer has notice or knowledge of the claim.

After a de novo review of the evidence, we find that the employer knew that claimant was involved in a work related incident in which he was injured. The issue, then, is whether or not the employer had notice or knowledge of the possibility of a claim. Such knowledge would trigger the duty to pay interim compensation pursuant to ORS 656.210(3).

> "Knowledge of the injury must be sufficient reasonably to meet the purposes of prompt notice of an industrial accident or injury. . . . However, knowledge of the injury should include enough facts as to lead a reasonable employer to conclude that workers' compensation liability is a possibility and that further investigation is appropriate."
> Argonaut Insurance Co. v. Mock, 95 Or App 1 (1989).

In the present case, the employer knew that claimant had sustained a work injury, and claimant returned to modified work the day following the incident. Because so, we find that the employer had sufficient facts to conclude that workers' compensation liability was a possibility, and thus a duty to pay interim compensation was triggered.

However, even if the employer had knowledge of the claim, there was no duty to pay unless claimant was eligible for interim compensation. A claimant is eligible only if he left work and suffered a loss of wages due to the alleged disability. See Bono v. SAIF, 298 Or 405 (1984). We conclude that claimant has not established that he was eligible for temporary disability benefits on the fourteenth day after notice or knowledge of the claim. ORS 656.210(3) provides that, "[n]o disability payment is recoverable for temporary total disability suffered during the first three calendar days after the worker leaves work as a result of the compensable injury unless the total disability continues for a period of 14 days or the worker is an inpatient in a hospital." Accordingly, claimant did not "leave work", within the meaning of Bono v. SAIF, until the injury caused him to miss work for more than three days.

Here, claimant left work on September 19, 1986, and again on September 24 and 25, 1986. Claimant again left work beginning on September 29, but for personal business reasons, and never returned.

We conclude that even if claimant can establish that he missed work on September 19, 24 and 25, 1986 because of the incident, he must establish that he missed days in addition to those three days to require the insurer to pay interim compensation. On October 1, 1986, the fourteenth day, therefore, claimant had missed, at most, three days of work as a result of the injury. Under ORS 656.210(3), then, he was not yet entitled to payment.

Where claimant is not eligible for compensation on the fourteenth day after notice or knowledge of the claim, OAR 436-60-150(3)(b) provides that the first installment of compensation shall be made "no later than the fourteenth day after . . . employer's notice or knowledge of temporary disability related to but subsequent to the injury, which is payable." The employer, here, had no way of knowing that temporary disability compensation was payable under ORS 656.210(3) until it received a Form 827, dated October 21, 1986, indicating that claimant was disabled due to the injury, commencing October13, 1986. An initial payment was made within 14 days of the employer's knowledge that claimant had missed more than 3 days of work due to the injury and thus was eligible for interim compensation.

In summary, we hold that the employer had notice or knowledge of the claim on September 18, 1986. Further, such knowledge triggered its duty to begin interim compensation, if due. Yet, because claimant has not established that he had missed work for more than three days as a result of the injury by the fourteenth day, no interim compensation was due. See ORS 656.210(3).

The employer's first notice that claimant had "left work" as a result of an alleged compensable injury was received no earlier than October 21, 1986, the date of the Form 827. Because the injury did not cause claimant to "leave work" at the outset and the first installment of interim compensation was made within 14 days of notice that claimant "left work", we conclude that interim compensation payments were timely made and that the claim was reasonably processed.

ORDER

The Referee's order, dated April 7, 1988, is affirmed.

In the Matter of the Compensation of
STEVEN RAY PITTMAN, Claimant
And In the Matter of the Complying Status of
GREAT NORTHWEST TOWING CORPORATION, Employer, and
Jacqueline Coly, Individually as Registered Agent for Employer
WCB Case Nos. 88-07088 & 88-07087
ORDER OF DISMISSAL
Tom Ewing (Saif), Attorney
Carl M. Davis, Assistant Attorney General

The alleged noncomplying employer, pro se, requests review of Referee Neal's order which dismissed her request for hearing. On review, the issue is the propriety of the Referee's dismissal. We dismiss the request for review for lack of jurisdiction.

FINDINGS OF FACT

The alleged noncomplying employer timely filed a hearing request concerning a Director's proposed order finding the employer to be noncomplying. On May 10, 1988, the Hearings Division issued a Notice of Hearing, which set a hearing for July 13, 1988. On July 18, the Referee entered an Opinion and Order dismissing the noncomplying employer's request for hearing. The Referee's order concludes in part:

"NOTICE TO ALL PARTIES: If you are dissatisfied with this Order, you may, not later than thirty (30) days after the mailing date of this Order, request a review by the Worker's Compensation Board..."

CONCLUSIONS OF LAW AND OPINION

If any party requests a hearing on a Director's proposed order regarding noncompliance or any other matter unrelated to a claim, the Board appoints a Referee to hold a hearing. ORS 656.283(4); Heinz J. U. Sauerbrey, 37 Van Natta 1512 (1985). That is the Board's only involvement in cases such as this. 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. ORS 183.480(1), (2); see Stanley Wilson, 40 Van Natta 387 (1988).

Although there appears to be another case under discussion regarding the denial of claimant's claim, which apparently was not requested by claimant, the employer's request for hearing related solely to the issue of noncompliance. Inasmuch as SAIF's denial of the claim was not at issue, any reference to that issue is gratuitous. Because the Referee's order solely concerned the noncompliance order, the Board does not have jurisdiction over the employer's request for review. Because we lack jurisdiction to review the Referee's order, the appeal must be dismissed.

It is regrettable that the state of this case and the Referee's statement of appeal rights may have misled the parties. However, our jurisdiction is statutory and an incorrect statement of appeal rights cannot expand or contract the jurisdiction. See Gary O. Soderstrom, 35 Van Natta 1710 (1983).

Accordingly, the request for Board review is dismissed.

IT IS SO ORDERED.

In the Matter of the Compensation of
CLINTON F. SEALS, JR., Claimant
WCB Case No. 87-05808
CORRECTED ORDER ON REVIEW
Andrew H. Josephson, Claimant Attorney
Roberts, et al, Defense Attorneys

Reviewed by Board Members Nichols and Crider.

Claimant requests review of Referee Tuhy's order that: (1) upheld the insurer's denial of medical services for a neck and back condition; and (2) denied claimant's request for a penalty and attorney fee.

ISSUES

On review, the issues are: (1) whether the medical services claim was barred by res judicata; (2) whether the Referee properly excluded a medical report offered into evidence by claimant; (3) compensability of the medical services claim; and (4) penalties and attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT AND ULTIMATE FACT

The Board adopts the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Res Judicata

The Referee concluded that claimant was barred from litigating his entitlement to ongoing medical services under the application of res judicata, relying on North Clackamas School Dist. v. White, 85 Or App 560 (1987). Subsequent to the Referee's decision, the Supreme Court reversed that decision in North Clackamas School Dist. v. White, 305 Or 48 (1988). In so doing, the Court held that, although the doctrine of res judicata is applicable in this forum, under the facts of the case the issue in the second proceeding was not, in fact, litigated in the first proceeding. Id. at 52, 56-58.

We conclude that this case is factually indistinguishable from White insofar as the question of what issues were, and were not, litigated in the first proceeding. Here, the issues before Referee Thye in the first proceeding were premature claim closure and, in the alternative, extent of disability. (Ex. 26-1). Referee Thye ruled that claimant's claim had not been closed prematurely and that claimant was not entitled to compensation for permanent disability. (Ex. 26-3, 4). The closest Referee Thye came to any decision regarding medical treatment was his conclusion that the treatment claimant was receiving at the time of claim closure was palliative. He then stated: "This type of care may be compensable under ORS 656.245 after a medically stationary level has been attained." (Ex. 26-3, emphasis added.) He made this remark in the context of discussing whether claimant was medically stationary as of claim closure. The Referee found that treatment was palliative not curative; that finding was necessary to his decision. He made no findings as to whether claimant's injury caused the need for medical services. We conclude that claimant is not barred from litigating the question of his current need for medical services. Accordingly, we reverse the Referee on this issue.

Exclusion of Evidence

Assuming the claim was not barred by res judicata, the Referee ruled that claimant's current need for medical services had not been established to be due in material part to his industrial injury. The Referee seemed to reach this

conclusion on the basis that claimant had not sought treatment for three and one-half years and had experienced his 1986 symptoms after playing softball extensively. Claimant contends that the Referee improperly excluded a medical report bearing on this question. We address this evidentiary matter before turning to the compensability issue.

The Referee issued his first order on August 3, 1987, and then withdrew his order on September 2, 1987 for reconsideration. The excluded medical report was written by claimant's former attending chiropractic physician on September 10, 1987. We conclude that the excluded report was or should have been reasonably obtainable with due diligence before the July 21, 1987 hearing. The Referee correctly excluded the report. See Bernard L. Osborn, 37 Van Natta 1054, 1055, aff'd mem Osborn v. SAIF, 80 Or App 152 (1986).

Compensability

We disagree with the Referee's ruling that claimant's need for treatment is not related to the compensable injury. The fact that symptoms were triggered by softball in 1982 does not necessarily mean that, in 1986, softball was the exclusive cause of claimant's symptoms. If the injury played a part, the services are compensable. Grable v. Weyerhaeuser Co., 291 Or 387 (1981). The only medical opinions in the record addressing this issue support a causal relationship between the injury and the treatment. (Ex. 31, 32, 34). These opinions were based on an accurate history. In the absence of contrary medical evidence, we defer to these opinions and conclude that the treatment is compensable. Accordingly, we reverse the Referee on this issue.

Penalties and Attorney Fees

The Referee declined to assess a penalty and associated attorney fee for the insurer's failure to accept or deny claimant's medical services claim within 60 days. We disagree.

Under ORS 656.262(10), if a carrier "unreasonably delays acceptance or denial of a claim . . . [it is] liable for an additional amount up to 25 percent of the amounts then due plus any attorney fees which may be assessed under ORS 656.382." The insurer has provided no explanation for its delay. Accordingly, we conclude that the delay is unreasonable and assessment of a penalty and attorney fee is appropriate.

The insurer argues that a penalty cannot be assessed because there are no "amounts then due." In this regard, the insurer relies on ORS 656.262(6), which provides that "[p]ending acceptance or denial of a claim, compensation payable to a claimant does not include the costs of medical benefits . . . ." (emphasis added). The insurer argues that the medical benefits in question were not "compensation" pending its denial, so that there were no amounts due and no unreasonable resistance to the payment of compensation.

We do not agree that ORS 656.262(6) is applicable in the present case, where the claim is for medical services on an accepted injury, as distinct from an initial claim for an injury or condition. See Eastmoreland v. Reeves, 94 Or App 698, 702 (1989). We, instead, rely upon ORS 656.005(8), which includes in the definition of "compensation" medical services provided for a compensable injury.

Accordingly, we reverse the Referee on this issue and assess a penalty and attorney fee under ORS 656.262(10).

Finally, claimant's counsel is statutorily entitled to a reasonable, insurer-paid attorney fee for services rendered at hearing and on 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, issued August 3, 1987, as reconsidered October 13, 1987, is reversed in part and affirmed in part. The insurer's medical services denial is set aside, and the claim is remanded to the insurer for further processing according to law. We assess a 25 percent penalty on all medical bills due at the time of the insurer's denial. The remainder of the Referee's order is affirmed. We authorize a client-paid fee, payable from the insurer to its counsel, not to exceed $696.

In the Matter of the Compensation of
CLAUDE SNOW, Claimant
WCB Case No. 88-09822
THIRD ORDER OF DISMISSAL
Hayner, et al, Claimant Attorneys
Schwabe, et al, Defense Attorneys

Claimant requests reconsideration of our January 22, 1990 Second Order of Dismissal which declined to award an assessed fee where the self-insured employer's request for review was dismissed prior to our review. In reaching our conclusion, we relied upon Agripac, Inc. v. Kitchel, 73 Or App 132 (1985). Seeking to remedy "this unfair situation", claimant asks either that the dismissal be withdrawn and the case proceed to review or that we make a finding that the compensation awarded by the Referee's order shall not be disallowed or reduced. We are without authority to grant either request.

We know of no basis for refusing to dismiss the self-insured eployer's request for review once it was withdrawn. Further, claimant did not timely file a request or cross-request for Board review of the Referee's order. ORS 656.289(3). Consequently, upon the withdrawal and dismissal of the employer's request for review of the Referee's order, that order became final. Thus, we no longer have jurisdiction to proceed with a review of the Referee's order. Eder v. Filcher Construction, 89 Or App 425 (1988). Lacking such jurisdiction, it logically follows that we cannot render a finding as claimant requests.

In conclusion, we certainly empathize with the situation which confronts claimant's counsel. However, based upon the aforementioned points and authorities, the limits of our statutory power are clear.

Accordingly, our prior orders are withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our prior orders, 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
HERBERT C. AUSBIE, Claimant
WCB Case No. 88-08507
ORDER ON RECONSIDERATION
Philip Schuster II, Claimant Attorney
Stafford J. Hazelett, Defense Attorney

On January 23, 1990, we abated our January 8, 1990 Order on Review which had reversed a Referee's order that set aside a denial of claimant's injury claim for bilateral bone spurs. After further consideration of the matter, we withdraw our prior order and issue the following order.

FINDINGS OF FACT

Claimant, 48 years of age, began working as a door, window, and molding installer in February 1988. When installing doors, claimant would often place the door on his feet to elevate it into position. When retrofitting windows or installing molding, claimant would also kneel and flex his toes. On February 18, 1988, claimant complained of foot pain and took the afternoon off. Claimant returned to work on February 19, 1988, and continued to work until March 3, 1988, when he was laid off due to lack of work. Claimant filed an industrial accident claim on March 5, 1988, indicating his feet were affected and that he had a history of bone spurs.

On March 3, 1988, Dr. Hayhurst, M.D., examined claimant. X-rays demonstrated medial, lateral and dorsal lipping. Initially, the diagnosis was degenerative arthritis. Dr. Hayhurst later diagnosed exostosis. On June 30, 1988, Dr. Wisdom, M.D., claimant's treating physician, reported that claimant's foot condition had undergone progressive deterioration over the years, and that this trend was likely to continue.

On March 22, 1988, the insurer denied the March 5, 1988 claim. (Ex. 4). On April 21, 1988, the insurer issued a second denial asserting that claimant's current condition was neither a compensable industrial injury nor an occupational disease.

Claimant had a bilateral bone spur condition, which preexisted his employment of February, 1988. His work activities, after that date, contributed to increased symptoms.

CONCLUSIONS OF LAW

The Referee concluded that claimant's foot condition was compensable using an accidental injury analysis. Although we agree that the condition is compensable, we do so based on different reasoning.

To establish a compensable industrial injury, claimant has the burden of proving that a work event was a material contributing cause of his disability or need for medical services. Harris v. Albertson's Inc., 65 Or App 254 (1983). If the condition resulted from a sufficiently discrete period of work activity, an industrial injury rather than an occupational disease, is indicated. See Valtinson v. SAIF, 56 Or App 184 (1982).

Here, claimant was employed as a carpenter. He claimed compensability based on a series of events within a discrete period of time. On February 18, 1988, claimant complained of foot pain, nevertheless, he continued to work until March 3, 1988, when he was laid off for reasons unrelated to his medical condition. Claimant filed the report of injury on March 5, 1988.

A compensable industrial injury requires a finding that the alleged medical condition was "sudden in onset." Valtinson, supra. In the case at bar, there was no incident that caused claimant's bilateral bone spurs to worsen at an identifiable moment. Dr. Wisdom indicated that claimant's foot condition was not caused by one identifiable incident, rather his foot condition flared up as a result of the day to day work duties of a carpenter.

Under these circumstances, we find that claimant's bilateral bone spurs developed over a period of time. Consequently, claimant's February 1986 trauma does not satisfy the "sudden in onset" requirement. Accordingly, his claim should be analyzed as an occupational disease rather than an accidental injury.

Before reaching claimant's occupational disease claim on its merits, it is first necessary to decide which version of ORS 656.802(1) is applicable. This provision was revised by the legislature in 1987 and the revised version of ORS 656.802(1) became effective January 1, 1988. Here, the injurious exposure alleged by claimant is the extensive use of his feet inherent in his job duties. Claimant continued to perform his job duties until March 1988 and thereafter sought medical treatment. Accordingly, we conclude that the new occupational disease law applies to claimant's claim. See Johnson v. SAIF, 78 Or App 143, 148, rev den 301 Or 240 (1986).

The current version of ORS 656.802(1) contains three subsections. We conclude that this case falls under subsection (c) of ORS 656.802(1). Dr. Wisdom describes the onset of claimant's condition as resulting from "multiple repeated episodes of trauma" and related the increased symptomatology to his work as a carpenter. Therefore, we analyze this case under subsection (c) of ORS 656.802(1). See Donna E. Aschbacher, 41 Van Natta 1242, 1244 (1989).

In order to prevail on an occupational disease claim under ORS 656.802(1)(c), claimant must prove that his work activities were a material contributing cause of his condition. Id. at 1246. If claimant's condition preexists his employment, he need not establish a pathological worsening, but only that the work activities materially contributed to a symptomatic worsening of the preexisting condition. Id. at 1249.

Here, Dr. Wisdom found that claimant's foot symptoms had been growing worse slowly, and that his employment as a carpenter had contributed to a flare-up of the preexisting condition. Although he did not feel that claimant's work activities caused or pathologically worsened his foot condition, Dr. Wisdom opined that claimant's work activities rendered the condition symptomatic and necessitated medical treatment.

We find Dr. Wisdom's opinion, as claimant's treating physician, to be thorough and well reasoned. Consequently, we find it persuasive. Weiland v. SAIF, 64 Or App 810 (1983); Somers v. SAIF 77 Or App 259 (1986). Accordingly, claimant has established that his work exposure was a material contributing cause of his symptomatic worsening.

ORDER

Our Order on Review, dated January 8, 1990, is withdrawn. The Referee's order, dated July 28, 1988, is affirmed. For services on review, claimant's counsel is awarded a reasonable assessed fee of $600.

In the Matter of the Compensation of
JIMMY C. BUTLER, Claimant
WCB Case No. 86-13658
ORDER ON REVIEW
Starr & Vinson, Claimant Attorneys
William Blitz (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

Claimant requests review of Referee Mirassou's order that upheld the insurer's denials of claimant's aggravation claims for his low back condition. Claimant also contends that his proposed back surgery is a reasonable and necessary medical service. On review, the issues are aggravation and medical services. We affirm.

FINDINGS OF FACT

The Board adopts the Referee's findings of fact as set forth in the "Findings" section of the order and opinion.

ULTIMATE FINDING OF FACT

Claimant's proposed low back surgery is not a reasonable and necessary medical service.

CONCLUSIONS OF LAW AND OPINION

Aggravation

We adopt the Referee's "Conclusions and Reasons" with the following modification.

We agree with the Referee that claimant has failed to prove a worsening of his condition or symptoms. However, we do not agree with the Referee's conclusion that, for purposes of proving a worsening, the last award of compensation was a June 28, 1985 Order on Review.

We have held that, when there has been a hearing on extent of disability, the date of the last award or arrangement of compensation is the date of the final opportunity to present evidence at the hearing, notwithstanding subsequent appeals. Joseph R. Klinsky, 35 Van Natta 332 (1983), aff'd mem 66 Or App 193 (1983). We apply similar rationale in the present case and find that claimant's extent of disability hearing in November 1984 was the last award of compensation for purposes of proving a worsening.

Our decision in regard to the date of the last award or arrangement of compensation does not change the outcome of this case. We conclude that claimant has not proven a worsening of his symptoms or condition since November 1984. See Perry v. SAIF, 307 Or 654 (1989).

Medical Services

Claimant asserts that his proposed back surgery is reasonable and necessary. Claimant's treating doctor, however, conditionally recommended surgery if claimant felt that he was unable to return to work. Since Dr. Smith's recommendation, claimant had returned to temporary work as a groundskeeper. In addition, Dr. Campagna, who examined claimant between 1985 and 1987, determined that surgery was not indicated. Because of Dr. Campagna's opportunity to observe claimant over a longer period of time and because the recommendation of the treating doctor was conditional, we find that claimant's proposed back surgery has not been shown to be reasonable and necessary. See Kienow Food Stores v. Lyster, 79 Or App 416 (1986).

ORDER

The Referee's order dated May 11, 1988 is affirmed.

In the Matter of the Compensation of
KENNETH R. DERRICK, Claimant
WCB Case No. 86-08269
ORDER ON REVIEW
Royce, et al, Claimant Attorneys
Schroeder & Sullivan, Attorneys
Gary Wallmark (Saif), Defense Attorney
Carl Davis, Assistant Attorney General

Reviewed by Board Members Perry and Howell.

Gibbs Brothers, a noncomplying employer, requests review of that portion of Referee Huff's order which assessed penalties and attorney fees for an unreasonable delay in the payment of compensation against the employer's claims processor, the SAIF Corporation. In his respondent's brief, claimant contends that the Referee erred in declining to award a carrier-paid attorney fee for prevailing against an alleged "de facto" denial of the claim. On review, the issues are penalties and attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact as our own.

CONCLUSIONS

The Referee assessed penalties against SAIF, as claims processor for the noncomplying employer, for an alleged unreasonable delay in the payment of compensation. The Referee also awarded claimant's attorney an associated attorney fee for his services at hearing regarding the issue of the alleged unreasonable delay.

In making his determination, the Referee relied upon ORS 656.262(3) and (10) for authority to assess a penalty against SAIF. Acknowledging that ORS 656.054 specifically regulates claims processing in noncomplying employer situations, the Referee nonetheless assessed a carrier-paid fee under ORS 656.382(1) for a delay in payment of compensation.

Penalties and Attorney Fees

The Referee concluded that ORS 656.262(3) subjects the noncomplying employer to a penalty and attorney fees under ORS 656.262(10). We disagree for the following reasons.

> "ORS 656.262(3) provides, that "Employers shall, immediately and not later than five days after notice or knowledge of any claims or accidents which may result in a compensable injury claim, report the same to their insurer. . . (emphasis supplied)."
>
> Subsection (10) of ORS 656.262 provides,
>
> "If the insurer or self-insured employer unreasonably delays or unreasonably refuses to pay compensation, or unreasonably delays acceptance or denial of a claim, the insurer or self-insured employer shall be liable for an additional amount up to 25 percent of the amounts then due plus any attorney fees which may be assessed under ORS 656.382."

The Referee found that there was no reason why the term "employers", as the term is used in ORS 656.262(3), should not be construed to include "noncomplying employers".

Both SAIF and the noncomplying employer contend that ORS 626.262(3) is inapplicable because even though the noncomplying employer was an "employer", it was not insured. Because the noncomplying employer was not insured for workers' compensation coverage, SAIF argues that it had no duty under ORS 656.262(3) to comply with the five-day reporting requirement. Further, SAIF asserts that ORS 656.054 specifically provides statutory authority with respect to claims processing requirements for noncomplying employers. Accordingly, SAIF contends that neither it, nor the employer, is subject to penalties and attorney fees under ORS 656.262(3) and (10) under these circumstances. We agree.

Here, claimant was injured on April 17, 1985. At the time of the incident, the employer was "noncomplying." As such, it did not have an insurer to whom it would have been required to report the incident pursuant to ORS 656.262(3). Therefore, we find that the noncomplying employer was not subject to the five-day reporting requirement.

ORS 656.262(10) authorizes assessment of a penalty and attorney fee against an insurer or self-insured employer. Even if the noncomplying employer had unreasonably delayed reporting this claim, it was not an insurer or self-insured employer. ORS 656.262(10) does not authorize assessment of a penalty and attorney fee against a noncomplying employer because of a noncomplying employer's delay. But See ORS 656.735.

Claims processing requirements for noncomplying employers are set forth in ORS 656.054. ORS 656.054 provides in part:

> "(1) 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. 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 installment 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 supplied)

Here, the noncomplying employer notified the Workers' Compensation Department of the injury on June 21, 1985. Claimant's attorney submitted claimant's eye injury claim to SAIF on October 24, 1985. Despite the notice, the first installment of compensation was not due to be paid until the Director referred the claim to SAIF. See ORS 656.054(1). Therefore, SAIF had no statutory duty to make its first installment of compensation until the Director referred the claim to it. Unfortunately, in this particular situation, the claim was not referred to SAIF until January 30, 1986, some six months later.

The Referee specifically found that SAIF promptly paid interim compensation payments after the Director referred the claim, timely accepted and processed claimant's claim to closure, and timely paid all compensation that was due. We agree with the Referee's findings, and therefore conclude that, under the circumstances, there was no unreasonable delay in the payment of compensation by SAIF. Accordingly, no penalties and attorney fees may be assessed.

Carrier-Paid Fee/De Facto Denial

We adopt the Referee's "Conclusions of Law" with respect to the "de facto" denial issue, as discussed in the last paragraph on page three of the Referee's order, with the following supplementation.

Claimant contends that the Referee erred in declining to award a carrier-paid attorney fee for prevailing against an alleged "de facto" denial of the claim. However, the Referee specifically found that no "de facto" denial was at issue. Thus, no carrier-paid fee could have been assessed in "prevailing against an alleged 'de facto' denial."

ORDER

The Referee's order, dated February 23, 1988, is reversed in part and affirmed in part. That portion of the Referee's order which assessed penalties and an associated $1,700 attorney fee for an alleged unreasonable delay in the payment of compensation, is reversed. The remainder of the Referee's order is affirmed.

February 6, 1990 Cite as 42 Van Natta 276 (1990)

In the Matter of the Compensation of
HOMER B. HARTMAN, Claimant
WCB Case No. 85-12969
ORDER ON REVIEW
Charles Duncan, Claimant Attorney
Schwabe, et al, Defense Attorneys

Reviewed by Board Members Crider and Nichols.

The self-insured employer requests review of Referee Mills' order that granted claimant permanent total disability, whereas a Determination Order awarded 40 percent (128 degrees) unscheduled permanent disability for a right shoulder injury. On review, the issue is permanent total disability. We affirm.

FINDINGS OF FACT AND ULTIMATE FACT

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

Claimant is able to lift no more than 10-15 pounds; cannot perform work overhead; and is limited in his ability to push due to the compensable shoulder injury. (Ex 9, 11D; Tr. 11-12).

Preexisting arthritis of the hands and wrists interferes with claimant's ability to perform tasks requiring manual dexterity. Preexisting arthritis of the spine interferes with claimant's ability to climb, walk more than four blocks, and sit for more than 15 minutes to one half hour.

He is precluded from doing all but light work.

Claimant did not seek to terminate vocational services. However, he was unable to return to any job for the employer-at-injury. The employer was offering a special severance pay package to employees who would retire from the company. Claimant retired pursuant to that program. He was told by his vocational counselor that if he retired from the employer, he would no longer be eligible for vocational assistance. Therefore, he signed a letter prepared by the counselor declining further services.

Claimant made reasonable efforts to find suitable employment.

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

Claimant's current physical limitations, in conjunction with his lack of education and transferable skills and his preexisting disabling conditions, make it futile for him to seek gainful employment.

The 12-hour-a-week position considered by claimant's vocational counselor is not gainful and suitable employment.

CONCLUSIONS OF LAW AND OPINION

We adopt the Referee's Conclusions of Law as found in the "Opinion" section of the order with the following supplementation.

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 total disability, under the "odd-lot" doctrine, arising from less than total physical incapacity plus non-medical conditions, which together result in permanent total disability. Welch v. Bannister Pipeline, 70 Or App 699 (1984); Wilson v. Weyerhaeuser, 30 Or App 403 (1977). Claimant must also establish that he has made reasonable efforts to perform any work at a gainful and suitable occupation, unless it is shown that efforts to obtain such gainful and suitable work would be futile. ORS 656.206(1)(a); Butcher v. SAIF, 45 Or App 318 (1983).

Claimant is not totally incapacitated on a physical or medical basis. Consequently, claimant can only prevail by proving that he falls within the "odd-lot" doctrine. Under that doctrine, a disabled person, with some residual physical capacity, may still be permanently totally disabled due to a combination of his physical condition and certain non-medical 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). As previously discussed, claimant must also demonstrate that he is willing to reenter the work force and that he has made reasonable efforts to do so.

The medical evidence establishes that claimant suffered a compensable shoulder fracture in 1986, for which he was subsequently awarded 40 percent (128 degrees) unscheduled permanent disability. Claimant's impairment from his shoulder injury was rated by his treating physician, Dr. Butters, as mild to moderate.

Claimant also suffers from a number of other preexisting physical disabilities, which, together with his shoulder injury, prevent him from returning to his work at the time of the injury. Specifically, claimant suffers from symptomatic degenerative arthritis and emphysema.

Claimant also suffers from disabling depression, stemming as far back as 1967 when he was hospitalized for it. Claimant has treated with antidepressant medication over the years. So long as he maintains the medication, he does not have significant difficulty. He also suffered a broken leg in 1963. As with the depression, there is no indication this injury now contributes to claimant's disability.

Claimant, 64 years of age at hearing, worked in the lumber industry practically all of his life. He has an eighth grade education, has limited reading skills, and no GED. Claimant's treating physician, Dr. Butters, reported that

claimant would never be able to return to the work he did at the time of the injury. We agree.

We conclude that claimant's disability, in combination with his preexisting disabling emphysema and degenerative arthritis prevent him from returning to his regular employment and restrict him to light work. This impairment along with his age, lack of education, lack of transferable skills, limited adaptability, limited dexterity and coordination, and the termination of his vocational rehabilitation efforts, prevent him from finding suitable and gainful employment. Finally, considering claimant's physical limitations and lack of transferable skills, we find that additional efforts to seek employment would be futile.

In making these findings, we rely on the results of the vocational assessment by Harry Mason and on the results of claimant's vocational efforts.

Vocational services began in September, 1985, and continued for eight months. Claimant cooperated fully with vocational counselors by voluntarily undergoing aptitude testing and completing a retraining program. Based on aptitude scores alone, claimant qualified for no occupational pattern groups. By adding one standard error of measurement, claimant qualified for seven occupations, all of which were determined by the vocational counselor, Mason, to be inappropriate, either because of the work setting, the training required, or the limited number of positions available. Three other vocations, related to claimant's prior work as a timber faller, were identified, but likewise were considered inappropriate because of claimant's lack of dexterity and knowledge. Mason concluded that claimant could not return to work without some training. Mason identified three potential on-the-job training programs; none were suitable for claimant.

Following the eight month period of vocational assistance and a resulting financial hardship, claimant accepted voluntary retirement and social security benefits from his employer at injury. Services were terminated at that time.

The employer argues that claimant's retirement and his letter declining further vocational services establish that he did not make reasonable efforts to seek work and thus is not entitled to permanent total disability. The employer relies on Georgia-Pacific Corp. v. Perry, 92 Or App 56 (1988).

We do not believe that claimant's conduct evinced unwillingness to work. The claimant in Perry did not cooperate with the vocational rehabilitation efforts, whereas claimant in the present case did. His termination of vocational services was caused by Mason, who informed claimant that when he voluntarily retired, all vocational assistance would be terminated.

We acknowledge that Mason did identify one part-time, 12-hour-a-week position which may have been within claimant's capabilities. Yet, there is no indication that such positions are generally available in the labor market. In any event, it was Mason, not claimant, who turned down the employment offer, indicating that the job did not suit claimant's needs. We agree with Mason's view that a 12-hour a week job was not suitable. We do not read Perry to say that the ability to do any part-time job, no matter how paltry the hours or pay, precludes a finding of permanent total disability, or that refusal to accept such a job is necessarily an unwillingness to seek regular, gainful employment such that we must decline to award permanent and total disability. It would not produce the kind of income that is gainful and suitable within the meaning of ORS 656.206.

Despite claimant's complete cooperation in vocational assistance activities, such activities did not result in successful job placement. We conclude that claimant has demonstrated that he is willing to reenter the work force and that he has made reasonable efforts to do so. Accordingly, we hold that claimant is entitled to an award of permanent total disability.

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 be awarded. See OAR 438-15-010(5).

ORDER

The Referee's order, dated June 20, 1988, is affirmed. A client-paid fee, not to exceed $1,750, payable from the self-insured employer to its counsel, is approved.

February 6, 1990 Cite as 42 Van Natta 279 (1990)

In the Matter of the Compensation of
MICHAEL P. McCORMICK, Claimant
WCB Case No. 87-14087
ORDER ON REVIEW
Jean Fisher LeDoux, Claimant Attorney
Norman Cole (Saif), Defense Attorney

Reviewed by Board Members Nichols and Crider.

Claimant requests review of that portion of Referee Tuhy's order that approved an attorney fee payable out of the Referee's net award of permanent partial disability benefits, as reduced by the offset allowed the SAIF Corporation for overpaid temporary disability benefits. SAIF responds by suggesting that the Board may not have jurisdiction to address the attorney fee issue. On review, the issues are attorney fees and jurisdiction. We modify in part.

We adopt the Referee's findings of fact, conclusions of law and opinion with the following supplement regarding the attorney fee and jurisdiction issues.

SAIF questions the Board's jurisdiction to address the attorney fee issue raised by claimant's attorney because this is a question regarding the amount of the fee, not entitlement to a fee. We disagree.

The attorney fee in this matter was paid out of compensation and is allowed under ORS 656.386(2). This is not an ORS 656.386(1) fee which is subject to resolution in circuit court. The fee allowed in subsection (1) is a fee paid by the insurer or self-insured employer. Where the sole issue is the amount of such a fee, exclusive jurisdiction lies in the circuit court. ORS 656.388; Greenslitt v. City of Lake Oswego, 305 Or 530 (1988). The Board, however, has jurisdiction to review the amounts of Referee awards of all other types of fees, whether or not any other issues have been raised to the Board. Ronald L. Warner, 40 Van Natta 1082 (1988); see also Amfac, Inc. v. Garcia-Maciel, 98 Or App 88 (1989). An attorney fee payable out of compensation is different from an insurer-paid fee. It is one which we have authority to review.

The Referee erred in ordering the attorney fee payable out of the net increase in compensation after allowing the insurer an offset. Former 438-47-085; Weyerhaeuser v. Sheldon, 46 Or App 344 (1987). The effect of this former rule as stated in Sheldon is to reduce the allowable offset by the amount necessary to pay the attorney 25 percent of the increased compensation as allowed by former OAR 438-47-025.

ORDER

The Referee's order, dated June 30, 1988, is modified in part and affirmed in part. The Referee's attorney fee award is modified to allow claimant's attorney a fee in the amount of 25 percent of the increased permanent partial disability compensation awarded by the Referee, prior to the offset for overpaid temporary disability benefits. The remainder of the Referee's order is affirmed.

February 6, 1990 Cite as 42 Van Natta 280 (1990)

In the Matter of the Compensation of
NANCY M. MOORE, Claimant
WCB Case No. 86-15944
ORDER ON REVIEW
Spears, et al, Attorneys
Saif Legal, Defense Attorney

Reviewed by Board Members Howell and Perry.

The SAIF Corporation requests review of Referee Leahy's order which set aside its denial of claimant's myocardial infarction. On review the issue is compensability. We reverse.

FINDINGS OF FACT

In August 1986, claimant was a 60-year-old female with a family history of coronary disease. Her mother died at age 50 and her father at age 86 of heart failure. Her brother had undergone coronary artery bypass surgery. She was diabetic, was borderline hypertensive, smoked, and had elevated cholesterol and triglyceride. She was at very high risk for developing atherosclerotic disease and complications such as myocardial infarction. (Exs. 1, 3A, 8A, 13A, 20 & 38A).

Claimant worked on August 2, 1986, at her job as a waitress for the employer. About two hours after she began, and while carrying a tray of cups, she experienced chest pains. Later, after carrying a 51 pound Coke container, she experienced increased chest pain. She sat and rested for about five minutes and the pain diminished. She then returned to work filling salt and pepper containers and waiting on customers. Her chest pain continued and increased and she was later taken to a hospital emergency room. (Tr. 13-18).

At the hospital, claimant was found to have experienced an acute, inferior wall myocardial infarction. She was treated and released. She was again hospitalized August 12, 1986, for a recurrent myocardial infarction and again on September 16, 1986, for mild congestive heart failure. She was hospitalized October 5, 1986, for angina.

Claimant's family physician, Dr. Phillips, treated her for her heart condition. He referred her to Dr. Priest, a cardiologist, who examined her in October 1986. Dr. Priest performed catheterization on October 10, 1986. It re

vealed severe diffuse coronary artery stenosis and occlusion of the coronary artery that supplied the area of claimant's heart which suffered the infarction. On October 16, 1986, claimant underwent coronary artery bypass surgery.

Claimant filed a claim for her myocardial infarction. SAIF denied the claim by letter dated October 7, 1986.

CONCLUSIONS OF LAW AND OPINION

The Referee found claimant's myocardial infarction to be compensable. We disagree.

Myocardial infarctions are generally treated as injuries. To establish the compensability of her heart attack claimant must show that her work materially contributed to that injury. See e.g. Somers v. SAIF, 77 Or App 259 (1986) and Hurst v. SAIF, 76 Or App 532 (1985). The question of medical causation in this case is one of expert analysis rather than expert observation. Accordingly, we accord the medical opinion of the attending doctor no special deference. Allie v. SAIF, 79 Or App 284 (1986).

Several doctors have offered opinions on the issue of medical causation. They include Dr. Phillips, the attending physician; Dr. Priest, the examining cardiologist; Dr. Flanagan, an internist and examining physician; Dr. Brodeur, a cardiologist who reviewed claimant's records; and Dr. Kloster, a cardiologist who reviewed claimant's records.

Dr. Kloster reported that claimant's serum cardiac enzyme profile upon admission to the hospital on August 7, 1986, was consistent with a myocardial infarction beginning when claimant's chest pain became constant while at work. Dr. Phillips agreed. Dr. Kloster reported that the most recent and consistent medical evidence indicated that myocardial infarctions occur 85 to 95 percent of the time from acute thrombic occlusion (a clot plugging a narrowed artery). Thrombus formation and acute occlusion causing myocardial infarctions usually result from a crack or fissure in atherosclerotic plaque. That process has no demonstrated relationship to physical exertion. No doctor disagreed with Dr. Kloster on these medical propositions (exs. 38A & 39).

Dr. Kloster felt that claimant's myocardial infarction was probably due to the most common cause of myocardial infarctions, thrombic occlusion, and that her work did not contribute. Dr. Priest concurred without elaborating (exs. 38A, 39 & 40).

Dr. Phillips felt that claimant's myocardial infarction was precipitated by exertion at work because it occurred during such work and because exertion places an increased load on the heart. He offered no other explanation. Dr. Brodeur also felt that claimant's exertion at work materially contributed to her myocardial infarction. He too indicated that exertion stressed claimant's heart and reduced the blood supply available to the heart, resulting in a myocardial infarction (exs. 40A & 40B).

In response to Dr. Phillips, Dr. Kloster reported and testified that the theory that physical exertion could stress the heart by affecting blood supply and provoking a myocardial infarction was quite prevalent in the 1970's. He noted that more recent angiographic studies demonstrated that such a relationship between exertion and myocardial infarctions was probably present in only about 10 percent of myocardial infarction cases. Additionally, the more strenuous the activity, the more likely the relationship between exertion and myocardial infarction. Dr. Kloster did not consider claimant's activities on the day of her myocardial infarction to be particularly strenuous. Dr.

Flanagan, who was aware of claimant's activities, agreed that they were not particularly strenuous. Dr. Flanagan felt that absent more strenuous activities, such as running up a hill or being in a fight, it would be difficult to relate claimant's myocardial infarction to her work activities.

We find Dr. Kloster's explanation of the cause of claimant's myocardial infarction to be most persuasive. His opinion, that claimant's myocardial infarction was due to thrombic occlusion, is supported by the presence of such occlusion in the artery that supplied the area of claimant's myocardial infarction. Dr. Kloster indicated that the fact that the occlusion was first confirmed two months after the first myocardial infarction did not affect his opinion. Furthermore, Dr. Kloster's opinion is supported by what is, according to the undisputed evidence, the most recent and reliable medical theories. (Ex. 43, p. 28).

We conclude that claimant has failed to prove that her work materially contributed to the cause of her myocardial infarction.

ORDER

The Referee's order dated February 18, 1988 is reversed. The SAIF Corporation's October 7, 1986 denial is reinstated and upheld. The Referee's attorney fee award of $3,000 is reversed.

February 6, 1990 Cite as 42 Van Natta 282 (1990)

In the Matter of the Compensation of
PAULINE G. MORRISON, Claimant
WCB Case No. 88-01373
ORDER ON REVIEW
Philip H. Garrow, Claimant Attorney
Schwabe, et al, Defense Attorneys

Reviewed by Board Members Gerner and Cushing.

The insurer requests review of that portion of Referee Emerson's order which set aside its denial of claimant's aggravation claim for her low back condition. Claimant cross-requests review of that portion of the Referee's order which upheld the insurer's denial of her bilateral scleroderma condition. The issues on review are compensability of claimant's low back aggravation and compensability of claimant's bilateral hand condition. We affirm.

FINDINGS OF FACT

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

ULTIMATE FINDING OF FACT

Claimant's 1984 compensable low back claim is a material contributing cause to her current disability and need for treatment.

CONCLUSIONS OF LAW AND OPINION

Low Back Aggravation

The Referee found that claimant's low back aggravation claim was compensable. We agree for the following reasons.

To establish a compensable aggravation under ORS 656.273(1), the claimant must prove: (1) a worsening of her condition since the last award or arrangement of compensation; and (2) a material causal connection between that worsening and the compensable condition. Stepp v. SAIF, 78 Or App 438 (1986).

From the record on review, it does not appear that the insurer is contesting that claimant is worse, but only that the worsening is not due in material part to the compensable 1984 claim. We therefore turn to the issue of material causation.

Claimant has an accepted 1984 claim for her low back. The Referee found that claimant had credibly testified that her current symptoms were of a similar nature and in a similar location as they were after the 1984 compensable claim. The Referee further found that claimant had continued to have some ongoing symptoms since the time of her 1984 claim. We agree.

Even with claimant's credible testimony, the issue of whether claimant's current low back condition is causally related to the 1984 compensable injury is a complex medical question. Thus, although claimant's testimony is probative, the resolution 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 106, 109 (1985).

Only two physicians address the question of whether claimant's compensable 1984 claim is a material contributing cause of her current low back condition. The other physicians involved herein only discuss whether claimant's current low back condition is primarily due to her ongoing work exposure or to her aging and underlying degenerative process. None of those physicians addresses the role of the compensable claim in the current disability and need for treatment.

Dr. Becker, an examining physician, concluded that the 1984 claim did not contribute to claimant's current condition. His opinion is based upon the presumption that all of claimant's current problems can be attributed to her age and the natural progression of her underlying degenerative disease process. On the other hand, Dr. Skotte, claimant's long time treating physician, concludes that the 1984 claim is a material contributing cause of her current condition. His rationale is based upon claimant's history and that the current examination findings are similar to those he found in 1984.

Absent persuasive reasons to the contrary, we generally give greater weight to the opinion of the treating physician. See Weiland v. SAIF, 64 Or App 810 (1983). In this case we see no reason not to do so. Dr. Skotte is not only one of claimant's current treating physicians, but was also the treating physician at the time of the 1984 claim. This puts Dr. Skotte in a better position to judge causation. We therefore find Dr. Skotte's opinion as to causation most persuasive.

Based upon claimant's credible testimony and Dr. Skotte's medical opinion, we find that claimant's 1984 compensable claim is a material contributing cause to her current disability and need for treatment. Claimant has proven that her aggravation claim is compensable.

Bilateral Scleroderma Compensability

The Board adopts the Referee's conclusions as its own.

ORDER

The Referee's order, dated July 18, 1988, is affirmed. Claimant's attorney is awarded an assessed fee of $800, to be paid by the insurer, for defending against the insurer's request for review regarding the aggravation claim. The Board approves a client-paid fee, not to exceed $2,466.25, payable by the insurer to its counsel.

In the Matter of the Compensation of
JULIE S. PETERS, Claimant
WCB Case No. 88-06820
ORDER ON REVIEW
Bottini & Bottini, Claimant Attorneys
Roberts, et al, Defense Attorneys

Reviewed by Board Members Gerner and Myers.

The self-insured employer requests review of that portion of Referee Fink's order which assessed a penalty and related attorney fee for alleged unreasonable failure to formally deny claimant's aggravation claim for a right shoulder injury and for alleged failure to pay interim compensation. On review, the issues are penalties and attorney fees. We reverse.

FINDINGS OF FACT

Claimant sustained a compensable injury to her right shoulder in October 1985 while employed as a warehouse worker. In September 1987, claimant could not return to her at-injury job, due to her physical limitations. Her claim was last closed by an October 1987 Determination Order which awarded 20 percent unscheduled permanent disability.

In January 1988, claimant's treating physician reported that claimant was not medically stationary. On March 29, 1988, the parties entered into a stipulation whereby the employer would process claimant's claim as an aggravation claim effective February 16, 1988. On April 26, 1988, claimant requested a hearing on the employer's "de facto" denial of aggravation, as well as entitlement to interim compensation, penalties and attorney fees. The employer began paying interim compensation effective April 26, 1988.

The Referee found that the October 1987 Determination Order prematurely closed claimant's claim. This issue was not appealed.

FINDINGS OF ULTIMATE FACT

The employer did not receive any medical verification of claimant's inability to work in February 1988.

CONCLUSIONS OF LAW

The Referee concluded that a penalty and attorney fee was warranted due to the insurer's alleged unreasonable failure to pay interim compensation and alleged unreasonable failure to accept or deny claimant's aggravation claim. We disagree.

PENALTIES AND ATTORNEY FEES

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, 31 (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).

In the instant case, prior to the October 1987 Determination Order, Dr. Marble opined that claimant could not return to warehouse work, her job at-injury and recommended vocational assistance. In January 1988, Dr. Long reported that claimant was not medically stationary as her condition could be improved by treatment. He also noted that claimant could no longer perform her warehouse work. Also in January 1988, Dr. Bald agreed that claimant could not return to her previous work and concurred in Dr. Marble's earlier recommendation that claimant be given vocational training.

There is no medical evidence in the record that suggests claimant was unable to work in early 1988. All of the physicians agree that claimant should not return to her job at-injury, but no opinion provides medical verification of an inability to work at an occupation compatible with her permanent limitations. Further, there is no evidence that claimant's condition worsened after closure. Emery v. Adjustco, 82 Or App 101, 107 (1986). Rather, the evidence indicates that claimant's claim was closed prematurely by the October 1987 Determination Order.

Under these circumstances, we conclude that the employer was not provided with medical verification of claimant's inability to work due to a worsening of her condition. As there was no medical verification, the employer had no duty to pay interim compensation. Accordingly, the employer's failure to pay interim compensation was not unreasonable, and a penalty or attorney fee is not warranted on this basis. Silsby, supra; Dorotha L. McDarment, 41 Van Natta 345, 346 (1989).

Aggravation Denial

A penalty and attorney fee may also be assessed under ORS 656.262(10) and 656.382(1) against a carrier which unreasonably delays acceptance or denial of a claim. Under ORS 656.262(10), a carrier has 60 days within which to accept or deny a claim.

The March 1988 Stipulation provided that the employer would process the January 1988 physician report as an aggravation claim effective February 16, 1988. Claimant requested a hearing on a "de facto" denial of her aggravation claim on April 26, 1988. The employer was obligated to issue a formal acceptance or denial within 60 days of claimant's aggravation claim and did not do so. Under these circumstances, the employer's behavior was unreasonable.

Despite the fact that the employer's conduct was unreasonable, we find no "amounts then due" on which to base a penalty for failing to accept or deny claimant's aggravation claim. The only amount related to the unreasonable behavior that would have been due at the time of hearing is interim compensation, and we have herein concluded that the employer was not obligated to pay such compensation. Further, the Referee found that claimant had not sustained an aggravation, but rather, that her claim was prematurely closed. Accordingly, there is no amount due, related to the employer's unreasonable behavior, on which a penalty may be based. See Wacker Siltronic Corporation v. Satcher, 91 Or App 654, 658 (1988). Therefore, we cannot assess a penalty for the employer's unreasonable behavior. ORS 656.262(10).

An attorney fee can be awarded in absence of a penalty if an employer's action constitutes unreasonable resistance to the payment of compensation. See Ellis v. McCall Insulation, 308 Or 74 (1989); Lloyd L. Cripe, 41 Van Natta 1774 (1989). Here, there is no evidence of an unreasonable resistance to the payment of compensation resulting from the employer's failure to formally accept or deny claimant's aggravation claim. We concluded herein that no interim compensation was due and the Referee found that claimant had not sustained an aggravation.

Accordingly, an attorney fee for the employer's unreasonable behavior cannot be awarded. Cripe, supra.

ORDER

The Referee's order, dated August 9, 1988, is reversed in part and affirmed in part. That portion which awarded claimant a 25 percent penalty on compensation due between February 16, 1988 and April 26, 1988 is reversed. That portion which awarded claimant's counsel a $400 attorney fee in conjunction with the 25 percent penalty is reversed. The remainder of the order is affirmed. A client-paid fee, not to exceed $1,362.50, is approved.

In the Matter of the Compensation of
NELLIE D. REINSCH, Claimant
WCB Case Nos. 88-07058, 88-07055, 88-07056 & 88-07057
ORDER ON REVIEW
Martin J. McKeown, Claimant Attorney
Davis & Bostwick, Defense Attorneys
Terrall & Miller, Defense Attorneys
Rankin, et al, Defense Attorneys

Reviewed by Board Members Cushing and Myers.

EBI Companies requests review of Referee Leahy's order which assigned responsibility to it for claimant's left elbow, shoulder, neck and low back conditions. On review, the issues are compensability and responsibility. We reverse.

FINDINGS OF FACT

Claimant compensably injured her back on May 4, 1983, while working for her employer, who was then insured by Crawford and Co. By stipulation dated February 26, 1985, claimant was awarded 10 percent unscheduled disability for neck and upper back conditions. She compensably injured her left elbow on June 25, 1987 while Lumbermen's was on the risk.

Claimant last worked for the employer in late September 1987. At that time, her elbow was medically stationary without permanent impairment. Claimant did not work again until March 15, 1988 when she went to work as a cabinet maker for EBI's insured. She spent much of her time holding a sander vertically and sanding the sides of cabinets. She had to bend during part of this process.

Claimant worked for nine work days. At the end of that time, claimant had pain in her neck, mid-back, low-back, legs, left shoulder and left forearm. She saw her long-time treating chiropractor, Dr. Hathaway, who diagnosed cervical, thoracic and lumbar strain as well as non-radicular leg pain and tendinitis of the left elbow.

The work at EBI's insured did not independently contribute to a worsening of the left arm complaints.

CONCLUSIONS AND OPINION

In order to shift responsibility for the accepted injuries, the work exposure at EBI's insured must have independently contributed to a pathological worsening of the accepted conditions. Hensel Phelps v. Mirich, 81 Or App 290

(1986). We conclude that as to the elbow and left shoulder, the evidence preponderates that the work exposure at EBI's insured did not independently contribute.

Dr. Hathaway, the treating chiropractor, deferred to Dr. Winslow, M.D. for an opinion on the left arm condition. Dr. Winslow wrote that the work at EBI's insured had caused a worsening; however at hearing, he explained that by a worsening he meant only a symptomatic worsening, not a worsening of the underlying condition. Consequently, his opinion is that the work at EBI's insured only caused a symptomatic worsening. Therefore, Lumbermen's remains responsible for the left arm conditions.

We conclude that there has been a failure of proof on the various back conditions. To shift responsibility, claimant and Crawford & Company, the insurer with the accepted neck and back claim, have the burden of proving that the employment at EBI's insured independently contributed to a worsening of the various back problems. Linda L. Wise, 42 Van Natta 115 (1990). We conclude that there has been a failure of proof.

The only evidence supporting an independent contribution to the various back problems comes from the treating chiropractor, Dr. Hathaway. We do not find his opinion persuasive.

In May 1988, Dr. Hathaway attributed the problems to an aggravation of claimant's prior injuries. In July 1988, Dr. Hathaway attributed the increased pain to the work at EBI's insured. He stated that the low back problems represented a worsening and that the neck and upper back problems were an aggravation. He stated there was a new injury to the mid and lower thoracic spine. We do not find his opinions sufficiently persuasive to convince us that it is more likely than not that the nine days of work at EBI's insured independently contributed to a worsening of the various back conditions. Consequently, Crawford and Co. remains responsible for the various back conditions.

ORDER

The Referee's order, dated August 23, 1988, is reversed. EBI Companies denial is reinstated and upheld. Lumbermen's denial of claimant's left arm claim is set aside. The arm claim is remanded to Lumberman's for processing consistent with this order and applicable law. Crawford & Company's denial of the neck and back claim is set aside. The back claim is remanded to Crawford for processing consistent with this order and the applicable law. The Referee's attorney fee award to be paid by EBI shall be equally paid by Crawford & Company and Lumbermen's. The Board approves a client-paid fee, not to exceed $1,280 for Crawford and Co.'s attorney. The Board approves a client-paid fee, not to exceed $1,088 for Lumbermen's attorney. The Board approves a client-paid fee, not to exceed $1,831.96 for EBI's attorney.

February 6, 1990 Cite as 42 Van Natta 287 (1990)

In the Matter of the Compensation of
ALFRED R. VARGAS, Claimant
WCB Case No. 87-00962
ORDER ON REVIEW
Quintin B. Estell, Claimant Attorney
Gary Wallmark (Saif), Defense Attorney

Reviewed by Board Members Nichols and Crider.

Claimant requests review of that portion of Referee Holtan's order which upheld the SAIF Corporation's denial of claimant's aggravation claim for a low

back condition. The sole issue on review is whether claimant's compensable condition worsened so that he is entitled to further disability compensation under ORS 656.273. We reverse.

FINDINGS OF FACT

Claimant compensably injured his low back on August 13, 1985 while working as a truck driver for a paving company. The claim was closed by Determination Order on March 5, 1986, with an award of 15 percent unscheduled permanent disability. An additional 10 percent unscheduled disability was awarded by Opinion and Order issued August 28, 1986. That award was based on claimant's condition at the time of a July 8, 1986 hearing. The award was claimant's last arrangement of compensation.

Claimant returned to modified work on July 15, 1986. On October 6, 1986, claimant worked a full day flagging traffic and experienced an increase in low back symptoms. As a result of the increase in symptoms, the treating chiropractor, Dr. Dahlstrom, took claimant off work indefinitely beginning October 7, 1986. Claimant remained off work in excess of 14 days.

FINDINGS OF ULTIMATE FACT

Claimant was capable of performing modified work as of May 1986. As a result of his return to modified work in July 1986, claimant experienced a symptomatic exacerbation of his low back condition. That exacerbation resulted in diminished earning capacity below the level fixed at the time of the August 1986 Opinion and Order. That order did not anticipate future exacerbations resulting in diminished earning capacity. Claimant's exacerbation resulted in 14 days of total disability.

CONCLUSIONS OF LAW AND OPINION

To establish an aggravation, claimant must show a worsening of his compensable 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. 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).

Claimant's last arrangement of compensation was the August 1986 Opinion and Order, which was based on claimant's condition at the time of a July 1986 hearing. The record contains no evidence of a pathological worsening of claimant's low back condition after the hearing. However, we are persuaded that claimant sustained a symptomatic exacerbation of his low back condition.

The Referee concluded that claimant's symptoms were "heightened". The record supports that conclusion. Following the alleged aggravation, claimant experienced a documented loss in lumbar range of motion. Claimant testified that his lower back pain and leg pain/numbness had increased on October 6, 1986 so that he was unable to stand or walk. Treating chiropractor Dahlstrom authorized time loss effective October 7, 1986 and opined that claimant had experienced an exacerbation.

The only contrary evidence is a report from BBV Medical Services, dated December 1986. According to that report, claimant stated his symptoms were the same as in 1985. However, in the same report the examining doctors note that claimant had complained of significant increase in back pain on October 6, 1986. Furthermore, claimant testified that the report was inaccurate.

Based on claimant's testimony, his documented loss in range of motion, and his treating chiropractor's opinion and authorization of indefinite time loss, we find that claimant sustained a symptomatic exacerbation of his low back condition.

The next inquiry is whether the symptomatic exacerbation resulted in a diminished earning capacity below the level fixed at the time of the last arrangement of compensation. In May 1986, Dr. Dahlstrom restricted claimant to a modified work plan which he successfully performed prior to the alleged aggravation. In July 1986, the examining doctors for BBV Medical Services opined that claimant's impairment rating was minimal, noting a full range of motion in the spine and lower back.

By comparison, the record indicates that claimant could not even report to modified work after the alleged aggravation. At the May 7, 1987 hearing, claimant testified that his low back pain was intolerable and that he could not stand or walk after the October 1986 exacerbation and had to leave work. The treating chiropractor authorized indefinite time loss and reported that the three-month period of work since July 1986 had materially worsened claimant's condition.

Based on this record, we are persuaded that claimant was not able to perform even a modified work program immediately after his exacerbation. Thus, claimant was less able to work than at the time of the last arrangement of compensation. Accordingly, we conclude that claimant's symptomatic exacerbation resulted in diminished earning capacity below the level fixed at the time of the August 1986 order.

The next inquiry is whether the last arrangement of compensation anticipated future exacerbations accompanied by a diminished earning capacity. The Referee found that claimant's increased symptoms were within a range contemplated by his 25 percent award of unscheduled disability. We disagree. The August 1986 Opinion and Order is silent as to whether the disability award was based on an expectation of waxing and waning symptoms. Moreover, the record contains no relevant evidence that future waxing and waning of symptoms resulting in periods of further diminished earning capacity were expected. Accordingly, we conclude that future exacerbations were not anticipated by the prior award. Consequently, claimant has proven a compensable aggravation.

Alternatively, the medical evidence establishes that claimant's symptomatic exacerbation resulted in at least 14 days of total disability. Thus, claimant has established a compensable aggravation even if the August 1986 Opinion and Order contemplated future exacerbations.

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 be awarded. See OAR 438-15-010(5).

ORDER

The Referee's order, dated June 10, 1987, is reversed. The SAIF Corporation's denial of December 31, 1986 is set aside. The claim is remanded to SAIF for further processing according to law.

In the Matter of the Compensation of
DELORES MOONEY, Claimant
WCB Case No. 87-01173
ORDER ON REVIEW
Robert L. Philmon, Claimant Attorney
Davis and Bostwick, Defense Attorneys

Reviewed by Board Members Cushing and Gerner.

Claimant requests review of that portion of Referee Peterson's order which upheld the self-insured employer's denial of claimant's aggravation and medical services claim for a low back injury. On review, the issues are compensability and aggravation. We reverse in part and affirm in part.

FINDINGS OF FACT

Claimant sustained a compensable injury to her low back in May 1982 while working as a motel maid. As a result of this injury, she was permanently restricted to performing sedentary to light work. Claimant was then retrained as a secretarial worker. Her claim was closed by a March 1985 Determination Order which awarded her 30 percent unscheduled permanent disability.

Claimant continued to experience low back pain. She was not able to obtain secretarial work and basically remained at home. In November 1986, claimant sought treatment for worsened symptoms. In December 1986, she filed an aggravation claim. In January 1987, the employer denied the aggravation claim on the basis that claimant's compensable condition had not worsened and that her current condition was not related to the compensable condition.

FINDINGS OF ULTIMATE FACT

Claimant's 1982 compensable injury is a material contributing cause of claimant's current low back condition.

Claimant's symptomatic exacerbation in November 1986 did not result in diminished earning capacity beyond that contemplated by the March 1985 Determination Order.

CONCLUSIONS OF LAW

At the outset, it is necessary to clarify the issues in the present case. The employer's denial purports to deny claimant's condition not only on the grounds that it had not worsened, but also on the basis that her current condition is unrelated to her compensable injury. The Referee upheld the employer's denial in toto, therefore it is necessary for us to first decide if claimant's current low back condition is compensably related to her industrial injury and second whether her compensable condition has worsened. We disagree with the Referee in regard to the former and agree with the Referee in regard to the latter.

Compensability

Claimant bears the burden of proving by a preponderance of the evidence that her 1982 compensable injury materially contributes to her current need for medical treatment. Milburn v. Weyerhaeuser Co., 88 Or App 375, 378 (1987). The compensable injury need not be the sole cause or most significant cause of the need for treatment, but only a material contributing cause. Van Blokland v. Oregon Health Sciences University, 87 Or App 694, 698 (1987).

Claimant is experiencing the same pain symptoms, in the same location, as she did following the 1982 compensable injury. There have been no intervening accidents. Dr. Smith opined that claimant's current condition remained secondary to the 1982 industrial injury, but did note that her obesity was also a contributing factor. Dr. Lumsden, who has treated claimant since the original injury, opined that claimant's current condition was a deterioration of her original injury and reported that her condition was almost the same as at the time he began treatment. There is no contrary medical evidence.

Under these circumstances, we conclude that claimant's 1982 compensable injury remains a material contributing cause of her current low back condition.

Aggravation

For every aggravation claim of an unscheduled condition, claimant must show increased symptoms or a worsened underlying condition and which results in diminished earning capacity. Edward D. Lucas, 41 Van Natta 2272 (1989). In those cases in which the last award or arrangement of unscheduled permanent disability compensation anticipated future periods of increased symptoms or exacerbation of the physical condition, accompanied by a diminished earning capacity, claimant must also prove that her earning capacity was diminished longer or in greater degree than was anticipated or that resulted in 14 consecutive days of total disability or inpatient hospitalization. Id.

Dr. Lumsden opined that claimant's condition had deteriorated which had returned her to a physical condition similar to her condition in 1983. Dr. Smith also opined that claimant's condition had deteriorated and that she was experiencing a symptomatic increase due in part to her obesity. There is no contrary medical evidence. We conclude, therefore, that claimant has sustained a symptomatic exacerbation of her compensable condition. The issue now becomes whether this symptomatic exacerbation resulted in diminished earning capacity. We conclude that it did not.

Claimant's last arrangement of compensation was the March 1985 Determination Order which awarded her 30 percent unscheduled permanent disability. At that time, she was limited to performing sedentary to light work.

Dr. Smith opined that although claimant's condition had deteriorated, she was still able to perform light work. Dr. Lumsden also reported that claimant's condition had deteriorated somewhat, but did not offer an opinion as to her ability to perform light work. He did note that claimant had been retrained for secretarial work, but had been unable to find such work.

We conclude that claimant has not shown that her earning capacity has been diminished by the symptomatic exacerbation. In reaching this conclusion, we rely mainly on Dr. Smith's opinion that claimant is able to perform light work. Under these circumstances, claimant has not established an aggravation as she has not shown that she is less able to work as a result of her symptomatic exacerbation. See Smith v. SAIF, 302 Or 396 (1986).

ORDER

The Referee's order, dated February 5, 1988, is reversed in part and affirmed in part. That portion which upheld the employer's denial of medical services is reversed. The employer's denial is set aside to the extent that it denies medical services and that portion of claimant's claim is remanded to it for processing according to law. For services on Board review, concerning the medical services issue, claimant's counsel is awarded a reasonable assessed fee of $700, to be paid by the employer. The remainder of the Referee's order is affirmed. A client-paid fee, not to exceed $639.50, payable from the self-insured employer to its counsel, is approved.

In the Matter of the Compensation of
DOUGLAS M. NIXON, Claimant
WCB Case No. 86-10353
ORDER ON REVIEW
Peter O. Hansen, Claimant Attorney
Daryll E. Klein, Defense Attorney

Reviewed by Board Members Myers and Gerner.

Claimant requests review of Referee Holtan's order which upheld the self-insured employer's denial of claimant's occupational disease claim for mental disorders. The issue is compensability. We reverse.

insured employer's denial of claimant's occupational disease claim for mental disorders. The issue is compensability. We reverse.

FINDINGS OF FACT

Claimant had been employed with the employer for over 14 years as a truck driver. Beginning in the mid-1980's a downturn in the employer's wood products industry caused the employer to seek to renegotiate the union contract governing claimant's wages and other benefits. The employer sought to reduce wage and benefit costs to maintain its competitive position in the marketplace.

FINDINGS OF FACT

Claimant had been employed with the employer for over 14 years as a truck driver. Beginning in the mid-1980's a downturn in the employer's wood products industry caused the employer to seek to renegotiate the union contract governing claimant's wages and other benefits. The employer sought to reduce wage and benefit costs to maintain its competitive position in the marketplace.

In early 1986, claimant began to experience headaches, weight loss, sleep disturbances, depression and anxiety. He sought medical treatment from Dr. Intile, medical doctor, and later on referral, from Dr. Johnson, medical doctor.

In early 1986, claimant began to experience headaches, weight loss, sleep disturbances, depression and anxiety. He sought medical treatment from Dr. Intile, medical doctor, and later on referral, from Dr. Johnson, medical doctor.

The employer did negotiate to reduce the wages and benefits paid to claimant and his co-workers under a new union contract. This action existed in a real and objective sense. It was capable of producing stress and it did cause stress to claimant. This action was the major cause of claimant's mental disorders of depression and anxiety and of the associated physical complaints. These mental and physical conditions necessitated medical treatment and caused temporary disability.

The employer did negotiate to reduce the wages and benefits paid to claimant and his co-workers under a new union contract. This action existed in a real and objective sense. It was capable of producing stress and it did cause stress to claimant. This action was the major cause of claimant's mental disorders of depression and anxiety and of the associated physical complaints. These mental and physical conditions necessitated medical treatment and caused temporary disability.

CONCLUSIONS OF LAW AND OPINION

In order to establish a compensable occupational disease claim for mental stress claimant must establish that: (1) real work events and conditions existed; (2) were objectively capable of causing stress; (3) required medical treatment or caused disability for a mental disorder; and (4) the major cause of the resulting disability or need for medical treatment was caused by work stressors when compared to off-work stressors. McGarrah v. SAIF, 296 Or 145, 164 (1983).

CONCLUSIONS OF LAW AND OPINION

In order to establish a compensable occupational disease claim for mental stress claimant must establish that: (1) real work events and conditions existed; (2) were objectively capable of causing stress; (3) required medical treatment or caused disability for a mental disorder; and (4) the major cause of the resulting disability or need for medical treatment was caused by work stressors when compared to off-work stressors. McGarrah v. SAIF, 296 Or 145, 164 (1983).

The Referee concluded that claimant had failed to prove a compensable occupational disease claim for his depression and anxiety because the uncertainty and stress caused by anticipated loss of wages and benefits were not compensable stressors. The Referee cited Elwood v. SAIF, 298 Or 429 (1985), for the proposition that loss of wages is akin to loss of employment, and therefore that those stressors were not compensable. We disagree.

The Referee concluded that claimant had failed to prove a compensable occupational disease claim for his depression and anxiety because the uncertainty and stress caused by anticipated loss of wages and benefits were not compensable stressors. The Referee cited Elwood v. SAIF, 298 Or 429 (1985), for the proposition that loss of wages is akin to loss of employment, and therefore that those stressors were not compensable. We disagree.

Elwood is a case that deals with the anticipation of termination, the events of termination, and the aftermath of termination. The present case does not deal in any way with termination or loss of job, but merely the reduction of wages due to a collective bargaining agreement. Elwood, on its facts and holding, does not apply to this type of case. Here, the stressors were real, related to his work exposure, and not barred by Elwood. Claimant has proven a compensable occupational disease.

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Claimant's counsel is statutorily entitled to a reasonable, insurer-paid attorney fee for services rendered at the 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 April 30, 1987, is reversed. The employer's denial of July 7, 1986 is set aside and the claim remanded for processing according to law.

February 7, 1990 Cite as 42 Van Natta 293 (1990)

In the Matter of the Compensation of
DONNA J. SUTTON, Claimant
WCB Case No. 87-16843
ORDER ON REVIEW
Malagon, et al, Claimant Attorneys
Meyers and Radler, Defense Attorneys

Reviewed by Board Members Gerner and Myers.

The self-insured employer requests review of those portions of Referee Wasley's order which: (1) found that claimant was entitled to temporary disability benefits from October 7, 1986 until claim closure; and (2) assessed a 5 percent penalty on the aforementioned temporary disability benefits for unreasonable failure to pay such benefits. In her brief, claimant cross-requests review contending that the 5 percent penalty should be increased and that she is entitled to an increased penalty-related attorney fee. On review, the issues are entitlement to temporary disability benefits, penalties and attorney fees and amount of attorney fees. We affirm in part and modify in part.

FINDINGS OF FACT

We adopt the findings of fact as set forth in the first two paragraphs of the "Findings of Fact and Conclusion" section of the Referee's order with the following supplementation.

The first Referee's order was affirmed and adopted by Order on Review dated March 21, 1989.

CONCLUSIONS OF LAW

Temporary Disability Benefits

We adopt the Referee's conclusions and reasoning concerning the payment of temporary disability benefits.

Penalties and Attorney Fees

The Referee found the employer's refusal to pay temporary disability benefits, payable pursuant to a prior referee's order, to be unreasonable and assessed a 5 percent penalty. We agree with the Referee that the employer's conduct was unreasonable and adopt his conclusions and reasonings in this regard. However, we modify the amount of the penalty.

An employer must pay temporary disability compensation ordered by a Referee within 14 days of the issuance of the order. OAR 436-60-150(3). Failure to pay compensation in the face of a clear order to do so is unreasonable delay or refusal to pay compensation. Irene M. Gonzalez, 38 Van Natta 954 (1986).

Here, the employer was ordered to process claimant's aggravation claim, including the payment of temporary disability benefits, by order of a Referee. However, the employer did not pay any temporary disability benefits and offers no explanation for this failure to pay.

Under these circumstances, we conclude that a 25 percent penalty is appropriate given the employer's failure to comply with the Referee's order and lack of explanation.

Attorney Fees

We find that the $1,500 attorney fee adequately compensates claimant's counsel for services concerning the penalty issue, therefore we adopt the Referee's conclusions and reasoning with regard to the attorney fee issue.

ORDER

The Referee's order, dated July 29, 1988, is modified in part and affirmed in part. In lieu of the Referee's award of a 5 percent penalty, claimant is granted a penalty equal to 25 percent of temporary disability benefits payable from October 7, 1986 through the date of the hearing. For services on Board review concerning the temporary disability benefits issue, claimant's counsel is awarded an assessed fee of $700. The remainder of the Referee's order is affirmed. A client-paid fee, not to exceed $1,436, payable from the self-insured employer to its counsel, is approved.

February 7, 1990 Cite as 42 Van Natta 294 (1990)

In the Matter of the Compensation of
CORA M. WATSON, Claimant
WCB Case No. 87-04611
ORDER ON REVIEW
Yturri, et al, Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Myers and Gerner.

Claimant requests review of those portions of Referee Wasley's order which: (1) declined to award permanent total disability; and (2) granted her 35 percent (112 degrees) unscheduled permanent disability in addition to the 25 percent (80 degress) unscheduled permanent disability awarded by Determination Order. On review the issue is whether claimant is entitled to an award for permanent total disability. We reverse and award permanent total disability.

FINDINGS OF FACT

At the time of hearing claimant was 61 years old. She has a ninth grade education. On April 10, 1981, while working as a cook for the employer, claimant injured her low back. The injury caused a chronic lumbar strain. She has preexisting spondylosis which was not disabling before the injury. Claimant had no significant back pain or back injuries before the compensable injury. Tests reveal the possibility of a slightly bulging disc at L5-S1. The disc is

not causing radiculopathy. As a result of this injury, claimant is limited to light work.

Claimant returned to work shortly after her injury. She worked for this employer and then two other employers until December 1981. She has not worked since that time.

Claimant cooperated with her vocational counselor and is motivated. The Director has terminated claimant's vocational assistance. Claimant has no transferable skills to light or sedentary work.

As a result of her compensable injury, claimant is permanently incapacitated from performing work at a gainful and suitable occupation.

CONCLUSIONS AND OPINION

In order to prove entitlement to an award for permanent total disability, claimant must prove by a preponderance of the evidence that as a result of her compensable injury, together with any preexisting disability, she is permanently precluded from performing suitable and gainful employment. ORS 656.206(3). Permanent total disability may be based on physical condition alone or on physical condition taken together with social and vocational factors affecting claimant's employability. Wilson v. Weyerhaeuser, 30 Or App 403 (1977). The latter are the so-called "odd lot" cases.

We conclude that claimant is not precluded by her physical condition alone from regularly performing suitable and gainful employment. The medical evidence establishes that claimant is capable of doing light or sedentary work.

We conclude, however, that a combination of claimant's compensable injury and her social and vocational factors renders her unemployable. Claimant's vocational counselor opined that claimant has no transferable skills which would lead to alternative employment. She believes that claimant could be retrained so that she would have the skills to do sedentary work. Based on this evidence, we conclude that, at the time of hearing, claimant was not capable of performing gainful and suitable employment.

The Referee concluded that claimant was not permanently and totally disabled because she could be retrained. While it is true that claimant may be able to be retrained, that is not relevant. We must rate claimant's disability as of the date of hearing and must not consider the possibility of later retraining. Gettman v. SAIF, 289 Or 609, 614 (1980).

We conclude that claimant has satisfied ORS 656.206(3)'s requirement that she make reasonable efforts to obtain employment. She cooperated with her vocational counselor and the vocational counselor characterized her as motivated.

ORDER

The Referee's order, dated February 24, 1988, is reversed. Claimant is granted an award for permanent total disability effective December 2, 1987. The insurer is permitted to offset permanent partial disability payments made on or after that date against this permanent total disability award. Claimant's attorney is allowed a reasonable attorney fee of 25 percent of the increased compensation awarded herein, not to exceed $6,000, to be paid directly to claimant's attorney.

In the Matter of the Compensation of
RANDALL P. ADAMS, Claimant
WCB Case Nos. 88-08615 & 88-07914
ORDER OF DISMISSAL
Wilbur C. Smith, Jr., Claimant Attorney
Randolph Harris (Saif), Defense Attorney

The Board issued an Order on Review in the above-captioned matter on January 11, 1990. Claimant requested that the Board rescind its order on the ground that the SAIF Corporation has withdrawn its request for review in this matter. On January 25, 1990, we issued an Order of Abatement in this matter so that SAIF would have an opportunity to respond to claimant's request. We have now received a letter from SAIF confirming that it withdrew its request for review in this matter in January 1989.

Accordingly, we conclude that the request for review in this matter should be dismissed.

IT IS SO ORDERED.

In the Matter of the Compensation of
PENNY J. BAKER, Claimant
WCB Case No. 87-03591
ORDER ON REVIEW
Emmons, Kropp, et al, Claimant Attorneys
Employers Defense Counsel, Defense Attorney

Reviewed by Board Members Myers and Gerner.

Claimant requests review of Referee Baker's order which upheld the insurer's denial of claimant's back injury claim. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

Claimant was employed by the employer as a waitress. On February 4, 1987, while assisting in closing the restaurant, claimant removed a 10 gallon trash can from the salad bar which had been collecting water. The can was full and claimant had to scoop some water out before carrying it to the back of the restaurant to dump it. While lifting the container to dump it she experienced immediate pain in the back of her neck which traveled down her back. The event was unwitnessed. Claimant returned to the restaurant, informed a coworker, Colling, of the injury and immediately went home. Colling observed the claimant was in pain.

The employer was aware of the injury the same day it occurred. Claimant first sought medical treatment for the injury on February 6, 1987 from Dr. Hebert, a chiropractor. On request of the insurer, claimant was examined by Dr. Peterson, a chiropractic orthopedist. On April 1, 1987, the insurer denied claimant's injury claim.

Claimant has been convicted in 1981 for first degree forgery. Claimant has been convicted in 1986 for unlawfully obtaining food stamps and public assistance. Both convictions are felonies.

FINDING OF ULTIMATE FACT

As a result of her February 4, 1987 back injury at work, claimant required medical services.

CONCLUSIONS OF LAW AND OPINION

The Referee reasoned that because the injury event was unwitnessed, that subsequent medical evidence did not reveal consistent complaints, that the history of the event itself was inconsistent and because claimant had been convicted of two crimes involving dishonest efforts to obtain money, that she had failed to prove a compensable injury.

The insurer argues that the Referee should be affirmed because the claimant is not credible. The Referee did not make any findings in regard to claimant's demeanor or credibility at hearing. We do not give any weight to the implied finding that claimant was not credible. Bowlin v. SAIF, 81 Or App 527, 531 (1986).

Reviewing the record de novo we find claimant's testimony consistent with the testimony of other witnesses at hearing, and thus find her credible. Claimant's history of the accident was corroborated by another employee, Colling. The employer, Ortiz, also believed that an incident occurred, but she does not believe that claimant was as severely hurt as she claims. There is no requisite amount of disability necessary to establish a compensable injury. Whatever the severity of the event, it caused claimant to seek medical care. This is sufficient to establish a compensable injury. ORS 656.005(7)(a).

There are some inconsistencies in this record. Claimant testified that she did not go to her grandmother's funeral on February 5, 1987. (Tr. 9). However, the insurer submitted an affidavit by a coworker, Watkins, that claimant had attended the funeral. We do not believe that the hearsay representations by the coworker on a matter so removed from the true issues in this case are sufficient reason to find claimant not credible.

Claimant testified that the 10 gallon can was completely full of water. (Tr. 5). Colling testified that this would make the container too full to lift. (Tr. 36). However, even the employer acknowledged that she could lift and carry a full container. (Tr. 56). Given the fact that Colling admitted to being restricted from carrying heavy items because of arthritis, we do not find his testimony sufficient to contradict claimant's assertion that she did carry a full container.

There are inconsistencies between claimant's description of the event at hearing and the description she gave to the independent examiner, Dr. Peterson. On whole, the two descriptions are generally compatible, except that Peterson reports that the pain started in the low back and traveled up (as opposed to claimant's description that the pain started in the neck and traveled down). Other inconsistencies in the record are not worthy of mention and are very removed from the issues at hand.

As to the two felony convictions, we do not believe that these are sufficient either by themselves or in tandem with the other minor inconsistencies in this record, to overcome the corroborating testimony by Colling that an injury occurred.

ORDER

The Referee's order dated March 14, 1988 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 $2,500 to be paid by the insurer. The Board approves a client-paid fee, not to exceed $887.50, payable by the insurer to its counsel.

In the Matter of the Compensation of
TERRANCE A. BENBOE, Claimant
WCB Case Nos. 87-07616 & 87-10233
ORDER ON REVIEW
Max Rae, Claimant Attorney
Rick Dawson (Saif), Defense Attorney

Reviewed by Board Members Nichols, Brittingham and Crider.

Claimant requests review of those portions of Referee Hettle's order that: (1) dismissed claimant's request for hearing concerning the SAIF Corporation's "de facto" denial of a nutritional program; (2) affirmed a Determination Order that awarded 15 percent (48 degrees) unscheduled permanent disability for a low back injury; and (3) declined to assess penalties and attorney fees for an alleged unreasonable failure to process claimant's medical services claim for eyeglasses. SAIF cross-requests review of those portions of the order that: (1) set aside its denial of claimant's medical services claim for massage therapy; and (2) awarded $50 as a reasonable attorney fee for claimant's counsel's efforts in evoking the rescission of its denial of the "eyeglasses" claim.

On review, the issues are jurisdiction, medical services, extent of permanent disability, penalties and attorney fees. We reverse with respect to the claims processing and massage therapy issues. The remainder of the Referee's order is affirmed as supplemented.

FINDINGS OF FACT

We adopt the Referee's findings, with the following additions.

On March 5, 1987, Dr. Palmer, claimant's treating physician, reported that claimant's treatment program consisted of "spinal manipulation, an extensive amount of soft tissue therapy and nutritional therapy."

On March 9, 1987, an independent medical examination performed by Western Consultants indicated that the nutritional program consisted of Dr. Palmer "selling the patient the following nutritional supplements which he takes 2-3 times a day: Protezymase II for the pancreas, inflamzyne for inflammation, Orodyn-M, a magnesium supplement for muscle cramps, and sterotrophic concentrate which is a raw adrenal concentrate." The Consultants concluded that these supplements were not needed, and in fact, counterproductive.

Since SAIF received no billings for the nutritional program, no letter of acceptance or denial was ever issued.

On March 30, 1987, claimant began massage therapy sessions prescribed by Dr. Palmer. These sessions consisted of 21 visits over a two month period. Medical services were accomplished by Mr. Quimby of "Your Family Massage Center", an unlicensed medical provider. Dr. Palmer remained in contact with both Mr. Quimby and claimant throughout the treatment period. However, this contact was composed of written and telephone communication. Dr. Palmer did not personally supervise the treatment sessions.

The billing from Vista Optical for claimant's eyeglasses was date stamped received by SAIF on June 8, 1987. On June 25, 1987, SAIF denied the billing. Claimant requested a hearing partially based upon the eyeglasses billing issue. On July 29, 1987, prior to hearing, this bill was paid by SAIF. Issuance of the original denial was due to a claims processing error by SAIF.

SAIF was also billed for the massage therapy. On June 3, 1987, SAIF requested the Medical Director to issue an order concerning reimbursability of the sessions. Both the Medical Director and the Director of Insurance and Finance declined to issue an order, and suggested it was appropriate for claimant to contest SAIF's refusal to reimburse by requesting a hearing. The massage therapy was denied on June 25, 1987 as well.

Dr. Palmer found claimant medically stationary on August 13, 1987, and released claimant to light duty with restrictions against use of his legs and arms. A physical capacities examination conducted on September 17, 1987, indicated that claimant: (1) was capable of occasional lifting from 36 to 55 pounds; and (2) should avoid crawling, and could occasionally climb and reach overhead. On September 20, 1987, claimant returned to work with a computer firm as an ingot evaluator. Shortly thereafter, claimant was given a full work release by Dr. Palmer. Since claimant had returned to work, Dr. Palmer considered claimant's impairment to be in the minimum to moderate range.

Although both Dr. Palmer and claimant testified as to improvement in claimant's back condition resulting from the massage therapy, permanent residuals of claimant's injury remain as reflected in loss of normal lumbar range of motion, and loss of lifting capacity and strength.

ULTIMATE FINDINGS OF FACT

Claimant has not submitted a medical services billing, or otherwise requested reimbursement for his nutritional program.

Claimant did submit billings for massage therapy for which SAIF issued a denial.

The massage therapy sessions were not conducted under the direct control and supervision of claimant's treating physician.

Claimant's permanent impairment resulting from the compensable injury is in the mild range.

SAIF issued its denial of claimant's claim for eyeglasses within 60 days of its receipt of the claim. Its denial, based on a claims processing error, was unreasonable.

CONCLUSIONS OF LAW

NUTRITIONAL PROGRAM

The Referee concluded that he did not have jurisdiction to consider claimant's request for hearing on the matter of compensability of claimant's medical services claim for the nutritional program. He noted that without submitting a billing for services to SAIF, and allowing SAIF 60 days to accept or deny the claim, the request for hearing was premature. We agree.

The statutory scheme does not permit a hearing on compensability of a claim prior to a timely acceptance or denial, or prior to the expiration of the time in which the carrier may investigate and consider the claim without risking penalties. Until one of those event occurs, it is not known whether a hearing will be necessary or, if so, what issue or issues will be presented at the hearing. Syphers v. K-W Logging, Inc., 51 Or App 769, rev den 291 Or 151 (1981).

The issue here addresses ongoing medical care following initial acceptance of a claim, specifically, the nutritional program prescribed by Dr. Palmer.

There have been no billings submitted, nor has a request for reimbursement for nutritional treatment been made by either claimant or Dr. Palmer. Hence, SAIF's duty to pay or issue a partial denial within 60 days of receipt of billings never arose. Inasmuch as there has been no denial, "de facto" or otherwise, claimant's request for hearing is not ripe for litigation.

Claimant suggests that the medical reports in the record are adequate as a "claim." However, regardless of whether references in these reports to a nutritional program can be construed as establishing notice of treatment to SAIF, its duty to pay or deny arises upon submission of a doctor's billing or request for reimbursement in order to constitute a "separate and distinct claim." Billy J. Eubanks, 35 Van Natta 131, 132, 135 (1983).

Accordingly, we agree with the Referee that he lacked jurisdiction to address the nutritional program issue.

MASSAGE THERAPY

SAIF moved to dismiss for lack of jurisdiction on the basis that a medical services claim for massage therapy is governed by OAR 436-10-050(2), and therefore, before the issue can be raised at the hearing level, an order must be issued by the Director of Insurance and Finance pursuant to OAR 436-10-110. The Referee denied the motion finding that claimant was entitled to medical treatment that is related to his claim, and is reasonable and necessary under ORS 656.245. The Referee further held that the Hearings Division has authority to hear any issue concerning a claim under ORS 656.283.

Proceeding to the merits of the claim, the Referee found the claim compensable. He reasoned that claimant's massage therapy was reasonable and necessary, and that Dr. Palmer adequately exercised direct control and supervision of claimant's treatment. The Referee cited OAR 436-10-050(2), and Verna B. Herb, 37 Van Natta 1247 (1985). We agree with the Referee on the jurisdictional issue, but reverse on the merits.

Claimant's submission of billings for rendered massage therapy is a claim for medical services as "other related services" under OAR 436-10-005(17), and also "physical restorative services" under ORS 656.245. Jeanette M. McMichael, 40 Van Natta 1131, 1132 (1988); Ronald A. Shamberger, 40 Van Natta 993 (1988). Therefore, SAIF's denial of claimant's medical services billing for massage therapy is a question concerning a claim and, thereby, sufficient to entitle claimant to a hearing on the matter. ORS 656.283.

It was SAIF's request that the Director issue an order denying reimbursement pursuant to former OAR 436-10-110(3)(b), because the services rendered were not reimbursable under OAR 436-10-050(2). OAR 436-10-110 describes the procedure for implementation of the Director's authority to levy civil penalties to enforce reporting requirements applicable to physicians. See ORS 656.252 and 656.254. It is not clear that the rule was intended to authorize sanctions against a provider who bills for services not deemed reimbursable by the rules. In any event, the rule is permissive. It authorizes, rather than directs, the Director to act.

Here, the Director's inaction does not preclude claimant, who has no role whatsoever in a proceeding under the aforementioned rule, from seeking a hearing to contest a denial of services. Accordingly, we conclude that SAIF's motion to dismiss was properly denied by the Referee.

We turn to the merits. Claimant is entitled to all reasonable and necessary treatment required for the recovery from his compensable injury. ORS

656.245(1); West v. SAIF, 74 Or App 317, 320 (1985); McGarry v. SAIF, 24 Or App 883, 888 (1976). At the time he was receiving massage therapy, March 30, 1987 through May 1987, OAR 436-10-050(2) provided that:

> "Attending physicians may prescribe treatment to be carried out by persons licensed to provide a medical service or by persons not licensed to provide a medical service who work under the direct control and supervision of the attending physician."

In finding the massage therapy sessions compensable, the Referee concluded that Dr. Palmer adequately exercised direct control and supervision over the treatments. We disagree.

At the time of the treatments, "direct control and supervision" meant that the attending physician was required to be on the same premises, at the same time, as the person providing the services. OAR 436-10-005(9) (Effective date March 16, 1987). Although Dr. Palmer established a treatment plan and testified that he was in constant contact with the provider by telephone and letter, he did not comply with the on-site requirement of the rule. Accordingly, we conclude that the massage therapy claim is not compensable.

The application of an administrative rule which limits the rights of a claimant to obtain reasonable and necessary medical services causally related to a compensable claim is not enforceable. Kemp v. Workers' Comp. Dept., 65 Or App 659 (1983), on recon, 67 Or App 270 (1984), rev den, 297 Or 227 (1984). Claimant contends that application of OAR 436-10-050(2), as defined by OAR 436-10-005(9), would limit his rights to be reimbursed for reasonable and necessary medical services and, as such, is impermissible. We disagree.

The Board is without authority to declare a rule invalid. Jurisdiction to do so is vested with the Oregon Court of Appeals. ORS 183.400. Consequently, we are bound by the rules promulgated by the Director insofar as they are consistent with the workers' compensation act. See Miller v. Employment Division, 290 Or 285 (1980); McPherson v. Employment Division, 285 Or 541, 551 n. 8 (1979); Judith A. Lange, 41 Van Natta 580 (1989).

Here, we do not consider OAR 436-10-050(2), as further defined by OAR 436-10-005(9), to be in conflict with ORS 656.245(1). Rather, we interpret the rules in a manner consistent with the statutory provisions of ORS 656.245(1). That is, in response to the lifetime guarantee of medical services for conditions resulting from the compensable injury, as contained in the statute, the aforementioned rules designate who may provide such medical services. Specifically, in regards to treatment prescribed, but not performed, by the attending physician, the rule requires that the treatment either be carried out by persons licensed to provide a medical service or, where the provider is not licensed, then under the direct control and supervision, (i.e., on the premises of the provider) of the attending physician. The purpose of the rules would appear to be to sanction medical services performed by licensed providers or, where the provider is unlicensed, to sanction services performed under the direct monitorship of an attending physician. We consider such a purpose to be both reasonable and in keeping with the statutory requirements.

EXTENT OF UNSCHEDULED PERMANENT DISABILITY

The Referee found that 15 percent (48 degrees) unscheduled permanent disability, as awarded by the Determination Order, adequately compensated claimant for his loss of earning capacity for his low back condition. We agree.

The criteria for rating of unscheduled disability is the permanent loss of earning capacity due to the compensable injury. ORS 656.214(5). In determining the loss of earning capacity, we consider medical and lay evidence of physical impairment resulting from the compensable injury and all of the relevant social and vocational factors set forth in former OAR 438-30-380 et seq. These rules are applied as guidelines, not as restrictive mechanical formulas. Harwell v Argonaut, 296 Or 505 (1984), Fraijo v. Fred N. Bay News Co., 59 Or App 260 (1982).

The medical and lay evidence supports a permanent physical disability rating in the mild range. Claimant is 30 years old and has a high school degree, plus one and a half years of college training in computer programming. His past jobs have included seven years in the navy as a computer programmer, and more recently as a "crystal grower" for a computer company. At the time of injury, he was employed as a psychiatric aide, which required medium lifting. Currently, he is employed with a computer firm as an ingot evaluator.

Although claimant has recovered sufficiently to enable him to return to full-time work, he has permanent residuals of impairment. Specifically, he experiences some reduced range of motion, and diminished lifting capacity. After considering this impairment, in conjunction with claimant's social and vocational factors, we agree with the Referee that claimant's loss of earning capacity is equal to 15 percent.

IMPROPER CLAIMS PROCESSING

On June 25, 1987, SAIF issued a denial which acknowledged acceptance of the prior July 1, 1986 back claim, denied claimant's entitlement to massage therapy, and also refused to pay for an eyeglasses billing. The eyeglasses billing should have been paid under claimant's separate nondisabling claim for broken glasses and nose injury, which SAIF had accepted on May 23, 1986.

Consequently, claimant's counsel requested a hearing based partially on compensability of the eyeglasses. Shortly before hearing, SAIF realized the eyeglasses billing had mistakenly been referred to the July 1, 1986 back claim and paid the billing. The Referee declined to find that the issuance of the denial was either untimely or unreasonable. We reverse.

A carrier is required to either pay or deny a claim within 60 days of receipt. Billy Eubanks, 35 Van Natta 131, 135 (1983). Here, there is evidence that the billing from Vista Optical was sent to SAIF in March of 1987. However, there is also testimony to the effect that the billing received by SAIF from Vista Optical was date stamped on June 8, 1987. There is no way to resolve the issue conclusively. The legal test is date of receipt, and it was claimant's burden to prove the date favorable to his position. This claimant failed to do. Thus, we cannot conclude that SAIF unreasonably delayed payment or was untimely in its denial of claimant's claim. Sandra Branham, 40 Van Natta 1267 (1988). Accordingly, there is no basis for assessing penalties or attorney fees for an untimely denial.

However, a denial issued without foundation is unreasonable and will support penalties and attorney fees. The claims examiner testified that when she received the eyeglasses billing she directed it to the July 1, 1986 back claim without bothering to check for a separate eyeglass claim, despite the fact a procedure existed for so checking. The claims examiner proferred no explanation of why she failed to do so. Inasmuch as an actual eyeglasses claim did in fact exist, SAIF's rationale can not be considered a reasonable one. Claimant should not have to bear the brunt of processing mistakes made by a carrier's employees, innocent though they may be. The responsibility was on SAIF to conduct a reasonable investigation into claimant's eyeglasses claim and render a decision based upon the merits of that claim.

Consequently, we find SAIF's conduct was unreasonable, and conclude that claimant is entitled to a penalty equal to 25 percent of Vista's billing of $133.95. ORS 656.262(10). The order of the Referee is reversed on this issue.

Claimant's counsel is statutorily entitled to a reasonable carrier-paid fee concerning this unreasonable denial issue. ORS 656.382(1); 656.262(10). OAR 438-15-030. However, we cannot award an "assessed" fee unless claimant's counsel files a statement of services. See OAR 438-15-005(2); 438-15-010(5). Because no statement of services has been received to date, an assessed fee shall not be awarded.

ORDER

The Referee's order dated November 25, 1987 is affirmed in part and reversed in part. That portion of the order that set aside the SAIF Corporation's denial of claimant's medical services claim for massage therapy is reversed. The denial is reinstated and upheld. The Referee's $750 attorney fee award for prevailing on this issue is reversed. That portion of the Referee's order that declined to assess a penalty for SAIF's unreasonable denial of claimant's medical services claim for eyeglasses is reversed. SAIF is assessed a 25 percent penalty based on claimant's eyeglasses billing of $133.95. The remainder of the Referee's order is affirmed.

Board Member Crider, dissenting in part.

The Board herein upholds denial of massage therapy services performed pursuant to a treatment plan prepared by the attending physician and under his continued direction. SAIF has never contended that massage therapy is not reasonable and necessary and, indeed, has conceded that therapy should be provided to claimant. TR. 11. Respondent's and Cross-Appellant's Brief at 11. The sole ground of its denial is that the therapist was not licensed. The denial relies on that portion of the Director's rules which declares that for purposes of the Workers' Compensation Law medical services may not be performed by unlicensed providers unless the services are performed under the on site direction and control of the attending physician. OAR 436-10-050(2) and OAR 436-10-005(9). This rule in effect defines a service, which may be delivered under the statutes and rules governing the practice of massage therapy, as noncompensable under the workers' compensation law. Because the rule denies certain reasonable and necessary medical services to workers, it is inconsistent with the statute; therefore, claimant is entitled to the service, the rules notwithstanding.

ORS 656.245(1) entitles an injured worker to all medical services that "the nature of the injury or the process of recovery requires...." The statute authorizes the Director to make rules for the administration of the program but not to limit access to treatment that is reasonable and necessary. Kemp v. Workers' Compensation Department, 65 Or App 659 (1983), on recon. 67 Or App 270, (1970), rev den 297 OR 227 (1984). The rule limits such access.

The rules in question do not simply define the term "medical services" as it appears in the statute. Instead, they narrow it. Massage therapy is an art practiced "for the purpose of, but not limited to, maintaining good health and establishing and maintaining good physical condition." ORS 687.011(4). The Director's rules recognize that it is a medical service. Therapy may be practiced either by a licensed massage technician or by any individual licensed under another statute to "do any acts included in the definition of massage in ORS 687.011 or persons working under the direction of any such person." ORS 687.021(2); ORS 687.031(1).

Nothing in the statute, the rules of the Board of Massage Technicians or the rules of the Board of Medical Examiners, defines the term "under the direction of" to require on site supervision during a treatment session. In another context in

which the statutes require "supervision and control" by a physician, however, the term is defined specifically to require "routine direction and regular review by the supervising physician," "maintenance of direct, verbal communication," but not "the physical presence at all times of the supervising physician." ORS 677.495. The rules of the Board of Medical Examiners, implementing this statute dealing with supervision of physician's assistants, have recognized that a differing level of supervision is appropriate in rural than in metropolitan areas. OAR 847-50-010 and -037.

The statutory scheme delegates to the licensing board by which the attending physician is licensed the authority to determine the nature of the supervision that must be exercised by a physician over unlicensed personnel. So long as therapy is rendered under supervision that is consistent with the rules of the licensing board, I am not persuaded that the Director may declare it noncompensable for lack of more stringent supervision.

I am concerned about the rigid requirements of the Director's rule not only because I believe them to be beyond his authority but also because, in particular cases, perhaps involving therapy needed more urgently than massage therapy, the "on site supervision" requirement will deny injured workers needed medical services. In some, if not many, areas of this state, services may not be available within a reasonable distance from a worker's home unless they are provided by an unlicensed provider working pursuant to a treatment plan established by an off site attending physician under the direction of an individual qualified to supervise the service under the terms of her or his license. In such cases, the rule will deny to the worker reasonable and necessary services. Where the statutes governing delivery of medical services generally do not deny the services to the public at large, I do not believe the Director is empowered to deny them to injured workers. Therefore, I dissent.

February 8, 1990 Cite as 42 Van Natta 304 (1990)

In the Matter of the Compensation of
THOMAS W. WILLMAN, Claimant
WCB Case Nos. 87-14321, 87-14320 & 87-19133
ORDER ON REVIEW
Pozzi, et al, Claimant Attorneys
Schwabe, et al, Defense Attorneys

Reviewed by Board Members Cushing and Gerner.

Claimant requests review of those portions of Referee Galloway's order which: (1) failed to address claimant's contentions concerning the insurer's alleged failure to properly close his claim pursuant to a prior stipulation; (2) upheld the insurer's denial of claimant's aggravation claim for his upper side and lower back condition; and (3) failed to address claimant's contention that he was entitled to penalties and attorney fees for the insurer's alleged unreasonable claims processing. Claimant has also moved the Board for an order remanding the case to the Hearings Division for a "fair and proper hearing" and for the taking of additional evidence. On review, the issues are remand, improper closure, aggravation, penalties and attorney fees. We deny the motion, affirm in part and reverse in part.

FINDINGS OF FACT

On February 12, 1979, claimant suffered a compensable neck and right shoulder injury. The claim was closed by a Determination Order dated July 29, 1981, which awarded 10 percent unscheduled permanent disability.

On February 9, 1987, over five years after the claim was initially closed, claimant visited Dr. Gripekoven, his treating physician. The diagnosis was stiffness and tightness in claimant's neck and pain down the right shoulder and around the right scapula, with discomfort in the dorsal spine. Gripekoven noted that claimant's condition was work related.

Claimant filed a new upper side, lower back injury claim on February 16, 1987. On March 26, 1987, by stipulation, claimant withdrew this "new injury" claim and his 1979 injury claim was reopened. The insurer began making temporary total disability benefit payments effective February 17, 1987, and such payments were to be ongoing until claimant became medically stationary, at which time the claim was to be closed, pursuant to the stipulation, "under ORS 656.268."

Between March 31, 1987 and April 30, 1987, claimant saw Gripekoven on four separate occasions. On April 21, 1987, Gripekoven determined claimant to be medically stationary and without permanent impairment. Claimant was released to regular work on May 1, 1987. On May 5, 1987, claimant alleged he suffered from a "new injury" claim, yet no claim was filed. He again visited Gripekoven on May 12, 1987, who again reported that claimant suffered from no permanent impairment.

On May 13, 1987, the insurer issued a notice of closure of the reopening of the claimant's February 12, 1979 claim. The notice of closure improperly stated the aggravation date as May 13, 1987. On June 11, 1987, the insurer issued a corrected notice of closure changing the aggravation date to July 29, 1981.

On July 2, 1987, Gripekoven sent the insurer a report which listed claimant's date of injury as May 5, 1987. The report stated that the injury "represented a temporary symptomatic flare-up of his underlying condition. There has not been any material worsening of his condition, and there has not been any new injury". Claimant was released to regular work on July 20, 1987.

On August 12, 1987, the insurer denied the reopening of claimant's claim for aggravation, noting that claimant's physician indicated that there was no material worsening of the claimant's underlying condition as a result of the "incident that occurred on May 5, 1987."

On September 15, 1987, claimant requested a hearing alleging that the denial of August 12, 1987 was improper because the claim denied was a "new claim" for an alleged injury on May 5, 1987, rather than an aggravation of his compensable February 12, 1979 injury claim. Claimant also alleged that the closures of May 13, 1987 and June 11, 1987 were improper because the carrier issued a notice of closure, rather than processing the claim through the Evaluation Division, in violation of the March 26, 1987 stipulation. Claimant requested that the denial letter of August 12, 1987 be set aside and that he be awarded penalties and attorney fees based on the insurer's unreasonable resistance to payment of compensation.

On September 22, 1987, claimant requested review of the notices of closure by the Evaluation Division. On December 2, 1987, claimant again requested review by the Evaluation Division.

On February 17, 1988, a Determination Order issued, setting aside the insurer's notices of closure dated May 13, 1987 and June 11, 1987. The Determination Order was not submitted as evidence at the hearing.

The Referee's order, dated May 31, 1988, upheld the insurer's denials of August 12, 1987 and November 20, 1987. The Referee did not discuss the issue of whether or not the insurer's May 13, 1987 and June 11, 1987 notices of closure were improper.

Following the request for review, claimant moved for remand to the Referee for the admission of two Determination Orders, dated February 17, 1988 and June 3, 1988. The June 3, 1988 Determination Order was issued after the Referee's May 31, 1988 order.

CONCLUSIONS OF LAW

Remand

On August 2, 1988, claimant made a motion to remand for the taking of additional evidence, alleging that newly discovered evidence was not available to be presented to the Hearings Division. The submitted evidence is comprised of two Determination Orders, one dated prior to the hearing and one issued post-hearing.

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).

However, under the circumstances of this case, we find that remand is not necessary. The Board may take administrative notice of facts "capable of accurate and ready determination by resort to sources whose accuracy cannot reasonably be questioned." ORS 40.065(2); Groshong v. Montgomery Ward, 73 Or App 403 (1985). This authority includes Determination Orders. See Leslie G. Mullenix, 41 Van Natta 2068 (1989).

Accordingly, we take administrative notice of the Determination Orders dated February 17, 1988 and June 3, 1988, and deny claimant's motion to remand.

Propriety of the Insurer's May 13, 1987 and June 11, 1987 Notices of Closure

The Referee failed to address claimant's contention that the insurer's closure of claimant's aggravation claim by the issuance of notices of closure was improper. Claimant argues that the claim should have been closed by the issuance of a Determination Order. Inasmuch as the notices of closure have been set aside by the Determination Orders, we do not reach the merits of claimant's contention.

Penalties and Attorney Fees/Alleged Unreasonable Claims Processing

The Referee also failed to address claimant's contention that the insurer's claims processing, by closing claimant's claim through the issuance of notices of closure, was contrary to the parties' stipulation and, thereby, unreasonable. Claimant asserts that the stipulation required closure by the issuance of a Determination Order. Conversely, the insurer asserts that it properly closed claimant's claim by issuing notices of closure, arguing that ORS 656.268(3) permits such closures.

To determine the reasonableness of the insurer's interpretation of ORS 656.268(3), the Board must evaluate the insurer's actions based on a review of both the March 26, 1987 stipulation and the controlling law at the time of the stipulation.

The Stipulated Order indicated that claimant's aggravation claim would be reopened with temporary disability ongoing until claimant became medically

stationary, at which time reprocessing would occur "pursuant to ORS 656.268." Therefore, the insurer was obligated to close, at the appropriate time, claimant's aggravation claim pursuant to ORS 656.268.

At the time of the 1987 stipulation, ORS 656.268(3) provided that:

> "When the medical reports indicate to the insurer or self-insured employer that the worker's condition has become medically stationary and the insurer or self-insured employer decides that the claim is disabling but without permanent disability the claim may be closed, without the issuance of a determination order by the Evaluation Division. The insurer or self-insured employer shall issue a notice of closure of such claim to the worker and to the Workers' Compensation Department." (Emphasis supplied.)

The statute goes on to say,

> "Within one year of the date of the notice of such a claim closure, a determination order subsequently shall be issued on the claim at the request of the claimant or may be issued by the Evaluation Division upon review of the claim if the division finds that the claim was closed improperly. . . . If an insurer or self-insured employer has closed a claim pursuant to this subsection, 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." (Emphasis supplied)

Claimant argues that the insurer's notices of closure were improperly issued. First, he asserts that he had previously been awarded 10 percent permanent disability. Because, at the time of the closure of the aggravation claim, he was disabled, but with permanent disability, claimant contends that the claim should not have been closed without the issuance of a Determination Order. As a result, claimant argues that the insurer failed to close the claim pursuant to ORS 656.268, as required by the stipulation.

Conversely, the insurer argues that claimant suffered no permanent disability attributable to the aggravation claim. Since claimant did not suffer permanent disability as a result of the aggravation claim, the insurer contends that its action in closing the claim by means of a notice of closure was reasonable under ORS 656.268 and the stipulation.

The issue is whether the insurer was reasonable in its interpretation of ORS 656.268(3). In resolving this issue, we focus on whether the term "permanent disability", as referred to in ORS 656.268(3), could reasonably be interpreted to mean "permanent disability attributable to the aggravation claim", or "permanent disability" as previously awarded with respect to the underlying claim which is later found to have been compensably aggravated.

It can be argued that the statute's reference to "permanent disability" and no specific reference to "permanent disability attributable to the aggravation claim" demonstrates that closure of such an aggravation claim must be

accomplished by a Determination Order. Yet, since aggravation claims are required to be processed in a manner consistent with initial claims and because the evidence when claimant's condition became medically stationary did not indicate that he had sustained permanent disability as a result of his aggravation claim, it can likewise be contended that claim closure through a notice of closure is permissible.

Inasmuch as the question of what closure approach is required by the statute is not before us, we need not resolve that issue today. Instead, we must determine whether the insurer's conduct was unreasonable. Under these circumstances, we do not consider the insurer's interpretation of the statute to be unreasonable.

We base our conclusion on the following reasoning. The insurer interpreted the medical reports as an indication that claimant suffered no "additional" permanent disability. Because the insurer had confirmation that claimant was medically stationary, and because there was no permanent disability attributable to the aggravation claim, the insurer's actions in closing the claim via notice of closure was reasonable under ORS 656.268(3) and the stipulation. Accordingly, we find that the insurer's interpretation of ".268(3)" was not unreasonable.

Insurer's August 12, 1987 Denial

Because the Determination Order dated February 17, 1988, set aside the two notices of closures in their entirety, the issue of determining whether claimant suffered an aggravation in August, 1987, which was denied, is moot. However, we discuss the reasonableness of the denial.

The Referee concluded that he was without jurisdiction to determine the reasonableness of the insurer's August 12, 1987 denial of claimant's aggravation claim. We disagree.

The insurer's August 12, 1987 denial stated that, "We have received Dr. Gripekoven's letter of July 2, 1987. The doctor indicates no material worsening of your underlying condition as a result of the incident which occurred on May 5, 1987." The insurer issued this denial after it had issued its June 11, 1987 closure of claimant's prior aggravation claim.

An insurer has 60 days from the date of notice of a claim in which to accept or deny such claim. ORS 656.262(6). In this particular instance, the insurer received medical information on July 2, 1987, alerting it of a new claim allegedly to have occurred on May 5, 1987. On August 12, 1987, based on the receipt of the medical information, the insurer issued a denial of claimant's May 5, 1987 aggravation claim. Thus, the insurer's August 12, 1987 denial of claimant's May 5, 1987 claim, treated by Gripekoven as an aggravation claim, was proper, and therefore, not unreasonable.

However, subsequent to the insurer's denial, the issuance of the Determination Order setting aside the notices of closure have rendered this "aggravation" issue moot. As a result of the Determination Order, the claim was in open status at the time of the aggravation denial. Thus, the denial should be set aside as moot. Carol Knapp, 41 Van Natta 851 (1989).

We conclude, therefore, that inasmuch as the claim was then in closed status, the insurer's denial of August 12, 1987 of claimant's aggravation claim was validly issued. However, the denial should be set aside because the claim was subsequently reopened by virtue of the February 17, 1988 Determination Order.

ORDER

The Referee's order, dated May 31, 1988, is affirmed in part and reversed in part. The insurer's denial of claimant's aggravation clam is set aside. For services at hearing and on review concerning this issue, claimant's attorney is awarded $1,350, to be paid by the insurer. A client-paid fee, not to exceed $1,228, payable from the insurer to its counsel, is approved.

February 9, 1990 Cite as 42 Van Natta 309 (1990)

In the Matter of the Compensation of
MICHAEL BODEMAN, Claimant
WCB Case Nos. 88-01433 & 88-04114
ORDER ON REVIEW
Royce, et al, Claimant Attorneys
Acker, et al, Defense Attorneys
Julia Philbrook (Saif), Defense Attorney

Reviewed by Board Members Perry and Howell.

Liberty Northwest Insurance Corporation requests review of Referee Leahy's order which: (1) set aside its denial of claimant's right shoulder impingement syndrome condition; (2) upheld the SAIF Corporation's denial of the same condition; and (3) awarded a carrier-paid attorney fee payable by Liberty Northwest. The issues on review are responsibility and attorney fees. We reverse.

Subsequent to the hearing, claimant and SAIF entered into a stipulated agreement pursuant to which SAIF paid to claimant's attorney a fee for services rendered in prompting SAIF to amend its denial. Our August 26, 1988 Interim Order Approving Stipulation is hereby incorporated into this Order on Review.

FINDINGS OF FACT

Claimant first suffered a compensable injury involving his neck and right shoulder in approximately 1982. He injured his neck and shoulder again on or about April 2, 1985. This was accepted as a cervical strain. The employer's insurer in both instances was SAIF.

In February 1986, claimant filed a claim for right upper back, neck and arm strain which was accepted as an aggravation of the 1985 claim.

On June 23, 1986, claimant had cervical surgery. Claimant's claim was closed by Determination Order on November 24, 1986 that awarded 5 percent (16 degrees) unscheduled permanent disability. By a Stipulated Order dated February 5, 1988, claimant received an additional award of unscheduled permanent disability of 15 percent (48 degrees) for a total of 20 percent (64 degrees).

Claimant's cervical problem subsided after his surgery, but he continued to complain of pain in the area of his shoulder.

When claimant worked at jobs for his employer that did not require strenuous use of his shoulder, the pain subsided. It became worse as the job required more use of the shoulder. Claimant was diagnosed as suffering from right shoulder impingement syndrome.

Liberty Northwest became the workers' compensation insurer for the employer on July 1, 1987.

On December 9, 1987, Liberty Northwest denied responsibility for claimant's right shoulder impingement syndrome and requested designation of a paying agent pursuant to ORS 656.307. On February 2, 1988, SAIF issued a denial of the right shoulder impingement syndrome. On April 8, 1988, SAIF issued a second denial of the condition in order to clarify that its earlier denial had been of responsibility only.

No ORS 656.307 order issued prior to the date of hearing.

CONCLUSIONS OF LAW AND OPINION

Responsibility

Claimant has two compensable claims involving his right shoulder for which SAIF is responsible. SAIF remains responsible for claimant's right shoulder condition unless it is proved that claimant's post July 1, 1987 employment independently contributed to a worsening of his condition. Hensel Phelps Construction v. Mirich, 81 Or App 290 (1986); Linda L. Wise, 42 Van Natta 115 (1990). We find no such evidence in the record.

Claimant saw Dr. Soot, orthopedic surgeon, on November 20, 1987, who stated that claimant's chief complaint is "right shoulder pain of many years duration". Dr. Soot diagnosed both an impingement syndrome in the rotator cuff, and a degenerative process at the AC joint. He opined that the worsening of the shoulder since July 1987 was probably a progression of the natural course of both conditions. He further opined that it was "questionable" whether claimant's employment while Liberty Northwest was on the risk worsened the pre-existing condition.

After considering the evidence in the record, we conclude that SAIF has failed to show that claimant's employment subsequent to the time Liberty Northwest became the insurer independently contributed to the worsening of claimant's condition. SAIF remains responsible for claimant's condition.

Attorney Fees

The Referee awarded claimant's attorney an assessed fee of $1,400 for his services at hearing, payable by Liberty Northwest. On review, Liberty Northwest argues that claimant's attorney is not entitled to a carrier-paid fee for his services at hearing because he did not "actively and meaningfully participate" at hearing. See ORS 656.307(5). We conclude, however, that ORS 656.307(5) is not applicable to this case.

The current version of ORS 656.307 authorizes an insurer-paid attorney fee if claimant "actively and meaningfully participates" in a ".307" arbitration proceeding. However, current ORS 656.307 applies only to those cases where the Board receives a ".307" order on or after the effective date of the amendments to ORS 656.307, i.e., January 1, 1988. Timothy R. Shroeder, 41 Van Natta 568, 570 (1989). Here, no ".307" order issued prior to hearing. Accordingly, current ORS 656.307 does not apply.

Under ORS 656.386(1), a claimant's attorney is entitled to a reasonable carrier-paid fee if the claimant prevails finally in a hearing before a Referee in a "rejected case." A "rejected case" is a case in which claimant's entitlement to receive compensation is at issue. In the absence of a ".307" order, claimant's entitlement to compensation remains at risk and claimant's counsel is entitled to a carrier-paid fee for services rendered at the hearing level. Ronald L. Warner, 40 Van Natta 1082, 1194 (1988). Accordingly, the Referee properly awarded claimant's attorney a carrier-paid fee. However, as a result of our determination on the merits of the responsibility question, SAIF rather than Liberty Northwest is responsible for payment of that fee.

ORDER

The Referee's order dated May 3, 1988 is reversed. Liberty Northwest Insurance Corporation's denial of December 9, 1987 is reinstated and upheld. The SAIF Corporation's denial of February 2, 1988, as clarified April 8, 1988, is set aside and the claim is remanded to SAIF for processing according to law. The carrier-paid attorney fee awarded by the Referee shall be paid by SAIF rather than Liberty Northwest. A client-paid fee not to exceed $1,627.50 is approved, payable by Liberty Northwest to its counsel. Claimant's attorney is awarded a $200 fee, payable by SAIF, for services on review concerning the denial issue.

February 9, 1990 Cite as 42 Van Natta 311 (1990)

In the Matter of the Compensation of
KIM L. HARAGAN, Claimant
WCB Case Nos. 88-01338 & 88-04599
ORDER ON REVIEW
Welch, et al, Claimant Attorneys
Scheminske & Lyons, Defense Attorneys
Stafford J. Hazelett, Defense Attorney

Reviewed by Board Members Myers and Gerner.

Claimant requests review of those portions of Referee Leahy's order which: (1) upheld Liberty Northwest Insurance Corporation's denial of claimant's aggravation claim for a low back injury; (2) upheld Aetna Casualty Company's denial of claimant's "new injury" claim for the same condition; (3) found that Aetna had properly calculated claimant's rate of interim compensation; (4) found that claimant was not entitled to interim compensation between January 18, 1987 and January 20, 1987; (5) declined to assess a penalty and attorney fee for alleged unreasonable failure to pay interim compensation between January 18, 1988 and January 20, 1988; and (6) declined to assess a penalty and related attorney fee for alleged unreasonable failure to comply with discovery requests. On review, the issues are compensability, responsibility, calculation of interim compensation, entitlement to interim compensation and penalties and attorney fees. We reverse in part and affirm in part.

FINDINGS OF FACT

In May 1986, claimant sustained a compensable injury to his neck while employed by Liberty Northwest's insured. The injury occurred when he was hit in the neck by a patient at a nursing home. His claim was closed by a February 1987 Determination Order that did not award permanent disability. The Determination Order was affirmed by a different Referee, who found that claimant was not a credible witness.

On November 3, 1987, claimant began working for Aetna's insured as a certified nurse's aide. On November 24, 1987, he filed a "new injury" claim with Aetna's insured, alleging a low back and neck injury that occurred while lifting a patient at a nursing home. He also filed an aggravation claim with Liberty Northwest. In January 1988, Aetna denied compensability as well as responsibility for his claim. In March 1988, Liberty Northwest denied compensability and responsibility.

While working for Aetna's insured, claimant worked as an on-call employee no more than three days per week and was paid $6.25 per hour on weekdays and $6.75 per hour on weekends. Aetna paid interim compensation through January 18, 1988. It issued its denial on January 20, 1988.

Claimant requested his payroll records from Aetna in January 1988. These records were never provided to claimant. He requested Exhibit 45 on January 29, 1988. This exhibit was not provided to claimant until March 24, 1988.

FINDINGS OF ULTIMATE FACT

Claimant's May, 1986 compensable injury is not a material contributing cause of his current condition.

Aetna's failure to pay compensation from January 18, 1988 through January 20, 1988, was unreasonable.

Aetna's failure to provide claimant with Exhibit 45 within 15 days of a specific written request was unreasonable.

Aetna's failure to provide claimant with his payroll records was unreasonable.

CONCLUSIONS OF LAW

Compensability

The Referee concluded that claimant had neither sustained an aggravation of his neck condition nor a new injury to his lower back and neck. We agree.

The Referee found that claimant was not credible based on his demeanor at hearing as well as the substance of his testimony. Inasmuch as claimant's testimony is riddled with inconsistencies, we agree with and adopt the Referee's finding that claimant is not credible. See Coastal Farm Supply v. Hultberg, 84 Or App 382 (1987).

In addition to claimant's lack of credibility, the medical evidence does not establish that either an aggravation or a "new injury" occurred. The Orthopaedic Consultants noted numerous subjective complaints, but reported that there were few, if any, objective findings to substantiate an injury occurring in November 1987. Both Dr. Stady and Dr. Hurd opined that claimant had sustained a new injury on November 24, 1987. Their opinions, however, are based upon the history given to them by claimant. As we have found claimant not credible, both Dr. Stady's and Dr. Hurd's opinions are not persuasive as they were relying upon claimant's history. See Miller v. Granite Construction Co., 28 Or App 473, 476 (1977).

Given claimant's lack of credibility, as well as the lack of persuasive medical evidence, we conclude that claimant has not sustained his burden of establishing that his current condition is causally related to his 1986 compensable injury or that his current condition is resultant from his work at Aetna's insured. Accordingly, claimant has proven neither an aggravation nor a "new injury".

As we have found the claims not compensable, the responsibility issue is moot.

Calculation of Temporary Disability

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 the employer at the time of hire.

Here, claimant was hired on November 3, 1987 as an on-call employee. That portion of the 801 form filled out by the employer indicated that claimant's schedule varied, but that he worked no more than 3 days per week, 7 1/2 hours per day. Claimant testified that he was hired as an on-call employee with the

intention of having him work 40 hours a week. As noted above, however, claimant is not a credible witness. We, therefore, assign little weight to his testimony regarding the parties' intent at hire.

We conclude that claimant has not established that Aetna miscalculated his rate of interim compensation.

Entitlement to Interim Compensation

A carrier is obligated to pay interim compensation for those periods of time that claimant is off work due to the injury, beginning no later than 14 days after the carrier had notice or knowledge of the claim, and continuing until a formal denial is issued. ORS 656.262(4); Bono v. SAIF, 298 Or 405 (1984); Roger G. Prusak, 40 Van Natta 2037 (1988).

Here, Aetna issued its denial on January 20, 1988. However, it only paid interim compensation through January 18, 1988. Aetna was obligated to pay interim compensation until the date of its formal denial. Bono, supra. Accordingly, claimant is entitled to interim compensation between January 18, 1988 and January 20, 1988.

Aetna has offered no explanation for this failure to pay interim compensation. Therefore, we conclude that a 25 percent penalty and related attorney fee is appropriate.

Discovery Violation

A penalty is assessed under ORS 656.262(10) against "amounts [of compensation] then due." An attorney fee, however, is assessed under ORS 656.382(1) when an insurer/employer "unreasonably resists the the payment of compensation." Lloyd L. Cripe, 41 Van Natta 1774 (1989).

Claimant contends that Aetna was unreasonable by failing to provide Exhibit 45 within 15 days of his written demand, and by not providing his payroll records. He seeks both a penalty and related attorney fee. Aetna has offered no explanation for its failure to comply with former OAR 438-07-015(2). This rule states that failure to comply with its provisions shall be considered unreasonable refusal or delay within the meaning of ORS 656.262(10). Accordingly, we conclude that Aetna's failure to comply with OAR 438-07-015(2) was unreasonable.

Although we have found Aetna's discovery violations unreasonable, we have already assessed a full 25 percent penalty on the only compensation due to claimant, therefore, we cannot grant a further penalty. See Sandra Branham, 40 Van Natta 1267, 1275 (1988); Rob Cohen, 39 Van Natta 649, 652 (1987). However, Aetna's discovery violations are an unreasonable resistance to the payment of compensation, therefore, an attorney fee can be awarded, and we find it appropriate to do so in this case. See OAR 438-07-015(2); Cripe, supra.

ORDER

The Referee's order, dated May 19, 1988, is reversed in part and affirmed in part. That portion which declined to award claimant interim compensation from January 18, 1988 through January 20, 1988 is reversed. Claimant is awarded interim compensation from January 18, 1988 through January 20, 1988, payable by Aetna Casualty Company. Claimant's counsel is awarded 25 percent of the increased compensation created by this order, not to exceed $3,000. Claimant is further awarded a penalty equal to 25 percent of the interim compensation due by virtue of this order, payable by Aetna. Claimant's counsel is awarded a reasonable assessed fee of $100, for prevailing on the interim compensation penalty issue, payable by Aetna. Claimant's counsel is further awarded a reasonable assessed fee of $100 for prevailing on the discovery violation penalty issue, payable by Aetna. The remainder of the order is affirmed. A client-paid fee, not to exceed $1,962.50, is approved, payable by Aetna to its counsel.

In the Matter of the Compensation of
GENE R. HARREL, SR., Claimant
WCB Case Nos. 86-15378 & 86-15377
ORDER ON REVIEW
Pozzi, et al, Claimant Attorneys
Schwabe, et al, Defense Attorneys

Reviewed by Board Members Myers and Gerner.

Claimant requests review of that portion of Referee Hoquet's order which: (1) declined to grant permanent total disability; (2) increased claimant's unscheduled disability award for his left shoulder condition from 10 percent (32 degrees), as awarded by a Determination Order, to 25 percent (80 degrees); and (3) increased claimant's unscheduled disability award for his right shoulder condition from 30 percent (96 degrees), as awarded by two previous Determination Orders, to 45 percent (144 degrees). Claimant has also moved the Board for an order remanding the case to the Hearings Division to consider additional evidence. In addition, claimant asks that we take administrative notice of an Own Motion Order which was issued on this claim after the Referee's order. On review, the issues are remand, administrative notice and extent of permanent disability. We deny the motions and reverse the Referee's decision not to grant permanent total disability.

FINDINGS OF FACT

Claimant, 62 years of age at the time of hearing, worked for the employer from 1955 until he retired in April 1988. Claimant has a 10th grade education, and no GED.

In March 1981, claimant compensably injured his low back after falling off a railroad tank car. Pursuant to a March 1982 stipulation, claimant was awarded 10 percent unscheduled permanent disability.

In October 1981, claimant compensably injured his left shoulder, after falling down some stairs at work. Pursuant to a December 16, 1983 order, and a subsequent review by the Board, claimant was awarded no permanent disability.

In November 1985 claimant sought treatment from Dr. Keizer, his treating orthopedist, for continuing pain and discomfort in his left shoulder. Keizer diagnosed a left rotator cuff tear and recommended surgery.

In February 1986, while awaiting authorization for his left shoulder surgery, claimant compensably injured his right shoulder, while opening a heavy elevator door. Dr. Duff, M.D., diagnosed right rotator cuff tear, bilateral osteoarthritis, chronic cervical spondylolysis and chronic bicipital tendinitis left shoulder. Surgery was recommended to repair the right rotator cuff tear. Claimant's impairment was rated as "mild to both shoulders" and claimant was advised to seek early retirement.

Claimant underwent rotator cuff surgery to the left shoulder in February 1986, and to the right shoulder in April 1986. Both claims were closed by Determination Orders issued on October 29, 1986, with awards of 10 percent unscheduled permanent partial disability for each shoulder. During the course of post-operative treatment, claimant developed neck pain.

In December 1986, claimant developed additional medical problems associated with his right shoulder. A second rotator cuff surgery was performed in January 1987. Claimant did not return to work until November 1987.

In July 1987, claimant underwent surgery which detected cervical spondylolysis C2-3, C3-4, C4-5, C5-6 and C6-7. A month later, Dr. Smith, M.D., diagnosed cervical dorsal strain. At that time, Dr. Keizer recommended that claimant not return to his gainful employment.

In September 1987, Keizer noted that claimant could return to his gainful employment under lighter working conditions with some restrictions. Claimant returned to work with restrictions on November 23, 1987, but was taken off work on December 3, 1987, by Dr. Kaizer, due to claimant's continuing shoulder condition. Keizer noted that claimant could not return to work, and restricted him from performing heavy lifting, turning or twisting frequently, and repetitive movements of the upper extremities with overhead work.

In March 1988, claimant, who continued to complain of neck, back and shoulder pain, was referred for vocational rehabilitation. Claimant reported to the vocational counselor and cooperated fully. However, no occupations were identified within his residual functional capacity. Claimant noted at that time that he was financially unable to retire.

Claimant attempted to return to modified work twice, once in July 1986, and again in November 1987. Both attempts were unsuccessful.

On March 4, 1988, a Determination Order issued awarding claimant an additional 20 percent unscheduled permanent disability for his right shoulder condition.

In April 1988, claimant retired because his physical and medical limitations no longer allowed him to return to work.

Claimant also suffers from a noncompensable severe and chronic cervical spondylolysis, a nonactive chronic duodenal ulcer, chronic bilateral osteoarthritis, chronic bicipital tendinitis left shoulder, diabetes myelitis, chronic and severe disabling neck pain and mild depression.

Claimant, at the time of the hearing, has physical restrictions including total restrictions on stooping/bending, twisting, kneeling and crouching. He is limited in his ability to stand, sit and walk to 30 minutes at a time. His lifting and carrying limitations indicate that he can not lift more than 10 pounds at a time, and then only occasionally. He also suffers from mild depression.

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

Claimant's current physical limitations, in conjunction with his lack of education and transferable skills, and his preexisting disabling and chronic medical conditions, make it futile for him to secure gainful employment.

Claimant's vocational services were terminated because of claimant's retirement.

CONCLUSIONS OF LAW

Remand

On May 8, 1989, claimant moved to remand 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 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 has filed a motion for remand to consider newly obtained evidence. The "new evidence" is medical documentation of a post-hearing operation which claimant asserts is probative of the severity of his disability. We find that any medical documentation subsequent to the time of the hearing is irrelevant to the question of claimant's disability at hearing. Thus, a subsequent surgery on claimant's shoulder does not affect his disability status as of the time of the hearing. Therefore, we deny claimant's motion to remand.

Administrative Notice

Claimant has also requested that the Board take administrative notice of the Board's Own Motion Order, issued on October 3, 1989. In that order, the Board stated the following:

> "Following our review of this record, we find that claimant is willing to work and that reasonable efforts to find work would be futile due to his compensable injury and its sequela. We find, therefore that claimant was in the work force at the time of his worsening."

The Board may take administrative notice of facts "capable of accurate and ready determination by resort to sources whose accuracy cannot reasonably be questioned." ORS 40.065(2); Groshong v. Montgomery Ward, 73 Or App 403 (1985). In this case the document which claimant seeks the Board to take administrative notice is an Own Motion Order. As with the remand request, such an order issued subsequent to the Referee's order is irrelevant to the determination of claimant's disability at the time of the hearing. Thus, we deny claimant's request to take administrative notice of our Own Motion Order issued subsequent to the Referee's order.

Extent of Permanent Disability

The Referee found that claimant was not permanently and totally disabled. In making his determination, the Referee found that claimant is capable of performing work of some kind, that he failed to meet the "seek work" requirements of ORS 656.206(3), and that it was unreasonable for him not to have tried alternative placement with the employer directly or with the assistance of his vocational consultant. The Referee concluded that claimant failed to meet his burden of proving that he is entitled to permanent total disability. We disagree with the Referee for the following reasons.

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) that arising from less than total physical incapacity plus non-medical conditions, which together result in permanent total disability. Welch v. Bannister Pipeline, 70 Or App 699 (1984); Wilson v. Weyerhaeuser, 30 Or App 403 (1977).

Claimant is not totally incapacitated on a physical or medical basis. Consequently, claimant can prevail only by proving that he falls within the "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 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 (Cascade Co., 772 Or App 397 (1985).

Lastly, under the "odd-lot" doctrine, claimant must demonstrate that he is willing to re-enter the work force and that he has made reasonable efforts to do so. Failure to look for work may be considered reasonable when such attempts would obviously be futile. See Butcher, v. SSAIF, 45 Or App 318 (1983).

The employer argues that claimant failed to meet his burden of proving that he is permanently totally disabled under the "odd-lot" doctrine. We disagree.

The medical evidence establishes that claimant suffered a compensable low back injury in 1981. He was awarded 10 percent unscheduled permanent disability by Determination Order for that condition. Claimant has also suffered from two compensable shoulder injuries, with a total of 50 percent unscheduled permanent disability.

Claimant also suffers from a number of other preexisting medical, physical and mental disabilities, which, together with his low back and shoulder injuries, prevent him from returning to his work at the time of the injury. Specifically, claimant suffers from a noncompensable severe and chronic cervical spondylolysis, stemming from 1957, a nonactive chronic duodenal ulcer, chronic bilateral osteoarthritis, chronic bicipital tendinitis left shoulder, high blood pressure, diabetes myelitis and mild depression.

Claimant, 62 years of age at hearing, has worked for the same employer for 33 years, practically all his adult life. He has a tenth grade education, has limited reading and writing skills, and no GED. Claimant's treating physician, Keizer, recommended in 1987, and again in 1988, that claimant not return to the work he had done for the past 33 years.

Vocational services began on March 3, 1988. To be eligible for vocational services, claimant must not be able to return to regular work, must not be able to return to any other suitable or available work, and must have a substantial handicap to employment and require assistance to overcome that handicap. Claimant was determined eligible for vocational assistance.

The employer argues that claimant has failed to prove that it would be futile for claimant to find another gainful occupation. In making such an assertion, the employer relies on the statements of Kirch, counselor for Stonebridge, who completed the initial vocational evaluation of claimant. We disagree.

Kirch testified relative to the procedures used in the vocational assistance program. Generally, Kirch testified that the first determination would be whether claimant could return to his employment at the time of the injury, either on a modified work plan, or performing some other function. If the answer was no, then the vocational rehabilitation counselors analyzed claimant's transferable skills and determined whether, based on those skills, there were any positions available to claimant other than his prior employment. Kirch determined claimant to be eligible for vocational services.

Claimant cooperated fully with Stonebridge rehabilitation efforts for several months. Kirch initially noted that "no occupations were identified in which the [claimant] would be able to utilize [his] skills." However, Kirch did

eventually identify three separate positions which might allow claimant to work within his capabilities. After determining that those three positions were actually outside of claimant's abilities, she identified two other jobs, fireman and lime sludge mixer. Yet, after evaluating the positions more carefully, Kirch determined that those occupations, as well, were outside of claimant's skill level.

Kirch, in concluding claimant was eligible for services, specifically reported that claimant "has a substantial handicap to re-employment. He requires assistance to identify vocational options available to him." However, Kirch concluded her report by noting that because claimant had chosen to retire, vocational services would be terminated.

Claimant was subsequently evaluated by H.J. Lageman & Associates, Inc. Lageman completed a full assessment of claimant's physical, mental and psychological capabilities. Further, Lageman considered the following factors in making his final determination: claimant's background information, his vocational activity, his work history, his perception of his own disability, his work tolerance, physical capacities and characteristics. Lageman also performed a complete vocational analysis, employability profile.

Lageman identified claimant's physical and mental limitations. He noted that claimant was totally restricted in stooping/bending, twisting, kneeling and crouching. Claimant is limited to sitting, standing and walking to approximately 30 minutes. He has lifting and carrying restrictions in that he is not to lift or carry in excess of 10 pounds, and then only occasionally. Lageman concluded the assessment by reporting that "due to the severity of [claimant's] physical capabilities, no occupations were identified within his residual functioning capacities." Lageman also noted that claimant suffered from a lack of transferable skills. Lageman opined that it would be futile for claimant to seek work. We are more pursuaded by the more well-reasoned opinion of Lageman. See Somers v. SAIF, 77 Or App 259 (1986).

Despite claimant's cooperation in vocational assistance activities, such activities did not result in successful job placement. Furthermore, because claimant accepted voluntary retirement, vocational services were terminated. We conclude that claimant has demonstrated that he is willing to re-enter the work force and that he has made reasonable efforts to do so because further work search was futile.

In sum, claimant's impairment attributable to the compensable injury, in combination with his preexisting disabling medical conditions, both physical and mental, prevent him from returning to his regular employment. His age, lack of education, lack of transferable skills and severely limited physical capabilities, prevent him from finding suitable and gainful employment. Finally, considering claimant's physical limitations and lack of transferable skills, we find that additional efforts to seek employment would be futile.

We hold that claimant is entitled to an award of permanent total disability.

ORDER

The Referee's order, dated July 1, 1988, is reversed. Claimant is awarded permanent total disability as of May 31, 1988. The employer is permitted to offset permanent partial disability payments made subsequent to the aforementioned date against claimant's permanent total disability benefits. Claimant's attorney is awarded 25 percent of the increased compensation created by this order, not to exceed $6,000. A client-paid fee, not to exceed $1,250, payable from the self-insured employer to its counsel, is approved.

In the Matter of the Compensation of
JOHN K. HUFFMAN, Claimant
WCB Case No. 85-13769
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Arthur Stevens (Saif), Defense Attorney

Reviewed by Board Members Nichols and Brittingham.

The SAIF Corporation requests review of Referee Howell's order that granted claimant permanent total disability in lieu of Determination Orders awarding 25 percent (80 degrees) for a low back and psychological condition. On review, the issue is extent of unscheduled permanent disability, including permanent total disability. We reverse.

FINDINGS OF FACT

Claimant was 52 years old at hearing. He has a sixth grade education. His prior work experience includes railroad labor and millwork. He has primarily been employed as a truck driver, including log, dump, and over-the-road trucks.

Claimant had his right lung removed in 1976 as the result of pneumonia. In 1979, he suffered a compensable injury to his right knee and underwent a patellectomy in which his right kneecap was removed. On January 11, 1984, claimant fell while employed as a log truck driver and reinjured his right knee. During treatment for this injury, he developed low back pain secondary to his knee injury.

Since 1984, claimant has attempted to return to work as a truck driver a number of times. Each attempt has been unsuccessful because of his physical restrictions.

An on-the-job training program was developed in 1985 to train claimant as a school custodian/maintenance person. This job involved light duty work. Claimant did clean-up and electrical, carpentry and plumbing maintenance and repair. He could work up to six hours per day, five days per week. Following this training period, claimant was unable to obtain employment, despite the availability of a wage subsidy program, due to reasons unrelated to his compensable injury.

Claimant continued to look for work until April 15, 1987, when he suffered a mild to moderate myocardial infarction. He underwent angioplasty and improved.

Claimant suffers constant low back pain and frequent pain in the right knee. His endurance has been reduced from the five to six hours per day he had demonstrated during his training period to about two and one half hours of activity since his heart attack.

Claimant is qualified for a part time position performing light maintenance.

FINDINGS OF ULTIMATE FACT

Claimant is permanently restricted to light duty work.

Claimant is not permanently incapacitated from regularly performing work at a gainful and suitable occupation, either as a result of his compensable injury and preexisting disabilities, or as a result of his physical disability in combination with his social, vocational, and educational background.

Claimant has suffered a 70 percent loss of earning capacity as a result of his compensable injuries.

CONCLUSIONS OF LAW AND OPINION

Permanent Total Disability

We agree with the Referee's conclusion that claimant is not totally disabled by physical incapacity alone. Like the Referee, we do not consider physical disability related to claimant's heart condition. Nor do we consider physical disability attributable to emotional problems resulting from the heart condition. Claimant's heart condition became disabling in April 1987, well after the January 1984 injury. A condition that becomes disabling after an injury is not considered in determining permanent total disability. Weyerhaeuser Co. v. Rees, 85 Or App 325 (1987).

We disagree with the Referee's conclusion that claimant is permanently and totally disabled under the "odd lot " doctrine. Wilson v. Weyerhauser, 30 Or App 403 (1977). The Referee found that claimant had earned wages of $8.00 an hour for a greater than 40-hour week and was receiving temporary total disability of about $1,200 per month in 1984. The Referee further found that claimant could perform light duty school maintenance work, 25 to 30 hours per week, at $5.00 per hour. The Referee concluded that a part time job paying less than half of claimant's temporary total disability award was not "gainful and suitable" employment as those terms are used in ORS 656.206. Accordingly, he concluded that claimant was permanently and totally disabled. We disagree.

The issue in a permanent total disability case is whether the claimant is precluded from regularly performing work at any gainful and suitable occupation, not whether claimant is capable of performing work paying a wage comparable to his pre-injury earnings. ORS 656.206(1). The purpose of permanent total disability is to maintain claimants who are totally precluded from supporting themselves. See Georgia Pacific v. Perry, 92 Or App 56 (1988); Harry J. Battilega, 38 Van Natta 617 (1986); Sharon Barkasey, 37 Van Natta 1652 (1985). It is appropriate to deny the maintenance benefits of a permanent total disability award when a claimant is capable of earning a living, even at a rate below his pre-injury earning rate. Walter L. LaChappelle, 36 Van Natta 1565 (1984). Here, we conclude that part-time work, 25 to 30 hours per week, at $5.00 per hour, is "gainful and suitable" employment within the meaning of ORS 656.206. We, therefore, conclude that claimant is not permanently and totally disabled.

Permanent Partial Disability

As we conclude that claimant is not permanently totally disabled, we rate the extent of his partial disability. The extent of unscheduled permanent partial disability is measured by the permanent loss of earning capacity due to the compensable injury. ORS 656.214 (5). To determine the loss of earning capacity, one considers 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. Claimant was 52 years old at the time of hearing. He has six years of formal education. He is not capable of performing the long-haul truck driving jobs he held prior to the injury. He is able to perform part-time light duty school maintenance work, but such work pays significantly less than claimant's job at the time of injury.

Taking into account claimant's age, education, work experience, adaptability, impairment, and the labor market, we find that an award of 70 percent (224 degrees) unscheduled permanent disability more adequately compensates claimant

for the loss of earning power he has suffered as a result of his compensable injuries.

ORDER

The Referee's order, dated October 21, 1987, is reversed in part and modified in part. In lieu of the Referee's permanent total disability award, and in addition to the 25 percent (80 degrees) unscheduled permanent disability awarded by Determination Orders, claimant is awarded an additional 45 percent (144 degrees) unscheduled permanent disability, giving him a total award to date of 70 percent (224 degrees) unscheduled permanent disability for his compensable injuries. The Referee's attorney fee award to claimant's attorney is adjusted accordingly.

In the Matter of the Compensation of
LEOLA JUDSON, Claimant
WCB Case No. 88-09706
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
Garrett, et al, Claimant Attorneys

Reviewed by Board Members Perry and Howell.

Claimant requests review of Referee Borchers' order that: (1) declined to consider the issue of medical services; and (2) declined to assess penalties and attorney fees for an alleged unreasonable denial. On review, the issues are res judicata and 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 Referee found that, under the doctrine of res judicata, a prior Settlement Stipulation barred claimant from litigating the issue of medical services. The Referee reasoned that because the issue of payment of medical bills was ripe for adjudication and could have been raised at the time of the stipulation, claimant was precluded from litigating her claim. We agree with the Referee's conclusion, but we base our opinion upon the following reasoning.

We do not agree with the Referee that res judicata bars claimant's claim for medical services. The stipulation entered into by the parties disposed of claims of aggravation and unscheduled disability, but did not expressly resolve the claim for medical services. The doctrine of res judicata applies if a claim is litigated to a final judgment; therefore it is not applicable in the present case. See Carr v. Allied Plating Co., 81 Or App 306, 309 (1986).

We conclude, however, that on the facts of this case, claimant waived her right to assert a claim for medical services. In her brief on review, claimant concedes that, at the time of the stipulation, medical bills were outstanding, the employer had stated its intention not to pay the bills and claimant and her attorney were aware of the situation. Claimant nevertheless signed a stipulation agreement which provided that "all issues raised by claimant's Request for Hearing, or that could have been raised, were conclusively settled or waived". At hearing, claimant testified that she understood the settlement would resolve the outstanding claims for medical services.

We find that, under these circumstances, claimant relinquished her right to bring a claim for medical services. Because claimant could have articulated such an entitlement at the time the stipulation was entered into, her failure to do so constitutes a waiver of her claim.

As we have affirmed the decision of the Referee, the issue of penalties and attorney fees is moot.

ORDER

The Referee's order dated August 17, 1988 is affirmed. A client-paid fee, not to exceed $656.50, is approved, payable by the self-insured employer to its counsel.

February 9, 1990 Cite as 42 Van Natta 322 (1990)

In the Matter of the Compensation of
DEAN E. POWERS, Claimant
WCB Case Nos. 87-09442 & 87-07927
ORDER ON REVIEW
Francesconi & Associates, Claimant Attorneys
Schwabe, et al, Defense Attorneys
Roberts, et al, Defense Attorneys

Reviewed by Board Members Howell and Speer.

Continental Casualty Insurance Company (CNA) requests review of Referee Thye's order that: (1) set aside its denial of claimant's "new injury" claim for his psychiatric condition; and (2) upheld American International Adjustment Company's (AIAC) denial of claimant's aggravation claim for the same condition. On review, the issue is responsibility. We affirm.

FINDINGS OF FACT

Claimant is a 29-year-old warehouseman who has had a history of functional gastrointestinal distress since 1975. Claimant began working for the employer in 1980. In June 1985, he was asked to train a new foreman for the employer. Claimant's co-workers resented the foreman and began to harass claimant for his attempts to assist the new employee. On an almost daily basis, the co-workers called claimant names and swore at him. On several occasions, he was nearly struck by a forklift.

In June 1986, claimant sought treatment for symptoms of vomiting, diarrhea and headaches. He was taken off work by his doctor and his gastrointestinal condition claim was accepted by AIAC. In August 1986, CNA replaced AIAC as the employer's insurer.

Claimant's symptoms improved and he returned to work in September 1986. Several days after claimant's return to work, one of his co-workers drove a forklift toward him and did not swerve until the last moment. He reported the incident to his doctor and was again taken off work.

Claimant returned to work in November 1986 and the harassment continued. After being taken off work in December, he did not return until August 1987, when he was reassigned to a different area.

In May 1987, AIAC denied responsibility for claimant's psychiatric condition claim. In June 1987, CNA denied responsibility for claimant's claim for the same condition.

Claimant's exposure, while CNA was on the risk, independently contributed to a worsening of his of his underlying psychiatric condition.

CONCLUSIONS OF LAW AND OPINION

The Referee found that CNA was responsible for claimant's claim. He concluded that claimant's underlying condition had worsened and become more symptomatic while CNA was on the risk. The Referee held that claimant's condition had improved prior to his return to work in September 1986, but the forklift incident significantly affected him. We agree with the Referee that CNA is responsible for claimant's psychiatric condition claim, but we base our conclusion upon the following reasoning.

Standard of Review

At the outset, we note that this case is subject to de novo review. Although ORS 656.307(2) has been amended to limit Board review of arbitrators' decisions in responsibility cases to questions of law, the amendments do not apply in this case. We have previously concluded that the Hearings Division's receipt of the .307 order is the critical event for purposes of determining which law governs in responsibility cases. See Timothy R. Schroeder, 41 Van Natta 568 (1989). Here, the Hearings Division received the .307 order on July 15, 1987. We conclude that the case is governed by pre-1988 law.

Responsibility

Under the last injurious exposure rule, full liability is placed on the carrier at the time of the most recent injury or exposure that bears a causal relation to the worker's disability. Boise Cascade Corp. v. Starbuck, 296 Or 238 (1984); Hensel Phelps Const. v. Mirich, 81 Or App 290 (1986). Responsibility will be placed upon the most recent insurer whose workplace conditions contributed, however slightly, to a worsening of claimant's underlying condition. Mission Ins. Co. v. Dundon, 86 Or App 470 (1987).

The Referee properly assigned responsibility to CNA, because it was the most recent insurer on the risk whose workplace conditions independently contributed to a worsening of claimant's underlying condition. We find Hensel Phelps, supra, to be controlling in the instant case. This case involves an aggravation/new injury situation because AIAC had previously accepted claimant's gastrointestinal distress claim. Yet, the application of the rule in Hensel Phelps does not alter the outcome of this case. Subject to the foregoing, we adopt the Referee's "Conclusions and Opinion" which found CNA responsible for claimant's condition.

ORDER

The Referee's order dated June 3, 1988, is affirmed. A client-paid fee, not to exceed $1,268, payable by American International Adjustment Company to its counsel, is approved. A client-paid fee, not to exceed $1,536, payable by Continental Casualty Insurance Company to its counsel, is approved.

In the Matter of the Compensation of
KENNETH W. SIMONSON, Claimant
WCB Case No. 87-10305
ORDER ON RECONSIDERATION
Frank J. Susak, Claimant Attorney
Schwabe, et al, Defense Attorneys

Reviewed by Board Members Nichols, Brittingham and Crider.

On October 17, 1989, we abated and withdrew our October 11, 1989 Order on Review for reconsideration. After further consideration of this matter, we issue the following order.

Claimant requests review of Referee Hoguet's order that: (1) upheld the self-insured employer's denial of claimant's claim for ongoing medical services; and (2) affirmed the employer's self-closure of claimant's injury claim. On review, the issues are jurisdiction and compensability. We affirm.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact, as supplemented by the following additional findings.

Claimant's reports of disability to his physicians were inconsistent with surveillance performed on him by a neighbor and an insurance investigator hired to observe him. Whereas claimant presented to the examining physicians as substantially disabled, surveillance revealed little in the way of observable disability.

Joel Johnson, claimant's neighbor, is credible. William Champion, the employer's investigator, is credible. Neither claimant nor his wife are credible.

CONCLUSIONS OF LAW AND OPINION

The employer closed the claim on June 12, 1987 by means of a Notice of Closure. On the same date, the employer issued a denial of any and all medical conditions after March 15, 1987. The denial advised claimant that his claim had been administratively closed. The denial contained the proper appeal rights. The Notice of Closure contained the proper notice with regard to claimant's right to request a Determination Order within a year of closure.

The Referee concluded that the employer's closure was proper. However, no explanation for this conclusion was provided.

Claimant contends that the Referee erred in finding the employer's claim closure to have been properly executed. Specifically, he asserts that he was not medically stationary on the date the employer closed his claim. Claimant also argues that the medical service denial was an improper pre-closure denial under Safstrom v. Riedel International, Inc., 65 Or App 728 (1983), and Roller v. Weyerhaeuser Co., 67 Or App 583 (1984). The employer argues that the aforementioned cases do not apply because its denial came after it closed the claim. The employer also contends that the Referee was without jurisdiction to consider claimant's hearing request concerning the alleged improper claim closure issue. Consequently, the employer submits that the only issue properly before us is the compensability of claimant's ongoing medical services.

Jurisdiction

After reviewing the procedural history of this claim, we find that the Referee was without jurisdiction to consider the issue of the alleged improper claim closure. In MacDonald v. Safeway Stores, Inc., 87 Or App 86 (1987), the claimant sustained a compensable injury for which he was treated and ultimately found stationary. The insurer closed the claim and the claimant later filed an aggravation claim, which the insurer denied. The claimant requested a hearing concerning the denial and the claim closure. The Board held that the Referee lacked jurisdiction to consider the claim closure issue. The court affirmed, concluding that, under former ORS 656.268(3), claimant was required to seek a Determination Order first.

Here, as in MacDonald, former ORS 656.268(3) is applicable. Therefore, if claimant wished to contest the Notice of Closure, it was necessary that he seek a Determination Order before requesting a hearing. Since claimant did not do so, the Referee was without jurisdiction to consider the claim closure issue.

Compensability

As previously noted, claimant asserts that the denial is improper under the principles espoused by the Safstrom and Roller decisions. We disagree.

Inasmuch as the denial issued post-closure, it is procedurally proper. See Guerrero v. Stayton Canning Co., 92 Or App 209 (1988). Moreover, considering the timing of the claim closure and the issuance of the denial, we do not view the employer's conduct as an attempt to shortcut the ordinary process of claim closure. See Chaffee v. Nolt, 94 Or App 83 (1988). In reaching this conclusion, the Safstrom-Roller analogy, as expressed in the Board's prior order, is expressly withdrawn and disavowed.

Accordingly, we proceed with our consideration of the compensability issue. The Referee did not specifically address whether claimant's medical services claim is compensable. After reviewing this record, we find that it is not.

Claimant must establish that his need for medical services is both reasonable and necessary as a result of his compensable injury. ORS 656.245(1). The Referee specifically found claimant not credible. The medical evidence supporting this claim is largely dependent on the history provided by claimant to his physicians. Consequently, we question the reliability of the histories given and do not find the medical reports generated from them to be persuasive. In conclusion, claimant has not established the compensability of his medical services claim.

ORDER

The Referee's order dated February 29, 1988 is affirmed. A client-paid fee, payable from the employer to its counsel, is approved, not to exceed $3,076.

Board Member Crider, concurring in part and dissenting in part.

I concur in that portion of the order concluding that the claim closure issue was not properly before the Referee because claimant had not first requested a Determination Order. However, I dissent from the balance of the order.

The insurer closed claimant's accepted injury claim by Notice of Closure dated June 12, 1987. The same day, the insurer denied "the effects and medical conditions you are suffering from after March 15, 1987." The denial addresses claimant's condition from March 15 through June 12, 1987, although that condition cannot be distinguished from the accepted condition.

The majority submits that because the denial did not issue before the Notice of Closure, it does not violate the principles stated in Roller v. Weyerhaeuser, 67 Or App 583 (1984), even though it affects a period pre-closure. The majority reasons that because the denial did not issue pre-closure, it was not used as a substitute for closure.

Although the denial actually was not used as a substitute for closure since the claim was closed, it was certainly used as a substitute for timely closure. If allowed to stand, it denies treatment for the accepted condition for a period well before closure just as effectively as if it had issued three months before closure.

Chaffee v. Nolt, 94 Or App 83 (1988) does not support this result. In Chaffee the denial addressed the claimant's condition only three days before closure. Thus, the compensability issue posed by the denial and the compensability issue posed in the disability evaluation process were all but identical. In contrast, the compensability issues posed by the denial and the disability rating in this case are very different. Therefore, the court's practical approach in Chaffee does not support this retrospective denial of the accepted condition. I dissent.

In the Matter of the Compensation of
JEFFREY R. UNTERSCHUETZ, Claimant
and In the Matter of Complying Status of
LANCE J. AND JANET E. CADDY, Employer
WCB Case Nos. 88-02542 & 88-02543
ORDER ON RECONSIDERATION
Pozzi, et al, Claimant Attorneys
S. David Eves, Attorney
Gary Wallmark (Saif), Defense Attorney

Claimant has requested reconsideration of that portion of our January 26, 1990 Order on Review that did not award a carrier-paid attorney fee for services rendered on review for successfully prevailing against the noncomplying employer's appeal from a Referee's order affirming the Director's Proposed and Final Order; Notice and denying the employer's challenge of the SAIF Corporation's claim acceptance. Enclosing a statement of services for its counsel's efforts on Board review, claimant seeks an attorney fee pursuant to ORS 656.382(2).

Prior to the hearing, the noncomplying employer placed compensability of the claim at risk by challenging SAIF's acceptance, on behalf of the noncomplying employer, of the claim. The Referee denied the employer's challenge. The employer requested Board review. Compensability of the claim remained potentially at risk on Board review. Destael v. Nicolai Company, 80 Or App 596 (1986). As a result of our decision, claimant's compensation has neither been disallowed nor reduced. Accordingly, claimant is entitled to an assessed fee for his counsel's services on Board review. See ORS 656.382(2).

After review of the statement of services submitted by claimant's counsel, and considering the factors set forth in OAR 438-15-010(6), we award a reasonable assessed fee for services on Board review of $742.50, to be paid by SAIF on behalf of the noncomplying employer.

Accordingly, our January 26, 1990 order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our January 26, 1990 order in its entirety. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
JOHN L. O'DAY, Claimant
WCB Case Nos. 87-05206 & 87-08482
ORDER ON REVIEW
Francesconi & Associates, Claimant Attorneys
Schwabe, et al, Defense Attorneys
Dennis Martin (Saif), Defense Attorney

Reviewed by Board Members Crider and Nichols.

Northwest Farm Bureau Insurance Company ("Northwest") requests review of Referee Hettle's order which: (1) set aside its denial of claimant's aggravation claim for a low back condition; (2) found that claimant was not an Oregon subject worker while working for SAIF's insured; (3) upheld the SAIF Corporation's denial of claimant's "new injury" claim for the same condition; and (4) awarded claimant's counsel an attorney fee payable by Northwest Farm Bureau. Claimant cross-requests review, contending that the Referee erred in finding that claimant was not a subject worker while working for SAIF's insured and in upholding SAIF's denial. On review the issues are subject worker, responsibility, and attorney fees. We reverse.

FINDINGS OF FACT

In June 1986, claimant sustained a compensable low back injury while working for Northwest's insured. The injury sustained was an acute lumbar strain. Claimant sought treatment from Dr. Leary, chiropractor, who released claimant from work until August 7, 1986. A November 1986 Determination Order closed the claim and did not award any permanent disability.

Claimant worked for Western Forestry Inc. planting trees at various periods in 1984 and 1985. He worked on a job-by-job basis; the terms were the same for each job. In September 1986 he again worked for Western Forestry. After completion of the work, Bruce Ferguson contacted claimant on behalf of Western Forestry and offered him another period of work. Claimant agreed to work and, in mid-December 1986, was transported to Coos County for the planting of trees. Western Forestry provided transportation, lodging and an allowance for food. Claimant received his paycheck in Dallas, Oregon and Oregon income taxes were withheld. The Coos County job ended approximately January 10, 1987.

After completion of the Coos County job, Bill Ferguson notified claimant of additional tree planting work in the state of Washington. Ferguson called on behalf of Ferguson Management, SAIF's insured. Arrangements for transportation, food, lodging, and payment were the same as for the Coos County job. Claimant performed identical work.

When claimant commenced work at the Coos County job and then the Washington job following his 1986 injury, he was having minimal back problems. He was able to work without limitation. He was treating about once every three weeks with Dr. Leary.

While working in Washington, on February 6, 1987, claimant bent over and experienced a pulling in the same area as his previous injury. The pain became intense over a period of three days. Claimant sought treatment from Dr. Leary. Claimant filed an aggravation claim with Northwest. On March 26, 1987, Northwest denied responsibility for the claim. Thereafter, claimant filed a new injury claim with Ferguson Management. At that time Ferguson Management had workers' compensation insurance in the state of Washington. In March 1987, the Washington Department of Labor and Industries denied the claim. Subsequently,

claimant filed a second claim with Ferguson Management through its Oregon insurer, the SAIF Corporation. In April 1987, SAIF denied the claim on the basis of responsibility and compensability.

Ferguson Management is a corporation wholly owned by Bill Ferguson. Western Forestry is a corporation created in 1984 in which Bill Ferguson is a shareholder. As of late March 1987, Ferguson Management's headquarters/business office was located in Falls City, Oregon. The business office was also the headquarters of Western Forestry and utilized the same office equipment and staff. Western Forestry was created to allow employes of Ferguson Management to become owners in the business and to take advantage of federal programs. Ferguson Management subcontracted all work to Western Forestry. With the exception of Bill Ferguson and some secretaries, all the employes of Ferguson Management became employes of Western Forestry. Initially, both companies operated solely out of Oregon.

In 1986, the Western Forestry owners decided to phase out Western Forestry and make Ferguson Management a Washington company, for reasons related to the cost of workers' compensation insurance. Each time work was performed in Washington, new tax forms would be filled out and employes would be hired on behalf of Ferguson Management. As of January 1987, Western Forestry had no employes. At the time claimant worked in Coos County he was an employee of Western Forestry. At the time he worked in Washington, he was an employee of Ferguson Management.

Ferguson Management paid workers' compensation insurance on behalf of claimant in Washington. In March 1987, Ferguson Management established a Washington office and closed its Oregon office. It continues to use Oregon residents as employes and to perform tree planting jobs in Oregon.

Claimant is an Oregon resident and his contract of employment with Ferguson Management was made in Oregon. At the time of the February 1987 incident, Ferguson Management was headquartered in Falls City, Oregon, claimant's paycheck was issued from Oregon, and Oregon income taxes were withheld from it.

FINDINGS OF ULTIMATE FACT

Claimant was employed in Oregon. He had temporarily left the state to work in Washington pursuant to that employment when he was injured.

Claimant sustained an injury causing disability or requiring medical services on February 6, 1987, while working for SAIF's insured.

The February 1987 injury independently contributed to a worsening of claimant's low back condition.

CONCLUSIONS OF LAW

Oregon Subject Worker

The Referee concluded that claimant was not an Oregon subject worker at the time of the February 1987 incident and therefore upheld SAIF's denial. We disagree.

ORS 656.126(1) provides:

> "If a worker employed in this state and subject to ORS 656.001 to 656.794 temporarily leaves the state incidental to that employment and receives an acci dental injury arising out of in the course of employment, the worker, or beneficiaries of the worker if the injury results in death, is entitled to the benefits of ORS 656.001 to 656.794 as though the worker were injured within this state."

In construing ORS 656.126(1), Oregon courts have applied a "permanent employment relation test." Phelan v. H.S.C. Logging, Inc., 84 Or App 632 (1988); Kolar v. B & C Contractors, 36 Or App 65 (1978). Under this test, "[t]he inquiry is focused on the extent to which claimant's work outside the state was temporary." Langston v. K-Mart, 56 Or App 709, 711, rev den 293 Or 235 (1982).

Claimant was a continuous resident of Oregon at all times material to his case. When he commenced work for Ferguson Management, both he and the employer were in Oregon. At that time, Ferguson's headquarters were in Falls City, Oregon. Claimant's paychecks originated in Oregon and Oregon income taxes were withheld. The crew he worked with was from Oregon. Although they worked in Washington, the crew returned to Oregon for periodic breaks.

Prior to his employment with Ferguson, claimant had worked for its subsidiary, Western Forestry, solely within the state of Oregon. He performed seasonal work. Based on past experience, he reasonably expected to perform additional work in Oregon after completion of the Washington job. It was the practice of Western Forestry and then Ferguson Management to man jobs with employes previously on their crews. The employer expected to continue doing planting in Oregon.

For purposes of our analysis, we give little weight to the fact that claimant first worked in Washington for a formally different entity than he had previously worked for in Oregon. It is apparent that the operation was essentially unchanged when all employes were moved from the Western Forestry payroll to the Ferguson Management payroll. The sole purpose of the change was to effect the employer's cost for workers' compensation premiums and not to change either its business activities or the terms and conditions of its relationship with its employes. Under these circumstances, claimant remained a permanent Oregon employe despite the change in structure of the employer. See e.g., Wright v. Industrial Indemnity Co., 68 Or App 302, 305 n. 2 (1984).

Under these circumstances, we conclude that at the time of the February 1987 incident, claimant was an Oregon employee within the meaning of ORS 656.126(1).

Responsibility

The Referee concluded that if claimant was found to be an Oregon subject worker, the February 1987 incident would constitute a new injury, and SAIF would be responsible for the injury. We have found claimant to be an Oregon subject worker. The insurers do not challenge compensability on any other basis. Consequently, his claim is compensable. Therefore, we must address responsibility.

In Hensel Phelps Construction v. Mirich, 81 Or App 290, 294 (1986), the court held that if work activities at the later employer/insurer independently contribute to the worker's disability (i.e., causes a worsening of the underlying condition) then the second employer/insurer is responsible for the worsening. But where symptoms remain unremitting after a first injury, the first employer/insurer generally remains responsible. CECO Corp. v. Bailey, 71 Or App 782 (1985).

Claimant's treating physician, Dr. Leary and the Independent Chiropractic Consultants opine that the February 1987 incident constituted a new injury. Although they do not use the magic words "independent contribution", the record establishes that claimant suffered an acute increase in symptoms after a period of quiescence. Further, in May 1987, Dr. Leary rated claimant's permanent

impairment as mildly moderate whereas he had described it as only mild following the June 1986 incident. There is no contrary medical evidence.

We conclude that the February 1987 incident independently contributed to a worsening of claimant's low back condition. Accordingly, SAIF is the responsible insurer.

Attorney Fees

The Referee awarded claimant's counsel an assessed fee, payable by Northwest. As we have found SAIF responsible herein, the attorney fee awarded to claimant's counsel is now payable by SAIF.

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 be awarded. See OAR 438-15-010(5).

ORDER

The Referee's order dated October 26, 1987 is reversed. Northwest Farm Bureau Insurance Company's denial is reinstated and upheld. The SAIF Corporation's denial is set aside and the claim is remanded to it for processing according to law. The attorney fee awarded by the Referee to claimant's counsel for services at hearing is payable by SAIF. A client-paid fee, not to exceed $1,294, is approved, payable by Northwest Farm Bureau Insurance Company to its counsel.

February 13, 1990 Cite as 42 Van Natta 330 (1990)

In the Matter of the Compensation of
ROBYN SUMMERS, Claimant
Own Motion No. 89-0763M
OWN MOTION ORDER
Popick & Merkel, Claimant Attorneys
Saif Legal, Defense Attorney

The SAIF Corporation has submitted to the Board claimant's claim for an alleged worsening of her October 29, 1982 industrial injury. Claimant's aggravation rights have expired. SAIF has accepted responsibility for the surgery and recommends that claimant's claim be reopened for the payment of temporary disability benefits. Claimant requests penalties and attorney fees for improper claims processing.

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.

Following our review of this record, we are persuaded that claimant's compensable injury has worsened requiring surgery. Accordingly, claimant's claim is reopened with temporary disability benefits to commence July 31, 1989, the date she 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. Claimant's attorney is awarded 25% of the additional compensation granted by this order, not to exceed $450, as a reasonable attorney fee. Reimbursement from the Reopened Claims Reserve is authorized to the extent allowed under ORS 656.625 and OAR 436, Division 45. When appropriate, the claim shall be closed by the insurer under OAR 438-12-055.

An insurer may be assessed a penalty and related attorney fee when it unreasonably delays the payment of compensation. ORS 656,262(10), 656.382(1). Our own motion rules require that, upon receipt of a claim for own motion relief, the insurer shall notify the claimant and the Board in writing whether it recommends that the claim be reopened or denied. OAR 438-12-025(2). Here, the record shows that SAIF received a request to reopen claimant's claim by letter dated October 6, 1989. SAIF submitted its recommendation to the Board on January 3, 1989, the 88th day after receipt of claimant's request. SAIF offers no reasonable explanation for their delay. Therefore, we find that SAIF's claims processing was unreasonable, see Lester v. Weyerhaeuser, 70 Or App 307, 312 (1984), and conclude that a penalty and attorney fee may be appropriate. A penalty shall not be assessed here, however, because we do not find that there were any amounts of compensation due and owing claimant during the period of unreasonable delay. See Wacker Siltronic Corporation v. Satcher, 91 Or App 654, 658 (1988). On the other hand, a penalty-related attorney fee shall be assessed under ORS 656.382(1) for SAIF's unreasonable resistance to the payment of compensation. See Ellis v. McCall Insulation, 308 Or 74, 78 (1989); Lloyd L. Cripe, 41 Van Natta 1774 (1989). We assess a penalty-related attorney fee of $200.

IT IS SO ORDERED.

In the Matter of the Compensation of
INEZ HORSEY, Claimant
WCB Case Nos. 88-03947, 88-05222, 88-05223, 88-06499, 88-06500 & 88-06501
ORDER ON REVIEW (REMANDING)
Malagon, et al, Claimant Attorneys
E. Jay Perry, Defense Attorney
H. Thomas Andersen (Saif), Defense Attorney
Schwabe, et al, Defense Attorneys

Reviewed by Board Members Howell and Speer.

The SAIF Corporation requests review of Arbitrator Bennett's order which found SAIF's insured, Pen & Press, responsible for claimant's carpal tunnel syndrome. On review the issues are responsibility and claimant's entitlement to an assessed attorney fee. We remand.

We review the arbitrator's order solely on questions of law. ORS 656.307(2); Timothy R. Schroeder, 41 Van Natta 568 (1989). We, therefore, accept the arbitrator's Findings of Fact.

The arbitrator correctly characterizes claimant's condition as an occupational disease. The first issue in this case is which of a series of employers is responsible for that occupational disease. In Linda L. Wise, 42 Van Natta 115 (1990), we recently noted that in an occupational disease context the critical event for assigning responsibility is the "onset of disability". The specific dispute in this case centers around when the onset of disability occurred.

In Bracke v. Baza'r, 293 Or 239, 247 (1982), the Supreme Court reaffirmed its adoption of the last injurious exposure rule as stated by Larson. The court quoted with approval Larson's establishment of "the onset of disability as the decisive event for fixing liability . . . ". Since Bracke, a number of cases have addressed the question of when the "onset of disability" occurs or, in the absence of disability, when the critical date or triggering event for fixing responsibility occurs.

We first note that in some cases there is no "onset of disability". When a worker suffers from an occupational disease during or following a series of potentially contributory employments but experiences no disability, the "triggering event" for assigning responsibility is the date the worker first seeks medical treatment for the condition. Progress Quarries v. Vaandering, 80 Or App 160 (1986); SAIF v. Carey, 63 Or App 68 (1983).

In some cases disability occurs first in the form of a permanent disability. In those cases the "onset of disability" is when the permanent disability manifests itself. Bracke v. Baza'r, supra appears to have been such a case, as were SAIF v. Baer, 60 Or App 163 (1982) and Robinson v. SAIF, 78 Or App 581 (1986). In each case responsibility was assigned to the worker's employer at the time a permanent allergy or sensitization occurred, even though subsequent employment conditions contributed to increased symptoms and even though time loss first occurred during coverage by a subsequent insurer. See SAIF v. Baer, supra. See also, FMC Corp. v. Liberty Mutual Insurance Co., 70 Or App 370 (1984), modified 73 Or App 223 (1985) (where the initial disability was permanent but first occurred after a series of employment exposures).

In two cases in which a worker experienced lost time from work due to an occupational disease, the "onset of disability" was considered to be the point in time at which employment last contributed to the cause or worsening of the condition prior to the time loss. In United Pacific Insurance v. Harris, 63 Or App 256 (1983) and SAIF v. Gupton, 63 Or App 270 (1983), the court spoke in terms of the "onset of disability" being when the last employment, at or prior to time loss, contributed to the cause or worsening of the underlying occupational disease. It is not entirely clear, however, whether the court in those cases might have been applying a two step, rather than one step, analysis. That is, the court may have found the onset of disability to have occurred when the worker experienced time loss, but then shifted responsibility to the last prior employment which actually contributed to the occupational disease. The latter approach would appear consistent with that portion of the last injurious exposure rule adopted from Larson (indicating that the onset of disability "[L]egally, is the moment at which the right to benefits accrues; . . .") and with the principle noted in Boise Cascade v. Starbuck, 296 Or 238, 244 (1984) that,"[T]he last injurious exposure rule is not intended to transfer liability from an employer whose employment caused a disability to a later employer whose employment did not."

Regardless of how the analysis is viewed, the result is to assign responsibility, where it can be determined, to the last employment prior to time loss which actually contributed to the cause or worsening of the underlying disease.

In the present case the arbitrator seems to have found that claimant experienced time loss due to her occupational disease while working for Casey's Station, one of three potentially responsible employers. However, he found that the "onset of disability" occurred when claimant first sought medical treatment and was diagnosed as suffering a disease. He found that employment with Pen and Press "could have" contributed to claimant's disease, but made no findings as to whether that employment actually contributed to claimant's disease.

We find that, because claimant experienced time loss while working for a potentially responsible employer, the arbitrator erred as a matter of law by relying upon the date of first medical treatment, rather than the onset of disability as defined above, as the triggering event for fixing responsibility.

Because we review only questions of law, we must remand for additional findings and a determination of which employer is responsible when the correct rule of law is applied.

As to the question of claimant's attorney fee, ORS 656.307(5) is clear on its face. If the Referee finds that claimant's attorney actively and meaningfully participated at hearing, an attorney fee may be assessed against the responsible employer. ORS 656.307(5).

ORDER

The arbitrator's order dated July 18, 1988, as reconsidered August 24, 1988, is vacated. This matter is remanded to the Hearings Division for assignment to Arbitrator Bennett for a determination of the responsible employer. Arbitrator Bennett may make that determination with or without further proceedings in any manner to achieve substantial justice.

February 14, 1990 Cite as 42 Van Natta 333 (1990)

In the Matter of the Compensation of
JOYCE E. MITTS, Claimant
WCB Case No. 87-11662
ORDER ON REVIEW
Kenneth Peterson, Jr., Claimant Attorney
Yturri, et al, Defense Attorneys

Reviewed by Board Members Brittingham and Nichols.

Claimant requests review of the portion of Referee Brazeau's order that declined to assess a penalty and attorney fee for the insurer's allegedly unreasonable refusal to pay her temporary total disability benefits. The insurer cross-requests review of the portion of the order that directed it to pay claimant temporary total disability benefits. On review, the issues are temporary total disability, penalties and attorney fees.

We reverse on the temporary total disability issue and affirm and adopt on the penalties and attorney fees issue.

FINDINGS OF FACTS AND ULTIMATE FACT

We adopt the following findings by the Referee:

> "Claimant filed an original request for hearing on June 27, 1986, alleging that the insurer had unreasonably failed to pay interim compensation benefits on an aggravation claim. The insurer ultimately responded by denying that claimant had sustained an aggravation. The matter went to hearing on May 5, 1987 before Referee Gary Thye. On June 4, 1987, the Referee issued an Opinion and Order finding, inter alia, that claimant's physician had authorized a reopening of her claim, as well as time loss benefits. The Referee ultimately disapproved the insurer's

aggravation denial and ordered it to 'process the claim until closure as provided by law ...'

"Among Referee Thye's findings and conclusions was that claimant was not entitled to 'interim compensation' because she had 'voluntarily removed herself from the labor market prior to her aggravation ...' The Referee cited Cutright v. Weyerhaeuser Co., 299 Or 290 (1985), Bono v. SAIF, 298 Or 405 (1984), and Weyerhaeuser Co. v. Bergstrom, 77 Or App 425 (1986) as authority for his conclusions. The Referee made no specific findings with regard to payment of temporary total disability benefits pending appeal.

"Following the Referee's order, the insurer did not pay temporary total compensation pending its appeal of the Referee's decision on the aggravation claim. Claimant subsequently filed a request for hearing, seeking payment of the unpaid benefits and penalties and attorney fees for an alleged unreasonable refusal to pay compensation. Claimant also sought review by the Workers' Compensation Board of Referee Thye's decision on the issue of interim compensation."

CONCLUSIONS OF LAW AND OPINION

Referee Brazeau concluded that Referee Thye's order, which set aside the insurer's denial of claimant's aggravation claim and ordered that the insurer "process the claim until closure as provided by law," required the insurer to begin paying temporary total disability benefits pending Board review of the order. Referee Brazeau reasoned that Referee Thye's finding that claimant had withdrawn from the work force at the time of her aggravation was addressed solely to claimant's entitlement to interim compensation and could not support the insurer's refusal to pay temporary total disability benefits in processing the aggravation claim. We disagree with the Referee's reasoning and conclusion.

To receive temporary total disability upon aggravation of an industrial injury, claimant must be in the work force at the time of the aggravation. Dawkins v. Pacific Motor Trucking, 308 Or 254, 258 (1989); Cutright v. Weyerhaeuser, 299 Or 290 (1985). Here, Referee Thye specifically found that claimant was not in the work force at the time of her aggravation. Although that finding was addressed to claimant's entitlement to interim compensation, it also precluded her substantive entitlement to temporary total disability. See id.

Contrary to claimant's assertion on review, Referee Thye's order to "process the [aggravation] claim until closure as provided by law" did not necessarily require the insurer to pay temporary total disability benefits. In certain cases, the processing of an aggravation claim may be limited to the payment of appropriate medical services and a redetermination of the claimant's permanent disability upon closure of the claim; such claims are sometimes called "dry" aggravation claims. Consequently, a reopening of a claim for aggravation does not ipso facto entitle claimant to temporary disability benefits. Here, the processing required for claimant's aggravation claim was expressly contingent on what was "provided by law." As discussed above, Oregon case law provided that a claimant who is not in the work force at the time of her aggravation is not entitled to temporary disability benefits upon reopening of her claim for aggravation. Accordingly, this insurer's refusal to pay temporary disability benefits

was permitted by law and, hence, in full compliance with the prior Referee's order.

Finally, we reject the suggestion that the insurer could not refuse to pay temporary disability benefits absent express authorization by Referee Thye. Generally, an insurer or employer must seek prior authorization to refuse, terminate, or reduce temporary disability benefits after the claimant's entitlement to those benefits has already been established. Here, claimant's entitlement to such benefits was never established. Indeed, as claimant concedes, the issue of her entitlement to temporary disability benefits under the aggravation claim was never raised before Referee Thye. In fact, the issue did not become ripe for litigation until claimant challenged the insurer's refusal to pay the benefits in the instant proceedings. We conclude, therefore, that the insurer was not required to seek prior authorization before refusing to pay claimant temporary disability benefits in processing her aggravation claim.

ORDER

The Referee's order dated November 20, 1987, as reconsidered on March 18, 1988, is reversed in part and affirmed in part. The portion of the order that ordered the insurer to pay claimant temporary disability benefits in its processing of her aggravation claim is reversed. The remainder of the Referee's order is affirmed. The Board approves a client-paid fee not to exceed $535.50, payable by the insurer to its counsel.

In the Matter of the Compensation of
BOBBY JACK TRAWEEK, Claimant
WCB Case No. TP-90003
THIRD PARTY ORDER
James W. Kirk, Claimant Attorney
Michael 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. We approve the settlement.

FINDINGS OF FACT

In March 1988 claimant sustained a compensable back injury as a result of a motor vehicle accident with a garbage truck. He has received conservative treatment primarily for degenerative conditions in his low back and neck.

Claimant also experiences cervical strains, which are attributable to the current injury, as well as two prior compensable neck injuries for which he has previously received a 10 percent award of unscheduled permanent disability. Claimant was receiving periodic treatment for his neck condition when the March 1988 accident occurred.

Since this compensable injury, he has not returned to his former job as a carpet cleaner and it is unlikely that he will be able to perform such activities in the future. There is conflicting medical evidence concerning the question of whether claimant's current back impairment is materially related to this compensable injury, to a preexisting degenerative condition, or to a combination of both. In any event, claimant has received a 32 percent unscheduled permanent disability award stemming from this compensable injury.

The blood-alcohol content for the driver of the garbage truck was .21 percent. Thus, criminal charges were lodged against the driver, which eventually culminated in a guilty plea to criminal assault and driving under the influence of intoxicants. An investigation conducted by claimant's counsel uncovered no evidence to suggest that the garbage company either knew or should have known that its driver had an alcohol abuse problem.

In November 1988, while the claim remained in open status, claimant was charged with the unlawful possession of a controlled substance and driving under the influence of intoxicants. In February 1989 he was convicted of these offenses and sentenced to the county jail for one year. Following four months of incarceration, claimant was transfered to his home, where he is currently serving the remainder of his sentence under an "electronic security program."

To date, the SAIF Corporation, as paying agency, has incurred actual claim costs totalling $35,611.46. These costs include medical expenses and temporary disability compensation, as well as the aforementioned 32 percent unscheduled permanent disability award.

Claimant engaged legal counsel to explore the possibility of pursuing a cause of action for negligence against the garbage company and its driver. During settlement negotiations, the third party insurer, on behalf of the garbage company and its driver, asserted its intention to rely on a medical opinion that suggested claimant would be able to return to his regular work without impairment. As a further defense, the third party insurer noted claimant's recent criminal convictions. Following a series of negotiation sessions, the third party insurer offered to settle the action for $35,000.

The offer is acceptable to claimant. SAIF declines to approve the settlement, contending that claimant has sustained significant impairment as a result of the compensable injury and that claimant's case has actual damage value far in excess of $35,000. Finally, asserting that the case "has great potential for punitive damages", SAIF argues that the offer is inadequate.

FINDINGS OF ULTIMATE FACT

The third party settlement offer of $35,000 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).

Both parties have advanced their respective positions concerning the purported strengths and weaknesses of claimant's action against the garbage company and its driver. After reviewing this record, we find support for each position. Under such circumstances and considering the aforementioned standard, we conclude that a settlement offer of $35,000 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.

In the Matter of the Compensation of
DAVID S. ZIMMERMAN, Claimant
WCB Case No. 86-15055
ORDER ON REMAND
Jeff Carter, Claimant Attorney
Roberts, et al, Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Agripac, Inc. v. Zimmerman, 97 Or App 512, rev den 308 Or 465 (1989). The court has concluded that our prior order, David S. Zimmerman, 40 Van Natta 862 (1988), had failed to apply the standard contained in Clark v. U.S. Plywood, 288 Or 255 (1980), and remanded to make findings necessary to determine whether claimant's injury claim was sustained as a result of activity that was expressly or impliedly allowed by the employer. We proceed with our reconsideration.

FINDINGS OF FACT

The Board adopts the "Findings of Fact" in our earlier order with the following supplementation.

On several occasions, claimant vacated the employer's premises by jumping from the employer's dock rather than by using a nearby flight of stairs.

The employer impliedly acquiesced in claimant's method of leaving the work premises.

CONCLUSIONS OF LAW AND OPINION

To be compensable, an injury must arise out of and in the course of employment. ORS 656.005(7)(a). "If the injury has sufficient work relationship, then it arises out of and in the course of employment...." Rogers v. SAIF, 289 Or 633,643 (1980). An on-premises injury has sufficient work relationship if it occurs while the employee is leaving work, unless the employee engaged in conduct not expressly or impliedly allowed by the employer. Clark v. U.S. Plywood, 288 Or 255 (1980); Agripac v. Zimmerman, 97 Or App 512 (1989).

In finding claimant's injury claim to be compensable, the Board did not apply the Clark standard. Concluding that the Board's failure to apply Clark was error, the court has reversed and remanded with instructions to make findings concerning the express or implied acquiescence of the employer to claimant's conduct.

We note that the employer's manual for the conduct of its workers prohibited "unsafe acts." However, jumping from the loading dock was not specifically defined as an unsafe act. Moreover, we find that claimant had previously participated in the conduct of jumping off the employer's loading dock. Finally, these activities were performed in view of supervisors and without a reprimand. Under such circumstances, we conclude that the employer had impliedly allowed claimant to jump from the dock. This injury, therefore, arose out of and in the course of employment and was compensable. Former ORS 656.005(8)(a).

Accordingly, on reconsideration, we continue to reverse the Referee's order dated February 20, 1987. As directed in our previous order, the insurer shall process the claim in accordance with law. For services at hearing and on Board review, claimant's $2,100 insurer-paid attorney fee award is reinstated.

Since claimant has finally prevailed after remand from the court, he is also entitled to an attorney fee for services rendered before every prior forum. See ORS 656.388(1). Yet, we are unable to award such a fee for services at the appellate level unless claimant's counsel submits a statement of services. See OAR 438-15-005(2); 438-15-010(5). Therefore, upon our receipt of such a statement of services, and assuming that we retain jurisdiction over this case, we shall proceed with our determination of a reasonable attorney fee for services at the appellate level.

IT IS SO ORDERED.

In the Matter of the Compensation of
MARIA ALONZO, Claimant
WCB Case No. 88-11045
ORDER ON REVIEW
Garlock, et al, Claimant Attorneys
Scheminske & Lyons, Defense Attorneys
Roberts, et al, Attorneys

Reviewed by Board Members Gerner and Myers.

Claimant requests review of those portions of Referee Howell's order which: (1) upheld the insurer's denial of claimant's chiropractic treatment as being not reasonable and necessary and not related to the compensable injury; and (2) failed to increase claimant's unscheduled permanent disability. The insurer cross-requests review, seeking authorization to offset an overpayment of temporary disability. The issues on review are compensability of chiropractic care and extent of unscheduled permanent disability.

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

The insurer seeks authorization to recover overpaid temporary disability benefits purportedly created by the Referee's order. This request was initially submitted to the Referee following the issuance of his order. However, because claimant had requested Board review of his order, the Referee declined to address the insurer's request.

We have previously held that when an issue is not raised at hearing and the record is closed, that issue will not subsequently be considered. Randy D. Johnson, 39 Van Natta 463 (1987). Moreover, when an offset request has not been addressed by a Referee while the Referee retains jurisdiction, we have concluded that the issue has been waived. Elsie L. Hobkirk, 40 Van Natta 778, 1947 (1988).

Here, the insurer's request for permission to offset the alleged overpayment was neither raised prior to the closure of the record nor addressed by the Referee while he retained jurisdiction over the case. Under such circumstances, we conclude that the insurer's offset request is not properly before us. Accordingly, the request insofar as it pertains to this proceeding is denied.

ORDER

The Referee's order dated November 2, 1988 is affirmed. The Board approves a client-paid fee, not to exceed $1,366, payable from the insurer to its former counsel. The Board approves a client-paid fee, not to exceed $478.50, payable from the insurer to its present counsel.

In the Matter of the Compensation of
DOROTHY AMSTUTZ, Claimant
WCB Case Nos. 88-10611 & 88-10610
ORDER ON REVIEW
Dean Heiling, Claimant Attorney
Acker, et al, Defense Attorneys

Reviewed by Board Members Myers and Gerner.

Claimant requests review of Referee Higashi's order which: (1) declined to award additional temporary disability benefits; and (2) declined to assess penalties and associated attorney fees for the self-insured employer's alleged unreasonable delay in payment of temporary disability. On review, the issues are entitlement to additional temporary disability, penalties and attorney fees. We affirm, but for different reasons than those expressed by the Referee.

FINDINGS OF FACT

Claimant worked for the self-insured employer, a paper company, from December, 1986 through February, 1987, during which she experienced tingling and numbness in her hands while working as a seedling grader. She sought treatment in mid-December from Dr. Daskolos, D.O., complaining of lower back, neck and hand pain. Claimant was released to work with no restrictions on December 22, 1986. Claimant returned to regular work.

On January 8, 1987, claimant was involved in an automobile accident. The injuries she received as a result of that accident are not related to claimant's wrist condition. She returned to regular work on January 17, 1987.

Her seasonal employment with the employer continued until February 27, 1987, when she was laid off.

Claimant filed a claim for her wrist condition on March 16, 1987.

On May 13, 1987, claimant began working as a motel maid. In June, 1987, claimant's wrist condition worsened, making her unable to perform some of her duties as a maid. On June 15, 1987, claimant began caring for an elderly man through the auspices of the Senior Services Division (SSD). Her wages for SSD exceed her wages for the paper company. On June 29, 1987, her employment with the motel was terminated because her wrist condition prevented her from performing her duties.

Claimant continued to work with SSD through October 15, 1987. During that employment, claimant sought treatment for her wrist condition from Dr. Golden, a neurosurgeon, who diagnosed bilateral carpal tunnel syndrome, and subsequently performed surgery on both wrists on August 18 and August 31, 1987, respectively. Thereafter, claimant returned to the work she had been doing before surgery. On October 15, 1987, claimant quit her work with the SSD for reasons unrelated to either her work or her compensable injury.

The employer denied claimant's claim for her wrist condition on August 28, 1987. Claimant requested a hearing.

By opinion and order, dated April 21, 1988, claimant's claim for her wrist condition was found compensable and remanded for payment of compensation and medical expenses.

Claimant was paid temporary disability benefits for the period during which she underwent, and recovered from, the surgery on both wrists. Compensation was paid from August 18, 1987 through September 30, 1987, but nothing thereafter. Claimant requested a hearing seeking additional temporary disability compensation.

CONCLUSIONS OF LAW

Claimant seeks temporary disability, either total or partial, from February 28, 1987 until the time which she becomes medically stationary.

The Referee found that claimant did not leave her work with the paper company because of her February, 1987 compensable injury, and concluded that claimant was entitled to temporary disability only for the period of time during which she underwent, and recovered from, the surgery for her carpal tunnel syndrome. He did not award any additional compensation. We agree that claimant is entitled to temporary total disability for the six week period of time during which she underwent carpal tunnel surgery and recovered therefrom. However, we disagree with the referee's analysis concerning claimant's entitlement to additional temporary disability before and after the surgery.

An individual is temporarily disabled, for a temporary period, if a worker has lost, "including preexisting disability, the use or function of any scheduled or unscheduled portion of the body which incapacitates the worker from regularly performing work at a gainful and suitable occupation." Cutright v. Weyerhaeuser, 299 Or 290 (1985). Furthermore, claimant is entitled to temporary disability benefits for the entire period of her disability. Botefur v. City of Creswell, 84 Or App 627 (1987); Silsby v. SAIF, 39 Or App 555, 562 (1979).

ORS 656.212 provides:

> "When the disability is or becomes partial only and is temporary in character, the worker shall receive for a period not exceeding two years that proportion of the payments provided for temporary total disability which the loss of earning power at any kind of work bears to the earning power existing at the time of the occurrence of the injury."

Further, where claimant's weekly wages were less during the period for which she sought compensation than at the time of injury, she is entitled to benefits for temporary partial disability. ORS 656.212. See Safeway Stores v. Owsley, 91 Or App 475, 478 (1988).

Here, claimant's seasonal employment with the paper company ended on February 28, 1987. At that time, claimant had been working regularly, without complaints of wrist pain. Thus, we find that claimant was not disabled as a result of her wrist condition when her employment with the paper company ended.

After leaving the paper company, claimant worked as a motel maid. Claimant continued to work as a motel maid until June 29, 1987, at which time she worked solely for the Senior Services Division (SSD), at wages which exceeded those at the paper company.

Claimant worked for SSD through August 17, 1987. Thereafter, she was off work as she underwent surgery. The employer paid claimant temporary disability during the period from August 18, 1987 through September 30, 1987. Claimant returned to her work with SSD on October 1, 1987, and continued to work for SSD

until October 15, 1987, when she quit for reasons unrelated to either her compensable condition or her work. She received no further disability benefits.

The medical evidence establishes that claimant stopped working as a motel maid due to her compensable injury. See Dorothy A. Amstutz, 41 Van Natta 2292 (1989). However, at the time she left that work, she was already working at SSD at a wage which exceeded her wages at the paper company. Consequently, we find that claimant was entitled to temporary disability from June 29, 1987 through August 17, 1987; but her entitlement was to temporary partial disability. See Robert L. Rodriquez, 40 Van Natta 2074 (1988); Larry L. Jay, 41 Van Natta 188 (1989). Since her wages at SSD were greater than at the lumber company, her rate of temporary partial disability would be zero.

Following claimant's recuperation from her surgeries, she returned to SSD on October 1, 1987 and worked until October 15, 1987. Since she had not been released, nor returned, to her regular work-at-injury, nor been determined medically stationary, she again became entitled to temporary partial disability. However, as previously discussed, this disability equaled zero.

On October 15, 1987, claimant left her work with SSD for reasons unrelated to her compensable condition. Thus, because she left work with SSD for reasons unrelated to either her work or her compensable injury, we find that claimant is not entitled to temporary total disability after October 15, 1987, but merely a continuation of the temporary partial disability rate she was entitled to while working at SSD. See Owsley, supra; Fink v.Metropolitan Defender, 67 Or App 79, rev den 296 Or 829 (1984). Since claimant's temporary partial disability rate at SSD was zero, claimant is not entitled to any additional disability payments after October 15, 1987.

Penalties and Attorney Fees

Here, we have found claimant to be entitled to temporary partial disability from June 29, 1987 through August 17, 1987 and subsequent to October 1, 1987. However, as noted, the rate of disability was zero.

The record is unclear whether the employer determined claimant's entitlement to temporary partial disability at a rate of zero, or unilaterally terminated disability payments. If the employer rated claimant's disability at zero, and as a result did not make disability payments to claimant, then the employer's actions were not unreasonable. However, if the employer unilaterally terminated benefits, without calculating claimant's disability rate, such action would have been unreasonable. In either case, claimant would not have any amount due nor did the employer's action result in a delay in the payment of compensation. Consequently, we conclude that the assessment of a penalty and an award of associated attorney fees is not appropriate. Lloyd L. Cripe, 41 Van Natta 1774 (1989).

ORDER

The Referee's order, dated October 4, 1988, is affirmed. A client-paid fee, payable from the sekf-insured employer to its counsel, not to exceed $680, is approved.

In the Matter of the Compensation of
EPIFANIO BARELA, Claimant
WCB Case No. 87-12711
ORDER ON REVIEW
Douglas L. Minson, Claimant Attorney
Julia Philbrook (Saif), Defense Attorney

Reviewed by Board Members Nichols and Brittingham.

The SAIF Corporation requests review of that portion of Referee Heitkemper's order that declined to allow an offset of permanent partial disability benefits that were paid pursuant to a Determination Order against claimant's permanent total disability award. The issue on review is offsets.

FINDINGS

A Determination Order was issued in this matter on August 4, 1987, which awarded claimant 25 percent unscheduled permanent partial disability. Claimant was also paid temporary disability benefits by SAIF through July 27, 1987. An Opinion and Order was issued on June 20, 1988, finding claimant permanently and totally disabled effective February 10, 1987.

On July 8, 1988, SAIF requested reconsideration seeking an offset of an overpayment of compensation to claimant. On July 18, 1988, the Referee issued an Order of Abatement. On August 4, 1988, the Referee denied SAIF's Motion for Reconsideration. The affidavit submitted with the motion establishes that SAIF paid the claimant $4,800 on the permanent partial disability award and $2,634.24 in overpaid temporary disability payments.

CONCLUSIONS OF LAW AND OPINION

The Court held in Pacific Motor Trucking Co. v. Yeager, 64 Or App 28 (1983), that an injured worker who is receiving payments for permanent total disability is not entitled to separate, additional payments for permanent partial disability. Claimant argues that even if he is not entitled to double payments, SAIF did not raise the issue of offset in a timely manner.

SAIF need only raise the issue promptly once an award for permanent total disability is granted. Julian E. Pournelle, 38 Van Natta 132 (1986). Donald W. Wilkinson, 37 Van Natta 937 (1985). Accordingly, because it raised its offset request while the Referee retained jurisdiction and the Referee addressed the request, SAIF is not precluded from claiming the offset of permanent partial disability. See Elsie L. Hobkirk, 40 Van Natta 778 (1988).

SAIF does not specifically raise as an issue the offset of the overpaid temporary total disability paid beyond February 10, 1987. However, SAIF argues that issue in its brief. The Determination Order granted the insurer authority to offset any overpaid temporary disability against permanent disability. Authorization to offset continues in effect unless and until it is revoked or until the overpayment is wholly recovered. Berliner v. Weyerhaeuser, 92 Or App 264 (1988). The offset authorized by the Determination Order remains in effect.

ORDER

The Referee's order dated June 20, 1988, as reconsidered August 4, 1988, is reversed in part and affirmed in part. The portion of the order that declined to allow an offset of permanent partial disability benefits against claimant's permanent total disability award is reversed. The SAIF Corporation may offset permanent partial disability benefits paid from February 10, 1987 against claimant's permanent total disability award. The remainder of the order is affirmed.

In the Matter of the Compensation of
MARK S. BELLWARE, Claimant
WCB Case Nos. 86-02346 & 86-00941
ORDER ON REVIEW
Pozzi, et al, Claimant Attorneys
Scheminske & Lyons, Defense Attorneys
Roy Miller (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

Aetna Casualty requests review of those portions of Referee Thye's order which: (1) set aside its denial of responsibility for claimant's back surgery; (2) upheld the SAIF Corporation's denial of responsibility for the same surgery; and (3) awarded claimant's attorney an assessed fee to be paid by Aetna. The issues on review are responsibility for medical services and attorney fees. We reverse.

FINDINGS OF FACT

The Board adopts the Referee's "Findings" through the third full paragraph on page two of the order, with the following supplementation.

Claimant's 1985 injury did not cause a worsening of claimant's L5-S1 disc condition.

CONCLUSIONS OF LAW AND OPINION

In cases where there are two accepted injuries to the same body part, there is a rebuttable presumption that the last industrial injury contributed independently to the worsened condition and, thus, that responsibility lies with the employer/insurer at the time of the last work-related injury. Industrial Indemnity Co. v. Kearns, 70 Or App 583 (1984). The last employer/insurer then has the burden to prove that the later work-related injury did not independently contribute to the worsened underlying condition which gives rise to the claim for compensation. If it is shown that the later injury resulted in increased symptoms only, without a pathological worsening, then the presumption has been rebutted.

Here, there is overwhelming evidence, including the opinion of Dr. Berkeley, claimant's treating neurosurgeon, that the bone spur which caused the need for surgery was a result of claimant's original 1979 injury. Moreover, there is no persuasive evidence that the 1985 injury independently contributed to the bone spur.

Dr. Berkeley stated that claimant's bone spur did not occur as a result of the May 1985 accident. He opined that it would have taken quite a few years for the spur to develop and become symptomatic, and stated more than once that the 1985 injury was only a contributing factor to the increase of claimant's painful symptoms. (Exs. 29, 33). As the physician who performed claimant's surgery, Dr. Berkeley's opinion is entitled to great weight.

We are persuaded that, although the 1985 injury contributed to a worsening of claimant's back pain, that injury did not independently contribute to the underlying condition of the bone spur requiring surgery. Because of this, we find that the second insurer, Aetna Casualty, has succeeded in shifting responsibility for claimant's bone spur surgery to SAIF. See DeSylvia v. Multnomah County School Dist. # 40, 91 Or App 381 (1988).

Attorney Fee

Aetna contends that the attorney fee of $1,500, awarded to claimant's attorney at hearing, is inappropriate because the insurers were contesting responsibility and, because compensability was not at issue, claimant's attorney was not required to actively participate. We agree.

In a responsibility proceeding, claimant is not entitled to an attorney fee unless he actively and meaningfully litigates responsibility. Mercer Industries v. Rose, 100 Or App 252 (1990); Petshow v. Farm Bureau Ins. Co., 76 Or App 563 (1985). Here, a .307 order had issued with regard to the medical services claim for back surgery. Claimant's right to the surgery was not in jeopardy. He was a nominal party, at best, with respect to the issue of which insurer paid for his surgery. Thus, claimant is not entitled to a carrier-paid fee. See Petshow, supra; Hunt v. Garrett Freightliners, 92 Or App 40 (1988); Anfora v. Liberty Communications, 88 Or App 30 (1987); Wilson v. Geddes, 90 Or App 64 (1988); Cascade Corporation v. Rose, 92 Or App 663 (1988).

ORDER

The Referee's order dated April 20, 1988 is reversed. The SAIF Corporation's denial of January 10, 1986 is set aside and claimant's back surgery claim is remanded to SAIF for processing in accordance with law. Aetna Casualty Company's denial of February 4, 1986 is reinstated and upheld. The Referee's award of a carrier-paid attorney fee is reversed. A client-paid fee not to exceed $2,063.50 is approved, payable by Aetna Casualty to its counsel.

February 15, 1990 Cite as 42 Van Natta 344 (1990)

In the Matter of the Compensation of
GARY W. BOOZE, Claimant
WCB Case No. 87-19700
ORDER ON REVIEW
Malagon, et al, Claimant Attorneys
Cowling & Heysell, Defense Attorneys

Reviewed by Board Members Howell and Speer.

The self-insured employer requests review of Referee Foster's order which increased claimant's unscheduled permanent disability award for a low back injury from 10 percent (32 degrees), as awarded by prior Determination Orders, to 25 percent (80 degrees). On review, the issue is extent of permanent disability. We reverse.

FINDINGS OF FACT

Claimant sustained a compensable low back and shoulder injury on January 18, 1984. The claim was closed on November 26, 1986 with an award of 10 percent (32 degrees) unscheduled permanent disability.

Claimant experienced an aggravation of his back injury on April 22, 1987, and was released from work by his treating physician, Dr. Black. After conservative treatment, the claim was closed by Determination Order dated December 23, 1987. Claimant was awarded temporary total disability through December 13, 1987, but did not receive an increase in unscheduled permanent disability.

Before the November 26, 1986 Determination Order issued, Dr. Black stated that claimant had mild impairment and that he should avoid repetitive lifting, but did not place a specific weight limit on claimant's lifting.

Before the Determination Order of December 23, 1987 issued, Dr. Black completed a "check-the-box" capabilities evaluation where he checked that claimant may never lift or carry over 50 pounds.

Medical examinations have indicated that claimant has underlying psychological problems, not related to his industrial injury. These problems affect his physical condition and interfere with his coping with life in general. Dr. Black, claimant's treating physician, recommended psychological counseling.

Claimant's inability to return to his regular employment in September 1987 was not due to his physical abilities but, rather, to his subjective fear of further injury while working at his mill job.

Claimant's compensable condition did not permanently worsen after the November 1986 Determination Order.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant has "permanent impairment as a result of his industrial injury." That fact is not in dispute as claimant has previously been awarded 10 percent unscheduled permanent disability. However, in order to receive an award of additional permanent disability after an aggravation of his compensable injury, claimant must prove a permanent worsening of his condition since the Determination Order of November 26, 1986. Stepp v. SAIF, 304 Or 375, 378 (1987). The Referee found a permanent worsening. We disagree.

Claimant argues that his treating physician placed more restrictions on his lifting after the aggravation and, because of those, he was more permanently disabled. However, we do not find persuasive evidence to indicate that claimant's lifting restrictions actually were increased after the aggravation of his back injury.

Claimant's repetitive lifting and bending was restricted by Dr. Black prior to his first award of unscheduled permanent disability. On the second capability rating worksheet, Dr. Black merely affixed a number limit to the restriction. There is no indication that the check-the-box form used by Dr. Black during the second evaluation of claimant's capabilities imposed increased restrictions above those that Dr. Black had placed on claimant before the aggravation.

In addition, Dr. Black agreed with the physical findings of the Orthopaedic Consultants that claimant did not have any increase in his impairment after his last award, and that he could return to his regular occupation without limitations. Ex. 42-5, 53. He released claimant to work at his regular employment, but claimant failed an attempt to do so because of subjective fears that he would further injure his back.

Claimant has had several psychological examinations, with the doctors concluding claimant has non-injury related problems that are preventing him from successfully returning to work. Consequently, claimant's psychological problems are not considered in our analysis.

We, therefore, conclude that claimant has not demonstrated a permanent worsening of his condition since the November 26, 1986 Determination Order. Accordingly, we reverse the Referee's reevaluation of his permanent disability.

ORDER

The Referee's order dated April 28, 1988 is reversed. The Determination Orders dated November 26, 1986 and December 23, 1987 are reinstated and affirmed.

February 15, 1990 Cite as 42 Van Natta 346 (1990)

In the Matter of the Compensation of
GERALD L. BUTLER, Claimant
WCB Case No. 88-04815
ORDER ON REVIEW
Victor Calzaretta, Claimant Attorney
Kate Waldo (Saif), Defense Attorney

Reviewed by Board Members Perry and Howell.

Claimant requests review of Referee Seifert's order which affirmed a Determination Order award of 15 percent (48 degrees) unscheduled permanent disability for his psychological condition. Claimant also objects to the Referee's exclusion of testimonial evidence from a co-worker and the admission of testimonial evidence from a vocational rehabilitation witness. On review, the issues are admission of evidence and extent of unscheduled permanent disability. We affirm.

FINDINGS OF FACT

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

Claimant has an Adjustment Disorder with Depression. Symptoms include disturbances of the sleep cycle and eating habits and loss of self confidence and interest in various activities. Claimant can return to any work without experiencing these symptoms, except his former employment.

CONCLUSIONS OF LAW AND OPINION

The Board adopts the "Opinion" of the Referee with the following comment on the evidentiary issue.

In workers' compensation hearings, the Referee is not bound by statutory rules of evidence and may conduct a hearing in any way necessary to achieve substantial justice. See ORS 656.283(7). After de novo review of the transcript, we conclude the Referee did not abuse his discretion under this standard.

ORDER

The Referee's order dated June 23, 1988 is affirmed.

In the Matter of the Compensation of
RICHARD DOWNS, Claimant
WCB Case No. 88-05729
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
H. Thomas Andersen (Saif), Defense Attorney

Reviewed by Board Members Brittingham and Nichols.

Claimant requests review of Referee Gruber's order that affirmed a Determination Order that awarded no scheduled permanent partial disability for a left arm injury. The issue on review is extent of scheduled permanent partial disability. We reverse.

FINDINGS OF FACT

We adopt the findings of the Referee with the following supplement:

Claimant has some weakness in his left arm that prevents him from lifting as much with his left arm as he did before the injury. Claimant's weakness does not allow him to hold weights with his left arm for as long a period of time as he could before the injury. Claimant's arm weakness makes it difficult for him to break bolts loose with a wrench.

CONCLUSIONS OF LAW AND OPINION

We adopt the first paragraph of the Referee's conclusions and reasoning. The Referee found Dr. Bert more persuasive and found that claimant had no impairment and, thus, no loss of function of his left arm. Claimant was last seen by Dr. Bert in February, 1988. He was subsequently examined by Dr. Conwell in May, 1988. Dr. Conwell accepted claimant's statement that he has weakness and that his arm fatigues easily. Dr. Conwell performed an examination and agreed with claimant's perception. The doctor, however, also found that some of claimant's muscles were weaker than he would expect and that it could be due to disuse. Dr. Bert has not seen claimant since he released him to do his regular job.

We find Dr. Conwell more persuasive in this matter because he has examined claimant more recently. This is not the type of case where the treating physician has any special persuasiveness because of his relationship to claimant.

Claimant and his partner in the myrtlewood business both testified at hearing. The Referee made no finding on credibility; however, some of claimant's statements appear to be inconsistent. He believes he has lost about one-third of the use of the arm, but also says he can do everything that he did before, though his arm becomes more fatigued and he needs help. Lay testimony regarding disability can be relied upon to carry claimant's burden of proof. The lay testimony and the report of Dr. Conwell are sufficient proof to show that the claimant has lost some function with his left arm due to this injury. Contrary to claimant's testimony, we find this loss to be minimal and reflected primarily as fatigue and mild weakness. Accordingly, we conclude that claimant has lost 5 percent of the use or function of his left arm.

ORDER

The Referee's order dated September 12, 1988 is reversed. Claimant is awarded 5 percent (9.6 degrees) scheduled permanent disability for the loss of use or function of the left arm. Claimant's attorney is awarded 25 percent of the increased compensation created by this order, payable directly to claimant's attorney.

In the Matter of the Compensation of
ROBERT R. ELDER, Claimant
WCB Case No. 87-15657
ORDER ON REVIEW
Malagon & Moore, Claimant Attorneys
Employers Defense Counsel, Defense Attorney

Reviewed by Board Members Cushing and Gerner.

The insurer requests review of that portion of Referee Livesley's order which granted permanent total disability, whereas a Determination Order declined to award additional permanent disability beyond a 50 percent (75 degrees) scheduled permanent disability award for loss of use or function of the left knee and 5 percent (16 degrees) unscheduled permanent disability award for the left shoulder. On review, the issue is permanent total disability. We reverse.

FINDINGS OF FACT

Claimant suffers from a preexisting brain tumor, which was excised by Dr. Serbu, M.D., in April, 1982. It left claimant with visual impairment, mild hemiparesis, loss of intellectual function and partial seizure disorder. Claimant continues to suffer seizures, for which he takes medication. At the time of his compensable injury, claimant's seizures were well controlled by his medication.

In November, 1984, claimant sustained a compensable left leg and elbow injury when his left lower extremity went into a pinch roller at work. He returned to work for five days, but was subsequently taken off work by his treating neurologist, Dr. Randle with restrictions including no bending, squatting, climbing or crawling and he was restricted in sitting, standing and walking.

The insurer accepted claimant's claim for injuries resulting from his November, 1984 injury, but specifically denied his problems relating to the brain tumor, impotence, seizure disorders and possible psychological stresses. This denial was not appealed.

Claimant began vocational training in February, 1985, which was subsequently terminated in October, 1985 because the position was not suitable for claimant given his physical restrictions.

Claimant was found medically stationary in April 1985 and a May, 1985 Determination Order awarded claimant 20 percent scheduled permanent disability for loss of his left knee.

In February, 1986, Randle rated claimant's impairment as moderate, noted claimant's restriction of standing less than one hour at a time, and limited him to sedentary work.

A March 1986, stipulation awarded claimant an additional 30 percent scheduled permanent disability for the loss of his left knee, for a total of 50 percent scheduled permanent disability, and awarded 5 percent unscheduled permanent disability for an injury to his left shoulder.

Claimant's claim was reopened for vocational services and he began training as an apartment manager. In October, 1986, his training plan was modified to "maintenance and landscape". There was an available job market for claimant upon completion of this program.

Claimant progressed satisfactorily in the approved training program until February, 1987, at which time he suffered from a "partial complex seizure," that resulted in a significant increase in diminished left side coordination. The seizure was not related to claimant's work activities. Claimant's training program was terminated because of his inability to perform in the program due to his increased seizures and increased diminished left side coordination.

Claimant, 45 years of age at hearing, has a high school education, and a two-year bookkeeping degree from college. His work history includes summer cannery work and 18 years of mill work. His intellectual ability is below average, with an IQ of 84. He has significant impairment in visual spatial functions, reduced comprehension, poor classification skills and evaluative abilities.

Claimant's preexisting seizure condition was not disabling at the time of his compensable injury, in that it was successfully controlled by medication.

Claimant had a mild left side coordination deficit at the time of the injury, but it did not materially interfere with his ability to perform his job.

CONCLUSIONS OF LAW

The Referee determined that claimant had met his burden of proving that he was permanently totally disabled. In doing so, the Referee considered both claimant's preexisting seizure condition and the effects of his February, 1986 seizure, which occurred subsequent to claimant's November, 1985 compensable injury. We disagree with the Referee for the following reasons.

"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). To be entitled to an award of permanent total disability, the permanent total disability must result from the compensable injury. ORS 656.206(2)(a). Permanent total disability which results from the post-injury worsening of a preexisting condition independent of the compensable injury does not entitle the claimant to compensation for permanent total disability. Emmons v. SAIF, 34 Or App 603, 605 (1978). If the compensable condition did not cause permanent worsening of a preexisting condition, we consider only impairment due to the preexisting condition as it existed on the date of the injury. Walter R. Searles, 41 Van Natta 627, 629 (1989); Donald L. Savage, 39 Van Natta 758, 760 (1987); Bob G. O'Neal, 37 Van Natta 255 (1985); aff'd mem O'Neal v. Borden, Inc., 77 Or App 194 (1985); see Alvin L. Dick, 41 Van Natta 2005 (1989).

Here, claimant suffers from a preexisting brain tumor, which causes recurrent seizures. However, claimant's seizures, at the time of his compensable injury, were well controlled with proper medication.

In December, 1986, following the compensable injury, claimant suffered another seizure which was brought on by an illness. DeLapp, claimant's rehabilitation consultant, noted in a December, 1986 report, that "[Dr.] Randle had informed [claimant] that the seizure activity was undoubtedly due to his illness and threshold level of his anti-seizure medication and no adjustment was needed." DeLapp reported that claimant had informed him that "there was no difficulty in his continued employment/training."

In February, 1987, claimant suffered another seizure, which caused increased left side impairment and ultimately led to the termination of his vocational rehabilitation training program. DeLapp reported, in his March, 1987

closing report, that claimant had discussed the relationship between claimant's seizure and his training program. DeLapp reported that claimant, his family physician, Dr. Moss, and Randle, determined that claimant's February, 1987 seizure was "not related to his work activities."

Therefore, we find that claimant's February, 1987 seizure was not related to claimant's work, nor was it causally related to claimant's compensable injury. Thus, in determining the extent of claimant's permanent disability, we are precluded from considering the disabling effects of claimant's seizures which occurred subsequent to his November, 1984 compensable injury.

To establish permanent total disability in this particular case, claimant must prove that he was 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 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 (1984).

On our de novo review of the record, we find claimant has failed to prove the he was unable to obtain suitable and gainful employment.

Claimant returned to his job-at-injury in January, 1985 but was subsequently released from work by Dr. Randle. Claimant was referred for vocational services in March, 1985. That training plan was terminated four months later because the position was not within claimant's capabilities. However, claimant began a second training program in April, 1986, which was modified in October, 1986. At that time, DeLapp reported that "they foresee no barriers [to] continued employment following the completion of [claimant's] training program."

In December, 1986, claimant suffered a seizure, for which he was treated and released to return to his regular training program. Claimant's duties were not restricted or limited because of the seizure. Claimant's employer, Parmenter, indicated at that time, that she did not "feel [claimant's] training was currently being threatened as a result of this seizure activity, but indicated that if his medication level must be increased to control these seizures and if his medication impaired his memory as which he had experienced in the past, that she would need to assess the appropriateness of his continued training/employment." Claimant's medication was not increased and he continued in the on-the-job program until he suffered a "partial complex seizure" which prevented him from returning to his vocational rehabilitation training plan.

Under the circumstances, we find that claimant was performing his training program in a satisfactory manner up until the time of his noncompensable February, 1987 seizure. It was that seizure which ultimately led to the termination of his vocational services. Thus, claimant has failed to prove that he was permanently totally disabled due to the combination of his preexisting seizure condition and his compensable injury.

ORDER

The Referee's order, dated August 17, 1988, is reversed. The referee's award of permanent total disability is reversed. The September 28, 1987 Determination Order is affirmed. A client-paid fee, not to exceed $868, payable from the insurer to its counsel, is approved.

In the Matter of the Compensation of
DONALD C. LEDINGTON, Claimant
WCB Case No. 88-03128
ORDER ON REVIEW
Peter E. Baer, Claimant Attorney
Dennis S. Martin (Saif), Defense Attorney

Reviewed by Board Members Crider and Nichols.

Claimant requests review of the portion of Referee Baker's order that upheld the SAIF Corporation's denial of claimant's claim for a myocardial infarction. Claimant also requests that the Board take administrative notice of an excerpt from a local newspaper article. On review, the issues are compensability and evidence. We affirm.

FINDINGS OF FACT

Claimant, then a 45-year-old race track betting window employee, suffered an onset of symptoms including tired and heavy arms and queasiness in the stomach after a stressful day at work in early November, 1987.

He apparently sought no treatment, but did file a claim for a stress or strain injury to the heart.

He continued to work a regular schedule. On the weekend of November 21 and 22, 1987, the symptoms again returned while he was at work. On November 23, he suffered an inferior wall myocardial infarction.

SAIF issued a denial of claimant's heart attack.

Claimant is a longtime smoker.

CONCLUSIONS OF LAW AND OPINION

On review, claimant asks the Board to take administrative notice of a newspaper article reprinting an interview with a medical doctor in which that doctor indicated that heart disease may be associated with workplace stress. We decline to do so.

The Oregon Code of Evidence suggests that judicial notice may be taken only of facts that are either:

> "(1) Generally known within the territorial jurisdiction of the trial court; or
>
> (2) Capable of accurate and ready determination by resort to sources whose accuracy cannot reasonably be questioned."

ORS 40.065. Rule 201 (b). Although we are not bound by the Rules of Evidence, we must conduct our proceedings consistent with the interests of substantial justice. ORS 656.283(7). The Rules of Evidence provide a useful guide to what may appropriately be administratively noticed in a workers' compensation proceeding. The matter sought to be established here is not capable of ready determination. Indeed, it is a controversial question of medical opinion which has been contested in this case by the report of a cardiologist. It is at the heart of the issues in this case. For these reasons, an opinion on the issue must be admitted only under circumstances in which the opinion is subject to cross-examination and refutation. See Groshong v. Montgomery Ward, 73 Or App 403 (1985). It is not noticeable.

We adopt the Referee's opinion (the final three paragraphs of his Opinion and Order).

ORDER

The Referee's order dated September 8, 1988 is affirmed.

February 15, 1990 Cite as 42 Van Natta 352 (1990)

In the Matter of the Compensation of
GEORGE K. O'KELLEY, Claimant
WCB Case Nos. 87-16162 & 87-16163
ORDER ON RECONSIDERATION
Malagon, et al, Claimant Attorneys
Employers Defense Counsel, Defense Attorneys
H. Thomas Andersen (Saif), Defense Attorney

Claimant requests reconsideration of that portion of our January 24, 1990 Order on Review that declined to award claimant's attorney an assessed fee for services rendered at hearing on a responsibility issue. In our Order on Review, we affirmed a Referee's Opinion and Order that set aside the SAIF Corporation's denial of claimant's aggravation claim for a low back condition, and upheld Liberty Northwest Insurance Corporation's denial of claimant's "new injury" claim for the same condition. We declined to award claimant's attorney an assessed fee for services at hearing on the responsibility issue based on our finding that claimant's attorney did not take a position on which carrier was responsible. See SAIF v. Phipps, 85 Or App 436 (1987).

On reconsideration, claimant's attorney contends that he took the position in closing argument at hearing that Liberty should be responsible for claimant's condition as a new injury. Claimant's attorney acknowledges that SAIF, rather than Liberty, was the carrier ultimately found responsible. Nevertheless, he contends that he is entitled to an assessed fee. He relies on the decisions in SAIF v. Phipps, 85 Or App 436 (1987) and Western Pacific Construction v. Bacon, 82 Or App 135 (1986).

We are not persuaded by claimant's argument. Claimant is not entitled to an ORS 656.386(1) fee for finally prevailing at hearing on a responsibility issue unless he takes the prevailing position on that issue. Id. The cases cited by claimant do not support his argument. In both Western Pacific and Phipps, the claimant took the ultimately prevailing position.

Accordingly, our January 24, 1990 Order on Review is abated and withdrawn. On reconsideration, we adhere to and republish our January 24, 1990 order, as supplemented herein, 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
ROY I. POWERS, Claimant
WCB Case No. 87-16411
ORDER ON REVIEW
Emmons, et al, Claimant Attorneys
Cummins, et al, Defense Attorneys

Reviewed by Board Members Brittingham and Nichols.

Claimant requests review of Referee Myzak's order that upheld the insurer's denial of his low back injury claim. The issue on review is compensability. We affirm.

FINDINGS OF FACT AND ULTIMATE 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.

We do not necessarily agree with the Referee's adoption of the positional risk doctrine set forth at 1 Larson, Workmen's Compensation Law 3-308 to 3-336, Sec. 12.00 - 12.14(f) (1989). Nevertheless, while not necessarily adopting this doctrine, assuming the doctrine is part of Oregon's worker's compensation law, we agree with the Referee's ruling that claimant's injury is not compensable under the doctrine. However, we do so for a different reason.

To shift the loss to the employer in an idiopathic fall injury it is reasonable to require a showing of at least some substantial employment contribution to the harm. 1 Larson, Workmen's Compensation Law 3-325 to 3-327, Sec. 12.14(b). The evidence in the record indicates that the door of the trailer was an additional 14 inches higher than it would have been on level ground. Nothing in the record indicates that the height aggravated the effects of his fall. Claimant's orthopedic physician, Dr. Burr, indicated that it was not claimant's striking of a step or a block of wood, but his coming down hard on the buttocks that was the most probable cause of compressing his vertebrae. Thus, there is insufficient evidence to show that the additional height was a substantial employment contribution to the harm. As a result, claimant has not demonstrated any "substantial employment contribution" to his injury.

ORDER

The Referee's order dated March 22, 1988 is affirmed. A client-paid fee of $2,129 is approved.

In the Matter of the Compensation of
THOMAS SWAN, Claimant
WCB Case No. 88-03756
ORDER ON REVIEW
Connolly & Bruce, Claimant Attorneys
Ronald Pomeroy (Saif), Defense Attorney

Reviewed by Board Members Crider and Nichols.

The SAIF Corporation requests review of the portion of Referee Mongrain's order that granted claimant permanent total disability, whereas Determination Orders and a stipulated order had awarded a total of 40 percent (128 degrees) unscheduled permanent disability for the mid-back condition and 15 percent (20.25 degrees) scheduled permanent disability for the loss of use or function of the right foot. Claimant contends that the Referee erred in admitting the testimony of a vocational rehabilitation counselor. On review, the issues are permanent total disability and evidence. We affirm.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact and make the following additional findings:

Prior to his compensable injury, claimant worked as a millwright, truck-driver, concrete finisher, construction worker, ranch hand, and, from 1949-1956, as an auctioneer. He has never done sedentary work.

He is precluded by his compensable injury from performing any of his former jobs. He is unable to do any work involving any significant amount of standing, walking or lifting. Most auctioneering work involves more than just crying the auction: it often involves a great deal of walking and set up work. Claimant is unable to perform these ancillary tasks. He has made continuing efforts to find auctioneering work within his capacities since 1982, the only work that any vocational counselor has identified as a possibility. He has been unable to find work in that field.

Claimant is willing to work. He has made reasonable efforts to find work. He is permanently incapacitated from regularly performing gainful and suitable employment.

CONCLUSIONS OF LAW AND OPINION

We adopt the Referee's Opinion.

Claimant contends, on review, that the Referee should have precluded Robert Shive, SAIF's vocational expert, from testifying because his comments are tainted by knowledge gleaned from a conversation claimant had with him against the advice of counsel. The testimony was properly allowed. Although claimant was not required to speak with Mr. Shive, it appears that he did so voluntarily. Under those circumstances, Mr. Shive had no obligation to terminate the conversation because claimant's attorney did not wish it to occur. He was properly permitted to testify to opinions and to the basis of those opinions, however derived.

ORDER

The Referee's order dated July 5, 1988, as amended July 25 and August 1, 1988, is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,000 payable by the SAIF Corporation.

In the Matter of the Compensation of
JACK TUNGETT, Claimant
Own Motion No. 86-0361M
OWN MOTION ORDER ON RECONSIDERATION
Emmons, et al, Claimant Attorneys
Rhoten, et al, Defense Attorneys

Claimant requests reconsideration of our October 7, 1988, Own Motion Determination that awarded temporary total disability from March 11, 1986, through August 17, 1988, less time worked, and increased his scheduled permanent disability award for the loss of use or function of the right leg (knee) from 30 percent to 70 percent. Submitting additional medical reports that were not in the record, claimant contends that he is entitled to additional temporary total disability and permanent disability, including permanent total disability.

The insurer contends that claimant's request for reconsideration should be denied because the additional medical reports were obtainable with due diligence prior to issuance of our October 7, 1988, Own Motion Determination. We disagree. At the time we issued our determination order, our rules did not impose any limitations on the right of any party to request reconsideration of a final order issued under our own motion authority. See WCB Admin. Order 5-1987. The current rules, effective April 1, 1989, provide that new evidence submitted with a reconsideration request will be considered only if we find that, inter alia, the evidence was previously unobtainable with due diligence by the requesting party. See OAR 438-12-065(3). However, we decline to apply the current rules retroactively to limit a party's right to reconsideration of an order that was issued prior to April 1, 1989, the effective date of these rules. Rather, we shall consider the additional evidence insofar as it is relevant to our reconsideration.

In any event, we decline to reconsider claimant's permanent disability award. Claimant's claim is presently in closed status and, consequently, his claim must now be considered under the current version of ORS 656.278(1)(a), which took effect January 1, 1988. The current law does not authorize us to grant additional awards of permanent disability, including permanent total disability. See Orville D. Shipman, 40 Van Natta 537 (1988). Therefore, we deny claimant's request for reconsideration insofar as it requests modification of claimant's permanent disability award.

On the other hand, the current own motion law permits us to grant additional awards of temporary disability under the circumstances specified in ORS 656.278(1)(a). Temporary disability compensation compensates claimant for loss of income due to a compensable injury until claimant's condition becomes medically stationary. Taylor v. SAIF, 40 Or App 437, 440, rev den 287 Or 477 (1979). In determining whether claimant is medically stationary, we must consider all of his compensable conditions. See Rogers v. Tri-Met, 75 Or App 470 (1985). Dr. Cronk, claimant's treating physician, declared claimant's compensable knee condition medically stationary on August 17, 1988. However, Dr. Garner reports by letter dated October 28, 1988, that claimant is currently seeking treatment for depression and anxiety, which Garner relate to the compensable injury. In response, the insurer represents that it neither received any claim for psychiatric care nor paid for any such care.

This is not the appropriate forum for determining compensability issues, except in cases involving medical services for pre-1966 industrial injuries. Consequently, it is Board policy to refer compensability issues for litigation before the Hearings Division. Here, although the record contains evidence relating claimant's need for psychiatric treatment to his compensable

knee condition, we decline to consider claimant's psychiatric condition in determining whether claimant is medically stationary.

Following our review of the record, we continue to find that claimant became medically stationary on August 17, 1988. Accordingly, our October 7, 1988, order is withdrawn. On reconsideration, we adhere to and republish our October 7, 1988, order in its entirety. The parties' rights of reconsideration and appeal shall run from the date of this order

IT IS SO ORDERED.

February 16, 1990 Cite as 42 Van Natta 356 (1990)

In the Matter of the Compensation of
ARNOLD G. WHEELER, Claimant
Own Motion No. 87-0276M
OWN MOTION ORDER ON RECONSIDERATION
Kilpatricks & Pope, Claimant Attorneys
Saif Legal, Defense Attorney

The SAIF Corporation requests reconsideration of our December 15, 1989, Own Motion Order that denied its request for reevaluation of claimant's permanent total disability award for lack of jurisdiction. In order to allow sufficient time to consider SAIF's motion, we abated and withdrew our order on January 18, 1990. SAIF apparently argues that ORS 656.278(1)(b) permits the Board to modify awards of permanent disability for injuries predating 1966. We disagree.

> In pertinent part, ORS 656.278(1) provides:
> "[T]he power and jurisdiction of the board shall be continuing, and it may, upon its own motion, from time to time modify, change or terminate former findings, orders or awards if in its opinion such action is justified in those cases in which:
> ****,
> "(b) The date of injury is earlier than January 1, 1966. In such cases, in addition to the payment of temporary disability compensation, the board may authorize payment of medical benefits."

Contrary to SAIF's suggestion, ORS 656.278(1)(b) does not authorize the Board to modify all former awards for injuries predating 1966. Rather, it expressly permits the Board to authorize payment of medical benefits, in addition to temporary disability compensation, for pre-1966 injuries. The express provision for temporary disability and medical benefits, absent a similar provision for permanent disability benefits, evidences legislative intent to exclude reevaluations of permanent disability from our continuing power and jurisdiction under ORS 656.278(1). Moreover, legislative intent to include reevaluations of permanent disability within our own motion authority does not appear anywhere on the face of the statute. Therefore, we adhere to our earlier conclusion that we lack continuing jurisdiction to reevaluate claimant's permanent total disability award under ORS 656.278.

On reconsideration, as supplemented herein, we adhere to and republish our December 15, 1989, 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
SUE C. CHESSELET, Applicant
WCB Case No. CV-89003
Findings of Fact, Conclusions and Final Order (Crime Victim Act)
Jim Scavera, Attorney
Thomas Ewing, Assistant Attorney General

Pursuant to notice, a hearing was conducted and concluded by Roger C. Pearson, special hearings officer, on November 20, 1989 at Coos Bay, Oregon. Applicant, Sue C. Chesselet, was present and represented by Jim L. Scavera. The Department of Justice Crime Victims' Compensation Program ("Department") was represented by Thomas Ewing, Assistant Attorney General. The court reporter was Kim Holder. The record closed November 20, 1989.

Applicant has requested review by the Workers' Compensation Board of the Department's Findings of Fact, Conclusions and Order on Reconsideration dated July 5, 1989. By its order, the Department denied applicant's claim for compensation, filed pursuant to the Compensation of Crime Victims Act. ORS 147.005 to 147.365. The Department based its denial on the applicant's failure to establish that her claim for left shoulder problems was the result of a criminal assault.

ISSUE

Was applicant the victim of an intentional, knowing or reckless act that resulted in serious bodily injury or death of another person and which, if committed by a person of full legal capacity, would be punishable as a crime in this state?

EVIDENTIARY RULING

At the commencement of the hearing, applicant offered three exhibits for submission into evidence. Two of these exhibits, 22A and 22b, are uncertified copies of Curry County District Court documents (a July 29, 1989 Information of District Attorney and a November 2, 1988 Judgment), which describe the indictment and conviction of applicant's ex-husband for Assault IV stemming from the incident presently at issue. The third exhibit, 19A, is an April 24, 1989 medical report from Dr. Bernstein, neurologist, which discusses applicant's left shoulder condition.

None of these exhibits had been considered by the Department in reaching its decision. Applicant acknowledges the statutory requirement that no evidence is admissable at a hearing that has not previously been considered by the Department. See ORS 147.155(5). However, contending that each of the exhibits were in existence at the time of the Department's decision and are relevant to the case, applicant seeks their admission.

The Department waives objection concerning the Information and Judgment, stating that it appeared the Department had been misinformed concerning the prosecution and conviction of applicant's ex-husband. Regarding the medical exhibit, the Department noted that the report went to the key issue, which was the causal relationship between the assault and applicant's left shoulder problem.

An immediate ruling on this matter was withheld, pending the issuance of this order. After considering the positions of the parties and the relevant statute, I conclude that the offered exhibits must be rejected. The jurisdictional requirement set forth in ORS 147.155 is clear. The Board lacks the authority to admit any evidence that has not previously been considered by the Department. Inasmuch as neither the court documents nor the medical report were reviewed by the Department in reaching its decision, they shall not be admitted.

FINDINGS OF FACT

On the evening of July 20, 1988, applicant returned home from performing her duties as a maid for the Lamplighter Motel. Her then-husband, Blythe "Bud" Chesselet, was watching television. Applicant requested that the volume be reduced. An argument ensued.

Eventually, Bud arose from the chair in which he was seated and approached applicant, who was standing in front of a reclining chair. Bud pushed applicant into the recliner, causing the chair, with applicant in it, to topple over backward. Applicant landed against a wall. As the struggle continued, Bud repeatedly grabbed and struck applicant about the neck, arms, and legs. At times, applicant's head was forced down so that her chin rested on her chest. Applicant was able to extricate herself from the scene only after kicking Bud in the groin area.

Applicant went to a neighbor's home. Law enforcement officials were immediately contacted. Deputy Flynn of the Curry County Sheriff's Department answered the call for assistance. His report suggests that applicant carried no visible signs of an assault, but that Bud walked "hunched over." Noting that applicant would be staying with a neighbor and seeking a Temporary Restraining Order the next day, Flynn took no further action.

The following day, Deputy Geerhart contacted applicant. By this time, applicant had bruises on her left leg, right arm above the elbow, and left arm below the elbow. When applicant returned with Geerhart to her home, Bud was no longer there. However, they found torn personal papers, broken pottery items, and kitchen utensils scattered around the residence. They also discovered that the rear window of the couple's car had been shattered.

Following the attack, applicant immediately experienced pain and difficulty moving her left arm and shoulder. Thinking that the problems were attributable to her bruises and reluctant to obtain medical care for financial reasons, applicant sought no treatment. She continued to perform her maid duties, which were generally light in nature, i.e., making beds, vacuuming floors and cleaning tubs. She was also able to compensate for her inability to apply pressure with her left hand, by primarily using her right hand.

The manager at the motel generally supports applicant's description of declining health beginning around the time of the attack by applicant's ex-husband. The manager wrote that applicant was "in good health and was not complaining or did not show that anything whatsoever was wrong" until "her trouble with her husband."

In mid-August 1988, applicant began working for a Sentry Market. Her duties were heavier than those she had performed while at the motel. Those duties included mopping floors with an industrial mop, stocking merchandise, and carrying tubs of chicken to a deep frier. Applicant's left arm and shoulder problems increased. These problems were the same that she had experienced since the assault, only more pronounced.

On August 29, 1988, applicant sought emergency room treatment, complaining of worsening left shoulder pain for the last few days. Dr. Meyer, the emergency room physician, noted that applicant had been mopping floors at the market and had experienced "bursitis" in the past. Diagnosing bursitis of the left shoulder, Dr. Meyer scheduled an x-ray.

September 1, 1988 x-rays demonstrated soft tissue calcification in the left shoulder. Dr. Fiet, radiologist, related the condition to calcific tendinitis or possibly an old trauma. Dr. Meyer reexamined applicant on September 12, 1988, at which time she was released to regular work. During that examination, Meyer noted that applicant had related a "history of trauma by her husband."

On September 19, 1988, applicant filed a claim for benefits as the victim of a crime. Noting two weeks of time lost from work, applicant sought benefits for an injury to her left shoulder which had caused calcified tendinitis or acute bursitis.

In October 1988, applicant quit her job with the market. She returned to the work force in December 1988, packing totes for a tree farm. She continued to work for the farm until April 1989, when she became employed as a cashier for a Myrtlewood Shop.

Following its investigation, the Department issued an order on December 21, 1988. Finding nothing to substantiate that applicant's left shoulder problems were related to the assault, the Department denied the claim.

In March 1989 applicant sought treatment for her left shoulder complaints from Dr. Adams, orthopedist. Applicant related her problem to the July 1988 assault. Diagnosing "[i]mpingement syndrome of the left shoulder, possible subluxation of the shoulder or subluxation of the biceps tendon", Adams attributed applicant's condition to the attack by her ex-husband.

In June 1989 applicant requested that the Department reconsider its order. On July 5, 1989, the Department found no basis for reversing its original order. Applicant requested Board review of the Department's decision.

Applicant's current complaints include a stiff neck and "hot pain" radiating down her left shoulder and arm. Because her left shoulder periodically "hangs up" or "catches", she avoids any heavy lifting with her left arm. Applicant has experienced bursitis in the past. However, bursitis was confined to her right shoulder. Prior to the July 1988 assault, she had not experienced any left shoulder problems. Since the assault, she has not experienced any further injury to the left shoulder.

CONCLUSIONS OF LAW

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

Applicant is entitled to an award under the Act, if, among other requirements, she is the victim of "a compensable crime." See ORS 147.015(1). "Compensable crime" is defined as an intentional, knowing or reckless act that results in serious bodily injury or death of another person and which, if committed by a person of full legal capacity, would be punishable as a crime in this state. ORS 147.005(4). "Injury" means actual bodily harm. ORS 147.005(8).

Applicant testified in a thoughtful and direct manner. In making this finding, I note that applicant's voice occasionally rose and she appeared agitated when answering some of the questions posed her by her own counsel, as well as the Department's. I do not attribute this periodic change in her tone, inflection, and attitude to defensiveness or evasiveness. Rather, I relate this change in applicant's manner of testifying to the emotions which were rekindled as she recalled the relevant events in her claim, particularly the assault itself. In conclusion, after closely and carefully observing her attitude and demeanor while testifying, I find applicant to be an entirely credible witness.

The Department does not contest the fact that the attack perpetrated by applicant's ex-husband would be punishable as a crime. However, it asserts tht applicant has failed to establish that the attack has resulted in serious bodily injury. Specifically, it contends that the medical evidence is insufficient to support a causal relationship between the attack and applicant's left shoulder problem. Thus, the Department argues that applicant has not proven that she is the victim of a "compensable crime" as defined in ORS 147.005(4).

I disagree with the Department's position. Applicant has credibly described the brutal physical assault on the night of July 20, 1988 and her worsening symptoms since that event. The physical signs of that attack, including bruises on the left arm, are further documented in Deputy Geerhart's report of the following day. Standing alone, this evidence would support the definition of an "injury", as set forth in ORS 147.005(8), i.e., actual bodily harm.

Considering applicant's financial circumstances and her belief that the left shoulder problems would eventually dissipate, her decision not to seek immediate medical treatment and continue with her work activities is understandable. Yet, when these complaints became too oppressive, she eventually did seek medical assistance. Such care resulted in medical treatment and some two weeks of time lost from work. When combined with the actual bodily harm depicted above, I conclude tht such disability constitutes "serious bodily injury" as required by ORS 147.005(4). I draw further support for this conclusion from ORS 147.035, which provides for the recovery of reasonable medical expenses and lost earnings for compensable claims.

The Department also argues that the record does not establish a causal relationship between the assault and applicant's left shoulder problems. Specifically, the Department contends that this question poses a complex medical issue, the resolution of which requires a thorough analysis from a medical expert. Considering the credibility of applicant's version of events, including the lack of prior similar left shoulder problems or subsequent incidents, I do not agree. However, even if I concurred with the Department's contention, I would find that causation has been established by the medical evidence.

Applicant's emergency room history to Dr. Meyer does not mention the July 1988 assault. Yet, Meyer soon learned of the attack from applicant after they discussed the x-ray findings, which demonstrated soft tissue calcification consistent with calcified tendinitis or possibly old trauma. Thereafter, Dr. Meyer referred to the attack as the "old trauma" mentioned in the radiologist's findings.

Dr. Adams similarly relates applicant's left shoulder problems to the July 1988 assault. After receiving a medical history consistent with applicant's credible testimony, Adams opined that the current cause of applicant's shoulder problem was the attack by her ex-husband.

In conclusion, the credible lay and medical evidence establishes that applicant was the innocent victim of an assault that resulted in serious bodily injury. Consequently, I am persuaded that her application for benefits under the Crime Victims' Compensation Program is compensable.

ORDER

I recommend that the Findings of Fact, Conclusions and Order on Reconsideration of the Department of Justice Crime Victims' Compensation Program dated July 5, 1989 be reversed. I further recommend that applicant's claim for benefits be remanded to the Department with instructions to accept and process the claim in accordance with law.

In the Matter of the Compensation of
SCOTT M. AMLIE, Claimant
WCB Case No. 88-04803
ORDER ON REVIEW
Max Rae, Claimant Attorney
Dennis Martin (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

Claimant requests review of Referee Borchers' order which: (1) affirmed a March 16, 1988 Determination Order award of 10 percent (15 degrees) scheduled permanent disability for loss of use of his right hand; (2) declined to direct the SAIF Corporation to pay scheduled permanent disability pursuant to a March 15, 1988 Determination Order; and (3) declined to award a penalty and associated attorney fee for SAIF's failure to pay the permanent disability benefits awarded by the first Determination Order. On review, the issues are extent of scheduled permanent disability, claims processing, penalties and attorney fees. We affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Extent of Scheduled Permanent Disability

The Board adopts the Referee's "Opinion" with respect to the issue of scheduled permanent disability.

Claim Processing

Because of a computer breakdown, the Evaluation Division issued two identical Determination Orders on claimant's claim. However, there was only one award of compensation, which was timely paid by SAIF. Claimant is not entitled to have that award of compensation paid twice.

Penalty and Attorney Fee

SAIF's action, by not requesting prompt clarification and rescission of the first Determination Order, was unreasonable. However, because SAIF paid the award of compensation, there are no "amounts then due" upon which to base a penalty. ORS 656.262(10). Moreover, SAIF's conduct was not an unreasonable resistance to the payment of compensation (ORS 656.382(1)) because the Determination Order award was promptly paid. Consequently, claimant is not entitled to a penalty and attorney fee under ORS 656.262(10) or ORS 656.382(1).

ORDER

The Referee's order dated July 28, 1988 is affirmed.

In the Matter of the Compensation of
CARL S. BETHELL, Claimant
WCB Case Nos. 87-02710 & 87-02709
ORDER DENYING RECONSIDERATION
FRANCESCONI & ASSOCIATES, Claimant Attorneys
ROBERTS et al, Defense Attorneys
SCHEMINSKE & LYONS, Defense Attorneys

On January 22, 1990, the Board issued an Order On Reconsideration which declined to award an assessed fee for services on review concerning our December 21, 1989 Order on Review. In our December 21, 1989 order, we affirmed those portions of Referee Bethlahmy's order that assigned AIAC responsibility for claimant's cervical back condition and a perilymph fistula and hydrops condition. Claimant contended that he is entitled to an assessed attorney fee for prevailing against AIAC's request for review. Claimant has now submitted a second request for reconsideration raising the same argument.

The request for reconsideration is denied. See Anfora v. Liberty Communications, 88 Or App 30, 33 (1987). (Claimant's participation to secure an extended period of aggravation rights where right to compensation is not at risk does not entitle him to attorney fees pursuant to ORS 656.382(2).) We adhere to our December 21, 1989 Order On Review, as supplemented by our January 22, 1990 Order On Reconsideration. The parties' rights of appeal shall continue to run from the date of our January 22, 1990 order.

IT IS SO ORDERED.

In the Matter of the Compensation of
VANESSA A. MILLER, Claimant
WCB Case No. 87-18988
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
Scheminske & Lyons, Defense Attorneys
Diane L. Gruber, Attorney

Reviewed by Board Members Myers and Gerner.

Claimant requests review of those portions of Referee Davis' order that: (1) declined to find that her left arm condition was prematurely closed by a Determination Order; and (2) alternatively, affirmed a Determination Order that awarded 10 percent (19.2 degrees) for the same condition. On review the issues are premature closure and alternatively, extent of scheduled permanent disability. We affirm.

FINDINGS OF FACT

Claimant has an accepted claim for left arm epicondylitis resulting from the repetitive use of the left elbow for the employer. While originally classified as nondisabling, the claim subsequently became disabling and was reopened for aggravation on September 30, 1987. On December 3, 1987, a Determination Order closed claimant's claim for 10 percent (19.20 degrees) scheduled permanent disability to her left arm.

Claimant was declared to be medically stationary by her attending physician, Dr. Rabie, M.D., on July 31, 1987. On September 23 1987, Dr. Wilson, M.D., declared that claimant was not medically stationary. By Stipulation and

Order dated October 29, 1987, the parties stipulated that claimant was medically stationary on July 31, 1987. This finding of fact was actually determined by the Stipulation and was essential to the settlement. On November 4, 1987, Dr Gritzka, M.D., declared that claimant was not medically stationary and recommended surgery. Dr. Nathan, M.D., after an independent medical examination on December 14, 1987, declared that claimant was not medically stationary.

Claimant has minimal physical impairment with respect to her left arm. She experiences pain when she lifts objects or uses her arm.

ULTIMATE FINDINGS OF FACT

As of July 31, 1987, no further material improvement in claimant's left arm would reasonably be expected from medical treatment or the passage of time. Claimant has lost 10 percent of the use or function of her left arm.

CONCLUSIONS OF LAW

The Board adopts the Referee's opinion with the following supplementation concerning the premature closure issue.

Although the Referee did not cite to the case of Scheuning v. J. R. Simplot & Company, 84 Or App 622 (1987) (evidence not available at the time of claim closure should be considered to the extent that it addresses a worker's condition at the time of closure), we find that he, in fact, properly considered the post-closure report of Dr. Rabie. See Ex. 19A. Moreover, we agree with the Referee's analysis of that report.

Because claimant failed to establish a valid reason to overturn the October 29, 1987 stipulation, the finding that claimant was medically stationary on July 31, 1987, is issue preclusive on this litigation.

ORDER

The Referee's order, dated February 29 1988, is affirmed. The Board approves a client-paid fee, payable from the self-insured employer to its attorney, not to exceed $2,190.50.

February 20, 1990 Cite as 42 Van Natta 363 (1990)

In the Matter of the Compensation of
KENNETH D. SKELTON, Claimant
WCB Case Nos. 88-01014, 87-07121 & 88-01013
ORDER ON REVIEW
Callahan and Gardner, Claimant Attorneys
Gary Jones, Attorney
Nelson, et al, Defense Attorneys
Rick Dawson (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

The SAIF Corporation requests review of Referee Nichols' order which: (1) set aside its denial, as the insurer for Haring Drywall, of claimant's claim for carpal tunnel syndrome; and (2) upheld SAIF's denial, as the insurer for A & R Superior Auto, and the denial of Liberty Northwest Insurance Corporation, as the insurer for Western Partitioners, of the same condition. SAIF also contends, on behalf of both of its insureds, that it was improperly joined in this matter. The issues on review are responsibility and joinder. We reverse.

FINDINGS OF FACT

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

Claimant filed 801 forms against Haring Drywall and A & R Superior Auto on October 29, 1987. SAIF denied those claims on January 18, 1988. Claimant first requested a hearing on January 21, 1988.

CONCLUSIONS OF LAW AND OPINION

Joinder

On review, SAIF argues that the Order of Joinder issued August 24, 1987 is invalid because SAIF was not notified of the responsibility issue by Liberty Northwest and, thus, did not have the opportunity to respond before joinder was accomplished. See OAR 436-60-180. However, we conclude that we need not resolve this issue.

The record shows that in addition to the OAR 436-60-180 "claims" filed by Liberty Northwest against SAIF's insureds, claimant also filed claims directly with SAIF's insureds. These were denied and claimant requested hearings on those denials. Therefore, even if joinder based on Liberty Northwest's action was improper, consolidation for hearing of claimant's requests was proper. OAR 438-06-065(1).

Responsibility

In cases involving multiple employment exposures, any one of which may have caused disability, the onset of disability controls the determination of which employment is assigned responsibility for an occupational disease. Bracke v. Baza'r, 293 Or 239, 248 (1982). In the absence of disability, responsibility is assigned to the employer/insurer on the risk at the time of the first medical treatment for the occupational disease. Bracke, supra; Linda L. Wise, 42 Van Natta 115 (1990). Claimant here first left work due to hand complaints and sought medical treatment on November 17, 1986, while he was employed with Liberty Northwest's insured, the earliest of the three employments involved in this dispute. At that time he missed some work and demonstrated decreased use or function of his hands. Therefore, the onset of claimant's disability was on that date and responsibility is initially assigned to Liberty Northwest.

Liberty Northwest can shift responsibility to a subsequent insurer if it can show that a subsequent employment actually contributed to a worsening of claimant's condition. See Spurlock v. International Paper Co., 89 Or App 461, 465 (1987). The Referee relied on a check-the-box questionnaire filled out by Dr. White, the surgeon who performed claimant's bilateral carpal tunnel release, to find that Liberty had successfully established that the two subsequent employments with SAIF's insureds contributed to a worsening of the condition. We disagree.

Although the Referee was persuaded by Dr. White's check-the-box questionnaire that claimant's employment subsequent to Western Partitioners materially contributed to a worsening of the condition, we are not persuaded by White's opinion. Because this issue is one of medical analysis rather than observation, we find the attending physician's opinion entitled to no special weight. Futhermore, a conclusory medical opinion without supporting analysis will be given little persuasive weight. Somers v. SAIF, 77 Or App 259 (1986).

Moreover, "recurrence of symptoms which does not affect the extent of a continuing underlying disease does not shift liability for the disabling disease to a subsequent employer." Bracke at 250. Here, the evidence does not show that the underlying disease had been aggravated. Claimant testified that his hands were becoming progressively worse, even before employment with Western Partitioners, to the point that while working at Western Partitioners he could not hold on to his drywall tools. During subsequent employment with SAIF's insureds, claimant experienced lesser or equal, but not greater, symptoms. In addition, Dr. Button, hand surgeon, examined claimant and opined that claimant's subsequent employments did not pathologically worsen his condition.

We conclude that Liberty Northwest has not successfully met its burden by proving that either of claimant's subsequent employments with SAIF's insureds actually contributed to a worsening of claimant's condition.

ORDER

The Referee's order dated March 21, 1988, as reconsidered on April 20, 1988 and on May 3, 1988, is reversed. The SAIF Corporation's denial dated January 18, 1988, issued on behalf of its insured Haring Drywall, is reinstated and upheld. Liberty Northwest Insurance Corporation's denial of April 16, 1987 is set aside and the claim is remanded to Liberty Northwest for processing according to law. For services on Board review, claimant's attorney is awarded an assessed fee, not to exceed $500, payable by Liberty Northwest. A client-paid fee payable to SAIF's outside counsel, not to exceed $450, is approved.

February 20, 1990 Cite as 42 Van Natta 365 (1990)

In the Matter of the Compensation of
ROBERT T. WALTHER, Claimant
WCB Case No. 86-02176
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Ronald Pomeroy (Saif), Defense Attorney

Reviewed by Board Members Speer and Howell.

The SAIF Corporation requests review of that portion of Referee Livesley's order that granted claimant permanent total disability, whereas a Determination Order awarded 25 percent (80 degrees) unscheduled permanent disability for a low back injury. On review, the issue is extent of unscheduled permanent disability, including permanent total disability. We reverse.

FINDINGS OF FACT

The Board adopts the Referee's "Findings of Fact" through the seventh full paragraph of the Opinion and Order, with the following supplementation.

Claimant has refused vocational rehabilitation services.

Claimant has mild permanent low back impairment and a disabling psychological condition, resulting from his compensable injury of January 1979.

Since becoming medically stationary claimant has done work in his shop fixing CB radios, installing antennae, installing a PA system in a church and developing a satellite disc system which he hoped to patent.

CONCLUSIONS OF LAW

Permanent Total Disability

In order to prove entitlement to permanent total disability benefits, claimant must prove that he is permanently incapacitated from regularly performing work at a gainful and suitable occupation. ORS 656.206(1)(a). Permanent total disability may result from less than total physical incapacity, when combined with nonmedical conditions, including "age, training, aptitude, adaptability to nonphysical labor, mental capacity, emotional condition, as well as the condition of the labor market." Wilson v. Weyerhaeuser, 30 Or App 403, 409 (1977). Unless claimant's physical incapacity in conjunction with his nonmedical disabilities renders work search futile, SAIF v. Scholl, 92 Or App 594, 597 (1988), he must also establish that he is willing to seek regular gainful employment and that he has made reasonable efforts to obtain such employment. ORS 656.206(3).

Here, the Referee concluded that the medical evidence does not support a conclusion that claimant's compensable back condition alone prevents him from working. We agree. However, the Referee further concluded that the back condition, combined with claimant's psychological condition, supported an award of permanent total disability. In reaching this conclusion, the Referee gave "great weight" to the opinion of Dr. Stipek, a psychologist and vocational consultant, that claimant is totally disabled from all gainful activity. We do not agree that Dr. Stipek is persuasive on this issue.

Dr. Stipek, examined claimant one time only at the request of claimant's attorney. On the other hand, Dr. Luther is claimant's treating psychiatrist, and has treated him for two years. He reported that claimant's symptoms included depressive neurosis, conversion symptomology, and possible mild paranoid ideation. He opined that claimant's mental disorders represented a class 2, 15 percent permanent impairment. He did not consider claimant totally disabled.

We find Dr. Luther's opinion to be most persuasive and conclude that claimant is not permanently totally disabled by his physical and psychological impairment alone.

As the Referee noted, vocational experts identified "a copious number of transferable skills in a myriad of positions within claimant's residual capacity. . . ". Moreover, reasonable efforts have not been made by claimant to attempt to obtain gainful, suitable employment utilizing those skills and within his physical, psychological and other vocational restrictions. Because we are not persuaded by Stipek's opinion, and because of claimant's demonstrated ability to perform various types of work on his own, we find that claimant has failed to demonstrate that attempts to obtain gainful, suitable employment would be futile. Claimant has failed to prove permanent total disability under the "odd-lot doctrine". We thus address the extent of unscheduled permanent disability.

Extent of Unscheduled Permanent 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 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).

Considering claimant's age of 47 years, his mild permanent low back impairment, his Class 2 mental impairment of the whole person, his prior work experience in the electronics field, along with the other relevant factors, we conclude that 75 percent (240 degrees) unscheduled permanent disability adequately and appropriately compensates claimant for his compensable injury and related mental condition.

ORDER

The Referee's order dated February 23, 1988, as amended March 2, 1988, is reversed. In lieu of the Referee's award and in addition to the 25 percent (80 degrees) unscheduled permanent disability awarded by Determination Order, claimant is awarded 50 percent (160 degrees) unscheduled permanent disability, giving him a total award to date of 75 percent (240 degrees) unscheduled permanent disability for a low back injury and associated mental condition. Claimant's attorney fee shall be adjusted accordingly.

February 21, 1990 Cite as 42 Van Natta 367 (1990)

In the Matter of the Compensation of
TOMMY V. ARMS, Claimant
WCB Case Nos. 88-03948, 88-07597 & 88-07596
ORDER ON REVIEW
Malagon, et al, Claimant Attorneys
Cummins, et al, Defense Attorneys
Kate Donnelly (Saif), Defense Attorney
Acker, et al, Defense Attorneys

Reviewed by Board Members Perry and Howell.

The self-insured employer requests review of that portion of Referee Bennett's order which: (1) set aside its denial of claimant's low back condition; and (2) upheld the SAIF Corporation's denials of the same condition. Claimant cross-requests review of those portions of the Referee's order which: (1) declined to assess a penalty and associated attorney fee for an allegedly unreasonable denial; and (2) declined to award a carrier-paid attorney fee. On review, the issues are compensability, responsibility, penalties and attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

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

An injury at the L4-5 level of claimant's spine was indicated after his December 15, 1980 industrial injury while employed by the self-insured employer. At that time, it was considered insignificant.

Claimant suffered an aggravation of his 1980 low back injury in January 1988, while at home digging and replanting fruit trees. Due to a misunderstanding when claimant first went to the emergency room for back pain on January 27, 1988, it was noted that claimant had injured his back while working with one of SAIF's insureds, Black Brothers Logging, rather than at home. That mistake continued through a second emergency room visit and into the surgeon's initial examination report. When claimant became aware of the error, he informed his surgeon, who in turn wrote a letter to claimant's attorney to rectify the misinformation and clarify the cause of injury.

The self-insured employer received a copy of the surgeon's clarifying letter on April 21, 1988, three months prior to hearing.

Dr. Gallo performed an L4-5 diskectomy on March 10, 1988. During that surgery, it was noted that claimant's disc had been degenerative and deteriorating for some time.

No ORS 656.307 order issued designating a paying agent.

CONCLUSIONS OF LAW AND OPINION

Compensability and Responsibility

The Board adopts the Referee's "Opinion" with respect to the issues of compensability and responsibility.

Unreasonable Claim Denial

Claimant argues that the self-insured employer unreasonably persisted in its denial of claimant's claim, even after it received information that should have proved claimant's surgery was not necessitated by any employment other than its own. We agree.

It is true that there was information in the two emergency room reports that would lead the employer and the surgeon to believe that claimant was injured at another employment. However, when claimant subsequently became aware of the misinformation, he immediately informed his surgeon who, in turn, informed claimant's attorney of the error by letter dated March 29, 1988. She noted that the error had resulted from her misunderstanding of claimant's history. The employer received a copy of the surgeon's letter on April 21, 1988, three months before hearing.

When an employer reasonably denies a claim, which here occurred on March 15, 1988, "continuation of that denial in the light of new medical evidence becomes unreasonable if, but only if, the new evidence destroys any legitimate doubt about liability." Brown v. Argonaut Insurance Co., 93 Or App 588, 592 (1988).

After de novo review of the record, we conclude that the evidence received by the employer, which stated that claimant had not hurt his back at a subsequent employment, was sufficient to destroy any legitimate doubt on the part of the employer that it was responsible for claimant's surgery. Therefore, its continuing denial in the face of such evidence was unreasonable. Accordingly, we shall assess a penalty and associated attorney fee. ORS 656.262(10); 656.382(1).

Carrier-Paid Attorney Fee

Claimant argues that he was entitled to a carrier-paid attorney fee for services at hearing under ORS 656.386(1) because compensability, as well as responsibility, was at issue. We agree, and find that SAIF is the insurer responsible for payment of that attorney fee because SAIF was the insurer which placed claimant's entitlement to compensation at risk by its compensability denial. See Joel D. Turpin, 41 Van Natta 1736 (1989).

ORDER

The Referee's order dated August 24, 1988 is affirmed in part and reversed in part. That portion which found the self-insured employer responsible for claimant's back surgery is affirmed. That portion which declined to assess a penalty and associated attorney fee for unreasonable claim denial is

reversed. The self-insured employer is ordered to pay a penalty, pursuant to ORS 656.262(10), equal to 25 percent of the amount due between April 21, 1988 and the time of hearing. Additionally, the self-insured employer is ordered to pay a reasonable penalty-related attorney fee, pursuant to ORS 656.382(1), in the amount of $300. For services at hearing, a carrier-paid attorney fee in the amount of $2,500, payable by SAIF Corporation in equal portions on behalf of its two insureds is awarded. For services on Board review regarding the denial issue, an assessed fee of $700 is awarded, payable by the self-insured employer. A client-paid fee is approved not to exceed $2,861, payable by the self-insured employer to its counsel. A client-paid fee is approved not to exceed $1,537.50, payable by the SAIF Corporation to its outside counsel representing Black Brothers Logging.

In the Matter of the Compensation of
RICHARD H. CHURCH, Claimant
WCB Case Nos. 88-02266, 88-08912, 88-05060 & 88-08913
ORDER ON REVIEW
Ralph Yenne, Claimant Attorney
Stafford Hazelett, Defense Attorney
Roberts, et al, Defense Attorneys
Charles Maier, Attorney

Reviewed by Board Members Cushing and Gerner.

Liberty Northwest Insurance Corporation requests review of those portions of Referee Nichols' order which: (1) set aside its denial of responsibility for claimant's back injury claim; (2) upheld United Pacific's denial of responsibility for the same condition; and (3) directed claimant's temporary disability rate to include wages claimant received for his work on another job site. Claimant cross requests review of the Referee's order which: (1) declined to determine the compensability of claimant's back injury claim with the two insurers because an order designating a paying agent under ORS 656.307 had issued; (2) declined to award a carrier-paid attorney fee; and (3) declined to assess penalties and associated attorney fees for alleged unreasonable claims processing. On review, the issues are compensability, responsibility, temporary disability rate, penalties and attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

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

Compensability of claimant's back injury claim was not at issue at the hearing.

Claimant contended at hearing that Liberty Northwest Insurance Corporation was responsible.

CONCLUSIONS OF LAW

The Board adopts the Referee's Conclusions of Law, as set forth in the "Opinion and Conclusions" portion of her order, with the following supplementation.

Compensability

Claimant contends that the Referee failed to address the issue of the compensability of claimant's back injury claim.

The Referee found that compensability was not in issue, pursuant to the issuance of a May 1988 ".307" order. Thus, we find that the issue of compensability had been conceded by both insurers, and as such, was not at issue at the hearing.

Attorney Fees

Claimant contends that his attorney is entitled to a carrier-paid fee, payable by Liberty Northwest Insurance Corporation, for services at hearing regarding the issue of responsibility. We agree. The Referee failed to address claimant's contention that it was entitled to a carrier-paid fee. We do so now.

Claimant is entitled to a carrier-paid attorney fee for services at hearing if claimant's attorney "actively litigated" the issue of responsibility. ORS 656.307(5) Mercer Industries v. Rose, 100 Or App 252 (January 17, 1990); SAIF v. Phipps, 85 Or App 436 (1987); Petshow v. Farm Bureau Ins. Co., 76 Or App 563, 569, rev den 300 Or 722 (1986). Here, claimant took the position at hearing that Liberty Northwest was responsible. The Referee assigned responsibility to Liberty Northwest. We find that claimant actively litigated the issue of responsibility, and claimant's attorney is entitled to a carrier-paid attorney fee for services at hearing, payable by Liberty Northwest.

Inasmuch as claimant's counsel rendered no services on review concerning the responsibility and temporary disability issues as raised by Liberty Northwest, no attorney fee pursuant to ORS 656.382(2) shall be awarded. Shirley M. Brown, 40 Van Natta 879 (1988).

ORDER

The Referee's order, dated August 24, 1988, is affirmed in part and reversed in part. For services at hearing, claimant's attorney is awarded a reasonable carrier-paid fee, payable by Liberty Northwest Insurance Corporation, of $1,750. The remainder of the order is affirmed. A client-paid fee, payable from United Pacific to its counsel, not to exceed $1,270, is approved.

In the Matter of the Compensation of
JAMES R. LASITER, Claimant
WCB Case No. 88-10337
ORDER ON REVIEW
Black, et al, Claimant Attorneys
David R. Fowler (Saif), Defense Attorney

Reviewed by Board Members Nichols, Brittingham and Crider.

Claimant requests review of Referee Baker's order that dismissed claimant's request for hearing on a denial that had been issued by the SAIF Corporation on April 22, 1988. On review the issue is the appropriateness of the dismissal order.

The Board affirms and adopts the order of the Referee with the following additional findings and conclusions. We take official notice of WCB Case Nos. 88-04555 and 88-04554. Those are the case numbers assigned to the prior matter that ultimately set aside the Proposed and Final Order finding Patricia Sue Welch, dba Welch Trucking, to be noncomplying. Case No. 88-04554 was entitled "In the Matter of the Compensation of James M. Lasiter." On March 29, 1988, claimant and his attorney were mailed copies of the notice of hearing which was scheduled for June 14, 1988, and were mailed copies of the Opinion and Order

issued by Referee Shebley which would have an impact on claimant's right to compensation. A denial letter had been issued by SAIF, as the processing agent, on April 22, 1988. Claimant's attorney filed the request for a hearing on the denial on June 21, 1988.

The result of Referee Shebley's order is to negate the claim as there is no longer a subject employer against which to file a claim. The Referee referred to this as the law of the case, we disagree with that terminology, but we do agree with the ultimate result of the Referee.

ORDER

The Referee's order, dated August 23, 1988, is affirmed.

Board Member Crider dissenting.

The Referee's order should be reversed and the case remanded for hearing.

The Board holds that claimant is not entitled to a hearing on the compensability of his claim because, in another proceeding, a referee found that he was not an employee of Welch Trucking and that Welch Trucking was not a subject employer. Apparently, the Board concludes that litigation of the issues of subjectivity and of claimant's employment status are precluded by res judicata. I disagree.

The elements of issue (or fact) preclusion are these: 1) the parties to the first proceeding are the same as the parties to the second; 2) the first proceeding concluded in a final judgment; and 3) the fact, litigation of which is to be precluded, was essential to the final judgment in the prior proceeding. North Clackamas School District v. White, 305 Or 48, modified 305 Or 468 (1988). SAIF did not establish these facts in the hearing record. Neither has the Board's resort to administrative notice established them in this record.

I am not persuaded that claimant was a party to the prior proceeding. Although claimant may have been notified of that proceeding and may have received a copy of Referee Shebley's order, that order does not indicate that the agency deemed claimant a party. Indeed, while the order enumerated the Director of the Department of Insurance and Finance and the SAIF Corporation as parties and stated that they had waived appearance, it did not so enumerate claimant or indicate that claimant, by failing to appear, had waived appearance. Moreover, neither the statute nor the administrative rules indicate that claimant should be a party to a proceeding on a Notice of Proposed and Final Order except where such a proceeding is consolidated with a hearing on a matter concerning a claim. ORS 656.740 and former OAR 436-80-030. Here, the two proceedings were not consolidated. Since nothing establishes that claimant was entitled to a hearing on the Notice of Proposed and Final Order, the agency did not name claimant as party, and claimant did not seek to participate at hearing, we cannot find that he was a party. ORS 183.310(6).

Even if claimant had been enumerated as a party to the prior proceeding and thus was technically a party under the Administrative Procedures Act, he would have been a nominal party with no stake in the claim asserted by the Director therein. Therefore, it is not consistent with fundamental fairness that he be bound by findings made by Referee Shebley after hearing. The June 14, 1988 hearing under ORS 656.740(1) concerned only one thing: Whether or not the Director could establish that Welch Trucking was noncomplying such that he might later assess a civil penalty under ORS 656.735 or recover claims costs from the company under ORS 656.054(3). Claimant had no stake whatever in the relief sought by the

Director. It mattered not at all to him whether the Director could collect penalties or recover costs.[1] The sole reason claimant would have had for participating in the hearing on the Proposed and Final Order would have been to protect himself against findings of fact that could be used for or against him in litigation concerning the compensability of his claim.

The law of res judicata should not be stretched to the point that an individual must participate in a proceeding in which the relief sought is of no concern to him solely to protect interests directly in issue in another proceeding. See analogously, Chavez v. Boise Cascade Corporation, 307 Or 632, 637 (1989). Since to apply the doctrine here necessarily implies that individuals must participate in matters of no direct concern to them, the doctrine should not be applied.

To remand for hearing, on the other hand, works no wrong on Welch Trucking, which has established that it is not a subject employer in order to protect itself from penalties and costs. The hearing on remand will involve SAIF and claimant only. Nevertheless, this course will create the potential for inconsistent "findings." Such inconsistency will inevitably occur from time to time when proceedings are not consolidated as they can be and should be under ORS 656.740(4)(c).

Finally, I note that there is no basis in this record for the Board's findings. Although exhibits were apparently exchanged in preparation for hearing, none were received by the Referee. Nor were any documents submitted via affidavit by SAIF in support of its Motion to Dismiss claimant's request for hearing. While the Board may take administrative notice of an agency order (Jenetta L. Gans, 41 Van Natta 1791 (1989)), I am not persuaded that we may take notice of the additional material from the file in WCB 88-04554 and 88-04555 upon which the majority relies. In doing so, we have relied to resolve the dispositive issue on documents that the parties have had no opportunity to cross-examine or rebut. This is inconsistent with our duty to provide fair proceedings. See Groshong v. Montgomery Ward Co., 73 Or App 403 (1985).

The party seeking to preclude litigation of an issue in reliance on res judicata must establish the elements of the defense. Troutman v. Erlandson, 287 Or 187 (1979). Having failed to establish the elements of the defense without the Board's improvident exercise of its authority to take notice, SAIF has failed to establish its right to preclude litigation of the subjectivity issues. Therefore, the hearing should proceed on the merits.

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[1] It apparently mattered very little to the Director either, as he did not appear and thus only the alleged noncomplying employer participated at hearing.

February 21, 1990 Cite as 42 Van Natta 372 (1990)

In the Matter of the Compensation of
VAL R. MCBRIDE, Claimant
WCB Case No. 88-09911
INTERIM ORDER (REMANDING)
Malagon, et al, Claimant Attorneys
Acker, et al, Defense Attorneys

Claimant requests review of Referee Nichols' order which: (1) upheld the self-insured employer's denial of a requested surgery; (2) affirmed a Determination Order finding concerning a medically stationary date; and (3) awarded claimant 21.5 percent (68.8 degrees) unscheduled permanent disability in lieu of

the 17 percent (54.4 degrees) unscheduled permanent disability awarded by Determination Order. Claimant has moved for an order remanding the case to the Hearings Division to consider additional evidence. On review, the issues are compensability of the surgery, premature claim closure, extent of unscheduled disability and remand.

Claimant moves to remand for the receipt of surgery reports and progress reports after the surgery. We consider the reports solely for the purpose of deciding the motion to remand.

The Referee's conclusion that the then proposed surgery was not reasonable and necessary was based, in part, on the fact that "the myelogram and MRI did not show any nerve compromise at the L4-5 and L5-S1 level." The reports submitted by claimant as appendices to his Motion to Remand dated February 15, 1989 and his letter of March 15, 1989 indicate that a disc protrusion was causing claimant's pain. These reports were not available or obtainable at the time of hearing because they are based on surgical findings and the surgery was not performed until after the record closed before the Referee.

We conclude that the proferred evidence was not obtainable at the time of hearing and is reasonably likely to affect the outcome of the case. See, Cain v. Woolley Enterprises, 301 Or 650, 654 (1986). Accordingly, we remand this case to the Presiding Referee to assign to a Referee to admit the evidence proferred by claimant with his motion for remand and his letter of March 15, 1989. The assigned Referee shall then determine whether this evidence changes the conclusions reached in Referee Nichols' order. The assigned Referee shall then issue an Order on Remand which shall be forwarded to the Board along with the entire record within 30 days of admission of the proferred evidence. The Board retains jurisdiction of this case. When the Order on Remand has issued and the case is returned to the Board, the Board will establish a new briefing schedule for the parties.

We have previously denied a motion to consolidate this case with WCB Case 89-00841; however, upon review of this case and a preliminary review of WCB Case 89-00841, we have determined that the issues in these cases are so intertwined that in the interests of substantial justice and administrative efficiency, the two cases should be reviewed together. Consequently, once this case is returned to us, it will be reviewed together with WCB Case 89-00841.

IT IS SO ORDERED.

February 21, 1990 Cite as 42 Van Natta 373 (1990)

In the Matter of the Compensation of
JAVIER MENDOZA (Deceased), Claimant
WCB Case No. 88-06734
ORDER ON REVIEW
Malagon & Moore, Claimant Attorneys
Norman Cole (Saif), Defense Attorney

Reviewed by Board Members Nichols and Brittingham.

The SAIF Corporation requests review of the portion of Referee Podnar's order that set aside its denial of death benefits for the deceased worker's cohabitant and the cohabitant's child. On review, the issue is entitlement to death benefits. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the findings of the Referee with the following changes and additions.

The deceased did not voluntarily assume the obligations of support nor did he hold himself out to all segments of society as standing in the place of a parent.

CONCLUSIONS OF LAW AND OPINION

We adopt the ARGUMENT and CONCLUSIONS portions of the Referee's order that dealt with entitlement to benefits for the cohabitant, Annette Mell. We reverse the portions of the order concerning the entitlement to benefits for the cohabitant's child, Katie Mell.

The burden of proof to show entitlement to benefits lies with the party seeking to receive those benefits. Annette Mell is seeking to obtain the benefits in behalf of Katie. We find Ms. Mell has failed to carry this burden.

The Referee found that the deceased worker stood in loco parentis to Katie and also provided her with substantial support, thus qualifying her for benefits under ORS 656.204(2) and 656.005(5). The benefits would be paid to Katie's mother as part of her award under ORS 656.204(2) only if Katie qualifies as a child of the deceased at the time of his death. ORS 656.005(5) defines "child" as used in this chapter. Katie is not a stepchild because her mother did not marry the deceased. We find she can qualify only if the deceased stood in loco parentis to her.

A person is said to stand in loco parentis when the obligations of parenthood have been voluntarily assumed and discharged. The deceased did not voluntarily assume the obligation of support nor did he hold himself out to all segments of society as standing in the place of a parent.

Katie has a natural father who pays support. Her mother applied for and received public financial assistance from ADC on behalf of Katie. Not until August 1987, when Ms. Mell reapplied for benefits, did she inform ADC that Mr. Mendoza was living with her or that he was contributing toward the support of the family. Based on these facts, we do not conclude that the deceased worker stood in loco parentis to Katie. Therefore, we reverse that portion of the order allowing death benefits on Katie's behalf.

ORDER

The Referee's order dated August 31, 1988 is affirmed in part and reversed in part. The portion of the order that set aside the denial of death benefits for Katie Mell is reversed. That portion of the denial is reinstated and upheld. The remainder of the order is affirmed. Because compensation awarded to the cohabitant was not disallowed or reduced on the SAIF Corporation's request for review, claimant's attorney is awarded an assessed fee of $800 for services on review concerning this issue, to be paid by SAIF.

In the Matter of the Compensation of
BARBARA J. PETERSON, Claimant, and
In the Matter of the Complying Status of
Larry L. Ashley, and Karen E. Blanchard, dba,
LARRY'S RESTAURANT AND LOUNGE, INC, Noncomplying Employer
WCB Case Nos. 86-18052 & 86-17465
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Enfield & Guimond, Attorneys
Thomas Sheridan (Saif), Defense Attorney
Annala, et al, Attorneys

Reviewed by Board Members Nichols and Brittingham.

Karen Blanchard, an alleged officer of Larry's Restaurant and Lounge, Inc., the allegedly noncomplying employer, requests review of the portion of Referee Bennett's order that found the employer to be noncomplying. Blanchard's sole contention on review is that she is not individually liable for the costs of claimant's claim. The issue on review is coverage.

We affirm and adopt the Referee's order with the following comment.

The employer requested a hearing on two issues: (1) whether the employer was noncomplying; and (2) whether claimant suffered a compensable injury while in its employ. No other issues were raised for hearing. At hearing the employer withdrew the compensability issue, leaving its complying status as the sole issue at hearing. Ms. Blanchard's individual liability for claim costs under ORS 656.735(4), which places liability on the officers and directors jointly and severally when the noncomplying employer is a corporation, was never raised as an issue before the Referee. Consequently, we decline to consider that issue at this late date. See Mavis v. SAIF, 45 Or App 1059 (1980); Linda D. Simpson, 40 Van Natta 958 (1988).

ORDER

The Referee's order dated May 31, 1988, is affirmed. Claimant's attorney is awarded an assessed fee of $500, to be paid by the SAIF Corporation as processing agent for the noncomplying employer.

February 21, 1990 Cite as 42 Van Natta 375 (1990)

In the Matter of the Compensation of
WENDY REYES, Claimant
WCB Case No. 88-08236
ORDER ON REVIEW
Peter E. Baer, Claimant Attorney
Williams, et al, Defense Attorneys

Reviewed by Board Members Gerner and Myers.

Claimant requests review of that portion of Referee Peterson's order which upheld the self-insured employer's denial of claimant's viral meningitis condition. In its brief, the employer contends that claimant failed to establish good cause for her untimely hearing request. On review, the issues are timeliness and compensability. Because we find that claimant did not have good cause for her untimely hearing request, we dismiss.

FINDINGS OF FACT

Claimant is a truck driver, who injured her right shoulder on April 27, 1987. The claim was subsequently accepted. Thereafter, claimant experienced increased shoulder and neck pain.

On January 15, 1988, Dr. Hoppock, M.D., emergency room physician, conducted a series of tests which reflected viral meningitis. Dr. Ralston, another emergency room doctor, was also present for the initial examination.

On February 8, 1988, the employer denied that claimant's viral meningitis condition was related to her April 27, 1987 right shoulder injury. Claimant received the denial on February 10, 1988. At first she was going to throw it away because she was tired, instead claimant put it in a drawer. At the time of the

denial, claimant was sick and depressed. She had no financial resources and remained in her house, trying to recover her health.

Dr. Worthington, Ph.D., clinical psychologist, and Diane Stewart Worthington, mental health therapist, first examined claimant on April 27, 1988. Thereafter, on May 18, 1988, they reported that claimant had experienced anxiety attacks, depersonalization, and out of body phenomena. (Ex. 41-2).

Claimant filed her Request for Hearing on May 17, 1988.

CONCLUSIONS OF LAW AND OPINION

The Referee proceeded to the merits of the claim, reasoning that the claim was not compensable even if claimant could establish "good cause". We agree that the claim is not compensable. However, we conclude that claimant has not shown good cause for her untimely hearing request, and thus decide the case primarily on that issue.

A hearing request must be filed within 60 days after claimant is notified of a denial. ORS 656.319(1)(a). A request filed after 60 days but not more than 180 days after notification of denial is valid if the claimant establishes that she had "good cause". The test for determining if good cause exists has been equated to the standard of "mistake, inadvertence, surprise or excusable neglect" recognized 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 to establish good cause for failure to file timely. Hempel v. SAIF, 100 Or App 68 (1990).

Claimant asserts that she was mentally disabled during the 60 day time limit for requesting a hearing. When claimant reviewed the denial on February 10, 1988, she had been exhausted and depressed. Claimant signed for the denial and then set it aside. Around the beginning of March 1988, she read the top portion of the denial. (Tr. 29). During this period claimant spent most of the time in bed, however she did go to her chiropractor twice a week, and was in constant contact with her rehabilitation counselor. Id.

On April 22, 1988, claimant met with an attorney. During her first meeting with her attorney, claimant asked about the need to talk to a psychologist. (Tr. 26). Thereafter, she was sent to Dr. Worthington for a psychological evaluation.

On April 27, 1988, Dr. Worthington opined that claimant was suffering from major depression and accompanying acute anxiety. He indicated that, "Further vocational pressures at this time would only lead to an exacerbation in her condition...". (Ex. 39) (Emphasis added). On May 18, 1988, Dr. Worthington, and Ms. Worthington opined that claimant was totally disabled by her psychological condition and was unable to participate in vocational rehabilitation until she has sought further help.

There is little objective evidence of depression during the 60 day period, following the February 8, 1988 denial. On February 23, 1988, a Western States Chiropractic chart record indicated that claimant was suffering from much less stress in her personal life. (Ex. 4). Likewise, during this period claimant was making contacts with employers and reporting the results of these contacts to her vocational counselor. She also went to see her chiropractor consistently from January through April, 1988. (Tr. 30).

These circumstances persuade us that claimant was capable of conducting her vocational and medical affairs. They do not establish mistake, inadvertence, surprise or excusable neglect for claimant's late filing of the hearing

request. Consequently, we hold that claimant has not proven good cause for her failure to timely file her request for hearing.

Accordingly, claimant's hearing request is dismissed.

Alternatively, we agree with the Referee that claimant's viral meningitis condition was not compensable.

Claimant has the burden of proving her contentions by a preponderance of the evidence. Hutcheson v. Weyerhaeuser, 288 Or 51 (1979). The issue of whether claimant's need for medical services is causally related to the April, 1987 compensable injury is a complex medical question. Thus, while 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).

Dr. Hoppock, M.D., emergency room doctor, opined that claimant's shoulder injury, "...could certainly have been a contributing factor in her developing meningitis, in that infections (viral or bacterial) are more likely to cause clinically significant disease in patients who are debilitated from concurrent or precedent illness." (Ex. 44-1,2). Claimant's physician need not use magic words to prove a casual relationship between the compensable injury and claimant's current condition. McClendon v. Nabisco Brands, 77 Or App 412 (1986). However, claimant must prove more than just the possibility of a causal connection. Gormley v. SAIF, 52 Or App 1055 (1981). Hence, Dr. Hoppock's medical opinion does not satisfy claimant's burden of proof.

Moreover, Dr. Ralston, M.D., emergency room doctor, opined that there was no correlation between claimant's past shoulder injury and the development of viral meningitis.

Inasmuch as claimant has failed to meet her burden to establish by a preponderance of the evidence that her compensable shoulder condition was a material cause of the viral meningitis condition, we do not find the viral meningitis condition to be compensable.

ORDER

The Referee's order, dated June 24 1988, is reversed. The claimant's hearing request is dismissed. The Board approves a client-paid fee, payable from the employer to its counsel, not to exceed $1,500.25.

February 21, 1990 Cite as 42 Van Natta 377 (1990)

In the Matter of the Compensation of
CLEO RIGGS, Claimant
WCB Case No. TP-89037
THIRD PARTY DISTRIBUTION ORDER
Cummins, et al, Attorneys
Pozzi, et al, Attorneys

The paying agency has petitioned the Board for resolution of a conflict concerning the "just and proper" distribution of proceeds from a third party settlement. See ORS 656.593(3). We conclude that the paying agency has established a portion of its asserted lien for current and future claim expenditures.

FINDINGS OF FACT

In 1986 claimant filed a claim for an asbestos-related disease of pleural plaques. In April 1987 the paying agency's denial of the claim was set

aside by Referee's order. Thereafter, the agency has provided compensation for the claim.

Claimant engaged legal counsel to explore the possibility of bringing suit against several third parties for his disease. With the paying agency's approval, a settlement of claimant's cause of action was achieved. The settlement was in excess of $100,000.

Dr. Patterson, claimant's treating pulmonologist, has provided a diagnosis of severe and extensive calcific pleural plaques consistent with asbestos exposure. As a result of this compensable condition, claimant experiences chest pain in the upper anterior chest of burning and minimally pleuritic quality, with some shortness of breath upon exertion. Treatment for this condition has been conservative, primarily consisting of prescribed medication. Noting claimant's repeated use of some of his pain medication, Dr. Patterson has recommended the reduction and/or avoidance of these prescriptions. Following claimant's most recent examination (May 1989), Patterson was encouraged by claimant's avoidance of Percodan.

In Dr. Patterson's opinion, claimant's condition will remain relatively stable, with perhaps gradual progression. Patterson does not anticipate that claimant's disease will ever be of such severity as to make him any more limited or to increase his pain and discomfort beyond its current level.

Claimant has a life-expectancy of 12 years. He will require two chest x-rays per year and routine examinations every three to four months. Neither radical treatment nor surgery is foreseen. Considering the x-rays and examinations, Dr. Patterson estimates annual medical expenses between $500 and $750.

In the approximately three years since the inception of the claim, the paying agency has incurred $973.31 in prescription expenses. Most of these charges occurred in 1988, while claimant resided in Texas and was not under Dr. Patterson's care. Upon his 1989 return to Oregon and Dr. Patterson, claimant's intake of prescribed medication has stabilized.

The paying agency has incurred $6,400 in permanent disability payments and $2,305.61 in medical costs. The disability compensation is not disputed. However, $350.28 of the medical bills are contested. These expenses consist of the following items: (1) $120 bill from Dr. Edwards, of the University of Oregon Health Sciences Center; (2) $14 bill from the University Radiologists for x-rays; (3) $120 bill from the University Hospital; (4) $95 bill from Dr. Patterson for a narrative report; and (5) $1.28 for a late charge on a pharmacy bill. Asserting that none of these items pertained to the treatment of claimant's compensable condition, claimant contends that they are not lienable.

Concerning claimant's need for future medical services, the paying agency predicts that it will incur annual expenses of $750 for medical bills and $1,200 for prescriptions. Considering claimant's 12-year life expectancy, the agency contends that reserves of $9,000 for medical expenses and $14,400 for prescribed medications are reasonable. Claimant objects to these figures, arguing that the paying agency has over-estimated these future claim costs.

CONCLUSIONS OF LAW

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).

Here, the paying agency has asserted its entitlement to $8,705.61 in actual claim costs. These expenses are composed of $6,400 in permanent disability payments and $2,305.61 in medical bills. Claimant does not argue that the agency is entitled to recover the permanent disability benefits and $1,955.33 in medical bills. However, the remaining $350.28 in medical charges are in dispute.

Specifically, claimant contends that the medical charges resulting from his examination by Dr. Edwards from the Oregon Health Sciences University hospital are not lienable because they were not incurred as treatment for his condition. Instead, claimant submits that these charges were incurred as a result of an independent medical examination.

We have previously held that claim evaluation reports are analogous to litigation reports and, as such, not properly includable in a paying agency's lien against a third party recovery. Carolyn J. Gant, 39 Van Natta 471 (1987); Darrell L. Rambeau, 37 Van Natta 144 (1986); Shawn Cutsforth, 35 Van Natta 515, 517 (1983). Here, in effect, claimant has contended that Dr. Edwards' examination, tests, and resulting report to the paying agency constitute just such an unlienable cost.

In response to claimant's contention, the paying agency asserts that Dr. Patterson, claimant's treating pulmonologist, recommended routine examinations to monitor the progression of claimant's condition and that Dr. Edwards' examination was one of those procedures. Yet, other than an affidavit from its claims representative stating that the amount of its lien is "true and correct", the paying agency offers no evidence to support its characterization of Dr. Edwards' examination. Under such circumstances, we conclude that the paying agency has failed to establish that Dr. Edwards' examination ($120), the radiology bill ($14), and the hospital bill ($120) are expenditures for "compensation, first aid or other medical, surgical or hospital service." See ORS 656.593(1). Consequently, these bills are not recoverable portions of the paying agency's lien.

The aforementioned analysis is equally applicable to a $95 bill from Dr. Patterson for preparing a report concerning claimant's future need for medical treatment and medication. In addition, a $1.28 late charge on a medical bill is similarly not recoverable because it is not an expense for compensation, first aid or other medical, surgical or hospital service. See ORS 656.593(1).

In conclusion, we hold that the paying agency is entitled to $8,355.33 of the remaining balance of the settlement proceeds as reimbursement for its actual lienable claim costs. This sum is composed of $6,400 in permanent disability benefits and $1,955.33 in medical expenses.

We next turn to the paying agency's lien for future claim costs. To support its lien for anticipated future expenditures, the paying agency must establish that it is reasonably certain to incur such expenditures. Donald P. Bond, 40 Van Natta 361, 480 (1988); Leonard Henderson, 40 Van Natta 31 (1988).

The paying agency projects that claimant will require $750 in annual medical expenses for routine examinations and chest x-rays. Based on claimant's

life-expectancy of 12 years, the agency forecasts a $9,000 lien for future medical costs. It bases this assessment on Dr. Patterson's estimate that claimant's yearly bills for such services will be between $500 and $750. Citing inflationary concerns, the paying agency has chosen the highest range of Dr. Patterson's estimate.

Other than the previously mentioned statement in the affidavit from its claims representative, the paying agency has neither provided evidence supporting its inflationary concerns nor has it submitted an estimate of the present value of such future medical expenditures. See ORS 656.593(3), (1)(c). We consider the contents of the affidavit insufficient to support the paying agency's contention that yearly medical expense figure of $750 is reasonable, particularly in light of Dr. Patterson's conclusions and the history of the claim.

During the approximately three years of this claim, claimant has incurred yearly medical expenses, excluding prescriptions, of $327.34. ($1,955.33 (lienable medical costs) - $973.31 (prescriptions for first 3 years) = $982.02; $982.02 / 3 = $327.34). At first blush, such an average suggests that the low range of Dr. Patterson's projection should provide a reasonable annual figure for such costs. However, Patterson has also expressed the opinion that claimant has "extensive calcific pleural plaques", which is "more severe than one usually sees." Due to this severe plaquing, Dr. Patterson recommends two chest x-rays and between three and four routine examinations per year.

Considering Dr. Patterson's estimate in light of the relative severity of claimant's condition, the need for periodic testing and examinations, and claimant's past medical expenses, we find that a reasonable figure for annual medical expenditures would be $625. When this figure is multiplied by claimant's 12-year life expectancy, a total of $7,500 is created. Based on the foregoing reasoning, we conclude that the paying agency has established, to a reasonable certainty, that it is entitled to $7,500 of the remaining balance of settlement proceeds as its lien for reasonably to be expected future medical expenditures.

Finally, the paying agency has projected that it will incur annual expenses for claimant's prescription medication totalling $1,200. Multiplying this figure by claimant's 12-year life expectancy, the agency asserts a lien totalling $14,400 for such costs.

The basis for the paying agency's estimation is claimant's use of at least four medications and Dr. Patterson's recommendation that claimant's use of such medication should be reduced. Noting that at least one of the drugs that claimant is presently taking (Percodan) is addictive, the agency contends that "it appears not unduly pessimistic to expect the claimant to be on medication of a extensive character for the rest of his life."

Dr. Patterson does not share the paying agency's pessimistic forecast concerning claimant's future condition and medication intake. Patterson has acknowledged that he is encouraging claimant to refrain from using pain medication "insofar as possible." However, Patterson opined that "there is good reason to believe that [claimant's] condition will remain relatively stable, perhaps gradually progressive." Moreover, despite the severity of claimant's condition and the possibility of its progression, Dr. Patterson concluded that there was not "much reason to think he will have more pain and discomfort."

In the roughly three years since the inception of the claim, the paying agency has incurred $973.31 in medication expenses. Averaged over the three years of the claim, these costs result in a yearly expense of $324.44. It could be contended that claimant's prescription charges in the recent past suggest a higher annual figure in that most of these charges were incurred during

calendar year 1988. Yet, this 1988 increase in prescription charges coincided with claimant's brief move to Texas. Upon his 1989 return to Oregon and Dr. Patterson's care, claimant's use of medication again stabilized.

After considering Dr. Patterson's opinion and the aforementioned prescription billings, we are not persuaded that it is reasonably certain that the paying agency will incur $1,200 in annual expenditures for claimant's medication. Instead, in light of the history of claimant's billings and Patterson's prognosis, we conclude that it is reasonable certain that the paying agency will incur $324.44 in annual claim costs for claimant's medication. Combining this figure with claimant's 12-year life expectancy, results in a total of $3,893.28, which shall constitute the paying agency's lien for future prescription medication.

Accordingly, we hold that the following distribution of the remaining balance of the third party settlement proceeds is "just and proper." ORS 656.593(3). The paying agency shall receive a total of $19,748.61. This sum is composed of $8,355.33 for actual reimbursable claim costs, $7,500 for future medical expenses, and $3,893.28 for future prescription medication. The remainder of the settlement proceeds shall be distributed to claimant. ORS 656.593(3); 656.593(1)(d). Claimant's counsel is directed to distribute the aforementioned balance in accordance with this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
HAROLD D. WARD, Claimant
WCB Case Nos. 87-02884 & 87-02328
ORDER ON REVIEW
Malagon, et al, Claimant Attorneys
Cowling & Heysell, Defense Attorneys

Reviewed by Board Members Gerner and Myers.

The insurer requests review of those portions of Referee G. Peterson's order that: (1) found that a Determination Order prematurely closed claimant's low back injury claim; (2) awarded an assessed fee to claimant's attorney; and (3) declined to authorize its request for an offset of overpaid temporary disability benefits. Although claimant has not formally cross-requested review, in his respondent's brief he argues that, should the Board find that his psychological claim was not prematurely closed, the following issues should be addressed: (1) whether he sustained an aggravation of his psychological condition; (2) the extent of his unscheduled permanent disability; and (3) the assessment of a penalty and attorney fee for setting aside the Determination Order as premature. On review, the issues are premature claim closure, aggravation, extent of unscheduled permanent disability, offset, penalties and attorney fees. We reverse.

FINDINGS OF FACT

Claimant injured his low back on February 8, 1983. Subsequently, his complaints of pain spread to his shoulders, back and hips. Early medical doctors found claimant's complaints out of proportion to his physical findings and psychiatric care was initiated to assist claimant's recovery. Dr. Henderson, psychiatrist, began treating claimant in March 1984. He diagnosed depression and psychogenic pain disorder (somatoform pain disorder). He also noted that

claimant had an underlying personality disorder and a history of alcohol abuse. On May 25, 1985, claimant's claim was first closed by Determination Order which awarded 25 percent permanent disability. The claim was subsequently reopened by order of a referee effective July 15, 1985.

Claimant was evaluated by Drs. Turco and Smith for his psychiatric condition. Dr. Smith, M.D., evaluated claimant and his medical record on February 17, 1986. He found no depression evident on examination and diagnosed a mixed personality disorder which he opined was not related to the 1983 injury. Dr. Turco, psychiatrist, evaluated claimant on February 17, 1986. He diagnosed mixed personality disorder and chronic alcohol abuse. Turco opined that there were no psychiatric sequela from the industrial injury at the time of his evaluation and that claimant was psychologically stationary. On May 29, 1986, Dr. Holmes with the Western Pain Center, concurred with the reports of Drs. Turco and Smith that claimant's psychiatric condition was not related to the industrial injury and that claimant's difficulties stemmed from a preexisting personality disorder.

On October 29, 1986, Dr. Womack, M.D., declared claimant medically and psychologically stationary. Henderson did not believe that claimant was psychologically stationary. On January 30, 1987, a Determination Order closed claimant's claim with no additional award for permanent disability.

On February 4, 1987, the employer denied claimant's aggravation claim and asserted that claimant's condition had not worsened since the Determination Order. On February 9, 1987, Henderson declared that claimant would be unable to work for 90 days. On February 20, 1987, claimant's family doctor, Everett, authorized 3 months of leave from work.

The parties stipulated that claimant was entitled to temporary disability benefits from July 15, 1985 through December 4, 1986, the medically stationary date, and that the Determination Order should be modified accordingly. The parties also agreed that claimant received temporary disability after the medically stationary date until January 30, 1987.

Claimant suffers minimal permanent physical impairment and no permanent psychological impairment due to the compensable injury. Claimant is 43 years old, has a 10th grade education and his GED. Claimant has worked primarily in heavy labor occupations and has few transferable skills. Claimant has lost 25 percent of his pre-injury earning capacity as a result of the injury.

CONCLUSIONS OF LAW AND OPINION

Premature Closure

It is claimant's burden to prove, by a preponderance of the evidence, that he was not medically stationary at the time of the January 30, 1987 Determination Order. The resolution of the correct medically stationary date is a complex medical question, largely resolved by expert opinion. Harmon v. SAIF, 54 Or App 121 (1985). We do not consider post-closure changes in claimant's condition. Scheuning v. J. R. Simplot & Co., 84 Or App 622 (1987).

Here, the experts are divided on the question of whether claimant was medically stationary at the time of the January 30, 1987 Determination Order. In March 1986, Turco opined:

> "Please note that this [claimant] is medically stationary. There is no need for any further treatment, as far as one might relate to an aggravation of his injury. Continuation of treatment, in many respects, reinforces this man's dependency needs. He is, in my opinion, highly manipulative and the likelihood of his manipulating his psychiatrist at this time is quite high."

His opinion is buttressed by that of Dr. Womack. Womack examined claimant in October 1986, and reported that he was "medically stable" at that time. Henderson, on the other hand, reported on January 29, 1987, that claimant "had certainly not reached a medically stationary point."

We ordinarily give greater weight to the opinion of attending physicians because of their greater exposure to the claimant's condition compared with consulting physicians. Weiland v. SAIF, 64 Or App 810 (1983). However, here we find persuasive reasons not to do so. Henderson does not believe that claimant was medically stationary. However, the sense in which Henderson uses the term "medically stationary" is not the same as that contemplated by ORS 656.005(17):

> "Medically stationary means that no further material improvement would reasonably be expected from medical treatment, or the passage of time."

Henderson views claimant's psychological condition as one which fluctuates depending upon the type and duration of his other life stressors. (Ex. 126-10, -37). He opined that claimant was not medically stationary in January of 1987, just before the Determination Order, because "of his level of agitation" and because "vocational placement is critical in allowing him to reach a psychiatrically medically stationary point." (Ex. 120). By "medically stationary" Henderson apparently means either a lack of variation in one's medical condition or the lack of a need for vocational services.

Neither meaning is consistent with the statute. A worker whose medical condition fluctuates may still be medically stationary because of the continued availability of care pursuant to ORS 656.245. Maarefi v. SAIF, 69 Or App 527, 531 (1984). Likewise, a worker who continues to need vocational services may also be medically stationary. Indeed, a declaration of medically stationary status can trigger the start of vocational services, without disturbing the finding that the worker is medically stationary. ORS 656.340(1)(b)(B).

We are further unpersuaded by Henderson's opinion. While insisting that claimant is not medically stationary after January 1987 even until claimant's last visit in August 1987, he still notes that no material improvement has occurred during that period of time. (Ex. 126-42, -51). Despite this insistence there is no assertion or explanation why or how the passage of time will materially improve claimant's condition either before or after the closure. We are not persuaded by Henderson's conclusory opinion. Marshall v. Boise Cascade, 82 Or App 130, 133 (1986).

Instead, we agree with the opinions of Drs. Turco, Smith and Womack that claimant was psychologically stationary by the time of closure. Therefore, claimant has failed to show that his claim was prematurely closed.

Aggravation

To establish an aggravation, claimant must prove that his 1983 injury materially caused a worsening of his psychiatric condition since the last arrangement of compensation. ORS 656.273(1). Here, claimant has not established that his psychiatric condition worsened after the January 30, 1987, Determination Order.

While Henderson released claimant from work for 90 days on February 9, 1987 a doctor's release is only evidence of disability, it is not dispositive of disability. Botefur v. City of Creswell, 84 Or App 627 (1987). We are not persuaded that claimant's condition worsened after the date of the Determination Order so as to justify reopening of the claim. Other than the off work slips

from Henderson and Everett and their implication of worsening, no doctor states that claimant's condition even changed, let alone worsened after closure. Henderson was of the opinion that claimant was not medically stationary at closure, but never does he state that claimant's condition worsened after closure. Indeed, in his deposition he states that claimant's condition was unchanged after closure. (Ex 126-51). Everett's timeloss authorization is equally unexplained and was evidently given simply because claimant's attorney requested such a slip, not because Everett noted a worsened physical condition. (Ex. 127-20). Since neither doctor states that claimant's condition has worsened, and since no explanation for either the worsening or timeloss authorization is given, we discount both opinions. Marshall supra.

Since no other evidence establishes that claimant was less able to work after closure, as compared to the time of closure, we find that he has failed to prove entitlement to claim reopening for aggravation. Perry v. SAIF, 307 Or 654 (1989); Smith v. SAIF, 302 Or 396 (1986).

Unscheduled Permanent Disability

The test for obtaining an award of unscheduled permanent disability is the worker's permanent loss of earning capacity due to the compensable injury. ORS 656.214(5). The criteria for rating the extent of claimant's unscheduled permanent disability is the permanent loss of earning capacity due to the compensable injury. To determine claimant's permanent loss of earning capacity, we consider his physical impairment as reflected in the medical record, the testimony at hearing, and all of the relevant social and vocational factors set forth in 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 has minimal permanent physical impairment and no permanent mental impairment due to the compensable injury. (Exs. 101, 102). Claimant is 43 years old and has obtained a GED certificate. Claimant has few transferable skill and has worked primarily in heavy labor occupations.

After our de novo review of the record, we conclude that claimant has lost 25 percent of his pre-injury earning capacity. Claimant is therefore entitled to no additional award of unscheduled permanent disability.

Assessed Fee

The Referee awarded claimant's attorney an assessed attorney fee (i.e., payable by the insurer) for services at the hearing. We disagree.

At the hearing level, claimant prevailed on the issue of premature claim closure. Insofar as the Referee set aside the January 30, 1987 Determination Order, all other issues raised by claimant became moot. The appropriate fee awardable for prevailing on premature closure was an approved fee, payable out of claimant's increased compensation. Not an assessed fee. Earl F. Childers, 40 Van Natta 481 (1988); Susan K. Spratt, 34 Van Natta 1028 (1982).

We have found above, however, that claimant has not proven premature claim closure. Therefore, claimant is entitled to neither an approved nor an assessed attorney fee.

Offset

The insurer argues that it is entitled to an offset for overpaid temporary disability benefits from December 4, 1986, the medically stationary date, through the January 30, 1987, the date of the Determination Order. We agree.

It is well settled that, upon claim closure, the insurer is entitled to recover any temporary disability benefits paid beyond the date claimant's compensable condition became medically stationary. Julie A. Trujillo, 40 Van Natta 1892 (1988). Such is the case here. Claimant was medically stationary on December 4, 1986. Temporary disability benefits continued to be paid by the insurer up to the date of the Determination Order. The insurer is entitled to an offset for the temporary disability paid after December 4, 1986. Accordingly, we grant the insurer's request for an offset of its overpaid temporary disability benefits from December 4, 1986, through January 30, 1987.

Penalties and Attorney Fees

Claimant did not raise the issue of penalties and attorney fees at the hearing. Moreover, he raises it on review without any allegation of unreasonableness under ORS 656.262(10) to warrant the assessment of either a penalty or fee.

Under such circumstances, we decline to address the issue of penalties and attorney fees.

ORDER

The Referee's order dated August 7, 1988 is reversed. The Determination Order of January 30, 1987 is reinstated and affirmed. The Referee's award of an assessed fee is reversed. The employer is authorized to offset temporary disability payments made after December 4, 1986 until January 30, 1987 against future permanent disability. Claimant is allowed no relief sought. The Board approves a client-paid fee, payable from the employer to its attorney, not to exceed $526.

February 22, 1990 Cite as 42 Van Natta 385 (1990)

In the Matter of the Compensation of
EUGENE F. CLAMPITT, Claimant
WCB Case No. 88-03997
ORDER ON REVIEW
Brian R. Whitehead, Claimant Attorney
Terrall & Miller, Defense Attorneys

Reviewed by Board Members Gerner and Myers.

The self-insured employer requests review of that portion of Referee Tenenbaum's order which set aside its denial of claimant's aggravation claim for a neck and back condition. On review, the issue is aggravation. We reverse.

FINDINGS OF FACT

We adopt the facts contained in the first six paragraphs of the findings section of the Referee's order with the following supplementation.

Claimant began seeing Dr. Hudson on March 1, 1988. As a result, claimant was released from work until April 7, 1988 and referred to physical therapy. On March 11, 1988, the employer issued its denial of claimant's aggravation claim.

On April 5, 1988, the Orthopaedic Consultants performed an independent medical examination. The Consultants noted that claimant had received temporary disability compensation as a result of another claim for approximately one month in June and July 1987. The Consultants reported that the "entire examination

[was] characterized by severe evidence of functional disturbances, with both refusals and inconsistencies." Finding no objective evidence to substantiate claimant's complaints, the Consultants recommended claimant return to work without limitation.

On the same date as the Consultants' examination, Dr. Hudson was unable to state whether claimant's condition had worsened since the Determination Order. Dr. Hudson referred claimant to Dr. Wilson, an orthopedist. Questioning claimant's cooperation during his examination, Dr. Wilson found little objective evidence to support claimant's complaints.

On May 4, 1988, claimant was seen by Dr. Campbell, who reported that claimant requested pain medication and a release from work. Dr. Campbell released claimant from work until May 12, 1988. An MRI showed a straightening of the curve of the cervical spine and no evidence of disc protrusion or nerve root impingement.

On May 12, 1988 claimant changed treating physicians to Dr. Hansen, a chiropractor, who released him from work until May 19, 1988.

Dr. Wilson agreed with the findings and report of the Orthopaedic Consultants. Subsequently, both Dr. Hudson and Dr. Wilson concluded that claimant's complaints had no relationship to his industrial injury.

In June 1988, Dr. Hansen referred claimant to Dr. Lawton, a chiropractor, for a consultation. Claimant did not provide an accurate history of his injury and treatment to either Dr. Hansen or Dr. Lawton. Dr. Lawton was of the opinion that claimant was not medically stationary and that his current condition was consistent with his history of the injury. Dr. Hansen stated that claimant was undergoing an aggravation or exacerbation of the condition that had been brought on by his compensable injury.

FINDINGS OF ULTIMATE FACT

Claimant's current condition has not worsened since the last award or arrangement of compensation. Claimant's current condition is not related to the compensable injury.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant's compensable symptoms had flared to an extent sufficient to constitute an aggravation. We disagree.

To establish a compensable aggravation, claimant must show: (1) a compensable worsening of his upper back condition since the last arrangement of compensation by Determination Order issued October 1, 1987; and (2) a material relationship between the worsening and his compensable injury. ORS 656.273(1); 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.

The only medical opinions which support claimant's aggravation claim are provided by Drs. Lawton and Hansen. We find them unpersuasive for several reasons. To begin, claimant has testified that he did not provide either with an accurate history of his injury or treatment. Medical opinion that is not based on a complete and accurate history is less persuasive. See Moe v. Ceiling Systems, 44 Or App 429 (1980); Miller v. Granite Construction Co., 28 Or App 473, 476 (1977).

Furthermore, we note that claimant evidences a pattern of visiting physicians to obtain release from work and when the release ends, going on to a new physician and obtaining another release from work. He saw Dr. Martin, his original chiropractor, in February 1988. He was referred to a neurologist and no release from work was granted. Rather than following this referral, claimant returned to Dr. Martin.

Claimant was then seen by Dr. Hudson and released from work from March 1 until April 7. Claimant did not return to Dr. Hudson after April 7. On May 4, 1988, claimant obtained a release from work from Dr. Campbell until May 12, 1988. On May 12, 1988, he saw Dr. Hansen who released him from work until May 19, 1988.

Such a pattern supports the findings of the Orthopaedic Consultants, that claimant was malingering. Moreover, after conducting a comprehensive examination and review of claimant's medical history, the Consultants considered claimant's current complaints to be unrelated to his compensable injury and his condition to have remained stationary. These conclusions were further supported by the opinions of Drs. Hudson and Wilson.

We find the opinions of the Consultants and Drs. Hudson and Wilson to be better reasoned and thorough. Consequently, we find them persuasive. Somers v. SAIF, 77 Or App 259 (1986). Accordingly, claimant has failed to establish that, as a result of his compensable injury or its residuals, he has experienced a pathological or symptomatic exacerbation of his condition.

ORDER

The Referee's order dated September 15, 1988 is reversed. The self-insured employer's denial is reinstated and upheld. The Referee's attorney fee award of $1,500 is reversed. The Board approves a client-paid fee, not to exceed $1,166.50, payable by the self-insured employer to its counsel.

February 22, 1990 Cite as 42 Van Natta 387 (1990)

In the Matter of the Compensation of
JOSEPHINE M. GANTT, Claimant
WCB Case No. 87-14731
ORDER ON REVIEW
Durham, et al, Claimant Attorneys
Roberts, et al, Defense Attorneys

Reviewed by Board Members Brittingham and Crider.

The self-insured employer requests review of that portion of Referee Menashe's order that found a Determination Order prematurely closed claimant's knee injury claim. With its brief, the employer moves for remand for the introduction of a medical report not admitted at hearing. On review, the issues are remand, premature closure, and alternatively, aggravation or extent of permanent disability. We deny the motion and reverse.

FINDINGS OF FACT

Claimant, 54 years of age at hearing, has a Bachelor's Degree in Sociology. She worked as a social service caseworker from 1969 until she suffered a compensable injury to her left knee in June 1985. Dr. Puziss, orthopedist, performed surgery in January, 1986.

Claimant had additional physical symptoms and an emotional reaction to the surgery and its aftermath. Beginning in April, 1986, claimant was evaluated and treated at the Emanual Pain Center by Dr. Pierce, clinical psychologist, for a major depressive episode with generalized anxiety and panic attacks precipitated by the knee surgery. Upon claimant's February 27, 1987 discharge, Dr. Pierce recommended that she continue with psychological treatment for another six weeks. Following a May 5, 1987 reevaluation, Dr. Pierce found claimant still somewhat emotionally vulnerable. However, Dr. Pierce did not treat or see claimant after May 5, 1987.

On February 5, 1988, Dr. Pierce reported that she had neither seen nor treated claimant since May 5, 1987. (Ex. 48DD) Referring to a May 1987 "Final Report", which was otherwise not in the record, Dr. Pierce reiterated a July 29, 1987 recommendation to claimant that no further treatment was needed. (Id.) Dr. Pierce had advised claimant that "she didn't feel there was anything she could do for me." (Tr. 63)

A September 2, 1987 Determination Order found claimant medically stationary as of June 17, 1987 and awarded 20 percent unscheduled permanent disability and 15 percent scheduled permanent disability for loss of use of the left leg.

On September 15, 1987, Dr. Anderson, neurologist, reported that, due to increased and continued pain flareups, claimant found herself "essentially completely incapacitated as regards looking for work." (Ex. 42)

On January 4, 1988, the employer denied claimant's aggravation claim.

In November, 1987, claimant began treating with Dr. Lee. Thereafter, both her physical and psychological condition improved greatly. She is again able to concentrate and organize her work. Her knee pain is reduced.

FINDINGS OF ULTIMATE FACT

The record has not been improperly, incompletely, or otherwise insufficiently developed.

On September 2, 1987, the date of claim closure, no further material improvement of claimant's condition would reasonably be expected from medical treatment or the passage of time.

Claimant's condition did not worsen between claim closure and hearing.

Claimant has suffered a 15 percent permanent loss of use of her left leg (knee) due to her compensable injury.

Claimant has suffered a 20 percent permanent loss of earning capacity due to her compensable injury.

CONCLUSIONS OF LAW AND OPINION

The Referee reasoned that the record was insufficient to support a conclusion that claimant's mental condition was stationary at claim closure. Accordingly, he found that the case had been closed prematurely. He further denied the employer's motion to reopen the record for admission of Dr. Pierce's May 5, 1987 report because the employer failed to explain why the document was not produced at the March 3, 1988 hearing. The Referee did not reach the issues of aggravation or, alternatively, the extent of the disability, because he had found the case prematurely closed.

Remand

Renewing its argument that the aforementioned report should be admitted into the record, the employer moves 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); Bernard L. Osborn, 37 Van Natta 1054, 1055 (1985), aff'd mem, 80 Or App 152 (1986).

In this case, the report was generated May 5, 1987 and the hearing was held March 3, 1988, almost 10 months later. No explanation is offered as to why the report was not discovered and produced in ten months, so no finding of due diligence is possible. Moreover, we consider the record, without the report, to be sufficiently developed. Consequently, we deny the motion to remand.

Premature Closure

A worker is medically stationary only if she is stationary considering both injury-related physical and injury-related mental conditions. Rogers v. Tri-Met, 75 Or App 470 (1985). It is undisputed that claimant was physically stationary at the Determination Order's closure date. The question is whether claimant was psychologically stationary at that time.

The Referee refused to rely on the Orthopaedic Consultants' June 17, 1987 report--which describes claimant as "medically stationary" (Ex 38-5)--because he found it did not assess claimant's mental state. He further reasoned that Dr. Pierce, the treating psychologist, did not issue a closing report. Based on these two factors, he found the record insufficient to support a conclusion that claimant's mental condition was stationary on September 2, 1987. Accordingly, he held that the claim was prematurely closed. We disagree.

It is claimant's burden to prove that her claim was prematurely closed. Austin v. SAIF, 48 Or App 7 (1980) The propriety of the closure turns on whether claimant was medically stationary at the time of the September 2, 1987 Determination Order considering claimant's condition at the time of closure and not as it develops subsequently. Sullivan v. Argonaut Ins. Co., 73 Or App 694 (1985); Alvarez v. GAB Business Services, 72 Or App 524 (1985). "Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17).

We note that Dr. Pierce's letter of February 2, 1988 (Ex. 48DD), refers to her May 5, 1987 "Final Report," suggesting its existence before closure, despite the fact it is absent from the record. We also note Dr. Pierce's description, in the same February 1988 letter, of a July 1987 telephone conversation with claimant, wherein she reiterated her "previous recommendations" and stated that she had not treated claimant since May 5. Based on this evidence, we conclude that claimant's treating psychologist did not expect improvement in claimant's psychological condition as of May 5, 1987.

This finding is further corroborated by claimant's admission that she did talk to Dr. Pierce on the telephone and that Dr. Pierce told her at that time there was nothing (more) she could do for her. (Tr. 63). Based on the foregoing, we find that claimant has not met her burden of proving that her psychological condition was not medically stationary at the time of claim closure. Consequently, her claim was not prematurely closed and we reverse.

Aggravation

In order to establish an aggravation, claimant must prove a worsened condition resulting from the compensable condition. ORS 656.273(1); Perry v. SAIF, 307 Or 654 (1989). We consider first claimant's scheduled condition, then her unscheduled condition.

To prove a worsening of a scheduled body part, claimant must show that she is more disabled, i.e., has sustained increased loss of use or function of that body part, either temporarily or permanently, since the last arrangement of compensation. International Paper Co. v. Turner, 304 Or 354 (1988). In those cases in which the last award or arrangement of unscheduled permanent partial disability compensation anticipated future exacerbations, accompanied by a diminished earning capacity, the claimant must also prove that her earning capacity was diminished longer or in greater degree than was anticipated, or that her exacerbation resulted in 14 consecutive days of total disability or inpatient hospitalization. Edward D. Lucas, 41 Van Natta 2272 (1989).

Claimant's last arrangement of compensation was the September 2, 1987 Determination Order, which awarded her 15 percent loss of use of her left leg.

Since the September 2, 1987 Determination Order, claimant began a physical therapy program which included exercise. No restrictions have been placed on her physical activity. No evidence indicates that claimant has experienced increased loss of use or function of her left leg. Accordingly, we find that claimant has not sustained a compensable aggravation of her left leg condition.

To establish a compensable aggravation of her unscheduled condition, claimant must prove that: (1) her condition has worsened since the last award of compensation, so that she is more disabled, either temporarily or permanently; and (2) her compensable injury was a material contributing cause of the worsened condition. ORS 656.273(1); Grable v. Weyerhaeuser Company, 291 Or 387, 400-01 (1981); Smith v. SAIF, 302 Or 396, 399 (1986). If the claim involves an unscheduled body part, "more disabled" means increased loss of earning capacity. See Smith v. SAIF, supra.

Claimant's last award or arrangement of compensation was the September 1987 Determination Order, which awarded her 20 percent unscheduled permanent partial disability. At the time of claim closure, the Orthopaedic Consultants diagnosed claimant as suffering from a psychogenic pain disorder. This is the basis for the unscheduled permanent disability award.

Between the September, 1987 Determination Order and the hearing, the only evidence suggesting worsening is Dr. Anderson's September 22, 1987 conclusory report. In response to the Determination Order, he asserted: "Unfortunately, with these increased and continued symptoms of flareups of pain, she finds herself essentially completely incapacitated as regards looking for work." (Ex. 42) There is no indication that Dr. Anderson was addressing a psychological as opposed to physical condition. Moreover, claimant herself indicates her psychological condition did not change from the time she entered the pain center before the Determination Order and when she began improving thereafter. (Tr. 49-50).

Moreover, a subsequent thorough evaluation by Dr. Worthington, psychologist, indicates that claimant's psychological condition improved rather than worsened after claim closure. (Ex 49-4) Inasmuch as we are not persuaded by Dr. Anderson's opinion that claimant's psychological condition worsened, we conclude that claimant has not demonstrated an exacerbation of that condition or a diminishment in her earning capacity.

Consequently, we further conclude that claimant has not established a compensable aggravation claim.

Extent of Permanent Disability

The extent of claimant's scheduled permanent partial disability is measured by the permanent loss of use or function of the injured member due to the industrial injury. ORS 656.214(2). In determining loss of use or function, we consider the medical and lay evidence in light of the rules set forth in former OAR 436-30-330, et seq.

Based upon the minimal permanent impairment to claimant's left knee, we conclude that the 15 percent scheduled permanent disability award previously granted claimant adequately and appropriately compensates her for the loss of use of her left leg due to her compensable injury. In reaching this conclusion, we rely upon the well-reasoned opinion offered by the Orthopaedic Consultants.

The extent of claimant's unscheduled permanent disability is measured by the permanent loss of earning capacity attributable to her compensable injury. ORS 656.214(5). Disability is rated at the time of hearing. See Gettman v. SAIF, 289 Or 609, 614 (1980).

In determining loss of earning capacity, we consider medical and lay evidence of her permanent impairment resulting from the compensable injury and all of the relevant social and vocational factors set forth in former OAR 436-30-380 et seq. We apply these rules as guidelines, not as restrictive mechanical formulas. See Harwell v. Argonaut Insurance Co., 296 Or 505, 510 (1984).

Based upon claimant's minimal psychological impairment at that time, and considering the aforementioned guidelines, we conclude that the 20 percent (64 degrees) unscheduled permanent disability award previously granted claimant adequately and appropriately compensates her for the loss of earning capacity due to her psychological residuals from the compensable injury.

ORDER

The Referee's order dated March 30, 1988, as republished April 29, 1988, is reversed. The September 2, 1987 Determination Order is reinstated and affirmed. The employer's denial of claimant's aggravation claim is upheld. A client-paid fee, payable from the self-insured employer to its counsel, is approved, not to exceed $1,528.

February 22, 1990 Cite as 42 Van Natta 391 (1990)

In the Matter of the Compensation of
LEE R. HANCOCK, JR., Claimant
WCB Case No. 87-00333
ORDER ON REVIEW
Rasmussen, et al, Claimant Attorneys
Schwabe, et al, Defense Attorneys

Reviewed by Board Members Gerner and Myers.

Claimant requests review of those portions of Referee Leahy's order which: (1) upheld the self-insured employer's partial denial of claimant's right shoulder condition; (2) upheld the employer's denial of the same condition as a new occupational disease; and (3) declined to assess penalties and attorney fees for delay in claims processing. The employer cross-requests review of that

portion of the Referee's order that declined to find that an "aggravation" claim had not been timely filed before the expiration of claimant's aggravation rights. On review, the issues are compensability of claimant's right shoulder condition, aggravation claim, penalties and attorney fees. We affirm.

FINDINGS OF FACT

Claimant has a preexisting right shoulder condition. In spring 1961, claimant sustained a noncompensable right shoulder injury. Claimant had continuing problems and stiffness after this injury which has been variously diagnosed as frozen shoulder syndrome, arthritis and bursitis.

On October 29, 1980, claimant sustained a compensable injury involving his ribs, back and left lung when he jumped from a runaway vehicle. Claimant experienced increased discomfort in his right shoulder after this injury for about a year. Claimant received medical services for this injury and lost time from work. His claim was closed by Determination Order dated July 7, 1981 which awarded 20 percent unscheduled permanent disability.

Claimant returned to work with the employer as an equipment driver in activities that involved the use of his right arm. Claimant found some of these jobs caused him pain in his right shoulder. After his work injury, and until 1984, claimant engaged in ranching activities that involved the use of his right arm and shoulder. In mid-1986 claimant's right shoulder pain increased and he sought additional medical care from Dr. Zimmerman, M.D., who recommended right shoulder arthrodesis.

On June 13, 1986, Zimmerman wrote to the employer. The employer received notice of the aggravation claim on September 2, 1986. The employer denied claimant's right shoulder condition on November 12, 1986 and did not pay any interim temporary disability benefits.

Claimant's aggravation rights ended on July 7, 1986.

FINDINGS OF ULTIMATE FACT

Claimant's aggravation claim was not filed within 5 years of his first claim determination.

Claimant's accepted 1981 injury is not a material contributing cause of his right shoulder condition.

Claimant's work for the employer is not the major cause of a pathological worsening of claimant's preexisting right shoulder condition.

The employer did not unreasonably delay or refuse to pay interim compensation benefits pending acceptance or denial of the aggravation claim.

CONCLUSIONS OF LAW AND OPINION

Timely Filing of the Aggravation Claim

To perfect an aggravation claim, claimant must file his claim within five years of the first determination. Former ORS 656.273(4)(a). Filing means receipt by the self-insured employer. Barr v. EBI Companies, 88 Or App 132 (1987). In this case we find that claimant has failed to prove receipt by the employer within the five year limitation. No evidence in this record establishes when claimant's doctor's June 1986 letter was first received by the employer. This information is necessary to establish a valid aggravation claim.

Dale C. Hurley, 39 Van Natta 790 (1987). Therefore, claimant has failed to prove timely filing of the aggravation claim.

The Right Shoulder Condition as a Result of the 1980 Injury

Claimant has the burden of proving that his current right shoulder condition is caused, in material part, by the originally accepted 1980 injury. Grable v. Weyerhaeuser Co., 291 Or 387 (1981). Because claimant's right shoulder condition presents multiple diagnoses, and because claimant has a preexisting right shoulder condition, we view this as a complex medical question requiring expert medical opinion for resolution. Kassahn v. Publishers Paper Co., 76 Or App 105 (1985).

Here, two medical doctors express opinions on causation. Dr. Bomengen, claimant's family doctor, diagnoses claimant's condition as "bursitis". He feels a combination of timber falling and his 1980 injury led him to have surgery. We are not persuaded by Bomengen's opinion. His opinion is conclusory and without explanation. Marshall v. Boise Cascade, 82 Or App 130, 133 (1986). His history of claimant being a "timber faller" is not accurate. (Ex. 56). Miller v. Granite Construction Co., 28 Or App 473 (1977). Moreover, Bomengen does not explain his complete reversal of opinion that he believed claimant's right shoulder condition was unrelated to the 1980 injury. (Ex. 18). Kelso v. City of Salem, 87 Or App 630 (1987). Therefore, we give Bomengen's opinion no weight.

Dr. Zimmerman is also of the opinion that the 1980 injury accelerated or contributed to his right shoulder arthritis. (Ex. 55A). However, Zimmerman's opinion is based exclusively on claimant's history to him. That history is wrong. Claimant continued to have problems with his right shoulder after his 1961 injury. Zimmerman's history indicates that claimant's problems from that injury completely resolved within three months. We find this historical error undermines Zimmerman's opinión. In addition, Zimmerman acknowledged that he had no prior medical records to review before reaching his conclusions. We view his history as incomplete. Therefore, we give Zimmerman's opinion no weight. Miller, supra.

No other medical opinion discusses claimant's current right shoulder condition in relationship to the 1980 injury. However, on two occasions claimant has undergone independent medical examinations with the Southern Oregon Medical Consultants, in April 1981 and February 1982. On both occasions the Consultants diagnosed preexisting right frozen shoulder unrelated to the 1980 injury. There is no indication that claimant's current condition is anything but a continuation of the same condition that was examined by the Consultants. They had an accurate history and performed an examination of claimant twice. We are persuaded by their opinions. Therefore, we conclude that claimant's current right shoulder condition is not related to the 1980 injury.

The Right Shoulder Condition as a New Occupational Disease

Claimant has the burden of establishing that work exposure, when compared to off work exposure, is the major contributing cause of a worsening of claimant's preexisting right shoulder condition. Weller v. Union Carbide, 288 Or 27, 35 (1979). Claimant did perform off work activities that involved the strenuous use of his right shoulder. No doctor made any conclusions regarding major causation by comparing at work shoulder activities with the off work shoulder activities. Therefore, we are unable to conclude that work was the major cause of a worsening of claimant's preexisting right shoulder condition. Mal v. Unique Building Maintenance Co., 93 Or App 703 (1988); Blakely v. SAIF, 89 Or App 653, 656, rev den 305 Or 672 (1988).

Penalties and Attorneys Fees for Unreasonable Claims Processing

Claimant contends that the employer unreasonably failed to pay interim compensation benefits. The employer, however, first received notice of claimant's medically verified inability to work after his aggravation rights had run. Therefore, there was no duty to begin to pay interim compensation. We conclude the employer did not unreasonably resist the payment of interim compensation and that claimant is not entitled to penalties and attorney fees.

ORDER

The Referee's order dated September 15, 1987 is affirmed. The Board approves a client-paid fee payable by the self-insured employer to its counsel, not to exceed $3,000.

February 22, 1990 Cite as 42 Van Natta 394 (1990)

In the Matter of the Compensation of
ERIC L. HOFFMAN, Claimant
WCB Case No. 88-02821
ORDER ON REVIEW (REMANDING)
Pozzi, et al, Claimant Attorneys
Breathouwer, et al, Defense Attorneys

Reviewed by Board Members Gerner and Myers.

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

Claimant requested a hearing on February 24, 1988. The hearing convened on May 12, 1988 with claimant present; the hearing was continued for an additional independent medical examination. The continued hearing was scheduled for July 21, 1988 and notices were sent to all parties including claimant. Claimant did not appear at the continued hearing; however, claimant's attorney did appear. Claimant's attorney represented that he had not been able to directly contact claimant and did not know why claimant was not present. Claimant's brother was present. At hearing, the Referee indicated that he would dismiss pursuant to his understanding of (former) OAR 438-06-071. The Referee indicated that he would reconsider his decision if, within 30 days of the Referee's order, claimant petitioned for reconsideration and was able to show good cause for not appearing.

On July 22, 1988, the Referee issued an Order of Dismissal dismissing claimant's request for hearing. On August 16, 1988, claimant's attorney wrote the Referee stating that he had just received a letter from claimant indicating that claimant had not received the notice of hearing because claimant's brother had failed to forward the notice to claimant as he had agreed to do, and further that the brother had sold all claimant's property without permission and had left town without further notice. The attorney moved for reconsideration of the Order of Dismissal and requested that the hearing be rescheduled.

On August 19, 1988 the Referee issued an order declining to reconsider. He reasoned:

> "I find the request insufficient for several reasons. First the request contains no affidavit from claimant, nor indeed any direct statements by him concerning lack of notice of the hearing. Furthermore, I am not convinced that the representations contained in claimant's attorney's letter...constitute 'good cause'."

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). The Referee correctly treated claimant's motion for reconsideration 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. He reasoned that claimant had not submitted an affidavit and that even if claimant's attorney's representations were true, claimant had not established sufficient grounds to justify a postponement. We agree that claimant should have attempted to justify a postponement by some sort of evidence. However, we do not agree that if the attorney's representations are true then claimant has not justified a postponement. According to the representations, claimant did not receive the notice of hearing. This fact, if true, is sufficient to justify a postponement.

Considering the fact that claimant apparently contacted his attorney only a few days before the Referee would have lost jurisdiction, we conclude that claimant should have an opportunity to submit evidence to support the representations contained in the attorney's letter. Accordingly, this case is remanded to the Referee to take evidence on the question of whether claimant has established extraordinary circumstances which would have justified a postponement. If the Referee determines that a postponement should have been granted, he shall hold a hearing on the merits, including claimant's testimony.

If the Referee determines that a postponement should not have been granted, the Referee shall decide the case on the merits, confining his consideration to the evidence submitted up to the date of the continued hearing. Mario Miranda, 42 Van Natta _____(February 1, 1990).

IT IS SO ORDERED.

February 22, 1990 Cite as 42 Van Natta 395 (1990)

In the Matter of the Compensation of
NELSON MUIR, Claimant
WCB Case No. 88-09761
ORDER ON REVIEW
Black, et al, Claimant Attorneys
Lester Huntsinger (Saif), Defense Attorney

Reviewed by Board Members Perry and Howell.

Claimant, pro se, requests review of Referee Melum's order which dismissed his Request for Hearing. On review, the issue is dismissal. We affirm.

FINDINGS OF FACT

In June 1988, claimant requested review of the SAIF Corporation's denial of his injury claim. A hearing was scheduled which claimant and his attorney attended. At the time of hearing, claimant asked that his Request for Hearing be dismissed.

The Referee's Order of Dismissal issued August 17, 1988. The order did not indicate whether the hearing request had been dismissed with or without prejudice. The order contained a statement explaining the parties' rights of appeal under ORS 656.289(3) and 656.295.

On August 31, 1988, the Board received claimant's timely request for review of the Referee's order. The letter requesting review also included a request for hearing.

CONCLUSIONS OF LAW AND OPINION

As a result of the Referee's order, claimant's request for hearing concerning the issue of compensability of his current condition was dismissed. Thus, at least as a procedural, if not a substantive matter, the order had the potential of impacting claimant's entitlement to compensation. In that respect, it is an appealable final order. See Lindamood v. SAIF, 78 Or App 15, 18 (1986); Mendenhall v. SAIF, 16 Or App 136, 139 (1974).

Claimant offers no arguments as to why the dismissal order was improper. Nor does our examination of the record disclose any impropriety. Therefore, the Referee's dismissal order will be affirmed. In addition we note that it is our policy to interpret any dismissal order issued by the Hearings Division as an order of "dismissal without prejudice," unless the order states otherwise. Robert L. Murphy, 40 Van Natta 442 (1988). Thus, absent any reference to "prejudice' in a dismissal order, such an order would not have any preclusive effect on subsequent litigation. Glenn L. Woodraska, 41 Van Natta 1472 (1989).

Here, claimant withdrew his hearing request. Yet, because the dismissal order did not state that the dismissal was 'with prejudice', we hold that the dismissal was "without prejudice." Therefore, the dismissal order will have no preclusive effect on subsequent litigation. See Woodraska, supra.

Because claimant's request for Board review was also accompanied by a request for hearing, the Board will forward the request to the Hearings Division for processing as a request for hearing. See Donald L. Lowe, 41 Van Natta 1873 (1989). We offer no opinion as to the timeliness of that request.

ORDER

The Referee's order dated August 17, 1988 is affirmed. Claimant's August 31, 1988, request for hearing is forwarded to the Hearings Division with instructions to process it as a request for hearing.

In the Matter of the Compensation of
CHRISTINE L. DAVIS, Claimant
WCB Case No. 86-17196
ORDER ON REVIEW
BLACK, CHAPMAN & WEBBER, Claimant Attorneys
COWLING & HEYSELL, Defense Attorneys

Reviewed by Board Members Nichols, Brittingham and Crider.

The insurer requests review of that portion of Referee Howell's order that declined to authorize an offset of an alleged overpayment of temporary disability compensation against the Referee's award of permanent disability compensation. The issue is entitlement to an offset of temporary disability. We affirm.

FINDINGS OF FACT AND ULTIMATE FACT

On July 31, 1985 claimant suffered a compensable injury. On October 20, 1986 the insurer requested claim closure, indicating time loss payments were made at the rate of $116.50 per week and were paid through October 8, 1986. The claim was closed by a November 6, 1986 Determination Order, which awarded various periods of temporary disability from August 1, 1985 through August 19, 1986. There was no award of permanent disability. The medically stationary date was determined to be August 19, 1986. The November 6, 1986 Determination Order was affirmed by a November 25, 1986 Determination Order.

On December 8, 1986 claimant's attorney filed a request for hearing. The sole issue was extent of permanent disability. On April 6, 1987 the insurer filed a response which: (1) denied the claim for additional permanent disability, and (2) asserted that it was entitled to offset an alleged overpayment of temporary disability in the amount of $1,074.57. Claimant did not reply to the insurer's response.

At hearing, claimant raised the issue of extent of permanent disability. The insurer's counsel agreed that the only issue to be litigated involved extent of permanent disability. The alleged overpayment was neither raised as an issue nor conceded. At the completion of the hearing, the record was closed.

CONCLUSIONS OF LAW AND OPINION

The Referee awarded 15 percent unscheduled permanent disability. Thereafter, the insurer moved for reconsideration, seeking authorization to recover its alleged overpayment. On reconsideration, the Referee found that claimant had not conceded the alleged overpayment and that the record contained no evidence in that regard. Therefore, the insurer's request to offset its alleged overpayment against claimant's permanent disability award was denied. We agree.

When an issue is not properly raised before a Referee at hearing, and the record is closed, that issue will not subsequently be considered. Randy D. Johnson, 39 Van Natta 463 (1987). We may remand to the Referee if we find that the record has been "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(5). To merit such remand, however, it must be clearly shown that material evidence was not obtainable with due diligence at the time of hearing. Kienow's Food Stores v. Lyster, 79 Or App 416 (1986); Delfina P. Lopez, 37 Van Natta 164 (1985).

Here, the insurer referred to the overpayment issue in its response to claimant's request for hearing. The issue, however,

was not properly raised before the Referee at hearing. At that time, the insurer's counsel agreed that the sole issue before the Referee was the extent of claimant's unscheduled permanent disability. Inasmuch as the record closed without the insurer properly raising the offset issue, we conclude that it was within the Referee's discretion to refuse to consider that issue.

We also decline to remand this case to the Referee. It has not been shown that material evidence pertaining to the alleged overpayment was unobtainable with due diligence at the time of the hearing. See Metro Machinery Rigging v. Tallent, 94 Or App 245 (1988).

We turn to claimant's entitlement to attorney fees for prevailing against the insurer's request for review on the offset issue. Claimant is entitled to an assessed fee if her compensation was not reduced as a result of the Referee's offset ruling. 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. Nor is claimant entitled to an approved fee under ORS 656.386(2), as she has not received any additional award of compensation.

ORDER

The Referee's order dated July 6, 1987, as reconsidered August 24, 1987, is affirmed. We approve a client-paid fee, payable from the insurer to its counsel, not to exceed $291.00.

Board Member Crider concurring in part and dissenting in part.

I join the Board's opinion insofar as it rejects the insurer's request for an offset. I believe, however, that claimant is entitled to an attorney fee for overcoming the insurer's effort to reduce her compensation. Therefore, I dissent on that issue.

The insurer sought Board review of the Referee's order that declined to authorize an offset. We have affirmed the Referee's order. In effect, we have declined to reduce her entitlement to future permanent disability compensation by refusing to allow such compensation to be reduced by the alleged overpaid temporary disability compensation. Consequently, claimant is entitled to an insurer-paid attorney fee for services on review under ORS 656.382(2).

In reaching a contrary conclusion, the Board relies on the Board's decision in Lawrence N Sullivan, 39 Van Natta 88 (1987). In Sullivan, we held that claimant was not entitled to an insurer-paid fee for successfully defending against a carrier's appeal of a Referee's order declining to grant an offset. Although Sullivan purported to follow the holding of Forney v. Western States Plywood, 297 Or 628, 633 (1984), Forney does not compel the Sullivan result.

Forney pertained to entitlement to an attorney fee where claimant requested a hearing challenging a unilateral offset. The referee and the Board concluded that the offset was permissible; claimant ultimately prevailed before the Court of Appeals. The Forney court rejected claimant's contention that he was entitled to an attorney fee under ORS 656.386(1) for "prevailing finally" because claimant did not prevail over a denial of the right to compensation; he simply prevailed in a dispute over recovery of an overpayment. The court also rejected claimant's plea for an attorney fee for failure to pay compensation due under an order because the offset, having been authorized by administrative

rule, was in effect approved by the determination order. The court finally concluded that no fee was assessable for unreasonable resistance to the payment of compensation where the insurer had relied, in withholding compensation to recover an overpayment, on the rule.

The Forney court found ORS 656.382(2) to be inapplicable. Here, as in Sullivan, it is applicable because the insurer, not claimant, is seeking review, and is attempting to reduce claimant's compensation by obtaining offset authorization. An offset is an "adjustment of compensation". ORS 656.268(10). A party seeking offset authorization contends that claimant wasn't entitled to all of the compensation she was paid. A request for review seeking an offset is, therefore, a request for a reduction in compensation.

Claimant has not conceded that she has been overpaid. We have not found that she was overpaid. Although she may agree that she was overpaid if this issue is timely raised in a future hearing, it cannot now be said as we do here that the amount of claimant's compensation was not put in issue by the offset request. Inasmuch as the insurer's request has been unsuccessful, claimant is entitled to an insurer-paid fee.

In the Matter of the Compensation of
JERRY HANSEN, Claimant
WCB Case No. 86-18118
ORDER ON REMAND
Willner & Associates, Claimant Attorneys
Rankin, et al, Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Pursuant to the court's February 9, 1990 order, claimant's petition for services rendered before the Board has been remanded for our determination.

On January 23, 1989, we reversed a Referee's order, which had upheld the insurer's denial of claimant's injury claim. Jerry Hansen, 41 Van Natta 134 (1989). The insurer petitioned for judicial review. On November 15, 1989, the court affirmed our order without opinion. Philips Industries v. Hansen, 99 Or App 488 (1989).

Thereafter, claimant submitted a petition for attorney fees to the court for his counsel's services at the hearing, Board, and court level. The court awarded an insurer-paid attorney fee for services rendered in defense of the Board order. That portion of the petition which pertained to the hearing and Board level has been remanded to us for consideration.

Claimant's counsel failed to provide a statement of services within 15 days of the filing of the last brief on Board review. See OAR 438-15-028(1)(c). Yet, despite the untimely submission of his request for an attorney fee, we proceed with our determination because jurisdiction over this issue has returned to us. See Marie C. Walsh, 41 Van Natta 777 (1989) (When a statement of services has been untimely submitted, the Board can address attorney fee requests, provided that it has jurisdiction to do so.)

After review of the petition for attorney fees and considering the factors set forth in OAR 438-15-010(6), we find that $2,600 is a reasonable insurer-paid attorney fee for claimant's counsel's services at hearing and on

review concerning the issue of compensability. In reaching this conclusion, we note that a portion of claimant's attorney's efforts on review were devoted to an evidentiary issue and a motion to remand. Inasmuch as each of these matters were decided in a manner contrary to claimant's position, such efforts have not been considered in our determination of a reasonable attorney fee.

IT IS SO ORDERED.

In the Matter of the Compensation of
JERRY M. McCLUNG, Claimant
WCB Case No. 87-18865
ORDER ON REVIEW
Rhoten, et al, Claimant Attorneys
Schwabe, et al, Defense Attorneys

Reviewed by Board Members Cushing and Myers.

The insurer requests review of Referee Bennett's order that: (1) found claimant had established good cause for his failure to file a request for hearing within 60 days of receipt of the insurer's denial; (2) set aside the insurer's denial of claimant's left foot amputation. Claimant cross-requests review of that portion of the Referee's order that awarded an assessed fee of $2,000 for prevailing against the insurer's denial. On review, the issues are timeliness, compensability, and attorney fees. We affirm.

FINDINGS OF FACT

Claimant worked as a security guard, patrolling the parking lot and buildings at a food processing plant. Claimant suffers from preexisting diabetes. He was first hospitalized for diabetes in 1968. In 1985, claimant suffered from a diabetic ulcer on the plantar aspect of the left foot, however, that sore healed itself.

In May, 1987, claimant developed a diabetic ulcer on the underside of his left foot below the small toe. On July 16, 1987, Dr. Gallagher, M.D., orthopedist, placed claimant in a short leg cast.

Claimant worked on July 18, 1987. He patrolled the parking lot for 7 hours. Towards the end of his shift, claimant experienced pain in the region of his left big toe. There was a new sore just beyond where the cast ended.

On July 23, 1987, Dr. Gallagher removed claimant's short leg cast. Claimant filed a claim on August 7, 1987, stating that "walking on job worsened the sore" on his left foot. (Ex. 4).

On August 13, 1987, claimant had a Syme amputation with removal of his toes and part of his foot. He was discharged from the hospital on August 20, 1987.

The insurer's denial was issued on September 2, 1987, and received by claimant two days later. The denial advised claimant that if he disagreed with the insurer's decision he should request a hearing from the Workers' Compensation Board within 60 days from the date of denial.

Claimant was readmitted to the hospital on September 2, 1987, complaining of diarrhea, nausea, and vomiting. During the period before his rehospitalization, claimant had lost a significant amount of weight due to heavy diarrhea and bleeding from the rectum. At the hospital, claimant was placed on IV and given antibiotics.

On September 4, 1987, after receiving the denial letter, Ms. McClung, claimant's former wife, called the Workers' Compensation Board twice and asked for the appeals forms. However, claimant never received the proper paperwork from the Board. Claimant was discharged from the hospital on September 9, 1987.

Claimant needed 24 hour assistance after September 9, 1987. Shortly thereafter, Senior Services Division hired Ms. McClung to provide that care. In turn, she cooked, gave insulin shots, wrapped bandages, soaked and provided warm pads for claimant's stump. (Tr. 22).

Between the September 9, 1987, hospital discharge and the October 1, 1987, hospitalization, claimant was on medication to keep him from having nightmares. Claimant would look at what was left of his foot and cry. He was concerned about what the future held for him. Towards the end of September, Ms. McClung noticed that claimant's stump was discolored.

Consequently, claimant returned to the hospital on October 1, 1987 for further amputation below the knee. He was discharged from the hospital on October 5, 1987.

During both periods claimant was placed on various medications for the pain, including Visken, Dyazide, Capoten, Perrous sulfate, Zantac, Percocet, Vistaril, and Valium. The medication caused claimant hallucinations.

Claimant went to see an attorney on December 10, 1987. He had stopped taking the medication a week before, and therefore regained his mental alertness.

Claimant's hearing request from the insurer's denial was received by the Hearings Division on December 14, 1987, more than 60 days after the denial.

Based on demeanor, both claimant and Ms. McClung were credible witnesses.

CONCLUSIONS OF LAW

Although claimant did not file a timely hearing request, the Referee found that he had good cause for failing to do so. Specifically, the Referee reasoned that claimant had demonstrated "excusable neglect" based on claimant's medical condition (two amputations), and the accompanying medication. We agree.

A hearing request must be filed within 60 days after claimant is notified of a denial. ORS 656.319 (1)(a). A request filed after 60 days but not more than 180 days after notification of denial is valid if the claimant establishes that he had good cause for failure to file within 60 days. ORS 656.319(1)(b). Claimant has the burden to establish good cause for failure to file timely. Hempel v. SAIF, 100 Or App 68 (January, 3, 1990).

It is undisputed that claimant's hearing request was not timely filed. That delay may nevertheless be excused if claimant had good cause for late filing. See ORS 656.319(1)(b). The test for determining if good cause exists has been equated to the standard of "mistake, inadvertence, surprise or excusable neglect" recognized 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). The courts are liberal in granting relief [under ORS 18.160], for the policy of the law is to afford a trial upon the merits when it can be done without violence to the statute. Voorhies v. Wood, Tatum, Mosser, 81 Or App 336, 339 (1986).

Based on demeanor, the Referee found claimant and Ms. McClung entirely credible witnesses. Accordingly, we defer to the Referee's determination of credibility because of his opportunity to observe the witnesses. See Humphrey v. SAIF, 58 Or App 360 (1982).

Here, claimant had his foot amputated on August 13, 1987. During this period, claimant was placed on various medications including Visken, Dyazide, Capoten, Ferrous sulfate, Zantac, Percocet, Vistaril, and Valium. On September 2, 1987, claimant was readmitted to the hospital, suffering from, "...four days of diarrhea, one day of nausea and vomiting." (Ex. 12-1). Also, on September 2, 1987, the insurer issued its denial regarding claimant's foot condition.

Ms. McClung received the denial letter, and read the contents to claimant. However, she was not sure that he understood the denial's meaning. (Tr. 29). Shortly thereafter, Ms. McClung twice called the Workers' Compensation Board for information regarding the appeals process. Despite these attempts, no pertinent information was sent to claimant or Ms. McClung.

Shortly thereafter, on September 8, 1987, claimant was discharged from the hospital. Afterwards, claimant noted that, "...I laid on the couch and was unable to hardly pick myself up. I could not roll over. I could not go to the bathroom on my own -- had to buy a potty chair -- and I walked around on a walker when I did walk." (Tr. 70).

Moreover, claimant's amputation began to fail from lack of vascular supply. Gangrene returned and infected the anterior one-half of the stump of the remaining portion of his left leg. Claimant was readmitted to the hospital on October 1, 1987, and underwent a second amputation just below the knee.

Claimant continued to take medication when he returned home on October 5, 1987. These medications caused him to hallucinate. Claimant indicated:

> "Well I spent most of my time laying on the bed, and I would hallucinate and think that I'd knock my water over or I was falling out of bed. My stub, if I lifted it up and put it on the mattress, would scare me to death, because I felt that I stuck it through a huge whole in the mattress. And I really had quite a hard time in knowing who I was and where I was. I just couldn't get it together." (Tr. 72) (Emphasis added).

During the month of October, claimant only left home to see his physician. (Tr. 72). In November, 1987, he left the house a few times to accompany Ms. McClung to the grocery store and to see his doctor. Claimant would sit in the car while she bought groceries.

Claimant ceased taking the medication during the first week of December, 1987. Thereafter, he began to think more clearly, and stopped hallucinating. Claimant sought legal counsel on December 10, 1987. The request for hearing was filed the next day.

We find that the combination of medication and claimant's physical/mental condition create sufficient good cause based on "excusable neglect". Once claimant regained full mental alertness, he diligently obtained legal counsel, and filed a request for hearing. We conclude that claimant has established "good cause" for his untimely hearing request.

Compensability

The Referee found that claimant had proven that his ulcer condition was causally related to his walking on gravel at work. We agree.

To establish compensability of his foot condition, claimant must show, by a preponderance of the evidence, that the July 18, 1987, work incident is a material contributing cause to his current disability or need for medical treatment. Hutcheson v. Weyerhaeuser, 288 Or 51, 56 (1979). The issue of whether claimant's need for medical services is causally related to the 1987 incident is a complex medical question. Thus, while claimant's testimony is probative, the resolution of this issue turns on an analysis of medical evidence. Uris v. Compensation Dept., 247 Or 420, 426 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985).

On January 27, 1988, the treating orthopedic surgeon, Dr. Gallagher, declared, "It is my opinion that it is more reasonable than not that Mr. McClung's ulcer on the plantar aspect of the left great toe developed as a result of his walking in his cast on gravel and uneven surfaces during his 8-hour work day." (Ex. 18-1). Gallagher continued on to note that claimant underwent amputation of the left foot because of the ulceration on the plantar aspect of the left great toe. Id. Moreover, on February 12, 1988, Gallagher reasoned;

> "As you know, Mr. McClung developed a deep and unhealing ulcer on the bottom of his left great toe while in this cast. I did state to Mr. Warren that I felt that the requirement that he walk on gravel had direct causation as regards the ulcer on the plantar aspect of the great toe and, therefore, did lead to amputation of the foot." (Ex. 20) (Emphasis added).

In addition, the treating physician for claimant's diabetic condition, Dr. Roberts, M.D., concurred with Dr. Gallagher's conclusions.

Ms. McClung testified that in June or July, 1987, claimant developed a sore on the bottom of his left foot. The sore resembled a callus where the top had come off. It was on the outside ridge of his left foot, and was closest to the little toe. After the cast was applied, claimant returned to work as a security guard. According to Ms. McClung, the new sore developed on claimant's big toe right where the cast would come into contact with his foot. On the night of July 18, 1987, claimant had patrolled for approximately seven hours, and walked an estimated fifteen miles. He repeated this routine the next day. When Dr. Gallagher removed the cast he found that the sore which had instigated the cast had healed, however, a new sore had developed. (Tr. 66).

The insurer did not dispute that the injury to claimant's foot was caused by the rubbing of the cast against the foot, which in turn aggravated the preexisting disease. Instead, the insurer asserts that there was nothing in the record which indicates that this same sore would not have developed from this cast, even if claimant had not been working. We find this assertion unpersuasive in light of the aforementioned medical opinions.

Dr. Gallagher was in a superior position to assess claimant's foot condition. While he did find the question of whether claimant's first sore would have healed on its own difficult, Gallagher pointed out that a prior diabetic ulcer on the plantar aspect of the left foot had healed in 1985, and more to the point, the ulcer in the case at hand had shown evidence of healing. Dr. Gallagher concluded that he would not have amputated claimant's foot based solely on the existence of the first diabetic ulcer. Moreover, Gallagher opined, "Two facts were obvious in August '87 prior to amputation. The first was that the ulcer underneath the great toe was not going to heal. The second fact was that the diabetic ulcer on the plantar aspect of the left foot was healing." (Ex. 18-2). Gallagher was claimant's treating physician for a substantial time, and as the treating physician was able to observe the evolution of claimant's foot condition. Significantly, he felt that claimant's two amputations were more probably than not caused by the work related ulceration on the plantar aspect of the great toe, rather than the original diabetic ulcer. Because of his first-hand exposure to and knowledge of claimant's condition, we give his opinion great weight. See Argonaut Insurance v. Mageske, 93 Or App 698, 702 (1988).

Based on demeanor, the Referee found both claimant and Ms. McClung to be entirely credible witnesses. We defer to the Referee's determination of credibility because of his opportunity to observe the witnesses. See Humphrey v. SAIF, 58 Or App 360 (1982). Here, claimant and Ms. McClung testified regarding the relationship between the cast and the development of the diabetic ulcer on the left big toe. There is no persuasive evidence in the record that undermines claimant's evidence concerning the onset of the second diabetic ulcer.

Claimant has proved, to a reasonable medical probability, a material relationship between the ulcer caused by walking on gravel at work, and the subsequent need for medical services. Accordingly, claimant's ulcer which gave rise to the amputation is compensable.

Attorney Fees

The Referee awarded claimant's attorney a reasonable attorney fee of $2,000, to be paid by the insurer. We agree.

We conclude that an attorney fee award of $2,000 reasonably compensates claimant's counsel for services rendered regarding the compensability issue. See Weyerhaeuser Co. v. Fillmore, 98 Or App 567, 571 (1989).

ORDER

The Referee's order, dated June 29, 1988, is affirmed. For services on review concerning the timeliness and compensability issues, claimant's attorney is awarded an assessed fee of $800, to be paid by the insurer. The Board approves a client-paid fee, payable from the insurer to its counsel, not to exceed $1,860.

In the Matter of the Compensation of
MARIO MIRANDA, Claimant
WCB Case No. 87-09985
ORDER ON REVIEW (REMANDING)
Ginsburg, Gomez & Neal, Claimant Attorneys
Julia Philbrook (Saif), Defense Attorney

Reviewed by Board Members Crider, Nichols, and Brittingham.

Claimant requests review of Referee Schultz's order dismissing his request for hearing on the issues of extent of permanent partial disability, medical services, premature closure and aggravation. On review, the issues are dismissal and remand. We reverse.

FINDINGS OF FACT

Claimant suffered a back injury on July 2, 1986. The SAIF Corporation accepted the claim for thoracic strain.

The claim was closed by Determination Order on June 15, 1987.

Claimant requested a hearing specifying the following issues: Temporary total and temporary partial disability; premature claim closure; aggravation; extent of unscheduled permanent partial disability; medical services; and penalties and attorney fees.

Hearing was set for April 26, 1988. Claimant appeared through counsel. He did not personally attend.

The Referee received exhibits.

SAIF moved to dismiss, contending that: a hearing could not be conducted in claimant's absence; there was no basis for continuance or postponement; and thus the request for hearing should be dismissed.

Claimant's counsel opposed the motion and requested to proceed in claimant's absence. He did not seek a postponement or continuance.

The Referee dismissed the request for hearing, relying on former OAR 438-06-071. On reconsideration, he concluded that the claimant could proceed on the penalty and attorney fee issue through counsel but that the hearing request must be dismissed as to the remaining issues.

Claimant requested review.

Claimant's opening brief addressed all of the issues raised in the request for hearing. SAIF moves to strike those portions of the brief addressing any issue other than dismissal. SAIF also moves to strike exhibits attached to claimant's brief.

Finally, claimant has moved to remand for hearing on the ground that claimant has now returned to the United States and is available for hearing.

CONCLUSIONS OF LAW AND OPINION

The Referee's order on reconsideration interpreted former OAR 438-06-071 to permit claimant to appear through counsel at hearing. However, the order concluded that a hearing cannot be conducted in this case, consistent with substantial justice, unless claimant is available for cross-examination. Claimant not being available, claimant's request for hearing was dismissed. In so holding, the Referee relied on John M. Barbour, 36 Van Natta 304 (1984); Edward R. Cantrell, 36 Van Natta 312 (1984); and Warren F. Stier, 36 Van Natta 334 (1984).

Since the Referee's order, the Court of Appeals decided a case which controls the issues here. In Williams v. SAIF, 99 Or App 367 (1989), the Court of

Appeals held that neither OAR 438-06-071 nor ORS 656.283(7) requires claimant to personally attend a hearing. Moreover, claimant is entitled to proceed based on the written record. Her case should not have been dismissed because she did not voluntarily appear and make herself available for cross-examination.

The version of former OAR 438-06-071, applicable to this case reads as follows:

> "Failure of a party to appear at a hearing without good cause constitutes a waiver of appearance. If the party failng to appear is the party that requested the hearing, the request for hearing may be dismissed unless good cause is shown and the other party is not prejudiced thereby."

This version of the rule, like the version addressed in Williams, allows claimant to appear either personally or by counsel. Claimant appeared through counsel. Therefore, dismissal was not proper under the rule. Moreover, the Board cases relied upon by the Referee are inconsistent with Williams. Consequently, claimant's request for hearing should not have been dismissed simply because he did not attend the hearing and was not available for cross-examination.

We remand the case for hearing on the merits. On remand, 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.

Given this disposition, we do not address SAIF's Motion to Strike or claimant's Motion to Remand.

ORDER

The Referee's order dated April 28, 1988, as reconsidered June 9, 1988, is reversed. Claimant's hearing request is reinstated, and the case is remanded to Referee Schultz for hearing consistent with the instructions in our opinion.

In the Matter of the Compensation of
JOHN J. ALCANTAR, Claimant
WCB Case Nos. 87-18551, 87-01266 & 88-01581
ORDER ON RECONSIDERATION
Callahan & Gardner, Claimant Attorneys
Lindsay, et al, Defense Attorneys
Roberts, et al, Defense Attorneys
Daryll E. Klein, Defense Attorney

AIAC has requested reconsideration of the Board's Order on Review dated January 24, 1990. On February 2, 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 24, 1990 order, we issue the following order.

Adjustco requests review of those portions of Referee Nichols' order that: (1) set aside its aggravation denial of claimant's back condition; and (2) up

held the "new injury" denial of American International Adjustment Company ("AIAC") for the same condition. On review, the issues are compensability and responsibility. We affirm.

FINDINGS OF FACT

Claimant, 39 at the hearing, sustained a compensable strain to his mid-and-upper back in July 1982. The injury occurred while he was working as a picker at a mushroom plant. Adjustco accepted the claim as a nondisabling injury, see former ORS 656.268(3). Treatment was conservative. By September 1982, he was medically stationary without permanent impairment.

Beginning in approximately 1984, claimant began to work as a janitor at the mushroom plant. This work primarily consisted of sweeping, mopping, and cleaning tables. He worked without apparent difficulty and did not seek either temporary disability benefits or medical services. In April 1985, AIAC began its coverage. Claimant continued to work as a janitor. Shortly thereafter, he began to experience a recurrence of mid-and-upper back pain. He sought treatment from Dr. Nickila, a chiropractor. Nickila treated conservatively and took him off full-time work for a few weeks beginning April 21, 1986.

In the fall of 1986, claimant was assigned to floor cleaning duties. This job required repetitive bending, pulling, and shoveling. He performed those activities eight hours a day, six days a week. After three to four weeks, he developed a sharp pain in his mid-and-upper back. As a result, he sought treatment from Dr. Shorb, a chiropractor. Shorb restricted him to part-time work for two months and referred him to Dr. Pollard, an orthopedic surgeon. Pollard examined claimant in December 1986. Shortly thereafter, claimant resumed full-time janitorial work.

Apparently after receiving the reports from Shorb and Pollard, Adjustco issued an aggravation denial in January 1987. Several months later, claimant filed a "new injury" claim with AIAC. AIAC timely denied the claim. In October 1987, United States Fidelity and Guaranty Company ("USFG") commenced coverage and claimant was assigned to garbage dumping duties. This required him to pick up 40 to 50 pound boxes of garbage from the floor, lift the boxes to chest level, and dump them in a bin. He performed this work one day for 10 hours. As a result, his back pain increased and he was apparently taken off work by Shorb. In December 1987, he filed a "new injury" claim with USFG, which was promptly denied.

The Orthopaedic Consultants examined claimant in February 1988, post hearing.

Claimant continued to experience back symptoms after the initial injury in 1982, though, until April 1986, they were not disabling. On two occasions in 1986, claimant's work gradually caused an increase in symptoms and resulted in further medical services and disability. His July 1982 injury is a material contributing cause of his back condition and need for medical treatment in April 1986 and thereafter.

Claimant's work activities during 1986 did not independently contribute to a worsening of his underlying back condition. Claimant's activity in the fall of 1987 resulted in a new injury.

CONCLUSIONS OF LAW AND OPINION

We note that while all parties describe the work activities in 1986 and 1987 as occupational injuries, the 1986 exposures are more properly classified

as occupational disease exposures, since the recurrence of disabling symptoms occurred gradually over a period of time without any specific identifiable incident. Valtinson v. SAIF, 56 Or App 184 (1982). We are not bound, on de novo review to the parties' classification of the 1986 exposures as injuries. Allen B. Cooper, 40 Van Natta 1915 (1988).

1986 Occupational Disease Exposures

AIAC denied responsibility for claimant's disability and medical services caused by work exposure in 1986, which we classify as an occupational disease. By arguing only responsibility at hearing, Adjustco conceded that claimant's condition in 1986 and 1987 was materially related to its 1982 accepted injury claim. See Judy Witham, 40 Van Natta 1982 (1988) (where acquiescence to a .307 order is a concession of all compensability defenses). Even though no .307 order issued in this case, by asserting only a responsibility defense at hearing, Adjustco waived its ability to assert that claimant's conditions in 1986 and 1987 were not related to its accepted claim.

In order to shift responsibility for claimant's current mid and upper back condition to AIAC, there must be evidence that the later work exposure "independently contributed to a worsening of the underlying condition." Hensel Phelps v. Mirich, 81 Or App 290 (1986).

No doctor opines that claimant's work exposure in 1986 independently contributed to a worsening of claimant's condition. Therefore, we conclude that Adjustco's accepted claim does not shift to AIAC for any occupational disease during its coverage.

1987 Injury

USFG denied claimant's claim for work exposure during the fall of 1987 which we classify as an occupational injury.

We find that claimant sustained a work-related injury in the fall of 1987 when, after one day of dumping garbage, he required additional medical services and suffered additional temporary disability. ORS 656.005(7)(a).

Having established a work-related injury, the question remains whether this injury independently contributed to a worsening of the underlying condition.

Dr. Nickila opines that the new work exposure independently contributes to claimant's underlying condition. That opinion was by way of a check-the-box answer on claimant's attorney's letter. (Ex. 13). This opinion is wholly conclusory and without any explanation. Marshall v. Boise Cascade, 82 Or App 130, 133 (1986); Gloria A. Bembry, 40 Van Natta 1076 (1988); Kenneth C. Snow, 39 Van Natta 743 (1987). Moreover, his conclusion appears to be at odds with his prior report that claimant's condition was primarily due to the 1982 injury and also with claimant's testimony that he had only one day's activity before he "got hurt" again, not the two month's activity related in his report. Because his opinion is conclusory, is based on inaccurate history and has an unexplained change of opinion, we give his opinion no weight. Kelso v. City of Salem, 87 Or App 630 (1987); Marshall, supra; Miller v. Granite Construction Co., 28 Or App 473 (1977).

Dr. Shorb opines that claimant's need for medical services and his resulting disability in the fall of 1987 "was primarily the result of current work activities." (Ex. 11). He is of the opinion that claimant's work activity in the fall of 1987 caused a new injury. (Ex. 14). While no medical evidence

directly addresses the critical question whether or not the new injury with USFG did or did not independently contribute to claimant's disability, we find the opinion of Dr. Shorb to be sufficient to prove that it did. See McClendon v. Nabisco Brands, Inc., 77 Or App 412 (1986) (where we can make appropriate fact-finding without the use of "magic words' by the physicians in the record). Therefore, we conclude USFG is responsible for claimant's condition after October 23, 1987.

ORDER

The Referee's order dated May 2, 1988 is affirmed. Claimant's attorney is awarded $200 for services on Board review, to be paid by Adjustco. The Board approves the following client-paid fees: (1) between Adjustco and its attorney, not to exceed $2,053.50; and (2) between AIAC and its attorney, not to exceed $701.50; and (3) between USFG and its attorney, not exceed $224.

February 26, 1990 Cite as 42 Van Natta 409 (1990)

In the Matter of the Compensation of
MAVIS BACKLIN, Claimant
WCB Case No. 87-15326
ORDER ON REVIEW
Yacob & Associates, Claimant Attorneys
Alice M. Bartelt, Defense Attorney

Reviewed by Board Members Nichols and Brittingham.

The insurer requests review of Referee Schultz's order that: (1) set aside an Order of the Director of the Workers' Compensation Department which held that claimant was not entitled to further vocational assistance; and (2) remanded the matter to the insurer for additional vocational services including the development of an authorized training program. We reverse.

ISSUE

Entitlement to further vocational assistance.

FINDINGS OF FACT

We adopt the "FINDINGS OF FACT" portion of the Referee's order, with the exception of his finding that the September 16, 1987, Stipulation and Order awarded claimant additional permanent partial disability (PPD) benefits. We find, instead, that the settlement order merely allowed for lump sum payment of the 25 percent PPD award previously granted by a prior referee's Opinion and Order of September 2, 1987.

CONCLUSIONS OF LAW AND OPINION

We adopt the first and second paragraphs of the "CONCLUSIONS AND OPINIONS" portion of the Referee's order as supplemented below; however, we disagree with the Referee's ultimate conclusion that the Director abused his discretion in denying further vocational assistance.

The standard of review under former ORS 656.283(2) is limited. However, the statute does not preclude examination and scrutiny of the underlying facts upon which the Director's decision is based. See generally Daniel T. Cobbin, 41 Van Natta 326 (1989). Therefore, we proceed to review, as a factual matter, the basis of the Director's decision.

The Director related claimant's continued unemployment to a highly competitive labor market, not to her compensable skin condition. See former OAR 436-120-100(4). After our review of the record, we find a reasonable basis for the Director's conclusion. The vocational objectives of direct-employment services were cashier and general office clerk. Although claimant acquired her cashiering experience more than 20 years ago, there is persuasive evidence that that experience remains an asset in obtaining employment. Ms. Blount, claimant's vocational rehabilitation counselor, contacted several employers who encouraged claimant to submit applications for cashier and/or office clerk (Ex. 16). At least one employer indicated that it would train its cashiers regardless of their past experience. Blount referred numerous job leads to claimant and, at one point, described the labor market as "very active with many employers hiring cashiers and clerks." Claimant submitted several applications, some of which resulted in interviews. Although claimant was not selected for any of those positions, some employers were impressed and encouraged her to apply again for future openings. Claimant's past nursing experience, outgoing personality and steady work history were regarded as vocational assets. The prospective employers did not appear to regard claimant's skin condition as a barrier to her employment.

The Referee, on the other hand, related claimant's unemployment to disability caused by the skin condition, and concluded that the Director abused his discretion. The Referee observed that the Director did not have knowledge of a prior Referee's order which increased claimant's unscheduled permanent disability award for her skin condition from 10 percent, as awarded by Determination Order, to 35 percent. However, Mr. Loft, the vocational consultant who initially reviewed the record for the Director, testified that knowledge of the increased permanent disability award would not have affected the ultimate decision to deny further vocational assistance (Tr. 16-17).

The Referee also noted that the Director did not have knowledge of claimant's severely low raw score -- 28 out of 100 -- on the finger dexterity portion of the General Aptitude Test Battery (GATB). Loft opined, however, that the finger dexterity score was so low that he would question the validity of that portion of the GATB (Tr. 18). Loft added that, in any event, cashiers no longer perform a tremendous amount of finger dexterity due to technological advances in that vocation, e.g., bar code scanning.

Although we agree with the Referee that the Director's order did not specifically address the vocational impact of claimant's age, we find no persuasive evidence in the record to show that her age is a barrier to reemployment. Based on our review of the record as a whole, the Director's finding, is supported by the record. The Director did not abuse his discretion in denying claimant further vocational assistance.

ORDER

The Referee's order dated February 5, 1988, is reversed. The Director's Review and Order dated September 11, 1987, is affirmed.

In the Matter of the Compensation of
BONITA DAVIS, Claimant
WCB Case No. 88-06860
ORDER ON REVIEW (REMANDING)
Welch, Bruun & Green, Claimant Attorneys
Jeff Gerner (Saif), Defense Attorney

Reviewed by Board Members Crider and Brittingham.

Claimant requests review of Referee Fink's order dismissing her request for hearing regarding the SAIF Corporation's delay in complying with a request for documents. On review, the issues are jurisdiction and penalties and attorney fees. We remand.

FINDINGS OF FACT

By letter dated March 31, 1988, claimant requested that SAIF produce documents related to her claim. SAIF received claimant's request on April 4, 1988. The record contains a transmittal letter for the documents, dated April 14, 1988, from SAIF to claimant's attorney. On this record, we are unable to determine when SAIF mailed the requested documents to claimant's attorney. The attorney received the documents on April 26, 1988. Claimant filed a hearing request in this matter on April 27, 1988. On this record, we are unable to determine whether a separate hearing request on this claim was pending when claimant requested the documents in March 1988.

FINDING OF ULTIMATE FACT

Claimant's right to receive compensation was directly in issue in the penalty and attorney fee matter before the Referee.

CONCLUSIONS OF LAW AND OPINION

Jurisdiction

At hearing, claimant contended that SAIF's delay in producing documents was unreasonable and warranted a penalty and associated attorney fee. SAIF moved to dismiss claimant's hearing request on the ground that the Hearings Division did not have jurisdiction of the penalty and attorney fee issue.

The Referee agreed with SAIF's position and dismissed the hearing request. The Referee reasoned that the Board's discovery rule, OAR 438-07-015(2), does not apply until a hearing request has been filed in a claim, and that the Director's discovery rule, applies prior to that time. The Referee apparently concluded that there was no pending hearing request in the present claim until claimant requested a hearing on April 27, 1988. He, therefore, concluded that the Director's rule applied to claimant's discovery request. The Referee then reasoned that the Hearings Division did not have jurisdiction in this case because the Director's rule, rather than the Board's rule, applied.

We disagree with the Referee's analysis. A determination as to which discovery rule applies in this case is not dispositive of the jurisdictional issue.

The Hearings Division has jurisdiction over matters concerning a claim, that is, matters in which a worker's right to receive compensation, or the amount thereof, is directly in issue. ORS 656.283(1) and 656.704(3). Failure to timely comply with a request for documents can be an unreasonable delay in payment of compensation under ORS 656.262(10), and/or an unreasonable resistance to the payment of compensation under 656.382(1). Claimant filed a hearing request on April 27, 1988, placing in issue her right to penalties and attorney fees for SAIF's alleged unreasonable delay in payment/resistance to payment of compensation. Accordingly, claimant's right to receive compensation was directly in issue in the matter before the Referee. The fact that the documents

may have been requested prior to filing of a hearing request does not deprive the Hearings Division of jurisdiction. Nor does the fact that the Director's discovery rule may be applicable in this case. See e.g., Morgan v. Stimson Lumber Company, 288 Or 595 (1980); Lawrence A. Durette, 42 Van Natta 413 (1990). We regularly exercise our power to assess penalties and attorney fees for delay of compensation in violation of a rule of the Director. See e.g., Lester v. Weyerhaeuser, 70 Or App 307 (1984); Dennis L. Higgins, 41 Van Natta 553 (1989).

Therefore, the Referee erred in concluding that he did not have jurisdiction over the penalty and attorney fee issue in this case. Accordingly, we reverse the Referee's jurisdictional ruling and proceed to the merits of the penalty and attorney fee issue.

Penalties and Attorney Fees

Claimant is entitled to a penalty if SAIF unreasonably delayed payment of compensation under ORS 656.262(10). She is entitled to an associated attorney fee if SAIF unreasonably resisted payment of compensation under 656.382(1).

In order to decide whether SAIF acted unreasonably in this case, we must first determine whether the production of documents was governed 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.

In the Referee's jurisdictional analysis, discussed above, he concluded that the Board's discovery rule does not apply until a hearing request is filed. We agree. The Board's discovery rule does not apply to production of documents prior to the filing of a hearing request. OAR 438-05-010; OAR 438-07-015(2); Lawrence A. Durette, supra. On this record, we are unable to determine if a hearing request was pending when claimant requested the documents in March 1988. We are aware that the hearing request for the present proceeding was not filed until April 1988. However, it is possible that an earlier hearing request had been made which was pending at the time claimant requested the documents.

Nor is the record sufficient for us to determine whether SAIF acted reasonably under the applicable rule, as we are unable to determine what documents were requested, when the documents were mailed by SAIF to claimant, what circumstances may affect the reasonableness of SAIF's conduct, and the reason for SAIF's delay, if any, in producing the documents. See Lawrence A. Durette, supra.

For these reasons, we conclude that the record has been insufficiently developed. Accordingly, we remand to the Referee with instructions to reconvene a hearing. The Referee should then issue an Order on Remand addressing the penalty and attorney fee issue. ORS 646.295(5).

ORDER

The Referee's order, dated July 6, 1988, is vacated and this matter is remanded to Referee Fink for further proceedings consistent with this order.

In the Matter of the Compensation of
LAWRENCE A. DURETTE, Claimant
WCB Case No. 88-10830
ORDER ON REVIEW
Charles D. Maier, Claimant Attorney
Gail Gage (Saif), Defense Attorney

Reviewed by Board Members Crider and Brittingham.

Claimant requests review of Referee Borchers' order that declined to assess an attorney fee regarding the SAIF Corporation's alleged unreasonable failure to produce discovery materials in a timely manner. On review, the issues are jurisdiction and attorney fees. We affirm.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact."

FINDINGS OF ULTIMATE FACT

Claimant's right to receive compensation was directly in issue in the attorney fee matter before the Referee.

SAIF provided the requested documents to claimant's attorney in a reasonable amount of time, given the circumstances of this case.

CONCLUSIONS OF LAW AND OPINION

Jurisdiction

By letter dated May 26, 1988, claimant's attorney wrote SAIF requesting all medical documents related to claimant's 1988 injury claim. SAIF received the request on June 1, 1988. It mailed the documents to claimant on June 22, 1988, and claimant received them on June 23, 1988. There was no hearing request pending in the claim when SAIF produced the documents.

At hearing, claimant contended that SAIF's production of documents was untimely and warranted an attorney fee under ORS 656.382(1). The Referee concluded that SAIF's disclosure was regulated by the Director's discovery rule, rather than the Board's rule, as there was no pending hearing request at the time SAIF produced the documents. The Referee then concluded that the Hearings Division did not have jurisdiction to determine SAIF's compliance with the Director's rule. She reasoned that issue was not a matter concerning a claim because there was no pending hearing request when SAIF produced the documents.

We disagree with the Referee's analysis. The Hearings Division has jurisdiction over matters concerning a claim, that is, matters in which a worker's right to receive compensation, or the amount thereof, is directly in issue. ORS 656.283(1) and 656.704(3). Failure to timely comply with a request for documents can be an unreasonable resistance to the payment of compensation under ORS 656.382(1). Claimant filed a hearing request on June 27, 1988, placing in issue his right to an attorney fee for SAIF's alleged unreasonable resistance to payment of compensation. Accordingly, claimant's right to receive compensation was directly in issue in the matter before the Referee. The fact that the documents may have been requested prior to filing of a hearing request does not deprive the Hearings Division of jurisdiction. Nor does the fact that the Director's discovery rule may be applicable in this case. See e.g., Morgan v. Stimson Lumber Co., 288 Or 595 (1980). We regularly exercise our power under ORS 656.262(10) and ORS 656.382(1) to assess penalties and attorney fees for delay of compensation in violation of a rule of the Director. See e.g., Lester v. Weyerhaeuser, 70 Or App 307 (1984); Dennis L. Higgins, 41 Van Natta 553 (1989).

Therefore, the Referee erred in concluding that she did not have jurisdiction over the attorney fee issue in this case. Accordingly, we reverse the Referee's jurisdictional ruling and proceed to the merits.

Penalties and Attorney Fees

Claimant is entitled to an attorney fee if SAIF's delay in producing the requested documents was an unreasonable resistance to the payment of compensation within the meaning of ORS 656.382(1). 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.

As discussed above, the Referee concluded that SAIF's actions were regulated by the Director's discovery rule rather than the Board's rule because there was no pending hearing request when SAIF produced the documents. We agree. 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.

This analysis is consistent with statutory provisions regarding the Board's authority to promulgate rules. Under ORS 656.726(4), the Board is empowered to "make and declare all rules which are reasonably required in the performance of its duties, including but not limited to rules of practice and procedure in connection with hearing and review proceedings and exercising its authority under ORS 656.278." (emphasis added). The remainder of ORS 656.726(4) relates exclusively to matters involving claims for which hearing requests have been filed. Although we are not prepared to decide that the Board is without authority to promulgate a rule requiring discovery prior to a hearing request, our concern about the extent of our authority does reinforce our view that OAR 438-05-010 was not intended to apply to requests for information made prior to a request for hearing.

We must, therefore, determine whether SAIF's production of documents was reasonable under the Director's rule. Although the Referee concluded that she did not have jurisdiction over this matter, she made an alternative ruling on the merits. She concluded that SAIF's production of documents in this case was not unreasonable under the Director's rule, so that claimant was not entitled to an attorney fee. We agree.

The Director's rule does not establish a specific time within which a carrier must comply with a request for documents. We conclude that the rule requires that documents be produced in a reasonable time given the circumstances surrounding the request. As a matter of course, SAIF assigns a lower priority to copying of documents in claims where there is no pending hearing request. As a result, turnover time in producing documents in such cases is usually 15 days or longer. Here, claimant received the requested documents 22 days after SAIF received her request.

We conclude that, in this case, production of documents within 22 days of receipt of a request is reasonable where there is no pending request for hearing. However, production within that period might not be reasonable where time pressures related to litigation, settlement discussions or other special circumstances necessitate more prompt disclosure.

Nevertheless, no such special circumstances exist in this case. Accordingly, we conclude that SAIF did not act unreasonably, and that claimant is not entitled to an attorney fee.

ORDER

The Referee's order, dated August 12, 1988, is affirmed in part and reversed in part. The Referee's jurisdictional ruling is reversed. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
HOLLIE J. RAHIM, Claimant
WCB Case No. 88-04154
ORDER ON REVIEW
Andrew H. Josephson, Claimant Attorney
Roberts, et al, Defense Attorneys

Reviewed by Board Members Myers and Gerner.

Claimant requests review of those portions of Referee Podnar's order which: (1) upheld the insurer's denial of claimant's aggravation claim for a back condition; (2) upheld the insurer's denial of claimant's ongoing chiropractic treatments; and (3) affirmed a Determination Order award of 5 percent (16 degrees) unscheduled permanent disability for claimant's back condition. On review, the issues are aggravation, medical services and extent of permanent disability. We affirm in part and modify in part.

FINDINGS OF FACT

Claimant compensably injured her upper back on June 30, 1986, while lifting boxes onto a dolly. That same day, claimant filed a claim for a low back strain/sprain. The insurer accepted claimant's back injury claim in August 1986.

From August 1986 through November 1987 claimant consistently complained of acute back pain, in varying degrees, and was treated conservatively with traction to the lumbar area, medications, physical therapy and chiropractic treatments.

In September 1986, claimant was referred to the Northwest Pain Center. Claimant also began chiropractic treatment with Dr. Graffeo, who recommended that claimant obtain ongoing chiropractic treatment for approximately four months and authorized work release for that time period.

Claimant returned to light duty work on March 18, 1987.

On November 4, 1987, a Determination Order awarded temporary total disability from July 2, 1986 through February 16, 1987, temporary partial disability from February 17 through August 31, 1987, and 5 percent (16 degrees) permanent disability for her back condition.

In late December 1987, claimant sustained an injury when she fell while working for her employer. That injury was not reported to Graffeo.

On January 7, 1988, claimant worked a particularly difficult shift at

work. The next morning claimant experienced increased pain that made it difficult for her to stand up straight. Claimant nonetheless returned to work for the next two days until Graffeo took her off work. Graffeo's release from work was premised on the erroneous information from claimant that no light duty work was available at that time with the employer. Light duty work within claimant's restrictions was available to claimant from January 9 to the date of hearing.

On March 11, 1988, the insurer denied claimant's aggravation claim for her back condition. Claimant requested a hearing.

On May 11, 1988, the insurer denied that claimant's "need for chiropractic treatment" was reasonable and necessary. Furthermore, the insurer denied all "ongoing" chiropractic treatment. Claimant requested a hearing.

Claimant continued to receive treatment from Graffeo until June 1988.

Claimant, 26 years of age at hearing, has a high school education and is limited to light duty work. Her work experience includes waitressing, cashiering and being a nursing home assistant.

The insurer's May 11, 1987 denial of all "ongoing" chiropractic treatment is prospective. Further, such chiropractic treatment rendered between May 11, 1987 and the date of hearing is neither reasonable nor necessary.

The Referee noted that based on his observation, claimant's demonstrated pain behavior at hearing was not consistent with her physical condition.

CONCLUSIONS OF LAW AND OPINION

Aggravation Claim

The Referee upheld the insurer's March 11, 1988 denial of claimant's aggravation claim, finding that claimant had not met her burden of proving that she suffered from an aggravation of her compensable back injury. We agree.

To establish a compensable aggravation under ORS 656.273(1), claimant must prove a worsening of her condition and a causal relation between the worsening and a compensable injury or disease. Van Horn v. Jerry Jerzel, Inc., 66 Or App 457, 459, rev den 297 Or 82 (1984). A worsening of the compensable condition must be established. Perry v. SAIF, 307 Or 654 (1989); Ybarra v. Castle & Cooke, Inc., 94 Or App 746, clarified 96 Or App 665 (1989). We apply our analysis as announced in Edward D. Lucas, 41 Van Natta 2272 (1989).

Claimant's condition did worsen symptomatically on January 7, 1988. This worsening did diminish claimant's earning capacity below the level fixed at the last arrangement of compensation. However, this record establishes that claimant would periodically experience symptomatic exacerbations of her condition which would cause diminished earning capacity. These fluctuations in claimant's condition were known and expected at the time of the November 4, 1987 Determination Order. We evaluate the evidence to determine whether this exacerbation is greater in either degree or duration than what was anticipated. Lucas, supra. Whether a particular exacerbation exceeds what was anticipated is a question of fact that requires evaluation of the medical and lay evidence.

Dr. Graffeo, who has always recognized that claimant's condition would fluctuate, does not comment that the January 7, 1988 exacerbation was unusual in terms of either degree or duration from what was expected for claimant's condition. Dr. Seres opined that no new conditions or pathologies had arisen as a

result of the January exacerbation and that claimant remained medically stationary. The medical evidence does not convince us that claimant's exacerbation exceeds that which was expected at the time of the Determination Order.

We also evaluate claimant's testimony to determine the degree and severity of this particular exacerbation in comparison to her condition at the time of the last arrangement of compensation. While claimant testified that she still had not returned to her pre-January 7, 1988 condition even by the time of hearing, we are not persuaded by that testimony. The medical records indicate that claimant exaggerates her complaints and is overfocused on her pain. We do not consider her testimony reliable to determine the degree or duration of her symptomatic flare-up. Likewise, Graffeo's opinion on the extent or duration of claimant's flare-up is not persuasive, based as it is on claimant's subjective reporting to him. Blakely v. SAIF, 89 Or App 653, 656, rev den 305 Or 672 (1988). This is especially true where, as here, Graffeo does not acknowledge nor consider the findings by other evaluating physicians that claimant's pain behavior is excessive, and her complaints exaggerated. Without this consideration we are unable to determine whether Graffeo's opinion accurately reflects an understanding of claimant's actual condition. Because neither the expert nor lay evidence establishes that claimant's exacerbation exceeds what was anticipated for her condition at the time of her Determination Order, we conclude that the current exacerbation does not entitle claimant to claim reopening under ORS 656.273 because her condition has not worsened. Smith v. SAIF, 302 Or 396 (1986).

Under Lucas we also evaluate whether claimant's condition resulted in 14 days of total disability or inpatient hospitalization. While our holding above that claimant's condition did not worsen makes this inquiry moot, we discuss the evidence in this case for clarification. Graffeo did authorize temporary total disability for a period exceeding 14 days. This authorization is not dispositive, however, because a doctor's authorization for temporary disability is evidence of disability, but it is not the only evidence. Botefur v. City of Creswell, 84 Or App 627, 630 (1987). We discount Graffeo's opinion that claimant was totally disabled because it was premised on the erroneous notion that the employer had no modified work available. (Ex. 66). We have already found that modified work within claimant's restrictions after January 7, 1988 was available to claimant. We decline to speculate that Graffeo would have authorized total disability despite the availability of modified employment. Other than the reason of the lack of modified work, Graffeo's authorization is unexplained and conclusory. We give it little weight. Marshall v. Boise Cascade, 82 Or App 130, 133 (1986). We are instead persuaded by the opinion of Dr. Seres. He and his team of evaluators at the Northwest Pain Center had the opportunity to evaluate claimant for the second time shortly after the January exacerbation. Dr. Seres opined that claimant could work in a modified capacity despite her increased symptoms.

Furthermore, claimant's own actions convince us that she was capable of working in a modified capacity after the January exacerbation. Claimant was actually able to do her work for another two days after her symptomatic worsening. Her condition did not worsen again at this time to make her totally disabled, nor is there any evidence that it worsened to the level of total disability at any time before hearing. We conclude that claimant's disability did not become total after her increase in symptoms after January 7, 1988 for a period exceeding 14 days. Claimant is not entitled to have her claim reopened. Gwynn v. SAIF, 304 Or 345 (1987).

Denial of Chiropractic Treatments

The Referee upheld the insurer's May 11, 1988 denial of claimant's "ongoing" chiropractic treatment. However, the Referee did not make specific findings or conclusions as to whether the "ongoing" chiropractic treatment was reasonable and necessary. The insurer argues that such treatment was neither reasonable nor necessary. We find that the initial issue presented here is not whether the treatments were reasonable and necessary, but whether the denial itself is proper given its prospective nature.

It is well settled that 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 "ongoing" chiropractic treatment. Such a denial is prospective. However, since the record indicates that claimant continued to receive chiropractic treatments until June 1988, the reasonableness and necessity of these post-denial treatments are also at issue. See Rater v. Pacific Motor Trucking Co., 77 Or App 418 (1986); Vandehey v. Pumilite Glass & Building Co., 35 Or App 187 (1978) (where post-denial claims are merged into the original denial for processing purposes and for hearing). We evaluate whether the treatments until the date of hearing were reasonable and necessary.

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 persuaded that claimant's chiropractic treatments until the June 3, 1988 hearing, were not reasonable and necessary.

Graffeo 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 Graffeo's opinion nonresponsive to the critical allegation that continued chiropractic care was psychologically detrimental to claimant and that she was developing a detrimental dependency on the care. Dr. Seres noted:

> "[T]he psychological makeup of this lady is such that continued manipulative treatment, passive modalities and other forms of supportive approach are highly counterproductive. Her psychological makeup suggests that she satisfies a lot of dependency needs in this way." (Ex. 75).

Likewise, Dr. Thompson, claimant's former treating physician, was similarly critical of continued chiropractic care for the same reason:

> "Judging from the patient's history and the little prolonged relief she gets from her chiropractic treatments, it would be my opinion that there are no objective findings that would further support chiropractic manipulation. In fact, I think that further chiropractic manipulation, because of the fact that

> this type of treatment I believe further aggravates the psychological factors that have been previously noted and causes her to focus more on her injury and symptoms." (Ex. 76).

Neither Dr. Graffeo nor any other doctor in this record considers and refutes the opinions of Seres and Thompson that the chiropractic care is psychologically detrimental to claimant. Such a reason is sufficient, if unrebutted, to support a finding that the care is not reasonable and necessary. Mladen Blazevic, 41 Van Natta 488 (1989); Franklin Brown, 40 Van Natta 87 (1988). Therefore, we conclude that claimant's current chiropractic care is not reasonable and necessary.

Extent of Permanent Disability

The Referee affirmed a Determination Order which awarded claimant 5 percent unscheduled permanent disability for her back condition. Claimant contends that she is entitled to an award in excess of 5 percent unscheduled disability, asserting that she has never been released to full-time work, nor has she been released to her original job duties. We agree and modify the Referee's order.

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).

Claimant, 26 at the time of the hearing, has a high school education. Although her impairment was not specifically rated by any physician, she is restricted to light duty work not involving repetitive activity.

On de novo review, after considering claimant's youth, average education, her work experience and her work restrictions, we conclude that claimant has lost 20 percent of her pre-injury earning capacity.

ORDER

The Referee's order, dated June 20, 1988, is affirmed in part and modified in part. The Determination Order is modified to award claimant an additional 15 percent (48 degrees) unscheduled permanent disability for a total award of 20 percent (64 degrees) unscheduled permanent disability. 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. The insurer's denial is set aside, in part, as prospective. For services at hearing and on review concerning the prospective denial issue, claimant's attorney is awarded $500, to be paid by the insurer. The unpaid treatments rendered between the date of the denial and the hearing are not compensable. A client-paid fee, payable from the insurer to its counsel, not to exceed $1,254.50, is approved. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
EDGAR BURTON, Deceased, Claimant
WCB Case No. 87-17676
ORDER ON REVIEW
Saif Legal, Defense Attorney

Reviewed by Board Members Nichols and Brittingham.

Claimant's widow, pro se, requests review of Referee Bennett's order that dismissed her hearing request from the SAIF Corporation's denial of her death benefits claim. On review, the issue is dismissal for failure to appear at hearing. We affirm.

FINDINGS OF FACT AND ULTIMATE FACT

Claimant requested a hearing on SAIF's September 25, 1987 denial of her death benefits claim. The hearing was scheduled for May 16, 1988. Prior to the hearing, claimant's widow, appearing pro se, advised Referee Lipton that she no longer wished to pursue the matter. Referee Lipton confirmed this by letter of May 11, 1988. When claimant's widow failed to appear at the scheduled hearing, the Referee dismissed the case. Claimant made no attempt to postpone the hearing or request a new hearing.

CONCLUSIONS OF LAW AND OPINION

Under the applicable Board rule, the failure of claimant or her representative to appear at hearing on May 16, 1988 amounted to a waiver of appearance. See former OAR 438-06-071 (WCB Admin. Order 5-1987, effective January 1, 1988). Because claimant requested the hearing, the Referee had to dismiss the hearing request for failure to appear unless a postponement was granted under former OAR 438-06-081. Claimant made no such request. For these reasons, the Referee's order dismissing claimant's request for hearing is affirmed.

ORDER

The Referee's order dated May 16, 1988 is affirmed.

In the Matter of the Compensation of
AMPARO CORDERO, Claimant
WCB Case No. 88-07044
ORDER ON REVIEW
Francesconi & Associates, Claimant Attorneys
Roberts, et al, Defense Attorneys

Reviewed by Board Members Cushing and Gerner.

The insurer requests review of Referee Galton's order which granted claimant an award of permanent total disability, whereas a Determination Order awarded 60 percent (192 degrees) unscheduled permanent disability for a low back injury. Claimant moves to supplement the record. We treat such a motion as one for remand. On review, the issues are remand and extent of permanent disability, including permanent total disability. We deny the motion, reverse the permanent total disability award, and modify the unscheduled permanent disability award.

FINDINGS OF FACT

Claimant, 36 years of age at hearing, has a third grade Mexican education. She comprehends simple conversational English. Claimant has worked as a housekeeper/baby-sitter.

She began working for the insured, a tree nursery, in 1979, her duties included, plant trimming, clipping, and potting small plants. At the time of her injury claimant was earning $4.40 per hour. The work was seasonal, lasting 8 to 10 months each year. During each hiatus, she baby-sat and/or sought work from other employers.

On March 4, 1984, claimant sustained a compensable injury to her low back. On March 20, 1985, Dr. Bonnett, orthopedic surgeon, performed fusion surgery. The fusion failed, resulting in the development of pseudoarthrosis. On July 11, 1986, Dr. Bonnett performed further surgery, repairing the pseudoarthrosis at L3-4 and L4-S1.

On July 10, 1987, Dr. Gritzka, M.D., orthopedist, released claimant for modified work at the insured. Claimant was advised to avoid squatting, crawling, climbing, walking on rough ground, reaching above her shoulders, working at heights and using her hands for repetitive find manipulation.

A Determination Order was issued on October 5, 1987. Claimant was granted an award of 60 percent unscheduled permanent partial disability. A second Determination Order was issued on October 14, 1987, adhering to the previously granted permanent disability award.

Claimant received a modified plant nursery position. The employment was of a seasonal nature. Each season involved a different type of plant nursery duties, including trimming, potting, and watering plants. These chores were an essential part of a successful planting or harvesting season. Claimant returned to work with the insured on January 25, 1988, and except for a short period, was employed steadily through the July 26, 1988, hearing. At that time, claimant was working five hours per day, five days a week. This modified position was regular and gainful employment.

CONCLUSIONS OF LAW

Remand

Claimant has requested that we remand this case to the Referee for consideration of one document. That document contains a statement from claimant's counsel alleging that the insured terminated claimant upon receipt of the Referee's order.

We may remand to the Referee should we find that the record has been "improperly, incompletely, or otherwise insufficiently developed." ORS 656.295 (5). To merit remand 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).

Here, we are not persuaded that the record concerning the permanent disability issue has been either improperly, incompletely or otherwise insufficiently developed. The document that was unavailable at hearing was irrelevant to the issue raised at hearing; i.e., the extent of claimant's permanent disability.

We conclude that the content of the letter is not material to a determination of claimant's permanent disability as it existed at the time of the hearing. Gettman v. SAIF, 289 Or 609, 614 (1980). Accordingly, remand is not warranted.

Permanent Total Disability

The Referee found that claimant would be unable to sell her services to any other employer and thus was entitled to permanent total disability. We disagree.

In order to prove entitlement to permanent total disability benefits, claimant must prove that she is permanently incapacitated from regularly performing work at a gainful and suitable occupation. ORS 656.206(1)(a). The ability to perform regular and gainful part-time employment precludes a permanent total disability award. Georgia Pacific Corp. v. Perry, 92 Or App 56 (1988).

Dr. Gritzka, claimant's treating physician, opined on March 3, 1987, that she could return to work in a sedentary capacity. Claimant was prohibited from doing repetitive bending, lifting, stooping, and there was a 20 pound weight lifting restriction. Thereafter, on February 9, 1988, Gritzka reported that claimant was able to sit and alternately stand for 2-3 hours at a time and lift approximately twenty pounds. He reported that claimant had a very restricted range of motion of lumbar spine secondary to complaints of pain, and that she was concerned about her ability to work.

Claimant was evaluated by Matias Vocational Assistance Services. On March 30, 1988, the vocational consultant opined that claimant would be able to make a successful return to full time employment.

After considering the medical and vocational evidence, we are not persuaded that claimant's compensable physical condition prevents her from performing regular and gainful employment activities. In fact, the vocational evidence suggests otherwise. The vocational consultant designated claimant's employment position as, "Plant Nursery-Modified". (Ex. 70-1). In such a position, claimant's work was to be recurrent on a seasonal basis. The employer planned to do all of the work in the main building. Hence, there was no need to transfer claimant's bench and chair to another greenhouse. Her duties included, plant tip trimming/patting, and the watering of small plants using a water hose for 30-45 minutes a day. Id.

Claimant returned to work on January 25, 1988. She began working in the warehouse trimming for three hours a day. By June 30, 1988, claimant was working five hours per day taking cuttings out of small branches. The cuts were then trimmed and placed in a container of water. This was light work that could be performed sitting or standing and required lifting of only a few ounces. (Ex. 88-1). At the time of the hearing, claimant was working more than four and half hours a day. (Tr. 12).

This evidence persuasively establishes that claimant's position was necessary to the successful operation of the employer's nursery. In other words, if claimant was unable to perform such duties, the employer would have assigned another worker to perform them. As demonstrated by claimant's ability to perform the duties of the position, we hold that claimant is capable of performing regular gainful employment activities.

In reaching his determination that claimant was permanently and totally disabled, the Referee relied on Wiley v. SAIF, 77 Or App 586 (1986). We find

Wiley distinguishable. There, the claimant was to be provided with a special chair and work environment. Although claimant never accepted the job, the court found that the mere possibility that he might have been able to perform the job for a short period did not warrant a finding that the claimant failed to meet the "seek work" requirement of ORS 656.206(3). Here, claimant has demonstrated her ability to fill a part time position and/or regular position.

Here, the vocational and medical evidence demonstrates that there is regular part time work available within claimant's physical limitations. Moreover, claimant has demonstrated her ability to perform the duties of that position. Under such circumstances, we do not consider the position to be a "make work" job nor do we consider claimant's capability of performing the job to be speculative.

Further, in this case, claimant has failed to offer any competent vocational evidence that she is unable to regularly perform work at a gainful and suitable occupation. Since it is claimant's burden to establish her incapacity to perform work at a gainful and suitable occupation, and she does not, her claim for permanent total disability additionally fails for this reason.

Partial Disability

The criteria for rating the extent of claimant's unscheduled permanent disability is the loss of earning capacity due to he 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 as 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).

Permanent partial disability is determined by the worker's permanent loss of earning capacity due to the compensable injury. Earning capacity is the ability to obtain and hold gainful employment in the broad field of general occupations...." ORS 656.214.

On July 10, 1987, Dr. Gritzka, claimant's treating physician, released claimant for modified work. Dr. Gancher, M.D., neurologist, reported that claimant's impairment was in the moderately severe range. He opined that claimant could work in a sedentary capacity with no repetitive bending, lifting or stooping, and a 20 pound weight lifting restriction. In addition, claimant's future employment should allow her to change positions every half hour, if not more frequently. Subsequently, Dr. Gritzka concurred with this assessment.

Given claimant's relatively young age, limited education, moderately severe permanent physical impairment, prior work experience, and limited transferable skills, we conclude that an award of 100 percent permanent disability appropriately compensates her for her loss of earning capacity due to the compensable injury of March, 1984.

ORDER

The Referee's order, dated August 29, 1988, is reversed. In lieu of the Referee's award of permanent total disability and, in addition to the Determination Order of 60 percent (192 degrees) unscheduled permanent disability, claimant is granted an award of 40 percent (128 degrees) unscheduled permanent disability, giving her a total award to date of 100 percent (320 degrees). Claimant's attorney is awarded 25 percent of the increased compensation created by this order. However, the total attorney fee awarded by the Referee and Board shall not exceed $3,800. A client-paid fee, payable from the insurer to its counsel, is approved, not to exceed $1,280.

In the Matter of the Compensation of
KENNETH W. EMERSON, Claimant
WCB Case No. 86-02178
ORDER ON REVIEW
Bettis & Ricker, Claimant Attorneys
Richard Barber (Saif), Defense Attorney

Reviewed by Board Members Perry and Howell.

The SAIF Corporation requests review of Referee Peterson's order that: (1) increased a Determination Order award of 4.75 percent (2.85 degrees) scheduled permanent disability for loss of hearing in the right ear only, to 32.25 percent (19.4 degrees) scheduled permanent disability for binaural hearing loss; and (2) increased a Determination Order award of 5 percent (16 degrees) unscheduled permanent disability, insofar as it concerned a bilateral tinnitus condition, to 20 percent (64 degrees). On review, the issues are scheduled and unscheduled permanent partial disability. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the findings of fact as set forth in the "Facts" section of the Referee's order.

CONCLUSIONS OF LAW AND OPINION

We affirm and adopt that portion of the Referee's order which awarded claimant 32.25 percent scheduled permanent disability for binaural hearing loss. See Ayres v Christian Logging Co., 64 Or App 187, 188 (1983); Frank E. Ayres, 34 Van Natta 1513 (1982).

We reverse that portion of the Referee's order that increased claimant's unscheduled permanent disability award insofar as it pertained to a bilateral tinnitus condition from 5 percent, to 20 percent.

In rating the extent of claimant's permanent disability, we consider his permanent impairment attributable to the compensable injury and all of the relevant social and vocational factors set forth in former OAR 436-30-380 et seq. We apply these rules as guidelines, not as restrictive mechanical formulas. Harwell v. Argonaut Insurance Co., 296 Or 505, 510 (1984).

On de novo review, after considering claimant's permanent impairment in light of the aforementioned social and vocational factors, and in comparing claimant's loss of earning capacity prior to his compensable injury in August 1983 versus his earning capacity at the time of the hearing, we conclude that the Referee's award should be reversed. Claimant has already had significant loss of earning capacity, which is attributable to his compensable back injury. Although claimant's tinnitus condition has also resulted in a loss of earning capacity, we find the Referee's award to be excessive. After review of the medical and lay evidence and considering the aforementioned factors, we find that a 5 percent unscheduled permanent disability award for his loss of earning capacity due to his compensable bilateral tinnitus condition is appropriate.

Claimant's counsel is statutorily entitled to a reasonable, insurer-paid attorney fee, concerning the scheduled permanent disability award, 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 be awarded. See OAR 438-15-010(5).

ORDER

The Referee's order dated January 7, 1988, as reconsidered February 26, 1988, is affirmed in part and reversed in part. The Determination Order, insofar as it awarded 5 percent (16 degrees) unscheduled permanent disability for a bilateral tinnitus condition is reinstated and affirmed. The remainder of the Referee's order is affirmed.

February 27, 1990 Cite as 42 Van Natta 425 (1990)

In the Matter of the Compensation of
CARMEN GUSMAN, Claimant
WCB Case No. 88-01864
ORDER ON REVIEW
Vick & Gutzler, Claimant Attorneys
Garrett, et al, Defense Attorneys

Reviewed by Board Members Speer and Howell.

Claimant requests review of Referee M. Johnson's order which declined to order payment of temporary disability compensation for an unspecified period. The insurer cross-requested review challenging the Referee's holding that chiropractic treatments were reasonable and necessary and that the insurer's denial of such treatment was unreasonable. On review the issues are claimant's entitlement to temporary disability compensation, the compensability of denied chiropractic treatment, and claimant's entitlement to a penalty and attorney fee for unreasonable denial. We reverse.

FACTS

Claimant, now a 31-year-old female, began working for the employer as a seasonal employee in 1980. Each year in about September, she was laid off, and each year in about December, she was returned to work. In each case, claimant was advised to return to work by the man with whom she lived, a permanent, full-time employee of the employer.

On February 24, 1987, claimant suffered a disabling compensable injury to her right elbow. That injury resulted in lateral epicondylitis (tennis elbow). Claimant received treatment for her injury from Dr. Moore, a chiropractor. She missed two or three weeks of work and then returned to light duty work.

Claimant continued working and continued treating with Dr. Moore. Chiropractic treatments provided some pain relief for two to three hours, but no curative or long term benefit. Treatments included not only treatment of claimant's injured elbow, but manipulation of her neck.

In October 1987, when the employer only had "pretty heavy" work available, claimant was laid off. A few weeks later she began receiving unemployment insurance benefits.

In November and again in December 1987, the employer informed claimant's housemate that it wanted her to return to work. Claimant did not return to work. In February 1988, she contacted the employer about returning to work and was advised that there were no positions available.

In January 1988, claimant had undergone an examination by Dr. Peterson, also a chiropractor. He diagnosed mild lateral epicondylitis. He

felt that chiropractic treatment was neither reasonable nor necessary and that it had continued too long. Based upon that report, the insurer denied continued chiropractic treatment.

Dr. Spady, an orthopedic surgeon, examined claimant on April 4, 1988 He, too, diagnosed lateral epicondylitis. He felt chiropractic treatment was of no benefit for such a condition and that such treatment likely contributed to claimant's chronic pain behavior by reinforcing it. Drug therapy was recommended and, if claimant refused, she was considered medically stationary.

At the time of hearing, claimant continued to receive unemployment insurance benefits. She had not returned to work and she had not been released to regular work by Dr. Moore, her attending physician. She was not yet considered medically stationary by Dr. Moore. Her claim had not yet been closed. At the time of hearing, there were some outstanding, unpaid chiropractic bills of Dr. Moore.

CONCLUSION

Temporary Disability Compensation

The Referee concluded that claimant was not entitled to temporary disability compensation after she was laid off in October 1987. We disagree.

Shortly before the Referee issued his order in this matter, the court issued its opinion in Fazzolari v. United Beer Distributors, 91 Or App 592 (1988). The court held, as a procedural matter, that an injured worker is entitled to continued payment of temporary disability compensation for a disabling injury until the worker is both medically stationary and released by the attending physician to return to regular work. ORS 656.268(1) & (2); Fazzolari, supra, 91 Or App at 595. However, an insurer may reduce temporary total disability benefits to temporary partial disability benefits upon the worker's return to work. ORS 656.212; former OAR 436-60-030(3); Fazzolari, supra, 91 Or App at 595.

In this case, claimant had not yet become medically stationary and she had not yet been released to return to regular work by her attending physician up to the date of hearing. The insurer was, therefore, not permitted to unilaterally terminate temporary total disability compensation payments. The insurer was permitted to reduce claimant's temporary total disability compensation to temporary partial disability compensation payments once claimant returned to modified work with the employer and until she was laid off in October, 1987. If claimant's wage during that period was equal to or greater than her wage on the date of injury, the amount of temporary partial disability compensation to which she was entitled was zero. Former OAR 436-60-030(2); Safeway Stores v. Owsley, 91 Or App 475 (1988).

When claimant was laid off by the employer, she was not yet medically stationary nor released to regular work. Her lay-off occurred because the employer no longer had work within her injury-related limitations. The insurer was, therefore, required to immediately reinstitute the payment of temporary total disability compensation. Gray v. SAIF, 70 Or App 313 (1984); Former OAR 436-60-030(6)(b). But see Safeway Stores v. Owsley, supra and former OAR 436-60-030(6)(b) (where claimant was discharged for reasons unrelated to a compensable injury and during a period of modified employment).

After the insurer was required to reinstitute temporary total disability compensation payments upon claimant's lay off, and once claimant began receiving unemployment insurance benefits, the insurer was entitled to once

again reduce claimant's temporary total disability compensation benefits to temporary partial disability compensation. That is, temporary total disability payments could be reduced by "earnings" in the form of the unemployment insurance benefits claimant received. Wells v. Pete Walker's Auto Body, 86 Or App 739 (1987). No further reduction of claimant's temporary disability compensation prior to hearing was authorized by law. Claimant was not offered, nor did she refuse, wage earning employment under the terms of former OAR 436-60-030(5), so as to allow a further reduction of her temporary disability compensation. See Eastman v. Georgia-Pacific Corp., 79 Or App 610 (1986). Neither is there evidence to support the insurer's argument that claimant withdrew from the labor market. In fact, she was required to be available for work and she was required to, and did, search for work as a requisite to the receipt of unemployment insurance benefits. See ORS 657.155.

In sum, claimant was entitled to temporary total disability compensation during her disability and until she returned to modified work with the employer in about March 1987. From March 1987 until October 1987, when she was laid off, she was entitled to temporary partial disability compensation, payable at a rate pursuant to former OAR 436-60-030(1) or (2). After her lay off in October and before she began receiving unemployment insurance benefits, claimant was entitled to temporary total disability compensation. After she began receiving unemployment insurance benefits, claimant was entitled to temporary partial disability compensation, payable pursuant to former OAR 436-60-030(1), where her unemployment insurance benefits represented her "post-injury wage earnings". No other reductions were authorized up to the time of hearing.

MEDICAL SERVICES

An injured worker is entitled to medical services which are reasonable, necessary and due to the compensable injury. ORS 656.245. The Referee concluded that a portion of the denied chiropractic treatments were compensable. He refused to consider another portion of the denied treatments. We disagree with both conclusions.

Dr. Moore treated not only claimant's injured elbow, but her spine (neck). The Referee refused to consider the ". . . rights of either party, in regards to claimant's neck condition . . ." However, medical services involving claimant's neck had been claimed by Dr. Moore's billings for such services. The insurer had denied such services by its denial letter and the parties litigated that issue before the Referee. We can find no reason why the compensability of medical services for claimant's neck should not have been addressed by the Referee. On de novo review we do so.

The evidence in this record shows no injury to claimant's neck as a consequence of her compensable elbow injury. Furthermore, there is no indication in this record as to why treatment of claimant's neck is necessary for claimant's injured elbow. We conclude that treatment of claimant's neck has not been shown to have been reasonable, necessary and due to claimant's compensable injury.

The Referee also found that Dr. Moore's treatment had some long term or curative benefit with respect to claimant's injured elbow. Claimant's testimony was both unclear and inconsistent in that regard. We are not persuaded that she experienced any benefit other than the two to three hours of diminished pain she testified to as a result of Dr. Moore's treatments. She testified that, despite nearly a year of treatment by Dr. Moore and despite improvement since being off work, her condition at the time of hearing was no better than at the time of injury.

Given the very temporary and limited benefit claimant received, along with the opinions of Drs. Peterson and Spady, who considered the disputed treatment not to be reasonable and necessary and to be possibly detrimental, we conclude that claimant has failed to prove that the denied treatments of her elbow were reasonable or necessary.

PENALTY AND ATTORNEY FEE

Without discussion, the Referee found the insurer's denial to have been unreasonable. We disagree. At the time it issued, the insurer's denial of continuing chiropractic treatment was supported by Dr. Peterson's opinion that such treatment was not reasonable and necessary. Subsequently, Dr. Spady offered the same opinion. The insurer had a reasonable basis to doubt its liability for the denied medical services. That is particularly true of the treatment for claimant's neck, which had not been related to her accepted elbow injury. A penalty and attorney fee are not warranted.

ORDER

The Referee's order dated July 6, 1988 is reversed. Claimant is entitled to temporary disability compensation as set forth above. Her agreement with her attorney is approved for payment of 25 percent of the increased compensation as a reasonable attorney fee, not to exceed $3,800 payable directly to claimant's attorney. The insurer's January 22, 1988 denial is reinstated and upheld. The Referee's attorney fee awards and assessment of a penalty are reversed. A client-paid fee, payable from the insurer to its counsel, is approved, not to exceed $1,327.

In the Matter of the Compensation of
KEVIN V. KIRKPATRICK, Claimant
WCB Case No. 88-01067
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Jim Dodge (Saif), Defense Attorney

Reviewed by Board Members Brittingham and Nichols.

Claimant requests review of Referee Brown's order that: (1) upheld the SAIF Corporation's denial of claimant's aggravation claim for a neck condition; and (2) increased claimant's unscheduled permanent disability for a back/neck injury from 30 percent (96 degrees), as awarded by a prior Determination Order, to 35 percent (112 degrees) unscheduled permanent disability. On review, the issues are aggravation and permanent partial disability. 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 exception of finding number 6.

FINDINGS OF ULTIMATE FACT

The last arrangement of compensation was the April 13, 1987 Determination Order as amended on April 17, 1987.

Claimant has suffered a symptomatic exacerbation of his compensable condition.

Claimant did not suffer an increase in his loss of wage earning capacity as a result of his symptomatic exacerbation.

As a result of his compensable back and neck condition, claimant has sustained permanent physical impairment in the mildly moderate range..

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant had not sustained a worsened condition and/or an increased loss of earning capacity since the last arrangement of compensation (April 17, 1987). We agree with the Referee's conclusion. However, we reach that conclusion on a different basis.

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 exacerbations, 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. Dr. Sutherland examined claimant on September 28, 1987 and found that claimant's neck condition was not stationary and recommended conservative treatment for claimant's increased neck pain.

Having met the first part of the analysis, i.e. was there an exacerbation of claimant's physical condition, the next issue becomes whether or not claimant sustained a loss of earning capacity as a result of the symptomatic exacerbation. Based upon the medical and lay evidence, we find that claimant's wage earning capacity has not been diminished by this exacerbation.

The last arrangement of compensation was the April 17, 1987 Determination Order, which affirmed a prior award of 30 percent unscheduled and 15 percent scheduled permanent disability. At the time the Determination Order issued, claimant had been limited to work in the light to medium categories and was restricted to lifting no more than 35 pounds. Dr. Sutherland's opinion, following the alleged aggravation, that claimant was unable to work is not persuasive as there is no evidence which would support a finding that Dr. Sutherland believed claimant could not perform jobs in the light to medium work categories and he had previously been limited from the more vigorous work categories.

The Western Medical Consultants opined that at the time of its examination, November 21, 1987, claimant was physically capable of performing work in the light to medium categories. Neither claimant nor his treating doctor have indicated his condition improved prior to seeing Western Medical Consultants in November 1987.

Claimant testified that in April 1987, the time of the last arrangement of compensation he was experiencing neck stiffness and a limited range of motion on a weekly basis. It is this complaint upon which claimant now bases his aggravation.

The preponderance of the evidence does not support a finding that claimant suffered an aggravation of his April 12, 1984 compensable injury. Dr. Sutherland, as claimant's treating physician, may be entitled to some deference.

Weiland v. SAIF, 64 Or App 810 (1983). Yet, when compared with the thorough opinion of the Western Medical Consultants, his opinions are not well reasoned or complete and are therefore not persuasive. See Somers v. SAIF, 77 Or App 259 (1986). We find therefore, that claimant has failed to meet his burden of proving an aggravation claim.

The Referee increased claimant's unscheduled permanent disability for a back and neck injury from 30 percent (96 degrees) to 35 percent (112 degrees). We agree.

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

Therefore, considering claimant's back and neck permanent impairment in light of the aforementioned guidelines, we conclude that an award of 35 percent unscheduled permanent disability appropriately compensates claimant for the permanent loss of earning capacity resulting from the compensable injury.

Finally, the issue of extent of scheduled permanent disability was not raised at the hearing (Tr. 3). Even though claimant's counsel purports to place scheduled disability at issue on review, we decline to address an issue not raised at hearing.

ORDER

The Referee's order dated May 10, 1988 is affirmed.

In the Matter of the Compensation of
the Beneficiaries of Leon V. Liacos, Deceased, Claimant
MARY K. LIACOS, Beneficiary of Leon V. Liacos, Deceased
WCB Case No. TP-87030
THIRD PARTY DISTRIBUTION ORDER ON REMAND
Royce, et al, Claimant Attorneys
James E. Griffin, Assistant Attorney General

This matter is before the Board on remand from the Court of Appeals. Liacos v. SAIF, 96 Or App 737 (1989). We previously concluded that SAIF's third party lien attached to the proceeds of the settlement before distribution of the proceeds to the deceased worker's adult children. Leon V. Liacos, 40 Van Natta 102, 339 (1988). The court has reasoned that its decision in Scarino v. SAIF, 91 Or App 350, rev den 306 Or 660 (1988), supported the surviving spouse's contention that the shares of the settlement proceeds attributable to non-beneficiaries under the Workers' Compensation Law should not be subject to SAIF's lien. Inasmuch as the Board's order issued prior to the court's decision in Scarino, the court remanded for reconsideration.

Subsequent to the court's decision, SAIF has advised us that the proceeds of the third party settlement should be made in accordance with Scarino. Noting that the proceeds have already been fully distributed to the appropriate individuals except for a remaining balance of $7,940.40, the parties agree that this amount be transferred to the surviving spouse.

Considering these circumstances, we conclude that the surviving spouse is entitled to the remaining balance of proceeds from the third party settlement. Accordingly, claimant's attorney is directed to pay the surviving spouse $7,940.40.

IT IS SO ORDERED.

February 27, 1990 Cite as 42 Van Natta 431 (1990)

In the Matter of the Compensation of
DEWEY A. LOGUE, Claimant
WCB Case Nos. 85-16107 & 87-09178
ORDER ON REVIEW
Stebbins & Coffey, Claimant Attorneys
Cummins, et al, Defense Attorneys
David O. Horne, Defense Attorney

Reviewed by Board Members Myers and Cushing.

Weyerhaeuser Company requests review of those portions of Referee Higashi's order that: (1) set aside its denial of claimant's right knee osteoarthritis condition; and (2) upheld Wausau's Insurance Company's denial of the same condition. On review, the issues are compensability and responsibility. We affirm.

FINDINGS OF FACT

Claimant worked for Wausau's insured from April 1961 through December 1969. During this period he worked as hook tender and high climber. Claimant's duties included heavy manual labor, climbing, walking and crawling.

In March 1967, claimant twisted his right knee, when he tried to avoid a falling rock. On August 15, 1968, while stepping over a small log, claimant's right knee popped and buckled, causing him to fall to the ground. He did not miss any work. Shortly thereafter, claimant was examined by Dr. Smith, M.D., orthopedic surgeon.

Claimant stopped working for Wausau's insured in December 1969, when its wood operation was closed. Claimant went to work for Weyerhaeuser Company in 1970, where he worked continuously in the woods until 1985. During this employment, he worked as a hook tender, high climber and head rigger. These duties involved heavy manual labor, climbing, crawling, and walking on uneven ground.

Claimant again injured his right knee on April 19, 1985. He had been carrying a block on his shoulder while climbing up a log, when he lost his balance. His foot went into a hole, causing him to twist his right knee. Dr. Smith reported that along with his knee pain, claimant experienced discomfort that extended from mid-calf up into the back. On October 1, 1985, Dr. Freudenberg, orthopedist, reported that claimant's knee occasionally gave way, and that knee soreness would develop after walking for a mile on a level surface.

On November 18, 1985, Weyerhaeuser issued a partial denial regarding claimant's right knee osteoarthritic condition.

On December 10, 1985, Dr. Freudenberg performed surgery to increase the functional capacity of the right knee. On September 9, 1986, Dr. Gripekoven, orthopedist, reviewed claimant's medical record.

On June 3, 1987, Wausau denied claimant's request for reopening of his prior claim for medical benefits.

CONCLUSIONS OF LAW AND OPINION

The Referee applied the "last injurious exposure" rule, and found that Weyerhaeuser, as claimant's last place of employment bore a causal relationship to his right knee osteoarthritis condition. We agree.

In compensability/responsibility cases, the threshold issue is compensability. Joseph L. Woodward, 39 Van Natta 1163, 1164 (1987). If the claim is compensable, then the trier of fact must address the issue of responsibility. See Runft v. SAIF, 303 Or 493, 498-99 (1987). Weyerhaeuser asserts that claimant's right knee condition is not a compensable condition stemming from his work at Weyerhaeuser.

Turning to the medical issue first, claimant bears the burden of proving that a condition giving rise to a need for medical treatment or disability is materially related to a compensable claim. Hutcheson v. Weyerhaeuser Company, 288 Or 51, 56 (1979). We consider this to be a complex medical question largely dependent on expert medical evidence. Kassahn v. Publishers Paper Co. 76 Or App 105, 109 (1985).

By letter dated April 10, 1988, Dr. Smith, claimant's treating physician, reported that claimant had osteoarthritis of the knee, and that he had been able to tolerate the condition until the injury of April 19, 1985. Smith opined that the incident exceeded the capacity of claimant's knee to resist stress: "...with the result that the knee became troublesome to the point where where he was unable to continue working. In this sense the incident independently contributed to a worsening of his condition." (Ex. 28-1) (emphasis added). Dr. Smith also pointed out absent the April, 1985 incident, surgery would not have been necessary. In addition, Dr. Freudenberg also felt that the April 1985 incident had independently contributed to a worsening of claimant's arthritic condition. Likewise, he pointed out that the April 1985 incident created the need for the December 1985 surgery. (Ex. 29-2).

To support its position that claimant's injuries at Wausau's insured were the sole cause of the osteoarthritic condition, Weyerhaeuser relied upon the opinions of Drs. Duff and Gripekoven. We are not persuaded by these opinions. Dr. Gripekoven reasoned that Dr. Freudenberg's operative report showed no acute changes to prove a nexus to the April 1985 injury. Yet, Gripekoven's opinion was based on a review of Freudenberg's written report, and not a personal examination. Likewise, Dr. Duff examined claimant once in 1985, prior to the surgery. Consequently, he did not have the results of the surgery upon which to assess any changes in claimant's condition precipitated by the April 1985 incident. In addition, both Drs. Duff and Gripekoven failed to recognize that claimant's knee pain had increased since the April 1985 injury.

Claimant testified that after the April 19, 1985 incident his knee got worse. He continued to work even though there was increased swelling and pain. Some of his work crew would assist him. He could no longer drag the fifteen pound power saw down into the canyon to buck logs. Moreover, his colleagues would have to pack some of claimant's blocks for him.

Weyerhaeuser argues that Dr. Smith had an inaccurate case history. It asserts that claimant returned to work without difficulty following the April 1985 incident. However, claimant's testimony shows that he was in pain, and that he required the assistance of his crew to complete various work assignments.

Dr. Smith was claimant's treating physician for an extended period of time. He is the only physician to have examined claimant both in 1968, at the time of the Wausau injury, and subsequently, in April 1985, at the time of the Weyerhaeuser injury. Because of his long term exposure to and knowledge of claimant condition, we accord his opinion great weight. Kienow's Food Stores v. Lyster, 79 Or App 416 (1986); Weiland v. SAIF, 64 Or App 810 (1987).

We conclude that claimant has sustained his burden of proving that the April 19, 1985 work incident is a material contributing cause of his need for medical treatment and disability of his right knee. Consequently, he has established a compensable claim with Weyerhaeuser.

Inasmuch as Wausau has not contested compensability, we now turn to the responsibility issue. The Referee determined that the April 19, 1985, injury independently contributed to the worsening of claimant's underlying condition. Consequently, he assigned responsibility for claimant's condition to Weyerhaeuser. We agree.

We are persuaded that the April 19, 1985 injury independently contributed to a worsening of claimant's condition. We are influenced by several factors. First, Dr. Smith concluded that claimant's April 19, 1985 injury had independently contributed to a worsening of claimant's condition. Smith reasoned that the April 1985 incident affected the underlying arthritic condition, which created the need for surgery in order to increase the functional capacity of the knee. Indeed, without the April 1985 incident, Smith opines that surgery would not have been necessary at that time. (Ex. 28-1,2). Finally, Dr. Fruedenberg, the physician who performed the surgery, agrees with Smith's conclusions that the April 1985 incident had independently contributed to a worsening of claimant's underlying right knee osteoarthritic condition.

We conclude that the April 19, 1985 work incident independently contributed to a worsening of claimant's underlying condition. We find that Weyerhaeuser is the responsible carrier.

ORDER

The Referee's order, dated August 1, 1988, is affirmed. For services on Board review, claimant's attorney is awarded an assessed fee of $750, to be paid by Weyerhauser. A client-paid fee not to exceed $1,819, payable from Weyerhaeuser to its counsel, is approved.

February 27, 1990 Cite as 42 Van Natta 433 (1990)

In the Matter of the Compensation of
WCB Case No. 86-01120
DONALD E. SMITH, Claimant
ORDER ON REVIEW
Malagon & Moore, Claimant Attorneys
Cummins, et al, Defense Attorneys

Reviewed by Board Members Brittingham and Nichols.

Claimant requests review of those portions of Referee Blevins' order which: (1) upheld the self-insured employer's denials of claimant's aggravation claims for his low back condition; and (2) declined to grant permanent total disability. In its brief, the employer contends that the Referee erred in awarding claimant 50 percent (160 degrees) unscheduled permanent disability

award for a low back injury, whereas a Determination Order had awarded no permanent disability. On review, the issues are aggravation and extent of unscheduled permanent disability, including permanent total disability. We affirm in part and reverse in part.

FINDINGS OF FACT

Claimant sustained a compensable injury to his low back in January 1985. He sustained the injury when he was stooped over and raised up striking his low back on a piece of lumber. The injury was a soft tissue injury, superimposed on degenerative disc disease. The employer closed the claim in March 1985 without an award of permanent disability. In April 1985, claimant returned to his treating physician, Dr. Cox, with complaints of low back and anterior thigh pain. Thereafter, the employer reopened his claim.

In September 1985, an MRI scan revealed that claimant had degenerative disc disease without evidence of spinal stenosis. A January 1986 Determination Order reclosed claimant's claim and did not award any permanent disability.

In July 1986, claimant was again seen by Dr. Cox, with complaints of low back and leg pain. Claimant's counsel forwarded Dr. Cox's report to the employer and requested that the claim be reopened. In September 1986, the employer denied reopening on the basis that claimant's compensable condition had not worsened. The employer further denied claimant's bilateral leg symptoms. In November 1986, Dr. Cox wrote the employer again requesting that claimant's claim be reopened. The employer issued a second denial confirming its September 1986 position that claimant's compensable condition had not worsened.

In March 1987, Dr. Cox again wrote the employer requesting that claimant's claim be reopened. In June 1987, the employer issued a third aggravation denial.

Claimant has a degenerative disc disease that preexisted the January 1985 compensable low back injury. The January 1985 compensable injury did not effect claimant's preexisting low back condition.

FINDINGS OF ULTIMATE FACT

Claimant's compensable low back injury has not worsened since the January 1985 Determination Order.

Claimant has not sustained a loss of earning capacity as a result of his compensable injury.

CONCLUSIONS OF LAW

Aggravation

We adopt the conclusions and reasoning, concerning the aggravation issue, as set forth in the "Opinion" section of the Referee's order.

Permanent Disability

The Referee concluded that the January 1985 industrial injury permanently aggravated claimant's underlying degenerative condition and awarded him 50 percent unscheduled permanent disability. We disagree.

The issue of whether claimant's industrial injury rendered his preexisting degenerative condition permanently symptomatic is a complex medical question. Thus, although claimant's testimony is probative, the resolution of

this issue turns largely on an analysis of the medical evidence. Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985).

Dr. Cox opined that that industrial trauma probably activated the preexisting condition. Dr. Rabin opined that the January 1985 incident represented a trauma superimposed on the degenerative condition and that all of claimant's current symptoms were directly related to the compensable injury.

We are not persuaded by the opinions of Drs. Cox and Rabin. Dr. Cox offers no analysis as to how the industrial injury activated claimant's underlying condition. Further, he does not explain his earlier report in which he opined that claimant had recovered from the industrial injury with no permanent residuals. Likewise, Dr. Rabin offers no explanation for his opinion and his conclusion that all of claimant's symptoms are due to the industrial injury is not supported by the medical record.

Conversely, Dr. Rosenbaum's opinion supports the conclusion that it was medically improbable that the industrial injury permanently exacerbated claimant's preexisting degenerative condition. Specifically, Rosenbaum concluded that the history of the January 1985 injury indicated that the incident was not severe enough to have activated claimant's underlying condition. Dr. Rosenbaum's opinion is supported by Dr. Howell and the Independent Chiropractic Consultants, who suggested that the industrial injury had no permanent effect on the degenerative condition, or its symptoms.

We find the well-reasoned opinion of Dr. Rosenbaum, as well as the supporting opinions of Dr. Howell and the Consultants to be persuasive. See Somers v. SAIF, 77 Or App 259 (1986). Accordingly, we do not consider claimant's preexisting degenerative condition in rating the extent of his permanent disability.

In light of our conclusion above, we next turn to whether claimant has sustained a loss of earning capacity as a result of his compensable injury. See ORS 656.214(5).

Dr. Howell opined that claimant had no evidence of muscle strain that could be referable to the industrial injury. Independent Chiropractic Consultants reported that claim had no objective indications of impairment or disability as a result of the compensable injury. Dr. Rosenbaum also opined that claimant had no objective impairment as a result of the compensable injury. Finally, Dr. Cox opined that claimant had no permanent residuals resulting from the compensable injury. Only Dr. Rabin feels that claimant has sustained permanent impairment. His opinion, however, is based on the premise that all of claimant's symptoms are related to the compensable injury.

Under these circumstances, we conclude that claimant has failed to establish a loss of earning capacity due to his compensable injury.

ORDER

The Referee's order dated October 19, 1987, is reversed in part and affirmed in part. That portion which awarded claimant 50 percent (160 degrees) unscheduled permanent disability is reversed. The Determination Order is reinstated and upheld. The remainder of the order is affirmed. A client-paid fee, not to exceed $2,375, is approved.

In the Matter of the Compensation of
ROBERT F. STERRITT, Claimant
WCB Case Nos. 86-08796 & 87-11261
ORDER ON REVIEW
Vick & Gutzler, Claimant Attorneys
James Dodge (Saif), Defense Attorney

Review by Board Members Perry and Howell.

Claimant requests review of Referee Borchers' order which upheld the SAIF Corporation's denial of claimant's hypertension. The issue on review is compensability. We affirm.

FINDINGS OF FACT

Claimant compensably injured his back and neck on November 9, 1985. Elavil (Amytriptoline) was prescribed for his headaches and neck pain beginning in March 1986 (Ex. 4-2). He subsequently complained of inordinate thirst, weight gain and chest pain. His treating neurosurgeon referred him to an internist, Dr. Berven. (Exs. 1-6 & 10)

Dr. Berven examined claimant and found his blood pressure to be elevated and found claimant to have tachycardia. Claimant's Elavil level was reduced and then terminated. His blood pressure remained elevated. Dr. Berven diagnosed essential hypertension and prescribed medication. Claimant's blood pressure then came under control. (Exs. 9-11, 15, 17, 18, 24 & 25)

By letter dated October 2, 1986, SAIF partially denied the compensability of claimant's hypertension. Over a year later claimant began treating with Dr. Srch, a chiropractor, for neck and back pain. (Exs. 25, 38 & 46)

CONCLUSION OF LAW AND OPINION

Dr. Berven, claimant's attending physician for hypertension, diagnosed essential hypertension. He indicated on one occasion that claimant's use of Elavil "may have" contributed to his hypertension. On another occasion, Dr. Berven stated that Elavil and other circumstances were "possible" factors in aggravating his preexisting hypertension. However, he also reported to claimant, in September 1986, that if Elavil had caused his high blood pressure, it should have by then resolved.

Claimant's treating neurosurgeon reported that Elavil "perhaps" was responsible for an itching condition claimant complained of, but that his hypertension was not related to his industrial injury.

Dr. Srch opined, after having read the Physician's Desk Reference, that Elavil was a likely contributing cause, along with injury related stress, in exacerbating claimant's hypertension.

We conclude, as did the Referee, that claimant has failed in his burden of proving, to a reasonable medical probability, that his hypertension, or a worsening of that hypertension, was a consequence of his compensable injury.

We give no weight to Dr. Srch's opinion regarding the contribution of Elavil to claimant's hypertension. Dr. Srch, a chiropractor, is not licensed to dispense prescription drugs [ORS 684.015(3)] and was shown to have no expertise in pharmacological or internal medicine matters. Unlike an M.D. or

D.O., we presume no such expertise based upon Dr. Srch's license as a chiropractor. We also find that Dr. Srch's opinion that injury related stress worsened claimant's hypertension is unpersuasive. The opinion is unexplained. Dr. Srch has been shown to have no expertise in such matters and he did not see claimant until 1-1/2 to 2 years after he was injured, diagnosed as having essential hypertension and successfully treated for that condition.

ORDER

The Referee's order dated September 30, 1988 is affirmed.

February 27, 1990 Cite as 42 Van Natta 437 (1990)

In the Matter of the Compensation of
RICHARD F. TAYLOR, Claimant
WCB Case Nos. 88-03008 & 88-03007
ORDER ON REVIEW
Peter O. Hansen, Claimant Attorney
Nelson, et al, Defense Attorneys

Reviewed by Board Members Howell and Speer.

Liberty Northwest Insurance Corporation (Liberty) requests review of that portion of Referee Mulder's order which assessed a penalty and attorney fee for unreasonable delay in providing claims information and in paying temporary total disability compensation (TTD). On review the issue is a penalty and attorney fee. We reverse.

FACTS

Claimant compensably injured his low back in December 1978 while working for the SAIF Corporation's (SAIF's) insured. As a result, he underwent surgery and received an award of permanent disability compensation.

On April 22, 1985, claimant compensably reinjured his back while working for Liberty's insured. That claim was closed by Determination Order on March 12, 1986.

Claimant returned to work and continued until February 1987, when he left work due to increased pain. Liberty denied reopening for aggravation by letter dated July 2, 1987. SAIF denied responsibility for medical services. Claimant requested hearings and the requests were consolidated and heard on October 6, 1987.

On December 9, 1987, the Referee issued an Opinion and Order finding Liberty responsible for claimant's condition after February 1987. The order was not mailed to SAIF or any representative for SAIF.

Liberty requested reconsideration of the December 9, 1987, order and pointed out that it had not been mailed to SAIF, one of the interested parties. On December 23, 1987, the Referee issued an Order of Abatement. SAIF was not sent a copy.

On January 28, 1988, the Referee issued an Order on Reconsideration, republishing the December 9, 1987 order. The republished order was not mailed to SAIF. Liberty requested review.

On April 25, 1988, we issued an "ORDER DISMISSING REQUEST FOR BOARD REVIEW AND DIRECTING REPUBLICATION OF REFEREE'S ORDER (REMANDING)". We found that, because the Referee's orders were not mailed to all parties, they were not final orders and, therefore, not reviewable.

On June 8, 1988, a second Referee republished the first Referee's December 9, 1987 order. It was then mailed to all interested parties. (We take official notice of the June 8, 1988 order.)

CONCLUSION

The Referee in the present case assessed a penalty and attorney fee against Liberty for unreasonable delay in paying TTD. He made no findings as to when such compensation was due nor if or when such compensation was paid.

Liberty argues that it was not required to begin paying TTD until within 14 days after the first "final order" holding it responsible. Since this occurred on June 8, 1988, when the second Referee published an order and mailed it to all interested parties, and because, Liberty asserts, it had begun paying TTD in February 1988, it did not delay paying TTD.

Claimant argues that the January 28, 1988 order of the first Referee was sufficient to require Liberty to begin paying TTD.

In Richard F. Taylor, 40 Van Natta 384 (1988), we held that the first Referee's orders were not final orders for purposes of ORS 656.295 (requests for Board review). The issue here is somewhat different.

OAR 436-60-150(3)(e) provides that TTD be paid within 14 days of a "litigation order" which orders temporary disability compensation. "Litigation order" is not defined by statute or rule. Here, the question is whether the first Referee's order of January 28, 1988 was a "litigation order" for purposes of the rule.

ORS 656.289(1) requires a Referee, within 30 days of the conclusion of a hearing, to determine the matter and make an order. Subsection (2) of the same statute provides: "A copy of the order shall be sent forthwith by mail to the director and to all parties in interest". The time within which to request review begins to run on the date of mailing. ORS 656.289(3).

We find that, until the first referee's order was mailed, pursuant to statute, it was not a "litigation order". The improperly mailed January 28, 1988 order did not obligate Liberty to make payment within 14 days of its issuance. The fact that the time for requesting review begins with mailing tends to support our reading of the statute. We also believe that to conclude otherwise could, in some cases, give rise to absurd results; that is, establishment of an enforceable litigation order prior to the act required to give notice to the parties of their rights and obligations under the order.

The order in question in this case was a single order disposing of consolidated hearing requests. The fact that Liberty received its copy of the order does not alter our conclusion that the January 28, 1988 order was not a "litigation order" for purposes of OAR 436-60-150(3)(e) until it was mailed "to all parties in interest" pursuant to ORS 656.289(2).

The first "litigation order" in this matter did not issue until June 8, 1988. Claimant has not shown a delay in, nor a resistance to, payment of compensation thereafter. A penalty for unreasonable delay in the payment of compensation may not be assessed under ORS 656.262(10). An attorney fee may not be awarded under ORS 656.382. Ellis v. McCall Insulation, 308 Or 74 (1989); Lloyd L. Cripe, 41 Van Natta 1774 (1989).

As to claimant's entitlement to a penalty and/or attorney fee for unreasonable delay by Liberty in providing claims information, there has been no showing by claimant that there was any compensation "then due", during the alleged delay with respect to which a penalty could be assessed. Neither has it been shown that, if Liberty unreasonably delayed providing such information, its delay represented resistance to the payment of compensation under ORS 656.382.

We conclude that claimant has failed to prove entitlement to a penalty or a related attorney fee.

ORDER

The Referee's order dated September 15, 1988 is reversed in part. That portion which assessed a penalty and attorney fee is reversed. The remainder of the order is affirmed.

In the Matter of the Compensation of
EDWARD L. BATESON, Claimant
WCB Case No. 88-06748
ORDER ON REVIEW
Emmons, et al, Claimant Attorneys
Roberts, et al, Defense Attorneys

Reviewed by Board Members Cushing and Myers.

The insurer requests review of those portions of Referee Borchers' order which affirmed a Determination Order's finding of when claimant became medically stationary. We reverse.

ISSUES

The insurer contends that claimant became medically stationary on April 22, 1987 rather than March 16, 1988 as found by the Determination Order. If the Board holds in its favor, the insurer seeks authorization to offset the overpayment created by the change in medically stationary dates against future awards for permanent disability.

FINDINGS OF FACT

Claimant compensably injured his low back in June 1982. The claim was closed in January 1984 with an award for 10 percent unscheduled permanent disability. Claimant's condition aggravated in 1986. The insurer's aggravation denial was set aside by Opinion and Order in June 1987.

Claimant's treating physician found claimant medically stationary as of April 22, 1987. According to the Orthopaedic Consultants, claimant remained medically stationary in November 1987. Nonetheless, the Consultants suggested that claimant undergo a CT scan and an MRI because of his protracted symptoms and to complete the medical record. An MRI revealed multilevel degenerative disc disease; however claimant remained medically stationary.

A Determination Order, issued on April 5, 1988, finding claimant medically stationary March 16, 1988.

As of April 22, 1987, there was no reasonable expectation that claimant's condition would materially improve with further treatment or the passage of time.

CONCLUSIONS AND OPINION

Medically stationary means that no further material improvement would reasonably be expected from medical treatment or the passage of time. The preponderance of the medical evidence in this case is that, as of April 22, 1987,

claimant was medically stationary. Claimant's treating chiropractor so stated and every other later examiner agreed.

The Referee concluded that claimant was not medically stationary because the Orthopaedic Consultants suggested further testing. A need for further testing does not, in and of itself, indicate that claimant is not medically stationary. In this case, the Consultants apparently felt that further testing was needed to complete the medical record. There is no requirement that a medical record must be "completed" before a claimant can be found medically stationary.

ORDER

The Referee's order, dated October 24, 1988, is affirmed in part and reversed in part. That portion of the Referee's order which found claimant medically stationary on March 16, 1988, is reversed. The Determination Order is modified to find claimant medically stationary April 22, 1987. The insurer is authorized to offset any overpayment created by this order against future awards for permanent disability. The Board approves a client-paid fee, not to exceed $1,593.50, payable by the insurer to its attorney.

February 28, 1990 Cite as 42 Van Natta 440 (1990)

In the Matter of the Compensation of
LORETTA A. BEAL, Claimant
WCB Case No. 88-13511
ORDER ON REVIEW
Merrill Schneider, Claimant Attorney
Schwabe, et al, Defense Attorneys

Reviewed by Board Members Gerner and Myers.

Claimant requests review of Referee Fink's order which affirmed a Determination Order that awarded no scheduled permanent disability for claimant's right arm. The issue on review 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.

CONCLUSIONS OF LAW AND OPINION

The criteria for the rating of scheduled disability is the permanent loss of use or function of the injured member due to the industrial injury. ORS 656.214(2). Claimant must not only prove that she has permanent disability by a preponderance of the evidence, but that the disability is due to the industrial injury. Where both a compensable and noncompensable condition affect the same body part, and are both capable of causing permanent disability, then the rating of permanent disability pursuant to ORS 656.214 becomes a complex medical question requiring competent medical testimony.

Claimant's compensable condition in this case involved her right arm only. Claimant also has a cervical condition (that is not compensable) that also resulted in disability and impairment into her right arm. In 1987, claimant had surgery on her neck that resolved most of the major problems in her neck, right arm, elbow and wrist.

Following the surgery, and upon closing the compensable claim, claimant's long time treating physician, Dr. Orth, stated that the right arm claim resulted in no permanent residuals and that the "ultimate problem in the Rt arm, elbow,

and wrist were resolved by the decompression laminectomy and cervical fusion." (Exs. 38, 39). Dr. Orth had also previously stated that he could not separate the cervical problem from the wrist and arm problem. (Ex. 20) There is no other medical evidence discussing the relationship of claimant's right arm complaints to her compensable injury.

Since Dr. Orth cannot separate the two conditions, and in fact indicates that the neck condition was the apparent cause of the arm problems, claimant has no medical evidence that the complaints she credibly testified to at hearing are due to the compensable injury and not the neck condition. Without that necessary evidence in this case claimant fails to carry her burden of proving permanent disability due to her compensable injury.

ORDER

The Referee's order, dated November 4, 1988, is affirmed. The Board approves a client-paid fee, not to exceed $1,296.50, payable from the insurer to its counsel.

February 28, 1990 Cite as 42 Van Natta 441 (1990)

In the Matter of the Compensation of
EDWARD J. CONNOR, Claimant
WCB Case No. 87-14925
ORDER ON REVIEW
Pozzi, et al, Claimant Attorneys
John B. Motley (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

Claimant requests review of that portion of Referee Galloway's order that approved the SAIF Corporation's method of calculating his temporary total disability benefits. The issue is the rate of claimant's temporary total disability benefits. We reverse.

FINDINGS OF FACT

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

Claimant commenced work with SAIF's insured in early 1985. On March 7, 1987, he was compensably injured. During the 26 weeks prior to his injury, i.e., September 6, 1986 to March 7, 1987, claimant received remuneration from SAIF's insured totalling $25,246.48.

FINDINGS OF ULTIMATE FACT

Claimant was regularly employed by SAIF's insured.

Claimant's remuneration was not based solely upon a daily or weekly wage but upon gross receipts less ten percent less certain expenses.

Claimant's remuneration from SAIF's insured during the 26 weeks prior to the March 7, 1986 injury averaged $971.02 per week.

CONCLUSIONS OF LAW AND OPINION

Former ORS 656.210 et seq provides the framework for the proper calculation of a worker's temporary total disability benefits. Subsection (2)(c)

of that statute provides, inter alia:

> "As used in this subsection, 'regularly employed' means actual employment or availability for such employment. For workers not regularly employed and for workers with no remuneration or whose remuneration is not based upon daily or weekly wages, the director, by rule, may prescribe methods for establishing the worker's weekly wage."

Here, claimant was employed as a truck driver by SAIF's insured. He was paid for his labor pursuant to a contract he entered into with SAIF's insured. 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 a check.

Claimant had an average gross revenue of $6,769 a month for 26 weeks preceding his compensable injury of March 7, 1987. SAIF's insured paid its premium for claimant's workers' compensation coverage, based on an assumed monthly wage equal to 25 percent (i.e., $1,690) of claimant's average monthly gross revenue of $6,769.

After claimant's compensable injury of March 7, 1987, SAIF began paying temporary total disability benefits. For the purposes of calculating claimant's rate of benefits, SAIF adopted the assumed monthly wage of $1,690, which it used to determine the employer's premium for claimant's workers' compensation coverage.

At the hearing, SAIF argued that it had acted pursuant to ORS 656.006(26), which provides, inter alia:

> "The State Accident Insurance Fund Corporation may establish assumed minimum and maximum wages, in conformity with recognized insurance principles, at which any worker shall be carried upon the payroll of the employer for the purpose of determining the premium of the employer." (Emphasis added).

It further argued that inasmuch as no statute or rule applied to claimant's situation, it was free to arrive at a "reasonable wage." See former OAR 436-60-020(o). The Referee agreed with SAIF's position. We disagree.

In our view, claimant is "regularly employed" within the meaning of ORS 656.210 et seq. He was a full-time employee and received a weekly check for his services. Therefore, ORS 656.210, not ORS 656.006(26), controls the rate of temporary total disability that claimant is to be paid.

ORS 656.210(2)(c) provides that in cases such as this, where the worker's remuneration is not based solely upon a daily or weekly wage, the Director may prescribe a method of establishing a weekly wage. The Director has done so. Former OAR 436-60-020(4) provided the method for computing temporary total disability for workers employed on call (subsection 4(a)); piecework (subsection 4(b)); varying hours, shifts or wages (subsection 4(c)); and on commission (subsection 4(l)). Claimant could properly be placed in any of the categories. The result, however, is the same. His weekly wage is the weekly average of his earnings during the 26 weeks prior to the date of injury.

In this case claimant's weekly wage was $971.02. He is entitled to temporary total disability based upon that wage plus any statutory increases. See ORS 656.210(1).

ORDER

The Referee's order dated March 18, 1988 is reversed in part. That portion of the order that approved the SAIF Corporation's method of calculating claimant's temporary total disability benefits is reversed. SAIF is directed to recalculate claimant's temporary disability benefits based upon a weekly wage of $971.02 plus any statutory increases. The remainder of the Referee's order is affirmed. Claimant's attorney is awarded 25 percent of the increased compensation created by this order, not to exceed $3,800, payable directly to the attorney.

February 28, 1990 Cite as 42 Van Natta 443 (1990)

In the Matter of the Compensation of
BETTE A. DELGADO, Claimant
WCB Case No. 88-13694
ORDER ON REVIEW (REMANDING)
Welch, et al, Claimant Attorneys
Randy Harris (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

Claimant requests review of Referee Thye's order which dismissed her request for hearing for failure to appear. On review, the issue is whether the Referee should have dismissed the request for hearing. We remand.

FINDINGS OF FACT

On November 1, 1988, the insurer's attorney and claimant's attorney appeared at hearing. Claimant did not appear. Claimant's affidavit states that she was ill from October 31, 1988, through November 3, 1988. Claimant further stated that she was receiving care at her sister's residence during that time and she had incorrectly noted on her calendar that the date of hearing was November 2, 1988. Claimant discovered her error on November 2, when she phoned her attorney to advise him that she would be unable to appear at the hearing due to her continuing illness.

Prior to the entry of the Referee's Order of Dismissal, claimant filed a motion for reinstatement supported by her affidavit. On November 18, 1988, the Referee issued an Order of Dismissal which stated that claimant's affidavit was not sufficient to support reinstatement of her hearing request.

CONCLUSIONS OF LAW AND OPINION

At the time of hearing, former OAR 438-06-071 was in effect. It stated:

> "Failure of a party or the party's representative to appear at the time and place scheduled for a hearing is a waiver of appearance. If the party that fails to appear is the party that requested the hearing, the referee shall issue an order dismissing the request for hearing for failure to appear unless a postponement is granted under OAR 438-06-081."

Former OAR 438-06-081 prohibited postponements except upon a finding of extraordinary circumstances beyond the control of the party requesting the postponement.

We conclude that the Referee was incorrect in dismissing the hearing request based on claimant's failure to appear at the hearing. Subsequent to the Referee's order, in Williams v. SAIF, 99 Or App 367 (1989), the court held that, under the current version of OAR 438-06-071, Referees are not authorized to dismiss a claimant's hearing request simply because the claimant did not appear at the hearing. The court reasoned that a claimant was entitled to offer the remainder of her evidence, even if she chose not to testify personally. The court further stated that the choice not to testify did not prevent an insurer from presenting its evidence in defense of the claim.

The relevant language of the version of OAR 438-06-071 cited above and the current version cited by the court in Williams is substantially the same. Both provide that if a party or the party's attorney fail to appear at hearing, then that failure to appear is a waiver of appearance and is grounds for dismissal if the party waiving is the party which requested the hearing.

Here, although claimant did not appear at the hearing, her attorney was present. In accordance with Williams, claimant's failure to appear is not grounds for dismissal under OAR 438-06-071. We therefore conclude that the hearing request should not have been dismissed.

Furthermore, we conclude that under the circumstances of this case, claimant has not waived her right to testify. We have recently held that under the rule applicable to this case,

> "a Referee must consider a motion for postponement of a hearing even after an order of dismissal has been issued...so long as the Referee retains jurisdiction." Mark R. Luthy, 41 Van Natta 2132 (1989).

Here, the Referee correctly treated claimant's motion and affidavit as a motion for postponement. He was not persuaded that the affidavit established extraordinary circumstances beyond claimant's control sufficient to justify a postponement. We disagree.

There is sufficient evidence on this record to make a finding under former OAR 438-06-081 that there were extraordinary circumstances beyond claimant's control which would justify a postponement. Claimant's failure to correctly note the date of hearing on her calendar is not dispositive. She has established through her affidavit that from October 31 through November 3, 1988, she was incapacitated due to illness. Claimant's illness therefore precluded her appearance at the November 1 hearing regardless of the fact that she had incorrectly noted the date of hearing. See Mark S. Lesowske, 41 Van Natta 2154 (1989). (Board found extraordinary circumstances where claimant was discharged from the hospital on the day of hearing; even if claimant had not forgotten about his hearing, he would have been unable to appear.)

We conclude that claimant has shown extraordinary circumstances which would have justified a postponement. Accordingly, we find that although she did not appear on the date of hearing, claimant has not waived her right to testify. We therefore remand this case to the Referee for a hearing on the merits.

IT IS SO ORDERED.

In the Matter of the Compensation of
TRUDY D. JACKSON, Claimant
WCB Case No. 88-10196
ORDER ON REVIEW (REMANDING)
Malagon, et al, Claimant Attorneys
Schwabe, et al, Defense Attorneys

Reviewed by Board Members Cushing and Gerner.

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

Claimant requested a hearing on June 16, 1988. The hearing convened on September 9, 1988. Claimant did not appear at the hearing; however, claimant's attorney did appear. Claimant's attorney represented that he did not know why claimant was not at the hearing and that his office had sent claimant a letter advising her of the hearing date and had been in telephone contact with her on September 8, 1988, the day before the hearing. The Referee stated that he would dismiss pursuant to his understanding of former OAR 438-06-071. The Referee indicated that he would reconsider his decision if, within 30 days of the Referee's order, claimant petitioned for reconsideration and was able to show good cause for not appearing.

On September 16, 1988, the Referee issued an Order of Dismissal dismissing claimant's request for hearing. On September 20, 1988, claimant's attorney wrote the Referee requesting abatement of the dismissal order in order for claimant to acquire medical verification of her inability to be at the hearing. Claimant alleged that she was suffering adverse affects from a myelogram performed on September 7, 1988, and that was the reason for her failing to appear at the hearing.

On September 27, 1988, the Referee entered an Order of Abatement which allowed claimant 15 days to produce "medical verification" of her inability to attend the hearing. Claimant failed to produce any evidence of her inability to attend the hearing within the 15 days allowed by the Referee. On October 14, 1988, the Referee reissued his Order of Dismissal.

Following the reissuance of the Order of Dismissal, on October 17, 1988, claimant's attorney submitted a letter along with a note on a prescription pad from Dr. Degan. The note stated:

> "Seen for arachnoid cyst. Referred to Dr. Roberson who had myelogram done 9/7. He is not avail. @ present because of a death in his family."

The note was dated October 12, 1988.

The Referee did not reconsider his decision after he received this new information.

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 her 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). The Referee correctly treated claimant's motion for reconsideration 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 she submitted no medical evidence of her inability to attend the hearing. Unfortunately, the Referee did not decide whether the note submitted after the dismissal was reissued established grounds to justify a postponement.

We agree that claimant did not attempt to justify a postponement by some sort of medical evidence in a timely fashion. However, we do not agree that if the attorney's representations are true then claimant has not justified a postponement. According to the representations, claimant suffered from severe adverse consequences of a myelogram which prevented her from appearing at the hearing. If true, these circumstances are sufficient to justify a postponement.

Likewise, considering the facts that claimant had contacted her attorney's office the day before the hearing (the day after the myelogram), but mentioned no adverse problem, and the note procured from Dr. Degan does not state that claimant was suffering from any problem that would prevent her appearance at hearing, claimant may not have shown facts to justify a postponement.

Considering these facts, we conclude that a hearing on the issue of the postponement is necessary, including a finding on claimant's credibility. Accordingly, this case is remanded to the Referee to take evidence on the question of whether claimant has established extraordinary circumstances which would have justified a postponement. If the Referee determines that a postponement should have been granted, he shall hold a hearing on the merits, including claimant's testimony.

If the Referee determines that a postponement should not have been granted, the Referee shall decide the case on the merits, and 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 14, 1988, is remanded to the Referee for proceedings consistent with this order. The Board approves a client-paid fee, not to exceed $1,682.25, payable from the insurer to its counsel.

In the Matter of the Compensation of
OLIVER JEFFRIES, Claimant
WCB Case No. 88-08346
ORDER ON REVIEW
Peter O. Hansen, Claimant Attorney
Roberts, et al, Defense Attorneys

Reviewed by Board Members Cushing and Gerner.

Claimant requests review of Referee Tennenbaum's order that found that claimant was not entitled to temporary disability as a result of the Referee's earlier order finding claimant's stress claim to be compensable. On review, claimant contends that he is entitled to temporary disability benefits.

On January 10, 1990, we reversed the Referee's earlier order, which had found that claimant's stress claim was compensable. Oliver Jeffries, 42 Van Natta 64 (1990). That order has become final by operation of law. ORS 656.295(8).

Contending that our conclusion that the claim is not compensable has rendered the issue raised in this case moot, the insurer has moved for dismissal of claimant's request for Board review. We deny the motion.

Because claimant timely requested Board review, the Referee's order has not become final. ORS 656.289(3). Furthermore, after conducting our review, we are authorized to affirm, reverse, modify or supplement the Referee's order, as well as make such disposition of the case as we determine to be appropriate. ORS 656.295(6). Finally, our recent determination that the claim is not compensable does not extinguish the question of whether the insurer properly exercised its processing obligations during the period the claim was considered compensable. ORS 656.313; Weyerhaeuser Company v. McCullough, 92 Or App 204, 208 (1988).

Turning to the merits, we affirm and adopt the order of the Referee.

ORDER

The Referee's order, dated September 29, 1988, is affirmed. A client-paid fee, not to exceed $948, payable from the insurer to its counsel, is approved.

February 28, 1990 Cite as 42 Van Natta 447 (1990)

In the Matter of the Compensation of
DIANE T. LINDHOLM, Claimant
WCB Case No. 88-05977
ORDER ON REVIEW (REMANDING)
Brian R. Whitehead, Claimant Attorney
Merrily McCabe (Saif), Defense Attorney

Reviewed by Board Members Perry and Howell.

Claimant requests review of that portion of Referee Foster's order which upheld the SAIF Corporation's denial of his occupational disease claim for right carpal tunnel syndrome. In its brief, SAIF contends that the Referee erred in finding "good cause" for claimant's untimely filing of her request for hearing from its first denial. On review, the issues are good cause for untimely hearing request and compensability. We remand.

FINDINGS OF FACT

Claimant filed an 801 form on December 8, 1987 for a neck and shoulder strain.

Claimant was diagnosed as having right median nerve compromise at the carpal tunnel level on December 23, 1987.

Claimant's neck and shoulder condition was denied by SAIF on December 30, 1987, on grounds of untimely filing of a claim. SAIF's denial did not refer to claimant's carpal tunnel condition.

Claimant discussed the denial with a person in the office at work who helped employees file workers' compensation claims. That person did not know whether claimant should appeal the denial, so she inquired at SAIF. She was told to have claimant send a letter to SAIF asking that SAIF consider her

claim as one for carpal tunnel syndrome rather than one for neck and shoulder problems.

Claimant sent a letter, which SAIF received on January 6, 1988, requesting that it consider her claim as one for carpal tunnel syndrome. SAIF denied the claim for carpal tunnel syndrome on March 28, 1988.

Claimant requested a hearing on both denials on April 14, 1988.

CONCLUSIONS OF LAW AND OPINION

Timely Request for Hearing

SAIF argues that claimant failed to timely request a hearing on the December 30, 1987 denial, and did not have good cause for the delay. We agree.

A request for hearing must be filed not later than the 60th day after claimant is notified of a denial of a claim. ORS 656.319(1)(a). A hearing request that is filed after 60 days, but within 180 days of a denial may be excused if claimant had good cause for the late filing. ORS 656.319(1)(b). The test for determining if good cause exists has been equated to the standard of "mistake, inadvertance, surprise or excusable neglect" recognized 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). Lack of diligence does not constitute good cause. Cogswell v. SAIF, 74 Or App 234, 237 (1985). Claimant has the burden of proving good cause. Id.

Claimant did not request a hearing on the December 30, 1987 denial until April 14, 1988, giving as her reason reliance on the oral statements of a SAIF employee. However, claimant was not told by the SAIF employee that her claim would be accepted upon receipt of the additional information or that her claim would remain open after the statutory time for appeal had passed. We conclude that claimant's reliance on the statements of the SAIF employee is not sufficient to establish good cause. See Cogswell v. SAIF, supra; Leonard Trigg, 41 Van Natta 1264 (1989).

SAIF also argues that its December 30, 1987 denial encompassed a denial of claimant's carpal tunnel condition. It contends that claimant knew that she had carpal tunnel syndrome when she filed the 801 even though she did not specifically mention it and, thus, the December denial effectively denied the carpal tunnel claim. We disagree.

Claimant filed the 801 on December 8, 1987 and it was not until December 23 that the carpal tunnel was diagnosed. Therefore, the claim could not have included the carpal tunnel condition. Accordingly, SAIF could not have denied the carpal tunnel condition in the December 30, 1988 denial letter. Cf. Johnson v. Spectra Physics, 303 Or 49 (1987) (insurer held to have accepted only those conditions "specifically" or "officially" accepted in writing).

We conclude that claimant did not timely file a request for hearing on the December 30, 1988 denial of her neck and shoulder strain and did not show good cause for the untimeliness. However, that denial does not bar the separate carpal tunnel claim.

The letter received by SAIF on January 6, 1988 was a claim by claimant for her carpal tunnel syndrome. See ORS 656.005(6). That claim was denied on March 28, 1988. Claimant filed a request for hearing on that denial on April 14, 1988. We find that claimant's hearing request on the carpal tunnel claim was timely.

Compensability

Before we can make a determination of the compensability of claimant's carpal tunnel syndrome we must decide whether this case is governed by the occupational disease law in effect in 1987 or the law that became operative January 1, 1988.

The Court of Appeals addressed the question of when the "injury" resulting from an occupational disease occurs in Johnson v. SAIF, 78 Or App 143, rev den 301 Or 240 (1986). The court held in Johnson that, for purposes of ORS 656.202(2), the "injury" resulting from an occupational disease occurs on the date of last exposure. Id. at 148.

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, there is a period of only a few days within which the new occupational disease law became effective and claimant filed her claim for carpal tunnel syndrome. It is necessary to determine whether claimant had a work exposure between the dates of January 1, 1988 and January 6, 1988. That evidence is not available in the record.

Accordingly, we remand this case to the Presiding Referee with instructions to assign a Referee to receive evidence on the date of claimant's last work exposure. If the Referee finds the last exposure was prior to January 1, 1988, the Referee is instructed to determine the compensability of claimant's carpal tunnel syndrome claim based upon the occupational disease law in effect prior to January 1, 1988. See former ORS 656.802(1)(a). If the Referee determines that the last exposure was after January 1, 1988, the Referee shall determine whether the claim is compensable under the current version of ORS 656.802(1). In addition, the Referee is instructed to dismiss claimant's hearing request insofar as it challenges SAIF's December 30, 1987 denial. These matters shall be contained in a final, appealable order.

ORDER

The Referee's order dated August 4, 1988 which upheld SAIF's denial of March 28, 1988 is vacated and the matter is remanded to the Presiding Referee for further proceedings consistent with this order.

February 28, 1990 Cite as 42 Van Natta 449 (1990)

In the Matter of the Compensation of
ANASTASIA SAMOJLOVSKI, Claimant
WCB Case Nos. 88-01765, 88-01766, 88-08906 & 88-08907
ORDER ON REVIEW
Welch, et al, Claimant Attorneys
Rankin, et al, Defense Attorneys
Nelson, et al, Defense Attorneys

Reviewed by Board Members Howell and Speer.

Liberty Northwest Insurance Company (Liberty) requests review of Arbitrator Zucker's order holding it, rather than United Pacific Insurance, responsible for claimant's low back condition and surgery. We review for questions of law and affirm.

The Board received the ".307 Order" in this matter on September 16, 1988. Therefore, the current version of ORS 656.307(2), regarding the scope of our review, applies. Timothy R. Schroeder, 41 Van Natta 568 (1989). Because

our review is limited to questions of law, we accept the Arbitrator's "FINDINGS OF FACT." ORS 656.307(2).

The Arbitrator in this matter found that claimant had suffered a compensable low back injury while Liberty was on the risk. She also found that subsequent work exposure while United Pacific was on the risk did not worsen claimant's underlying condition, but merely increased her symptoms. Given those factual findings, we hold that the Arbitrator utilized the proper law and applied it correctly in determining that Liberty was responsible. Louisiana-Pacific v. Blank, 81 Or App 284 (1986); Hensel Phelps Construction v. Mirich, 81 Or App 290 (1986); SAIF v. Phipps, 85 Or App 436 (1987); Clarke v. Little W Logging, 93 Or App 1 (1988).

ORDER

The Arbitrator's order dated September 15, 1988 is affirmed. A client paid fee to United Pacific's attorney is approved, not to exceed $969.

February 28, 1990 Cite as 42 Van Natta 450 (1990)

In the Matter of the Compensation of
DORIS M. STARK, Claimant
WCB Case No. 88-07648
ORDER ON REVIEW
Merrill Schneider & Associates, Claimant Attorneys
Daniel L. Meyers & Associates, Defense Attorneys

Reviewed by Board Members Nichols and Crider.

Claimant requests review of that portion of Referee Neal's order that: (1) awarded temporary total disability benefits through November 23, 1987, whereas a Determination Order had awarded benefits through January 5, 1988; (2) declined to increase claimant's unscheduled permanent partial disability above the 25 percent (80 degrees) awarded by Determination Order; and (3) authorized the self-insured employer to offset benefits paid after November 23, 1987 and an overpayment due to miscalculation of the temporary total disability rate. The issues on review are extent of unscheduled permanent disability, entitlement to and rate of temporary disability benefits, and offset.

The Board affirms and adopts the order of the Referee with the following comment on the time loss rate calculation. Claimant was paid temporary total disability based on the assumption that she worked an 8-hour day, four days per week on a regular basis. The employer sought authorization to offset the difference between benefits calculated at that rate and those recalculated at a rate based on a 26-week average.

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. Even if the claimant was considered to be a regular employee, she worked varying hours. Therefore, her benefits could still be calculated under the Director's rules. Lowry v. Du Log, Inc., 99 Or App 459 (1989). Therefore, the Referee correctly concluded that an overpayment had occurred and an offset was appropriate.

ORDER

The Referee's order dated September 6, 1988, as amended September 12, 1988, is affirmed. The Board authorizes a client-paid fee, not to exceed $1,610, payable by the self-insured employer to its counsel.

In the Matter of the Compensation of
ALFONSO VILCHES, Claimant
Own Motion No. 89-0258M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Industrial Indemnity, Insurance Carrier

Claimant requests review of the insurer's November 17, 1989, Notice of Closure which terminated temporary disability benefits as of April 11, 1989. Claimant is requesting additional disability compensation which the Board construes as a request for an award of permanent disability and/or additional temporary disability.

The Board's own motion authority has been significantly restricted by the new law which took effect on January 1, 1988. There is no authority which would allow the Board to grant claimant an award of permanent disability benefits. Orville D. Shipman, 40 Van Natta 537 (1988). Therefore, claimant's request for further permanent disability benefits must be denied.

On the other hand, we may award additional temporary disability benefits under the current law. By Own Motion Order dated May 26, 1989, we reopened claimant's claim with temporary disability benefits to continue "until claimant returns to his regular work at his regular wage or is medically stationary, whichever is earlier." The insurer terminated temporary disability benefits based on medical evidence that claimant returned to work on April 12, 1989. However, the record is devoid of any evidence to show that claimant returned to his regular job, much less at his regular wage, prior to becoming medically stationary on August 28, 1989. Indeed, our review of the medical evidence shows that claimant, who apparently works as a physical education teacher, went back to work with continuing right knee symptoms and significant restrictions on weight-bearing activities. Therefore, based on this record, we do not find that claimant returned to his regular work at his regular wage on April 12, 1989, or any subsequent date. Claimant's treating physician declared him medically stationary on August 28, 1989. Based on that uncontroverted opinion, we find that claimant became medically stationary on August 28, 1989.

Accordingly, claimant is awarded additional temporary disability benefits for the period from April 12, 1989, through August 28, 1989, less time worked. As supplemented with the additional award, we affirm the insurer's Notice of Closure.

IT IS SO ORDERED.

In the Matter of the Compensation of
NADINE WOOD, Claimant
WCB Case No. 88-10289
ORDER ON REVIEW
Connall & Lorenz, Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Myers and Gerner.

The insurer requests review of Referee Schultz's order which increased claimant's unscheduled permanent disability award from 20 percent (64 degrees), as awarded by Determination Order, to 60 percent (192 degrees). On review, the sole issue is extent of unscheduled permanent disability. We modify.

FINDINGS OF FACT

At the time of hearing, claimant was 50 years of age. She has a ninth grade education. She has worked as a Human Resource Assistant for the Children's Services Division, as a machine operator in a pharmaceutical company, as a meat packer and in her job-of-injury as a janitor.

Claimant compensably injured her right shoulder on December 19, 1985 when a dumpster lid landed on her shoulder. In January 1986, claimant slipped and fell landing on her buttocks and causing a compression fracture at T9. The compression fracture has been accepted as a compensable consequence of the on the job injury. Claimant has also developed psychological sequelae from the compensable injury.

As a result of her shoulder problems, claimant has suffered approximately a 2 percent impairment. As a result of the compression fracture, claimant has suffered approximately a 6 percent impairment. Claimant's disabling pain adds an additional 5 percent impairment. Her psychological impairment adds another 5 percent. As a result of her compensable injury and its sequelae, claimant is precluded from returning to her regular work.

CONCLUSIONS AND OPINION

Claimant has the burden of proving by a preponderance of the evidence the loss of earning capacity due to the compensable injury. The Referee concluded that claimant's low back and right leg complaints were due to the compensable injury; consequently, he considered them in rating claimant's unscheduled disability. We disagree. We find no medical evidence supporting the conclusion that these complaints were caused by the compensable injury. Furthermore, there are no contemporaneous references to these problems following the slip and fall in January 1986 which caused the compression fracture at T9, in the mid-back. Consequently, we conclude that claimant has failed to prove by a preponderance of the evidence that her low back and right leg complaints were due to the compensable injury.

Although we defer to the Referee's conclusion that claimant was a credible witness, we are unable to rely on her testimony concerning her impairment and limitations because we are unable to differentiate between the limitations and problems due to the compensable sequelae of the injury from the noncompensable low back and right leg complaints.

We, therefore, rely on the expert evidence of the treating physician and the treating psychiatrist in finding claimant's impairment. Considering the impairment to the shoulder, the impairment to the mid-back, the impairment due to disabling pain and the impairment due to psychological problems we conclude that claimant has a mild impairment due to the compensable injury.

Considering claimant's mild impairment together with her age, limited work experience and job history as well as the fact that her compensable injury restricts her from returning to her regular work, we rate her loss of earning capacity at 40 percent.

ORDER

The Referee's order, dated October 3, 1988, is modified. Claimant's total unscheduled permanent disability is modified to 40 percent (128 degrees) unscheduled permanent disability. The Board approves a client-paid fee, not to exceed $1,436.50, payable by the insurer to its attorney.

In the Matter of the Compensation of
JEANETTE E. BOLLINBERG, Claimant
WCB Case No. 88-10815
ORDER ON REVIEW
Malagon, et al, Claimant Attorneys
Acker, et al, Defense Attorneys

Reviewed by Board Members Howell and Speer.

The self-insured employer requests review of Referee Melum's order which set aside its denial of claimant's claim for myofascial-type syndrome in the upper extremities and bilateral carpal tunnel syndrome. On review the issue is compensability. We affirm.

FINDINGS OF FACT

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

Claimant's symptoms developed in late 1986 and early 1987. (Tr. 8, Tr. 14, Exs. 3-1, & 5).

Dr. Jewell's examination showed claimant "has a right volar radial carpal ganglion...(and) a positive Tinel's sign noted within the transverse carpal ligament." (Ex. 3-2).

Nerve conduction studies performed by Dr. Karasek, M.D., neurologist, indicate "bilateral distal median neuropathy, electrically mild, but definite." (Ex. 4). Dr. Karasek's second nerve conduction study produced the same results. (Ex. 6).

Claimant used to knit but she hasn't done so for years because her hands are too sore and she doesn't have the time. (Tr. 34 and 36).

FINDING OF ULTIMATE FACT

Claimant's work conditions with the employer, involved repetitive trauma to her arms and hands and materially contributed to her need for medical treatment and disability.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant's claim was one for an occupational disease. He concluded that claimant had shown that her work activities were the major contributing cause of her condition or, if the condition preexisted her employment, that it was the major contributing cause of an aggravation or worsening of her condition. We agree that claimant's condition is compensable, but 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 cause the disease. Johnson v. SAIF, 78 Or App 143, rev den 301 Or 240 (1986). Claimant last worked as a trimmer for the employer, Jan. 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 for the employer as a "trimmer," a position which involves repetitive and

physically demanding arm exertion while pruning seedling roots with a machine. We conclude this 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). Carole J. Damm, 42 Van Natta 225 (1990).

The employer argues that claimant's claim is not valid but solely vindictive because she was fired. Additionally, the employer argues that knitting caused her condition.

Claimant's alleged vindictiveness cannot affect the medical findings obtained through objective scientific testing. Dr. Karasek opines that the documented neuropathy is "most likely carpal tunnel" but he suggests that a spine series be performed because claimant also "has enough neck symptomatology" to indicate something going on at the spine could also have caused the neuropathy. (Ex. 5). Later, Dr. Karasek suggests surgical release. (Ex. 7). Dr. Jewell, M.D., supports Dr. Karasek's findings and reports that claimant's work activities are the "major contributing cause of her carpal tunnel syndrome and upper extremity cumulative trauma disorder". (Ex. 13A).

The only evidence regarding claimant's knitting is that claimant has not knitted for years. Because our opinion is based on the material causation standard, even if claimant still knitted, this would not negate finding that her work as a seedling trimmer materially caused her carpal tunnel and upper extremity cumulative trauma disorder.

We conclude that a preponderance of the evidence demonstrates that claimant's work as a trimmer for the employer materially contributed to her need for medical services for her diagnosed carpal tunnel condition and upper extremity cumulative trauma disability.

ORDER

The Referee's order dated October 19, 1988, is affirmed. Claimant's attorney is awarded an assessed fee of $900, to be paid by the employer. The Board approves a client-paid fee, not to exceed $1,122, to be paid by the employer to its counsel.

In the Matter of the Compensation of
KYONG C. LEWIS, Claimant
WCB Case No. 89-11832
ORDER DENYING MOTION TO DISMISS
Merrill Schneider, Claimant Attorney
Beers, et al, Defense Attorneys

Reviewed by Board Members Nichols and Crider.

Claimant has moved for an order dismissing the insurer's request for Board review of Referee Schultz's order on the ground that the Referee abated his order. The motion is denied.

FINDINGS OF FACT

The Referee's order issued January 9, 1990. On January 24, 1990, claimant submitted a motion to the Referee requesting abatement of the order and reopening of the record. On January 26, 1990, the insurer mailed by certified mail its request for review of the Referee's order to the Board. On January 31, 1990, the Board mailed a computer-generated letter to the parties acknowledging a request for review.

On February 1, 1990, the Referee withdrew and abated his order. On February 14, 1990, the Referee withdrew his abatement order.

ULTIMATE FINDINGS OF FACT

The insurer filed its request for Board review of the Referee's January 9, 1990 order before the Referee withdrew the order for reconsideration.

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).

Here, claimant requested abatement of the Referee's order before the insurer sought Board review of that order. However, the Referee did not abate his order until February 1, 1990, which was after the insurer had "filed" its request for review on January 26, 1990. See OAR 438-05-046(1)(b). Inasmuch as the request for review was filed before the Referee withdrew the order for reconsideration, the Referee was without authority to take such action. See OAR 438-07-025(1).

This case is distinguishable from the court's recent decision in SAIF v. Fisher, 100 Or App 288 (January 24, 1990). In Fisher, the Board had withdrawn its Order on Review for reconsideration a day after its order had been appealed. When the Board learned of the petition for judicial review, it withdrew its abatement order and declined to withdraw its Order on Review for reconsideration. In addressing the question of whether the Board had authority to withdraw an order for reconsideration, the Fisher court noted that, with one exception, there was nothing in ORS 656.295 limiting the power to take such action. Identifying that exception as the 30-day right to appeal period of ORS 656.295(8), the court held that the Board has the authority to withdraw an order for the purpose of reconsideration at the request of a party or on its own motion provided that it did so before the order becomes final.

Turning to the question of whether the petition for judicial review affects the authority of the Board to withdraw its order, the Fisher court reasoned that there were no such limitations in either ORS chapter 656 or ORS chapter 183. Concluding that the Board had authority to abate its order and had not issued a new, reviewable order after its abatement order, the court held that the case remained pending before the Board because the Board had not issued a decision on reconsideration.

At first blush, there would seem to be no meaningful distinction between the Board's and a Referee's authority to abate an appealed order. See ORS 656.295(8); 656.289(3). As in Fisher, it would appear that the sole exception to a Referee's authority to withdraw an appealed order is that the withdrawal must occur within 30 days of the Referee's order. See ORS 656.289(3).

However, upon closer inspection, we conclude that a significant distinction does exist concerning the Board's and a Referee's authority to withdraw an already appealed order for reconsideration. That distinction rests in OAR 438-07-025(1), which expressly permits a Referee to reopen a record and reconsider a decision on a party's motion or on his/her own motion, provided that a request for Board review has not been filed.

Here, as previously noted, the insurer had filed its request for Board review of the Referee's order prior to the Referee's abatement order. Inasmuch as the Referee was without authority to withdraw his order under such circumstances, his order of abatement was a nullity.

Accordingly, claimant's motion to dismiss is denied. A hearing transcript has been ordered. Upon its receipt, copies will be provided to the parties and a briefing schedule implemented. Thereafter, this case shall be docketed for review.

IT IS SO ORDERED.

March 1, 1990 Cite as 42 Van Natta 456 (1990)

In the Matter of the Compensation of
KATHERINE A. RELPH, Claimant
WCB Case No. 84-03505
SECOND ORDER ON RECONSIDERATION
Coons & Cole, Claimant Attorneys
Roberts, et al, Defense Attorneys

The insurer has requested reconsideration of that portion of the Board's Order on Reconsideration, dated August 14, 1989, that adhered to and republished its June 30, 1989, Order on Review, which affirmed the Referee's Order insofar as it declined to authorize an offset of allegedly overpaid temporary disability benefits paid after December 4, 1984. On September 13, 1989, we issued an Order of Abatement to further consider this offset issue. After reconsidering the issue, we conclude that the insurer is entitled to offset the temporary disability compensation it paid between December 5, 1984, and November 15, 1985.

The insurer has argued that the temporary disability compensation it paid after December 4, 1984 and before November 15, 1985 was an overpayment. Its rationale is that claimant stopped participating in an authorized vocational program, see ORS 656.268(5), on December 4, 1984, and did not suffer a compensable worsening, see ORS 656.273(1), until November 16, 1985. Therefore, the insurer submits that claimant was not entitled to temporary disability compensation during that period.

The Referee disagreed with the insurer's argument, finding that claimant was not medically stationary beginning December 5, 1984. See Exs. 37 & 38-3. Considering our previous conclusion that claimant failed to prove a compensable aggravation as of December 5, 1984, we disagree with the Referee's reasoning.

ORS 656.268(5) provides that temporary disability compensation shall continue to be paid "while the worker is enrolled and actively engaged in [vocational] training." When the worker ceases participation in such training, ORS 656.268(5) further instructs that the Evaluation Division shall close the claim pursuant to ORS 656.268(4), unless the worker is not medically stationary.

Here, claimant terminated her participation in vocational training on December 4, 1984. On that date her condition was also medically stationary.

Under such circumstances, we conclude that claimant was not entitled to additional temporary disability compensation after December 4, 1984, until she suffered a compensable worsening on November 16, 1985. Consequently, we conclude that the insurer is authorized to offset the temporary disability it overpaid between December 5, 1984, and November 15, 1985, against future awards of permanent disability, if any.

Accordingly, on reconsideration, as modified herein, we adhere to and republish our June 30, 1989 order, as reconsidered August 14, 1989, effective this date. A supplemental client-paid fee, payable from the insurer to its counsel, is approved, not to exceed $1,398.50.

IT IS SO ORDERED.

In the Matter of the Compensation of
KAREN M. SCHOFIELD, Claimant
WCB Case No. 87-08290
ORDER ON REVIEW
Pozzi, et al, Claimant Attorneys
Roberts, et al, Defense Attorneys

Reviewed by Board Members Howell and Speer.

The self-insured employer requests review of those portions of Referee Hoguet's order that: (1) set aside its denial of claimant's aggravation claim for her left carpal tunnel syndrome; and (2) assessed penalties and attorney fees for an alleged improper submission of the claim for closure. On review, the issues are aggravation, penalties and attorney fees. We reverse in part, modify in part and affirm in part.

FINDINGS OF FACT

The Board adopts the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Aggravation

The Referee found that claimant had been restricted to a three-day work week since a March 21, 1988 Determination Order, which was her last award of compensation. The Referee concluded that claimant had proven her aggravation claim because she was less able to work and had therefore suffered an additional loss of earning capacity.

Claimant's aggravation claim for her left carpal tunnel syndrome involves compensation for a scheduled disability. Because compensation for a scheduled disability is for loss of use of a scheduled body part, ORS 656.214, 'more disabled' in this case means increased loss of use of that body part. International Paper Co. v. Turner, 304 Or 354 (1987).

Claimant was restricted to a three-day work week prior to her last award of compensation. Accordingly, for purposes of establishing aggravation, we cannot consider the fact that claimant's work schedule was reduced. Theodore. W. Lincicum, 40 Van Natta 1760, aff'd mem 100 Or App 100 (1989). In addition, neither the medical evidence nor claimant's testimony indicate that

she has sustained increased loss of use or function of her left hand since March 21, 1988.

On May 12, 1988, Dr. Nathan, M.D., examined claimant for the third time and opined that claimant's condition had not worsened since March 1988. Dr. Berkeley, claimant's treating doctor, reviewed Dr. Nathan's evaluation and stated:

> "I do not entirely agree with Dr. Nathan's statement that Ms. Schofield's condition did not worsen since March 1988. The reason for taking Ms. Schofield off full time work and allowing her to work only three days a week was because there was some worsening in her symptoms and this worsening still persists...".

However, as previously noted, claimant's worsening and her restriction to a three-day work week occurred prior to the March 21, 1988 Determination Order.

Claimant testified that as early as mid-December, 1987, she was having problems with her (left) hand. She testified that during the week of March 7, 1988, her first full week of work after surgery, her hand pain became very severe and she sought treatment from Dr. Berkeley. (On March 17, 1988, Dr. Berkeley restricted claimant to a 3-day work week.) At the time of hearing, claimant testified that she had numbness and swelling in her hand. She also testified to difficulty in sorting paper and lifting books.

We do not find the medical evidence or claimant's testimony to be sufficient to establish an aggravation. The record does not establish that since the time of the March 21, 1988 Determination Order, claimant has sustained increased loss of use or function of her left hand.

Penalties and Attorney Fees

The Referee found that the employer acted unreasonably in prematurely requesting closure of claimant's claim resulting in the May 15, 1987 Determination Order. The Referee's finding, in part, was based upon medical evidence that was not available to the employer at the time of claim closure.

We agree with the employer's contention that evidence not available to it at the time of claim closure should not be taken into consideration in determining the reasonableness of the employer's conduct. See Scheuning v. J.R. Simplot & Co., 84 Or App 622 (1987). We nonetheless find that the employer's conduct in this instance was unreasonable. A report that claimant was "reaching a medically stationary point", and evidence that claimant worked full time without seeking treatment does not permit the employer to subsequently determine that claimant was, in fact, medically stationary. Therefore, we conclude that the Referee's assessment of a penalty and associated attorney fee was appropriate.

The Referee awarded a lump sum assessed attorney fee to claimant's attorney for his services regarding both the setting aside of the aggravation denial as well as the penalty issue. Because we are reversing on the denial issue, claimant is entitled to an assessed fee only on the penalty issue. Therefore, the Referee's attorney fee award shall be modified accordingly. Moreover, penalties and associated attorney fees are not "compensation" within the meaning of ORS 656.382(2). Thus, claimant is not entitled to attorney fees for successfully defending such an award on Board review. Saxton v. SAIF, 80 Or App 631 (1986); Dotson v. Bohemia, Inc. 80 Or App 233 (1986).

ORDER

The Referee's order dated July 18, 1988 is reversed in part, modified in part and affirmed in part. The self-insured employer's aggravation denial is reinstated and upheld. The Referee's attorney fee award is modified. In lieu of the Referee's award, claimant is awarded an assessed fee of $500 for services at hearing on the penalty issue. The remainder of the Referee's order is affirmed. A client-paid fee payable from the self-insured employer to its counsel, not to exceed $1,322.50, is approved.

In the Matter of the Compensation of
VIRGIL K. COMSTOCK, Claimant
WCB Case No. 87-08680
ORDER ON REVIEW
Stebbins & Coffey, Claimant Attorneys
Foss, et al, Defense Attorneys

Reviewed by Board Members Gerner and Cushing.

The self-insured employer requests review of that portion of Referee Emerson's order which granted claimant permanent total disability, whereas a Determination Order had awarded no permanent disability for a neck condition. On review, the issue is permanent disability, including permanent total disability. We reverse in part, affirm in part and modify in part.

FINDINGS OF FACT

On January 13, 1983, claimant sustained a low back injury. This claim was accepted by the employer. Claimant returned to work and reinjured his low back, including his shoulder and neck, on December 12, 1983, when he slipped and fell. This injury was combined with the earlier claim. On May 4, 1984, the claim was closed with an award of 20 percent unscheduled disability for the low back. Claimant returned to work as a deck sawyer.

On May 9, 1985, claimant underwent surgery for his left ankle. On June 6, 1985, claimant had surgery performed on his left shoulder. On June 13, 1985, the employer partially denied claimant's then current cervical condition as being unrelated to the accepted injury. Thereafter, the employer also denied the compensability of claimant's left ankle and left shoulder conditions. On August 15, 1985, claimant was allowed an additional 20 percent unscheduled permanent disability for his low back condition. On July 28, 1987, the partial denial of claimant's cervical condition was set aside and the claim reopened by Opinion and Order which found that claimant's December 1983 fall worsened his preexisting degenerative condition. Claimant's neck condition became medically stationary on April 24, 1985. On May 28, 1987, a Determination Order reclosed the claim and awarded no additional permanent disability.

Claimant has preexisting noncompensable conditions in his left ankle and left shoulder. He has a compensable hearing loss. He is 61 years old, has a tenth grade education and no G.E.D. Claimant is receiving both Social Security Disability payments and early retirement benefits from his employer. Claimant has not worked nor sought work since April 1985. He does not believe he can work and he has not looked for work. His former job as deck sawyer is regular and gainful employment within his current restrictions.

Claimant's wife is totally disabled. Claimant provides for her care himself. If he did not, he would have to hire someone else to do so.

Claimant has full range of motion in his neck, experiences pain with use, and is moderately impaired.

CONCLUSIONS OF LAW AND OPINION

Extent of Disability

The Referee concluded that claimant was permanently precluded from regularly performing work at a gainful and suitable occupation. Reasoning that it would be futile for claimant to seek work, the Referee granted permanent total disability. We disagree.

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).

The record indicates that claimant is not motivated to return to work. He believes he cannot work. (1Tr. 139). He did not testify that he wants to work. He expressed a reluctance to return to work because he would have to hire someone else to take care of his invalid wife. (1Tr. 132). In 1985, when his claim was denied and he needed money, he chose to retire early rather than attempt to find work, even though there was a financial disincentive to do so. (1Tr. 93-95). He applied for Social Security Disability Benefits. While claimant testified that if offered he would have taken the job as a deck sawyer, (1Tr. 122), he later recanted this testimony. (1Tr. 124-127). He also admitted to telling Dr. Adams that if he did not get the job he wanted with the employer he wanted to be retired. (2Tr. 229). We conclude that claimant has not established that he is willing to seek regular gainful employment.

Claimant is also required to establish that he has made reasonable efforts to obtain regular gainful employment. We find that a reasonable effort to obtain employment would include an attempt to return to work with the employer in the deck sawyer position. This position is regular gainful employment. This position is within claimant's physical restrictions. Claimant had actually successfully performed the job until the time he was taken off work for the noncompensable ankle and shoulder surgeries. The employer showed a willingness to modify the job if it caused him physical distress. (1Tr. 118; 2Tr. 19). Since claimant made no attempt to return to work in this position, we conclude that he 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 an effort to obtain employment will be excused. The Referee concluded that because of the combination of claimant's age, education, transferable skills, physical restrictions and the urging of his physicians to retire that "claimant reasonably believed that it would be futile for him to seek other employment." The Referee thus excused claimant from the necessity of making reasonable efforts to obtain employment. We disagree with the Referee's analysis and conclusion.

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. The question is whether it is futile

for claimant to make reasonable efforts, not whether claimant reasonably believes it to be futile.

Dr. Bert, claimant's attending doctor for the noncompensable ankle and shoulder conditions, is the only doctor to opine that it would be futile for claimant to seek work. His opinion, however, is without explanation and is conclusory. Claimant was gainfully employed at the time Bert released him from work to have ankle and shoulder surgery. Bert does not explain why it would be futile to attempt to return to work to the job as a deck sawyer when the surgeries improved claimant's condition. There is no indication that the job became more physically demanding in the interim. Claimant's other conditions remained basically the same. Without some explanation, we are unable to conclude that it would be medically futile for claimant to seek to return to his deck sawyer job with the employer so as to excuse his failure to make reasonable efforts to obtain employment. Moreover, Bert's opinion of futility is based on an evaluation of claimant's compensable and noncompensable conditions. (Ex. 98-15). However, futility must be evaluated with regard to claimant's compensable conditions only. SAIF v. Stephen, 308 Or 41, 48 (1989). His opinion is not probative.

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 has failed to establish entitlement to permanent and total 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 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's cervical spine is moderately impaired due to pain. Claimant's prior work history includes primarily heavy work. On de novo review of the entire record, we conclude that claimant has lost an additional 25 percent of his preinjury earning capacity due to the compensable neck condition.

ORDER

The Referee's order, dated March 25, 1988, is reversed in part, modified in part and affirmed in part. The Referee's award of permanent total disability is reversed. Claimant is allowed an additional 25 percent (80 degrees) unscheduled permanent partial disability for his neck condition. Claimant's attorney is awarded 25 percent of the increased compensation. However, the total attorney fees awarded on the permanent total disability and permanent partial disability issues by the Referee's and Board's orders shall not exceed $3,800. The Referee's offset of overpaid temporary disability benefits after April 24, 1985 is modified to be allowed against the permanent disability benefits awarded herein. The remainder of the Referee's order is affirmed. The Board approves a client-paid fee payable from the employer to its counsel, not to exceed $1,365.

In the Matter of the Compensation of
VAL R. MCBRIDE, Claimant
WCB Case No. 88-09911
INTERIM ORDER ON RECONSIDERATION (REMANDING)
Malagon, et al, Claimant Attorneys
Acker, et al, Defense Attorneys

The self-insured employer has requested reconsideration of our February 21, 1990 Interim Order (Remanding), which remanded this case to the Hearings Division for introduction of post-hearing surgery and progress reports. Contending that the aforementioned reports are already present in a subsequent case, (WCB Case No. 89-00841), which is presently pending review, the employer asserts that remand is unnecessary. Alternatively, the employer objects to the introduction of the out-of-state surgeon's reports without cross-examination.

We disagree with the employer's contentions concerning the necessity for remand. As stated in our Interim Order, we intend to eventually conduct our review of this case together with WCB Case No. 89-00841. Despite such an intention, we are not authorized to make findings and render conclusions in one case based on evidence admitted in another case. Rather, our review must be based on the record developed before the Referee. ORS 656.295(3), (5).

Inasmuch as we have found the record in this case, which presently lacks the aforementioned reports, to be inadequately and insufficiently developed, we cannot consider them unless we remand to the Referee for their inclusion into this record.

However, the evidentiary objections currently raised by the employer merit reconsidering a portion of our order. The employer argues that unless Dr. Schweigel is available for cross-examination by the employer, then his reports should not be admitted. We agree. Inasmuch as these reports did not exist at the time of hearing, the employer is entitled to the opportunity to cross-examine Dr. Schweigel.

Accordingly, we modify our order as follows: We remand this case to the Presiding Referee to assign to a Referee, who shall admit the evidence proffered by claimant with his motion to remand and his letter of March 15, 1989, if the authors of the reports are made available for cross-examination. If cross-examination of the author of any report proffered is not available then that report shall not be admitted. The assigned Referee shall then determine whether any evidence admitted changes the conclusions reached in Referee Nichols' order. The assigned Referee shall then issue an Order on Remand which shall be forwarded to the Board along with the entire record within 30 days of the date of the order. The Board retains jurisdiction of this case. When the Order on Remand is issued and the case is returned to the Board, the Board will establish a new briefing schedule for the parties.

ORDER

The Interim Order (Remanding), dated February 21, 1990, as amended herein, is hereby republished.

In the Matter of the Compensation of
MARY A. NORRIS, Claimant
WCB Case No. 88-02471
ORDER ON REVIEW
Black, et al, Claimant Attorneys
Cowling & Heysell, Defense Attorneys

Reviewed by Board Members Cushing and Gerner.

The insurer requests review of Referee Mongrain's order which set aside its denial of claimant's chiropractic treatments which were in excess of the Director's guidelines. On review the issue is medical services. We reverse.

FINDINGS OF FACT

Claimant, 33 years old at the time of the hearing, suffered a compensable upper back injury on October 13, 1986. Claimant experienced neck pains and headaches.

Dr. Knudson, chiropractor, has been claimant's treating physician since October 20, 1986. Claimant was also treated by Dr. Narus, osteopath, and Dr. Morgan, physiatrist.

On December 18, 1987, claimant underwent an independent medical examination by the Western Medical Consultants. Concluding that claimant's condition was medically stationary, the Consultants recommended that her palliative treatment not exceed twice a month.

Shortly thereafter, on January 4, 1988, the insurer issued a partial denial for treatment in excess of the Director's guidelines.

From October 1987 through May 1988, claimant experienced neck and headache pain. She was seen by Dr. Knudson nine times in October, ten times in November, ten times in December, nine times in January, eight times in February, six times in March, seven times in April and five times in May.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant's chiropractic treatment was reasonable and necessary in that it related to the mechanism of claimant's pain and in controlling the symptoms. We disagree.

A claimant is entitled to all reasonable and necessary curative or palliative medical care required for recovery from a compensable injury or 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). 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. Worker's Comp. Dept., 65 Or App 659. 669 (1983), modified, 67 Or App 270. rev den 297 (1984).

Although the Board generally gives greater weight to the conclusions of a treating physician, it will not so defer when there are persuasive reasons to do otherwise. See Weiland v. SAIF, 64 Or App 810, 814 (1983).

As a result of her compensable injury, claimant suffered from intermittent neck pain. In February 1988, claimant was treated by Dr. Knudson eight times for manipulation and massage. Monthly treatments at a similar frequency continued through May 1988. Moreover, during this time claimant was also treated by Dr. Narus on at least six occasions.

By letter dated April 29, 1988, Dr. Knudson responded to the insurer's January 1988 denial. He noted that claimant, "...deserves to try to regain a homeostatic state comparable to before her injury." (Ex. 29). Knudson does not elaborate on what medical results were intended by the term "homeostatic". During his deposition, Dr. Knudson asserted that the excess treatment was necessitated by a severe headache and lower back ache caused by an injury sustained during the independent medical examination. Likewise, Dr. Knudson analogized claimant's spinal adjustment as: "...similar to a medical physician prescribing a drug and that particular patient taking this medication to help them with their headache." (Knudson, Depo. 22).

Knudson referred claimant to Dr. Narus, who related no objective medical evidence linking her deteriorated condition to the independent medical examination. He felt that the continued medical treatment was necessary to alleviate the fibromyositis that claimant was suffering from as a result of her work injury. Moreover, Dr. Narus opined that claimant's migraine headaches were not related to her compensable injury, and actually represented a muscle tension headache.

On the other hand, the Western Medical Consultants examined claimant on December 18, 1987, and reported that claimant had reached maximum improvement, and that her permanent impairment was minimal. The Consultants found that claimant should receive minimum palliative treatments, two times a month for a three month period, since they felt that claimant had become dependent upon the extensive chiropractic treatment.

In conclusion, we find the Consultants' opinion well reasoned and thorough. Consequently, we consider it to be persuasive. Somers v. SAIF, 77 Or App 259 (1986). Accordingly, we are not persuaded that chiropractic treatments in excess of two times per month were reasonable and necessary medical services.

ORDER

The Referee's order, dated August 11, 1988, is reversed. The insurer's 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 $1,117, payable from the insurer to its counsel.

In the Matter of the Compensation of
RICHARD J. PETERS, Claimant
WCB Case No. 86-01810
ORDER ON REVIEW
Jeff Carter, Claimant Attorney
Stafford J. Hazelett, Defense Attorney

Reviewed by Board Members Gerner and Cushing.

The insurer requests review of those portions of Referee Borchers' order which: (1) found that claimant was a subject worker; (2) found that the insurer was not prejudiced by claimant's untimely filed claim; (3) set aside its denial of claimant's injury claim for a right foot and head condition; and (4) awarded an assessed fee of $2,000. On review, the issues are coverage, timeliness, compensability and attorney fees. We reverse.

FINDINGS OF FACT

Claimant was 56 years old at the time of hearing. In February, 1985, claimant and Mr. Ganoe agreed to be truck driving partners. At that time, Ganoe had an agreement with Double DD Trucking Lines Inc. (the insured in this case) to drive a truck and deliver loads for them. That agreement included that Ganoe would be paid by the load; that no taxes would be taken from the load settlement; that the amount of the load settlement would be a percent of the load; that Ganoe would pay for all of his expenses (i.e., gas, oil, food, lodging, etc.) in hauling the load; that Ganoe would call the main office to receive new assignments upon completing a load; that Ganoe could refuse assignments; that the requirement of successfully completing an assignment was to timely deliver the load to the required location in good condition; that failure to successfully complete assignments could result in Ganoe not being given any more assignments; and that hours and route were up to Ganoe.

Ganoe and claimant had an agreement that when Double DD would make out a settlement check to Ganoe, he would pay claimant a straight 50 percent of whatever that load brought in. The checks were made out to Mr. Ganoe, who in turn would cash the check, and pay claimant after all of their expenses (i.e., gas, oil, food, lodging, etc.) were deducted. Claimant and Ganoe split all the expenses equally.

Before claimant could operate the truck Ganoe was using, he had to pass a written examination, and a road test. These tests are part of state licensing requirements for all persons operating trucks. Both of these examinations were administered by Mr. Diede, the owner of the insured.

Mr. Kuhlman owned the truck driven by claimant and Ganoe. Kuhlman leased the vehicle to Double DD. He provided no direction or control over claimant's employment activities. Double DD had an arrangement with Ganoe regarding the lease and use of the truck.

Ganoe and claimant exercised all the rights of Ganoe's agreement with the insured.

Claimant was injured in a truck accident on March 22, 1985. Claimant received treatment for a laceration of the instep and toes of his right foot.

By letter dated May 7, 1985, claimant mailed a signed 801 Form, dated April 29, 1985, to the insured. Claimant identified Mr. Kuhlman as the employer.

Mr. Diede, for the the insured, returned claimant's letter to claimant's attorney with a handwritten note. The note indicated that claimant was not an employee of Double DD. Claimant requested a hearing.

CONCLUSIONS OF LAW

SUBJECT WORKER

The Referee found that claimant was a subject worker of Mr. Diede, who was a subject employer. We disagree.

The test for determining who is a subject worker within the meaning of the Workers' Compensation Act is the employer's right to control the performance of the services. ORS 656.050(14) & (27). The test requires an application of the traditional "right to control" analysis and a consideration of the "nature of the work." Woody v. Waibel, 276 Or 189, 196, 554 P2d 492 (1976); Castle Homes, Inc. v. Whaite, 95 Or App 269, 271 (1989).

The factors to be considered under the traditional test of the right to control include: (1) evidence of the right to, or the exercise of, control; (2) the method of payment; (3) the furnishing of equipment; and (4) the right to fire at will without liability. Castle Homes, Inc. v. Whaite, supra.

We first note that any evidence of actual control would support an employer-employee relationship. On the other hand, absence of any evidence of the actual exercise of control does not necessarily require a finding that the alleged employee was an independent contractor. This results from the fact that it is the right to control services, rather than the actual exercise of control, that is determinative. Bowser v. State Ind. Acc. Comm., 182 Or 42, 49-56 (1947).

Turning to the record, we do not find any direct evidence of either the right to, or the actual exercise of, control. Considering the question, Professor Larson has noted that, "If the right of control of details goes no further than is necessary to ensure a satisfactory end result, it does not establish employment." A. Larson, Workers' Compensation Law, 277 (1984). Here the insured told Ganoe where truck shipments were to be delivered. Yet, thereafter, it was the responsibility of Ganoe to reach that final destination. Likewise, it was Ganoe's responsibility to call the insured for assignments. Nothing prevented Ganoe from not calling for a new job or rejecting jobs offered to them. Therefore, we find no direct evidence that the insured retained the right to control the services of Ganoe. The insured only exercised enough control to insure that the job got done. Marcum v. SAIF, 29 Or App 843, (1977). This is insufficient evidence to establish control. Although a close question, we conclude that application of the control test indicates that Ganoe is an independent contractor. Since claimant was Ganoe's partner and his association and agreement with the insured was derivative from his partnership with Ganoe, we conclude that the control test also indicates that claimant is an independent contractor.

We turn to an examination of the parties' rights to terminate the relationship. An employee/employer relationship would be considered if the insured could fire claimant without incurring liability for not performing part of the expected job. This would be true regardless of the fact that the insured did not exercise actual control over claimant and his partner. Bowser, supra, 182 Or at 56.

In this regard, the parties did not have a written employment contract. As to termination, claimant testified, "Well, I don't think anybody ever did the

firing except Carl himself. (Pause) But if you would go out and, say, you'd be two days late delivering a load or something, yeah, you'd get fired." (Tr. 17). We interpret this reference to "fire" to suggest that if the product was not delivered on time, Ganoe, and therefore, his partner the claimant, could expect no more assignments from the insured. This indicates that the insured had some control over when the product was delivered but not the means or route taken. However, we consider such evidence insufficient to show that the insured held the right to "fire" claimant as an employee for violations of work rules, hours, or the like.

Turning to the method of compensation, claimant testified that the insured would issue a check payable to Ganoe, who would then cash the check. In general, payment of an hourly wage suggests an employer-employee relationship. Bowser, supra, 182 at 60. However, in this case, the insured would make out a check to Ganoe, who would then pay claimant pursuant to their agreement. The insured never directly paid claimant. There was no tax withholding or other deductions by the insured. We conclude that, under these facts, the method of payment supports an independent contractor relationship.

With regard to furnishing the equipment, Ganoe furnished all the equipment for the partnership. Claimant and Mr. Ganoe shared the cost of regular expenses such as food, lodging, fuel and oil. This is also evidence suggestive of an independent contractor relationship.

In sum, the relevant factors regarding the traditional "right-to-control" test support an independent contractor relationship. Therefore, we conclude that the insured was not responsible pursuant to ORS 656.029 for providing workers' compensation coverage for claimant.

Compensability

The Referee found that claimant's right foot and head injuries were compensable. We disagree.

An employee must be a "subject worker" in order to recover under the Workers' Compensation Act. ORS 656.027. We have previously found that claimant is an independent contractor and not an employee of the insured. Considering this finding, it is unnecessary to address the timeliness, compensability and attorney fee issues.

ORDER

The Referee's order, dated July 28, 1988, is reversed. The insurer's denial is reinstated and upheld. The Referee's attorney fee award is reversed.

March 2, 1990 Cite as 42 Van Natta 467 (1990)

In the Matter of the Compensation of
YEONG SCHWENGEL, Claimant
WCB Case No. 88-08853
ORDER ON REVIEW
Vick & Gutzler, Claimant Attorneys
Roberts, et al, Defense Attorneys

Reviewed by Board Members Speer and Howell.

The insurer requests review of those portions of Referee Quillinan's order which: (1) increased claimant's unscheduled permanent disability award

for neck, shoulder and chest injuries from 14 percent (44.8 degrees) as awarded by Determination Order to 50 percent (160 degrees); and (2) assessed a 25 percent penalty and an attorney fee for unreasonable delay in accepting or denying claims for medical services. The issues on review are unscheduled permanent disability and a penalty and attorney fee. We modify in part and reverse in part.

FACTS

At hearing and on review, the parties have agreed that the values under the "standards for the evaluation of disabilities" as determined by the Evaluation Section of the Workers' Compensation Division for claimant's age, education and impairment are correct. We accept those values which are: for age (41 years) 1 (former OAR 436-35-290(4)); for education 5 (former OAR 436-35-300(3), (4) & (5)); and for impairment 8 (former OAR 436-35-350(2) & 436-35-360(2)-(5)). (Ex. 47A).

Claimant had, at the time of hearing, not returned to work. She was unable to perform her "usual and customary work" [her work at the time of injury (former OAR 436-35-270(3)(a))]. Claimant was capable of performing work between the sedentary and light categories.

CONCLUSION

Unscheduled Permanent Partial Disability

The insurer argues that the Referee erred by evaluating claimant's disability de novo. It is unclear whether the Referee exercised de novo review. She held that "ORS 656.726, requires claimant to prove by clear and convincing evidence that the degree of permanent disability suffered is more than that awarded." The Referee went on to conclude that claimant had proved by clear and convincing evidence that the Evaluation Section had inaccurately determined her permanent disability and that her loss of earning capacity was greater than that awarded by the Evaluation Section.

Following the Referee's order in this matter, we addressed the question raised by the insurer. In Michelle Griffith, 40 Van Natta 2086 (1988), we held that the scope of the referees' and this Board's review under ORS 656.283(7) is de novo on the hearing record. It continues to be the general rule that disability is rated at the time of hearing. See Emmons v. SAIF, 34 Or App 603 (1978). Furthermore, the facts upon which the evaluation of disability is made under the standards need only be established by a preponderance of the evidence.

The parties agree that the standards adopted by the Director pursuant to ORS 656.726(3)(f)(A) must be applied in this case. ORS 656.295(5). The applicable standards are those in effect at the time the claim was closed and evaluated by the Evaluation Section. Former OAR 438-10-010 (Temp.) and OAR 438-10-010. In this case the standards adopted effective July 1, 1988 (Former OAR 436-35-001 et seq.) must be applied.

Former OAR 436-35-270 through 436-35-440 apply to the rating of unscheduled permanent partial disability. Former OAR 436-35-270(1). The determination of permanent partial disability under those standards is made by determining the appropriate values for age, education, adaptability and impairment. The appropriate 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. The result is the percentage of unscheduled permanent partial disability. Former OAR 436-35-280.

In this case the parties have stipulated or otherwise agreed to the values to be assigned for age, education and impairment. Those values are +1, +5, and +8, respectively. We accept those values for purposes of rating claimant's disability.

The only remaining value to be determined is the value for adaptability. Former OAR 436-35-310. We have found that claimant is unable to perform her "usual and customary work". See former OAR 436-35-270(3)(a). We based that finding upon claimant's several failed attempts to do so and upon the medical opinions that she cannot do so. We have also found, as did the Referee, that claimant's residual physical capacity falls between the sedentary and light ranges. See former OAR 436-35-310(c) & (d). We base that finding upon the results of the only physical capacities evaluation performed on claimant. That evaluation was done near the time claimant became medically stationary and is more persuasive than the estimates of claimant's capacities made by various physicians.

The appropriate adaptability value is obtained by averaging the values assigned to light and sedentary residual physical capacities. Former OAR 436-35-310(4). Those values are +4 and +8 respectively. Thus, the proper value for adaptability in this case is +6.

When claimant's age value (1) is added to her education value (5), the sum is 6. When that value is multiplied by claimant's adaptability value (6) the product is 36. When that value is added to claimant's impairment value (8) the result is 44 percent (140.8 degrees) permanent partial disability. Former OAR 436-35-280(7). (We note that the Referee did the same calculation but made an arithmetic error when she added 36 and 8 and obtained the sum of 40.)

The Referee found that claimant had established by clear and convincing evidence that English language deficiencies resulted in permanent partial disability to claimant in excess of that obtained by application of the standards. We disagree. There is no evidence in this record indicating the impact of claimant's language deficiency on her earning capacity. "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). Because there is no evidence of the impact of claimant's language skills on her earning capacity nor any other evidence indicating that her disability is greater than 44 percent (140.8 degrees), we do not find clear and convincing evidence that claimant's disability exceeds that obtained by application of the standards.

Penalty and Attorney Fee

The Referee found that the insurer had "de facto" denied medical service claims (billings from chiropractor Anderson) in excess of four per month prior to May 9, 1988 and "de facto" denied billings in excess of two per month thereafter. The Referee concluded that such denied claims were neither reasonable nor necessary and, therefore, not compensable. Neither party challenges that conclusion.

The Referee found that the insurer had unreasonably delayed acceptance or denial of the disputed claims. A penalty was assessed against the insurer and an attorney fee was awarded for those unreasonable delays.

Assuming that the insurer did unreasonably delay acceptance or denial of the medical service claims in dispute before the Referee, a penalty may not be assessed against such claims. ORS 656.262(10) provides for a penalty

based upon a percentage of "amounts then due". Here, because the denied claims were not compensable, there was no compensation "then due". Therefore, a penalty is not authorized by law. Ellis v. McCall Insulation, 308 Or 74 (1989). Furthermore, because the unpaid bills were not compensation, the insurer did not unreasonably resist the payment of compensation. An attorney fee is, therefore, not authorized under ORS 656.382. Ellis, supra; Lloyd L. Cripe, 41 Van Natta 1774 (1989).

ORDER

The Referee's order dated October 3, 1988 is modified in part, reversed in part, and affirmed in part. That portion of the Referee's order which awarded claimant an additional 36 percent (115.2 degrees) unscheduled permanent disability compensation is modified. Claimant is awarded 30 percent (96 degrees) unscheduled permanent disability compensation in addition to the 14 percent (44.8 degrees) awarded by Determination Order for a total award of 44 percent (140.8 degrees). Claimant's attorney fee is adjusted accordingly. That portion of the Referee's order which assessed a penalty and associated attorney fee is reversed. The remainder of the Referee's order is affirmed. A client-paid fee, payable from the insurer to its counsel, up to $1,548 is approved.

March 2, 1990 Cite as 42 Van Natta 470 (1990)

In the Matter of the Compensation of
MIKE SEPULL, Claimant
WCB Case No. 86-04403
ORDER ON REVIEW
Brian R. Whitehead, Claimant Attorneys
Bottini, et al, Defense Attorneys

Reviewed by Board Members Myers and Gerner.

The insurer requests review of those portions of Referee M. Johnson's order which: (1) affirmed a Determination Order's award of 15 percent (48 degrees) unscheduled permanent disability; (2) set aside those portions of a medical services denial which denied compensability of thermography; and (3) set aside those portions of the medical services denial which denied chiropractic treatment within the administrative guidelines. Claimant cross-requests review, contending that he is entitled to a greater award for unscheduled disability.

We note that Exhibit 60 is missing from our record on review. However, inasmuch as the parties have agreed that the case may be reviewed without Exhibit 60, we consider the parties to have waived any irregularities created by the absence of this exhibit.

ISSUES

The Determination Order, dated December 24, 1986, awarded claimant 15 percent unscheduled disability. The insurer contends that the 15 percent unscheduled disability award is excessive. It seeks to have the award reduced to zero. Claimant, on the other hand, seeks to have the award increased.

The insurer's denial, dated December 5, 1986, denied all current chiropractic treatment. The Referee and the parties all treat the denial as also specifically denying certain diagnostic procedures known as thermography. The insurer contends that chiropractic treatments in issue are for a condition which was not materially caused by the compensable injury. The insurer further contends that, even if the condition is caused by the compensable injury, the

chiropractic treatments are not reasonable and necessary. Finally, the insurer contends that the thermography is not a reasonable and necessary diagnostic tool.

FINDINGS OF FACT

Claimant was 25 years of age at the time of hearing. He has a twelfth grade education. He has worked as a busboy and a cook. At the time of hearing, he was working as a file clerk and shuttle driver for the treating chiropractor.

On September 10, 1985, claimant was working as a cook for the employer. He injured his right elbow and low back when he slipped while carrying a pan of food. He struck his left elbow on a table. Claimant strained his low back. The insurer accepted the claim. Claimant then began treating with Dr. Wilson, a chiropractor. On February 11, 1986, Dr. Wilson requested authorization to perform a thermogram. He performed a thermogram on March 14, 1986.

In April 1986, Dr. Teal, M.D., examined claimant and found claimant was medically stationary and was left with only minimal residuals from the low back injury. Later that month, Dr. Poulson, M.D., examined claimant at Dr. Wilson's request. He suspected that claimant had a degenerating disc. A CT scan confirmed a mild central bulging disc at L5-S1. The Orthopaedic Consultants examined claimant in May 1986. They found no evidence of neurological or orthopedic findings. They recommended against further chiropractic treatment because it was contributing to ongoing and developing symptoms.

Claimant was injured in a motor vehicle accident on July 10, 1986. Within 24 hours of the accident, claimant was complaining of increased low back pain. Claimant also injured his neck in the motor vehicle accident. Dr. Wilson performed thermograms on July 11, 1986, November 10, 1986 and April 23, 1987. The July 1986 and April 1987 thermograms were directed at the residuals from the motor vehicle accident. Dr. Wilson treated claimant for the motor vehicle accident and billed the automobile insurance carrier for treatments through April 23, 1987. He also continued to treat claimant for the compensable injury and billed the insurer for chiropractic treatments through June 22, 1987. Claimant often received treatments directed at both the residuals of the compensable injury and the residuals of the motor vehicle accident at the same time.

On December 5, 1986, the insurer issued its denial, denying the compensability of current chiropractic treatments on the bases that they were not for a condition related to the compensable injury and were not reasonable and necessary treatments for that injury.

Dr. Wilson has a significant financial interest in claimant's claim. He referred claimant to an attorney and urged claimant to contest his denial.

Dr. Wilson also owns the thermography service to which he sends most of his workers' compensation and automobile injury clients.

Claimant has no permanent impairment as a result of his compensable injury. The chiropractic treatments, after July 10, 1986, were not reasonable and necessary treatment for the compensable injury and its sequelae. The thermographic evaluations are not reasonable and necessary diagnostic tools for the compensable injury and its sequelae.

CONCLUSIONS AND OPINION

In order to prove entitlement to an award for unscheduled permanent partial disability, claimant must prove by a preponderance of the evidence that,

as a result of his compensable injury, he has sustained some permanent impairment which limits his ability to work. Claimant has failed to sustain his burden of proof.

We rely on the well-reasoned opinions of Drs. Tilden and Duncan over the opinion of Dr. Wilson. Although we normally defer to the opinion of the treating physician, absent persuasive reasons not to do so, we do not defer to Dr. Wilson's opinion in this case. Dr. Wilson has a significant financial interest in claimant's claim. Furthermore, he has acted as an advocate for claimant rather than as an objective medical examiner. We conclude that there are persuasive reasons not to defer to Dr. Wilson. On the other hand, Dr. Tilden persuasively explained that claimant has no objective signs of permanent impairment. Furthermore, claimant's responses during an independent examination were actually inconsistent with objective reality. Dr. Duncan explained that the compensable injury was a relatively minor injury. He agreed with Dr. Tilden that claimant showed no objective signs of permanent impairment.

We conclude that claimant has no permanent impairment as a result of his compensable injury. Accordingly, we reduce the unscheduled disability award to zero.

Claimant also has the burden of proving by a preponderance of the evidence that the chiropractic treatment in issue was reasonable and necessary treatment for the compensable injury. We note that the Referee concluded that chiropractic treatment in excess of certain administrative guidelines was not reasonable and necessary but that treatment within the administrative guidelines was reasonable and necessary. The issue, as decided by the Referee, was not the issue at hearing and is not the issue before us. The issue as raised by the denial and the parties at hearing was whether any chiropractic treatments after July 10, 1986 were reasonable and necessary treatments for the compensable injury. We conclude that they were not.

We again discount the opinion of Dr. Wilson based on bias. We rely on the well-reasoned and persuasive opinions of Drs. Tilden and Duncan that after December 1985 further chiropractic treatment was contraindicated because any residuals from the compensable injury should have resolved by that time.

Finally, claimant has the burden of proving by a preponderance of the evidence that the thermography was a reasonable and necessary diagnostic tool. We conclude that it was not. We again discount Dr. Wilson's biased opinion. We rely on the well-reasoned and persuasive opinions of Drs. Tilden and Duncan that thermography has no better diagnostic or predictive reliability than mere chance.

ORDER

The Referee's order, dated June 1, 1988, is affirmed in part\and reversed in part. That portion of the Referee's order which affirmed the Determination Order's award of 15 percent (48 degrees) unscheduled permanent disability is reversed. Claimant's unscheduled permanent disability award is reduced to zero. That portion of the Referee's order which set aside the insurer's partial denial of thermography is reversed. That portion of the Referee's order which set aside the insurer's partial denial of chiropractic treatments within the administrative guidelines is reversed. The Referee's $1,000 attorney fee award is reversed. The denial, dated December 5, 1986, is upheld. The balance of the Referee's order is affirmed. The Board approves a client-paid fee, not to exceed $1,672, for the insurer's attorney's services before the Board.

In the Matter of the Compensation of
RICHARD R. HENDRICKSON, Claimant
WCB Case No. 87-14194
CORRECTED ORDER ON REVIEW
Coons & Cole, Claimant Attorneys
Davis & Bostwick, Defense Attorneys

Reviewed by Board Members Brittingham and Nichols.

The insurer requests review of that portion of Referee McMurdo's order that set aside its "de facto" denial of claimant's medical services claim for low back surgery. Claimant cross-requests review of that portion of the order that declined to assess a penalty and attorney fee for the insurer's alleged unreasonable claims processing. On review the issues are scope of review, medical services, penalties and attorney fees. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact, and make the following additional findings.

Prior to the accepted January 1987 injury, claimant had a history of low back injuries and related flare-ups of back pain which lasted no more than two months and resolved with bed rest. Since the January 1987 injury, claimant has experienced continual low back pain despite bed rest and conservative treatment.

Claimant's first request for surgery authorization was received by the insurer on September 11, 1987. The insurer responded with a letter, dated September 22, 1987, notifying claimant that he was scheduled for an independent medical examination on October 8, 1987. The insurer received the report from that examination on October 29, 1987. On November 2, 1987, it wrote Dr. Smith, the treating neurosurgeon, suggesting further referral and evaluation. The insurer did not issue a formal acceptance or denial of the claim, and claimant requested a hearing on the "de facto" denial on December 10, 1987. The insurer has never formally accepted or denied claimant's surgery request.

The insurer did not specify the grounds for its "de facto" denial prior to or at hearing. A substantial portion of the insurer's cross-examination of claimant concerned causation-related matters that were not relevant to the separate issue of reasonable and necessary treatment. Claimant did not make a timely objection at hearing to the litigation of the causation issue.

FINDINGS OF ULTIMATE FACT

The insurer has not waived its right to raise the causation issue on Board review. There is sufficient evidence in the record to rule on this issue, and claimant has had a reasonable opportunity to offer evidence.

Claimant's compensable injury is a material contributing cause of his current need for low back surgery. The requested surgery is reasonable and necessary treatment for claimant's compensable injury.

The insurer's failure to issue a formal response to claimant's surgery request was unreasonable resistance to the payment of compensation.

CONCLUSIONS OF LAW AND OPINION

Scope of Review

An insurer can deny a medical services claim because the condition is not causally related to the compensable injury, or because the requested service is not reasonable and necessary. In the present case, the Referee confined his review to the reasonable and necessary issue and did not address causation. On review, the insurer challenges claimant's surgery request on both causation and reasonable and necessary grounds. Claimant contends that the insurer has waived its right to challenge causation by not raising that issue prior to hearing.

The insurer has never limited the scope of its "de facto" medical services denial. To the contrary, a substantial portion of the insurer's cross-examination of claimant concerned causation related matters that were not relevant to the reasonable and necessary question. The nature of the insurer's cross-examination should have put claimant's attorney on notice that it was not waiving a causation challenge.

Under these circumstances, we conclude that the insurer has not waived its right to challenge causation, and that claimant has been given a reasonable opportunity to present evidence on this issue. We further conclude that there is sufficient evidence in the record to rule on causation. Accordingly, we address the insurer's causation challenge. See Anderson v. West Union Village Square, 44 Or App 67 (1980); Neely v. SAIF, 43 Or App 319 (1979). Compare Patricia N. Hall, 40 Van Natta 1873 (1988) (referee properly declined to address reasonable and necessary challenge where formal denial issued solely on basis of causation).

Causation Challenge

In support of its causation challenge, the insurer relies on the absence of medical evidence expressly linking claimant's need for surgery to the January 1987 injury. It further argues that such evidence is necessary to establish the requisite causal relationship in light of claimant's significant prior history of low back injuries.

We are not persuaded by the insurer's argument. The requested surgery is for claimant's bulging lumbar disc. Claimant must, therefore demonstrate that the compensable injury materially contributed to claimant's current disc condition and related pain. The fact that claimant's disc condition may have preexisted the compensable injury does not defeat the claim so long as the injury caused an increase in symptoms so that claimant now requires surgery. See Von Kohlbeck v. SAIF, 68 Or App 272 (1984); Harris v. Albertson's, Inc., 65 Or App 254, 256 (1983).

The record establishes the requisite causal link between the compensable injury and claimant's current symptoms. Since the injury, he has experienced continual, disabling low back pain despite bed rest and conservative treatment. Prior to the injury, his flare-ups of back pain were less severe and they resolved with conservative treatment. There is no medical opinion that claimant's current level of discomfort and disability is unrelated to his compensable injury. To the contrary, the existence of a causal link is implicit in the medical evidence. Under these circumstances, we are persuaded that claimant's injury was a material cause of his current symptoms and need for low back surgery.

Reasonable and Necessary Challenge

We affirm and adopt the Referee's decision and rationale on this issue.

Penalties and Attorney Fees

Claimant contends that the Referee erred in refusing to assess a penalty and attorney fee for the insurer's failure to issue a formal response to his surgery request. The Referee declined to assess a penalty and fee "[g]iven the split in the medical opinion, and the lack of evidence of recalcitrance" on the insurer's part. We understand the Referee to be ruling that the insurer had good cause to defer acceptance or denial pending further investigation. The insurer contends that penalties and attorney fees are not appropriate because claimant was on time loss and the surgery issue was reasonably contested.

Given the facts of this case, we conclude that the insurer's claims processing was unreasonable. It should have issued an acceptance or denial within 60 days of claimant's September 11, 1987 claim. At the insurer's request, the Orthopaedic Consultants examined claimant, opined that surgery was not reasonable and necessary, and issued a report explaining their position. That report would have supported a reasonable denial. Moreover, the insurer received the report on October 29, 1987 and had ample opportunity to issue a timely denial of the claim. The fact that time loss was paid on the claim is not a mitigating factor where the claim at issue is for medical services. Nor is it relevant that the "de facto" denial was reasonable on the merits; the insurer had a duty to issue a timely acceptance or denial without regard to the merits of the claim.

Accordingly, we conclude that the insurer acted unreasonably in failing to formally respond to claimant's surgery request. There are no amounts due on which to base a penalty because the surgery had not been performed at the time of hearing. ORS 656.262(10); Lester A. Carmen, 37 Van Natta 1686 (1985). However, claimant is entitled to an insurer-paid, i.e., assessed attorney fee for unreasonable resistance to the payment of compensation. ORS 656.382(1). Claimant's counsel is also entitled to a reasonable, assessed fee for services on review regarding the medical services issue. 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 March 15, 1988 is reversed in part and affirmed in part. The ruling that claimant is not entitled to a penalty-related attorney fee is reversed. The remainder of the order is affirmed. We approve a client-paid fee, not to exceed $416.50, payable by the insurer to its counsel. (Costs, including incurred secretarial time, incurred by an attorney in pursuing a matter on behalf of a party are not included in fees paid to an attorney and do not require Board authorization. See OAR 438-15-005(7); Janelle I. Neal, 40 Van Natta 359 (1988).)

In the Matter of the Compensation of
FREDRICK D. OXFORD, Claimant
Own Motion No. 89-0672M
OWN MOTION ORDER ON RECONSIDERATION
Malagon, et al, Claimant Attorneys
Saif Legal Department, Defense Attorney

Claimant requests reconsideration of the portion of our January 23, 1990, Own Motion Order that declined to assess a penalty and related attorney fee for the SAIF Corporation's allegedly unreasonable processing of the above-captioned claim. Claimant contends that the Board does not have jurisdiction under its own motion authority to consider the penalty and attorney fee issue. Alternatively, claimant argues that a penalty and attorney fee should have been assessed. Additionally, claimant's attorney seeks Board approval of an attorney fee payable out of compensation for services culminating in our January 23, 1990, Own Motion Order.

After reviewing the retainer agreement submitted by claimant's attorney, we approve a reasonable attorney fee of 25 percent of the additional compensation awarded by the Board's January 23, 1990, order, not to exceed $300.

Because the aggravation rights have expired on claimant's claim for the November 20, 1978, industrial injury, that claim is subject to our exclusive own motion authority. See ORS 656.273(4), 656.278(1); Miltenberger v. Howard's Plumbing, 93 Or App 475 (1988). If the processing of that claim results in an unreasonable delay in paying compensation, we are authorized under ORS 656.262(10) to assess a penalty based on amounts of compensation "then due," and any attorney fee which may be assessed under ORS 656.382(1). See, e.g., Sara I. Swartwout, 41 Van Natta 1471 (1989); Suzanne S. Wilson, 41 Van Natta 1319 (1989). Not later than the 60th day after receipt of an own motion claim, an own motion insurer must notify claimant and the Board in writing whether it recommends that a claim be reopened or denied. OAR 438-12-025(2). Here, SAIF received claimant's own motion claim on October 17, 1989, and issued its own motion recommendation by letter dated December 15, 1989. However, the Board did not receive the recommendation letter until January 5, 1990. Additionally, claimant submits persuasive evidence that SAIF's recommendation letter was not postmarked until January 4, 1990. SAIF offers no explanation for the discrepancy between the date of the letter and the mailing date. We are persuaded that SAIF unreasonably delayed the payment of compensation. We may not assess a penalty, however, because there were no amounts of compensation due at the time of the unreasonable delay. On the other hand, we may assess a penalty-related attorney fee even in the absence of amounts of compensation "then due." For SAIF's unreasonable resistance to the payment of compensation, we assess a penalty-related fee of $200.

On reconsideration, as supplemented herein, we adhere to and republish our January 23, 1990, order in its entirety. The parties' rights of appeal and reconsideration shall run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
REINE R. WEBB, Claimant
WCB Case No. 88-02445
ORDER ON REVIEW
Max Rae, Claimant Attorney
Kevin L. Mannix, Defense Attorney

Reviewed by Board Members Myers and Gerner.

The insurer requests review of those portions of Referee Quillinan's order which: (1) set aside its denial of chiropractic treatment for a low back condition; and (2) increased claimant's unscheduled permanent disability to 25 percent (80 degrees) whereas a Determination Order had awarded no permanent disability. Claimant cross-requests review of those portions of the order which: (1) allowed the insurer an offset for overpaid temporary disability; and (2) declined to award additional temporary disability. On review, the issues are compensability of medical services, permanent disability, temporary disability and offset. We affirm in part, modify in part and reverse in part.

FINDINGS OF FACT

Claimant sustained a low back sprain/strain on November 22, 1985 while engaging in lifting activities for the employer. She sought medical care from Dr. Athay, M.D., on November 25, 1985. Athay released her from work. Claimant's symptoms subsided by December 1985. (Ex. 1-12).

Claimant sought no further care until November 5, 1986 when she changed attending physicians to Dr. Whitmire, chiropractor. Whitmire noted intermittent low back pain, right leg pain and authorized time loss. Eight days later the insurer denied claimant's claim for temporary disability and her medical benefits because her then current condition was unrelated to the original injury.

A Determination Order issued November 26, 1986 awarding claimant temporary disability only from November 27, 1985 through December 24, 1985. By Stipulated Order the insurer's denial was "set aside in its entirety" and the claim was remanded for processing. The November 26, 1986 Determination Order was not appealed, for the purposes of this case, within one year of its issuance. Another Determination Order issued February 10, 1988 awarding temporary disability only from November 5, 1986 through January 4, 1988. The insurer denied claimant's current chiropractic treatment, manipulations and physiotherapy on March 17, 1988. Claimant timely appealed both the Determination Order and the denial.

Claimant has a preexisting scoliosis back condition which, though asymptomatic at the time of her injury, is disabling. Her small body frame and muscle build inherently limit her to light to medium work only. She is 22 years old and has a high school education. She has limited work experience as a baby sitter, newspaper delivery person and kitchen helper. Claimant's discomfort is due in part to her scoliosis condition which was made symptomatic by her industrial injury and is due in part to the residuals of her chronic sprain/strain. Claimant's injury did not worsen her preexisting scoliosis condition. Chiropractic treatments reduce claimant's symptoms for one week.

CONCLUSIONS OF LAW AND OPINION

Extent of Unscheduled Disability

The insurer asserts that the Referee's award of unscheduled permanent disability was excessive because it considered the disabling effects of claimant's noncompensable scoliosis condition. We agree.

Only the disabling effects of the injury caused scoliosis symptoms are compensable. The disability attributable to the scoliosis condition itself is not. Barrett v. D & H Drywall, 300 Or 553 (1985). The restrictions placed on claimant by her attending doctors, not to do heavy lifting, no carrying, twisting, bending or stooping on a repetitive basis, include consideration of the limitations imposed by the scoliosis condition itself. (1Tr. 70). These restrictions are in part precautionary to avoid reinjury and reflect an understanding that claimant is more prone to injury because of the scoliosis condition. Since their opinions do not factor out the noncompensable disability, we give them little weight.

The evaluators at BBV Medical Services partition the impairment due to the scoliosis from the impairment due to the industrial injury. They find no medical impairment due to the injury and minimal impairment due to the scoliosis. Finding BBV's assessment persuasive, we conclude that the majority of claimant's current restrictions are due to the scoliosis condition itself, and are not due to the symptoms she continues to experience as a result of the injury.

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). Claimant does have compensable disabling symptoms due to her industrial injury. We consider these symptoms 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).

On de novo review of the medical and lay evidence, we conclude that claimant has lost 10 percent of her preinjury earning capacity due to the compensable injury.

Reasonableness and Necessity of Medical Care

The insurer asserts that claimant's current chiropractic care is not reasonable and necessary because it is not for the compensable sprain/strain but for the noncompensable scoliosis and because the treatment gives no material benefit. The injury has caused the scoliosis to become symptomatic, therefore those symptoms are compensable consequences of the industrial injury. The chiropractic treatment reduces these same symptoms for approximately one week. We conclude that the current chiropractic treatment is reasonable and necessary palliative care and that it is compensable.

Offset

Claimant asserts that the Referee erred in allowing the insurer an offset for overpaid temporary disability when the issue of overpayment and offset was not raised at the beginning of the hearing, but was raised by motion for reconsideration after the Referee's order issued. We agree.

The overpayment the insurer sought to recover was already in existence and was ripe for adjudication at the beginning of hearing. In the interests of efficiency and in the exercise of our authority over the rules of practice and procedure at hearings, we conclude that the insurer was required to raise the offset and overpayment issue during the hearing before the record closed. ORS 656.726(4); OAR 438-06-031, 438-07-025; William G. Page, 39 Van Natta 693 (1987); Randy D. Johnson, 39 Van Natta 463 (1987); but see Julian E. Pournelle, 38 Van Natta 132 (1986) and Donald W. Wilkinson, 37 Van Natta 937 (1985) (where offset is allowed to be raised after an order allowing PTD because the issue of overpaid PPD was not ripe and mature until the order issued). Having failed to

timely raise the issue, it is deemed waived for the purposes of this proceeding. Randy D. Johnson, supra.

Entitlement to Additional Temporary Disability

Claimant asserts she is entitled to additional temporary disability from December 24, 1985 through November 5, 1986. The insurer asserts that claimant is barred from seeking entitlement to this period of disability because the Determination Order of November 26, 1986 has become final by operation of law. We agree with the insurer.

The time period for which claimant seeks temporary disability precedes the November 26, 1986 Determination Order. Therefore, entitlement to receive this period of compensation is dependent upon an appeal from, and amendment of, the November 26, 1986 Determination Order. This Determination Order is not a part of the present case because it was not appealed. Claimant's attempt to raise the issue at the April 1988 hearing was untimely, since it was raised more than one year after the Determination Order's issuance. Former ORS 656.319(4). Because the appeal was untimely, we are without authority to modify that order to afford claimant relief. Id.

ORDER

The Referee's order dated June 2, 1988, as reconsidered August 1, 1988, is affirmed in part, modified in part and reversed in part. That portion which increased claimant's unscheduled permanent disability to 25 percent (80 degrees) is modified to award 10 percent (32 degrees) unscheduled permanent disability. That portion which allowed the insurer to offset a $192.72 overpayment is reversed. The remainder of the order is affirmed. For services on review concerning the medical services issue, claimant's attorney is awarded an assessed fee of $700, to be paid by the insurer. The Board approves a client-paid fee, not to exceed $2,845.50, payable by the insurer to its counsel.

March 6, 1990 Cite as 42 Van Natta 479 (1990)

In the Matter of the Compensation of
ISMEAL M. BARAJAS, Claimant
WCB Case No. 88-10277
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Jim Dodge (Saif), Defense Attorney

Reviewed by Board Members Brittingham and Nichols.

The SAIF Corporation requests review of Referee Brown's order that set aside its denial of claimant's claim for a stab wound. On review the issues are: (1) whether SAIF can use the "aggressor defense" to avoid liability; and (2) whether the injury was sufficiently work-related to be compensable. We affirm.

The Board adopts the Referee's findings of fact with following supplementation. Claimant's injury occurred while he was working away from home for the employer and living with coworkers in a motel. Claimant was injured after he and his fellow workers returned to their motel from a trip into town, where they became intoxicated. Claimant was stabbed by a coworker after further liquor was consumed at the motel. The Referee concluded that the incident was compensable. The Board agrees, but for following reasons.

The Board does not necessarily agree with the Referee's "traveling employee" analysis. Furthermore, in finding this claim compensable, the Referee relied on the Board's decision in David Zimmerman, 40 Van Natta 862 (1988). That decision has since been reversed. Agripac, Inc. v. Zimmerman, 97 Or App 512 (1988). Nevertheless, we agree with the Referee's ultimate conclusion that the claim is compensable.

A "compensable injury" is an accidental injury "arising out of and in the course of employment requiring medical services or resulting in disability or death." Former ORS 656.005(8)(a) (now ORS 656.005(7)(a)). The "arising out of and in the course of employment" language involves the application of a unitary work-connection approach whereby the ultimate inquiry is the same: Is the relationship between the injury and the employment sufficient that the injury should be compensable? Rogers v. SAIF, 289 Or 633, 642-43 (1980).

In determining whether an injury is work-related, the Court of Appeals, in Mellis v. McEwen, Hanna, Grisvold, 74 Or App 571 (1985), identified seven factors to be considered in evaluating the activity at the time of injury. We apply those factors to the activity in this case, i.e., an argument between coworkers while staying at a motel.

First, whether the activity was for the benefit of the employer. Here, the dispute arose between workers living together at a motel. This lodging was paid for by the employer and was of benefit to him.

Next, whether the activity was contemplated by the employer. Here, the employer contemplated that the workers would live and socialize at the motel.

Next, whether the activity was an ordinary risk of, and incidental to the employment. Here, recreational activities were limited because the employees were away from home. The living situation created tensions which led to the injury, and the assailant was provoked into the attack because he was upset over his recent demotion.

Next, whether the employee was paid for the activity. Here, claimant was not being paid at the time he was stabbed.

Next, whether the activity was on the employer's premises. Here, the activity did not occur on the employer's premises, although the workers were required to live at the motel, and the employer paid for the lodging.

Next, whether the activity was directed by or acquiesced to by the employer. Here, the employer provided transportation into town and did not prohibit drinking during off hours.

Next, whether the employee was on a personal mission of his own. Here, the employee was not on a personal mission of his own; he was at the motel, where he was required to live.

After weighing all the factors, we conclude that claimant has established that his injury is work-related. Accordingly, we affirm the Referee.

ORDER

The Referee's order dated September 23, 1988 is affirmed. For services on Board review, claimant's attorney is awarded an assessed fee of $1,200, to be paid by the SAIF Corporation.

In the Matter of the Compensation of
KENNETH L. DUBAY, Claimant
WCB Case No. 88-08214
ORDER ON REVIEW
Pozzi, et al, Claimant Attorneys
H. Thomas Andersen (Saif), Defense Attorney

Reviewed by Board Members Brittingham and Crider.

The SAIF Corporation requests review of that portion of Referee Bennett's order that granted claimant permanent total disability. On review, the issue is permanent total disability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact and make the following additional findings.

As of March 28, 1985, the date of the last arrangement of compensation, both claimant's compensable right and left knee conditions were stationary subject to likely future need for total replacement. Claimant's left knee was the more painful. Therefore, on October 9, 1985 replacement surgery was performed in that knee. Replacement surgery was performed on the right knee less than three weeks later. Neither claim was reclosed until claimant had undergone a second surgery on the right knee.

FINDINGS OF ULTIMATE FACT

Claimant is permanently incapacitated from regularly performing work at a gainful and suitable occupation due to his compensable injuries.

Claimant is willing to work. He has made reasonable efforts to obtain employment. In any event, but for the compensable injuries to his right and left legs, he would have returned to work.

CONCLUSIONS OF LAW AND OPINION

We adopt the Referee's opinion with the following comment.

In considering claimant's request for an award of permanent total disability, the Referee considered claimant's disability due his 1980 compensable injury to the left leg as well as his 1977 compensable injury to the right leg. Because both conditions are compensable, he evaluated both conditions as they existed at the time of hearing. SAIF contends that the Referee should have considered claimant's right leg disability only as it existed at the time of the 1980 left leg injury. In other words, SAIF contends that the compensable right leg injury should be treated as a preexisting, noncompensable injury. We disagree.

Disability is generally rated as it exists on the date of hearing. Gettman v. SAIF, 289 Or 185 (1980). In permanent total disability cases, however, preexisting noncompensable conditions are considered only as they existed at the time of the compensable injury. John D. Kreutzer, 36 Van Natta 285, aff'd mem 71 Or App 355 (1984). We have rejected the contention that compensable conditions, other than conditions related to the claim before us, should be treated as noncompensable conditions. Thus, in Barton M. Grover, 39 Van Natta 297 (1987), aff'd sub nom, EBI Companies v. Grover, 90 Or App 524 (1988), we held that when the issue is permanent total disability, all compensable conditions must be rated as they exist at the time of hearing. We noted that to con

clude otherwise would often preclude claimant from combining the effects of compensable injuries. In one claim arising out of the first injury, it would be impossible to consider the later disability at all. In the claim arising out of the second injury, we would wear blinders forbidding us to see any deterioration of the first condition after the second injury. To forbid combining, we concluded, is inconsistent with ORS 656.206(1)(a).

SAIF contends that the compensable disability cannot be combined in this case because claimant's right knee condition, the subject of claimant's other compensable claim, last contributed to claimant's total disability. Again, we disagree. Which condition last contributed to a worker's total disability is important only when, because we must simultaneously rate claimant's disability in each claim, responsibility for payment of the award must be assigned. Therefore, in Grover, supra, where we had before us in a single proceeding, requests for hearing concerning the extent of claimant's disability in two separate claims, we assigned responsibility to the insurer whose injury last contributed to the total disability. When we have only one claim before us, however, the responsibility concepts discussed in Grover play no part.

In this case, then, we must simply determine, first, whether claimant's left knee condition has permanently worsened since the last arrangement of compensation so as to entitle him to a new rating of disability. Stepp v. SAIF, 304 Or 375 (1987). If so, then we must determine whether claimant is permanently incapacitated from performing gainful and suitable work in light of his compensable conditions and preexisting noncompensable disability.

No one argues that claimant's left knee condition has not worsened since the March 1985 hearing after which he was awarded 60 percent scheduled permanent partial disability in each leg. Since that time, he has undergone a total left knee replacement. Moreover, whereas the Orthopaedic Consultants opined in June 1984 that claimant was "employable in occupations which do not require prolonged standing and walking", and Referee Seymour found in 1985 that claimant could perform sedentary work, the Consultants opined in 1988 that claimant's impairment in each leg was severe and that "it is doubtful he is a reasonable candidate for a return to gainful employment". Claimant's left knee condition having permanently worsened, the Referee properly assessed claimant's total compensable disability as it existed at the time of hearing.

If SAIF is correct in its contention that compensable disability can be combined as it existed at the time of hearing only in the claim which last contributed to claimant's total disability, we would be hard pressed to determine which last contributed in this case. Claimant became totally disabled on October 9, 1985 when he was hospitalized for surgery to the left leg. Although two surgeries were later performed on the right leg, the first was performed immediately on the heels of the left leg surgery. Moreover, claimant was awarded temporary total disability benefits in this claim through March 16, 1988, when claimant's treating surgeon declared him medically stationary, apparently in both knees. Under these circumstances, we are not persuaded that either compensable condition last contributed to claimant's permanent disability.

For these reasons, we affirm.

ORDER

The Referee's order dated August 24, 1988 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,400, payable by the SAIF Corporation.

In the Matter of the Compensation of
JOSEPHINE M. GANTT, Claimant
WCB Case No. 87-14731
ORDER ON RECONSIDERATION
Durham, et al, Claimant Attorneys
Roberts, et al, Defense Attorneys

The self-insured employer requests reconsideration of our February 22, 1990 order, which among other things, reversed a Referee's order that found a Determination Order had prematurely closed claimant's knee injury claim. Specifically, the employer seeks permission to recover the temporary disability benefits paid pursuant to the Referee's order against claimant's future permanent disability awards.

The employer's request is contrary to law. ORS 656.313(2) expressly provides that should the Board subsequently order that compensation paid to claimant pending Board 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 Hutchinson v. Louisiana-Pacific, 67 Or App 577, 581, rev den 297 Or 340 (1984); Laverne L. Manselle, 39 Van Natta 1133 (1987).

Accordingly, our February 22, 1990 order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our February 22, 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
CELIA G. GARIBAY, Claimant
WCB Case No. 88-04689
ORDER ON REVIEW (REMANDING)
Charles D. Maier, Claimant Attorney
Roberts, et al., Defense Attorneys

Reviewed by Board Members Crider and Nichols.

Claimant requests review of Referee Emerson's order that dismissed his hearing request. The sole issue on review is res judicata. We reverse and remand.

FINDINGS OF FACT

Claimant compensably injured his back on October 11, 1987. He was taken off work and treated conservatively. The insurer accepted the injury claim and began paying temporary disability benefits. In November 1987, claimant requested a hearing alleging that the insurer failed to pay a week of temporary disability benefits and failed to pay the correct rate of temporary disability benefits. Claimant also sought penalties and related attorney fees for the insurer's allegedly unreasonable failure to pay the correct amount of temporary disability benefits. A hearing was set for February 12, 1988 before Referee Garaventa.

Prior to hearing, claimant's attorney was advised that the insurer had not paid several medical bills that were allegedly related to claimant's industrial injury. Claimant's attorney initially sought to raise the issue of unpaid medical bills for hearing; however, he later withdrew that issue before the

scheduled hearing and it was not considered by Referee Garaventa. On March 3, 1988, the Referee issued her Opinion and Order, awarding claimant additional temporary disability benefits, and assessing penalties and attorney fees against the insurer.

On March 25, 1988, claimant requested a hearing on the the unpaid medical bills. Claimant also sought a penalty and attorney fee for the insurer's failure to pay those bills. The insurer moved for dismissal of the hearing request, contending that the hearing request was precluded by res judicata. The Referee agreed and dismissed the hearing request with prejudice.

CONCLUSIONS OF LAW AND OPINION

The rules of res judicata generally operate to preclude litigation of claims and issues and are applied "where they facilitate prompt, orderly and fair problem resolution." North Clackamas School Dist. v. White, 305 Or 48, 50, modified 305 Or 468 (1988). The rule that precludes litigation of claims is called "claim preclusion," while the rule that precludes litigation of issues is called "issue preclusion." White, supra; Restatement (Second) of Judgments, Introduction at 1-5 (1982).

Claimant's assertion of entitlement to unpaid medical benefits in the instant proceeding is a claim, not an issue of fact. That claim would be barred by the prior litigation if the claim was or could have been litigated in the prior proceeding. 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). The medical benefits claim was not litigated in the prior proceeding. If, however, the medical benefits claim is part of the same cause of action that was litigated in the prior proceeding, we shall conclude that the claim could have been litigated in the prior proceeding. Carr v. Allied Plating Co., supra. A "cause of action" is an aggregate of operative facts which compose a single occasion for judicial relief. Carr v. Allied Plating Co., supra, 81 Or App at 310. The number of operative facts viewed as included within a single cause of action must be determined pragmatically, on the basis primarily of practical trial convenience considerations. See Dean v. Exotic Veneers, Inc., 271 Or 188, 192-93 (1975); Carr v. Allied Plating Co., supra.

This Referee broadly concluded that the "aggregate of operative facts composing a single occasion for relief" in this forum includes any issue concerning the claim for compensation in general that can be raised at a hearing. Finding that the issue of unpaid medical services could have been raised at the prior hearing, the Referee held that claimant is now precluded from raising the issue at this proceeding. We disagree.

As we discussed above, claimant's entitlement to medical benefits presents a claim, not an issue of fact. Litigation of that claim would likely turn on medical evidence regarding the causal relationship between the need for the disputed medical services and the industrial injury, as well as the reasonableness and necessity of the services themselves. See ORS 656.245(1); Van Blokland v. Oregon Health Sciences University, 87 Or App 694, 697-98 (1987); West v. SAIF, 74 Or App 317, 320 (1985). In contrast, the prior proceeding involved factual issues relating to temporary disability, e.g., duration of disability and rate of benefits. ORS 656.210. Although claimant's entitlement to both medical benefits and temporary disability arise from the industrial injury, they do not involve the same set of operative facts. The facts necessary to establish entitlement to medical benefits are separate and distinct from those necessary to establish entitlement to temporary disability. Indeed, the demands of proof are different for each. Consequently, we do not conclude that the medical benefits claim and temporary disability claim are part of the same "cause

of action." The Referee erred in holding that claimant's medical benefits claim was barred by res judicata.

ORDER

The Referee's dismissal order, dated May 16, 1988, is reversed. Claimant's hearing request, filed on March 25, 1988, is reinstated, and the case is remanded to the Referee for further proceedings consistent with this order. The Board approves a client-paid fee not to exceed $748.

March 6, 1990 Cite as 42 Van Natta 485 (1990)

In the Matter of the Compensation of
TERESA HESSELGRAVE, Claimant
WCB Case No. 88-07168
ORDER ON REVIEW
Philip H. Garrow, Claimant Attorney
Terrall & Miller, Defense Attorneys

Reviewed by Board Members Gerner and Cushing.

The self-insured employer requests review of that portion of Referee Brazeau's order that set aside its denial of claimant's upper back muscular condition claim. Claimant cross-requests review of that portion of the order that held that the Referee was without jurisdiction to determine if the chiropractor subpoenaed to the hearing to testify was an expert witness and therefore entitled to expert witness fees. The issues on review are compensability, jurisdiction and expert witnesses status.

FINDINGS OF FACT

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

Dr. Bemis was subpoenaed to the hearing by the insurer and called as its own witness. The vast majority of Dr. Bemis' testimony was that of a lay witness. The insurer, on direct examination, asked Dr. Bemis a few questions that required her expert chiropractic analysis and training to answer.

Dr. Bemis, at least in part, was called as an expert witness by the insurer.

CONCLUSIONS OF LAW AND OPINION

Compensability

We adopt the Referee's conclusions of law on the issue of compensability.

Expert Witness Fees

The Referee concluded that he was without jurisdiction to decide an issue of expert witness fees. We agree that the issue of the amount of the fee to be paid is outside the Referee's jurisdiction, but the underlying factual issue of whether Dr. Bemis was a lay witness or an expert witness is a matter within the jurisdiction of the Referee to decide. We therefore will decide the factual issue, but like the Referee we decline to decide the amount of a fee.

Medical service rates, and amounts of medical witness fees, are within the jurisdiction of the Director. ORS 656.248; OAR 436-10-090(21). Factual determinations of whether a witness is a lay witness or an expert witness, for the

purposes of practice and procedure in the Workers' Compensation hearings forum, is a matter within the jurisdiction of the Hearings Division and Board. See ORS 656.726(2)&(4); OAR 438-07-005(3). We conclude that we have jurisdiction to determine what kind of a witness Dr. Bemis was.

A "lay witness" is a person who is qualified to testify because he has first hand knowledge of the situation or facts at issue. This witness is merely one that is reporting observations or details known to him. An "expert witness" is a person who is so qualified, by scientific or specialized knowledge gained from formal study, training or specialized experience, as to enable him to form a definite opinion of his own respecting a division of science, branch of art, or department of trade about which persons having no particular training or special study are incapable of forming accurate opinions. Licensed physicians carry sufficient knowledge and expertise in the area of the healing arts to qualify as "expert witnesses" within the meaning of this definition.

In this case the insurer called Dr. Bemis as a witness. The vast majority of the questions asked by the insurer did not require the use of Dr. Bemis' special knowledge as a physician. This would normally qualify Dr. Bemis only as a lay witness.

Although the vast majority of the insurer's questioning did not involve the use of Dr. Bemis' expertise, the insurer, on direct examination, did ask Dr. Bemis' opinion regarding two medical reports in the record and claimant's physical presentation in her office. These are questions that require Dr. Bemis' special expertise as a physician. Therefore, Dr. Bemis was, in part, acting as an expert witness during the direct examination of the insurer.

The record, post-hearing, reflects that the fee dispute was referred to the Director. The Director referred this matter to the Hearings Division to try under his authority. This issue was then consolidated with the instant case on review for a decision on the Director's referral by the Board. The Board does not have jurisdiction to hear Director referral cases, either in the first instance or on review, unless it deals with vocational rehabilation. ORS 656.283. We therefore cannot address the issue of the amount of the fee. This matter must be heard in the first instance by a hearings officer upon the director's referral and any appeal therefrom is to be taken directly to the Court of Appeals. ORS 656.704(2).

ORDER

The Referee's order dated October 27, 1988 is affirmed. Claimant's attorney is awarded an assessed fee of $850, to be paid by the insurer. The Board approves a client-paid fee, payable from the employer to its counsel, not to exceed $1,893.50.

In the Matter of the Compensation of
CAROLE J. KNOX, Claimant
WCB Case No. 88-12993
ORDER ON REVIEW
Peter O. Hansen, Claimant Attorney
David B. Smith (Saif), Defense Attorney

Reviewed by Board Members Crider and Brittingham.

Claimant requests review of that portion of Referee Fink's order that upheld the SAIF Corporation's denial of her claim for depression. On review, the issue is compensability. We affirm.

FINDINGS OF FACT AND ULTIMATE FACT

Claimant, age 48 at hearing, sustained a compensable injury when she slipped and fell on August 1, 1979 while working as a nurse's aide. She has been treated conservatively.

She has received a total of 65 percent unscheduled permanent partial disability for her compensable low back condition.

Claimant has a long history of psychological difficulties. She suffered what she calls a "nervous breakdown" in 1959 after the birth of her first son. She was hospitalized for psychological difficulties following a car accident in 1966. She has been depressed since at least the mid-1970s, prior to the compensable back injury. She has treated with Dr. Petroske, M.D., since 1980, with a diagnosis of major depression, recurrent type.

By letter dated July 25, 1988 SAIF denied treatment for claimant's major depression for the reason that the condition preexisted the compensable injury. Claimant requested a hearing.

CONCLUSIONS OF LAW AND OPINION

Claimant contends that her psychological condition was caused, at least in part, by the compensable back injury. She may prevail if we find that her compensable condition is a material contributing cause of her psychological condition or its worsening. Jeld-Wen v. Page, 73 Or App 136 (1985). We are unable to make that finding.

Dr. Petroske, claimant's treating psychiatrist, has reported that claimant's depression is "multi-determined." He indicated that her depression "could be due to her physical capacities due to back injuries." But, he also indicated that claimant was dealing with a situation involving separation from a long term "male roommate" and the prospect of testifying against her son. (Ex. 31b).

Dr. Quan, psychiatrist, examined claimant for the insurer. He concurred in the diagnosis of depression and indicated that he could not say that claimant's condition was primarily caused by the injury. (Ex. 34).

Claimant asks us to read these two opinions together to establish the requisite causal connection between the injury and the condition. She contends that although neither opined that the injury bore a causal relationship to the depression, Dr. Quan's statement that he could not say that the condition was primarily caused by the injury suggests that he would be able to say that the condition was caused in part by the injury. Claimant, of course, need not produce evidence which uses the magic words "material contributing cause." Nevertheless, we, like the Referee, are unwilling to make the assumption that claimant asks us to make. Given the fact that claimant has longstanding depression and has struggled with a number of difficult life circumstances since the compensable injury, we cannot read the opinions to state that the preexisting depression was worsened by the compensable injury.

Therefore, claimant has failed to sustain her burden of proof.

ORDER

The Referee's order, dated October 26, 1988, is affirmed.

In the Matter of the Compensation of
NELLIE D. REINSCH, Claimant
WCB Case Nos. 88-07058, 88-07055, 88-07056 & 88-07057
ORDER ON RECONSIDERATION
Martin J. McKeown, Claimant Attorney
Davis & Bostwick, Defense Attorneys
Terrall & Miller, Defense Attorneys
Rankin, et al, Defense Attorneys

EBI Companies requests reconsideration of our February 6, 1990 Order on Review seeking an order compelling Crawford and Company to reimburse it the compensation paid claimant before we reinstated EBI's responsibility denial. We decline to order reimbursement.

Our jurisdiction is restricted to matters concerning a claim, which is defined as those matters in which "a worker's right to receive compensation, or the amount thereof, are directly at issue." ORS 656.704(3); ORS 656.726(2). Reimbursement disputes between insurers and self-insured employers are not matters concerning a claim. EBI Companies v. Kemper Group Insurance, 92 Or App 319 (1988); Reynolds-Croft, Inc. v. Bill Morrison Co., 55 Or App 487 (1982). After we have made our determination that the other insurers are the responsible paying parties, reimbursement from those parties is secured by order from the Director of the Department of Insurance and Finance not this Board. ORS 656.307(3); Liberty Northwest Ins. Corp. v. SAIF, 99 Or App 729 (1989).

Accordingly, our February 6, 1990 order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our February 6, 1990 order in its entirety. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
EUGENE C. BROWN, Claimant
WCB Case No. 88-00157
ORDER ON REVIEW
Peter O. Hansen, Claimant Attorney
Carrol J. Smith (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

Claimant requests review of those portions of Referee St. Martin's order that: (1) declined to grant an award of permanent total disability; and (2) increased claimant's unscheduled permanent disability for a low back condition, from 40 percent (128 degrees) as awarded by Determination Order, to 60 percent (192 degrees). On review, the issues are extent of unscheduled permanent disability, including permanent total disability. We affirm.

FINDINGS OF FACT

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

Claimant has mildly moderate permanent physical impairment in the low back due to the February 1986, compensable injury. (Ex. 24).

Claimant's demonstrated physical capacities qualify him for occupations in the light work range as defined by the U.S. Department of Labor. (Exs. 18-2, 21, 22, 24, 25 & 30).

On December 22, 1987, claimant was released to modified work at "any date at which appropriate work can be arranged." (Ex. 30).

Claimant has not made reasonable efforts to seek work.

CONCLUSIONS OF LAW AND OPINION

We adopt the Referee's opinion with the following supplementation on the permanent total disability issue.

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. Welch v. Banister Pipeline, 70 Or App 699, 701 (1984). Under the "odd-lot" doctrine, a person who is physically capable of performing work of some kind may still be permanently and totally disabled due to a combination of medical and nonmedical factors, such as his age, education, work experience, adaptability to nonphysical labor, mental capacity and emotional conditions which effectively foreclose him from gainful employment. Clark v. Boise Cascade Corp., 72 Or App 397, 399 (1985).

In addition claimant must make reasonable efforts to seek work, unless it would be futile for him to do so. ORS 656.206(3); Butcher v. SAIF, 45 Or App 318 (1983).

Throughout his claim, claimant's manifested pain behavior has been inconsistent with and exaggerated over the reported level of pain. (Exs. 18-3, 29). We are persuaded by the collective opinions of the physicians that from a purely physical standpoint, claimant's mildly moderate permanent physical impairment does not render claimant permanently totally disabled. Claimant is capable of performing light or sedentary work. We, therefore, conclude that claimant is not permanently totally disabled based upon physical factors alone.

Pursuant to an "odd-lot" analysis, 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 the availability of employment within the labor market. Wilson, supra 30 Or App at 412. In this regard, the vocational counselors and claimant's treating physician found claimant to be resistant to the possibility of returning to work. (Exs. 21, 22, 23, 29 & 31). Moreover, on February 20, 1985, claimant declined further vocational assistance. (Ex. 34a-6).

Claimant's treating physician, Dr. Gritzka, M.D., in response to the question whether claimant was permanently and totally disabled, replied that claimant could not perform his previous work, but could perform in sedentary work. (Ex. 35). Although claimant has resisted vocational rehabilitation, there are various vocational opportunities available to claimant based upon his transferable skills, prior work history and physical capabilities. (Exs. 18, 21, 22, 31).

In sum, claimant has been unwilling to make reasonable efforts to obtain gainful and suitable work nor has he shown that it would have been futile for him to seek such employment. Therefore, under the "odd-lot" doctrine,

claimant cannot be found permanently totally disabled. We conclude that claimant is not entitled to an award of permanent total disability.

ORDER

The Referee's order, dated April 22, 1988, is affirmed.

March 7, 1990 Cite as 42 Van Natta 490 (1990)

In the Matter of the Compensation of
ERNESTO CHAVEZ, Claimant
WCB Case No. 88-06066
ORDER ON REVIEW (REMANDING)
Max Rae, Claimant Attorney
Gary Wallmark (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

Claimant requests review of those portions of Referee Daron's order which: (1) found that claimant's left leg injury claim was not prematurely closed; and (2) affirmed a Determination Order which awarded 5 percent (6.75 degrees) scheduled permanent disability for loss of use of the left foot (lower leg). In the alternative, claimant requests that the Board remand the matter for consideration of new evidence. On review the issues are premature closure, extent of permanent disability and remand. We remand.

FINDINGS OF FACT

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

Claimant's claim was closed by Determination Order dated March 28, 1988. On June 27, 1988, claimant was seen by Dr. Butler, D.C., who referred claimant to Dr. Buza, M.D., neurosurgeon. (Ex. 20). On August 18, 1988, Dr. Buza indicated that claimant "may have causalgia" and recommended that they "...try a sympathetic block...I believe that conservative management should be indicated at this time. I do not believe at least at this point surgery should be considered until these other modalities are tried." (Ex. 20A-3).

Dr. Hiebert, M.D., surgeon, scheduled sympathetic blocks August 31, 1988 through September 30, 1988. (Ex. 22). By the time of hearing, claimant had had two sets of nerve blocks and was expecting several more treatments. (Tr. 21-22).

Hearing was held on September 8, 1988.

CONCLUSIONS OF LAW AND OPINION

A claim is properly closed when claimant's condition is determined to be medically stationary. "Medically stationary" means that "no further material improvement would reasonably be expected from medical treatment, or the passage of time. ORS 656.005(7). In determining whether claimant was medically stationary at the time of closure, post-closure evidence may be considered insofar as it is relevant to whether claimant's condition at the time of closure was likely to improve with time or treatment. Schuening v. J.R. Simplot & Co., 84 Or App 622 (1987). However, Schuening requires that claimant's medically stationary status be reviewed as of the time of closure without considering subsequent changes in claimant's condition.

In June 1988, when claimant saw Dr. Butler, his condition was the same as it had been when the claim was closed. Moreover, we conclude that claimant's condition had not changed when he sought further medical services in June-August, 1988. Instead, he was still seeking relief for the continued pre-closure pain/condition.

Claimant seeks remand for admission to the record of post-hearing reports from Drs. Buza and Hiebert. Pursuant to ORS 656.295(5), we may remand to the Referee for further evidence taking, correction or other necessary action when we determine that a case has been improperly, incompletely, or otherwise insufficiently developed or heard by a Referee. 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). To merit remand, it must be shown that material evidence was not obtainable with due diligence before the hearing. Bernard L. Osborn, 37 Van Natta 1054, 1055, aff'd mem 80 Or App 152 (1986). In this regard, we consider the proferred evidence on review only for purposes of claimant's remand motion.

Dr. Hiebert's reports indicate that on August 31, 1988, the first of a series of left lumbar sympathetic nerve blocks was performed. Dr. Hiebert reported that the nerve blocks were "an attempt to provide [claimant] with permanent relief of his symptoms." Dr. Buza explained that the purpose of the nerve blocks was to decrease the pain in the left leg by sectioning the sympathetic trunk to increase the sensation in the leg. Dr. Hiebert reports, "The patient was pain free subsequent to the procedure, indicating that the patient's symptoms are likely sympathetically mediated." After the nerve block series was completed proving that claimant's pain could be alleviated with surgery, Dr. Buza recommended surgery. Claimant underwent lumbar surgery on October 28, 1988.

We conclude that the results of the nerve blocks were not obtainable with due diligence before the hearing because they had not been completed. Additionally, we conclude that the absence of the medical reports regarding the nerve blocks and subsequent surgery renders the record concerning the issue of whether claimant's claim was prematurely closed by the Determination Order dated March 28, 1988, incompletely and insufficiently developed.

Accordingly, we remand this case to the Presiding Referee to assign to a Referee to admit the evidence proferred by claimant with his appellant's brief. The assigned Referee shall then issue a final appealable order reconsidering those issues raised at hearing.

ORDER

The Referee's order dated October 6, 1988 is vacated. This matter is remanded to the Presiding Referee for further proceedings consistent with this order.

In the Matter of the Compensation of
MARSHA A. JOSLIN, Claimant
WCB Case No. TP-90004
THIRD PARTY ORDER
Popick & Merkel, Claimant Attorneys
Michael 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. We approve the settlement.

FINDINGS OF FACT

In July 1988 claimant sustained a compensable back injury as a result of a motor vehicle accident. Her vehicle was rear-ended. Each of the vehicles sustained minimal visible damage.

Claimant has received conservative treatment for cervical, dorsal, and lumbar strain. A "broad-based disk bulge at L4-5 without focal compression" has been detected, but no surgery has been recommended. Claimant has been prescribed an elastic brace for her low back.

Although a psychological component has been noted, no personality disorder has been diagnosed. Despite this lack of diagnosis, a psychiatric examiner suggests that claimant converts her psychological distress (unrelated to her compensable injury) to her physical complaints. Claimant's former attending physicians concur with this observation.

Claimant has been involved in four or five prior motor vehicle accidents. All of the accidents have been minor, for which she has neither sought treatment nor experienced pain.

Claimant returned to her work as a housekeeper on a part-time basis shortly after her injury. In December 1988, she was released to full time duties, where she attempts to avoid heavy lifting.

A July 1989 Determination Order awarded 10 percent unscheduled permanent disability. That award was increased to 14 percent by virtue of a January 1990 stipulated order.

To date, the SAIF Corporation, as paying agency, has incurred actual claim costs totalling $11,451.94. These costs include medical expenses and temporary disability compensation, as well as the aforementioned 14 percent 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 $16,250.

SAIF declines to approve the settlement, contending that the offer is "grossly undervalued." Asserting that liability is uncontested and that claimant's claim costs are real, SAIF submits that the case is worth "at least $25,000 to $35,000."

FINDINGS OF ULTIMATE FACT

The third party settlement offer of $16,250 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).

In support of its contention that the settlement is grossly unreasonable, SAIF refers to the medical opinion of Dr. Cohen, claimant's current treating physician, and Dr. Turco, an independent psychiatric examiner. Cohen concluded that the disc bulge was related to the compensable injury, and Turco opined that claimant was not intentionally malingering.

Yet, Cohen became involved in claimant's case after Dr. Riggs, M.D., a former attending physician, had concluded that she had no neurological deficits and no permanent impairment. Moreover, Turco also opined that claimant would always have an element of somatic fixation in which she would convert psychological distress (unrelated to the compensable accident) to her physical complaints. Finally, Dr. Riggs, as well as Dr. Moskowitz, a former treating chiropractor, concurred with Turco's assessment.

After reviewing the parties' respective positions concerning 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 $16,250 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.

March 7, 1990 Cite as 42 Van Natta 493 (1990)

In the Matter of the Compensation of
PAULETTE D. LEHMAN, Claimant
WCB Case No. 88-04124
ORDER ON REVIEW
Minturn, et al, Claimant Attorneys
Lester Huntsinger (Saif), Claimant Attorney

Reviewed by Board Members Nichols, Brittingham and Crider.

Claimant requests review of the portion of Referee Brazeau's order that terminated her award of permanent total disability. Claimant argues that the Hearings Division has no jurisdiction over this matter. The issues on review are jurisdiction and extent of permanent disability, including permanent total disability.

We affirm and adopt the order of the Referee with the following references on jurisdiction: ORS 656.325(6) and 656.283.

ORDER

The Referee's order dated June 20, 1988, as reconsidered July 25, 1988, is affirmed.

Board Member Crider dissenting.

The Referee, in this benefit adjustment proceeding, terminated claimant's award of permanent total disability on the SAIF Corporation's request for hearing. Because it is my understanding that an insurer is not entitled to seek a reduction in previously awarded permanent disability via a request for hearing, but rather must direct its request to the Department of Insurance and Finance, I dissent.

Claimant, who was compensably injured in 1972, was awarded permanent total disability by Board order in 1976. The award was affirmed by the Circuit Court in 1978.

Many years later, the SAIF Corporation, pursuant to the procedure established in ORS 656.206(5), submitted evidence to the Department of Insurance and Finance which it contended supported termination of claimant's permanent total disability award. The Department declined to adjust the award and issued an order, on the form used for determination orders, indicating that claimant's entitlement would continue. SAIF requested a hearing seeking reduction of claimant's benefits. Claimant moved to dismiss the request for hearing. The Referee denied the motion and, after hearing, terminated claimant's award.

The Referee erred in denying the motion to dismiss. The statutory scheme provides generally for award of permanent disability when a claim is closed. At that time, an insurer may challenge a determination order as excessively generous by request for hearing, just as claimant may challenge it as too parsimonious. ORS 656.319. Thereafter, claimant's permanent disability compensation may be reduced only if the Department concludes, pursuant to ORS 656.325(3), that the award should be reduced. An insurer is not entitled to request a hearing pleading that a referee reduce an award where the Department has chosen not to do so. Farmers Insurance Company v. Hopson, 53 Or App 109, 111 (1981). Bentley v. SAIF, 38 Or App 473, 478 (1979).

The statute vests in the Department the discretion to adjust--or not to adjust--permanent disability awards. The insurer's role is simply to provide information necessary to the Department's exercise of that discretion. Thus,

> "Each insurer shall reexamine periodically each permanent total disability claim for which the insurer had current payment responsibility to determine whether the worker is currently permanently incapacitated from regularly performing work at a gainful and suitable occupation. Reexamination shall be conducted every two years or at such other more frequent interval as the Director may prescribe. Reexamination shall include such medical examinations, reports and other records as the insurer considers necessary or the director may require. The insurer shall forward to the Director the results of each reexamination."

ORS 656.206(5). The Director, then, is authorized to adjust the award if that, in his opinion, is warranted:

> "[T]he [permanent disability] award shall be subject to periodic examination and adjustment in conformity with ORS 656.268."

ORS 656.325(3). The Director's rules provide that when the Evaluation Section finds that the evidence demonstrates that a worker is no longer permanently and

totally disabled, a Determination Order shall issue. OAR 436-30-065(5). If such an order issues, the claimant may request a hearing. OAR 436-30-065(6). The insurer is not entitled to a hearing when an order issues declining to adjust an award. Farmers Insurance Company v. Hopson, supra, 53 Or App at 116.

The rationale for this apparent asymmetry is that an adjustment proceeding is a matter between claimant and the Director. The post-adjustment hearing on the Determination Order is the functional equivalent of the hearing that would normally be conducted prior to agency action under the Administrative Procedure Act. At hearing, the insurer acts only to establish the facts necessary to sustain the Director's action. Harris v. SAIF, 292 Or 638 (1982).

In this case, the majority has concluded that despite the statute, despite the rules and despite repeated judicial affirmation that the Director's action in an adjustment proceeding is reviewable in a hearing only when compensation is reduced, the insurer was entitled to a hearing at which it might seek to establish that claimant's compensation should be reduced simply because Evaluation notified the parties of its action on reexamination of the award via a Determination Order and because ORS 656.325(6) permits any party to request a hearing on a dispute under that section. That is error. In Hopson, itself, the Board, in the administrative capacity now filled by the Director, had issued an order continuing claimant's permanent disability status. The order notwithstanding, the court held that the action was not appealable. At that time, ORS 656.325(6) read precisely as it does now. I submit, therefore, that SAIF is not entitled, in this case, to initiate a reduction proceeding where the Director chose not to do so.

The consequences of the Board's decision are not insubstantial. If an insurer may request a hearing seeking to reduce a permanent total disability award every two years even where the Director declines to adjust the award, our most seriously disabled workers may be subjected to virtually continuous litigation in order to protect their awards. Moreover, if an insurer may challenge the Director's refusal to reduce a total disability award, what in the majority's analysis will preclude it from also challenging, at any time, the Director's refusal to reduce any other permanent disability award? The regulatory scheme, as explained in the case law, furthers the state's interest in stability in the workers' compensation system. Bauman v. SAIF, 62 Or App 323, 329 n. 4, aff'd 295 Or 788 (1983). Today's holding would seriously undermine that stability.

March 7, 1990 Cite as 42 Van Natta 495 (1990)

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

Reviewed by Board Members Brittingham, Nichols, and Crider.

Fire & Casualty Company (F & C) requests review of those portions of Referee Michael Johnson's order that: (1) set aside its denial of responsibility of claimant's aggravation claim for his low back condition; and (2) granted claimant 10 percent (32 degrees) unscheduled permanent disability for the same condition, in lieu of a Determination Order awarding no permanent disability.

On review, the issues are responsibility and extent of unscheduled permanent partial disability. Claimant has not submitted a brief on review. We affirm in part and reverse in part.

FINDINGS OF FACT

Claimant, 58 at hearing, has been employed as a laborer in the logging and construction industries for many years. He injured his back on April 14, 1981 when he bent over to pick up a piece of lumber at SAIF's insured, Bohemia, Inc. Dr. Hirons prescribed medication and authorized two weeks of time loss. SAIF accepted the claim.

In January 1983, claimant began working for Mel Sines Construction, insured by F & C. After three days of lifting and carrying railroad cross-ties, he had back pain and left work. Two days later, on January 13, 1983, he sought treatment from Dr. Boyd, M.D. Lumbar x-rays showed degenerative joint disease. Dr. Boyd released claimant to work on January 17, 1983. F & C accepted the claim as nondisabling. The claim was reclassified as disabling pursuant to a stipulation between the parties, dated May 1, 1984.

Claimant did not return to work for Mel Sines because no work was available. He returned to Dr. Boyd in May 1983, reporting increased low back pain. Dr. Boyd prescribed physical therapy, took claimant off work for three weeks, and then released him to modified work. By July 1, 1983, claimant was again able to perform heavy work without difficulty, and Dr. Boyd released him to regular work.

On July 7, 1983, claimant began working for Alpine Veneers, insured by SAIF. After a few months, he was transferred to a position as a cleanup man. His duties on cleanup included working bent at the waist at a 90 degree angle under a conveyor chain picking up pieces of wood and pushing sawdust; shoveling sawdust; and sweeping.

In December 1983, claimant returned to Dr. Boyd complaining of progressively worsening low back pain, dating back to July 1983. Dr. Boyd prescribed medication and instructed him to return as needed.

Claimant continued to experience mild low back pain but sought no further treatment until June 4, 1984, when he experienced an increase in lumbar pain while working cleanup for Alpine Veneers. He had been working in a bent over position for 45 minutes and was unable to straighten up. He sought treatment from Dr. Boyd, who authorized five days of time loss. Claimant was markedly improved by June 9, 1984, and Dr. Boyd provided no further treatment after that date.

A Determination Order, issued February 25, 1985, closed the 1983 injury claim with F & C with no award of permanent disability.

Claimant currently experiences constant aching in his right lower back. He continues to work for Alpine Veneer as a cleanup man.

Claimant filed an aggravation claim with SAIF/Bohemia and a new injury/occupational disease claim with SAIF/Alpine Veneers. SAIF issued denials of both claims, and claimant requested a hearing. F & C was joined as a party, and it orally denied responsibility for claimant's condition at the beginning of the hearing.

FINDINGS OF ULTIMATE FACT

Claimant's work incident with Alpine Veneers in June 1984 did not independently contribute to a pathological worsening of his low back condition.

Claimant's current low back pain is not disabling.

CONCLUSIONS OF LAW AND OPINION

Responsibility

The Referee assigned F & C responsibility for claimant's low back condition. Although we do not entirely agree with the Referee's rationale, we agree with his ultimate decision.

At claimant's request, the Referee dismissed his hearing request regarding the denials issued by SAIF on behalf of Bohemia, Inc. and Alpine Veneers. Claimant requested dismissal as to these denials for reasons which are not clear from the file and against the advice of his attorney. Thus, the only denial at issue at hearing was F & C's responsibility denial.

Under the circumstances of this case, F & C is responsible for claimant's condition unless it can use the "last injurious exposure rule" defensively by showing that claimant's subsequent employment with Alpine Veneers' independently contributed to a pathological worsening of his condition. See Hensel Phelps v. Mirich, 81 Or App 290 (1986); Boise Cascade Corp. v. Starbuck, 296 Or 238 (1984). Claimant argues that F & C is barred from using the rule defensively to avoid responsibility. We disagree.

The Supreme Court in Runft v. SAIF, 303 Or 493 (1987), held that a carrier could not use the last injurious exposure rule defensively to avoid responsibility where it failed to join other potentially responsible carriers. Here, claimant joined the other potentially responsible carriers and then withdrew his hearing request as to those carriers. Under these circumstances, F & C bears no responsibility for the fact that SAIF/Alpine Veneers is no longer a party to this suit. Consequently, based on the procedural aspects of this case, it should not be barred from using the rule defensively because claimant withdrew his claims against SAIF/Alpine Veneers.

We must, therefore, address whether claimant's subsequent employment with Alpine Veneers independently contributed to a pathological worsening of his condition. We conclude that it did not. Treating physician Boyd initially described claimant's condition after the June 1984 incident as an aggravation of his old back injury. Moreover, claimant's flare-up following that incident had substantially resolved after 5 days of time loss, and he received no further treatment after that time. On this record, we are not persuaded that claimant's work activity in June 1984 independently contributed to a pathological worsening of his low back condition.

In reaching this decision, we are aware that Dr. Boyd opined in an October 5, 1984 report that the June 1984 incident was "a new injury." However, Dr. Boyd based this conclusion on his opinion that each of claimant's low back flare-ups were "unrelated incidents in that each one needs separate consideration." The fact that claimant required "separate consideration", i.e., treatment, after the June 1984 incident does not establish that the incident independently contributed to a worsening of his condition.

Accordingly, we conclude that F & C remains responsible for claimant's current low back condition, and we affirm the Referee on this issue.

Extent

Claimant's injury claim with F & C was last closed by a February 1985 Determination Order awarding no permanent disability. The Referee concluded that claimant sustained minimal permanent low back impairment as a result of his injury with F & C. Consequently, he awarded claimant 10 percent unscheduled permanent partial disability. We disagree.

Claimant last sought treatment for his low back condition on June 9, 1984. At that time, Dr. Boyd reported that claimant was 100 percent better, demonstrated no tenderness of the low back, and could move almost normally. There is no medical evidence that claimant has sustained any permanent low back impairment. Claimant testified that he experiences constant aching in his low back and can no longer due heavy lifting. However, he then acknowledged that he had not tried to do that kind of work since his 1983 injury. In light of this record, we are not persuaded that claimant's low back pain is disabling, or that he has otherwise sustained any permanent disability as a result of his compensable injury. Accordingly, we reverse the Referee's award of permanent disability.

ORDER

The Referee's order dated May 18, 1987 is affirmed in part and reversed in part. That part of the order that awarded claimant 10 percent (32 degrees) unscheduled permanent disability for a low back condition is reversed. The February 25, 1985 Determination Order is affirmed in its entirety. The remainder of the Referee's order is affirmed. The Board authorizes a client-paid fee, not to exceed $150, payable by Fire & Casualty Company to its counsel.

Board Member Crider, concurring in the result.

I concur in the Board's conclusion that Fire & Casualty's denial must be set aside. I do so, however, because I do not believe that Fire & Casualty was entitled to use the last injurious exposure rule defensively in order to shift responsibility to Alpine Veneer.

The majority, on the other hand, holds that although responsibility was the only issue at hearing, Fire & Casualty was entitled to seek to avoid responsibility by establishing that Alpine Veneer, an employer which was not a party to the proceeding, was responsible under the last injurious exposure rule. I disagree.

When compensability has been established--by issuance of a .307 order, by concession of the parties, or by evidence at hearing--an employer may not avoid responsibility by establishing that a later employment independently contributed to the compensable condition unless it has joined that employer in the hearing. Runft v. SAIF, 303 Or 493 (1987). The policy reasons for the ruling in Runft are sound and they control this case.

The purpose of the joinder requirement is to protect claimant's right to compensation for a compensable injury. OAR 436-60-180 places the duty to make certain that the responsible insurer is a party to the proceeding on a denial squarely on the insurer. We may not relieve the insurer of this duty simply because claimant requests that we do so. If we pursue this course we eliminate the worker's protection by leaving him vulnerable to pressure not to pursue claims against the current employer.

Inasmuch as Fire & Casualty failed to object to dismissal of the requests for hearing on the denials of Alpine Veneer and Bohemia, it may not establish that it is not responsible.

In the Matter of the Compensation of
DAVID L. SMITH, Claimant
WCB Case No. 88-13051
ORDER ON REVIEW
Stebbins & Coffey, Claimant Attorneys
Acker, et al, Defense Attorneys

Reviewed by Board Members Howell and Perry.

The self-insured employer requests review of Referee Brown's order which found claimant entitled to temporary disability compensation from October 14, 1988 until claim closure. Claimant requests that we correct a scrivener's error by awarding temporary disability compensation from January 14, 1988 until claim closure. On review the issue is claimant's entitlement to temporary disability compensation.

We affirm and adopt the order of the Referee with the following modification and comments:

The employer argues that because claimant's unemployment after January 13, 1988 was due to reasons other than her compensable injury, she is not entitled to temporary disability compensation. We disagree.

As the Referee correctly noted, as a procedural matter, 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). Temporary total disability compensation may be reduced to temporary partial disability compensation if an injured worker returns to modified work. ORS 656.212; OAR 436-60-030(3); Fazzolari v. United Beer Distributors, supra. If the worker's wage at modified work is equal to or greater than the wage on the date of injury, the amount of temporary partial disability due will be zero. OAR 436-60-030(2); Safeway Stores v. Owsley, 91 Or App 475 (1988).

Because claimant returned to modified work, the employer was authorized to reduce his temporary total disability to temporary partial disability pursuant to OAR 436-60-030(1) or (2). However, because none of the prerequisites to termination under ORS 656.268 occurred (claimant was not released for regular work, he was not medically stationary and his claim had not been closed), the employer was not authorized to completely terminate temporary disability compensation payments. Fazzolari v. United Beer Distributors, supra. Once the employer withdrew its offer of modified work by laying claimant off, he was entitled to reinstatement of full temporary total disability compensation payments. OAR 436-60-030(6)(b); Gray v. SAIF, 70 Or App 313 (1984). But see Safeway v. Owsley, supra and OAR 436-60-030(6)(b) (where claimant is discharged for reasons unrelated to a compensable injury but attributable to the claimant). When claimant began receiving unemployment insurance benefits the employer was again authorized to reduce his temporary disability compensation from total to partial, utilizing those benefits as "earnings" and in accordance with OAR 436-60-030(1). Wells v. Pete Walker's Auto Body, 86 Or App 739 (1987).

We agree with claimant that the Referee's order contains a clerical error. It is apparent that it was intended to award temporary disability compensation beginning January 14, 1988 rather that October 14, 1988.

ORDER

The Referee's order dated November 1, 1988 is modified in part and

affirmed in part. Claimant is awarded temporary disability compensation beginning January 14, 1988 and until claim closure. The order is otherwise affirmed. For services on review, claimant is awarded a reasonable attorney fee of $1,100, to be paid by the employer. A client-paid fee, payable from the employer to its counsel, is approved not to exceed $1,098.

March 8, 1990 Cite as 42 Van Natta 500 (1990)

In the Matter of the Compensation of
JOHN K. HUFFMAN, Claimant
WCB Case No. 85-13769
ORDER ON RECONSIDERATION
Bischoff & Strooband, Claimant Attorneys
Arthur Stevens (Saif), Defense Attorney

The SAIF Corporation requests reconsideration of our February 9, 1990 Order on Review that reversed a Referee's award of permanent total disability, but increased claimant's unscheduled permanent disability award from 25 percent (80 degrees) to 70 percent (224 degrees). Specifically, SAIF seeks clarification of claimant's attorney's entitlement to a fee for services on review.

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 $2,000. SAIF requested review, contending that claimant was not entitled to permanent total disability. 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.

Under such circumstances, we conclude that claimant's attorney is entitled to a fee payable from the increased compensation created by our order. See ORS 656.386(2). Pursuant to claimant's retainer agreement, this fee shall not exceed $3,000. SAIF is permitted to credit the attorney fee awarded by the Referee's order against the attorney fee awarded herein.

Accordingly, our February 9, 1990 order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our February 9, 1990. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

March 8, 1990 Cite as 42 Van Natta 500 (1990)

In the Matter of the Compensation of
JAMES M. SIRON, Claimant
WCB Case No. 89-18551
ORDER DISMISSING REQUEST FOR REVIEW
Pozzi, et al, Claimant Attorneys
Steven D. Hallock, Defense Attorney

Cigna Insurance has requested Board review of Referee Tenenbaum's December 20, 1989 Order Denying Motion to Join. We have reviewed the request to determine whether the Referee's order is a final order, which is subject to our review. Joseph Wilson, 40 Van Natta 66 (1988). We conclude that we lack jurisdiction to consider the request.

FINDINGS OF FACT

In September 1989, claimant requested a hearing concerning Cigna's denial of his medical services claim. Thereafter, Cigna moved for an order joining two other insurers. On December 20, 1989, the Referee denied the joinder motion. On January 16, 1990, the Board received Cigna's request for review of the Referee's December 20, 1989 order.

ULTIMATE FINDINGS OF FACT

The Referee's December 20, 1989 order did not finally deny or allow the claim, nor did it fix the amount of claimant's compensation.

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 neither finally disposed of, nor allowed, the claim. Moreover, the order did not fix the amount of claimant's compensation. Rather, the order denied Cigna's motion to join two other insurers as parties for a future hearing.

Inasmuch as further action before the Hearings Division was required as a result of the Referee's order, we conclude that it was not a final order. Price v. SAIF, supra; Lindamood v. SAIF, supra; John C. Wood, 41 Van Natta 237 (1989). Consequently, we cannot consider the issues raised by Cigna's request for review.

Accordingly, the request for Board review is dismissed.

IT IS SO ORDERED.

In the Matter of the Compensation of
ROBERT E. CAIN, Claimant
Own Motion No. 90-0041M
OWN MOTION ORDER
SAIF Legal Department, Defense Attorney

The SAIF Corporation has voluntarily reopened the above claim for temporary disability benefits pursuant to ORS 656.278. Additionally, SAIF has submitted to the Board claimant's claim for medical benefits related to his January 27, 1964 injury. Claimant's aggravation rights have expired. SAIF recommends reopening of the claim to provide medical benefits and requests that the Board authorize reimbursement from the Reopened Claims Reserve for temporary disability benefits that it pays voluntarily and for medical benefits awarded by the Board.

In cases involving pre-1966 injury claims, as here, we may exercise our "own motion" authority to reopen a claim for payment of further benefits. ORS 656.278(1)(b). After reviewing the record, we are persuaded that claimant's compensable injury has worsened requiring surgery. Accordingly, claimant's

claim is reopened for the payment of medical benefits connected with the treatment of glaucoma in the left eye, and temporary disability benefits commencing July 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.

March 9, 1990 Cite as 42 Van Natta 502 (1990)

In the Matter of the Compensation of
WAYNE N. GENTRY, Claimant
Own Motion No. 85-0347M
OWN MOTION DETERMINATION
Nichols & Bogardus, Attorneys

The Board issued its Own Motion Order in the above-entitled matter on January 27, 1987, reopening claimant's claim for a worsened condition related to his industrial injury of September 12, 1975. We decline to close this claim. The insurer has submitted the claim for closure, recommending an award of permanent total disability.

By letters dated June 22, 1989, and August 25, 1989, Dr. Bomengen declared claimant "medically stationary" and "stable." However, in the August 25 letter, Bomengen also advised that claimant was being considered for a penile prosthesis implant in November. There are no further reports in the record regarding the prospective implant surgery. Because surgery is under consideration for the continuing effects of the compensable injury at the time of Bomengen's letters, we are not persuaded by his declaration that claimant is medically stationary. Absent persuasive evidence that claimant is medically stationary, we conclude that claim closure would be premature at this time. Accordingly, the insurer's own motion request for claim closure is denied.

Parenthetically, we note that the Court of Appeals has held that the Board's own motion authority to award permanent disability benefits ceased when the current own motion law became effective on January 1, 1988. Independent Paper Stock v. Wincer, 100 Or App 625 (March 7, 1990). The court further held that OAR 438-12-018, upon which the Board relied in awarding permanent disability on claims that were reopened before January 1, 1988, impermissibly exceeded the Board's statutory authority. Id. Consequently, when medical reports persuasively indicate that claimant is medically stationary and this claim is submitted to us for closure, we will not be authorized to award any permanent disability benefits on the claim.

IT IS SO ORDERED.

In the Matter of the Compensation of
KERRY L. LAURITSEN, Claimant
Own Motion Nos. 87-0283M & 86-0570M
OWN MOTION ORDER ON RECONSIDERATION
Galton, et al, Claimant Attorneys
Roberts, et al, Defense Attorneys
Schwabe, et al, Defense Attorneys

Counsel for Liberty Northwest Insurance Corporation and CNA Insurance Companies seek Board authorization of client-paid fees for services in this matter which culminated in our March 16, 1988, Own Motion Order. The statements of services from counsel were submitted within 30 days of the Board's order. See former OAR 438-15-027(1)(c) (WCB Order No. 5-1987).

After reviewing the statements of services and attorney retainer agreements submitted by both counsel and considering the factors set forth in OAR 438-15-010(6), the Board approves the following client-paid fees: (1) not to exceed $1,570, payable from Liberty Northwest to its counsel; and (2) not to exceed $32, payable from CNA Insurance Company to its counsel.

We note, however, that Board approval of a client-paid fee is not required where the total for the legal services does not exceed $500 and no request for hearing has been filed. OAR 438-15-020. Therefore, it was not necessary that counsel for CNA obtain our approval.

IT IS SO ORDERED.

In the Matter of the Compensation of
KAREN K. MALSOM, Claimant
WCB Case No. 87-08556
ORDER ON REVIEW
Cash Perrine, Claimant Attorney
Davis & Bostwick, Defense Attorneys

Reviewed by Board Members Brittingham and Crider.

Claimant requests review of those portions of Referee Michael Johnson's order that: (1) declined to award temporary total disability compensation regarding her aggravation claim for a low back condition; and (2) declined to assess a penalty and attorney fee for the insurer's alleged unreasonable refusal to pay that compensation. The insurer cross-requests review of that portion of the Referee's order that set aside its denial of claimant's aggravation claim. On review, the issues are scope of review, aggravation, entitlement to temporary total disability compensation, penalties and attorney fees. We reverse on the temporary total disability compensation, penalty and attorney fee issues.

FINDINGS OF FACT

Claimant, 46 at hearing, compensably injured her low back in April 1984 while employed as a waitress/bartender. She sought medical treatment from Dr. Ries, a chiropractor, who diagnosed a lumbar and cervical strain. The insurer accepted the injury, and the claim was closed without permanent disability by Notice of Closure, issued December 4, 1984.

Following claim closure, claimant continued to receive chiropractic care and experienced occasional flare-ups of low back pain. On March 3, 1987, Dr.

Sultany, a rheumatology and internal medicine specialist, examined claimant for the insurer. In the course of Sultany's independent medical examination (IME), claimant experienced an acute flare-up of low back pain following a range of motion test. Dr. Ries then referred her to Dr. Kendrick, a neurologist. Kendrick ordered new x-rays and an MRI, which disclosed:

> "[A] moderate to large sized herniated fragment of disc material extending into the right lateral recess at the 4-5 level compromising the right fifth lumbar root."

Claimant was not employed at the time of the March 1987 IME. Following her compensable injury of April 1984, she worked for several months but finally quit due to low back pain. She returned to work again a few months later but, as before, had to quit working several months later due to back pain. She worked in a restaurant for a short time in 1985, but she was not able to continue because of back pain and irritability. She worked at a small grocery-liquor store for a few months in 1986, and then quit due to back pain.

On April 19, 1987, the insurer received a Supplemental Medical Report from Dr. Ries advising that claimant had suffered an "aggravation [sic] to her spine during the IME exam in Portland." The next day, Dr. Kendrick performed a microlumbar diskectomy at the right L5-S1 interspace.

On May 20, 1987, the insurer formally denied payment of interim compensation on the basis that claimant was not employed at the time of her alleged aggravation. The insurer formally denied claimant's aggravation claim and her current medical treatment on August 13, 1987.

ULTIMATE FINDINGS OF FACT

Claimant's compensable injury was a material contributing cause of her herniated disc and related need for treatment.

Claimant did not voluntarily withdraw from the labor force prior to her aggravation in March 1987. She was willing to seek work, made reasonable efforts to find work and, in fact, held several jobs following her compensable injury in April 1984.

The insurer's failure to pay temporary disability compensation was unreasonable.

CONCLUSIONS OF LAW AND OPINION

Scope of Review/Aggravation

The Referee analyzed claimant's claim as one for continuing medical services under ORS 656.245. We instead analyze the claim as one for aggravation under ORS 656.273.

An insurer can deny an aggravation claim because the condition is not causally related to the compensable injury or occupational disease, or because claimant has not sustained a worsening since the last arrangement of compensation. Smith v. SAIF, 302 Or 396 (1986). On review, the insurer challenges claimant's aggravation claim on both grounds. However, the insurer's denial was issued solely on compensability grounds, and it did not raise a worsening challenge at hearing. (Tr. 8). Under these circumstances, it would not be proper for the Board to address the worsening issue on review. See Anderson v.

West Union Village Square, 44 Or App 685 (1980); Neely v. SAIF, 43 Or App 319 (1979). Patricia N. Hall, 40 Van Natta 1873 (1988).

Accordingly, we confine our review to the causation issue. The Referee concluded that claimant's 1984 injury materially contributed to claimant's current low back condition. We agree and adopt the Referee's opinion and rationale subject to the above comment.

Entitlement to Temporary Total Disability

A worker who retires from the labor force prior to an aggravation is not entitled to temporary total disability benefits. Cutright v. Weyerhaeuser Co., 299 Or 290 (1985). The Referee found that claimant was not entitled to temporary total disability benefits because she was not employed at the time of her March 1987 aggravation. We disagree.

Claimant continued to work and seek work following her compensable injury in April 1984. She worked at several different restaurants and one grocery store. She left those jobs because of low back pain related to her compensable injury, not because she was no longer willing to work. On this record, we conclude that claimant had not withdrawn from the work force at the time of the March 1987 aggravation. Chapel of Memories v. Davis, 91 Or App 232 (1988); Sykes v. Weyerhaeuser Co., 90 Or App 41 (1988). Accordingly, claimant is entitled to temporary total disability benefits commencing March 3, 1987, the date of her aggravation.

Penalties and Attorney Fees

Claimant contends that she is entitled to a penalty and associated attorney fee regarding the insurer's failure to pay temporary total disability compensation. We agree.

The insurer's May 20, 1987 denial contained the following statement: ". . . since you were not employed at the time of your alleged aggravation, time loss compensation is not owing." The mere fact that claimant was not working at the time of an aggravation is not sufficient to establish that she had withdrawn from the labor force. The denial provided no other basis for denying time loss, and the insurer has not demonstrated that it based its denial on other information providing a reasonable basis for the denial. For this reason, we conclude that the insurer's denial was unreasonable.

Moreover, even if the denial had not been unreasonable on its face, the insurer acted unreasonably in not paying interim compensation on claimant's aggravation claim. The insurer received Dr. Ries' aggravation report on April 19, 1987. It did not pay interim compensation benefits prior to its aggravation denial of August 13, 1987. The purpose of interim compensation is to encourage the prompt acceptance or denial of a claim. Jones v. Emanual Hospital, 280 Or 147, 151 (1977). That purpose was circumvented by the insurer's May 1987 denial of time loss benefits.

Accordingly, we reverse the Referee on this issue and assess a penalty and associated attorney fee. ORS 656.262(10) and 656.382(1).

ORDER

The Referee's order dated March, 14, 1988, as adhered to and republished June 29, 1988, is affirmed in part and reversed in part. That portion of the order that declined to award claimant temporary total disability compensation is

reversed. That portion of the order that declined to assess a penalty and associated attorney fee regarding the insurer's failure to pay temporary disability compensation is reversed. The insurer is instructed to pay temporary disability compensation commencing March 3, 1987 and to continue to pay such compensation until these benefits can be terminated in accordance with law. Claimant is awarded a penalty in the amount of 25 percent of the temporary total disability compensation due under this order up to the time of hearing. For services regarding the penalty issue, claimant's attorney is awarded an assessed fee of $500, payable by the insurer. The remainder of the order is affirmed. Claimant's attorney is allowed an approved fee, in the amount of 25 percent of the increased temporary disability compensation awarded under this order, not to exceed the $3,000 maximum fee provided by retainer agreement. For services on review regarding the aggravation issue, claimant's attorney is awarded an assessed fee in the amount of $750, payable by the insurer. The Board authorizes a client-paid fee, not to exceed 1,284.50, payable by the insurer to its counsel.

March 9, 1990 Cite as 42 Van Natta 506 (1990)

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

Claimant has requested that the Board review the SAIF Corporation's June 28, 1989 Notice of Closure in the aforementioned case. The request was received by the Board on February 28, 1990.

Claimant previously submitted a request for hearing, citing issues of premature closure and scheduled permanent disability. In that case claimant sought to challenge the Notice of Closure. That hearing request for hearing was dismissed October 6, 1989, for lack of subject matter jurisdiction. WCB Case No. 89-13536. Contrary to claimant's contentions, the order appears to be final.

Under Board rules, a request for review of a carrier closure shall be filed with the Board. The request must be submitted to the Board in a timely manner. See OAR 438-12-060(1). In order to be timely, the request for review must be submitted within 60 days of the date of mailing date of the Notice of Closure. Id. Here, claimant's request for review was untimely, as it was not filed with the Board until February 28, 1990.

Accordingly, the request for review of the Notice of Closure is denied.

IT IS SO ORDERED.

In the Matter of the Compensation of
JAMES L. BURSAW, Claimant
WCB Case No. 85-09497
ORDER ON REVIEW
Nancy Marque (Saif), Defense Attorney

Reviewed by Board Members Perry and Howell.

Claimant, pro se, requests review of Referee Livesley's order which: (1) found that claimant's shoulder condition was not prematurely closed; (2) increased his unscheduled permanent disability award for his left shoulder condition from 25 percent (80 degrees) as awarded by a Determination Order, to 35 percent (112 degrees); (3) declined to award scheduled permanent disability for loss of use or function of claimant's left arm; (4) found that SAIF did not improperly offset amounts of temporary total disability; and (5) declined to award additional temporary disability compensation. On review the issues are extent of permanent disability, premature closure, offsets and temporary total disability. We affirm in part and reverse in part.

FINDINGS OF FACT

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

On September 9, 1986, SAIF issued a "Notice of Training End, Effective Date 8-28-86." (Ex. 42).

CONCLUSIONS OF LAW AND OPINION

We adopt the Referee's conclusions and opinion with the following exception.

At hearing, claimant raised the issue of his entitlement to temporary total disability after August 28, 1986. SAIF raised no objection. However, the Referee did not discuss this issue in his Opinion and Order. We do so now. In this regard, SAIF's letter of September 9, 1986, purports to retroactively terminate claimant's training because claimant was not actively participating in the program. Such retroactive termination is inconsistent with the administrative rules governing training plans. Former OAR 436-120-140(1)(d), (now OAR 436-120-085(10)). Accordingly, we conclude that claimant is entitled to temporary total disability through September 9, 1986, the date of notice of the termination of the training program.

ORDER

The Referee's order dated September 23, 1988 is affirmed in part and reversed in part. Claimant is awarded temporary total disability benefits from August 29, 1986, through September 9, 1986. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
HERMAN C. HICKMAN, Claimant
WCB Case No. 87-07560
ORDER ON REVIEW
Brothers, et al, Claimant Attorneys
Roberts, et al, Defense Attorneys

Reviewed by Board Members Howell and Speer.

The self-insured employer requests review of Referee Myers' order that granted claimant an award of permanent total disability. On review, the issue is extent of permanent disability, including permanent total disability. We reverse.

FINDINGS OF FACT

The Board adopts the Referee's findings of fact.

ULTIMATE FINDINGS OF FACT

Work that claimant is capable of performing is available in the labor market.

Claimant has not looked for work since February 1986. It would not be futile for him to do so.

CONCLUSIONS OF LAW AND OPINION

Permanent Total Disability

Under the "odd lot" doctrine, 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. Livesay v. SAIF, 55 Or App 390 (1981). Such nonmedical considerations include age, education, adaptability to nonphysical labor, mental capacity and emotional conditions, as well as the conditions of the labor market. Id.

When an injured worker has some capacity for employment, he is statutorily required to make reasonable efforts to find work, although he need not engage in job seeking activities that, in all practicality, would be futile. ORS 656.206; Smith v. Brooks-Scanlon, 54 Or App 730 (1981). The ultimate determination of disability must be based on the claimant's current condition, not on his potential for future employment after retraining. Gettman v. SAIF, 289 Or 609 (1980).

The Referee found that claimant was not permanently and totally disabled on the basis of his physical condition alone, but he concluded that claimant had no transferable skills for regular sedentary work. The Referee found that it would have been futile for claimant to search for regular sedentary work. We disagree.

Findings of futility are reserved for the extreme situation where, for example, the record shows the individual is physically totally disabled or is not capable of retraining. See Georgia Pacific Corp. v. Perry, 92 Or App 56 (1988). Here, claimant's vocational consultant, Daniel Gaither, testified that claimant was, within the doctors' restrictions, capable of doing bench work that utilized his current skills and abilities. In addition, Mr. Gaither testified that such work was available in the labor market. Moreover, Mr. Gaither reported that claimant has transferable skills for performing the job of

millwright supervisor. Under the circumstances, we conclude that claimant has failed to prove that efforts to seek work would have been futile and we reverse the Referee's award of permanent total disability.

Scheduled disability

The criteria for the rating of scheduled disability is the permanent loss of use or function of the injured member due to the industrial injury. ORS 656.214(2). Former OAR 436-30-330 and 436-30-340 set forth guidelines to assist in the determination of the extent of permanent disability caused by a foot injury. We apply these rules as guidelines, not as restrictive mechanical formulas. SAIF v. Baer, 61 Or App 335 (1983).

Here, we are persuaded that claimant has suffered severe permanent impairment of his left foot as a result of his compensable injury. Claimant's treating podiatrist, Dr. Evoy, rated claimant's impairment as being 100 percent loss of his foot, as consistent with a short leg amputation. Dr. Sulkosky, M.D., rated claimant's impairment as being equal to a below-the-knee amputation. He further reported that claimant had no function in his foot.

Following our de novo review of the medical and lay evidence, we conclude that an award of 100 percent (135 degrees) permanent scheduled disability, appropriately compensates claimant for the total permanent loss of use or function of his left foot (ankle).

ORDER

The Referee's order, dated January 22, 1988, as reconsidered March 16, 1988, is reversed. The award of permanent total disability benefits is reversed. The Determination Order is modified to award claimant 65 percent (87.75 degrees) scheduled permanent disability in addition to claimant's prior award of 35 percent (47.25 degrees) scheduled disability for a total award to date of 100 percent (135 degrees) scheduled permanent left foot disability. Claimant's attorney is awarded a reasonable attorney fee of 25 percent of the additional scheduled permanent disability awarded by the order, not to exceed $3,800. The employer is permitted to credit the attorney fee awarded by the Referee's order against the attorney fee awarded herein. A client-paid fee, not to exceed $1,254, is approved.

March 12, 1990 Cite as 42 Van Natta 509 (1990)

In the Matter of the Compensation of
FRANKLIN JEFFERSON, Claimant
WCB Case No. 89-01963
ORDER DENYING MOTION TO DISMISS
H. Adunni Warren, Claimant Attorney
Norman Cole (Saif), Defense Attorney

The SAIF Corporation has moved for an order dismissing claimant's request for Board review of a Referee's order on the ground that notice of the request was not timely provided to the parties. The motion is denied.

FINDINGS OF FACT

The Referee's order issued December 27, 1989. On January 26, 1990, claimant mailed by certified mail his request for review of the Referee's order to the Board. The request also contained a certificate of service indicating

that a copy had been mailed to SAIF and its legal counsel on January 26, 1990 to SAIF's Salem address.

On January 31, 1990, the Board mailed a computer-generated letter to the parties acknowledging a request for review. SAIF received this acknowledgment on February 1, 1990. Neither SAIF nor its Portland legal counsel received a copy of claimant's request for review.

ULTIMATE FINDINGS OF FACT

Claimant's request for review was mailed to the Board within 30 days from the Referee's order. Copies of the request were mailed to SAIF and its counsel within 30 days from the date 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). In the absence of prejudice to a party, timely service of a request for review on an employer's insurer or attorney, is sufficient compliance with ORS 656.295(2) to vest jurisdiction with the Board. Argonaut Insurance Co. v. King, supra, pages 850-51; Nollen v. SAIF, 23 Or App 420, 423 (1975).

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 December 27, 1989 order was January 26, 1990. Claimant's request for Board review was filed January 26, 1990, the date his request was mailed by certified mail. See OAR 438-05-046(1)(b). Consequently, claimant's request was timely mailed to the Board. See ORS 656.289(3).

Enclosing an affidavit from its legal counsel, SAIF asserts that it did not receive a copy of claimant's request for review. Consequently, SAIF contends that its first notice of claimant's request for review occurred when SAIF received the Board's February 1, 1990 acknowledgment letter. February 1, 1990 is more than 30 days after the Referee's December 27, 1989 order.

In response to SAIF's motion to dismiss, claimant has submitted an affidavit from his attorney's legal assistant. The assistant states that he mailed copies of the request for review to SAIF and its legal counsel on January 26, 1990. This affidavit coincides with the certificate of mailing previously contained in claimant's request for review.

Claimant's proof of service by mail is in compliance with the Board's rules. See OAR 438-05-046(2)(a), (b). Thus, this service by mail was

complete upon mailing. OAR 438-05-046(2)(a). SAIF's apparent lack of receipt of the copies of claimant's request for review does not establish that copies were not mailed to SAIF and its counsel as previously certified.

Finally, no contention has been made that SAIF's insured has been prejudiced by not directly receiving notice of claimant's request for review. Absent such a finding, we hold that claimant's timely service upon SAIF and its counsel is adequate compliance with ORS 656.295(2).

Accordingly, the motion to dismiss is denied. A hearing transcript has been ordered. Upon its receipt, copies will be provided to the parties and a briefing schedule implemented. Thereafter, this case shall be docketed for review.

IT IS SO ORDERED.

March 12, 1990 Cite as 42 Van Natta 511 (1990)

In the Matter of the Compensation of
EDWARD K. MCGUIRE, Claimant
WCB Case Nos. 87-12554, 87-07348, 87-07480, 87-07481 & 87-10318
ORDER ON RECONSIDERATION
Bloom, Marandas & Sly, Claimant Attorneys
Norman Cole (Saif), Defense Attorney
Roberts, et al, Defense Attorneys
Schwabe, et al, Defense Attorneys
Lindsay, Hart, et al, Defense Attorneys
Acker, Underwood, et al, Defense Attorneys

On January 30, 1990, we issued an Order of Abatement in this matter to allow sufficient time to reconsider our Order on Review, dated January 4, 1990. In our Order on Review, we assigned responsibility for claimant's neck, upper back and right shoulder condition to Liberty Northwest Insurance Corporation, as insurer for Lile International Company (Lile). Liberty Northwest/Lile filed a motion for reconsideration, contending that responsibility properly rests with Rose City Van & Storage (Rose City), also insured by Liberty Northwest. Oregon Insurance Guaranty Fund, Liberty Northwest/Rose City and claimant have filed responses to Liberty Northwest/Lile's motion. On reconsideration, we amend our Order on Review and assign responsibility to Liberty Northwest/Rose City.

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 on August 12, 1986. Bracke v. Baza'r, 293 Or 239 (1982).

In our January 4, 1990 Order on Review, we found that claimant's last employment prior to the onset of disability was for Lile, on July 19, 1986. We further found that the work activity with Lile was of the type that caused claimant's current condition. Accordingly, we assigned responsibility in the first instance to Liberty Northwest/Lile.

On reconsideration, Liberty Northwest/Lile argues that claimant's last employment prior to the onset of disability was for Rose City, rather than Lile. We agree. A payroll record for Rose City, identified as Ex. 12B, indicates that claimant worked for Rose City during the period July 26, 1986 through August 8, 1986. There is no evidence to the contrary.

Based on this payroll record, we conclude that claimant's last employment prior to the onset of disability was with Rose City. We further conclude that claimant's work for Rose City as a furniture mover involved the type of strenuous activity that caused his current condition. As a result, responsibility rests in the first instance with Liberty Northwest/Rose City.

Liberty Northwest/Rose City can transfer responsibility to a prior insurer by showing that prior employment was the sole cause of the disability or that it was impossible for employment with Rose City to have caused the condition. Boise Cascade Corporation v. Starbuck, 296 Or 238, 244 n. 3 (1984); FMC Corporation v. Liberty Mutual Ins. Co., 70 Or App 370, modified 73 Or App 223 (1984). Alternatively, it can transfer responsibility forward to a subsequent insurer by showing that a later employment independently contributed to a pathological worsening of the condition. Bracke v. Baza'r, supra at 250-251.

We conclude that responsibility should remain with Liberty Northwest/Rose City. Claimant worked for Rose City in June and July 1986. Treating neurologist Crumpacker and treating chiropractor Walsh both signed statements to the effect that claimant's work activity in June and July 1986 aggravated his underlying condition, and that work activity after that time merely contributed to increased symptoms. We defer to their opinion because they are the treating physicians and there is no contrary medical opinion on this issue. In light of their opinion, Liberty Northwest/Rose City has not demonstrated that prior work activity was the sole cause of the condition or that it was impossible for work activity with Rose City to have contributed to the condition. Nor has it established that subsequent work activity independently contributed to a pathological worsening, as distinct from a mere symptomatic increase. Consequently, Liberty Northwest/Rose City remains responsible for claimant's condition.

Accordingly, as amended herein, we adhere to and republish our January 4, 1990 order. The Referee's order dated March 29, 1988, as reconsidered April 18, 1988, is affirmed in part and reversed in part. That portion of the order that assigned responsibility to Liberty Northwest Insurance Corporation, as insurer for Lile International Company (Lile), is reversed. Liberty Northwest's denial on behalf of Lile is reinstated and upheld. Liberty Northwest's denial on behalf of Rose City Van & Storage (Rose City) is set aside, and the claim is remanded to Liberty Northwest for further processing. The remainder of the Referee's order is affirmed. The assessed attorney fee awarded in our January 4, 1990 order shall be paid by Liberty Northwest as insurer for Rose City. For services on reconsideration, we award claimant's attorney a supplemental assessed fee, in the amount of $500, payable by Liberty Northwest as insurer for Rose City. We authorize a supplemental client-paid fee, not exceeding $705, payable by Liberty Northwest, as insurer for Lile, to its counsel.

IT IS SO ORDERED.

In the Matter of the Compensation of
JON E. ROBINSON, Claimant
WCB Case Nos. 88-05306, 88-04282 & 88-05305
ORDER ON REVIEW
Coons & Cole, Claimant Attorneys
Beers, et al, Defense Attorneys
Roberts, et al, Defense Attorneys

Reviewed by Board Members Nichols and Brittingham.

Claimant requests review and EBI Companies cross-requests review of that portion of Referee Thye's order that: (1) set aside EBI's denial of claimant's "new injury" claim for a low back condition; and (2) upheld United Pacific's denial of claimant's aggravation claim for the same condition. The issue on review is responsibility.

The Board affirms and adopts the order of the Referee with the following comment on the standard of review. This case concerns a matter concerning a claim because claimant contends his time loss benefits would be greater if United Pacific were found to be the responsible insurer. Therefore, the standard of review is as provided for matters concerning a claim. ORS 656.307(2) and 656.704(3).

ORDER

The Referee's order dated September 27, 1988 is affirmed. The Board approves a client-paid fee, not exceeding $1,252, payable by United Pacific to its counsel.

March 13, 1990 Cite as 42 Van Natta 513 (1990)

In the Matter of the Compensation of
DEBORAH ANDERSEN, Claimant
WCB Case No. 88-12163
ORDER ON REVIEW
Bottini & Bottini, Claimant Attorneys
Roberts, et al, Defense Attorneys

Reviewed by Board Members Howell and Speer.

Claimant requests review of Referee Leahy's order which upheld the self-insured employer's denial of claimant's stress condition claim. On review the issue is compensability. We affirm.

FINDINGS OF FACT

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

On April 8, 1988, claimant made her first report to her supervisor regarding her fellow employee's alleged drug related problem. (Tr. 53).

Sometime after making such report, claimant told her fellow employee that management was asking questions about her alleged drug use. (Tr. 57). Claimant also told a third employee that she, claimant, was going to report the alleged drug use to management. This third employee told the employee suspected of using drugs that claimant was making the report. (Tr. 73).

Claimant's last day of work was April 12, 1988. She called her supervisor requesting time off due to the stress of this situation. The supervisor indicated to claimant that he needed her at work and that such personal problems should not interfere with her work. (Tr. 96). He discussed claimant's resignation. (Tr. 53).

Claimant began working for Hank's grocery on April 13 or 14, 1988. She worked there for 12 hours and resigned. (Tr. 15)

Claimant first sought medical treatment on April 19, 1988 and signed a Form "801" on April 20, 1988. (Tr. 30-33 and Ex. 1).

On the "801," claimant wrote, "Due to Traci's boyfriend coming to my house and the manager of the Hillsboro store not keeping our conversation in private I've had stress and left the store." (Ex. 1).

On June 1, 1988, Dr. Boyd, M.D., claimant's treating physician, reported other current stressful events causing claimant to say her life was "coming apart": (1) her parents were divorcing; (2) her father was recently diagnosed as having multiple sclerosis; (3) she had a motor vehicle accident on May 7, 1988 for which she was seeing a physician for back and neck conditions; and (4) she had not been able to get another job. (Ex. 9).

CONCLUSIONS OF LAW AND OPINION

Claimant alleges that she incurred her emotional upset because the employer breached her confidence and told the alleged drug user that claimant had turned her in, whereupon the alleged drug user's boyfriend confronted claimant at her home causing her so much stress that claimant could not work the next day and ultimately had to quit. The testimony shows that it was claimant herself who leaked the story to the alleged drug user and that the employer had not begun to act on the allegations.

Claimant must prove that she has a mental disorder with a diagnosis that is generally recognized in the medical or psychological community; and that the events which are the source of her stress exist in "a real and objective sense." ORS 656.802(1)(b) & 656.802(2)(a) & (c). Moreover, she must prove by clear and convincing evidence that her condition arose out of and in the course of her employment. ORS 656.802(2)(d). To establish that her condition arose out of and in the course of her employment, claimant must prove by clear and convincing evidence that her work exposure was a material cause of her condition. Donna E. Aschbacher, 41 Van Natta 1242 (1989); Ellen L. Crawford, 41 Van Natta 1257 (1989). Claimant fails to sustain her burden on several counts.

First, claimant's condition is diagnosed as "work-related emotional upset (situational tension and gastritis)." (Ex. 3). We are not persuaded that this is a "mental or emotional disorder" that is generally recognized in the medical or psychological community.

Additionally, claimant has not shown that her stress was materially caused by work related events that existed in a real and objective sense. In this regard, the doctors stated that claimant's "upset" was work-related because claimant told them it was work related. However, the event in which claimant contends caused her emotional upset -- the employer's breach of confidence-- did not occur. Dr. Klein, M.D., when informed by the employer's counsel that the history given to her by claimant may not have been totally correct, (i.e., that the employer did not breach claimant's confidence but that claimant leaked the information herself), wrote a retraction letter stating that if things had not happened as claimant reported, then she could not conclude that claimant's stress was job related but rather "arises from her own personality." (Ex. 17). Moreover, evidence of other traumatic, non-work related events in claimant's life further negates finding that claimant's "upset" arose out of and in the course of her employment.

ORDER

The Referee's order dated October 21, 1988 is affirmed. The Board approves a client-paid fee, not to exceed $1,394, payable by the employer to its counsel.

March 13, 1990 Cite as 42 Van Natta 515 (1990)

In the Matter of the Compensation of
MANUEL R. BOYD, Claimant
WCB Case Nos. 88-11686 & 87-03442
ORDER ON REVIEW
Robert E. Nelson, Claimant Attorney
Kevin L. Mannix, Defense Attorney
David Smith (Saif), Defense Attorney

Reviewed by Board Members Crider and Brittingham.

Liberty Northwest Insurance Corporation requests review of Referee McGeorge's order that: (1) set aside Liberty Northwest's denial of claimant's "new occupational disease" claim for his cervical spine and shoulder area; and (2) upheld the SAIF Corporation's denial of claimant's aggravation claim for the same condition. Liberty Northwest also contends that the Referee improperly declined to reopen the record to admit a medical report from claimant's treating physician. On review, the issues are remand and responsibility.

Remand

Liberty Northwest contends that this case has been insufficiently developed because the Referee refused to reopen the record to admit Dr. Gray's June 22, 1988 medical report. 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). Liberty Northwest argues that it exercised due diligence in seeking Dr. Gray's opinion, but that Dr. Gray misplaced it and did not mail it until after the hearing.

We conclude that Liberty Northwest has not exercised due diligence in acquiring Dr. Gray's report. If Dr. Gray did not mail it, Liberty Northwest should have contacted him prior to the hearing and requested that he do so. The Referee properly refused to reopen the record for admission of the report. Accordingly, the request for remand is denied.

The Board affirms and adopts the Referee's responsibility ruling with the exception of the last paragraph of the "Opinion" section. In that paragraph, the Referee declined to address Liberty Northwest's contention that the March 1983 Disputed Claim Settlement (DCS) between claimant and SAIF should be set aside. Liberty Northwest contends that the DCS should be set aside for mutual mistake of fact due to the misdiagnosis of claimant's condition.

Where there is a bona fide dispute over compensability of a claim, the parties may, with the approval of a Referee, the Board or the court, by agreement make such disposition of the claim as is considered reasonable. ORS 656.289(4). The legislature must have intended that we exercise our independent judgment in determining whether a bona fide dispute over compensability exists

between the parties. Arlie Johns, 32 Van Natta 88 (1981), aff'd mem 58 Or App 534 (1982). We regard vacating prior settlements to be an extraordinary remedy to be granted sparingly only in the most extreme situations. Mary Lou Claypool, 34 Van Natta 943, 946 (1982); James Leppe, 31 Van Natta 130 (1981).

The record fails to establish that the dispute settled by the March 1983 settlement was not bona fide. See Roberts v. Willamette Industries, 82 Or App 188 (1986). Where there was a bona fide dispute at the time of the DCS, the fact that one position was later undercut by new evidence does not support setting aside the settlement. Consequently, we conclude that the DCS should not be set aside.

ORDER

The Referee's order dated August 29, 1988 is affirmed. The Board authorizes a client-paid fee, not to exceed $2,630, payable by Liberty Northwest Insurance Corporation to its counsel.

March 13, 1990 Cite as 42 Van Natta 516 (1990)

In the Matter of the Compensation of
PATRICK L. BUCHANAN, Claimant
Own Motion No. 86-0278M
OWN MOTION ORDER ON RECONSIDERATION
Allen T. Murphy, Claimant Attorney
Saif Legal Department, Defense Attorney

Claimant requests reconsideration of our August 22, 1989, Own Motion Order on Remand which adhered to our November 18, 1987, Own Motion Order on Reconsideration that granted him permanent total disability. Submitting a statement of services for his counsel's efforts before the Board on its own motion, before the Court of Appeals on judicial review, and back before the Board on remand, claimant seeks a carrier-paid attorney fee pursuant to ORS 656.382(2).

Claimant's 1970 industrial injury claim was closed with a permanent total disability award by Own Motion Determination on Reconsideration issued November 18, 1987. Claimant's attorney was also awarded an attorney fee equal to 25 percent of the additional compensation, not to exceed $700. The SAIF Corporation appealed that order to the Court of Appeals. The court reversed and remanded for reconsideration, finding the Board's order insufficient for judicial review. By Own Motion Order on Remand issued August 22, 1989, the Board adhered to and republished the November 18, 1987, order with additional supplementation.

Claimant's attorney submitted his statement of services to the Board on August 29, 1989. Although the statement could have been construed as a request for reconsideration of the August 22, 1989, order, the order was not abated and it became final by operation of law. See OAR 438-12-065. We might nevertheless have had jurisdiction to consider the attorney fee issue if the August 22 order had not addressed the issue. However, the August 22 order, by adopting and republishing the earlier order, also incorporated the provision awarding the $700 out-of-compensation fee. Because the August 22, 1989, order addressed the attorney fee issue and is now final, we lack jurisdiction to consider claimant's attorney's request for an assessed fee. See Robert D. Janini, 40 Van Natta 1127 (1988).

Accordingly, claimant's request for reconsideration is denied.

IT IS SO ORDERED.

In the Matter of the Compensation of
EDWARD J. CONNOR, Claimant
WCB Case No. 87-14925
ORDER OF ABATEMENT
Pozzi, et al, Claimant Attorneys
John B. Motley (Saif), Defense Attorney

The SAIF Corporation requests 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 sufficient time to consider the motion, the above-noted Board order is abated and withdrawn. Claimant 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
HARVEY W. MARSHALL, JR., Claimant
Own Motion No. 87-0640M
OWN MOTION DETERMINATION
Industrial Indemnity, Insurance Carrier

The Board issued its Own Motion Order in the above-entitled matter on November 27, 1987, reopening claimant's claim for a worsened condition related to his industrial injury of August 11, 1976. The claim has now been submitted for reimbursement authorization and closure. We decline to close the claim.

Although claimant was declared medically stationary as of March 22, 1989, he subsequently entered an authorized training program (ATP) which is scheduled to end in May, 1990. Because claimant is entitled to receive temporary disability benefits during his participation in the ATP, see ORS 656.268(5), claim closure would not be proper until the completion of training. Thereafter, claimant is entitled to claim closure and redetermination by the Evaluations Section pursuant to ORS 656.268(5). Reimbursement from the Reopened Claims Reserve is not appropriate as claim was reopened prior to January 1, 1988. The insurer's own motion request for claim closure and reimbursement authorization is denied.

IT IS SO ORDERED.

In the Matter of the Compensation of
CARMEN SALINAS, Claimant
WCB Case No. 86-07447
ORDER ON REVIEW
James D. Fournier, Claimant Attorney
Garrett, et al, Defense Attorneys

Reviewed by Board Members Brittingham and Crider.

Claimant requests review of Referee Daron's order that affirmed a Determination Order finding her condition medically stationary on November 18, 1985, and awarding no scheduled permanent disability for loss of use or function of her left index finger. The insurer has filed a motion to strike claimant's "reply memorandum". The issues are the insurer's motion to strike, temporary total disability compensation and extent of scheduled permanent disability. We affirm in part and reverse in part.

FINDINGS OF FACT

Claimant compensably injured her left index finger on October 21, 1985, when she lacerated it while harvesting cauliflower. She was treated that day by Dr. P.C. McDonald, M.D., who sutured the finger and repaired the extensor apparatus. Dr. McDonald saw claimant again on October 28, 1985, and removed the sutures. He reported the laceration was healing well. He last examined claimant on November 5, 1985, at which time she was experiencing pain in various parts of her hand, including the lacerated finger.

Claimant began treating with Dr. Gail, M.D., on November 11, 1985. He examined claimant on December 19, 1985 and reported significant disability in her left index finger. Dr. Gail referred claimant to Dr. Struckman, an orthopedist.

On December 30, 1985, Dr. Struckman noted residual inflammation in the soft tissue around the laceration and an extensor apparatus contracture. He referred claimant to physical therapy and whirlpool treatment, and then reexamined claimant on January 13, 1986 after she received that treatment. At that time, claimant's finger was doing well and the exam was normal, except for mild discomfort when she attempted to "pinch" her finger and hand. Dr. Struckman instructed claimant to return on a "prn" basis.

The insurer paid temporary disability compensation from October 21, 1985 through November 12, 1985. Closure was requested on February 7, 1986. A Determination Order, issued February 19, 1986, awarded claimant temporary total disability benefits from October 21, 1985 through November 18, 1985.

On January 22, 1987, claimant sought treatment from Dr. Robert W. McDonald, M.D., complaining of pain, weakness and numbness in her left index finger. He noted full range of motion and no evidence of muscle or nerve degeneration. He did note some residual decrease in grip strength in the left hand.

Claimant was examined by Dr. Becker, orthopedist, on February 20, 1987. He could find no neural or orthopedic residuals of claimant's left finger injury.

On March 3, 1987, claimant sought treatment from Dr. Peters, M.D., complaining of pain in the left index finger with exposure to cold. Dr. Peters provided no treatment other than a recommendation that claimant wear a glove.

ULTIMATE FINDINGS OF FACT

On January 13, 1986, no further material improvement was reasonably expected from medical treatment for claimant's left index finger or the passage of time. However, she was capable of performing her regular work on December 30, 1985. She experienced no permanent loss of use or function of her left index finger as a result of her 1985 compensable injury.

CONCLUSIONS OF LAW AND OPINION

Motion To Strike

Claimant filed her appellant's brief on February 11, 1988. The insurer timely filed its respondent's brief on February 24, 1988. Claimant submitted a reply memorandum on September 30, 1988. The insurer moves to strike the reply memorandum as untimely filed. Under OAR 438-11-020(2), reply briefs must be filed within seven (7) days of mailing of the respondent's brief. The motion to strike is allowed.

Temporary Total Disability Compensation

The Referee concluded that claimant was medically stationary on November 18, 1985, as found by the Determination Order. Claimant contends that she was not medically stationary until January 20, 1986 and is, therefore, entitled to further temporary total disability compensation.

We agree that claimant was not medically stationary on November 18, 1985. ORS 656.005(17) defines "medically stationary" as that point in time when no further material improvement can reasonably be expected from medical treatment or the passage of time. Here, the record contains opinions on this issue from a number of physicians.

On December 31, 1985, Dr. P. C. McDonald, the initial treating physician, completed a form indicating that claimant was currently medically stationary, had last received "curative" treatment on November 5, 1985, and was released to return to work as of November 19, 1985. This opinion is inconsistent with a First Medical Report he completed on October 30, 1985, indicating that claimant was medically stationary and released to work as of that date. The December 31, 1985 report is also inconsistent with a subsequent January 2, 1986 report in which Dr. McDonald stated that he "saw no reason for [claimant] to be out of work on November 5." In light of these inconsistencies, we assign little weight to Dr. McDonald's opinions.

Dr. Gail also rendered a number of opinions on claimant's medically stationary status. His opinions are also inconsistent and, therefore, unpersuasive. On January 17, 1986, Dr. Gail completed a Supplemental Medical Report in which he indicated that claimant was not medically stationary and estimated the length of further time loss as one to two months. However, on that same day he completed a form for claimant's attorney in which he indicated that total disability would end on January 20, 1986.

We rely, instead, on the reports of Dr. Struckman, who first treated claimant on December 30, 1985, on referral from Dr. Gail. When Dr. Struckman examined claimant on that date, he noted residual soft tissue inflammation and extensor apparatus contracture. Although he opined that claimant was capable of working, he did not consider her to be stationary and he prescribed physical therapy. He reexamined claimant on January 13, 1986, after she had participated in physical therapy. At that time, he reported that claimant had mild pain with

pinching, but was doing very well, had full range of motion and was capable of working. He released claimant to return "prn".

We defer to Dr. Struckman because he was a treating physician and he rendered consistent, well-reasoned opinions as to claimant's medically stationary status. His opinions indicate that claimant was medically stationary as of January 13, 1986. Accordingly, we conclude that claimant was first medically stationary on January 13, 1986.

However, all treating and examining doctors had released claimant back to regular work by December 30, 1985. In particular, Dr. Struckman opined that claimant was capable of performing her regular work as of that date. There is nothing in the record to persuade us otherwise. Accordingly, we defer to Dr. Struckman's opinion and conclude that claimant was capable of performing her regular work as of December 30, 1985. Consequently, claimant is entitled to additional temporary disability benefits through that date. Fazzolari v. United Beer Distributors, 91 Or App 592 (1988).

Extent of Scheduled Permanent Disability

The Referee found that the preponderance of the medical evidence was that claimant had suffered no permanent disability to her left index finger. We agree.

The criteria for rating the extent of scheduled permanent disability is the loss of use or function of the injured member. ORS 656.214(2). On January 13, 1986, Dr. Struckman observed that claimant had full range of motion with only mild discomfort in her left index finger. In September 1986, Dr. Gail reported that claimant had full range of motion, full strength, and no sensory loss in the left index finger. Dr. Becker, orthopedist, examined claimant on February 20, 1987 and could find no neurological or orthopedic residuals from her compensable injury.

Dr. Robert McDonald notes some residual decrease in grip strength in claimant's left hand. However, claimant did not complain of grip strength in her testimony at hearing. Moreover, the aformentioned medical opinions do not support the conclusion that claimant has sustained permanent impairment. Accordingly, we do not rely on Dr. McDonald's opinion and, instead, conclude that claimant has not sustained any permanent disability in her left index finger.

ORDER

The Referee's order, dated November 18, 1987, is affirmed in part and reversed in part. That portion of the order that denied claimant's request for additional temporary disability compensation is reversed. The Determination Order, issued February 19, 1986, is modified to award additional temporary total disability compensation through December 30, 1985. The remainder of the Referee's order is affirmed. Claimant's attorney is allowed an approved fee of 25 percent of the increased temporary disability benefits paid under this order, not to exceed $3,800, payable by the insurer, out of that compensation, directly to claimant's attorney.

In the Matter of the Compensation of
JOHN E. SALINAS, Claimant
WCB Case No. 87-17773
ORDER ON REVIEW
Emmons, et al, Claimant Attorneys
Merrily McCabe (Saif), Defense Attorney

Reviewed by Board Members Speer and Howell.

The SAIF Corporation requests review of Referee Myzak's order which held that claimant was entitled to temporary total disability compensation (TTD) equal to 2/3 of the monies paid by the employer, Action Building Maintenance (Action), plus the amount of temporary partial disability compensation (TPD) that claimant was receiving as a result of a prior injury. On review, the issue is temporary disability. We reverse.

FINDINGS OF FACTS

We adopt the Referee's "FINDINGS OF FACT" with the following supplementation: Claimant's first injury, on May 9, 1976, occurred while he was employed by Helms Brothers, which was insured by SAIF. Claimant and Action entered into a written "On-The-Job Training Contract" in which claimant was to be paid $5.50 per hour for work performed as part of the training program.

CONCLUSIONS OF LAW

Claimant's October 21, 1987 injury was accepted by SAIF, on behalf of Action, as a new injury, rather than an aggravation of his May 9, 1976 injury. That acceptance is not challenged. See SAIF v. Partible, 98 Or App 244 (1989). Compare Wood v. SAIF, 30 Or App 1103 (1977).

ORS 656.210(1) provides that; "[W]hen the total disability is only temporary, the worker shall receive during the period of that total disability compensation equal to 66-2/3 percent of wages,...." The Referee concluded that claimant's "wages" on October 21, 1987, the date of his second injury, included not only the wages agreed to by claimant and the employer in their written contract, but also TPD then being paid claimant as a result of his earlier injury. We disagree.

ORS 656.005(26) defines "wages" as "... the money rate at which the service rendered is recompensed under the contract of hiring in force at the time of the accident,...." The TPD claimant was receiving at the time of his October 21, 1987 injury was not paid by Action to claimant nor was it paid pursuant to the contract under which claimant was employed. Neither was TPD paid for "service rendered" by claimant to Action. Rather, claimant was paid TPD as "compensation" by SAIF, on behalf of another employer, and as a result of a prior injury with that other employer. See ORS 656.005(8). We conclude that the TPD claimant was receiving on the date of his October 21, 1987 injury was not a part of his "wages." To hold, as the Referee did, that TTD should be based, in part, on TPD being paid on a prior injury, would require Action to pay TTD in excess of the 66-2/3 percent of the money rate at which claimant was recompensed for services for Action at the time of his October 21, 1987 accident. Such a result is not authorized by statute. See Bolton v. Oregonian Pub. Co., 93 Or App 289 (1988). TPD paid as a result of claimant's 1976 injury may not be used in computing claimant's TTD rate owing as a result of his 1987 injury.

We note that claimant may have been entitled to compensation in addition to the TTD owing as a result of his October 21, 1987 injury. If that

TTD was less than the TTD owed as a result of the May 9, 1976 injury and if claimant was entitled to continued TTD as a result of the first injury, he would be entitled to the higher amount. Apportionment could have been obtained through the Compliance Section of the Workers' Compensation Division. OAR 436-60-020(4) and former OAR 436-60-020(2).

ORDER

The Referee's order dated November 9, 1988 is reversed. Claimant is entitled to temporary disability compensation as set forth above.

March 13, 1990 Cite as 42 Van Natta 522 (1990)

In the Matter of the Compensation of
ANDY J. WRIGHT, Claimant
WCB Case No. 87-02002
ORDER ON REVIEW
Robert J. Guarrasi, Claimant Attorney
Davis & Bostwick, Defense Attorneys

Reviewed by Board Members Crider and Nichols.

Claimant requests review of Referee Quillinan's order that upheld the insurer's "backup" denial of claimant's back injury claim. On review, the issues are remand, res judicata/collateral estoppel, the propriety of the "backup" denial and compensability. We affirm.

FINDINGS OF FACT

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

The insurer accepted claimant's back injury claim on October 14, 1985. It issued a backup denial on January 28, 1987.

On October 29, 1987, claimant moved for an order compelling the insurer to disclose the basis for its Bauman denial. Referee Mirassou denied claimant's motion by Interim Order dated November 19, 1987 because "[t]he information which [claimant] seeks is within his knowledge as the individual who executed the insurance application which contained the alleged misrepresentation."

Referee Black convened a hearing in this matter on December 11, 1987. Insurance agent Fischer was not present at the hearing. Claimant's attorney requested that the hearing be reconvened when Fischer was available, or that the record be held open so that Fischer could be deposed. On January 27, 1988, Referee Black issued an "Interim Order" continuing the hearing for further development of the record regarding the propriety of the backup denial. The record was held open and agent Fischer was deposed.

The insurer's attorney had previously represented the insurer regarding a workers' compensation claim filed by claimant's father, Jack Wright. In Jack Wright's case a question arose as to the status of Jack Wright and Son Auto Paint and Body Shop. The insurer took the position that Jack Wright was a sole proprietor. The claim was resolved by Stipulation dated October 16, 1987. The Stipulation did not finally resolve the issue of whether the business was a sole proprietorship or a partnership.

FINDINGS OF ULTIMATE FACT

The Board adopts the Referee's findings of ultimate fact set forth in paragraph two of the "Opinion and Conclusion" section of the order and makes the following additional finding of ultimate fact: The partnership did not elect coverage for Andy Wright.

CONCLUSIONS OF LAW AND OPINION

We adopt the Referee's opinion with the following comment.

Remand

Claimant contends that Referee Mirassou improperly denied his discovery request and that insurance agent Fischer should have been cross-examined rather than deposed. Claimant requests that the Board remand the case for further development of the record. We may remand to the Referee should we find that the record has been "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(5).

While Referee Mirassou may have improperly denied claimant's discovery request, any prejudice to claimant was cured when Referee Black subsequently allowed a continuance. See OAR 438-07-015.

Regarding agent Fischer's deposition, at the December 1987 hearing before Referee Black, claimant's attorney stated, "...I move to keep the record open so that we can either obtain a deposition or reconvene the hearing when Mr. Fischer is available." Agent Fischer was in fact deposed. In light of these facts, we conclude that the record in this case has been sufficiently developed.

Accordingly, claimant's request for remand is denied.

Res Judicata/Collateral Estoppel

Claimant argues that the insurer should be estopped from arguing that his father's business is a partnership because the insurer took the position that the business was a sole proprietorship in a separate claim with claimant's father. That claim was resolved by Stipulation, dated October 16, 1987. The Stipulation, however, did not resolve the issue of the status of the business. As the issue has not been previously litigated, the doctrine of res judicata/collateral estoppel does not apply. We are not aware of any other authority under Worker's Compensation law prohibiting the insurer from taking inconsistent positions in these two claims.

Accordingly, we affirm the Referee's decision upholding the insurer's backup denial.

Propriety of the Backup Denial

Claimant argues that under the Board's decision in Tom C. Reeves, 38 Van Natta 31 (1986), a negligent misrepresentation cannot support a backup denial. Claimant also cites Reeves for the proposition that a third party's misrepresentation is insufficient to invoke the Bauman misrepresentation exception.

The misrepresentation in this case was not mere negligence. Both claimant and his father signed documents characterizing the business as a sole proprietorship when they knew it was a partnership. This persuades us that they acted in a manner that was more than negligent.

With regard to the contention that the misrepresentation was made by a third party and thus does not justify a backup denial, we also disagree. Each partner is the agent of the partners for the transaction of partnership affairs. ORS 68.210(1); Stone Fox v. Vandeway Development Co., 290 Or 799 (1981). Here, when the employer signed the application for workers' compensation coverage he signed as claimant's agent. Therefore, no third party misrepresentation occurred.

Claimant argues that the insurer has not carried its burden of proving that its "acceptance" was made in reliance on the misrepresentation, citing Liberty Northwest v. Salyers, 91 Or App 538 (1988) and Carolle J. Tucker, 36 Van Natta 1374, 1376 (1984). Claimant asserts that the proper inquiry under these cases is whether the insurer would have initially agreed to provide coverage if it had been aware that the business was a partnership.

Claimant's argument is flawed; the cited cases hold that the insurer must show how its acceptance of the claim -- not the underlying policy -- could have been affected by the insurer's knowledge of the undisclosed fact. Here, the insurer has clearly shown that it would not have accepted the claim if it had known that claimant was a partner in the business.

Therefore, the issuance of the backup denial was proper.

ORDER

The Referee's order, dated August 17, 1988, is affirmed. A client-paid fee is authorized, not to exceed $2,493, payable by the insurer to its counsel.

March 15, 1990 Cite as 42 Van Natta 524 (1990)

In the Matter of the Compensation of
STEVE CHAMBERS, Claimant
WCB Case Nos. 88-06883 & 88-03427
ORDER ON REVIEW
Welch, Bruun & Green, Claimant Attorneys
Stafford Hazelett, Defense Attorney
Merrily McCabe (Saif), Defense Attorney

Reviewed by Board Members Brittingham and Nichols.

The SAIF Corporation requests review of those portions of Referee Seifert's order that: (1) set aside its denial of responsibility for claimant's "new injury" claim for a low back condition; and (2) upheld Liberty Northwest Insurance Corporation's denial of responsibility for claimant's medical services claim for the same condition. Claimant cross-requests review of the portion of the order that declined to assess penalties and related attorney fees for both insurers' allegedly late denials. On review, the issues are responsibility and penalties and attorney fees.

We affirm and adopt on the responsibility issue and denial of penalties and attorney fees against Liberty Northwest. We affirm that portion of the Referee's order concerning the assessment of penalties against SAIF. However, we reverse that portion of the order that did not award an attorney fee to be paid by SAIF for its unreasonable resistance to the payment of compensation.

An insurer must furnish claimant written notice of acceptance or denial of a claim within 60 days after receiving notice or knowledge of the claim. ORS 656.262(6). If the insurer unreasonably delays acceptance or denial of the claim, the insurer shall be assessed a penalty of up to 25 percent of any

amounts of compensation "then due." ORS 656.262(10). A penalty-related attorney fee may also be assessed for the insurer's unreasonable resistance to the payment of compensation. ORS 656.382(1).

The Referee found that SAIF issued its denial one day late, but reasoned that the delay was de minimis and declined to assess a penalty or attorney fee. We disagree with the Referee's finding and conclusion.

Claimant persuasively testified that, after sustaining his injury with SAIF's insured on September 29, 1987, he immediately reported the injury to his supervisor, the employer's production foreman. (Tr. 18). Claimant later completed an initial claim form (Form 801) and filed it with the employer. (Ex. 104). The form indicates that claimant sustained a low back strain on September 29, 1987. In box number 22 of the form, which is labelled "[d]ate employer first knew of injury or occupational disease," the employer's representative wrote "9-29-87." Based on this evidence, we find that the employer knew of the injury on September 29, 1987, and, hence, had knowledge of claimant's claim on that date. See Hayes-Godt v. Scott Wetzel Services, 71 Or App 175, 179 (1985); Phyllis Baldwin, 40 Van Natta 1085, 1088 (1988).

An employer must report a claim to its insurer within five days after receiving notice or knowledge of the claim. ORS 656.262(3). Here, SAIF apparently did not receive notice of claimant's claim from its insured until December 1987. However, the employer's conduct in failing to report the claim in a timely manner is legally attributable to its insurer. See Nix v. SAIF, 80 Or App 656 (1986), rev den 302 Or 158 (1987). Hence, notwithstanding the employer's conduct, SAIF is deemed to have received notice of claimant's injury claim on September 29, 1987. Thereafter, SAIF had 60 days, or until November 28, 1987, to accept or deny the claim. SAIF did not issue its written notice of denial until February 5, 1988, more than two months late. We do not find any reasonable justification for the delay. We find, therefore, that SAIF's delay in processing the claim was unreasonable. See Lester v. Weyerhaeuser, 70 Or App 307, 312 (1984).

However, to support the assessment of 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). Here, the record does not establish what, if any, amounts were "then due" as of the date of SAIF's denial. Consequently, no penalty will be assessed.

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. Cindi A. Cadieux, 41 Van Natta 2259 (1989). We conclude that SAIF's untimely denial was an unreasonable resistance to the payment of compensation. Accordingly, SAIF is assessed an attorney fee of $400 for its unreasonable resistance to the payment of compensation. See ORS 656.382(1).

ORDER

The Referee's order dated July 20, 1988, is affirmed in part and reversed in part. For the SAIF Corporation's unreasonable resistance to the payment of compensation, claimant's attorney is awarded $400, to be paid by SAIF. For services on review concerning SAIF's request, claimant's attorney is awarded an assessed fee of $750, also to be paid by SAIF.

In the Matter of the Compensation of
STEVEN M. GINTHER, Claimant
WCB Case Nos. 87-07462 & 87-06177
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
Cooney, Moscato, et al., Defense Attorneys

Reviewed by Board Members Nichols and Brittingham.

Claimant requests review of those portions of Referee Seifert's order that: (1) affirmed a Determination Order award of 10 percent (32 degrees) unscheduled permanent disability for claimant's 1985 low back injury; and (2) authorized the insurer to offset an overpayment of temporary total disability in claimant's 1985 low back claim against permanent partial disability compensation payable on claimant's separate 1984 bilateral wrist claim. On review, the issues are extent of unscheduled permanent disability and offset. We reverse on the offset issue.

FINDINGS OF FACT AND ULTIMATE FACT

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

CONCLUSIONS OF LAW AND OPINION

The Board affirms and adopts the Referee's ruling on the extent issue.

The insurer claimed an offset of an overpayment in claimant's low back claim against permanent partial disability awarded on his separate hand claim. The Referee allowed the offset, noting that the applicable statute, ORS 656.268(10), did not indicate that the offset of future compensation must be against the determination to which it pertains. We disagree.

Former OAR 436-54-320 specifically allowed offsets of overpayments made earlier on the same claim. The current administrative rule does not expressly confine offsets to overpayments in the same claim. See OAR 436-60-170. This interpretation of the rule is consistent with the language of ORS 656.268(10): "Any determination or notice of closure may include necessary adjustments in compensation paid or payable prior to the determination or notice of closure." We conclude that the current rule does not authorize an offset of benefits paid on one claim against amounts due on another claim. See Cascade Steel Rolling Mills v. Madril, 62 Or App 598, 600-01 (1983); Lawrence W. Scott, 40 Van Natta 1721 (1988); Dale L.Tichenor, 40 Van Natta 867 (1988).

Claimant contends he is entitled to an attorney fee for prevailing on the offset issue. Our ruling on the offset issue did not effect claimant's right to compensation. ORS 656.386(1). See Forney v. Western States Plywood, 297 Or 628, 633 (1984). Accordingly, claimant is not entitled to an assessed fee.

ORDER

The Referee's order dated July 20, 1988 is affirmed in part and reversed in part. That part of the order allowing an offset is reversed. The remainder of the order is affirmed. The Board authorizes a client-paid fee, not to exceed $1,300, payable by the insurer to its counsel.

In the Matter of the Compensation of
APRIL MAYBERRY, Claimant
WCB Case No. 88-06746
ORDER ON REVIEW
Emmons, et al, Claimant Attorneys
Garrett, et al, Defense Attorneys
David Ray Fowler (Saif), Defense Attorney

Reviewed by Board Members Howell and Perry.

Claimant requests review of that portion of Referee Daron's order which upheld the SAIF Corporation's denial, on behalf of the alleged employers, of claimant's claim for facial injuries. Richard and Susan Anderson, the alleged employers, cross-request review of those portions of the Referee's order which: (1) held that claimant was a subject worker and that the Andersons were subject employers; and (2) declined to approve a client-paid attorney fee. On review the issues are subjectivity, compensability and attorney fees.

The Board affirms that portion of the order finding that the Andersons were subject employers and that claimant was a subject worker, and reverses that portion of the order which upheld SAIF's denial of compensability of claimant's facial injuries. Additionally, we affirm that portion of the order denying approval of the Andersons' attorney fees.

FINDINGS OF FACT

The original arrangement between claimant and the Andersons was that claimant and her husband were to live in the extra house, rent free, on the Anderson's property, and keep, free of charge, claimant's two horses on the Anderson's pasture and in their barn, in exchange for claimant's "watching" the property as security and caring for the Andersons' horses, when the Andersons went out of town, which they expected to do frequently. (Tr. 24, 26-27, 36, 76).

The rental value of the stalls for claimant's two horses is $100 per month, per horse. (Tr. 29).

Claimant received remuneration in the form of free housing for herself and her husband, and free shelter for her two horses at a dollar value in excess of $200 per month.

The scope of claimant's work activities for the Andersons grew to incorporate feeding the Andersons' horses on a daily basis, cleaning the Andersons' horses' stalls, training and showing the Andersons' horses. (Tr. 28, 30). Claimant worked with (trained) two or three of the Andersons' horses, showed the horses, and the Andersons instructed claimant as to what they wanted her to do with specific horses. (Tr. 37, 79).

The Andersons' 1987 Schedule F, form 1040, tax return indicates that they own a horse farm which they "materially participated" in operation of as a "business," and for which they listed their horses as income-producing farm livestock. They deducted their expenses for "DUES-FEES-LICENSES-SHOWS-TRNG (training)-ADV (Advertising)-PUB (publicity)-FARRIER-AUCTION- TRAVEL." (Ex. 8). The Andersons' advertise in monthly horse journals that they breed horses for a fee, have studs for service, charge for mare care and sell horses. (Ex. 11). The Andersons share the income from their horse business. (Tr. 74).

On October 24, 1987, claimant was kicked on the right side of her face by the Andersons' horse, "Little Harold," (Harold), when she tried to mount

him. (Ex. 1, Tr. 33). Mrs. Anderson was present and watching as claimant was injured. (Tr. 34). Claimant sustained a fractured jaw, cheek bone and anterolateral maxillary sinus. (Ex. 5).

On February 5, 1988, claimant signed the "801" form that the Andersons "declined" to complete. (Ex. 1).

The Compliance Division found that claimant was not a subject worker and the Andersons were not subject employers. (Ex. 1-A). Pursuant to OAR 436-80-060, the matter was referred to SAIF for processing. SAIF denied claimant's facial injury claim on April 5, 1988. (Ex. 2).

The Referee found none of the witnesses "to be very credible," and that they were "tainted with self interest." Therefore, in reaching the above findings, we rely upon those facts upon which the parties agree, as well as admissions by the parties in conjunction with the documentary evidence.

CONCLUSIONS OF LAW AND OPINION

Subjectivity

We must first determine whether the Andersons are "employers" and claimant is a "worker." In this regard, "employer" means "any person...who contracts to pay a remuneration for and secures the right to direct and control the services of any person." ORS 656.005(13); "worker" means "any person, including a minor whether lawfully or unlawfully employed, who engages to furnish services for a remuneration, subject to the direction and control of an employer..." ORS 656.005(27).

There is no documentation regarding the "employment" arrangement between claimant and the Andersons. However, the parties agree that the original arrangement provided that claimant and her husband were to live in the extra house, rent free, on the Anderson's property, and keep, free of charge, claimant's two horses on the Anderson's pasture and in their barn, in exchange for claimant's "watching" the property as security and caring for the Andersons' horses, when the Andersons went out of town. The testimony indicates that claimant's work activities grew to incorporate caring for the Andersons' horses on a daily basis even while the Andersons were home, including training and showing specific horses belonging to the Andersons. The Andersons did not merely acquiesce to claimant's increased work activities, they gave instructions to claimant as to what they wanted her to do with their horses and benefitted from claimant's increased work activities. In sum, we are persuaded that claimant was engaged "to furnish services for a remuneration, subject to the direction and control of [the Andersons]."

The Andersons argue that claimant's employment status is excepted under ORS 656.027(3)(a) and (3)(a)(A) which allow exception for the worker whose employment is casual and not in the course of the trade, business or profession of the employer. "Casual" refers to employments where the work in any 30-day period involves a total labor cost of less than $200. ORS 656.027(3)(b). We disagree.

First of all, claimant cannot be considered a "casual worker" because the Andersons incurred labor costs totalling more than $200. Even excluding the value of the house claimant and her husband were given to live in on the Andersons' property, the Andersons admitted that housing claimant's two horses is worth $100 each. Therefore, labor costs to the Andersons from the arrangement with claimant are not "less than $200."

Secondly, the Andersons are in "business" and claimant's presence directly relates to this "business." On their 1987 Income Tax Return, the Andersons specifically declared that they were in the horse-trade-training-showing "business" for which they declared income and for which they deducted their expenses.

The Andersons also argue that since their arrangement with claimant only involved claimant's "remodeling" the small house that claimant and her husband would live in, and "watching" the property when the Andersons went out of town, claimant's employment status is specifically excepted from the definition of "subject worker" under ORS 656.027(2). ORS 656.027(2) excepts those workers "employed to do gardening, maintenance, repair, remodeling or similar work in or about the private home of the person employing the worker."

We have concluded that the arrangement extended well beyond that originally contemplated. However, even the work activities intended to be performed by claimant under the original agreement are not the type of "maintenance" and "remodeling" contemplated by the statute. Employments under ORS 656.027(2) are those which are for the benefit of the nonbusiness homeowners who receive no pecuniary profit from maintaining their private home and who should not be made to bear the burden of workers' compensation protection. First of all, we have stated that the Andersons are in business. Additionally, claimant was not there to maintain the Andersons' "private home" but to provide services directly related to the Andersons' business. The Andersons could travel freely to horse shows and sell their product; they did not have to pay cash to someone else, a professional, to feed, train, and show their horses. And the extra house on the Andersons' property that claimant helped paint and decorate was for claimant to live in, not the Andersons' personal dwelling.

Accordingly, we agree with the Referee that the Andersons were "employers" under ORS 656.005(13), who controlled the work activities of claimant who, in turn, provided services for the Andersons and is a "worker" under ORS 656.005(27). Additionally, we agree with the Referee that, contrary to the arguments offered by the employers, the employment arrangement was not casual and was in the course of the business of the employers.

Compensability

The ultimate inquiry under ORS 656.005(8)(a), defining a compensable injury as an accidental injury arising out of and in the course of the employment, is whether the relationship between the injury and employment is such that the injury should be compensable. Rogers v. SAIF, 289 Or 633 (1985). To answer this question, we turn to the seven-part test of Mellis v. McEwen, Hanna, Gisvold, 74 Or App 571 (1985).

The first inquiry is whether the activity was for the benefit of the employer. The employers testified that in the past they have paid trainers to prepare their horses for shows or the race track. (Tr. 91, 97-98). Here, the Andersons would benefit from claimant's training Harold to ride under saddle -- he would be ready to race and they would not have to pay someone else to train him or, at the least, he would be more prepared by the time he would go to a trainer so that their ultimate training costs would be less.

The next inquiry is whether the activity was contemplated by the employer and employee either at the time of hiring or later. The Andersons deny that they asked claimant to ride Harold. (Tr. 34). However, Mr. Anderson testified that he pointed out to claimant that they wanted Harold trained for the race track. (Tr. 78). Mrs. Anderson testified that claimant had trained and shown several of their horses and had specifically helped train another of

the their horses for the racetrack prior to the incident with Harold. (Tr. 37). On the day of the injury, Mrs. Anderson came out of the house and watched as claimant first lounged Harold, and then proceeded to saddle and mount Harold. Mrs. Anderson observed as claimant was injured. (Tr. 34). We, therefore, conclude that the activity was contemplated by the parties.

Moreover, the above discussion leads us to the conclusion that riding Harold became incidental to and an ordinary risk of the expanded employment arrangement between claimant and the Andersons.

In addition, claimant received remuneration in the form of free rent for herself, her husband and her two horses.

There is no dispute but that the activity was performed on the employers' premises.

Further, Mrs. Anderson was present and watching the training session at the time claimant attempted to mount Harold. Accordingly, claimant's activity leading to her injury was directed, or at least acquiesced in, by the Andersons.

Lastly, under Jordan v. Western Electric, 1 Or App 441 (1970); and Halfman v. SAIF, 49 Or 23 (1980), we address whether claimant was on a personal mission of her own at the time of her accident. In Jordon and Halfman, the claimants were on coffee breaks when their injuries occurred. A coffee break is a personal mission whereby the employer receives little benefit. Here, the Andersons argue that claimant's riding Harold was for her own benefit to increase her expertise as a horse trainer. However, riding Harold, even though such riding would increase claimant's proficiency as a trainer, provided the Andersons with an immediate benefit -- not having to pay someone else to train Harold as claimant trained him. Such immediate benefit to the employer tips the scale less from personal mission for claimant to work related for the benefit of the employer.

Accordingly, claimant's facial injuries are compensable.

Attorney Fees

Because the employers' attorney did not submit a statement of services, the Referee refused to approve an attorney fee. The appropriate statute requires:

> "No claim or payment for legal services by an attorney representing the worker or by an attorney, other than a salaried staff attorney, representing the insurer or self-insured employer, or for any other services rendered before a referee or the board, as the case may be, in respect to any claim or award for compensation to or on account of any person, shall be valid unless approved by the referee or board, or if proceedings on appeal from the order of the board with respect to such claim or award are had before any court, unless approved by such court." ORS 656.388.

The employers' attorney argues that the statutory requirement for approval of attorney fees does not apply because there was no evidence to show that the employers were "insurers" or "self-insured employers."

We do not accept the employers' statutory interpretation. To the contrary, the statute clearly applies to the employers' attorney. In this re

gard, the provision expressly applies to "any other services rendered before a referee or the board...." We interpret this statutory reference to include services such as those rendered here by the employers' attorney. Therefore, we conclude that the Referee properly denied approval of an attorney fee to the employers' attorney because he did not submit a statement of services for approval by the Referee. See OAR 438-15-001 through 438-15-035.

ORDER

The Referee's order dated August 19, 1988, is affirmed in part and reversed in part. The SAIF Corporation's denial, issued on behalf of the Andersons, is set aside and the claim is remanded to SAIF for processing according to law. For services at hearing and on Board review concerning subjectivity and compensability, claimant's attorney is awarded a reasonable fee of $2,400, to be paid by SAIF on behalf of the noncomplying employer.

March 15, 1990 Cite as 42 Van Natta 531 (1990)

In the Matter of the Compensation of
RODERICK A. MESPELT, Claimant
WCB Case Nos. 87-05743 & 87-15620
ORDER ON REVIEW
Brian L. Pocock, Attorney
Gail Gage (Saif), Defense Attorney

Reviewed by Board Members Crider and Brittingham.

Claimant, pro se, requests review of Referee Seymour's order that: (1) upheld the SAIF Corporation's July 15, 1987 and August 27, 1987 denials of chiropractic treatment for claimant's neck and low back condition; and (2) affirmed a Determination Order awarding no unscheduled permanent partial disability for injury to the cervical spine. Claimant contends that he was denied due process when Referee Seymour issued an order after the hearing was conducted by Referee Hayduke. Claimant asks the Board to remand the case for a new hearing. On review, the issues are due process and remand, medical services and extent of permanent disability.

We affirm and adopt the Referee's order with the following supplementation.

Claimant contends that he was denied due process when this case was decided by Referee Seymour. Referee Seymour did not conduct the hearing. With the consent of claimant's counsel, on claimant's behalf, however, Referee Seymour decided the case on the transcript of the hearing and closing argument. Claimant argues that due process entitles him to a decisionmaker who has observed the witnesses at hearing.

We disagree. Due process does not require that an administrative decisionmaker have an opportunity to hear and see the witnesses at hearing. Were that the case, many of the administrative hearing procedures utilized routinely in this state would be unconstitutional as the ultimate decisionmaker in many such processes is not the hearings officer. While we do not suggest that this situation is the ideal, it does not constitute a denial of due process. Moreover, in this case, claimant consented to the procedure. No error was committed.

ORDER

The Referee's order dated October 12, 1988 is affirmed.

In the Matter of the Compensation of
ANNIE M. NEUBERGER, Claimant
WCB Case No. 88-10151
ORDER ON REVIEW
Parker & Bush, Claimant Attorneys
Meyers & Radler, Defense Attorneys

Reviewed by Board Members Myers and Cushing.

The self-insured employer requests review of that portion of Referee Thye's order which set aside its denial of claimant's occupational disease claim for neck and arm complaints. On review the sole issue is compensability. We reverse.

FINDINGS OF FACT

Claimant has worked as a meat wrapper for the employer for several years. In October 1987 she saw Dr. Ash, M.D., a neurologist, complaining that her right hand was going to sleep. Claimant reported a history of several years of problems with pain from the top of her head to her low back. Dr. Ash suspected radiculopathy from a disc at C7 or C8. Claimant continued to work at her job as a meat wrapper.

Claimant began seeing a chiropractor, Dr. Dawson, in February 1988. At that time she was complaining of left arm, shoulder, neck and upper back pain. When the Orthopaedic Consultants examined claimant in April 1988, claimant had an entirely normal physical examination. There was no objective evidence of cervical radiculopathy.

Claimant has a tendency to somatize. Consequently, whenever she feels stress it manifests as musculoskeletal pain and discomfort.

CONCLUSIONS AND OPINION

Because claimant continued to work for the employer before and after seeing Dr. Dawson, the last exposure which could have contributed to her condition occurred after January 1, 1988. Consequently, we apply the current version of ORS 656.802 to determine whether her occupational disease claim is compensable. Donna E. Aschbacher, 41 Van Natta 1242 (1989). Under ORS 656.802(1)(c) claimant has the burden of proving by a preponderance of the evidence that a series of traumatic events which occurred at work were a material cause of her condition or of a symptomatic worsening of a preexisting condition. Aschbacher, supra at 1249. We conclude that claimant has failed to meet this burden of proof.

We rely upon the opinions of the Orthopaedic Consultants and Dr. Parvaresh over the opinion of the treating chiropractor, Dr. Dawson. We do so because we find those opinions better reasoned and more consistent with claimant's history than the opinion of Dr. Dawson.

ORDER

The Referee's order dated November 16, 1988 is affirmed in part and reversed in part. That portion of the Referee's order which set aside the employer's denial is reversed. The denial of June 2, 1988 is hereby reinstated and upheld. The Referee's attorney fee, relating to this issue, of $1,300 is also reversed. The balance of the Referee's order is affirmed. The Board approves a client-paid fee, not to exceed $1,359, payable by the self-insured employer to its attorney.

In the Matter of the Compensation of
SHERI L. ROBERTSON, Claimant
WCB Case No. TP-88017
THIRD PARTY ORDER ON REMAND
Karen Werner, Claimant Attorney
Peter O. Hansen, Claimant Attorney
David Runner, Assistant Attorney General

This matter is before the Board on remand from the Court of Appeals. Robertson v. Davcol, Inc., 99 Or App 542 (1989). We previously concluded that SAIF was entitled to a share of the proceeds of a settlement between claimant, her noncomplying employer and its manager. Sheri L. Robertson, 40 Van Natta 1885 (1988). Holding that SAIF is entitled to no share of the proceeds, the court has remanded with instructions to make a distribution order to claimant.

Accordingly, claimant's attorney is directed to distribute the remaining balance of settlement proceeds to claimant.

IT IS SO ORDERED.

In the Matter of the Compensation of
JULIO R. SANCHEZ, Claimant
WCB Case No. 87-18485
ORDER ON REVIEW
Brian R. Whitehead, Claimant Attorney
Kate Waldo (Saif), Defense Attorney

Reviewed by Board Members Brittingham and Crider.

Claimant requests review of Referee Michael Johnson's order that upheld the SAIF Corporation's denial of claimant's current neck, back and shoulder condition and need for treatment on the ground that claimant's request for hearing was untimely. Claimant requests that if we find that claimant's request for hearing was timely, we remand the case to the Referee for a decision on the merits. On review, the issues are timeliness, remand and compensability. We reverse.

FINDINGS OF FACT

Claimant was compensably injured on February 13, 1987, when a stack of five gallon tubs of ice cream fell on him, hitting him in the neck, back and shoulder. SAIF accepted a cervical/thoracic sprain/strain.

Claimant was unable to work until March 26, 1987, when he was released to part-time modified work by Dr. Lawton, chiropractor. On May 27, 1987, claimant was released to work with the proviso that he not push, pull, lift or carry more than ten pounds or lift overhead. He returned to work for SAIF's insured.

On August 8, 1987, before the claim was closed, claimant was involved in an off-work motor vehicle accident. At that time, claimant continued to be restricted in his activity due to the compensable injury. The accident caused a worsening of claimant's cervicothoracic condition. Dr. Lawton reauthorized temporary total disability compensation. Claimant has not worked for SAIF's insured since the accident.

On September 21, 1987, SAIF issued a denial of claimant's current disability and need for treatment, contending that it was caused by the motor vehicle accident. The denial anticipated that SAIF would resume responsibility for the compensable condition when claimant returned to his pre-accident status. The denial was sent to claimant but not to his attorney although claimant's attorney had written to SAIF less than three months earlier advising that he had been retained as counsel relative to the compensable injury and requesting copies of medical records, claims documents and the like.

Claimant received the denial but did not request a hearing because he believed that his attorney was handling it.

Claimant's attorney filed a request for hearing on December 7, 1987.

FINDINGS OF ULTIMATE FACT

Claimant filed his request for hearing more than 60 days, but less than 180 days, after the denial issued. There was good cause for late filing of the request.

The compensable injury was a material contributing cause of claimant's condition and need for treatment following the motor vehicle accident.

CONCLUSIONS OF LAW AND OPINION

Timeliness

The Referee dismissed the request for hearing because it was not filed within 60 days of the denial as required by ORS 656.319(1)(a) and he concluded, relying on our decision in Leon E. Cowart, 40 Van Natta 22 (1988), that claimant had not established good cause for late filing. The Court of Appeals has since reversed that decision. Cowart v. SAIF, 94 Or App 288 (1988).

A request for hearing is timely if filed within 180 days if there is good cause for failure to timely file. ORS 656.319(1)(b). Good cause, as used in ORS 656.319 means the same kind of "mistake, inadvertence, surprise or excusable neglect" that permits relief from a default judgment under former ORS 18.160, now ORCP 71(B)(1). Anderson v. Publishers Paper Co., 78 Or App 513, 517, rev den 301 Or 666 (1986).

In Cowart v. SAIF, supra, the court dealt with a similar circumstance in which a denial was not mailed to the claimant's attorney. The claimant relied on his attorney to protect his rights and so did not act within 60 days. The court held that, given OAR 436-60-105, claimant had reason to believe that his attorney would be sent a copy of the denial and could act on it. His failure to act on his own, therefore, was excusable neglect.

The same is true here. Although the record does not establish that claimant had instructed his attorney to contest any denial that issued, his attorney had taken steps to protect his rights. He had reason to believe that his attorney would receive the denial and that he need do nothing further. We conclude that claimant had good cause for late filing of his request for hearing.

Remand

Claimant, in his appellant's brief, requests that if we reverse on the timeliness issue we remand to the Referee for a decision on the merits. We decline to do so.

The issues at hearing included both timeliness and compensability. Both issues were fully developed at hearing. The record was not improperly, incompletely or otherwise insufficiently developed by the Referee such that we are incapable of deciding the compensability issue on the current record. Therefore, we decline to remand.

Compensability

The Referee did not reach the compensability issue. Because we have concluded that the request for hearing was timely, we must.

SAIF, by its denial, sought to escape responsibility for payment of the costs of claimant's treatment and disability while he recovered from the automobile accident. The denial anticipated that SAIF would resume responsibility for the compensable condition when claimant returned to his pre-accident status. However, an insurer remains responsible for claimant's condition so long as it is materially caused by the disability. Thus, if the compensable condition is worsened by a noncompensable injury, the insurer continues to be responsible for claimant's condition provided that the compensable injury is a material contributing cause of that worsened condition. Grable v. Weyerhaeuser Company, 291 Or 287 (1981).

Thus, although claimant had been able to work prior to the motor vehicle accident and was unable to work thereafter and although his need for treatment increased with the accident, SAIF was not entitled to disclaim responsibility for claimant's care if we find that the compensable injury concurred with the accident to cause his condition.

In finding that claimant's condition was caused in part by the compensable injury, we rely on the opinions of Dr. Lawton, the treating physician, and Dr. Fry, an orthopedic surgeon who examined claimant for SAIF both before and after the motor vehicle accident. Dr. Lawton, within two weeks of the accident, reported that the accepted condition had been worsened by the accident but remained a material cause of claimant's condition. Dr. Fry, examining claimant six months after the accident, concluded that the accident had aggravated his compensable injury.

We further note that although claimant had improved greatly between the time of the compensable injury and the motor vehicle accident, he had not fully recovered. Both Dr. Lawton and Dr. Fry had opined that claimant still suffered some impairment from the compensable injury in June, 1987. Moreover, both opined that by early 1988, when the effects of the motor vehicle accident had largely subsided, claimant remained mildly impaired due to the compensable injury. There is thus no reason to doubt the opinions of the physicians concerning the continuing effect of the injury on claimant's condition.

We, therefore, set aside the denial.

ORDER

The Referee's order dated June 27, 1988, is reversed. 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 $2,000, payable by SAIF.

In the Matter of the Compensation of
RONNIE D. STURGILL, Claimant
WCB Case No. 88-02859
ORDER ON REVIEW
Rasmussen & Henry, Claimant Attorneys
Scheminske & Lyons, Defense Attorneys
Roberts, et al., Attorneys

Reviewed by Board Members Gerner and Myers.

The self-insured employer requests review of those portions of Referee Baker's order that: (1) found that claimant's low back and right leg injury claim was prematurely closed; and (2) assessed a penalty and attorney fee for the employer's alleged unreasonable refusal to pay temporary total disability while claimant was enrolled in a pain center. On review, the issues are premature closure, temporary disability, penalties and attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

In December 1983, claimant suffered a compensable right knee injury. Dr. Freudenberg, orthopedist, performed an arthroscopic subtotal right meniscectomy. On May 15, 1984, Dr. Freudenberg performed a second arthroscopy. In the fall of 1984 claimant returned to modified work.

On February 4, 1985, claimant was evaluated by Dr. Holbert, orthopedist, who noted a neuroma of the saphenous nerve in claimant's knee. Dr. Holbert performed surgery on May 28, 1985.

In the fall of 1985, claimant again returned to work. He was suffering from back pain, which Dr. Holbert suspected of being related to abnormal gait since the knee injury. (Ex. 64-1). A March 1986 myelography did not reveal a disk problem. A May 1986 CT scan revealed some annular bulging at both the lumbosacral and the L4-5 levels. Dr. Holbert took claimant off work on March 4, 1986.

On May 20, 1986, Dr. Holbert performed further right knee surgery. On December 22, 1986, Dr. Holbert referred claimant to Dr. Spady, orthopedist, regarding claimant's back pain. Dr. Spady opined that treatment would not materially alter claimant's impairment, and described his condition as medically stationary. (Ex. 66-4).

Dr. Holbert referred claimant to Dr. Larson, orthopedist. On March 2, 1987, Dr. Larson reported no need for further surgical treatment of the knee and his feeling that "most of his problems are coming from his back discomfort." (Ex. 66-4).

At the employer's request, Dr. Zivin, neurologist, performed an independent medical examination in April 1987. Zivin advised against any type of surgical procedure (knee or back). (Ex. 69-11). Dr. Thompson, orthopedist, also performed an independent evaluation and concluded that claimant was medically stationary, regarding both his back and knee. (Ex. 70-5).

On July 28, 1987, following a reexamination, Dr. Holbert agreed that claimant was medically stationary. (Ex. 72-1). On January 28, 1988, Dr. Holbert's associate, Dr. Bert, agreed with Dr. Thompson's opinion that claimant was medically stationary. (Ex. 78). Dr. Bert also recommended a Pain Center approach.

A March 18, 1988 Determination Order granted temporary disability through January 28, 1988 and awarded 40 percent (60 degrees) for permanent partial loss of use of the right leg (knee).

Claimant participated in a pain center program from April 6, 1988 to April 29, 1988. During this time, he was unable to work as a result of his compensable injury. The employer did not provide temporary disability compensation for that period.

FINDINGS OF ULTIMATE FACT

By January 28, 1988, no material improvement in claimant's compensable condition was reasonably anticipated as a result of medical treatment or the passage of time.

Claimant attended the Northwest Pain Center from April 6, 1988 through April 29, 1988. During his attendance, claimant was away from his home and unavailable to work.

CONCLUSIONS OF LAW AND OPINION

Temporary Total Disability

The Referee found that claimant's psychological condition was not really addressed until the April 1988 pain center program. Since the pain center program had been recommended prior to claim closure, the Referee concluded that the January 28, 1988 Determination Order prematurely closed the claim. We disagree.

The question of claimant's entitlement to additional temporary total disability initially depends, in part, on the date he became medically stationary. Claims can be closed only if the worker's compensable condition has become medically stationary. ORS 656.268(1). "Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). Claimant has the burden to prove that he was not medically stationary when the claim was closed. Berliner v. Weyerhaeuser Co., 54 Or App 624 (1981).

The resolution of the medically stationary date 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). In this case, Drs. Spady, Larson Thompson, Holbert, and Bert had pronounced claimant to be medically stationary by January 28, 1988. This is the date the Determination Order found claimant to be medically stationary. We find the aforementioned opinions persuasive, particularly those of Drs. Holbert and Bert, who, at various times, treated claimant's condition. The medical reports indicate that the doctors were fully aware of claimant's complex problems resulting from his compensable injury and they were persuaded that no further improvement in his condition, either physical or mental, could be reasonably expected. For the foregoing reasons, we conclude that claimant became medically stationary on January 28, 1988.

While we disagree with the Referee on the date claimant became medically stationary, we agree that claimant should have been provided with temporary total disability for the period of time he attended the Northwest Pain Center. Temporary total disability is payable for the period a claimant is unavailable to work due to attendance at a full-time pain program necessitated by a work-related injury. Weyerhaeuser Company v. Surprise, 89 Or App 296, n.3 (1988).

Here, we are persuaded by the record that claimant's attendance at the pain center was full-time. The record indicates that claimant was away from his wife for 3 1/2 weeks. Such evidence persuades us that claimant was away from home during this period and, therefore, prevented from any potential employment opportunities. Consequently, claimant is entitled to temporary total disability benefits from April 6, 1988 through April 25, 1988, which corresponds with the period he attended the pain center.

Penalties and Attorney Fees

We adopt the Referee's conclusions and opinions concerning the assessment of a penalty and attorney fee for the employer's failure to pay temporary total disability compensation during claimant's attendance at the pain center.

ORDER

The Referee's order, dated August 17, 1988, is affirmed in part and reversed in part. The Determination Order, dated February 18, 1988, is reinstated and affirmed insofar as it pertained to the medically stationary date and temporary disability award. The employer is directed to pay claimant temporary total disability compensation from April 6, 1988 through April 29, 1988. Claimant's attorney is awarded 25 percent of this increased compensation, not to exceed $1,050. The remainder of the Referee's order is affirmed. The Board approves a client-paid fee, not to exceed $1,513, payable by the self-insured employer to its former counsel.

In the Matter of the Compensation of
JOHN K. TAGWERKER, Claimant
WCB Case No. 87-04769
ORDER ON REVIEW
W. D. Bates, Jr., Claimant Attorney
Nancy Marque (Saif), Defense Attorney

Reviewed by Board Members Crider and Nichols.

Claimant requests review of those portions of Referee Young's order that: (1) affirmed that portion of a Determination Order that awarded temporary total disability benefits through September 30, 1986; and (2) allowed the SAIF Corporation to offset temporary total disability paid after the aforementioned date against claimant's award of scheduled permanent disability for a leg condition. The issues on review are temporary total disability and offset. We modify.

FINDINGS OF FACT

Claimant, 64 years old at hearing, worked for the employer as a bus driver for 15 years. He compensably injured his right knee in 1979 and again in April 1986. He left work as a result of the second compensable injury and underwent right knee replacement surgery.

Claimant had intended to retire in 1990. Following his 1986 knee injury, however, he applied for early retirement on October 22, 1986, retroactive to October 1, 1986. He has received retirement benefits from the employer since October 1, 1986.

Claimant was medically stationary on December 22, 1986.

SAIF paid temporary total disability benefits to claimant after September 30, 1986, until claim closure on March 6, 1987. The Determination Order terminated temporary total disability after September 30, 1986 and permitted SAIF to offset "overpaid" temporary total disability against claimant's award of scheduled permanent disability.

ULTIMATE FINDING OF FACT

Claimant was in the work force at the inception of his April 1986 knee injury claim. He left work as a result of this compensable injury.

CONCLUSIONS OF LAW AND OPINION

The Referee increased the Determination Order award of 40 percent scheduled permanent disability to 60 percent. The Determination Order allowed SAIF to offset temporary total disability paid after September 30, 1986, against the award of scheduled disability. The Referee affirmed this offset on the grounds that claimant was not in the work force after that date and was therefore not eligible for temporary total disability. We disagree.

On review, claimant argues he is statutorily entitled to temporary total disability benefits until he is declared medically stationary. We agree.

However, ORS 656.268(10) states:

> "Any determination or notice of closure ... may include necessary adjustments in compensation paid or payable prior to the determination or notice of closure, including disallowance of permanent disability payments prematurely made, crediting temporary disability payments against permanent disability awards and payment of temporary disability payments which were payable but not paid." (Emphasis added.)

SAIF argues that it is entitled to offset temporary total disability payments paid after the date of claimant's retirement because claimant was no longer in the work force, citing Cutright v. Weyerhaeuser, 299 Or 290 (1985). We disagree.

Unlike the claimants in Cutright v. Weyerhaeuser, supra, and Karr v. SAIF, 79 Or App 250 (1986), claimant had not withdrawn from the workforce at the inception of his claim. This rationale is supported by the court's recent decision in Weyerhaeuser Company v. Kepford, 100 Or App 410 (February 14, 1990). In Kepford, the court held that because the claimant was a member of the work force when he became disabled, it did not matter that he retired or had withdrawn from the work force after that time. Since the claimant was entitled to receive temporary total disability upon his disability, the court reasoned that he was entitled to continue to receive such benefits until he became medically stationary and was released for work.

A similar situation presents itself here. Claimant was in the work force at the inception of his injury claim. His subsequent retirement did not alter the fact that he remained totally disabled from performing work activities as a result of a compensable injury. He remained entitled to temporary total disability benefits until he was released to work and was found to be medically stationary. Former ORS 656.268(2).

Accordingly, we conclude that claimant was entitled to temporary total disability benefits from the inception of his claim to the date he was declared

medically stationary, December 22, 1986. SAIF may offset any temporary total disability payments made after that date until claim closure.

ORDER

The Referee's order dated November 6, 1987, is modified in part. In addition to the temporary total disability awarded by the Determination Order, claimant is awarded temporary total disability benefits from October 1, 1986 through December 22, 1986. Claimant's attorney is awarded 25 percent of the increased compensation created by this order, not to exceed $3,000, payable directly to the attorney. The SAIF Corporation is permitted to offset any temporary total disability paid beyond December 22, 1986 against any current or future permanent disability awards. The remainder of the Referee's order is affirmed.

March 15, 1990 Cite as 42 Van Natta 540 (1990)

In the Matter of the Compensation of
BETTY S. TEE, Claimant
WCB Case No. 88-11538
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Mitchell, et al., Defense Attorneys

Reviewed by Board Members Cushing and Gerner.

The self-insured employer requests review of that portion of Referee Hoguet's order which granted claimant permanent total disability, whereas a Determination Order had awarded an additional 20 percent (64 degrees) unscheduled disability for a total award of 50 percent (160 degrees) unscheduled disability for this injury. On review, the issue is permanent total disability. We reverse in part, modify in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact on pages one through three of his order with the following supplementation.

Three vocational experts testified at hearing. Claimant is employable with training in the clerical field. Claimant is employable without training as a telemarketer and hotel/motel inspector. Both these jobs are gainful and suitable employments. Claimant is motivated to work and has made reasonable efforts to obtain employment.

Claimant is 46 years old with a formal education through the eighth grade. Claimant has obtained a GED. Claimant's prior job history includes one year as an apartment manager and as a meat wrapper for the employer. Most of her adult life claimant has been a homemaker. Claimant has a mildly moderate permanent impairment.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant was permanently and totally disabled because he was more persuaded by the vocational testimony of McNaught over the testimony of vocational expert Gaffui and because the telemarketing and hotel/motel inspectress jobs were "unrealistic and/or nonexistent." We disagree.

The Referee discounted the testimony of Gaffui because "she had not worked for claimant for very long" and because she had less experience as a vocational expert than did the other two experts. While it is true that Gaffui had only worked with claimant for approximately four months, in that time she had substantially more contact with claimant than did McNaught who only met with claimant for 20 minutes. Furthermore, there is nothing in the record to conclude that the length of service as a vocational counselor had any impact on the conclusions expressed by any vocational expert.

Gaffui opined that both the telemarketing job and the hotel/motel room inspectress jobs were gainful and suitable employments for claimant. McNaught disagreed because claimant's physical condition would continue to have recurrent exacerbations, making claimant unreliable to prospective employers. He also opined that telemarketing is a highly person-oriented job which is not appropriate for anxious/depressed people, like claimant. However, McNaught's testimony was expressed in terms of generalities, regarding workers in general, and not that claimant would not be appropriate for these jobs. We are not persuaded by such generalities divorced from the particularities of claimant's condition. Gaffui, on the other hand, had first-hand knowledge that claimant's interpersonal skills were excellent based on contact with persons associated with claimant's social activities. Gaffui's opinion, that the telemarketing job had such a high turnover that jobs would always be available even though claimant had recurrent exacerbations, was unrebutted by any other testimony, including McNaught's. We are more persuaded by Gaffui's opinion both because it was unrebutted in part and because it was based on first-hand knowledge of claimant's interpersonal skills.

Having concluded that claimant is not permanently and totally disabled, we proceed to the permanent partial disability issue.

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).

Considering claimant's prior award of disability and the limited availability of the two identified gainful and suitable jobs, we conclude she has lost an additional 25 percent earning capacity beyond what she has received for the combined effects of this and the prior low back injury. ORS 656.222.

ORDER

The Referee's order, dated October 26, 1988, is reversed in part, affirmed in part and modified in part. That portion which granted permanent total disability benefits is reversed. In addition to the Determination Order award of 20 percent (64 degrees) unscheduled disability, claimant is granted 25 percent (80 degrees) unscheduled disability, for a total award of 75 percent (240 degrees) unscheduled permanent disability for this injury. Claimant's attorney is awarded 25 percent of the additional compensation granted by this order, not to exceed $3,800. The employer is permitted to credit the attorney fee paid pursuant to the Referee's order against the attorney fee awarded herein. The remainder of the Referee's order is affirmed. The Board approves a client-paid fee, not to exceed $1,385, payable by the self-insured employer to its counsel.

In the Matter of the Compensation of
ROBERT L. VELTMAN, Claimant
WCB Case No. 88-05961
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Cummins, et al., Defense Attorneys

Reviewed by Board Members Myers and Gerner.

The insurer requests review of Referee Tenenbaum's order which set aside the insurer's denial of a claim for botulism poisoning. We affirm.

ISSUES

The first issue is whether the insurer has proven prejudice as a result of an allegedly late filing of the claim.

The second issue is whether claimant's botulism was caused by eating beets at the employer's home.

The final issue is whether the dinner at the employer's home was within the course and scope of claimant's employment.

FINDINGS OF FACT

In September 1986, claimant began working for the employer's construction company as a cement finisher. Claimant's regular residence is in Forest Grove but, while he was working for the employer, he shared a bachelor apartment in Redmond with his son, another employee of the employer.

On October 2, 1986, claimant's son and the rest of the crew were working on a project at Boardman. Claimant was the only employee working in Redmond. On that evening, after work, claimant stopped by the employer's home which doubled as the company headquarters to receive his work instructions for the next day. Employees habitually received instructions for the next day's work in the evening at the company headquarters. Because Mr. Sophy, the employer, was tied up on the telephone, he was unable to speak to claimant to give him instructions for the next day's work. Consequently, Mr. Sophy asked claimant to stay for dinner so that he could talk to him about the next day's assignment. Claimant felt that he had some obligation to go to dinner.

Claimant returned to his son's apartment, washed up and then went back to the Sophy home/office. Claimant ate dinner with Mr. and Mrs. Sophy and their seven-year-old twin sons. Claimant was not paid for the time he was at dinner. During dinner, Mr. Sophy explained to claimant that he needed to take the company pickup home with him that night so that he could pick up a load of two-by-fours. He also told claimant about several small jobs which he wanted claimant to do the next day. Claimant and Mr. Sophy agreed that it was better to discuss the next day's work face to face than over the telephone.

During dinner, claimant ate a serving of beets from which he contracted botulism. Claimant was hospitalized for approximately three months due to the effects of the botulism.

Claimant did not file a workers' compensation claim for approximately two years after the botulism poisoning; however, the employer was aware of the botulism poisoning and that it may have been caused by the beets within a few weeks of claimant's eating the beets.

CONCLUSIONS AND OPINION

LATE FILING

A claim may be barred for late filing unless the employer had actual notice of the injury or the insurer has not been prejudiced as a result of the late filing. We agree with the Referee that the employer had notice of this injury. The employer was aware that claimant had possibly gotten sick as a result of eating beets at the employer's house and that there was at least some business purpose for the meal.

Even if the employer did not have sufficient notice, the insurer has failed to produce any evidence of prejudice.

CAUSATION

We adopt the Referee's findings and conclusions on the causation issue. We note that we rely primarily upon the opinion of Dr. Williams that claimant contracted botulism poisoning from the beets because we find his opinion well reasoned and consistent with the facts of the case. There is no evidence in this record, other than early differential diagnoses, that claimant's illness was caused by anything other than botulism and that claimant contracted the botulism from anything other than the beets he consumed over dinner with the employer.

COURSE AND SCOPE

The ultimate inquiry, in determining whether an injury is "an accidental injury...arising out of and in the course of employment," ORS 656.005(7)(a), is whether the relationship between the injury and the employment is sufficient that the injury should be compensable. Rogers v. SAIF, 289 Or 633 (1980). The Court of Appeals has identified seven factors to consider in deciding whether an 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 employe either at the time of hiring or later...;
>
> "c. Whether the activity was an ordinary risk of, and incidental to, the employment...;
>
> "d. Whether the employee was paid for the activity...;
>
> "e. Whether the activity was on the employer's premises...;
>
> "f. Whether the activity was directed by or acquiesced in by the employer...;
>
> "g. Whether the employe was on a personal mission of his own...." Jordan v. Western Electric, 1 Or App 441, 443-4 (1970); quoted with approval, Mellis v. McEwan, Hanna, Gisvold, 74 Or App 571, 574 (1985).

We rely primarily upon claimant's testimony to evaluate each of these factors. The Referee found claimant and Mr. and Mrs. Sophy credible based on demeanor; however, because of inconsistencies between the Sophys' testimony and the record, she found the Sophys not entirely reliable. We agree.

There is no question that the dinner was for the benefit of the employer. The employer invited claimant to dinner because he needed to explain claimant's job assignment for the next day and was unable to do so earlier because he was tied up on the telephone. Certainly, the Sophys also had a social purpose and claimant benefited by not having to eat alone, but the overriding purpose of the meal was to talk business. This factor weighs in favor of a work relationship between the dinner and claimant's employment.

Eating dinner with the employer was not an activity contemplated by the employer or claimant at the time of hiring or later; however, stopping by the employer's home/office after work was contemplated by both during the course of their relationship. This factor weighs equally for and against a relationship between the dinner and claimant's employment.

Eating dinner with the employer is not an ordinary risk of or incidental to claimant's employment as a cement finisher. This factor weighs against a relationship between the dinner and claimant's employment.

Claimant was not paid for the time spent eating dinner. This factor weighs against a relationship between the dinner and the employment.

The dinner took place on the employer's premises. This factor weighs in favor of a relationship between the dinner and the employment.

The employer requested that claimant stay for dinner. At the least, the activity was acquiesed in by the employer. Because claimant felt some pressure to stay for dinner, the employer almost directed claimant to perform the activity. This factor weighs in favor of a relationship between the dinner and the employment.

Finally, claimant was not on a mission of his own. He was at dinner because the employer asked him to stay so that the employer could discuss business with him. This factor weighs in favor of a relationship between the dinner and the employment.

After weighing all these factors, we conclude that there is a sufficient work relationship between claimant's eating the dinner and his employment that the poisoning should be compensable. We are particularly persuaded by the fact that the main purpose for having claimant to dinner was to direct claimant's work activities for the next day.

ORDER

The Referee's order, dated October 13, 1988, is affirmed. Claimant's attorney is awarded an assessed fee of $2,000, to be paid by the insurer. The Board approves a client-paid fee, not to exceed $2,500, to be paid by the insurer to its attorney.

In the Matter of the Compensation of
LARRY L. WAFFORD, Claimant
WCB Case No. 88-06245
ORDER ON REVIEW
Charles G. Duncan, Claimant Attorney
Employers Defense Counsel, Defense Attorneys

Reviewed by Board Members Nichols and Brittingham.

The insurer requests review of Referee Livesley's order that: (1) increased claimant's unscheduled permanent disability award for a low back condition from 10 percent (32 degrees), as awarded by Determination Order, to 35 percent (112 degrees); and (2) awarded claimant 5 percent (7.5 degrees) scheduled permanent disability for loss of use or function of his left leg whereas a Determination Order had awarded none. The issue on review is extent of permanent disability, both scheduled and unscheduled. We modify and reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the exception of the fifth full paragraph on page 2 of the order.

CONCLUSIONS OF LAW AND OPINION

The criteria for rating scheduled disability is the permanent loss of use or function of the injured member due to the industrial injury. ORS 656.214(2). The insurer argues that the medical record does not support the Referee's award of permanent disability for claimant's left leg. None of the medical experts who have treated or evaluated claimant for this injury have found evidence of radiculopathy. Dr. Gambee, the treating physician, feels it would be speculative to relate claimant's leg complaints to his altered gait. Claimant believes that because he had no leg complaints prior to the injury, the existence of such complaints now is sufficient to carry his burden to prove permanent disability in the scheduled area. Lay testimony can be persuasive; however we are unwilling to rely on lay evidence in this matter where claimant's treating doctor finds no neurological problem with the leg, and the remainder of the medical evidence agrees that there is no evidence of radiculopathy as an explanation of claimant's leg complaints. Consequently the Referee's award of scheduled disability should be reversed.

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

Dr. Gambee, the treating physician, noted a loss of extension and flexion in claimant's lumbar spine and felt he would be limited to light to medium level work. Diagnostic tests indicated that the claimant has disc protrusions at L2-3 and bulges at L4-5 and L5-6. There is no evidence however, that this has resulted in any nerve impingement.

Claimant has considerable training and skill in welding and related skills. Claimant has returned to work and still has a significant portion of the labor market available to him. Considering all the factors that affect the

rating of unscheduled disability, we conclude that an award of 25 percent adequately compensates the claimant for his low back injury.

ORDER

The Referee's order dated September 9, 1988 is modified and reversed. The award of scheduled permanent disability granted by the Referee is reversed. In lieu of the Referee's award of unscheduled permanent disability, and in addition to the Determination Order award of 10 percent (32 degrees) unscheduled permanent disability, claimant is awarded 15 percent (48 degrees) unscheduled permanent disability, giving him a total of 25 percent (80 degrees) unscheduled permanent disability for his low back injury. A client-paid fee, not to exceed $210, payable by the insurer to its counsel, is approved.

March 16, 1990 Cite as 42 Van Natta 546 (1990)

In the Matter of the Compensation of
ANITA J. BRONSON (STRATTON), Claimant
WCB Case Nos. 88-00828 & 87-15926
ORDER ON REVIEW
Welch, Bruun & Green, Claimant Attorneys
Todd C. Ainsworth, Defense Attorney
Roberts, et al., Defense Attorneys

Reviewed by Board Members Myers and Gerner.

AIAC requests review of those portions of Referee Mulder's order which: (1) set aside its denial of claimant's "new injury" claim for a low back condition; (2) upheld Industrial Indemnity's denial of claimant's aggravation claim for the same condition, and; (3) awarded claimant's counsel an assessed attorney fee, payable by AIAC. On review, the issues are responsibility and attorney fees. We affirm.

FINDINGS OF FACT

Claimant sustained a compensable low back and cervical injury in May 1979, while employed by Industrial Indemnity's insured. The claim was closed by an October 1979 Determination Order which awarded temporary disability benefits only. Claimant returned to her work as a warehouse person, but continued to experience some symptoms referrable to her low back. Claimant went to work for another employer in December 1980.

In late 1984, claimant sought treatment from Dr. Urban, chiropractor, for pain symptoms in her back and neck. She filed an aggravation claim with Industrial Indemnity and a new injury claim with her new employer. Both carrier's denied claimant's claims. She began working for another employer in 1985, and that employer also denied claimant's condition. In March 1986, an earlier Referee found that Industrial Indemnity remained responsible for claimant's back condition and recommended that her claim be reopened under the Board's Own Motion jurisdiction.

In June 1987, claimant began working for AIAC's insured as a warehouse person.

In July 1987, the Board affirmed the Referee's order and directed Industrial Indemnity to reopen claimant's claim under its Own Motion jurisdiction. Thereafter, on reconsideration, the Board awarded temporary disability benefits and 10 percent unscheduled permanent disability.

On July 7, 1987, claimant filed a claim against AIAC, asserting a low back injury that occurred while she was lifting miscellaneous parts. A July 21, 1987 MRI scan revealed a posterior herniation of the L5-S1 disc. In October 1987, AIAC denied responsibility for claimant's low back condition. In December 1987, claimant petitioned the Board for Own Motion relief. In January 1988, Industrial Indemnity denied responsibility for claimant's current low back condition on the basis that it was not related to the 1979 compensable injury.

In January 1988, a ".307 order" was requested, however no such order was issued due to the fact that claimant's claim against Industrial Indemnity was in Own Motion status.

FINDINGS OF ULTIMATE FACT

The July 1987 incident, while claimant was employed by AIAC's insured, independently contributed to a worsening of her underlying back condition.

CONCLUSIONS OF LAW AND OPINION

Responsibility

The Referee concluded that claimant sustained a "new injury" while employed by AIAC's insured. We agree.

In Hensel Phelps Construction v. Mirich, 81 Or App 290, 294 (1986), the court held that if work activities at the later employer/insurer independently contribute to the worker's disability (i.e., causes a worsening of the underlying condition) then the second employer/insurer is responsible for the worsening. The first employer/insurer remains responsible if a work incident at the second employer/insurer takes the form of a recurrence of the first and the second incident did not contribute to the causation of the disabling condition. Boise Cascade Corp. v. Starbuck, 296 Or 238, 244 (1984).

Dr. Urban, who has treated claimant since 1984, opined that the July 1987 lifting incident materially worsened claimant's underlying back condition. He reported that a subsequent MRI scan revealed a herniated disc and that claimant was experiencing new symptoms including radicular leg pain, blood in the stool, and constipation, which he attributed to claimant's repetitive lifting on July 11, 1987. He further reported that prior to the incident she had impairment in the mild to moderate range, but following the incident, her impairment was in the moderate range.

Dr. Duncan opined that the x-rays and MRI scan indicated that the July 1987 incident was a "new injury" in that it materially worsened claimant's underlying condition. In conjunction with Dr. Duncan's opinion, Dr. Samuel opined that the July 1987 incident had produced a significant worsening which increased claimant's impairment level.

Conversely, Dr. Cottrell, opined that claimant did not have a herniated disc, but did have a bulging disc. He related this to claimant's weight and lordosis and felt her current symptoms were a progression of the 1979 compensable injury. Dr. Thompson originally opined that the 1987 incident independently contributed to a worsening of claimant's condition and caused the disc bulge. However, he later opined that the worsening was only symptomatic and that the disc bulge was probably caused by work activities between 1983 and 1987. Finally, Dr. Hazel concurred in a letter from AIAC's counsel which stated that claimant had only experienced a symptomatic worsening.

Claimant credibly testified that following the July 1987 incident she experienced substantially increased pain. A few days following the incident she began noticing a tingling sensation in her legs and then her legs went out from underneath her. She credibly testified that she had never experienced the tingling and numbness sensations in her legs and had never had her legs go out from underneath her prior to the July 1987 incident.

In the absence of persuasive reasons to do otherwise, we generally accord greater weight to the opinion of a worker's treating physician. Weiland v. SAIF, 64 Or App 810, 814 (1983).

Here, we are persuaded by the opinion of Dr. Urban and the supporting opinions of Drs. Duncan and Samuel. Dr. Cottrell does not persuasively explain how claimant's condition is a continuation of the 1979 injury, particularly in light of the fact that she was able to work and sought no treatment until 1984. Likewise, Dr. Thompson does not adequately explain his change in opinion. Conversely, Dr. Urban has treated claimant since 1984 and was treating claimant both before and after the July 1987 incident. See Kienow Foods v. Lyster, 79 Or App 416, 421 (1986). Further, his opinion is supported by Dr. Talbot's interpretation of the MRI scan and claimant's credible testimony. Under these circumstances, AIAC is responsible for claimant's current back condition.

Attorney Fees

We adopt the Referee's conclusions and reasoning concerning the attorney fee issue with the following supplementation.

In the instant case, both AIAC and Industrial Indemnity denied responsibility only. Despite this, an order pursuant to ORS 656.307 could not be issued as claimant's claim against Industrial Indemnity was in Own Motion status. At hearing, and on review, claimant has actively taken the position that AIAC is responsible. Under these circumstances, the Referee correctly awarded claimant's counsel an assessed fee payable by AIAC, the responsible carrier. See Mercer Industries v. Rose, 100 Or App 252 (1990).

ORDER

The Referee's order, dated July 6, 1988, is affirmed. For services on Board review concerning the responsibility issue, claimant's counsel is awarded a reasonable assessed fee of $700, payable by AIAC. A client-paid fee, not to exceed $1,532.50, payable by AIAC to its counsel, is approved.

March 16, 1990 Cite as 42 Van Natta 548 (1990)

In the Matter of the Compensation of
ROSS E. COWAN, Claimant
WCB Case Nos. 86-18095, 87-14187, 87-17285 & 87-17286
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Alice Bartelt, Defense Attorney

Reviewed by Board Members Crider and Brittingham.

Travelers Indemnity Company requests review of those portions of Referee Mirassou's order that: (1) set aside its denial of claimant's occupational disease claim for post-polio syndrome; and (2) upheld Pacific Northwest Bell's (PNB) denial of claimant's aggravation claim for the same condition. In his brief, claimant requests review of that portion of the order that directed PNB

to pay interim compensation from July 21, 1987 through August 31, 1987. On review, the issues are compensability and interim compensation. We affirm in part and modify in part.

The Board adopts the Referee's findings of fact and ultimate fact, and affirms and adopts the Referee's compensability ruling.

The Board modifies the Referee's award of interim compensation. The insurer has a duty to start paying interim compensation no later than 14 days after the filing of a claim. Once the duty arises, the insurer must pay interim compensation retroactive to the date the insurer received notice of the claim, which in this case is July 7, 1987. Roger C. Prusak, 40 Van Natta 2037 (1988). Accordingly, we modify the Referee's order and award additional interim compensation through that date.

ORDER

The Referee's order is affirmed in part and modified in part. In addition to the Referee's award of temporary disability compensation from July 21, 1987 through August 31, 1987, claimant is awarded interim compensation from July 7, 1987 through July 20, 1987. The remainder of the order is affirmed. Claimant's attorney is awarded an approved fee in the amount of 25 percent of the increased compensation created by this order, provided that the total approved fee between the Referee and Board order does not exceed $3,800, payable by Travelers Indemnity Company directly to claimant's attorney. For services on review regarding the compensability issue, the Board awards claimant's attorney a $700 assessed fee, payable by Travelers.

March 16, 1990 Cite as 42 Van Natta 549 (1990)

In the Matter of the Compensation of
DOLORES P. HOFFMAN, Claimant
WCB Case No. 88-08475
INTERIM ORDER (REMANDING)
Mundorff et al., Claimant Attorneys
Thomas Sheridan (Saif), Defense Attorney

The SAIF Corporation requests review of Referee Knapp's order that excluded Exhibit 17 and set aside its denial of claimant's claim for a right hand condition. On review, the issues are evidence and compensability. We reverse on the evidentiary issue and remand.

FINDINGS OF FACT

This case was initially scheduled for hearing in May, 1988. It was reset for August 16, 1988.

SAIF submitted its Exhibits 1-16 in advance of hearing.

At hearing, SAIF submitted an additional exhibit, a report by Dr. Charles D. Layman. It was marked Exhibit 17. The report was authored August 15, 1988 and received by SAIF on August 16, 1988. It had not been disclosed to claimant prior to hearing.

Claimant objected to its receipt on the grounds that there was not good cause for SAIF's failure to obtain and disclose the report at an earlier time. The Referee agreed and excluded the exhibit.

FINDINGS OF ULTIMATE FACT

SAIF disclosed Dr. Layman's report to claimant within seven days of receiving it.

CONCLUSIONS OF LAW AND OPINION

SAIF contends that the Board rules required the referee to admit any document that has been timely disclosed under the rules without regard to questions of diligence and good cause. We agree.

OAR 438-07-018(1) requires the insurer 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 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.

Dr. Layman's report was timely disclosed; therefore, it should have been admitted. Therefore, this case has been "improperly, incompletely or otherwise insufficiently developed." We remand to the Referee. On remand, Exhibit 17 shall be admitted. In addition, the Referee shall allow claimant time to cross-examine or rebut the late-produced evidence.

The Board retains jurisdiction over this matter. After further development of the record, the Referee is directed to issue an Order on Remand discussing the effect, if any, the new evidence would have had on his prior order. Inasmuch as we retain jurisdiction, the Referee's order shall be advisory only and shall have no effect upon the Referee's Opinion and Order. Upon receipt of the Referee's Order on Remand, the Board shall take this matter under advisement.

IT IS SO ORDERED.

March 16, 1990 Cite as 42 Van Natta 550 (1990)

In the Matter of the Compensation of
KARLA H. RICHARDSON, Claimant
WCB Case Nos. 88-06441 & 88-00151
ORDER ON REVIEW
Andrew H. Josephson, Claimant Attorney
Rankin, et al., Defense Attorneys

Reviewed by Board Members Brittingham and Crider.

Claimant requests review of that portion of Referee St. Martin's order that: (1) upheld the self-insured employer's amended denial of more than two chiropractic treatments per month for claimant's low back condition; and (2) awarded 15 percent (48 degrees) unscheduled permanent partial disability for the

back, whereas a Determination Order had awarded none. On review, the issues are medical services and extent of unscheduled permanent disability. We affirm.

FINDINGS OF FACT

Claimant, a word processor, compensably injured her back when she fell backward in a chair on May 7, 1986. Claimant suffered a strain injury characterized by spasms. She was referred to physical therapy. She was released to work one week after the injury but had difficulty tolerating even light work. She was due to have a baby in mid-July, so she remained off work for the duration of the pregnancy.

In November, claimant was again released to work and again encountered difficulties. Her physician continued to encourage her to work at least part time. She was advised to get exercise and to lose weight. She was released to regular work on February 16, 1987. Her claim was closed without permanent disability by Determination Order dated February 18, 1987.

Shortly thereafter, the claim was again reopened and claimant advised to work part time. Claimant sought treatment from Dr. Apple, D.C. She treated with him two or three times per week.

On December 8, 1987, the employer denied further chiropractic care. However, on April 22, 1988, that denial was replaced by a denial of treatment which had been rendered in excess of two treatments per month. When the December denial issued, claimant limited treatment to two per month.

The claim was reclosed by Determination Order on April 22, 1988. No permanent disability was awarded.

Claimant suffers mild impairment due to continued neck and low back pain, and minimal loss of range of motion related to the compensable injury. She has no neurological deficit. She is able to perform full time work although she believes that she cannot. Pain limits her ability to lift in excess of 20 pounds, to bend or twist, and to work continuously without an opportunity to change positions.

Claimant was 32 years old at hearing. She has graduated from high school and has two years of community college work in word processing-related skills. She has been employed as a clerical worker, a bus driver, a child care worker and a cashier.

Chiropractic care has provided some pain relief; but it has not improved her condition over time. Relief is partial only and lasts approximately three days. It does not bring claimant to the point that she believes that she can work a full day.

FINDINGS OF ULTIMATE FACT

Claimant has lost 15 percent of her earning capacity due to the compensable injury.

Treatment in excess of two times per month was not reasonable and necessary.

CONCLUSIONS OF LAW AND OPINION

Extent of Unscheduled Permanent Disability

Claimant contends that she is entitled to greater permanent partial disability than that awarded by the Referee. We disagree.

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 persuasive medical and lay evidence of physical impairment resulting from the compensable injury as well as social and vocational factors including those set forth in OAR 436-30-380 et seq.

Dr. Tilson, M.D., who treated claimant until August, 1987, recognized that claimant was experiencing back pain but believed that, in the absence of neurological findings, she could return to full time work of the type she performed before the injury. He recommends that she be given an opportunity to change positions frequently to reduce pain.

The Western Medical Consultants, who examined her after she became medically stationary, reported that claimant suffers neck and back pain, but also found no neurological deficit and only minimal impairment based on loss of range of motion. They too believed claimant could work full time in her prior position.

We are persuaded that claimant's pain as well as her minimal loss of range of motion limit her ability to function. Nevertheless, we believe that she is able to perform, at a minimum, a full day's light work provided she has an opportunity to move around.

We give less weight to the opinion of Dr. Apple, chiropractor, to whom she transferred her care in August 1987. We do so because he has opined that claimant is permanently restricted to working two hours at one time sitting, one hour at one time standing and one hour at one time walking for a total of four hours per day. In light of Dr. Tilson's report that frequent opportunities to move around will increase claimant's ability to work, it is unlikely that she is actually limited to only four hours per day. Dr. Apple also limited her to occasional bending and no twisting. Such limitations probably reflect her subjective pain, but there is no evidence that reasonable limitations preclude her from doing light work.

Claimant also relies on the report of Dr. Whitton, D.C., who examined claimant for Dr. Apple, for her contention that she is more than 15 percent disabled. The reliance is misplaced, for although Dr. Whitton found claimant mildly moderately impaired, he attributed 80 percent of her impairment to degenerative joint disease. We conclude that he, like Dr. Tilson and the Western Medical Consultants, would find claimant very modestly impaired due to the compensable injury.

While claimant believes that she is very significantly disabled, it appears that she suffered a fairly minor injury. She testified to limitations that are far in excess of those imposed even by Dr. Apple. We conclude that she does suffer pain but we place limited weight on the extent of that reported pain and, instead, place primary reliance on the medical reports.

Claimant's work experience and education set her in relatively good stead to find light work. Therefore, we concur in the Referee's evaluation of the extent of claimant's disability.

Medical Services

Claimant contends that, contrary to the Referee's conclusions, treatment in excess of twice per month is reasonable and necessary. We disagree.

Dr. Apple has reported that claimant needs treatment on a once per week basis in order to prevent degeneration and to keep claimant employed. However, claimant suffered a strain injury, and there is nothing in the record which suggests that it is of a type that is likely to degenerate. Moreover, claimant reports receiving only minimal and transitory relief. Ex. 68-5, Tr. 27. Although she says that her productivity declined when she reduced her frequency of treatment, she has continued to work four hours per day essentially since she returned to work after the birth of her child, and has never worked more without regard to the type or level of treatment she has received.

In light of the lack of any improvement in claimant's condition with treatment and the relatively minor degree of relief she experiences from it, we rely on the opinion of the Western Medical Consultants and find that treatment in excess of twice per month is not reasonable and necessary.

ORDER

The Referee's order dated September 23, 1988, is affirmed. A client-paid fee, not to exceed $943.50, payable by the self-insured employer to its counsel, is approved.

March 20, 1990 Cite as 42 Van Natta 553 (1990)

In the Matter of the Compensation of
JASON L. BAIL, Claimant
WCB Case No. 87-15445
ORDER ON RECONSIDERATION
Olson, et al., Claimant Attorneys
Terrall & Miller, Defense Attorneys

The self-insured employer has requested reconsideration of those portions of our December 8, 1989 Order on Review that: (1) directed the employer to pay temporary disability benefits awarded by Determination Order; and (2) assessed a penalty and associated attorney fee for the employer's alleged unreasonable failure to pay such benefits. We abated our order on January 4, 1990 in order to allow the parties additional time to submit argument on the issues raised by the employer's motion. Having received and considered the parties' submissions, we proceed with our reconsideration.

Pursuant to a November 27, 1987 Determination Order, the employer was directed to pay temporary partial disability benefits to claimant for the period July 28, 1986 through September 10, 1987. Relying upon claimant's job termination on August 8, 1986 for reasons unrelated to his injury, the employer did not pay any temporary disability benefits to claimant for the period from August 8, 1986 through September 10, 1987. Citing Georgia-Pacific v. Piwowar, 305 Or 494 (1988), we found that the employer should have paid temporary disability benefits pursuant to the Determination Order pending a hearing on entitlement to those benefits. We concluded that claimant was procedurally entitled to such benefits. However, we further concluded that claimant was not substantively entitled to the benefits because he was away from work after August 7, 1986 as a result of his job termination rather than because of his compensable injury. Accordingly, we directed the employer to pay the benefits in question, then allowed the employer an offset of that amount against future awards of permanent disability.

The employer contends that a distinction exists between awards of temporary total disability and temporary partial disability. The employer apparently concedes that if the November 27, 1987 Determination Order had

awarded temporary total disability benefits, then the employer would have been required to pay those benefits pending a hearing. However, the employer argues that, under the facts here, it was not obligated to pay any temporary partial disability benefits pursuant to the Determination Order. Claimant, on the other hand, contends that the employer is impermissibly interjecting the question of substantive entitlement to benefits into a solely procedural matter.

We agree with the employer. Claimant returned to modified work with no reduction in wages following his compensable injury. Claimant subsequently left work for reasons unrelated to his compensable injury. In accordance with Safeway Stores v. Owsley, 91 Or App 478 (1988), the amount of temporary partial disability compensation to which he was entitled was zero. Therefore, while the employer was required to calculate and pay temporary partial disability benefits awarded by the November 27, 1987 Determination Order, those calculations result in an amount owing of zero. In light of our decision, we conclude that assessment of a penalty and award of associated attorney fees was not appropriate.

Accordingly, we vacate those portions of our order that directed the employer to pay temporary disability benefits to claimant for the period on and after August 8, 1986 and that awarded a penalty and related attorney fee. On reconsideration, as amended, we adhere to and republish our December 8, 1989 order in its entirety. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

March 20, 1990 Cite as 42 Van Natta 554 (1990)

In the Matter of the Compensation of
JOE O. REID, Claimant
WCB Case No. 88-08768
ORDER ON REVIEW
Peter O. Hansen, Claimant Attorney
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Crider and Brittingham.

Claimant requests review of Referee Podnar's order that: (1) awarded claimant temporary total disability for the period January 15, 1988 through April 4, 1988 but did not for the period April 5, 1988 through August 17, 1988; and (2) declined to assess a penalty and attorney fee for unreasonable failure to pay temporary total disability compensation. On review, the issues are temporary total disability, and penalties and attorney fees. No briefs were submitted on review. We reverse.

FINDINGS OF FACT

Claimant worked as a transport driver for the employer. During the time that claimant worked for the employer, he also operated a limousine service for which he employed drivers. He left work for the employer on August 14, 1987 due to a compensable mental disorder.

The occupational disease claim was initially denied. After hearing, Referee Mulder issued an Opinion and Order, dated February 29, 1988, setting aside the denial and ordering the employer to provide benefits in accordance with law. The order was affirmed by final order of the Board. Joseph O. Reid, 40 Van Natta 1633 (1988).

On March 14, 1988, the 14th day after the issuance of the Opinion and Order, the employer's claims representative wrote a letter to claimant that advised him that due to his income from the limousine service, he was entitled to temporary partial disability benefits only; she requested that he produce his "tax statements" for 1987. The representative received a response on March 17, 1988. The response consisted of a list of the fares collected by the limousine service during 1987; claimant indicated that the list was the only information he had; he provided the representative with his telephone number.

The claims representative made no further contact with claimant. She simply forwarded the correspondence to the adjuster's attorney. Claimant contacted the representative by telephone on several occasions, but she declined to discuss the matter of his temporary disability compensation. On May 9, 1988, claimant's attorney wrote to the adjuster's attorney to advise him that claimant had already provided the representative with the only information that related to his income. He asked that compensation be paid. No temporary disability compensation was paid.

Claimant earned no income from the limousine service or any other source from January 19 through August 16, 1988. On August 17, 1988, he returned to work.

On April 4, 1988, claimant attended an independent medical examination conducted by Dr. Turco. Turco examined claimant, took a history and concluded that claimant was psychiatrically stationary and capable of working on a regular basis.

FINDINGS OF ULTIMATE FACT

Dr. Turco was not claimant's attending physician. Claimant was not released to work by his attending physician on April 4, 1988.

The employer, through its claims adjuster, unreasonably delayed and refused to pay temporary disability compensation. This refusal was a resistance to payment of compensation.

CONCLUSIONS OF LAW AND OPINION

At hearing, claimant sought an award of temporary disability compensation for the period January 19 through August 17, 1988, and penalties and attorney fees.

Temporary Total Disability Compensation

The Referee awarded claimant temporary total disability compensation only through April 4, 1988 on the ground that "Turco's report satisfies the requirements of Fazzolari v. United Beer Distributors, 91 Or App 592 (1988)." We disagree and award additional temporary total disability through August 16, 1988.

An employer must pay a worker temporary disability from the day he leaves work due to the compensable injury until the claim is closed by the Department of Insurance and Finance unless claimant has become medically stationary, and his return to regular employment has been approved by the attending physician. ORS 656.268(1) and (2)(c). See also, Fazzolari v. United Beer Distibutors, 91 Or App 592 (1988) (construing former ORS 656.268). As Dr. Turco was not the attending physician, the employer was not procedurally entitled to cease paying compensation when Dr. Turco opined that claimant was able to return to work.

Furthermore, we decline to determine whether or not claimant was actually able to work after April 4, 1988, and thus was not substantively entitled to compensation. The question of substantive entitlement is more appropriately decided first upon closure of the claim. See Ralph E. Moen, 41 Van Natta 1231 (1989). Nevertheless, because claimant seeks an award of compensation only until he was reemployed on August 17, 1988, we shall not order payment beyond

that date. Beyond that point, the employer should be guided in the processing of this claim by the statute and the rules, not by this order.

Penalties and Attorney Fees

The Referee declined to assess penalties and attorney fees for the employer's failure to pay temporary disability compensation, apparently finding that the employer's conduct was not unreasonable. The Referee relied on the view that the employer had every reason to believe that claimant was earning income from the limousine business that should be deducted from his temporary disability benefits. We, on the other hand, find that the employer's conduct was unreasonable.

The employer is required to pay temporary disability compensation within 14 days of a referee's order finding a claim compensable. OAR 436-60-150(3)(e). It is further the employer's duty to calculate the amount of benefits. Although a claimant must cooperate with the insurer's efforts to gather information to make the calculation, even a claimant's refusal to cooperate does not entitle the employer to unilaterally withhold benefits. Only the Director may suspend benefits for failure to cooperate. Austin v. Consolidated Freightways, 74 Or App 1327 (1985). Even if we had found that claimant refused to cooperate, we, therefore, would find the employer's failure to pay pending investigation impermissible.

In any event, it does not appear that in this case claimant failed to cooperate with a reasonable investigation of facts relevant to calculation of compensation. He apparently did try to cooperate. He gave the claims representative the information most analogous to what he understood the less than unambiguous term "tax statements" to mean. He attempted to talk to the claims representative. If she had talked to claimant, she might have asked him such relevant questions as whether or not he had earned any wages since leaving work for the employer. She apparently did not.

In sum, the employer unreasonably refused to pay compensation. We assess a penalty of 25 percent of the compensation due under this order. The same conduct constituted an unreasonable resistance to the payment of compensation. Consequently, claimant's counsel is statutorily entitled to a reasonable, insurer-paid attorney fee for services in connection with the failure to pay compensation. 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 22, 1988, is affirmed in part, modified in part and reversed in part. In addition to the temporary total disability awarded by the Referee's order, claimant is awarded temporary total disability benefits from April 5, 1988 through August 16, 1988. Claimant is also awarded a penalty of 25 percent of the compensation due for the period January 19, 1988 through August 16, 1988. The remainder of the Referee's order is affirmed. Claimant's attorney is awarded 25 percent of the increased compensation created by this order, payable by the employer directly to claimant's attorney. However, the total out-of-compensation attorney fees awarded by the Referee and Board orders shall not exceed $3,000. The Board approves a client-paid fee, not to exceed $240, payable by the employer to its attorney.

In the Matter of the Compensation of
WAYNE E. WILLIAMS, Claimant
Own Motion No. 89-0735M
OWN MOTION ORDER
Baldwin & Brischetto, Claimant Attorneys
SAIF Legal Department, Defense Attorney

The SAIF Corporation requests that the Board exercise its own motion jurisdiction to modify the portion of the Board's November 29, 1988, Order on Review that set aside the Determination Order issued on August 7, 1981. We decline to do so.

Beginning January 1, 1988, the Board's own motion authority to "modify, change or terminate former findings, orders or awards" under ORS 656.278(1) is limited to those cases in which:

> "(1) There is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. In such cases, the board may authorize the payment of temporary disability compensation from the time the worker is actually hospitalized or undergoes outpatient surgery until the worker's condition becomes medically stationary, as determined by the board; or
> "(2) The date of injury is earlier than January 1, 1966. In such cases, in addition to the payment of temporary disability compensation, the board may authorize payment of medical benefits."

Here, claimant's industrial injury occurred after January 1, 1966, and therefore does not qualify for relief under paragraph (2) above. Additionally, there is no evidence that claimant's 1981 injury has worsened so as to qualify for relief under paragraph (1). In any event, even if one of the above conditions had been satisfied, the Board's own motion authority under ORS 656.278(1) is now limited to authorizing payment of temporary disability or medical benefits; it does not extend to reinstating a prior Determination Order that has been set aside by Board order.

Finally, our own motion authority has never been appropriately exercised to correct an alleged error that could have been addressed by direct appeal. Arlene T. Fulkerson, 41 Van Natta 55 (1989); Robert S. Neeland, 40 Van Natta 52 (1988); Harley J. Gordineer, 39 Van Natta 1407 (1987). SAIF did not appeal the November 29, 1988 order on review. It may not reargue the issues pursuant to our own motion jurisdiction.

Accordingly, the Board lacks the authority under ORS 656.278(1) to grant own motion relief in this case. SAIF's request for own motion relief is denied.

IT IS SO ORDERED.

In the Matter of the Compensation of
TOMMY L. BROWN, Claimant
WCB Case No. 87-09828
ORDER ON REVIEW
Charles Robinowitz, Claimant Attorney
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Cushing and Gerner.

Claimant requests review of those portions of Referee Davis's order which: (1) found that a physician's letter did not constitute an aggravation claim; and (2) declined to award interim compensation and assess penalties and attorney fees for the self-insured employer's failure to process the aforementioned letter as an aggravation claim. The employer cross-requests review of those portions of the Referee's order which: (1) increased claimant's scheduled permanent disability award for loss of use or function of the left leg (knee) from 30 percent (45 degrees), as awarded by a prior Determination Order, to 40 percent (60 degrees); and (2) affirmed the Determination Order award of temporary disability and a medically stationary date finding. On review, the issues are interim compensation, aggravation, medically stationary date, scheduled permanent disability, penalties and attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

Claimant worked in a paper recycling operation for the employer. On February 1, 1980, he jumped from a baler machine and injured his left knee.

Dr. Berselli, claimant's treating surgeon, performed a left knee arthroscopy in 1981. Thereafter, claimant developed a post operative wound infection that required an open surgical procedure.

A Determination Order of August 31, 1984, awarded 30 percent scheduled permanent disability for loss of the left leg (knee).

On February 6, 1986, claimant began working as a repair technician for another employer, a cable company. This employment ended in April 1986.

On June 5, 1986, Dr. Berselli performed another left knee arthroscopy. Scarring along the the medial aspect of the patella and medial femoral condyle was detected. In October 1986, Dr. Moore, surgeon, became claimant's treating physician.

On January 23, 1987, claimant was examined by Dr. Grossenbacher, orthopedist. Claimant reported persistent swelling of the knee, and that his knee would "let him down". (Ex. 22-1). He continued to experience knee pain, and walked with the assistance of a cane.

On January 25, 1987, Dr. Grossenbacher found claimant medically stationary based on objective findings of previous reports, noting that claimant experienced persistent subjective complaints and continuing knee pain. On February 16, 1987, a handwritten chartnote by Dr. Klubert, M.D., indicated that claimant was discharged from physical therapy because of lack of progress and poor compliance.

A Determination Order of March 27, 1987, granted additional temporary benefits, but no additional award for permanent disability. The medically stationary date was set at February 16, 1987.

On July 19, 1987, while attending an auto race, claimant's knee gave out, causing him to fall into some gravel. Claimant suffered deep abrasions to the left knee.

Claimant wore an immobilizer knee brace for approximately two and one-half months after the July 19, 1987 incident. The brace had iron rods running up the side, which prevented claimant from bending his left knee.

By letter dated August 13, 1987, Dr. Moore informed the employer that claimant was limited to bench work due to an injury on July 19, 1987. After the July 1987 incident, claimant's range of motion was limited to only a right angle for flexion and 180 degree of extension. Moore also indicated that after the administration of medication, claimant would return to his pre-July 1987 injury status.

On August 25, 1987, the employer informed claimant that medical billings related to the fall would be paid, but that he was not eligible for temporary disability since he was not employed at the time of the fall. The employer did not issue a denial advising claimant of his right to request a hearing.

In October 1987, claimant began working as an "on call" airport custodian.

As a result of the compensable injury, claimant has suffered a 40 percent loss of use and function of his left leg (knee).

CONCLUSIONS OF LAW AND OPINION

Medically Stationary Date

Concluding that claimant was medically stationary on February 16, 1987, the Referee affirmed the Determination Order finding on this issue. We find that claimant was medically stationary on January 20, 1987. Therefore, we reverse.

An injured worker will be considered medically stationary when no further material improvement of the compensable condition would reasonably be expected from medical treatment, or the passage of time. ORS 656.005(17). The term "medically stationary," however, does not mean that there is a lack of need for continuing medical care. Maarefi v. SAIF, 69 Or App 527, 531 (1984). 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).

On January 20, 1987, Dr. Grossenbacher, orthopedist, examined claimant. Finding that further operative procedures were not necessary, and that any further surgery would encourage an already existing pain/disuse cycle, Grossenbacher opined that claimant was medically stationary. This opinion was based on objective findings of previous operative reports, as well as subjective complaints, and persistent pain in the knee area. (Ex. 22-2).

Dr. Berselli was unwilling to point to a specific date when claimant would be medically stationary. Yet, he indicated that claimant would be able to do a sedentary job approximately three months after the June 1986 surgery, which would be early September 1986. Berselli was concerned that claimant might have to undergo further knee surgery. We find this concern unpersuasive because a possible future worsening is irrelevant to the determination of the medically stationary date. Moreover, Dr. Berselli predicted that claimant would be medically stationary three months from the June 1986 operation. This prediction supports Grossenbacher's January 20, 1987 medically stationary date.

Likewise, Dr. Moore concurred with Dr. Grossenbacher's opinion to the extent he felt that claimant was approaching a medically stationary date. Concerned by the likelihood of future problems, Moore did not consider claimant's condition to be medically stationary. Yet, as previously discussed, such concerns do not have a bearing on claimant's current medically stationary date.

Here, we are persuaded that claimant was medically stationary on January 20, 1987, instead of February 16, 1987. Evidence of claimant's medical progress indicates that on January 20, 1987, he had reached a point where no significant change in his condition could be expected. The only other contrary evidence is from a chartnote signed by Dr. Klubert, to the effect that claimant was not taking physical therapy as of February 16, 1987, and that the physical therapist was prepared to discharge him. Inasmuch as this note is conclusory and does not discuss the relevant issue of whether claimant's condition is medically stationary, we find it unpersuasive. Accordingly, we find claimant medically stationary as of January 20, 1987.

Aggravation Claim

The Referee found that claimant had not made a valid claim for aggravation. We disagree.

ORS 656.273(3) provides: "A physician's report indicating a need for further medical services or additional compensation is a claim for aggravation." By letter dated August 13, 1987, Dr. Moore informed the employer that claimant was limited to bench work due to an injury on July 19, 1987. Moore also indicated that after the administration of medication, claimant would return to his pre-July 1987 injury status.

In our view, Dr. Moore's letter of August 13, 1987, was an aggravation claim. It informed the employer that claimant needed further treatment for an injury suffered when his knee buckled, causing a fall onto gravel. As a result, claimant's movement was more limited than prior to the July 19, 1987 incident. See Krajacic v. Blazing Orchards, 84 Or App 127 (1987).

We proceed to the merits of the aggravation claim.

In order to establish a compensable aggravation, claimant must prove a worsened condition resulting from a compensable condition. ORS 656.273(1); Perry v. SAIF, 307 Or 654 (1989). To prove a worsening of a scheduled body part, claimant must show that he has experienced increased loss of use or function of his left leg since the last award of compensation, the March 1987 Determination Order. See International Paper Co. v. Turner, 304 Or 354 (1988). The increased loss of use or function must be greater than any future periods of increased disability, that is increased loss of use or function, contemplated by the last arrangement of compensation. Edward D. Lucas, 41 Van Natta 2272 (1989).

Dr. Berselli was claimant's treating physician from August 1981 until September 1986. Thereafter, Dr. Moore, M.D., became claimant's treating physician. He examined claimant on July 20, 1987, the day after the incident, and found fluid on the knee. Moore found claimant's range of motion was limited to a right angle for flexion and 180 degree extension. He prescribed inflammation medication and antibiotics. Moore also indicated that claimant was wearing a knee brace. The emergency room had given claimant an immobilizer knee brace. He used the brace for the next two and one-half months. The brace had iron rods running up the side, which prevented claimant from bending his left leg.

Dr. Moore examined claimant again on August 13, 1987, and opined that claimant was currently unable to do anything but bench work because of the knee. Moore suspected that claimant would probably be in that category for another four to eight weeks. Moore also predicted that claimant's knee would return to its preaggravation status, which included limitations concerning heavy labor, walking long distances, squatting, or lifting. These reports are persuasive that claimant suffered a symptomatic exacerbation of his compensable condition.

Prior to the March 27, 1987 Determination Order, Dr. Berselli noted claimant's symptoms and restricted him to sedentary work. (Ex. 19-18). On January 27, 1987, Dr. Grossenbacher, reported that future surgery for claimant was a possibility. On March 12, 1987, Dr. Moore reported that claimant continued to have swelling about the joint and obvious atrophy, and that he would undergo further arthritic changes in the knee joint. These reports persuade us that future symptomatic flare-ups were contemplated at the time of the last award of compensation.

Following the July 19, 1987 race track incident, Dr. Moore restricted claimant to bench work. He found there was fluid in the joint, pain on resistance, as well as abrasions over the knee. (Ex. 27). Moore also noted that claimant's range of motion was limited to only a right angle for flexion, and 180 degrees of extension. Prescribing anti-inflammatory medications and acknowledging claimant's use of a knee brace, Moore opined that claimant's reduced use or function of the left leg (knee) would last for a period of four to eight weeks. Id. On this record, we are persuaded that the duration and extent of claimant's diminished loss of use or function exceeded that associated with his prior and future contemplated exacerbations of his left leg (knee) condition.

Accordingly, we conclude that claimant has sustained a compensable aggravation of his left leg (knee) condition.

Interim Compensation, Penalty, and Attorney Fees

Entitlement to interim compensation in the form of temporary disability depends on whether, before the denial of an aggravation claim, there has been a medical verification of claimant's inability to work as a result of a worsening of the compensable injury. ORS 656.273(6); Berkey v. Fairview Hospital, 94 Or App 28, 31 (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).

In the instant case, claimant must show that he has a medically verified inability to work. By letter dated August 13, 1987, Dr. Moore opined that claimant had been able to do bench work dating back to the July 19, 1987 incident. There is insufficient medical evidence showing that claimant was unable to work following the July 1987 incident. Under these circumstances, we conclude that the employer was not provided with medical verification of claimant's inability to work due to a worsening of his condition.

Unreasonable failure to timely accept or deny a claim may result in the assessment of a penalty and related attorney fee. ORS 656.262(10). The Referee concluded in this regard that the employer had not been presented with a valid aggravation claim, hence there was no need to issue a formal denial regarding the claim. As previously discussed, we have concluded that an aggravation claim

was submitted to the employer. However, considering the circumstances surrounding the submission of Dr. Moore's report and the contents of that report (the reference to the off-the-job fall), we do not consider the employer's conduct to have been unreasonable. Accordingly, no penalty or attorney fee shall be assessed.

Extent of Permanent Disability

We adopt the Referee's conclusions of law and opinion regarding permanent disability benefits.

ORDER

The Referee's order, dated April 27, 1988, is affirmed in part, and reversed in part. The March 27, 1987 Determination Order is modified to find that the medically stationary date is January 20, 1987, rather than February 16, 1987. The self-insured employer is authorized to recover overpaid temporary disability benefits paid between January 20, 1987 and February 16, 1987, against claimant's future awards of permanent disability. Claimant's aggravation claim is remanded to the self-insured employer for processing according to the law. For services at hearing and on review concerning the aggravation issue, claimant's attorney is awarded an assessed fee of $1,500, to be paid by the employer. All remaining portions of the Referee's order are affirmed. The Board approves a client-paid fee, payable from the employer to its counsel, not to exceed $1,380.

March 21, 1990 Cite as 42 Van Natta 562 (1990)

In the Matter of the Compensation of
MARIA CARDENAS, Applicant
LUIS CARDENAS, (Deceased), Victim
FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER (CRIME VICTIM ACT)
WCB Case No. CV-89004
Wilbur C. Smith, Attorney
Thomas Ewing, Assistant Attorney General

Maria Cardenas, (hereafter referred to as "applicant"), the mother of Luis Cardenas, decedent, has requested Board review of the Department of Justice's September 5, 1989 Order on Reconsideration. By its order, the Department denied applicant's claim for compensation under the Compensation for Crime Victims' Act ("Act"). ORS 147.005 to 147.375. The Department concluded that Luis Cardenas was not the victim of a compensable crime as defined in ORS 147.005(4).

Following our receipt of the request for Board review, applicant was advised that she was entitled to present her case to a hearing officer. To exercise her right to a hearing, applicant was instructed to notify the Board within 15 days from the date the Department mailed her copy of its record. The Department mailed a copy of its record to applicant on September 19, 1989. Having neither received a hearing request nor written argument, we have conducted our review based solely on the record. See OAR 438-82-030(2).

The standard for our review under the Act is de novo, based on the entire record. ORS 147.155(5); Jill M. Gabriel, 35 Van Natta 1224, 1226 (1983). Based on our de novo review of the record, we make the following findings.

FINDINGS OF FACT

On April 10, 1989, Luis Cardenas, 18 years of age, was at the residence of Barbara Bowling, 28 years of age. Cardenas had primarily been at the Bowling residence since he had left his parent's home the previous day. Cardenas had been distraught over a dispute with his family.

Following an unsuccessful attempt to locate work, Cardenas and Bowling had returned to her residence for dinner. Around 5:30 p.m., while the meal was being prepared, Lori Glass, a 20-year-old friend of Bowling's, arrived at the residence with a fifth of tequila. Glass, Cardenas, and Bowling shared the bottle. Cardenas drank the majority of the bottle's contents.

Later that evening, Glass drove Cardenas and Bowling to the home of Cardenas' cousin. After a short visit, Glass drove them to a bank, where Glass got some money. Thereafter, they proceeded to a liquor store, where Bowling purchased another bottle of tequila. While driving around town, contacting Glass' ex-boyfriend, and checking on Glass' baby, the second bottle was consumed. Once again, Cardenas drank most of the tequila.

At around 7:00 p.m., they returned to Bowling's residence. Glass and Bowling assisted Cardenas in walking to the house. Concerned that Cardenas would become ill, they placed him on his stomach on a sheet next to the toilet in a bathroom. Glass and Bowling then left the house and returned to Glass's residence. They returned to Bowling's home at 7:30 p.m. At that time, Bowling checked on Cardenas and noted that his head was in a different position.

Bowling and Glass then drove back into town until 10 p.m., when Bowling returned to her home. Unable to wake Cardenas, Bowling went to bed. She repeated these attempts to arouse Cardenas at 5:30 a.m. and 6:30 a.m., but was unsuccessful. Finally, at 9:00 a.m., Bowling turned Cardenas over and, recognizing the severity of his condition, contacted emergency personnel.

An autopsy revealed that Cardenas' blood-alcohol level was .50 percent. The cause of death was diagnosed as "acute alcoholism." Following a police investigation, the case was referred to the District Attorney, who was considering charging Bowling with Furnishing Alcohol to a Minor.

In May 1989, applicant filed her claim for benefits under the Act, contending that her minor son was the victim of a compensable crime because Bowling had provided alcohol to him. Following its investigation, the Department issued an order on June 20, 1989.

The Department recognized that furnishing alcohol to a minor was against the law. However, the Department noted that Cardenas had consumed the alcohol willingly. Citing ORS 147.005(4), the Department reasoned that, in order to receive benefits, an applicant must be a victim of a "compensable crime", which means an intentional, knowing or reckless act that results in serious bodily injury or death of another person and which, if committed by a person of full legal capacity, would be punishable as a crime in this state. Concluding that the record did not reveal that any intentional, reckless or knowing act was perpetrated against Cardenas, the Department held that applicant had not met the statutory requirements for a compensable crime.

In August 1989, applicant requested that the Department reconsider its order. Applicant contended that, although Bowling may not have intended the results of her actions, she had certainly acted with the objective of providing alcohol to Cardenas. Consequently, applicant argued that Bowling's actions had been intentional and criminal. Applicant further asserted that, considering

that her son was a minor, his voluntary consumption of the alcohol was irrelevant.

Following further consideration, the Department continued to find that the circumstances surrounding Cardenas' death did not meet the criteria of a "compensable crime" as defined in ORS 147.005(4). Therefore, on September 5, 1989, the Department found no basis for reversing its original order. Applicant requested Board review of the Department's decision.

CONCLUSIONS OF LAW

Applicant is entitled to an award under the Act, if, among other requirements, she is the victim of a "compensable crime." See ORS 147.015(1). "Compensable crime" is defined as an intentional, knowing or reckless act that results in serious bodily injury or death of another person and which, if committed by a person of full legal capacity, would be punishable as a crime in this state. ORS 147.005(4).

"Intentional" is defined as an act with a conscious objective to cause the result or engage in the conduct described. ORS 161.085(7). "Knowing" means that a person acts with an awareness that his/her conduct is of a nature so described or that a circumstance so described exists. ORS 161.085(8). "Reckless" is defined as an act where the person is aware of and consciously disregards a substantial and unjustifiable risk that the result will occur or that the circumstance exists. ORS 161.085(9). The risk must be of such nature and degree that the disregard thereof constitutes a gross deviation from the standard of care that a reasonable person would observe in the situation. id.

Applicant must also establish that the death or injury to the victim was not substantially attributable to the wrongful act of the victim. ORS 147.015(5). "Substantially attributable to the wrongful act" means attributable to an unlawful act voluntarily entered into from which there can be a reasonable inference that, had the act not been committed, the crime complained of would not have occurred. OAR 137-76-010(7). Furthermore, the Department shall determine the degree or extent to which the victim's acts or conduct provoked or contributed to the injuries or death of the victim, and shall reduce or deny the award of compensation. ORS 147.125(3).

Here, the Department acknowledged that furnishing alcohol to a minor was an act contrary to law. However, reasoning that the act of furnishing the alcohol to the deceased was not taken either intentionally, knowingly, or recklessly to cause Cardenas' death, the Department concluded that applicant had not established a compensable crime under ORS 147.015(1). The Department further found that the deceased had consumed the alcohol voluntarily, thereby implicitly holding that the death was substantially attributable to the decedent's wrongful act. See ORS 147.015(5).

Applicant contends that, although Ms. Bowling may not have intended the results of her actions, she certainly intended to furnish alcohol to the decedent. Since the consumption of that unlawfully provided alcohol resulted in decedent's death, applicant asserts that her son was the victim of a compensable crime. Moreover, applicant argues that the decedent's voluntary consumption of the alcohol is irrelevant because ORS 471.410, which pertains to furnishing alcohol to minors, does not recognize the minor's consent as a defense.

After conducting our de novo review of the record, we conclude that Ms. Bowling intended to furnish alcohol to the decedent. If convicted, such an action is punishable as a Class A misdemeanor. ORS 471.410(3). Yet, although unlawful, such an action was neither intentionally, knowingly, nor recklessly

taken to cause or result in the death of the decedent. Consequently, it is not a "compensable crime" as statutorily defined in ORS 147.015(1).

Furthermore, we agree with claimant that the consent of the minor is not a defense to the crime of furnishing alcohol to a minor. However, under the Act, as a victim, the minor's acts or conduct are expressly required to be considered in determining to what degree and extent those acts or conduct provoked or contributed to the victim's injury or death. ORS 147.015(5).

After considering the record, we conclude that the victim's actions in voluntarily consuming the alcohol substantially contributed to his death from alcohol poisoning. Accordingly, we agree with the Department's decision to deny the claim for benefits.

In conclusion, we sincerely regret the tragedy that has befallen applicant. Moreover, our decision should not be interpreted as condoning Ms. Bowling's actions in providing alcohol to the decedent. Instead, as explained above, such actions do not constitute a "compensable crime" as statutorily defined. Thus, applicant's remedy does not rest with the Crime Victims' Compensation Program.

ORDER

The June 20, 1989 Findings of Fact, Conclusions and Order of the Department of Justice Crime Victims' Compensation Program, as reconsidered September 5, 1989, is affirmed.

March 21, 1990 Cite as 42 Van Natta 565 (1990)

In the Matter of the Compensation of
CHARLES W. FLOYD, Claimant
WCB Case Nos. 88-08409 & 88-05990
ORDER ON REVIEW
Royce, et al., Claimant Attorneys
Stafford J. Hazelett, Defense Attorney
Williams, et al., Defense Attorneys
Rankin, et al., Attorneys

Reviewed by Board Members Myers and Gerner.

Liberty Northwest Insurance Company requests review of those portions of Referee Mulder's order that: (1) set aside its denial of claimant's "new injury" claim for a low back condition; and (2) upheld Lumbermen's Insurance Company's denial of claimant's aggravation claim for the same condition. On review, the issue is responsibility. We reverse.

FINDINGS OF FACT

On July 19, 1985, claimant suffered a compensable rib fracture and lumbosacral strain when he tripped over a floor buffer. He was employed as a custodian for a school district. Lumbermen's was on the risk.

Dr. Smucker, M.D., found claimant medically stationary on September 3, 1985, and released him for light duty work for a period of two weeks. (Ex. 5).

The employer's workers' compensation insurance changed from Lumbermen's to Liberty Northwest on July 1, 1986.

Claimant returned to work during the last part of 1985. He continued to feel back pain. Over the next two years claimant could not lift, nor bend down. Accordingly, claimant modified his tools to accomplish his work duties.

Dr. Smucker released claimant from regular work, effective August 21, 1987. Concluding that claimant experienced back pain caused by the July 19, 1985 fall, Smucker reported that claimant had experienced a history of persistent back problems since mid-August 1985.

On September 23, 1987, Dr. Hoppert, M.D. examined claimant. He reported that claimant experienced sharp low back pain and that this discomfort increased when in a stooped position.

By the fall of 1987, claimant noted that his back had gotten worse. By letter dated October 13, 1987, Dr. Smucker related that claimant for two years had worked around his back problems, and that the pain had basically persisted over that period. Subsequently, over Christmas break 1987, claimant had two sections of an assigned building to clean. After working all but the final day of the break, he asked for time off and saw a doctor.

On March 2, 1988, Dr. Utterback, orthopedic surgeon, reported that claimant experienced continual ache and pain at the midline lumbosacral region.

On April 1, 1988, Lumbermen's issued a denial of claimant's aggravation claim. On June 24, 1988, Liberty Northwest denied claimant's "new injury" claim.

CONCLUSIONS OF LAW AND OPINION

The Referee found claimant's employment activities, while Liberty Northwest was the insurer, independently contributed to the development of new and more severe symptoms. Consequently, the Referee found Liberty Northwest responsible for claimant's low back condition. We disagree.

In Hensel Phelps v. Mirich, 80 Or App 290 (1986), the court held that the last carrier is responsible for a worker's disability and medical treatment if an injury or the work activities at the time it is on the risk independently contributed, even slightly, to a worsening of the worker's underlying condition. On the other hand, the first insurer remains responsible if the second injury takes the form of a recurrence of the first, and the second incident did not contribute to the causation of the disabling condition. Boise Cascade Corp. v. Starbuck, 296 Or 238, 244 (1984).

The causation of claimant's back condition is a complex medical question. Hence, while claimant's testimony is probative, the resolution of this case turns on medical evidence. Kassahn v. Publishers Paper Co., 76 Or App 259, 263 (1986).

Here, the evidence establishes that claimant's employment subsequent to July 1, 1986 did not independently contribute, even slightly, to a worsening of claimant's underlying back condition. The medical history indicates that claimant has experienced ongoing pain since the 1985 injury. Accordingly, we conclude that Lumbermen's, as insurer for claimant's compensable 1985 injury, remains responsible for claimant's back condition. Our conclusion is based on the following reasoning.

Dr. Smucker, who had first examined claimant on August 14, 1985, saw claimant on August 21, 1987. Smucker noted that claimant had suffered from back pain since 1985, and that there was no definite date of reinjury to the back.

Moreover, Dr. Smucker reported that he had no indication that claimant's work had changed in difficulty or caused a new strain to the back. He continued, "I also find it highly unlikely that anything other than his work duty has caused his problem since his problem started two years ago and now he is complaining of very similar symptoms. In fact, he states his symptoms have never been resolved, he just put up with them." (Ex. 10-1, emphasis added).

On the other hand, nearly a year later, Smucker changed his opinion and reasoned that claimant's vigorous cleaning during the summer of 1987 had exacerbated his lumbar strain. Smucker's change of opinion was based on reports given to him by claimant. Nevertheless, he had noted no such change in August 1987, a mere few months after the purported exacerbation. Moreover, it would appear that Smucker's opinion is limited to finding a symptomatic exacerbation, rather than a worsening of the underlying condition. Given this inconsistent finding, we accord Dr. Smucker's medical opinion lesser weight.

Dr. Utterback, orthopedic surgeon, opined that claimant's current symptomatology was related to a degenerative joint disease of the lumbar spine, obesity and poor body maintenance. (Ex. 15-2).

Dr. Mandiberg, orthopedic surgeon, felt that claimant's degenerative arthritis preexisted the 1985 injury. He opined that it was medically probable that the 1985 injury caused the, "...previously asymptomatic disease to be symptomatic and has remained so since that time." (Ex. 18-5). Although Mandiberg concluded that claimant's work activity independently contributed to the worsening of his condition, the aforementioned quote suggests that he was referring to a symptomatic increase. Lacking such definiteness, we do not consider it persuasive.

Noting that claimant had experienced ongoing back pain since the compensable 1985 injury, Dr. Wilson, neurological surgeon, opined that claimant was suffering from degenerative disc disease. Wilson indicated that claimant's work activities were not a material contributing factor to his complaints, and that there was no material worsening of claimant's underlying degenerative disc disease of his lumbar spine in 1987. (Ex. 18E-4).

Drs. Utterback and Hoppert concurred. Dr. Utterback opined that the July 1985 incident, "...did not influence the course of his basic underlying arthritis, nor is there any permanent effect from that event." (Ex. 23). Likewise, Dr. Hoppert, orthopedic surgeon, opined that claimant's degenerative disc disease may have been a natural progression of the July 1985 occurrence, and that the disease could have been preexisting or worsened by the July 1985 incident itself. (Ex. 22).

After consideration of the aforementioned medical opinions, we find Dr. Wilson's opinion well reasoned and thorough. Consequently, we consider it to be persuasive. Somers v. SAIF, 77 Or App 259 (1986). Accordingly, we conclude that claimant's work activities while Liberty Northwest was on the risk did not independently contribute to a worsening of his underlying back condition. Accordingly, Lumbermen's is the responsible insurer.

Reimbursement

Liberty Northwest requests reimbursement of claims costs paid to date which they assert should have been the responsibility of Lumbermen's. We decline to order reimbursement.

Our jurisdiction is restricted to matters concerning a claim, which is defined as those matters in which "a worker's right to receive compensation, or

the amount thereof, are directly at issue." ORS 656.704(3); ORS 656.726(2). Reimbursement disputes between carriers are not matters concerning a claim. EBI Companies v. Kemper Group Insurance, 92 Or App 319 (1988); Reynolds-Croft, Inc. v. Bill Morrison Co., 55 Or App 487 (1982). After we have made our determination that the other insurers are the responsible paying parties, reimbursement from those parties is secured by order from the Director of the Department of Insurance and Finance not this Board. ORS 656.307(3); Liberty Northwest Ins. Corp. v. SAIF, 99 Or App 729 (1989).

ORDER

The Referee's order dated September 21, 1988, as amended September 30, 1988, is reversed. The Liberty Northwest denial is reinstated and upheld. Lumbermen's denial is set aside and the claim is remanded to Lumbermen's for processing according to law. A client-paid fee, not to exceed $824.50, payable by Lumbermen's to its former counsel, is approved.

March 21, 1990 Cite as 42 Van Natta 568 (1990)

In the Matter of the Compensation of
PINKY P. HOLDER, JR., Claimant
WCB Case No. 88-13714
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Employers Defense Counsel, Defense Attorneys

Reviewed by Board Members Myers and Cushing.

The insurer requests review of Referee Mirassou's order which assessed a penalty and attorney fee for the insurer's late payment of medical billings. We affirm.

ISSUES

The insurer contends that the Referee erred in refusing to admit into evidence exhibit 4.

The insurer also contends that claimant has failed to prove by a preponderance of the evidence that the insurer received the medical billings which were allegedly paid late; therefore, claimant has failed to prove that they were paid late.

FINDINGS OF FACT

We adopt the Referee's findings of fact and ultimate findings of fact.

CONCLUSIONS AND OPINION

The insurer argues that the Referee erred in refusing to admit exhibit 4 into evidence. It argues that, because the technical rules of evidence do not apply in a workers' compensation hearing, the Referee should not have refused to admit the exhibit merely because it is a hearsay statement and that the declarant was unavailable for cross-examination.

We agree that the Referee should have admitted exhibit 4. It is relevant evidence which was timely disclosed and timely offered. Consequently, we consider exhibit 4 in our review of this case. However, because it is a hearsay

statement on the central factual issue in this case and because the declarant is unavailable for cross-examination, we accord the exhibit very little weight.

On the merits, we adopt the Referee's conclusions of law and opinion.

Inasmuch as penalties and attorney fees are not "compensation" within the meaning of ORS 656.382(2), claimant is not entitled to an attorney fee for successfully defending those awards on review. Saxton v. SAIF, 80 Or App 631 (1986); Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The Referee's order, dated November 14, 1988, as supplemented November 21, 1988, is affirmed in part and reversed in part. That portion of the Referee's order which refused to admit exhibit 4 into evidence is reversed. The balance of the Referee's order is affirmed.

March 21, 1990 Cite as 42 Van Natta 569 (1990)

In the Matter of the Compensation of
CHARLES W. INMON, Claimant
WCB Case No. 88-06764
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
Cooney, et al., Defense Attorneys

Reviewed by Board Members Cushing and Gerner.

The self-insured employer requests review of those portions of Referee Shebley's order which: (1) found that claimant's claim for a left inguinal hernia was timely filed; and (2) set aside its denial of claimant's claim for a left inguinal hernia. On review, the issues are timeliness and compensability. We affirm as to the timeliness issue and reverse as to the compensability issue.

FINDINGS OF FACT

Claimant experienced bilateral inguinal hernias while in the Marine Corps in 1954. These were surgically repaired that same year.

Claimant began working for the employer in 1980. In January 1987, he felt a "bee sting" sensation in his left groin while lifting a heavy steel plate. A short time thereafter, he noticed a bulge on the left groin. He reported this incident and mentioned the left sided bulge to both his lead man and supervisor within a few days of discovering it. Claimant continued to work and did not seek any medical treatment for this condition until June 1987.

In June 1987, claimant sought treatment from Dr. Davis, M.D. In July 1987, claimant filed a claim with the employer for a left sided hernia which was accepted. In August 1987, Davis surgically repaired the left sided hernia. Claimant returned to regular work on October 5, 1987. A December 1987 Notice of Closure closed his claim awarding temporary disability benefits only.

In March 1988, claimant filed a claim with the employer for a right sided hernia, alleging that it had also occurred in January 1987. At that time claimant had a bulge on the right groin. In April 1988, the employer denied claimant's right sided hernia.

CONCLUSIONS OF LAW AND OPINION

Timeliness

The Referee concluded that claimant's claim was not time-barred by ORS 656.265. We agree.

ORS 656.265(4)(a) provides that a claim is not barred if the employer has knowledge of the injury or death, or the insurer or self-insured employer has not been prejudiced by the the failure to receive notice. The carrier bears the burden of proving that there has been prejudice from an untimely filing. Raifsnider v. Caveman Industries, Inc., 55 Or App 780 (1982). The passage of time is not itself sufficient to show prejudice; the carrier must prove some actual prejudice. Ford v. SAIF, 71 Or App 825, rev den 299 Or 118 (1985).

Here, the employer has presented no evidence establishing that it was prejudiced by claimant's late filing. Further, by virtue of claimant's accepted left hernia claim, the employer has the necessary medical documentation during the relevant time period. Accordingly, we agree with the Referee that claimant's claim is not time-barred by his untimely filing.

Compensability

The Referee concluded that claimant's right hernia condition was a compensable result of the January 1987 incident. We disagree.

To establish compensability of his right-sided hernia, claimant must prove, by a preponderance of the evidence, that the January 1987 incident was a material contributing cause of the condition. Hutcheson v. Weyerhaeuser, 288 Or 51 (1979).

The Referee found the claimant to be a credible witness. Although we generally defer to a Referee's finding of credibility, we decline to do so in this case. We find claimant's testimony inconsistent with the contemporaneous medical documentation as well as his own prior statements, therefore we give it little weight. See Davies v. Hanel Lumber Co., 67 Or App 35 (1985)

Claimant testified that he noticed a bulge in his right side shortly after the January 1987 incident. He further testified that in June 1987, Dr. Davis had informed him that he also needed a right hernia operation, but that it would not be performed until after the left side hernia surgery. However, contemporaneous chart notes reflect only a left sided hernia and there is no mention of a proposed right hernia operation. Further, in a statement made to an investigator in August 1987, claimant did not mention a right sided bulge or hernia and did not mention a proposed surgical procedure involving the right groin.

The only medical evidence concerning causation is a letter from Dr. Davis to claimant's counsel. Dr. Davis opined that if the left side hernia was related to the January 1987 incident, it was reasonable to assume that the right sided hernia was also related to the incident. He reported a history of a right sided bulge dating back to his first examination in June 1987. However, Dr. Davis' chart notes do not reflect a right side bulge until March 1988.

We are not persuaded by Dr. Davis' opinion. We do not find his opinion well reasoned and it is inconsistent with his own contemporaneous chart notes. Further, he relies on claimant's history which we have found herein to be unreliable. See Moe v. Ceiling Systems, 44 Or App 429 (1980).

Under these circumstances, we conclude that claimant has failed to establish that the January 1987 incident was a material contributing factor to his right hernia condition. Accordingly, the right hernia condition is not compensable.

ORDER

The Referee's order, dated August 18, 1988, is reversed in part and affirmed in part. The self-insured employer's denial is reinstated and upheld. The Referee's attorney fee award of $1,750 is reversed. The remainder of the Referee's order is affirmed. A client-paid fee, not to exceed $1,341.50, payable from the employer to its counsel, is approved.

March 21, 1990 Cite as 42 Van Natta 571 (1990)

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

Reviewed by Board Members Howell and Speer.

Liberty Northwest Insurance Corporation (Liberty Northwest) requests review of Referee Knudsen's order which granted permanent total disability, whereas prior Determination Orders resulting from separate injuries for the SAIF Corporation's insured and Liberty Northwest's insured awarded a total of 25 percent (80 degrees) unscheduled permanent disability and 5 percent (6.75 degrees) scheduled permanent disability for loss of use or function of the right foot. The issue on review is extent of permanent disability, both scheduled and unscheduled. We reverse the Referee's award of permanent total disability.

Liberty Northwest argues that it should have been allowed, post-hearing, to submit evidence pertaining to the issue of permanent total disability. Because we reverse the Referee's award of permanent total disability, we need not address that issue.

FINDINGS OF FACT

We adopt the Referee's "Summary of Facts" with the following supplementation.

Claimant's scheduled and unscheduled impairment after his first injury, while employed by SAIF's insured, was minimal.

Claimant's unscheduled impairment after his second injury, while employed by Liberty Northwest's insured, was mildly moderate and resulted in a lifting restriction of no greater than 50 pounds. Moreover, after claimant's second injury, he could not return to work at his regular employment.

CONCLUSIONS OF LAW AND OPINION

At hearing, the only issue before the Referee was extent of permanent partial disability. Nevertheless, the Referee found claimant to be permanently totally disabled. Liberty Northwest contends that the Referee should not

have addressed permanent total disability because that issue was not raised by claimant at, or prior to, the hearing. We agree.

Permanent partial disability and permanent total disability are exclusive of each other. See Gwynn v. SAIF, 304 Or 345, 350 (1987). Moreover, different legal standards apply to each. To establish entitlement to permanent total disability, an injured worker must establish permanent incapacity from regularly performing work at a gainful and suitable occupation. ORS 656.206(1). In addition, an injured worker must prove a willingness to seek regular gainful employment and that the worker has made reasonable efforts to do so. ORS 656.206(3). By comparison, unscheduled permanent partial disability is awarded for loss of earning capacity, and scheduled permanent partial disability is awarded for loss of use or function of a scheduled body part. ORS 656.214.

As a result of the differing legal standards, different proof is necessary to both establish and defend against claims for the two types of permanent disability. Most notable is the prevalence of evidence from vocational experts in a permanent total disability case, whereas such evidence is frequently not present in a permanent partial disability case.

Here, claimant alleged only entitlement to additional permanent partial disability. Liberty Northwest's evidence was intended to defend against such a claim, rather than a claim for permanent total disability. Therefore, Liberty Northwest was prejudiced by the Referee's conduct awarding permanent total disability without allowing it an opportunity to defend on that issue. Consequently, we reverse the Referee's award of permanent total disability. We would also note that the record does not establish that claimant is permanently and totally disabled on the merits.

Because we reverse the award of permanent total disability, we must address the extent of claimant's permanent partial disability. The criteria for rating the extent of claimant's scheduled permanent disability is loss of use or function of the scheduled body part. ORS 656.214. The criteria for rating the extent of claimant's unscheduled permanent disability is the permanent loss of earning capacity due to the compensable injury. ORS 656.214(5). To determine claimant's permanent loss of earning capacity, we consider his physical impairment as reflected in the medical record, the testimony at hearing, and all of the relevant social and vocational factors set forth in 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 was 59 years old at the time of hearing. His education includes high school as well as nurses training received while in the army. He has no degree in nursing, but has worked as a Licensed Practical Nurse for many years. Following his first injury, claimant successfully returned to work with the only limitations being his inability to go up and down stairs much. However, due to restrictions resulting from his second, low back injury claimant cannot return to his regular work.

Claimant's first injury resulted in minimal neck/shoulder permanent impairment and minimal right foot impairment. Considering the extent of impairment, and other pertinent social and vocational factors, we conclude that the Determination Order of June 16, 1987, awarding an unscheduled award of 10 percent (32 degrees) for the neck/shoulder injury, and awarding a scheduled award of 5 percent (6.75 degrees) for the right foot injury, appropriately compensates claimant for his permanent disability resulting from his first injury.

We next consider the appropriateness of the award resulting from claimant's second injury while employed by Liberty Northwest's insured. Whereas

claimant was minimally impaired following his first injury, he was mildly moderately impaired following his second injury. We, therefore, conclude that claimant suffered increased impairment in the mild range "due to" his second injury. See ORS 656.214(5) and 656.222; Lawrence W. Scott, 40 Van Natta 1721 (1988).

Considering claimant's mild physical impairment resulting from his second injury, lack of nursing degree, limited work experience, inability to return to regular work, and other social and vocational factors, we conclude that an additional award of 20 percent (64 degrees) unscheduled permanent disability appropriately compensates claimant for his permanent loss of earning capacity due to his December 1986 low back injury.

ORDER

The Referee's order dated December 3, 1987, as reconsidered February 1, 1988 and May 16, 1988, is reversed. The June 16, 1987 Determination Order is affirmed. The July 8, 1987 Determination Order is modified. In addition to the 15 percent (48 degrees) unscheduled permanent disability awarded by Determination Order, claimant is awarded 20 percent (64 degrees) unscheduled permanent disability for a total award of 35 percent (112 degrees) unscheduled permanent disability. Claimant's attorney is awarded a fee of 25 percent of the compensation due claimant pursuant to this order, to be paid by Liberty Northwest from such compensation and not to exceed $3,000. Liberty Northwest is permitted to credit attorney fees paid pursuant to the Referee's award against the attorney fee awarded herein.

March 21, 1990 Cite as 42 Van Natta 573 (1990)

In the Matter of the Compensation of
JOZSEF POZSGAI, Claimant
WCB Case No. 88-09033
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
Stafford J. Hazelett, Defense Attorney

Reviewed by Board Members Cushing and Gerner.

Claimant requests review of that portion of Referee Podnar's order which: (1) declined to grant permanent total disability; and (2) affirmed a Determination Order award of 30 percent (96 degrees) unscheduled permanent disability for a back injury. On review, the issue is extent of unscheduled permanent disability, including permanent total disability. We affirm.

FINDINGS OF FACT

Claimant, 60 years of age at hearing, is a metal polisher who immigrated to the United States in 1956. He graduated from high school in Hungary, and attended one and a half years of college. His previous occupations include metal polishing, punch operator, and providing foster care for the elderly.

Claimant compensably injured his back in August, 1987. He was treated by Dr. Kaesche, orthopedic surgeon, who diagnosed thoracic and lumbar strain, treated claimant conservatively and released him from work. Claimant returned to regular work in September 1987. That same month, the insurer accepted claimant's back injury claim. Claimant returned to Kaesche, in December 1987, and complained of continued back pain. Kaesche diagnosed chronic lumbar strain and released claimant to return to light duty work.

Claimant first reported right knee pain to Kaesche in January 1988. His right knee condition is not related to his August 1987 compensable back injury.

Dr. Kaesche determined, in January 1987, that claimant's back condition, though chronic, had stabilized.

In April 1988, the insurer issued a partial denial of claimant's right knee condition. The following month, a Determination Order issued awarding claimant 30 percent unscheduled permanent disability for his back condition.

In June 1988, claimant was evaluated by Dr. Gambee, M.D., independent medical examiner. Gambee reported "low back strain by history without objective findings," and noted evidence of bursitis of the left shoulder. Gambee recommended treatment, for claimant's right shoulder condition, and return to regular work.

Claimant appealed both the partial denial of his right knee condition and the May 1988 Determination Order.

At the time of hearing, claimant remained on light-duty-work status with bending and stooping restrictions.

CONCLUSIONS OF LAW AND OPINION

Permanent Total Disability

The Referee concluded that claimant was not permanently and totally disabled. 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); Shaw v. SAIF, 78 Or App 588 (1986). 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).

Here, claimant is not totally physically disabled. Neither claimant's treating orthopedic surgeon, Kaesche, nor the independent medical examiner, Gambee, found claimant to be totally physically incapacitated. Kaesche released claimant to return to light work duty in December 1987, and noted that claimant "is fit for work with some restrictions as far as prolonged standing and stooping forward." He further stated that, "subjectively, I can find no concrete basis for restricting his activities." Gambee diagnosed "low back strain by history without objective findings" and noted "no indication from the low back standpoint why [claimant] can't return to his regular job." Under such circumstances, we conclude that claimant's physical disability alone does not entitle him to an award of permanent total disability.

Claimant argues that he is permanently and totally disabled under the "odd-lot" doctrine. In making such an assertion, claimant relies on the opinion of vocational rehabilitation counselor, McNaught.

Claimant, 60 years of age at hearing, graduated from high school and attended one-and-a-half years of college. He is capable of performing light duty work, with few restrictions. His previous occupations include metal polishing, punch operator, and providing foster care for the elderly. In addition to his compensable back condition, claimant also suffers from bursitis in his left shoulder, at times disabling, and experiences pain associated with his right knee condition.

Claimant's vocational counselor, McNaught, testified that claimant has no transferable skills and, after considering his age, education and work experience, his chances of obtaining employment would be slim. However, McNaught noted that claimant's chances of obtaining employment would be improved if he was provided with assistance. McNaught's opinion as to claimant's ability to obtain employment is solely based on claimant's rendition of his limitations. We note, however, that there is no objective medical evidence to support the severity of physical restrictions as subjectively reported by claimant. Further, both physician's reported that claimant was able to return to his previous work, with limited restrictions.

While we consider the testimony of the vocational counselor helpful in determining the extent of claimant's disability, we must take note that the basis for McNaught's conclusions stem solely from claimant's subjective complaints made either to his physicians or his counselor. Because the subjective complaints are not supported by any objective medical evidence, we do not give much weight to claimant's subjective opinions as to his restrictions in determining extent of disability. We find the opinions of Drs. Kaesche and Gambee more persuasive. Therefore, we conclude that claimant is not permanently and totally disabled under the "odd-lot" doctrine.

Extent of Permanent Partial Disability

The Referee found that claimant failed to meet his burden of proving that he suffered a loss of earning capacity greater than the 30 percent awarded by Determination Order. We agree.

The extent of unscheduled permanent partial disability is measured by the permanent loss of earning capacity due to the compensable injury. Barrett v. D & H Drywall, 300 Or 325 (1985), clarified, 300 Or 553 (1986). It is claimant's burden to prove he has incurred a permanent loss of earning capacity as a result of his October 1986 injury. Hutcheson v. Weyerhaeuser Co., 288 Or 51 (1979).

In rating the extent of claimant's unscheduled permanent partial disability, consideration is given to his physical impairment as reflected in the medical record and testimony at hearing. Garbutt v. SAIF, 297 Or 148 (1984). Relevant social and vocational factors are considered in the totality of the circumstances. See former OAR 436-30-380 et seq. The rules are merely guidelines used in the evaluation of the extent of permanent partial disability. They are not mechanically applied. Harwell v. Argonaut Insurance Co., 296 Or 505 (1984).

Both claimant's treating orthopedic surgeon and the independent medical examiner reported that claimant was able to return to light duty work and noted limitations only in the areas of prolonged standing and stooping forward. Further, Dr. Gambee specifically noted that he could find no objective findings to warrant working restrictions.

After considering the medical and testimonial evidence, we conclude that claimant's prior award of 30 percent unscheduled permanent disability appropriately compensates him for his loss of earning capacity due to his compensable back injury.

ORDER

The Referee's order, dated September 13, 1988, is affirmed.

In the Matter of the Compensation of
JOE STOUT, Claimant
WCB Case No. 88-13659
ORDER ON REVIEW
Charles E. Woods, Claimant Attorney
Gary T. Wallmark (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

The SAIF Corporation requests review of those portions of Referee Foster's order that: (1) directed it to pay additional temporary disability compensation; (2) assessed penalties and attorney fees for an unreasonable delay or refusal to pay temporary disability benefits; (3) directed SAIF to pay claimant's medical services claim; and (4) assessed a penalty-related attorney fee for late payment of medical bills. On review, the issues are temporary total disability, medical services and penalties and attorney fees. We reverse.

FINDINGS OF FACT

Claimant, 24 years old at hearing, has cerebral palsy. Although he has previously worn braces on both legs, in November 1987, claimant wore a leg brace on the left leg only.

On November 17, 1987, claimant was sweeping at work when he twisted his right lower leg. Claimant had cramping in his lower leg muscles, and although he completed his shift, he was unable to work the following day. He treated with Dr. Holme, M.D., who authorized two days time loss. Claimant returned to work after the next weekend and the employer transferred him to lighter duties and fewer hours of janitorial work.

Claimant was medically stationary on November 21, 1987, and his doctor reported no permanent impairment.

In January 1988, claimant missed several days of work due to pain in his right lower leg. On March 24, 1988, claimant sought treatment from Dr. Holme when he twisted his lower right leg at work. Dr. Holme advised claimant to take the rest of the week off from work. On April 5, 1988, claimant missed one hour of work to treat with Dr. Holme. He did not miss work at any other time during that month.

At hearing, SAIF conceded payment of Dr. Holme's November 1987 bill, but denied the March and April 1988 bills on the grounds that the billings were not compensably related to the claim. SAIF received the billings one month prior to the hearing.

SAIF paid time loss for November 20, 1987, but denied time loss from March 23 to March 26 as unrelated to the compensable injury.

CONCLUSIONS OF LAW AND OPINION

Temporary Disability

The Referee found that claimant's inability to work on April 14 and 15, 1988, was directly related to his industrial injury. He concluded that time loss should have been paid to claimant for those dates. We disagree.

We conclude that time loss is not appropriate because claimant has failed to provide medical evidence that the time loss was due to his compensable

injury. Whether claimant is entitled to temporary total disability on April 14 and 15, 1988, depends upon whether the evidence shows that he was disabled on those dates due to the compensable injury. ORS 656.210; Botefur v. City of Creswell, 84 Or App 627 (1987).

Claimant was released for regular work on November 21, 1987, and was declared to be medically stationary on that date. Claimant's physician, Dr. Holme, reported that there was no permanent impairment from the injury.

At hearing, claimant testified that he did not miss time from work on April 14 or 15, 1988. Even if he had testified to time off work, we conclude that claimant's testimony alone would be insufficient because claimant suffered from a noncompensable condition (cerebral palsy), which also affected his right leg. See Uris v. Compensation Department, 247 Or 420, 426 (1967); Kassahn v. Publishers Paper, 76 Or App 105 (1985) (when causation in a case is a complex medical question, competent medical evidence is required). Thus, although claimant's testimony is probative, the resolution of the issue largely turns on an analysis of the medical evidence. We therefore find that claimant has not shown that, as of April 14 or 15, he was disabled due to his compensable condition.

Penalties and Attorney Fees for Unreasonable Refusal to Pay Time Loss

The Referee found that SAIF should have paid claimant's time loss for April 14 and 15. He subsequently assessed a 25 percent penalty and an attorney fee of $300. Because claimant is not entitled to temporary disability, it follows that he is also not entitled to a penalty or attorney fee on that issue.

Medical Services

The Referee found that SAIF was required to pay three of claimant's medical bills for a total of $89. SAIF conceded that one of the bills (a $35 bill for services in November 1987) was compensable. We disagree with the Referee and conclude that claimant's bills for medical services rendered on March 24 and April 5, 1988, are not compensable.

For the reasons mentioned above, we find that claimant has failed to prove that medical services provided on March 24 and April 5, 1988, are related to his compensable injury. Dr. Holme, claimant's treating doctor, did not indicate how the treatments were related to claimant's compensable condition. Accordingly, we find that the March and April bills are not compensable.

Attorney Fee for Late Payment of Medical Bills

The Referee awarded an attorney fee of $450 for SAIF's failure to pay medical bills. We reverse the Referee's award.

SAIF conceded at hearing that medical treatment provided in November 1987 was compensable. However, SAIF's claims examiner credibly testified that none of the bills were received by SAIF until one month before hearing. A medical bill is a claim and payment is not due until 60 days after the carrier has notice or knowledge of the claim. ORS 656.262; Billy J. Eubanks, 35 Van Natta 131 (1983). We conclude that SAIF's processing of the claim was not untimely, as it did not receive the bills until one month before hearing.

ORDER

The Referee's order dated September 28, 1988 is reversed in part. Those portions of the Referee's order which directed the SAIF Corporation to pay temporary total disability for April 14 and 15, 1988 and a penalty thereon are reversed. That portion of the order which directed SAIF to pay for the March 24 and April 15, 1988 medical services is reversed. The Referee's penalty-related attorney fee awards are also reversed. The remainder of the Referee's order is affirmed.

March 21, 1990 Cite as 42 Van Natta 578 (1990)

In the Matter of the Compensation of
LEO S. WALL, Claimant
WCB Case No. 88-02996
ORDER ON REVIEW
Emmons, et al., Claimant Attorneys
Davis & Bostwick, Defense Attorneys

Reviewed by Board Members Gerner and Cushing.

The insurer requests review of Referee Emerson's order which set aside its partial denial of claimant's low back and right hip conditions. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

Claimant has been employed with the insured since 1984. He has had intermittent low back pain since the middle 1960's and intermittent right hip pain since the middle 1970's. In the six months prior to his industrial accident, claimant had pain in his right hip and groin area and his low back. (Ex. 3). In the month before his injury he had right leg pain, low back pain and hip pain and had been seeking chiropractic care for these conditions from Dr. Schaeffer, a chiropractor. (Ex. 1; Tr. 35, 45).

On August 22, 1986, claimant attempted to lift a 485 pound drum of oil with a "barrel wrench" when the wrench slipped and the drum struck and scraped the inside of claimant's right leg from the mid thigh to below the knee. Claimant sought treatment from Dr. Endicott for the injury.

Claimant first told Endicott of his low back, groin and right leg problems in July 1987. Claimant did not tell Endicott of his pre-injury low back, groin and right leg problems. Endicott relates claimant's low back and right hip problems to the industrial injury.

Endicott referred claimant to Dr. Haines for treatment of the low back condition in January 1988. Claimant did not tell Haines of his pre-injury difficulties with his low back, groin, right hip and leg. Haines relates claimant's low back and right leg problems to the industrial injury.

Dr. Thompson, orthopedist, examined claimant at the request of the insurer. Thompson does not relate the low back, groin, right hip and leg conditions to the industrial injury. Dr. Altman reviewed the medical record only. He does not relate the low back, groin, right hip and leg conditions to the industrial injury.

Claimant's low back condition has been diagnosed as mild lumbar osteoarthritis. His hip has been diagnosed as having early degenerative disease.

CONCLUSIONS OF LAW AND OPINION

The Referee found claimant credible and relied upon the opinions of Endicott and Haines to conclude that the low back and right hip conditions were materially related to the industrial injury. We disagree.

The opinions of both Endicott and Haines are conclusory and infer causation based on a temporal relationship between the injury and the low back and hip symptoms. However, neither doctor was aware that claimant experienced the same problems before the injury. (Tr. 45). Without the knowledge of these pre-injury problems, and without an explanation based on something more than a temporal relationship, we do not find their opinions persuasive. Instead, we rely upon the opinions of Altman and Thompson and conclude that claimant's low back, hip and right leg problems are not materially related to the industrial injury.

ORDER

The Referee's order, dated October 3, 1988, is reversed. The insurer's partial denial is reinstated and upheld. The Referee's $1,800 assessed attorney fee award is reversed.

March 22, 1990 Cite as 42 Van Natta 579 (1990)

In the Matter of the Compensation of
RICHARD A. HOGENSON, Claimant
WCB Case No. 88-06042
ORDER ON REVIEW (REMANDING)
Welch, et al., Claimant Attorneys
Tom Ewing (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

The SAIF Corporation requests review of Referee Peterson's order that: (1) denied its motion to set aside an order of reinstatement of request for hearing; and (2) set aside its denial of claimant's aggravation claim for a left hand condition. On review, the issues are remand and aggravation. We reverse and remand.

FINDINGS OF FACT

Claimant requested a hearing on April 15, 1988. The hearing was set for July 7, 1988. Claimant's counsel and the employer's counsel were present, but claimant failed to appear. The Referee dismissed the request for hearing subject to reinstatement if claimant submitted a request for reinstatement which set forth sufficient explanation for his failure to appear.

Claimant submitted an affidavit that stated that he had been unemployed in Oregon and had traveled to Nevada to seek employment. Claimant further stated that he had been without funds and was unable to return to Oregon for the hearing. The Referee found that claimant's affidavit provided good reason and good cause for his failure to appear. The Referee accordingly ordered the matter reinstated and a hearing was held on September 23, 1988. Claimant testified at hearing.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant was unable to appear at his hearing because he was unemployed and could not afford to travel from Nevada to Oregon at the time. The Referee found that claimant's reasons for failure to appear provided good cause and he denied SAIF's motion to reconsider the order of reinstatement. We do not agree that claimant has shown extraordinary circumstances for his failure to appear. See OAR 438-06-071 and 438-06-081.

In a case similar to the present one, we recently found that a claimant's inability to afford the cost of attending the hearing did not constitute an "extraordinary circumstance" justifying postponement. Glenn L. Woodraska, 41 Van Natta 1472 (1989). In Woodraska, claimant had moved for postponement of the hearing on the basis that he could not travel to Oregon due to his financial and physical conditions. We declined to find extraordinary circumstances and we noted that the cost of attending a hearing, along with other litigation expenses, generally is borne by the parties. Claimant had requested a hearing and then chosen to move to another state, therefore we concluded that he was required to bear the costs of returning to Oregon to prosecute his claim. Id.

The Referee was correct to not dismiss the hearing request due to claimant's failure to appear at the hearing. See Williams v. SAIF, 99 Or App 367 (1989) (Referees are not authorized to dismiss a claimant's hearing request because the claimant does not appear at the hearing where claimant's counsel does appear). However, because he failed to appear at the hearing and has not shown extraordinary circumstances for such failure, claimant has waived his right to testify. See Valencia Hinds, 41 Van Natta 2238 (1989).

Accordingly, we remand to the Referee for reconsideration. He shall decide the case without benefit of claimant's testimony. He shall make whatever other evidentiary rulings that will achieve substantial justice, considering claimant's unavailability to testify or be cross-examined. The hearing shall be conducted consistent with our instructions in Mario Miranda, 42 Van Natta 405 (February 1, 1990).

ORDER

The Referee's order dated October 11, 1988 is vacated. This matter is remanded to the Referee for further proceedings consistent with this order.

March 22, 1990 Cite as 42 Van Natta 580 (1990)

In the Matter of the Compensation of
BETH M. MURDOCK, Claimant
WCB Case Nos. 87-18096 & 87-18097
ORDER ON REVIEW
Roberts, et al., Defense Attorneys
Joseph McNaught (Saif), Defense Attorney

Reviewed by Board Members Nichols and Brittingham.

Claimant requests review of Referee Emerson's order that: (1) upheld the SAIF Corporation's denial of claimant's aggravation claim for a low back strain; (2) concluded that claimant had not established good cause for untimely filing of his request for hearing on Liberty Northwest Insurance Corporation's denial of claimant's "new occupational disease" claim for the same condition; and (3)

upheld Liberty's denial. The issues on review are timeliness, compensability and responsibility. We affirm in part and modify in part.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact and those findings contained in the first paragraph on page five of the order that relate to the issue of timeliness.

CONCLUSIONS OF LAW AND OPINION

We adopt that portion of the Referee's Conclusions and Opinion that relate to the issue of compensability and responsibility.

The Referee made some conclusions regarding timeliness of claimant's request for review on Liberty's denial; however, he did not dismiss the request for hearing on that denial. Liberty had raised the timeliness issue at hearing. Claimant requested review of the Referee's order without specifying particular issues; neither claimant nor either insurer filed a brief. Because we are not certain which issues were specifically raised on review, we will address all issues that were raised at hearing.

Liberty issued its denial on September 14, 1987. The denial was received by claimant within a few days thereafter and claimant consulted with an attorney. The attorney corresponded with Liberty on the meaning of the denial, attempting to clarify if the insurer was denying both compensabilty and responsibility or only responsibility. Clarification was received sometime in October 1987, but the attorney did not request a hearing on the denial until November 27, 1987.

The date of mailing, not the date of receipt, starts the running of the time within which the request for hearing must be received by the Hearings Division. Claimant's request was not received within 60 days. Claimants who do not timely file their request have the burden to show good cause for failure to timely file. Cogswell v. SAIF, 74 Or App 234 (1985). Good cause means the same kind of "mistake, inadvertance, surprise or excusable neglect" that would also permit relief from default judgment under ORCP 71B or former ORS 18.160. Brown v. EBI, 289 Or 455 (1980).

The negligence of an attorney in filing the request for hearing is not good cause. Sekermestrovich v. SAIF, 280 Or 723 (1977). The request for hearing in this matter should have been dismissed as requested by Liberty.

ORDER

The Referee's order dated September 9, 1988 is affirmed in part and modified in part. The order is modified to dismiss the request for hearing on the denial issued by Liberty Northwest Insurance Corporation. The remainder of the order is affirmed. A client-paid fee of $649.50 is approved, payable by Liberty to its counsel.

In the Matter of the Compensation of
DONALD F. SCHEELAR, Claimant
WCB Case No. 88-04593
ORDER ON REVIEW
Allen, Stortz et al., Claimant Attorneys
Cooney, Moscato & Crew, Defense Attorneys

Reviewed by Board Members Brittingham and Nichols.

The self-insured employer requests review of Referee Foster's order that: (1) increased claimant's unscheduled permanent disability award for a back injury from 15 percent (48 degrees), as awarded by a Determination Order, to 40 percent (128 degrees); (2) increased claimant's scheduled permanent disability award for loss of use or function of the left leg from 20 percent (30 degrees), as awarded by Determination Order, to 30 percent (45 degrees); (3) increased claimant's scheduled permanent disability award for loss of use or function of the right leg from 20 percent (30 degrees), as awarded by Determination Order, to 30 percent (45 degrees); and (4) increased claimant's scheduled permanent disability award for loss of use or function of the right arm from 20 percent (38.40 degrees), as awarded by Determination Order, to 30 percent (57.60 degrees). On review, the issues are extent of scheduled and unscheduled disability. We affirm.

FINDINGS OF FACT AND ULTIMATE FACT

The Board adopts the Referee's findings of fact with the following supplementation.

At the time of hearing, claimant's correct age was 60 years.

Dr. Grewe measured claimant's cervical range of motion as: flexion, 30 degrees; extension, 20 degrees; lateral right, 30 degrees; lateral left, 30 degrees; rotation, 80 degrees. Claimant experiences severe pain daily in his right shoulder, made worse with use of his right arm. He has difficulty driving, steers only with his left hand, and cannot turn and back his car.

Claimant's loss of grip and muscle strength in his right arm is of neurological origin. Dr. Grewe rated his loss of grip strength at 25 percent and loss of biceps/triceps strength at 20 percent. Claimant has sensory loss and associated pain that interferes with function in his right forearm and lateral arm. Claimant can perform only sedentary work and is unable to carry his insurance binders or any weight over about a pound with his right arm. He occasionally drops cups or glasses when his right arm goes numb.

Claimant must take Coumadin for the chronic thrombophlebitis in both legs. He wears extra-strong support hose to control the edema, but they are not completely effective. He has mild pain in both legs from the edema for the first two hours in the morning, after which the pain becomes progressively worse. Occasionally he must have his right stocking removed because of the pain. He then leaves work in order to elevate his legs. He has fallen several times because of numbness in the bottoms of his feet attributable to the edema. Because claimant cannot sit for extended periods, his driving is limited to a 50-mile radius; because of the increase in pain during the day, he must arrange long interviews for the morning hours.

Claimant can no longer walk fast, jog, kneel, squat, dance, do housework, or play basketball with his sons. He is home-bound in the evenings, which he spends in a recliner elevating his feet in order to reduce the pressure on his legs.

CONCLUSIONS OF LAW AND OPINION

The Board adopts the Referee's opinion with the following comment.

The employer argued that the Referee should not have relied on treating physician Grewe's impairment rating to increase claimant's disability awards. Grewe rated impairment of the whole person and did not provide separate ratings for the scheduled and unscheduled injuries. Moreover, Grewe based his rating on an unidentified source, rather than the Department's claims evaluation rules or the AMA Guides to the Evaluation of Permanent Impairment.

We agree that the Referee erred to the extent he relied on Dr. Grewe's impairment rating. Nevertheless, documented objective findings and claimant's testimony support the Referee's disability awards.

The extent of unscheduled permanent partial disability is measured by the permanent loss of earning capacity due to the compensable injury. ORS 656.214(5). To determine the loss of earning capacity, one considers 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.

Documented objective findings establish significant loss of range of motion in claimant's neck. Claimant credibly testified that he suffers severe pain in his right shoulder that restricts his movement and reduces his strength. We consider this physical impairment along with claimant's age of 60, his high school education, his vocational preparation, and his return to regular work. We conclude this record supports the Referee's award of 40 percent (128 degrees) unscheduled permanent disability for claimant's neck and right shoulder.

The extent of scheduled permanent disability is measured by the permanent loss of use or function of the injured member due to the industrial injury. ORS 656.214(2). Dr. Grewe identified measurable loss of grip strength and loss of biceps/triceps strength. Claimant credibly testified to a highly diminished loss of strength in his right arm. Claimant has chronic thrombophlebitis in both legs. He credibly testified to marked edema in each of his legs, only partially controlled by elastic supports, that has resulted in extensive curtailment of his pre-injury activities. We conclude this record supports the Referee's scheduled permanent disability awards of 30 percent (57.60 degrees) for the right arm; 30 percent (45 degrees) for the left leg; and 30 percent (45 degrees) for the right leg.

ORDER

The Referee's order dated July 6, 1988, as amended July 8, 1988, is affirmed. For services on review, claimant's attorney is awarded a $700 assessed fee, payable by the self-insured employer. We approve a client-paid fee, not to exceed $2,073.50, payable by the employer to its counsel.

March 22, 1990 Cite as 42 Van Natta 583 (1990)

In the Matter of the Compensation of
ELDON L. SEEDER, Claimant
WCB Case Nos. 87-15629 & 87-15628
ORDER ON REVIEW
Becker & Hunt, Claimant Attorneys
Thomas Sheridan (Saif), Defense Attorney
Acker, et al., Defense Attorneys

Reviewed by Board Members Howell and Speer.

The SAIF Corporation requests review of those portions of Referee McGeorge's order that: (1) set aside its denial of claimant's aggravation claim

for his low back condition; and (2) upheld Liberty Northwest Insurance Corporation's "new injury" denial of the same condition. On review, the issue is responsibility. We affirm.

FINDINGS OF FACT

This is a case involving one employer and two insurers. The employer was insured by SAIF until July 1, 1986, when it began coverage with Liberty Northwest.

Claimant, 45 at time of hearing, began working for the employer in approximately 1979, as a lacquer finisher of brass parts. In March 1985, he sustained an injury to his low back and left lower extremity. Shortly thereafter, he filed an industrial injury claim and sought treatment from Dr. Eubanks, M.D. Dr. Eubanks diagnosed a lumbosacral strain. SAIF accepted the claim as a nondisabling injury.

Claimant returned to his at-injury job without restriction. However, he continued to experience pain in his low back and left leg. On April 4, 1986, he reinjured himself at work. He was examined by Dr. Smith, M.D., on April 9, 1986. Dr. Smith ordered lumbar x-rays and released claimant to work with restrictions on lifting. The x-rays revealed degenerative changes, but no signs of disc protrusion or herniation.

After a follow-up examination with Dr. Smith in May 1986, claimant went without further medical attention until he returned in November 1986. Dr. Smith then referred claimant to a physical therapist for approximately one month of regular treatments.

In early May 1987, claimant experienced low back pain as well as pain and numbness in his left hip, thigh and knee. Claimant returned to Dr. Smith on May 20, 1987. Dr. Smith ordered a CAT Scan which revealed disc herniations at L4-5 and L5-S1. As a result, Dr. Smith took claimant off work and recommended a two-week period of bed rest. Shortly thereafter, claimant filed an aggravation claim with SAIF and a "new injury" claim with Liberty Northwest. Both claims were denied.

Claimant began treating with Dr. Trail, M.D., in July 1987.

In October 1987, an ORS 656.307 order issued designating SAIF as the paying agent. The .307 order found that while claimant was employed by Liberty Northwest's insured, claimant's weekly wage was $261.25. While claimant was employed by SAIF's insured, his weekly wage was $200. Based on the weekly wages at the time of injury, the temporary total disability rates effective October 7, 1987 would be $179.37 and $146.02, respectively.

In November 1987, claimant underwent corrective low back surgery.

Claimant's symptoms progressively worsened following his March 1985 and April 1986 injuries. His work activities while Liberty was the insurer did not independently contribute to a worsening of his underlying condition.

CONCLUSIONS OF LAW AND OPINION

Responsibility

The Referee found that there was evidence of "actual causation" dur

ing the time SAIF was on the risk, and he concluded that SAIF remained responsible for claimant's disabling condition. We agree that SAIF is responsible but we base our conclusion upon the following reasoning.

The determinative legal inquiry concerning responsibility is whether claimant's work while Liberty was on the risk independently contributed to a worsening of his compensable, underlying condition. Hensel Phelps Construction v. Mirich, 81 Or App 290 (1986). Claimant need not have experienced a traumatic incident. Home Ins. v. EBI, 76 Or App 112 (1985). In this case he did not. The pivotal question is a complex one, the answer to which is dependent upon expert medical opinion. Kassahn v. Publishers Paper, 76 Or App 105 (1985).

There are three medical opinions in this case. None, however, persuasively support the proposition that claimant's underlying back condition worsened as a result of his work activities after July 1, 1986 (the date the employer changed its coverage from SAIF to Liberty Northwest). Dr. Smith's last opinion was given in May 1986. According to Dr. Smith, claimant had a "recurrent lumbosacral strain" that was exacerbated by his work activities and that, in turn, exacerbated his underlying degenerative joint disease.

Dr. Stewart reported that:

> "By nature of the (claimant's) history, it indicates that his injury in March of 1985 most likely resolved and was stationary. He was doing well until he had a new injury in April of 1986, but I guess that is neither here nor there."

Lastly, Dr. Trail incorrectly stated that claimant "first sustained injury to his lower back area around 5/6/87. Prior to that his complaint was upper back pain." Given Dr. Trail's incorrect history, we do not find his opinion to be persuasive.

Claimant's compensable injury of March 1985 was accepted as a nondisabling lumbar "strain." X-rays taken shortly thereafter were "neg(ative) for pathology." After several days off work, claimant returned to his regular job without restriction. Thereafter, he went without medical treatment for over a year until his flare-up of April 1986. Additional X-rays taken at that time revealed degenerative changes. In May 1987, claimant's low back pain increased. A CAT scan taken the following month revealed disc herniations at L4-5 and L5-S1. As a result, he was taken off work and eventually underwent corrective surgery.

We are unable to find reliable medical evidence that claimant's work activities after July 1, 1986, independently contributed to a worsening of his underlying condition. In addition, claimant's testimony indicates that his symptoms had progressively worsened over a long period of time following his compensable injury. We, therefore, find that SAIF remains responsible for claimant's low back condition.

A claimant's attorney is entitled to a carrier-paid fee for services rendered on Board review when a carrier initiates review of an issue which threatens 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, Liberty's weekly temporary total disability rate is approximately $61 more than that of SAIF. The amount of claimant's compensation was

not at risk on review because the party that sought review, SAIF, had the lower temporary disability rate. Had it prevailed in establishing that Liberty was responsible, claimant's compensation would have been increased, not decreased. Under such circumstances, claimant's attorney is not entitled to a carrier-paid fee for services on Board review. See Curtis R. Keys, 42 Van Natta 183 (1990).

ORDER

The Referee's order dated March 16, 1988 is affirmed. A client-paid fee, payable from Liberty Northwest to its attorney, not to exceed $654, is approved.

In the Matter of the Compensation of
DEBBIE J. WILSON, Claimant
WCB Case No. 88-07477
ORDER ON REVIEW (REMANDING)
Myrick, et al., Claimant Attorneys
Employers Defense Counsel, Defense Attorneys

Reviewed by Board Members Brittingham and Nichols.

Claimant requests review of Referee Mongrain's order that dismissed claimant's request for hearing due to claimant's failure to appear at the time and place set for hearing. Claimant seeks to have the dismissal set aside and to have the matter remanded to the Hearings Division for a hearing on the merits. We reverse and remand.

ISSUE

Whether claimant's request for hearing should have been dismissed due to claimant's failure to appear.

FINDINGS OF FACT

On July 28, 1988, the insurer's attorney and claimant's attorney appeared at hearing. Claimant, who lives in California, did not appear. Claimant's attorney moved for a postponement. The insurer's attorney moved for a dismissal. The Referee cited former OAR 438-06-071 as authority and indicated on the record that he would dismiss claimant's request for hearing.

On August 3, 1988, the Referee issued an order of dismissal subject to reinstatement upon a showing of good cause within 14 days. The good cause showing was to have included an affidavit from claimant as to why she did not appear at the scheduled hearing. On August 30, 1988, based on an affidavit received by the Referee on August 22, 1988, the Referee vacated the dismissal of August 3, 1988, and reinstated the request for hearing. On September 20, 1988, the Referee, after a motion to reconsider, issued an order of dismissal. The Referee did not address claimant's motion for postponement in his dismissal order.

CONCLUSIONS OF LAW AND OPINION

We recently held that, under the rule in effect at the time of this hearing, the Referee has an obligation to consider a motion for postponement even after an order of dismissal has entered. Mark R. Luthy, 41 Van Natta 2132

(1989). In this case, the motion was made before the hearing. The Referee should have decided whether a postponement was warranted.

Based on the record before us, we cannot determine whether this matter should have been postponed. We, therefore, find that the record has been incompletely developed. See ORS 656.295(5).

We further conclude that the Referee was incorrect in dismissing the hearing request based on claimant's failure to appear at the hearing. Williams v. SAIF, 99 Or App 367 (1989); Mario Miranda, 42 Van Natta 405 (1990).

Accordingly, this case is remanded to the Referee for reconsideration. If the Referee determines that a postponement of the July 28, 1988 hearing should have been granted, the Referee shall proceed with a hearing on the merits. If the Referee determines that a postponement of the July 28, 1988 hearing should not be granted, the Referee shall proceed with a hearing on the merits but shall not receive any exhibit which was not submitted in connection with the prior hearing, not allow any witness, including claimant, to testify who was not available to and planning on testifying at the prior hearing or under subpoena to testify at the hearing.

ORDER

The Referee's order, dated September 20, 1988, is vacated. Claimant's hearing request is reinstated, and this case is remanded to the Referee for further proceedings consistent with this order.

March 26, 1990 Cite as 42 Van Natta 587 (1990)

In the Matter of the Compensation of
IOLA P. CARR, Claimant
WCB Case No. 87-17373
ORDER ON REVIEW
Peter O. Hansen, Claimant Attorney
Roberts, et al, Defense Attorneys

Reviewed by Board Members Cushing and Gerner.

The insurer requests review of Referee Hoguet's order which: (1) set aside its denial of claimant's claim for a left knee condition; and (2) set aside its denial of claimant's medical services claim for psychiatric treatment. On review, the issues are compensability and medical services. We affirm in part, modify in part, and reverse in part.

FINDINGS OF FACT

Claimant sustained a compensable injury to her right arm and knee in April 1977. The injury occurred when she slipped and fell while working as a finish grind attendant for the employer. Claimant initially sought treatment for problems with her right arm (elbow). That claim was closed by a July 1978 Determination Order which awarded claimant 5 percent scheduled permanent disability. An October 1978 Stipulation increased claimant's scheduled award to 15 percent.

Claimant experienced no significant problems with her right knee until February 1980 when she sought treatment from Dr. Berselli, orthopedist. Dr. Berselli performed arthroscopic surgery in February 1980. In January 1981, Berselli performed another arthroscopy, a patellar shave and a lateral retinacular release.

In November 1981, claimant began to experience pain in her left knee. In August 1981, claimant sought treatment from Dr. Colistro, psychologist, for reactive depression. The insurer accepted the psychological problem as a compensable sequalae of her industrial injury.

In August 1983, a Determination Order awarded claimant 10 percent scheduled disability for her right leg (knee). An April 1984 Stipulation increased claimant's scheduled award for the right knee to 30 percent. The Stipulation further awarded claimant 15 percent unscheduled permanent disability for her psychological condition. Thereafter, claimant continued periodically but regularly to treat for her right knee problem. She also continued to treat with Dr. Colistro twice per month on a palliative basis.

In 1984, claimant entered into an authorized training program. Her claim was subsequently closed by a May 1985 Determination Order which awarded temporary disability benefits only. In late 1986, claimant's right knee condition worsened. Dr. Berselli requested authorization for additional arthroscopic surgery and patellar shaving with possible patellectomy. This procedure was performed in March 1987. During this time period, claimant continued to treat with Dr. Colistro for her psychological problems.

In July 1987, the insurer denied claimant's psychiatric care on the basis that it was not reasonable and necessary and was no longer related to her industrial injury. In May 1987, Dr. Berselli reported that claimant was experiencing left knee symptoms. He requested authorization to perform an arthroscopic exam of the left knee with possible patellar shaving. In October 1987, the insurer denied claimant's left knee condition on the basis that it was not related to her industrial injury.

As a result of problems with her compensable right knee condition, claimant fell, landing on her knees and other body parts and shifted her weight to her left leg.

Claimant has become dependent upon Dr. Colistro's psychiatric treatment. This dependency is harmful to claimant.

CONCLUSIONS OF LAW AND OPINION

Left Knee Condition

We adopt the conclusions and reasoning regarding claimant's left knee condition as set forth in the "Opinion" section of the Referee's order.

Psychological Condition

The Referee set aside the insurer's denial of claimant's ongoing psychiatric treatment. The denial was based on: (1) a lack of causal relationship between claimant's current condition and the compensable injury; and (2) reasonableness and necessity of her current treatment with Dr. Colistro. We agree with the Referee that claimant's psychiatric condition is compensable; however, we disagree that her current treatment is reasonable and necessary.

Dr. Colistro opined that claimant's psychiatric condition remained secondary to her industrial injury and subsequent surgeries. Dr. Klein did not feel claimant had a significant psychiatric problem but opined that her condition was resultant from overfocusing on her physical symptoms. Dr. Rieter also opined that claimant's current condition was somatic and was due to overfocusing on her physical condition. Finally, Dr. Hayes opined that claimant had a

psychogenic pain disorder, but that any treatment would most likely be related to a preexisting personality disorder.

Under these circumstances, we find that claimant's industrial injury and its sequalae remain a material contributing factor to her current psychiatric condition. Almost all of the medical evidence relates claimant's psychiatric condition, in some degree, to her compensable injury. To the extent that Dr. Hayes' opinion relates her current conditions solely to a preexisting personality disorder, we do not find it persuasive. We now turn to the reasonable and necessary issue.

Claimant is entitled to medical services so long as they are reasonably and necessarily incurred for the treatment of her compensable injury. McGarry v. SAIF, 24 Or App 883, 888 (1976).

Dr. Colistro has treated claimant for a reactive depression condition, on at least a twice-a-month basis, for approximately seven years. He opined that his treatment was necessary to help claimant control her pain behavior and depression.

Dr. Reiter opined that claimant is not depressed but, rather, is anxious and overly focused on her somatic symptoms. He further opined that claimant had reached the maximum benefits from psychotherapy and recommended that further treatment be discontinued. Dr. Hayes also opined that claimant was dependent on psychotherapy and that further treatment would reinforce her dependency. Finally, Dr. Klein found no significant psychiatric problem and opined that claimant was stationary with no psychiatric limitations.

Given the length of Dr. Colistro's treatment, with no significant change in claimant's psychiatric condition, we are not persuaded by Dr. Colistro's opinion. Further, he offers no persuasive explanation regarding the reasonableness and necessity of his treatment and does not address claimant's dependency on his treatment. We instead are persuaded by the opinions of Drs. Reiter, Hayes and Klein and conclude that Dr. Colistro's treatment is neither reasonable or necessary in light of claimant's dependency.

As claimant has not finally prevailed upon the insurer's denial in full, we will modify the Referee's award of attorney fees at hearing concerning the denial.

ORDER

The Referee's order dated July 18, 1988, is reversed in part, modified in part, and affirmed in part. That portion which set aside the insurer's denial of claimant's current psychiatric care on the basis that it was not reasonable and necessary is reversed. That portion of the denial is reinstated and upheld. In lieu of the Referee's attorney fee award for services at hearing, claimant's counsel is awarded $1,500. The remainder of the order is affirmed. For services on review concerning the compensability of the left knee and psychiatric conditions, claimant's counsel is awarded a reasonable assessed fee of $600. A client-paid fee, not to exceed $1,553, payable by the insurer to its counsel, is approved.

In the Matter of the Compensation of
JIMMY D. ELLIS, Claimant
WCB Case No. 88-11791
ORDER ON REVIEW
Vick & Gutzler, Claimant Attorneys
Stafford J. Hazelett, Defense Attorney

Reviewed by Board Members Myers and Gerner.

The insurer requests review of that portion of Referee Higashi's order which set aside its denial of an industrial injury of June 10, 1988. On review, the sole issue is compensability. We reverse.

FINDINGS OF FACT

Claimant worked for the employer as a production worker in its recreational vehicle manufacturing plant. On May 25, 1988, claimant noticed back pain, which he attributed to his work. He lost no time from work and saw no physician for back pain between May 25, 1988 and June 10, 1988.

On June 10, 1988, claimant was working in a paint booth. He bent over and suddenly sneezed. Following the sneeze he felt an immediate increase in pain. The pain was much more severe than it had been from May 25, 1988 until that time. Claimant saw a chiropractor and ultimately a neurosurgeon. A CT scan revealed a ruptured disc at L5-S1.

Claimant filed a claim for the June 10, 1988 incident on June 15, 1988. The insurer denied that claim on June 28, 1988. Claimant timely appealed that denial.

Claimant filed a claim for the May 25, 1988 onset of pain on July 5, 1988. The insurer denied that claim on July 14, 1988. Claimant did not appeal that denial until the date of hearing, October 4, 1988. The Referee found that claimant did not have good cause for appealing this denial within 60 days. Claimant does not contest that finding.

CONCLUSIONS OF LAW AND OPINION

Claimant has the burden of proving by a preponderance of the evidence that his injury arose out of and in the course of his employment. Phil A. Livesley Co. v. Russ, 296 Or 25, 28 (1983). Claimant must show a causal link between the occurrence of the injury and a risk connected with his employment. Id at 29. The Supreme Court in Livesley noted that an employee who suffers an appendicitis attack on the job is not entitled to workers' compensation benefits.

In this case, claimant sneezed while at work. Although we might surmise that claimant sneezed as a result of working in an enclosed paint booth, there is absolutely no evidence that claimant's whereabouts on the job or the particular conditions of the job caused the sneeze. We are unwilling to draw an inference of a causal connection between the sneeze and a risk associated with claimant's work where there is a dearth of evidence to support that inference. Accordingly, we conclude that claimant has failed to prove by a preponderance of the evidence that his injury arose out of and in the course of his employment.

ORDER

The Referee's order, dated November 29, 1988, is affirmed in part and reversed in part. Those portions of the Referee's order which set aside the insurer's denial of June 28, 1988 and which awarded an assessed fee $1,600, are reversed. That denial is reinstated and upheld. The balance of the Referee's order is affirmed.

In the Matter of the Compensation of
NATALIA GALVAN, Claimant
WCB Case No. 88-04485
ORDER ON REVIEW
Michael B. Dye, Claimant Attorneys
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Myers and Cushing.

The insurer requests review of those portions of Referee Menashe's order which: (1) set aside its denial of an occupational disease claim for a left arm condition; and (2) assessed a penalty and attorney fee for late payment of interim compensation. On review, the issues are compensability, penalties and attorney fees. We reverse.

FINDINGS OF FACT

Claimant worked for the employer for several years. In the Fall of 1987 she began working as a pillow closer. On March 2, 1988 she filed a claim alleging that her work activities caused left arm pain. Claimant continued to work up to the date she filed her claim.

In October 1987 claimant was involved in an off-the-job altercation with her sister. She first began complaining of left shoulder pain after the altercation. Claimant's sister was also her baby-sitter. The sister stopped babysitting after the altercation. Thereafter, claimant began missing time from work and began asking to be laid off so that she could collect unemployment compensation.

CONCLUSIONS AND OPINION

The Referee correctly applied current ORS 656.802 rather than former ORS 656.802 because claimant's last employment exposure which could have caused her disability occurred after January 1, 1988. Donna E. Aschbacher, 41 Van Natta 1242 (1989). Under ORS 656.802(1)(c) claimant has the burden of proving by a preponderance of the evidence that her work activities were a material cause of her need for medical treatment or her disability. Aschbacher, supra. The Referee concluded that claimant had met her burden of proof. We disagree.

The Referee relied upon claimant's testimony and the opinion of the treating chiropractors, Dr. Romanick and Dr. Poul. He declined to make an express finding about claimant's credibility. Rather, he relied on the presumption that every witness is presumed to speak the truth and then stated that based on claimant's demeanor he was unable to find her untrustworthy. In the absence of an express credibility finding based on demeanor, we are in as good a position as the Referee to make a credibility finding. Based on inconsistencies between claimant's testimony and the testimony of other witnesses, we are unwilling to rely on claimant's testimony. In particular, claimant testified that she never complained that the altercation with her sister caused her pain. Two other witnesses contradicted that testimony.

Because we are unable to rely on claimant's testimony, we are also unable to rely on the opinions of the treating chiropractors because their opinions are based primarily upon claimant's history. On the other hand, when presented with the history of the altercation, Western Medical Consultants opined that the altercation was the more likely cause of claimant's pain complaints than was her work activities. Consequently, we conclude that claimant has failed to prove by a preponderance of the evidence that her work activities were a material cause of her need for treatment or disability.

Claimant concedes that there is no evidence to support the conclusion that the insurer failed to pay interim compensation. Accordingly, the penalty and fee awarded by the Referee will be reversed.

ORDER

The Referee's order dated November 10, 1988 is reversed. The insurer's denial of March 17, 1988 is reinstated. The penalty and all attorney fees awarded by the Referee to claimant or claimant's attorney ($2,000) are reversed. The Board approves a client-paid fee, not to exceed $4,232.50, payable by the insurer to its attorney.

In the Matter of the Compensation of
RANDOLPH P. GAUL, Claimant
WCB Case No. 88-04876
ORDER ON REVIEW
Peter O. Hansen, Claimant Attorney
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Myers and Cushing.

The self-insured employer requests review of those portions of Referee Schultz's order which: (1) set aside the employer's partial denial of claimant's psychological condition; (2) increased claimant's time loss rate; and (3) set aside a Determination Order as premature. On review, the issues are compensability, time loss rate, premature closure and as an alternative issue extent of unscheduled permanent disability. We affirm.

We affirm and adopt the Referee's order with the following supplementation to his conclusions.

The self-insured employer argues that under the 1987 amendments to ORS 656.802, claimant must prove by clear and convincing evidence that his psychological condition arose out of and in the course of his employment. See ORS 656.802(2). We disagree.

The employer's argument is misplaced. ORS 656.802 defines occupational diseases. In the context of that statute, to be compensable as an occupational disease, claimant does have the burden of proving by clear and convincing evidence that the mental disorder arose out of and in the course of employment. However, this case is not an occupational disease case. 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, 507-8 (1972). Accordingly, we agree with the Referee that claimant has the burden of proving by a preponderance of the evidence that the compensable injury is a material cause of the psychological condition. We also agree with the Referee that claimant has carried his burden of proof.

Turning to the issue of whether claimant was medically stationary, we rely on Dr. Worthington's opinion that as a result of the psychological condition, claimant was temporarily disabled when he first examined claimant in May 1986 and that, thereafter, he continued to improve psychologically. Furthermore, on March 24, 1986 Dr. Pasquesi stated only that claimant's orthopedic problem was medically stationary. He noted that the psychological problem was significant,

but did not consider it because he could not determine how much of it was due to the compensable injury. The Determination Order found claimant medically stationary on March 25, 1986; however the Evaluation Section did not consider claimant's psychological condition. On May 31, 1986, the treating doctor for the orthopedic problems, Dr. Richards, opined that until the psychological condition resolved the orthopedic problems were never going to resolve. Based on these opinions, we conclude that at the time of claim closure there was a reasonable medical expectation that psychological treatment would materially improve claimant's condition. See Scheuning v. J.R. Simplot & Co., 84 Or App 622 (1987).

ORDER

The Referee's order, dated October 25, 1988, is affirmed. Claimant's attorney is awarded an assessed fee of $1,000, to be paid by the self-insured employer. The Board approves a client-paid fee, not to exceed $2,392.50, payable from the self-insured employer to its counsel.

March 26, 1990 Cite as 42 Van Natta 593 (1990)

In the Matter of the Compensation of
MARILYN F. GOSNELL, Claimant
WCB Case No. 86-00103
ORDER ON REVIEW
Emmons, et al., Claimant Attorneys
John Motley (Saif), Defense Attorney

Reviewed by Board Members Speer and Howell.

Claimant requests review of those portions of Referee Baker's order that: (1) rejected her contention that her claim had been prematurely closed; (2) upheld the SAIF Corporation's "de facto" denial of her aggravation claim; and (3) rejected her request for an award of permanent total disability. In its respondent's brief, SAIF urges the Board to reverse that portion of the Referee's order that increased claimant's award of unscheduled permanent partial disability for her low back from the 40 percent (128 degrees) granted by Determination Order to 65 percent (208 degrees). On review, the issues are premature closure, aggravation, and permanent disability, including permanent total disability.

We affirm those portions of the Referee's order concerning the premature closure and aggravation issues. We grant permanent total disability.

FINDINGS OF FACT

Claimant compensably injured her low back on August 10, 1984 when she slipped and fell on her left buttock. She sought treatment from Dr. Endicott, a family practitioner. Dr. Endicott noted pain and weakness affecting claimant's left leg and referred her to Dr. Tsai, a neurosurgeon. Dr. Tsai diagnosed a herniated disc at L4-5 and performed surgery.

Claimant complained of continued low back pain and left leg weakness and numbness. Dr. Tsai could identify no objective basis for claimant's level of complaints and opined that she had experienced a "conversion reaction." He referred her to Health Resource Systems, Inc. (HRS), an occupational and restorative health services provider, for further evaluation.

Dr. Anderson, an orthopedic surgeon and the Director of HRS, examined claimant in July 1985 and noted complaints out of proportion to the objective findings. He diagnosed "symptom magnification syndrome." Claimant began the HRS program of physical therapy and exercise in late August 1985. By October 24, 1985, claimant was complaining of extreme pain and had begun walking "bent over." She then discontinued participation in the program.

By November 1985, claimant was medically stationary. Her claim was closed by Determination Order dated December 13, 1985 with a 40 percent unscheduled award for claimant's low back and a 15 percent scheduled award for her left leg.

In January 1986, SAIF referred claimant for vocational assistance. After an initial assessment, claimant was enrolled in classes at a community college. She began classes on September 29, 1986. Four days later she saw Dr. Endicott, complaining of a severe increase in low back and left leg pain. Dr. Endicott recommended that claimant discontinue her schooling and she did.

SAIF accepted claimant's increase in symptoms as an aggravation and reopened her claim in March 1987. The aggravation claim was closed by Determination Order dated August 18, 1987 with no additional award for permanent partial disability.

During mid September 1987, claimant began to experience increasing low back pain and left leg pain and weakness. On September 28, 1987, she sought treatment from Dr. Endicott. Dr. Endicott put claimant in the hospital for pelvic traction and evaluation by Dr. Tsai. Dr. Tsai noted signs of radicular irritation and performed a steroid injection in the area of the S1 nerve root. There was no improvement in claimant's condition. She was discharged from the hospital on October 4, 1987.

On October 19, 1987, claimant was examined by Dr. Davies, a psychologist. Dr. Davies administered a MMPI, reviewed the medical record, and conducted a personal interview. He diagnosed a "severe character disorder with infantile-hysterical, hypomanic and borderline features" and a "hysterical conversion reaction with hypochondriasis, psychophysiological overreactivity, and somatoform pain disorder." Davies indicated that claimant's condition was medically stationary in that it was not amenable to treatment and would not improve with the passage of time.

After comparing claimant's 1985 MMPI findings with her current test results, Dr. Davies concluded that claimant's psychiatric condition had become worse secondary to compensation factors. Dr. Kuttner, an examining psychiatrist, agreed that claimant's compensable injury had permitted her underlying psychiatric problems to become a major disability as a conversion reaction.

Dr. Tsai concluded that claimant's physical and psychological problems had permanently incapacitated her from regularly performing any type of gainful and suitable employment. Because of these disabilities, Tsai foresaw no potential for vocational rehabilitation efforts.

Claimant timely requested hearings on both the December 1985 and August 1987 Determination Orders. The requests were consolidated for hearing.

Claimant was 40 years old at the time of the hearing. She dropped out of school before completing the twelfth grade, but later obtained a GED. Her work history is mainly in the cannery industry. Because of her compensable injury and psychological condition, claimant experiences constant low back and left leg pain and is unable to lift more than 10 pounds or to sit or stand for

more than 15 minutes. Other than participating in vocational assistance efforts, claimant has not attempted to look for employment.

FINDINGS OF ULTIMATE FACT

1. At the time of the December 1985 and August 1987 Determination Orders, no material improvement in claimant's compensable condition was reasonably expected with medical treatment or the passage of time.

2. Claimant was hospitalized in October 1987 but experienced no increased loss of earning capacity nor any increased loss of use of her injured leg during hospitalization.

3. Claimant's permanent impairment as a result of her compensable injury and her conversion reaction renders her permanently incapacitated from regularly performing work at a gainful and suitable occupation. It would be futile for claimant to look for work.

CONCLUSIONS OF LAW

1. Premature Closure

Claimant contends that her psychological condition is compensable and was not declared medically stationary until October 1987 and thus that both the December 1985 and August 1987 Determination Orders were prematurely issued. Assuming without deciding that claimant's premises are correct, we disagree with her conclusion.

ORS 656.005(17) provides: "'Medically stationary' means that no further material improvement would reasonably be expected from medical treatment, or the passage of time." According to Dr. Davies, the psychologist who examined claimant in October 1987, claimant's psychological condition was not amenable to treatment and would not improve with the passage of time. Similar views were expressed by Dr. Kuttner, a psychiatrist who examined claimant in January 1988. There is no contrary evidence. Under these circumstances, we conclude that claimant's psychological condition was medically stationary before both Determination Orders and the Determination Orders were not prematurely issued.

2. Aggravation

To establish a compensable aggravation, claimant has the burden of proving a worsening of her condition since the last arrangement of compensation and a resulting increase in her loss of earning capacity or an increased loss of use or function of her injured leg. See Smith v. SAIF, 302 Or 396 (1986); and International Paper Co. v. Turner, 304 Or 354 (1987), on rem 91 Or App 91 (1988).

The last arrangement of compensation was the August 18, 1987 Determination Order. We find that claimant was permanently and totally disabled at that time. She did not, therefore, experience an increased loss of earning capacity thereafter. Neither has she shown an increased loss of use or function of her injured leg. Claimant has failed to prove her claim for aggravation.

3. Extent of Disability

The Referee rejected claimant's request for an award of permanent total disability. He found her psychological condition not compensable on the ground that "the evidence does not establish that the industrial injury or its sequelae

materially caused or aggravated any permanently disabling psychological condition." We disagree.

There is little doubt that claimant is permanently totally disabled if her psychological condition is compensable. (See Ex. 77-3, 83C, 85A-2, 87, 88, 89-5; Tr. 90, 95). Her pain complaints are such that she is incapable of any significant activity. Seeking employment in such a condition would be futile. Whether claimant is entitled to an award of permanent total disability, therefore, turns upon whether claimant's compensable injury was a material contributing cause of a worsening of her preexisting psychological condition.

Resolution of this issue turns on an evaluation of the two psychological professionals who examined claimant. Both Drs. Kuttner and Davies agree that claimant had a personality disorder which preexisted the industrial injury and that this disorder was characterized by hysterical and dependent tendencies. (Ex. 83A-8, 89-5). They also agree on a basic diagnosis of an hysterical conversion reaction and that claimant's industrial injury has served as the focus for, and prompted the manifestation of, this reaction. (Ex. 83A-8, 89-5 to 6).

Davies opined that claimant's compensable injury allowed her preexisting personality defects to manifest themselves. Kuttner agreed, concluding that claimant's injury materially contributed to a previously nondisabling psychological condition.

These opinions are further supported by other physicians including Dr. Kendicott, claimant's attending physician, and Dr. Tsai, claimant's surgeon. Based on the aforementioned medical opinions, we conclude that claimant's compensable injury materially contributed to her psychological disability. See Weyerhaeuser Company v. Rees, 85 Or App 325, 328 (1987). Consequently, we have considered her psychological condition in determining the extent of her permanent disability.

After considering the medical evidence, we are persuaded that claimant's compensable physical and psychological impairment have permanently incapacitated her from regularly performing work at a gainful and suitable occupation. See ORS 656.206(1)(a). We are further persuaded that claimant was willing to seek work and, considering her impairments, that her attempts to return to the work force by means of her participation in vocational assistance have been reasonable. See ORS 656.206(3).

Alternatively, we hold that it would be futile for claimant to participate in vocational rehabilitation efforts or to seek employment. See Brech v. SAIF, 72 Or App 388 (1985). Accordingly, we conclude that claimant is entitled to permanent total disability benefits.

ORDER

The Referee's order dated March 25, 1988 is affirmed in part and reversed in part. That portion of the Referee's order that awarded claimant additional permanent partial disability is reversed. Claimant is awarded permanent total disability, effective August 18, 1987. The SAIF Corporation is authorized to offset against this award any permanent disability compensation paid after the effective date of this award. In accordance with the attorney fee agreement between claimant and her attorney, claimant's attorney is awarded an attorney fee of 25 percent of the increased compensation granted by this order, not to exceed $2,000. Claimant's attorney is also awarded an assessed fee of $425 for services with respect to SAIF's request to reduce claimant's compensation. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
DEAN A. GRUDZINSKI, Claimant
WCB Case No. 88-10851
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Acker, et al., Defense Attorneys

Reviewed by Board Members Cushing and Myers.

The self-insured employer requests review of Referee Tenenbaum's order that: (1) set aside its denial of claimant's occupational disease claim for bilateral shoulder and elbow conditions; (2) assessed penalties and attorney fees for unreasonable denial; and (3) approved a client-paid fee. On review, the issues are compensability, penalties and attorneys fees. We reverse.

FINDINGS OF FACT

Claimant is a right-handed 36-year-old individual, who had been employed by the employer, a freight carrier, for 4 years.

In February 1988, claimant began working as a hostler on the break-up pad. His duties involved disconnecting trailers, shutting off valves, cranking down landing gears and disconnecting air lines. These duties occupied 50-75 percent of claimant's time, depending on the side of the pad he worked on. The rest of the time, claimant would drive a utility vehicle and perform other minimal physical duties.

On March 25, 1988, claimant received a counseling session after his Shift Operation Manager had observed him reading a newspaper while he was on duty. Later that day, claimant filed an 801 form. He indicated that employment duties during the month of February caused the shoulder and elbow pain. Claimant offered no more specific time frame for the development of the pain.

On that same day, Dr. Torres, M.D., reported that both of claimant's shoulders and elbows hurt him. Claimant left work on March 25, 1988.

On May 24, 1988, the employer denied claimant's claim, noting that it did not feel the shoulder and elbow conditions were compensably related to his employment exposure.

By letter dated May 27, 1988, Dr. Kiest, orthopedic surgeon, reported that claimant had suffered a February 1, 1988 on-the-job accident. He noted that claimant was experiencing "no real difficulties" at the time of the examination, and that he was able to return to work. Dr. Kiest asserted that claimant would not have any permanent impairment.

Dr. Torres noted that claimant was released for regular work on May 28, 1988, whereupon he again worked as a hostler. (Ex. 9; Tr. 56).

Claimant had filed two previous workers' compensation claims, hence he was familiar with how the system worked.

Based on our review of the record, we find that claimant lacks credibility.

CONCLUSIONS OF LAW AND OPINION

Compensability

The Referee found claimant's occupational disease claim to be compensable. 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 February 1988 led to the shoulder and elbow pain. He filed his workers' compensation claim on March 25, 1988. Accordingly, the new occupational disease law which became effective January 1, 1988, is applicable. ORS 656.802.

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). The causation of claimant's shoulder and elbow conditions is a complex medical question. Thus, while his 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 his burden.

We generally defer to a Referee's assessment of credibility when his or her finding is based on demeanor. Humphrey v. SAIF, 58 Or App 360 (1982); Robert W. Cooper, 40 Van Natta 486 (1988). On the other hand, when the Referee's credibility finding is based on the substance of the witnesses' testimony, rather than demeanor, we are in as good a position to assess credibility as is the Referee. Coastal Farm Supply v. Hultberg, 84 Or App 282 (1987).

In the present case, the Referee indicated that she found both the surveillance film and claimant's testimony to be consistent with his story. After reviewing the record, we disagree with the Referee's conclusions.

Claimant's version of events conflicted with evidence offered by the employer. In a statement taken on April 5, 1988, claimant reported that for the previous month he had not been "...using [his] arms or ... [my] shoulders for any type of stressful activity." (Ex. 12, pages 17-18). He related that he experienced discomfort in his right and left shoulder and left elbow. Id. at 19. He indicated that he was physically limited by pain and that he couldn't "lift anyway". Id.

On the other hand, the employer produced a video filmed on April 7, 1988, two days after claimant's statement. (Ex. 13). In the video, claimant did perform stressful activities, such as carrying both his children, including his approximately 30-pound daughter. At one point, claimant lifted his daughter from ground level, and easily placed her on his shoulders. Afterwards, he spun around several times, while holding on to the girl's feet. Claimant then removed her from his shoulders without displaying any apparent difficulty or pain. Shortly thereafter, claimant set about to fix his picnic table. He placed one knee on a bench and leaned under the table, where upon he started to hammer underneath the table top. While hammering, claimant had to flex both his shoulder and elbow muscles. During this exercise claimant demonstrated no apparent pain. We find claimant's testimony significantly impeached by the video recording of his activities.

Furthermore, claimant failed to adequately explain the delay in filing his claim. Claimant indicated that he was aware that work-related pain and soreness was to be reported immediately to management. (Tr. 30). Indeed, claimant indicated that he had filed his two previous workers' compensation claims on the same day that pain developed. (Tr. 31). Since he had filed prior workers' compensation claims, claimant was aware of the company policy regarding prompt notification of a claim.

Here, claimant was witnessed reading a newspaper while sitting in a yard vehicle. This led to a counseling session regarding claimant's work performance. During the meeting with his shift operations manager, claimant made no reference to shoulder or elbow pain. It was only after this meeting that claimant filed the 801 claim indicating that he had suffered an on-the-job injury. (Tr. 68). In light of the delay and circumstances surrounding claimant's filing his 801 form and the activities filmed on the surveillance video, we conclude that claimant is not a credible witness.

Regarding claimant's medical condition, Dr. Torres opined that claimant had a "...tender Rt. latero superior shoulder, Lt. antecubital area". (Ex. 4). He indicated that these findings were subjective. On May 10, 1988, Torres noted that his findings were based on the history given to him by claimant. Since we have found claimant not credible, Dr. Torres's opinion is less persuasive as it was not based on an accurate history. See Miller v. Granite Construction Co, 28 Or App 473, 476 (1977).

Dr. Kiest, orthopedic surgeon, examined claimant on May 27, 1988. He reported that claimant attributed the pain in his right shoulder to repetitive work activity. Claimant reported a gradual worsening of the right shoulder and elbow discomfort, along with the development of left shoulder and elbow pain. Dr. Kiest based his medical opinion on claimant's version of events. He reported that claimant had no complaints as of the date of the examination. Kiest made no other findings as to the causal relationship between claimant's elbow and shoulder conditions and the alleged work activity. Consequently, his opinion is also accorded lesser weight as it was not based on a credible medical history. Id.

In evaluating medical opinions, we give weight to those that are well reasoned and based on complete information. Dr. Torres' and Kiest's diagnoses are based on history provided by claimant. Claimant is not a credible witness. Therefore, we are unable to find that either physician had an accurate understanding of claimant's condition and its causal relationship to his employment activities. Consequently, their opinions regarding causation lack persuasiveness. Id.

Inasmuch as we cannot rely on claimant's testimony, his version of events nor the medical opinions, we are unable to find a causal relationship between claimant's shoulder and elbow conditions and his employment. Consequently, claimant has failed to meet his burden to establish that his work as a hostler for the employer materially contributed to his bilateral shoulder and elbow conditions.

Unreasonable Denial

The Referee found the employer's denial of claimant's occupational disease claim to have been unreasonable. We disagree.

The employer based its denial on the lack of objective medical findings regarding claimant's condition and on the questionable timing between the alleged industrial injury and the filing of the 801 form. We conclude that the employer had a legitimate doubt concerning whether a causal relationship had been established between the bilateral shoulder and elbow conditions and claimant's work. Brown v. Argonaut Insurance Company, 93 Or App 588 (1988). Therefore, the employer's denial was not unreasonable.

Attorney Fees

The Referee approved a client-paid fee of $1,200. The employer contends this fee was inadequate. After review of the statement of services for the employer's counsel and considering the factors set forth in OAR 438-15-010(6), we approve a client-paid fee, for services at hearing and on Board review, not to exceed $1,857.50, payable from the employer to its counsel.

ORDER

The Referee's order, dated October 13, 1988, is reversed. The employer's denial is reinstated and upheld. The Referee's attorney fee award of $1,300 to claimant's counsel is reversed. In lieu of the Referee's approval, the Board approves a client-paid fee, not to exceed 3,710.50, payable by the employer to its counsel, for her services at hearing and on Board review.

March 26, 1990 Cite as 42 Van Natta 600 (1990)

In the Matter of the Compensation of
CLAUDIA I. HAMILTON, Claimant
WCB Case No. 87-10358
ORDER ON REVIEW
Bernt A. Hansen, Claimant Attorney
Schuyler T. Wallace, Jr., Defense Attorney
Cummins, et al., Defense Attorneys

Reviewed by Board Members Myers and Gerner.

The self-insured employer requests review of those portions of Referee Higashi's order which: (1) set aside a Determination Order as premature; (2) declined to reduce temporary disability; (3) declined to reduce claimant's scheduled permanent disability award of 35 percent (52.5 degrees) for loss of use or function of the right leg (knee); and (4) declined to address the propriety of the employer's aggravation denial. On review, the issues are premature closure, extent of temporary disability, extent of permanent disability and aggravation. We reverse.

FINDINGS OF FACT

Claimant injured her right knee on October 11, 1984. This injury necessitated surgery on March 8, 1985 and a second surgery shortly thereafter of a postsurgical infection. Claimant was declared medically stationary by her then attending physician, Dr. Snider, on October 24, 1985. A Determination Order, issued January 21, 1986, awarded temporary disability until November 7, 1985 and 35 percent (52.50 degrees) scheduled permanent disability to the right leg. Claimant and employer appealed the Determination Order. (Ex. 31).

Claimant changed attending physicians and sought care from Dr. Teal, orthopedic surgeon. Teal requested authorization to perform another surgery. On May 22, 1987, the employer denied the surgery request. Claimant appealed. On June 11, 1987, a hearing was held before Referee Emerson. The issues arising from the Determination Order, including premature closure, were reserved for later litigation, but the WCB Case assigned to the issues was not placed in inactive status and instead the referee disposed of the entire WCB case with his August 5, 1987 Opinion and Order. Referee Emerson found that the surgery was reasonable and necessary and set aside the employer's denial. This order was not appealed. On June 17, 1987, the employer denied a claim for aggravation. Claimant appealed.

Claimant underwent her third surgery to her knee on July 30, 1987. Due to the surgery, claimant experienced a temporary increase in the loss of use and function of her leg. She became medically stationary from the surgery on September 21, 1987.

Both claimant's attempt to raise the issue of premature closure and the employer's attempt to reduce the temporary and permanent disability from the January 1986 Determination Order occurred orally at the November 2, 1987 hearing. By the date of hearing, the January 21, 1986 Determination Order had become final by operation of law.

CONCLUSIONS OF LAW AND OPINION

Premature Closure, Extent of Permanent and Temporary Disability

The Referee erred when he reviewed the propriety of the January 21, 1986 Determination Order. The parties, at the June 11, 1987 hearing, "reserved" the issues of extent of permanent and temporary disability and premature closure after having raised those issues by a request for hearing. The Referee in that case went on to litigate and finally resolve the other "nonreserved" issues raised by that request for hearing.

The "reservation" or "preservation" of issues raised by the request for hearing amounts to a dismissal of those issues without prejudice when the Referee issues a final order addressing other issues raised by the request for hearing. The parties then have leave to reraise the issues that were "reserved" at any time within the time limits set out by ORS 656.319. See David L. Mallette, 38 Van Natta 843 (1986).

In this case, no new request for hearing was filed appealing the Determination Order prior to the time that the order became final by operation of law. ORS 656.319(4). Because the appeal of the Determination Order was untimely, we reverse the Referee and reinstate the Determination Order in its entirety.

Aggravation

While the employer's denial was issued on June 17, 1987, we consider the aggravation claim to encompass claimant's condition until hearing. Rater v. Pacific Motor Trucking Co., 77 Or App 418 (1986); Vandehey v. Pumilite Glass & Building, 35 Or App 187 (1978). After the aggravation denial issued in this case, claimant underwent a third surgical procedure on her injured knee. Claimant is entitled to have her claim reopened beginning July 30, 1987, the date of her surgery. ORS 656.273.

ORDER

The Referee's order, dated March 4, 1988, as amended July 5, 1988, is reversed. The January 21, 1986 Determination Order is reinstated. The employer's denial is set aside. Claimant's aggravation claim is remanded to the employer for processing according to law. For services at hearing and on review, claimant's attorney is awarded an assessed fee of $1,500, to be paid by the employer. The Board approves a client-paid fee, not to exceed $2,676.50, payable from the employer to its former counsel.

In the Matter of the Compensation of
VERDA SACHSE HARMON, Claimant
WCB Case No. 87-09996

In the Matter of the Compensation of
DEBORAH M. McFARLAND JOHNSON, Claimant
WCB Case No. 87-09997
ORDER ON REVIEW
Brothers, et al., Claimant Attorneys
Johnson, Marceau, et al., Defense Attorneys

Reviewed by Board Members Howell and Speer.

Claimants in this consolidated proceeding request review of Referee Quillinan's order that: (1) found that the employer was not a subject employer and claimants were not subject workers; and (2) upheld the SAIF Corporation's denial of claimants' injury claims. On review, the issue is whether claimants are subject workers. We reverse.

FINDINGS OF FACT

The Board adopts the Referee's findings of fact with the following supplementation.

Claimant Harmon was fired on one occasion for leaving town without the approval of Utalla Pilots (Utalla). Another pilot was fired when she drove as a pilot by her own arrangement and did not first consult Utalla.

Utalla instructed pilots in regard to proper dress and conduct while they were on a job.

Pilots were instructed to give drivers Utalla business cards. They were also told not to give the drivers their own phone numbers. Pilots did not set their own rate of compensation.

CONCLUSIONS OF LAW AND OPINION

The Referee found that Utalla was not an employer because it did not contract to pay remuneration to the pilots and it did not control the services of the pilots. See ORS 656.005(13). We disagree with the Referee's conclusion.

Claimants have the burden to prove by a preponderance of the evidence that an employer/employee relationship exists. The test for determining who is a subject worker is the employer's right to control the performance of the services. The right-to-control analysis consists of the following factors: (1) direct evidence of the right to, or the exercise of, control; (2) the method of payment; (3) the furnishing of equipment; and (4) the right to fire. Woody v. Waibel, 276 Or 189 (1976); Castle Homes, Inc. v. Whaite, 95 Or App 269 (1989).

Although the Referee found lack of control because the pilots were free to accept work from other services or truckers, the pilots were required to pay a commission to Utalla for calls that were not arranged through Utalla. A driver testified at hearing that she had been fired for driving as a pilot by her own arrangement. Under these circumstances, the pilots' "freedom" to accept work from other services or truckers was largely illusory.

In regard to the method of payment, the individual pilots did not participate in the decision between the truck drivers and Utalla as to the rate of compensation. Although the arrangements varied, the pilots typically received 90 percent of the compensation and Utalla received or retained a 10 percent commission.

Pilots provided their own cars, light bars and insurance. The pilots also paid for the maintenance of the vehicles. Utalla provided business cards and billing forms with its name upon them. Utalla also provided a blanket light permit for use in Nevada.

Pilots were told that if they did not perform the job the way Utalla wished, they would be fired. Claimant Harmon was fired once for leaving town without prior approval of Utalla. Another pilot was fired when she drove as a pilot without first contacting Utalla.

Under the circumstances, we find sufficient evidence to establish control. Utalla was an employer and the pilot drivers were employees of Utalla Pilots for purposes of workers' compensation coverage.

Because claimants' injuries arose out of and in the course of employment with the employer, their injuries are compensable. ORS 656.005(7)(a).

Claimants' 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 claimants' 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 May 16, 1988 is reversed. The SAIF Corporation's denials of April 27, 1987 are set aside. These claims are remanded to SAIF Corporation for acceptance and payment of compensation in accordance with Workers' Compensation Law.

March 26, 1990 Cite as 42 Van Natta 603 (1990)

In the Matter of the Compensation of
DANIEL P. MANN, Claimant
WCB Case No. 88-04709
ORDER ON REVIEW
Aller & Morrison, Claimant Attorneys
Cowling & Heysell, Defense Attorneys

Reviewed by Board Members Cushing and Gerner.

Claimant requests review of that portion of Referee Quillinan's order that declined to find a home whirlpool unit a reasonable and necessary medical service for claimant's low back injury. On review, the issue is medical services. We affirm.

FINDINGS OF FACT

We adopt all of the Referee's findings of fact as our own except those contained in the last paragraph. We add the following supplementation.

Claimant lives approximately 30 miles from where he works. A public health spa is located between where he works and his home. Neither claimant nor his doctor know the hours at which the spa is open. Claimant works a rotating shift including day, swing and graveyard.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that the home whirlpool was not reasonable and necessary because claimant was able to work without spa treatments for three months, because claimant's condition had not improved with spa treatments, because claimant was no worse off than similarly situated workers, because claimant could change his job to one less strenuous and thus avoid the need for spa treatments altogether, because claimant could move closer to the public spa, because claimant could purchase a portable home bathtub unit and because the treatments were too fleeting. We disagree with the Referee's analysis.

Medical services governed by OAR 436-10-040(8) require expert medical opinion to be found reasonable and necessary. However, the Referee did not restrict her inquiry to weighing the lay and medical evidence of reasonableness and necessity, but instead substituted her own judgment to conclude that the whirlpool spa was not reasonable and necessary. We proceed to evaluate the medical evidence.

The only medical opinion justifying the need for the home whirlpool spa comes from claimant's physician, Dr. Peterson. He is of the opinion that use of a public spa was just as reasonable as is the purchase of a home unit for full palliative benefits, but he prescribed the home unit because the hours claimant worked made the public spa "not practical." We are not persuaded that this justification establishes that claimant "requires an item not usually considered necessary in the great majority of workers with similar impairments" without a showing that the public spa is actually unavailable. OAR 436-10-040(8). Both claimant and his doctor speculate that the public spa would be unavailable to claimant because of his work hours. Where a public spa is as medically reasonable as is a home purchased unit, claimant must at a minimum establish the unavailability of the public spa to meet the uniqueness requirement of the administrative rule. Because claimant failed to establish the unavailability of the public spa, we conclude that the home whirlpool unit is not reasonable and necessary. Id.

We adopt the "penalties" and "attorney lien" portions of the Referee's opinion.

ORDER

The Referee's order dated October 27, 1988 is affirmed. The Board approves a client-paid fee, not to exceed $381, payable from the insurer to its counsel.

March 26, 1990 Cite as 42 Van Natta 604 (1990)

In the Matter of the Compensation of
PATRICIA A. McCLURE, Claimant
WCB Case Nos. 88-03574 & 88-11755
ORDER ON REVIEW
Longo, et al., Claimant Attorneys
Schwabe, et al., Defense Attorneys
David O. Horne, Defense Attorney

Reviewed by Board Members Myers and Cushing.

Wausau Insurance Company requests review of those portions of Referee Seymour's order which: (1) set aside its responsibility denial for claimant's "new injury" claim for a right shoulder condition; and (2) upheld United Employer Insurance's responsibility denial of claimant's aggravation claim for the same condition. On review, the issue is responsibility. We reverse.

FINDINGS OF FACT

Claimant sustained a compensable injury to her right arm and shoulder while carrying trays of food at United's insured in March 1986. Her condition was originally diagnosed as right bicipital tendinitis. Claimant continued to experience pain after her initial injury which would increase with activity. She was released to work with permanent restrictions on the use of the right arm. Later diagnoses included bursitis, chronic strain, chronic capsulitis and rotator cuff tear. The claim was first closed by Determination Order dated August 4, 1987, which awarded temporary disability only.

Claimant changed jobs to work as a waitress with Wausau's insured beginning February 1987. Her work activities caused another recurrence of the shoulder pain.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant's work for Wausau's insured independently contributed to claimant's condition and shifted responsibility for the condition to Wausau. He reasoned that if claimant's problem was rotator cuff tear, that this was a new condition which must have been caused by Wausau's insured. If her problem were bursitis, he relied upon claimant's treating physician, Dr. Scheinberg, and his opinion that the work at Wausau's insured contributed "slightly" to claimant's disability. We disagree.

In successive injury cases, the first employer remains responsible unless the later work exposure independently contributes to a worsening of the underlying condition. Hensel Phelps v. Mirich, 81 Or App 290 (1986). An increase in symptoms alone is not enough to shift responsibility. James River Corporation v. Youngblood, 80 Or App 472 (1986).

The diagnosis of rotator cuff tear is an alternative diagnosis for the original condition claimant sustained with United's insured; it is not shown to be a new diagnosis arising only after claimant's work with Wausau's insured. In fact, Dr. Nelson stated that the rotator cuff tear was directly related to the March 1986 injury. (Ex. 36-2). Without a showing that claimant has sustained some new additional condition arising out of employment with Wausau's insured, we are unable to conclude that this employment independently contributed to claimant's condition. Likewise, Scheinberg's opinion that the new work exposure with Wausau's insured "contributed only slightly to her disability and a need for medical treatment", is not persuasive because it does not state that such a contribution worsened the claimant's underlying condition from the 1986 injury.

In conclusion, we are not persuaded that claimant's work exposure with Wausau's insured independently contributed to a worsening of her underlying condition. Consequently, United is responsible for claimant's current condition.

ORDER

The Referee's order dated November 2, 1988, is reversed in part and affirmed in part. That portion which set aside Wausau's denial is reversed. Wausau's denial is reinstated and upheld. United's denial dated March 21, 1988, is set aside and the claim is remanded to United for processing according to law. United is responsible for claimant's attorney fee as awarded by the Referee. The remainder of the order is affirmed. The Board approves a client-paid fee, not to exceed $656.25, payable from United Employer Insurance to its counsel.

In the Matter of the Compensation of
DARVEL W. ROGERS, Claimant
WCB Case No. 88-12036
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Mitchell, et al., Defense Attorneys

Reviewed by Board Members Gerner and Myers.

The self-insured employer requests review of Referee Thye's order which directed it to pay medical and related expenses pending its appeal of a opinion and order that found it responsible for claimant's condition. The issue on review is payment of medical bills pending appeal. We reverse.

FINDINGS OF FACT

A hearing was held in WCB cases 87-10754 and 87-10763 on March 2, 1988. The employer herein was one of the two parties contesting that case. No order, issued pursuant to ORS 656.307, was received in that case but at hearing all the parties, including the employer herein, agreed that responsibility was the only issue. The parties expressly waived all issues of compensability.

An Opinion and Order in that case issued on March 31, 1988. That order found the employer herein responsible for claimant's condition and claim. The employer timely perfected an appeal of the order finding it responsible for claimant's claim and condition.

During the pendency of the appeal in WCB cases 87-10754 and 87-10763, the responsible employer has refused to pay medical and related expenses to claimant and his medical providers.

CONCLUSIONS OF LAW AND OPINION

The Referee found that, when, in an earlier case, compensability was conceded and the only issue was responsibility between two insurers, the carrier found responsible could not avoid paying medical and related expenses pending appeal of the responsibility determination. We disagree.

Claimant argued, and the Referee agreed that, since this case involved only a responsibility determination, the carrier found responsible could not avoid paying medical and related expenses pending appeal of that responsibility determination. As authority for this proposition, claimant cites OAR 436-60-180(14) and Steve Chambers, 40 Van Natta 467 (1988). These two authorities do not support that proposition in this case because they are based upon the fact that an order pursuant to ORS 656.307 was issued by the Director. Although the only issue in this case was responsibility, no ".307 order" was ever issued by the Director.

Since this is not a situation governed by ORS 656.307, or the Director's rules, we must look to the statutes to see whether in this type of case payment of medical and related expenses are required pending appeal. ORS 656.313(1)&(4) state:

> "(1) Filing by an employer or the insurer of a request for review or court appeal shall not stay payment of compensation to a claimant."
>
> ...
>
> "(4) Notwithstanding ORS 656.005, for the purpose of this section, 'compensation' means benefits payable pursuant to the provisions of ORS 656.204 to 656.208, 656.210 and 656.214 and does not include the payment of medical services."

ORS 656.313(4) is clear and unambiguous in this situation. The statute expressly does not require payment of medical services pending appeal. The statute does

not make an exception to this rule for cases that involve only a determination of responsibility, but where no .307 order has been issued. Appeals of orders containing .307 determinations do not fall within this statute because those matters are governed by a separate statute and administrative rules.

Since the medical and related expenses in this case fall within those protected from payment pending appeal under ORS 656.313(4), the employer need not pay them pending its appeal.

ORDER

The Referee's order, dated November 3, 1988, is reversed. The Board approves a client-paid fee, not to exceed $614.

March 26, 1990 Cite as 42 Van Natta 607 (1990)

In the Matter of the Compensation of
STEPHEN A. SCARRATT, Claimant
WCB Case No. 88-12306
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Stafford J. Hazelett, Defense Attorney

Reviewed by Board Members Myers and Gerner.

The insurer requests review of those portions of Referee Quillinan's order which: (1) set aside claimant's injury claim for a bilateral wrist condition; and (2) assessed a penalty and attorney fee for an unreasonable denial. The issues on review are compensability, penalties and attorney fees. We affirm in part, modify in part, and reverse in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact, except those contained in paragraph five of her finding of fact section, as our own, and supplement them with the following additional findings of fact. Claimant's use of a jackhammer materially contributed to a temporary increase in his wrist symptoms, resulting in his need for treatment. However, claimant's underlying arthritic condition was neither caused nor worsened by his use of the jackhammer.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant's use of the jackhammer was sufficiently discrete and identifiable to qualify claimant's claim as one for an industrial injury. See Valtinson v. SAIF, 56 Or App 184 (1982). The Referee found that this injury episode had caused claimant to develop symptoms in his wrist which required medical treatment. Based upon these findings, the Referee found the claim compensable. We agree with these conclusions and adopt them as our own.

The Referee further concluded that claimant's underlying wrist arthritis condition had been worsened by the jackhammer incident. Lastly, the Referee assessed a penalty and attorney fee because she found the insurer's denial to be unreasonable. We disagree with the Referee on these last two conclusions.

When a compensable injury makes an underlying condition temporarily symptomatic without causing or worsening that condition, the carrier's liability may be limited to the effects of the temporary symptomatic increase. Donald L.

Call, 39 Van Natta 672 (1987). In other words, there is no liability for the underlying condition per se. Call, supra; Roy L. Bier, 35 Van Natta 1825 (1983).

Here, while all the physicians agree that claimant has sustained a worsening of symptoms due to his injury, there is only one favorable reference to the injury causing a worsening of the underlying condition. Dr. Buttons, in his report dated September 23, 1988, stated that the injury "perhaps hastened" the worsening of the underlying condition. An opinion that an injury "perhaps hastened" the worsening of an underlying condition is not an opinion based upon reasonable medical probability, but merely upon possibility or speculation. This is insufficient for claimant to meet his burden of proof on whether the injury worsened his underlying arthritic condition. Gormley v. SAIF, 52 Or App 1055 (1981).

In contrast to that opinion is the opinion of Dr. Struckman, who persuasively concludes that the compensable injury did not worsen claimant's underlying condition. Under these circumstances, we conclude that claimant's underlying arthritic condition was not worsened by his injury and is not a compensable part of his claim.

In relation to the unreasonableness of the denial, the insurer was in possession of Dr. Struckman's chart note of February 1, 1988 prior to the issuance of its denial. That note indicated that claimant's underlying condition had not worsened. The insurer was not unreasonable in treating this claim as one of a possible occupational disease, for which Dr. Struckman's opinion was sufficient to create a legitimate doubt as to its compensability. We therefore conclude that the insurer's denial was not unreasonable.

ORDER

The Referee's order dated November 7, 1988 is affirmed in part, modified in part, and reversed in part. The insurer's denial is reinstated and upheld insofar as it pertains to a denial of claimant's underlying wrist condition. The Referee's attorney fee award concerning the denial issue is modified from $1,500 to $1,000. The Referee's assessment of a penalty and a $300 attorney fee for an unreasonable denial are reversed. The remainder of the order is affirmed. For services on review concerning the insurer's denial of claimant's temporary symptomatic increase, claimant's attorney is awarded an assessed fee of $700, to be paid by the insurer.

March 26, 1990 Cite as 42 Van Natta 608 (1990)

In the Matter of the Compensation of
DEANNA L. SOUTHERLAND, Claimant
WCB Case No. 88-12307
ORDER ON REVIEW
Jean Fisher LeDoux, Claimant Attorney
Roberts, et al., Defense Attorneys

Reviewed by Board Members Cushing and Gerner.

Claimant requests review of Referee Mulder's order which: (1) found that claimant had established "good cause" for an untimely request for hearing from the insurer's denial; and (2) upheld the insurer's denial of claimant's back injury claim. On review, the issues are timeliness and compensability. Because we find that claimant did not have good cause for her untimely hearing request, we dismiss.

FINDINGS OF FACT

On March 31, 1988, Dr. Johnson, chiropractor, submitted a first medical report which indicated claimant had experienced back pain after lifting a couple of boxes. (Ex. 3). Johnson checked the "work related" box on the report.

By chart note dated April 4, 1988, Dr. Takacs, chiropractor, reported that claimant had experienced a pull in her low back when lifting a box of ketchup approximately a week and half before.

On April 5, 1988, claimant filed an 801 form.

On April 13, 1988, the insurer issued a denial of benefits. It was received by claimant on April 19, 1988.

Dr. Takacs reported examining claimant on April 21, 1988. She showed Takacs her denial forms and asked what should be done. Dr. Takacs indicated that he would contact her claim representative and that, in the future, claimant should report injuries promptly to her employer. (Ex. 7-2).

Claimant's hearing request from the insurer's denial was received by the Hearings Division on July 15, 1988, more than 60 days after the date of the denial.

CONCLUSIONS OF LAW AND OPINION

Although claimant did not file a timely hearing request, the Referee found that she had good cause for failing to do so. Specifically, the Referee reasoned that claimant had demonstrated "good cause" because she relied on Dr. Takacs' representation that he would file the hearings request for her. We disagree.

A hearing request must be filed within 60 days after claimant is notified of a denial. ORS 656.319(1)(a). A request filed more than 60 days but not less than 180 days after notification of denial is valid if claimant establishes good cause for failure to file within 60 days. ORS 656.319(1)(b). Claimant has the burden to establish good cause for failure to file timely. Hempel v. SAIF, 100 Or App 68 (1990).

It is undisputed that claimant's hearing request was not timely filed. That delay may nevertheless be excused if claimant had good cause for late filing. See ORS 656.319(1)(b). The test for determining if good cause exists has been equated to the standard of "mistake, inadvertence, surprise or excusable neglect" recognized 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).

Here, claimant acknowledges receiving the denial letter. Subsequently, she took that letter and several other papers to Dr. Takacs. He read the documents, and asserted that he had dealt with the insurer before. Accordingly, he informed claimant that he would write a letter to the insurer informing them that he believed claimant had suffered an on-the-job injury. (Tr. 5). By letter dated April 25, 1988, Takacs informed claimant that he would talk to her claim's representative about the injury. (Ex. 7-2). It was claimant's impression that everything would be resolved. Claimant first realized something was amiss, when approximately a month later she received a medical bill, at which point she contacted an attorney.

In this case Dr. Takacs was not the agent of claimant. He was not specifically instructed to file the request for hearing, nor did he agree to do so. Dr. Takacs acknowledged that he would contact claimant's claim representative, but offered no other specific assurances. Claimant relied on Dr. Takacs to file the request for hearing. However, she provided no rationale as to why she expected him to assume such an important obligation. Consequently, since claimant did not make Dr. Takacs her agent to file for her, claimant's reliance on Dr. Takacs to file for her does not constitute "good cause".

In the alternative, assuming Takacs was an agent of claimant, we nonetheless conclude that claimant still has failed to establish "good cause" for late filing. An agent's failure to timely file does not automatically provide "good cause" to claimant for failure to file timely. The courts have held that a failure of an agent to file a request for hearing does not constitute good cause, unless the failure to file timely would be good cause if attributed to claimant. See EBI Companies v. Lorence, 72 Or App 75 (1986). Here, Takacs simply did not file a timely request for hearing, and no excuse whatsoever was presented for that failure. Without such an excuse, there is no basis to find any "good cause" which, if attributed to claimant, would provide a basis to establish her "good cause". Id.

Under these circumstances, we conclude that claimant has not established "good cause" for her untimely filing of a request for hearing. Accordingly, claimant's hearing request is dismissed.

Alternatively, we agree with the Referee that claimant's back condition is not compensable.

Claimant's version of events conflict with the testimony given by claimant and her coworkers. Therefore, the compensability of claimant's claim ultimately rests upon her credibility and reliability. The Referee found that claimant's reliability had been eroded to the point that she had not proven her case on the merits. We agree.

Claimant indicated, on the 801 form, that she suffered the alleged industrial injury on March 21, 1988. The 801 form was not submitted until April 5, 1988. Claimant testified that she told one of her supervisors that she was experiencing back pain a week after the incident. Nonetheless, claimant did not indicate that her back had been injured while on the job. More to the point, she failed to tell anyone of the work connection until going to the emergency room. Claimant indicated that she worked a half day on March 30, 1988, and had to leave because of the back pain. Claimant explained that she failed to tell her supervisor of the back pain which resulted from lifting the boxes of ketchup because, "It just -- it slipped my mind. I didn't -- I was hurting so bad I just wanted to go home." (Tr. 10-11, emphasis added.) Consequently, claimant failed to adequately explain the time lag between the alleged industrial injury and the resulting back pain which caused her to leave work.

Claimant's testimony also contained several contradictory statements. She described herself as being healthy and without physical problems prior to March 1988. However, claimant's assistant manager indicated that she had experienced physical problems prior to March 1988. The assistant manager related that claimant frequently complained of being sick and having trouble with her hands, neck and knees. Moreover, no co-employee or supervisor was aware that claimant was experiencing any limitations due to her back while she was working.

In this case, claimant has testified to contradictory actions. She indicated that her alleged industrial injury occurred on March 21, 1988. Claimant alleged that it took approximately a week for her back to start bothering her.

In the interim period, claimant had two private meetings with her manager. On March 21, 1988, the manager counseled claimant on her work performance. During this meeting no mention was made of back pain. At the time of the quarterly evaluation on March 31, 1988, the manager spent five minutes alone with claimant. During their conversation, claimant again failed to indicate that she had hurt her back on March 21, 1988. Yet, this was the same day that claimant testified she went to the emergency room suffering from severe back pain.

In sum, claimant's testimony on questions important to proving her claim are so vague and contradictory as to be unreliable.

Inasmuch as we cannot rely upon claimant's testimony, her version of events as well as the medical opinions concerning a causal relationship between her back condition and a work incident are not persuasive. Consequently, claimant has failed to meet her burden to establish by a preponderance of the evidence that her back condition was caused by a work-related incident.

ORDER

The Referee's order, dated November 28, 1988, is reversed. The claimant's hearing request is dismissed. The Board approves a client-paid fee, payable from the insurer to its counsel, not to exceed $1,362.

March 26, 1990 Cite as 42 Van Natta 611 (1990)

In the Matter of the Compensation of
REINE R. WEBB, Claimant
WCB Case No. 88-02445
ORDER ON RECONSIDERATION
Max Rae, Claimant Attorney
Kevin L. Mannix, Defense Attorney

Claimant has requested reconsideration of the Board's Order on Review dated March 5, 1990. Having received the insurer's response, we proceed to reconsider our order.

Claimant requests the award of a reasonable insurer-paid attorney fee for her success at reversing the Referee's allowance of an offset. Since the issue of offset was presented to the Board by claimant's cross-request for review, the award of attorney fees is governed by ORS 656.386. Claimant is not entitled to an insurer assessed fee under ORS 656.386(1). Forney v. Western States Plywood, 297 Or 628 (1984). Claimant is, however, entitled to an out-of-compensation fee pursuant to ORS 656.386(2). In this case, claimant's attorney has already been awarded the maximum allowable out-of-compensation fee of 25 percent of the increased permanent disability which is made without regard to the offset. OAR 438-15-085(2). Therefore, we are unable to award any additional attorney fees. ORS 656.386(2).

Accordingly, our prior order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our March 5, 1990 order. The parties' right of appeal shall run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
JIMMIE C. WILSON, Claimant
WCB Case Nos. 88-05021 & 88-06710
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Terrall & Miller, Defense Attorneys

Reviewed by Board Members Gerner and Myers.

The self-insured employer requests review of those portions of Referee Gruber's order which: (1) set aside its denial of claimant's medical services claim for a weight loss program; (2) set aside its denial of claimant's medical services claim for treatment rendered by a nurse practitioner; (3) ordered the insurer to pay two medical billings; and (4) assessed a penalty and related attorney fee for failure to pay one of the medical billings. In his brief, claimant cross-requests review of those portions of the order which: (1) upheld the self-insured employer's denial of his medical services claim for an exercycle; and (2) declined to assess a penalty and related attorney fee for both unpaid medical billings. On review, the issues are compensability of medical services, penalties and related attorney fees. We affirm in part, modify in part, and reverse in part.

FINDINGS OF FACT

Claimant filed a claim for bilateral carpal tunnel syndrome with the employer in October 1986. That claim was accepted by the employer. Also in October 1986, claimant filed a claim for a low back strain, which was accepted by the employer. Claimant was initially treated by Dr. Ross, osteopath, for both his carpal tunnel and low back problems. Dr. Ross referred claimant to Dr. Lundsgaard, orthopedist, for treatment of the carpal tunnel condition; however, Dr. Ross continued to be the treating physician for claimant's low back strain. Dr. Ross is associated with the Oakridge Medical Clinic.

Dr. Lundsgaard performed a left carpal tunnel decompression surgery in January 1987. He performed a right carpal tunnel decompression surgery in March 1987. During the period from October 1986 through April 1987, claimant continued to experience periodic flare-ups of back pain accompanied by a continuous ache in the lower back. He continued to go to the Oakridge Medical Clinic for treatment of his low back condition and received treatment at the clinic from both Dr. Ross and from a licensed nurse practitioner, Mitch Boriskin.

In May 1987, claimant had a recurrence of carpal tunnel symptoms in his right hand. In a June 8, 1987 letter to the employer's processing agent, Mitch Boriskin noted that, due to claimant's chronic back pain, both he and Dr. Lundsgaard recommended that claimant enroll in a weight-reduction program. At that time, claimant weighed in excess of 370 pounds. In a June 26 letter, claimant's counsel requested the processing agent approve a weight-loss program.

In July 1987, claimant was still experiencing right hand symptoms and he sought treatment from Dr. Ellison, orthopedist. Dr. Ellison recommended surgical exploration and reconstruction of the retinacular ligament. That procedure was performed in October 1987. In December 1987, claimant continued to have right wrist symptoms and Dr. Ellison requested authorization to perform another exploratory surgery.

On January 18, 1988, Boriskin prescribed an exercise bicycle for claimant. Claimant had previously purchased such a bicycle without prescription.

In February 1988, the employer issued a denial which denied claimant's request for a formal weight loss program. The denial further denied reimbursement for the exercise bicycle as well as any treatment provided by a nurse practitioner.

Twelve days prior to the hearing, claimant's counsel submitted medical billings from Sacred Heart Hospital and Oakridge Medical Clinic. These billings were addressed to claimant. Both billings indicated that a carrier had been billed previously, but did not specify any particular carrier.

CONCLUSIONS OF LAW AND OPINION

Medical Services

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 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.

1. Weight Loss Program

The Referee concluded that claimant had established that the weight reduction program was necessary for treatment of his compensable low back condition. We disagree.

Mitch Boriskin stated that claimant had chronic back pain and needed to be enrolled in a weight reduction program. Dr. Lundsgaard agreed that claimant needed to lose weight, but questioned whether a formal weight loss program would be effective given claimant's lack of motivation. The Orthopaedic Consultants opined that weight loss would improve claimant's general back condition.

Dr. Flanagan reported that claimant needed to lose weight but opined that weight loss program would be ineffective. He explained that claimant's weight problem was genetic and recommended that a gastric bypass procedure would be the only effective treatment for claimant's obese condition.

We are persuaded by the thorough opinion of Dr. Flanagan. He explains in great detail why claimant will not benefit from a formal weight loss program. Further, his opinion is supported by Dr. Lundsgaard who also opined that a formal weight loss program would not be effective. By contrast, Mitch Boriskin's opinion is limited to the statement that claimant needs a weight loss program without any explanation in regards to reasonableness and necessity of such treatment. Finally, although the Consultants recommend weight loss, they offer no opinion as to a formal weight reduction program.

Under these circumstances, we conclude that claimant has failed to establish that a weight loss program is reasonable and necessary as a result of his compensable low back injury.

2. Nurse Practitioner Treatment

We adopt the Referee's "Conclusions and Reasoning" with regard to the compensability of the nurse practitioner services.

3. Exercycle

We adopt the Referee's "Conclusions and Reasoning" concerning the compensability of the exercycle with the following supplementation.

The only evidence concerning the exercise bicycle is a prescription written by Boriskin after claimant had purchased the bicycle. The prescription offers no explanation regarding the reasonableness and necessity of the bicycle. Further it offers no reasoning why claimant requires the exercise bicycle where it is not a necessary item for the majority of workers with similar impairments. See OAR 436-10-040(8).

4. Medical Billings

The Referee ordered the employer to pay for two medical billings, one from Sacred Heart Hospital, (Ex. 100A), and the other from Oakridge Medical Clinic (Ex. 105A). We conclude that the Referee was without jurisdiction to decide this issue.

ORS 656.262(6) allows an employer/insurer 60 days in which to accept or deny a claim. A claim is deemed denied "de facto" after expiration of the 60-day period, if the employer/insurer has not accepted or denied. Syphers v. K-W Logging Inc., 51 Or App 769, rev den 291 Or 151 (1981). A premature request for hearing on the issue of whether a claim should be accepted is ineffective and void. Syphers, supra; Barr v. EBI Companies, 88 Or App 132 (1987).

In the instant case, Exhibit 100A is a copy of a billing from Sacred Heart Hospital which is addressed to claimant. It states that "Your carrier has not paid. This is not a request for payment." Exhibit 105A is a copy of a billing from Oakridge Medical Clinic which is also addressed to claimant. It indicates that the charges were billed to claimant's insurance. Neither billing indicates what the treatment consisted of, nor what insurance company was being billed. There is no persuasive evidence that these billings were mailed to the employer or its processing agent. Further, there is no persuasive evidence in the record which establishes that these billings were received by the employer or its processing agent until a few days prior to the hearing when they were submitted as exhibits.

Under these circumstances, we conclude that claimant's request for hearing concerning these two billings was premature, ineffective and void. Syphers, supra.

Penalties and Attorney Fees

As we have concluded herein that the Referee was without jurisdiction to rule on the merits of the two medical billings, it follows that he could not assess a penalty or related attorney fee based on either billing. Accordingly, we reverse the Referee's assessment of a penalty and attorney fee for failure to pay the billing from Sacred Heart Hospital.

ORDER

The Referee's order, dated August 18, 1988, is reversed in part, modified in part, and affirmed in part. That portion of the order which set aside the employer's denial of a weight loss program is reversed. That portion of the employer's denial which denied the weight loss program is reinstated and upheld. The Referee's $2,500 attorney fee and award for the services at hearing concerning the wrist surgery, nurse practitioner, and weight loss program is reduced to $1,750 for services at hearing regarding the surgery and nurse practitioner. That portion of the order which ordered the employer to pay the submitted medical billings from Sacred Heart Hospital and Oakridge Medical Clinic is vacated as premature. That portion which assessed a penalty and related attorney fee of $200 based on the Sacred Heart Hospital billing is vacated as premature. The remainder of the order is affirmed. For services rendered on review regarding the nurse practitioner issue, claimant's counsel is awarded a reasonable assessed fee of $300. A client-paid fee, not to exceed $1,500 is approved.

In the Matter of the Compensation of
DAVID W. WOODARD, Claimant
WCB Case No. 87-14951
ORDER ON REVIEW
Aspell, et al., Claimant Attorneys
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Gerner and Cushing.

The self-insured employer requests review of those portions of Referee Mirassou's order which: (1) awarded temporary disability benefits after claimant was medically stationary; and (2) awarded 5 percent (7.5 degrees) scheduled permanent disability for loss of use or function of the right leg (knee) whereas a Determination Order had awarded no permanent disability. On review, the issues are entitlement to temporary disability, and extent of permanent disability. We affirm in part and reverse in part.

FINDINGS OF FACT

Claimant is a 44-year-old logger who injured his right ankle on January 9, 1985, when his leg was caught between two logs. He sustained time loss and returned to work as a bucker until his attending physician, Dr. Casey, restricted him from walking on uneven surfaces. In June 1985, claimant began truck driving for the employer and later returned to bucking in January 1986. At that time claimant began to experience pain and swelling in the right knee. The employer partially denied the right knee condition and claimant appealed. Claimant became medically stationary for the knee condition on March 14, 1986, eight months before the scheduled December 4, 1986 hearing.

By Opinion and Order dated February 13, 1987, Referee St. Martin set aside the employer's partial denial and remanded the knee claim for processing. The employer processed the claim by issuing a Notice of Closure on February 24, 1987, within 14 days of the litigation order. The Notice awarded temporary disability from January 1986 through the medically stationary date of March 14, 1986. The employer did not pay temporary disability through the date it issued its Notice, but only through the medically stationary date as found in the Notice itself.

Claimant requested a Determination Order, which modified the Notice but affirmed the medically stationary date. Claimant appealed the Notice and the Determination Order to hearing.

Claimant has weakness, disabling pain and swelling in his knee with overuse and walking on uneven ground.

CONCLUSIONS OF LAW AND OPINION

Extent of Disability

We adopt the Referee's "conclusions and reasons" on this issue.

Temporary Disability Benefits

The Referee concluded that claimant was entitled to temporary disability after he was medically stationary through the date of the Opinion and Order reversing the knee condition denial until the Notice of Closure issued. We disagree.

The employer has the duty to pay any temporary disability benefits due

within 14 days of a litigation order reversing a denial and finding a claim compensable. OAR 436-60-150(3)(e). The employer must pay all retroactive temporary disability to within seven days of the date of payment. OAR 436-60-150(4). Furthermore, the employer must continue to pay temporary disability until the worker is medically stationary and the claim is closed. Fazzolari v. United Beer Distributors, 91 Or App 592 (1988). However, claimant's substantive entitlement to benefits is only through the medically stationary date. Julie A. Trujillo, 40 Van Natta 1892 (1988).

The employer asserts that it had no duty to pay temporary disability benefits after the medically stationary date through the date of the Opinion and Order and until its Notice of Closure, because its Notice issued within 14 days of the litigation order. Claimant asserts that the employer had the duty to pay through the date of its Notice regardless of the prior medically stationary date in reliance upon Vip's Restaurant v. Krause, 89 Or App 214, on recon 91 Or App 472 (1988). We agree with the employer.

A Notice of Closure or Determination Order issued within 14 days of a litigation order finding a claim compensable has the effect of superceding the procedural duty under the litigation order to retroactively pay benefits to within 7 days of payment. A Notice of Closure or a Determination Order establish a worker's substantive entitlement to benefits. Determination of a worker's substantive entitlement to temporary disability compensation is authorization to terminate any continuing procedural duty to pay under statute. Former ORS 656.268(2), current 656.268(2)(c). Where, as here, the substantive entitlement is determined before the procedural duty to pay has fully matured (i.e. within 14 days of the litigation order), the procedural duty to pay never matures and is replaced by the new duties under the Determination Order or Notice of Closure.

Vip's Restaurant, contrary to claimant's arguments, supports the employer's position. There, the employer was ordered to accept a claim on February 18, 1986. The employer paid temporary disability benefits only until January 31, 1985, the date the claimant had been found medically stationary. However, the court held that the employer's actions were not allowed because no Determination Order had issued authorizing "termination of such payments". Id. at 217, citing former ORS 656.268(2). A Determination Order in that case did not issue until over four months after the litigation order; therefore, the employer failed to comply with the 14-day duty to bring the claimant's temporary disability current and to continue to pay such disability until termination was authorized. OAR 436-60-150(e), supra.

However, the court did note that an employer could protect itself from overpayments to the worker by promptly seeking closure, and thus obtaining the authorization to cease payments. Vip's Restaurant, supra at 217. That is exactly what the employer has done in the present case. It obtained statutory authorization to cease temporary disability payments by invoking the self-closure provisions of former ORS 656.268(3) in a timely manner, as opposed to the untimely manner done by the employer in Vip's Restaurant. Therefore, we conclude the award to claimant of temporary disability after the medically stationary date was improper in this case.

ORDER

The Referee's order, dated April 22, 1988, as reconsidered September 19, 1988, is affirmed in part and reversed in part. That portion which awarded additional temporary disability benefits is reversed. The remainder of the order is affirmed. For services defending against the employer's appeal to reduce permanent disability, claimant's attorney is awarded an assessed fee of $300, payable by the employer in addition to compensation. The Board approves a client-paid fee, not to exceed $855, payable from the employer to its counsel.

In the Matter of the Compensation of
JOHN J. ALCANTAR, Claimant
WCB Case Nos. 87-18551, 87-01266 & 88-01581
SECOND ORDER ON RECONSIDERATION
Callahan & Gardner, Claimant Attorneys
Lindsay, et al., Defense Attorneys
Roberts, et al., Defense Attorneys
Daryll E. Klein, Defense Attorney

Castle and Cooke has requested reconsideration of the Board's Order on Reconsideration dated February 26, 1990 that held it had waived compensability defenses by raising only the issue of responsibility at hearing.

Castle and Cooke objects to our conclusion that it waived its right to assert a compensability defense that claimant's condition lacked a causal connection to its accepted injury because it denied only responsibility. In our order we relied upon Judy Witham, 40 Van Natta 1982 (1988) as support for our conclusion. We continue to adhere to our earlier conclusion that Castle and Cooke waived compensability defenses.

Castle and Cooke argues that Judy Witham is not applicable to this case because it was premised on the doctrine announced by the Supreme Court in Bauman v. SAIF, 295 Or 788 (1983) and applies only to the situation where the carriers have formally conceded to the issuance of a ".307 order." We agree that the analysis underlying Judy Witham does not apply in this case, but the result does. In Judy Witham two carriers disputed responsibility for the claimant's low back and neck conditions. Both carriers initially conceded the compensability of the claim. As a result of those concessions, a ".307 order" was issued. More than 60 days after the claim, one of the carriers attempted to amend its denial to include compensability. We held that the carriers were precluded under Bauman from backing-up and denying compensability and that the issuance of a ".307 order" constituted a specific formal acceptance of compensability by both insurers.

In the present case, Castle and Cooke argue that no ".307 order" has issued, and thus it has not formally accepted compensability. Therefore, it argues, it is not precluded from denying compensability. We agree that Bauman does not preclude it from denying compensability. Instead, we hold that by not formally raising the compensability issue at hearing, that defense is waived as a matter of practice and procedure. ORS 656.726(4). We have held that fundamental fairness dictates that parties have a reasonable opportunity to present evidence on an issue and that such an opportunity does not exist if there is no notice that the issue is in controversy. Donald A. Hacker, 37 Van Natta 706, 707 (1985). We have also recognized that some defenses and issues need to be made expressly or else they are deemed waived. See Karen K. Malson, 42 Van Natta 503 (March 9, 1990) (where an aggravation denial was litigated at hearing on the issue of causation, the employer could not raise a no worsening defense on Board review).

We perceive a substantial difference between a denial of responsibility and a denial of compensability. If the other parties to a responsibility hearing are to know that compensability defenses are being raised, the issue must be made known to them. In this case, Castle and Cooke did not formally raise the defense that claimant's condition was not causally related to their original accepted injury at hearing. Therefore, by not raising the defense, the other parties were not allowed a reasonable opportunity to present evidence on that issue and it is deemed waived.

Castle and Cooke argues that:

> "A responsibility denial does not admit or concede that one's own employment is a contributing cause of the disputed disability. Rather, such a denial means only that the carrier believes the disability is compensable, that is, that it resulted from one or more work injuries or exposures. The employer does not waive its ability to argue that the disability is not related to its employment."

We disagree. Responsibility is a lesser included defense. It is relevant and may be addressed only after compensability is established. Raul A. Herrara, 40 Van Natta 1281 (1988); Scott E. Parker, 40 Van Natta 941 (1988). By arguing only responsibility at hearing, compensability is conceded.

Turning to the case at hand, Castle and Cooke is an employer with an accepted claim for a mid and upper back condition. It came to hearing denying only responsibility and did not raise compensability as an issue at hearing. Claimant is entitled to rely upon that representation and to assume that compensability vis-a-vis that claim was not at issue. Accordingly, Castle and Cooke waived its compensability defense of causal connection because it did not raise the issue. (Nothing, however, precluded Castle and Cooke from raising the issue at hearing. Had this surprised any of the other parties, they would have been permitted to request a postponement. OAR 438-06-031.)

Accordingly, our February 26, 1990 Order on Reconsideration is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our February 26, 1990 order in its entirety. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

March 27, 1990 Cite as 42 Van Natta 618 (1990)

In the Matter of the Compensation of
CARY O. MILLER, Claimant
WCB Case No. 87-12639
ORDER ON REVIEW
John J. Cosgrave, Claimant Attorney
Roberts, et al., Defense Attorneys

Reviewed by Board Members Crider and Brittingham.

Claimant requests review of those portions of Referee Knapp's order that: (1) ordered that claimant's claim be reopened for aggravation as of October 20, 1987; (2) declined to assess a penalty and associated attorney fee for the insurer's alleged unreasonable denial of his aggravation claim; and (3) awarded claimant's attorney an assessed fee of $1,400 for prevailing on the denial. Claimant contends that his claim should be reopened as of December 22, 1986 and that the Referee's award of attorney fees for prevailing on the denied claim is inadequate. On review, the insurer reiterates its argument, first made at hearing, that claimant's request for hearing was untimely. The Referee refused to consider this argument on the basis that the insurer had failed to raise it prior to hearing. We conclude that the Referee should have addressed the insurer's timeliness argument. We further conclude that claimant's request for hearing was timely. On the merits, we affirm the Referee.

ISSUES

1. Timeliness. Whether the insurer was precluded from raising its timeliness objection at hearing? If not, whether claimant timely requested a hearing on the aggravation denial, or, alternatively, established "good cause" for his failure to timely request a hearing?

2. Aggravation. Whether claimant proved a worsened condition prior to October 22, 1987?

3. Penalties and Attorney Fees. Whether the insurer's denial of claimant's aggravation claim was unreasonable, thereby warranting the imposition of a penalty and attorney fees?

4. Attorney Fees. Whether the Referee's attorney fee award at hearing was adequate?

FINDINGS OF FACT

The Board adopts the Referee's factual findings with the following supplementation.

On January 8, 1987, Dr. Berkeley wrote a letter to the insurer requesting authorization to perform surgery. The insurer mailed its denial of surgery to claimant by certified mail on February 23, 1987. A copy of the denial letter was also sent by regular mail to claimant's attorney. Claimant received the denial on February 25, 1987, when his girlfriend claimed it for him at the post office. Claimant did not immediately request a hearing on the denial.

On April 6, 1987, Dr. Thomas reported that claimant's symptoms were related to his compensable injury, and that claimant was a surgical candidate. Thereafter, during April, claimant contacted the insurer to inquire how it intended to respond to Dr. Thomas' report. Claimant was told that the insurer intended to issue a second denial. When claimant did not receive a second denial, he again contacted the insurer. The insurer informed him that a denial was forthcoming. Claimant contacted the insurer several times. Claimant also checked with the post office. However, he did not receive a second denial. On August 14, 1987, claimant filed a request for hearing. This request was filed 172 days following notification of the denial.

CONCLUSIONS OF LAW AND OPINION

Timeliness

At hearing, the insurer contended that claimant's request for hearing was untimely. The Referee refused to consider this contention. Citing Thomas E. Harlow, 38 Van Natta 1406 (1986), the Referee reasoned that the insurer had failed to raise the issue in writing within 10 days of the hearing. See ORS 656.283(5).

We do not agree that the insurer's failure to raise its timeliness defense within 10 days of the hearing precludes it from doing so at hearing. The issue before us in Harlow was whether a referee had jurisdiction to consider a challenge to three Determination Orders where the claimant's attorney first requested that the Referee consider the Determination Orders at hearing. We concluded that jurisdiction was lacking. We reasoned that the claimant had failed to comply with the strict requirements of ORS 656.283(5) by failing to give "[a]t least 10 days' prior notice" of his intent to request hearing regarding

the Determination Orders. There being no request for hearing regarding the issues, the claimant's contentions should not have been entertained.

Here, the insurer did not raise a new claim at hearing. Instead, the insurer presented a defense to a claim for which claimant had requested a hearing. Harlow, as it interpreted ORS 656.283(5), is not controlling. Further, to the extent the timeliness defense resulted in surprise to claimant, he could have requested a continuance. See OAR 438-06-031. In this case, claimant did not contend that he was unprepared to meet the timeliness defense; rather, the Referee chose not to entertain the defense on his own motion. We conclude that the Referee should have addressed the insurer's argument. Because the record is fully developed on this issue, we proceed to consider the question on review. Destael v. Nicolai Co., 80 Or App 546 (1986).

A request for hearing from a denial of a claim for compensation should be filed within 60 days after the claimant was notified of the denial. ORS 656.319(1)(a). A request filed later than 60 days, but within 180 days after notification, is timely if the claimant establishes "good cause" for failing to file the request within 60 days. ORS 656.319(1)(b). "Good cause" has been defined as "mistake, inadvertence, surprise or excusable neglect" as those terms have been employed under ORCP 71B and former ORS 18.160. Anderson v. Publishers Paper Co., 78 Or App 513, 517, rev den 301 Or 666 (1986).

Claimant argues that he did not file a hearing request on the first denial because he was led to believe that a second denial was forthcoming. Claimant contends that his reliance upon the insurer's representation regarding a second denial constitutes "good cause" for his failure to request a hearing within 60 days of the denial. We agree.

In reaching this conclusion, we note that the facts of our case are distinguishable from those before the court in Cogswell v. SAIF, 74 Or App 234 (1985). In Cogswell, SAIF issued a denial of compensability. The claimant was subsequently referred to Dr. Stewart. Upon hearing Dr. Stewart's diagnosis, the claimant contacted SAIF. A SAIF claims representative told the claimant that Dr. Stewart's reports would be reviewed upon receipt. The day following receipt of the report, SAIF decided that the denial should stand. The claims representative unsuccessfully attempted to contact the claimant that day to inform him of the decision. That was also the final day of the 60-day period. The claims representative tried twice again to contact the claimant. The claimant was finally contacted by mail and informed of the decision. Three weeks later, the claimant requested a hearing.

On review, the court affirmed the Board's order which affirmed the referee's dismissal. The court noted that SAIF had not misled the claimant into thinking that his claim would remain open after the statutory time for appeal had passed. Id. at 237. The court further noted that, apart from a concern about a sister who was ill, the record showed no event which could have interfered with the claimant's timely filing a request for hearing. The court concluded that the claimant's lack of diligence did not constitute good cause. Id.

Here, the unrebutted evidence establishes that the insurer represented to claimant that a second denial would issue upon receipt of Dr. Thomas' report, thus providing claimant with an opportunity to challenge that denial. When claimant did not receive a second denial, he contacted the insurer and was again informed that a denial would be forthcoming. When he did not receive the denial, he contacted the insurer several additional times. He also checked with the post office. Under the circumstances, we conclude that, rather than exhibiting a lack of diligence, claimant has established "good cause" for his delayed hearing request.

Aggravation Date

We adopt the Referee's Opinion with regard to the date of claimant's aggravation.

Penalties and Attorney Fees

We adopt the Referee's Opinion on this issue also.

Amount of Assessed Fee at Hearing

Claimant contends that the Referee's assessed attorney fee award of $1,400 is inadequate. We consider the adequacy of the Referee's attorney fee award in light of the factors set forth in OAR 438-15-010(6). After review of claimant's statement of services and considering the factors set forth in the applicable rule, we conclude that the assessed fee award by the Referee reasonably compensates claimant's counsel for his services in setting aside the insurer's aggravation denial.

ORDER

The Referee's order dated January 28, 1988 is affirmed. For prevailing on the insurer's timeliness argument, 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 $1,348, payable by the insurer to its counsel.

March 27, 1990 Cite as 42 Van Natta 621 (1990)

In the Matter of the Compensation of
LYNETTE K. NORTON, Claimant
WCB Case No. 88-08815
ORDER ON REVIEW (REMANDING)
Emmons, Kyle, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Crider and Nichols.

Claimant requests review of Referee Garaventa's order dismissing her request for hearing and, on reconsideration, declining to postpone the hearing. On review, the issues are postponement and dismissal. We reverse.

FINDINGS OF FACT

Claimant filed a request for hearing, initially specifying the issue of extent of disability. She later filed a supplemental request for hearing indicating that she also wished to contest two denials which had issued on May 31, 1988.

A hearing was scheduled for August 17, 1988. It was reset for October 19, 1988 at 9:00 a.m.

At the time and place specified for hearing, attorneys for claimant and the self-insured employer appeared. Claimant was not present at 9:00 a.m.

At 9:20 a.m., the proceeding commenced. Claimant's attorney indicated that he had expected claimant to attend and had no explanation for her failure to arrive. The self-insured employer moved to dismiss. The motion was granted.

On October 24, 1988, claimant's attorney moved for reconsideration. He contended that she had mistaken the time for hearing and had arrived at the Hearings Division at 9:40 a.m. the date of hearing. He asked that the hearing be rescheduled.

The Referee held that the circumstances stated by claimant's attorney did not justify postponement. She declined to reconsider her order of dismissal.

CONCLUSIONS OF LAW AND OPINION

The Referee's order of October 24, 1988 together with the order on reconsideration dated November 9, 1988, interpreted OAR 438-06-071 to require dismissal of a request for hearing, unless a postponement is appropriate, whenever claimant appears through counsel at hearing but does not personally attend the hearing.

Former OAR 438-06-071 provided, at the time of hearing:

> "Failure of a party to appear at a hearing without good cause constitutes a waiver of appearance. If the party failing to appear is the party that requested the hearing, the request for hearing may be dismissed unless good cause is shown and the other party is not prejudiced thereby."

Since the Referee's order, the Court of Appeals has decided a case which controls the issues here. 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. The court concluded that the Board erred in affirming dismissal of the request for hearing because claimant did not personally attend and make herself available for cross-examination. We have concluded that the former version of the rule, like the one before the court in Williams, does not require that a claimant personally attend a hearing. Mario Miranda, 42 Van Natta 405 (1990).

Inasmuch as claimant's attorney appeared to prosecute her case, we conclude that the request for hearing should not have been dismissed. Therefore, we remand for hearing.

We have held that the procedure for conduct of the hearing on remand in cases such as this one depends on whether or not a postponement should have been granted. If a postponement should have been granted, then the hearing should be conducted as any other hearing. If, however, a postponement should have been denied, then no exhibit may be received which was not submitted in connection with the prior hearing and no witness, including claimant, may testify if that witness was not available to and planning on testifying at the prior hearing or was not under subpoena to testify at that hearing. Debbie J. Wilson, 42 Van Natta 586 (1990) citing Mario Miranda, supra.

We, therefore, turn to the postponement issue. The Referee concluded that claimant had failed to establish extraordinary circumstances warranting a postponement. She made this finding based on the representations of claimant's counsel alone. We are unable to state, based on this record, that the request should or should not have been granted. Although OAR 438-06-081, governing postponements, allows postponements only in extraordinary circumstances, the rule must not be applied with unforgiving rigidity. The rule lists a number of circumstances that do not justify postponement. A claimant's mistake concerning the time of, and late arrival at the hearing is not one of those exclusions. Therefore, the justification for a postponement under such circumstances must be

considered in light of the facts of the particular situation. Under some circumstances, a failure to appear at hearing on time may warrant postponement.

Therefore, on remand, the Referee shall take evidence concerning the circumstances of claimant's failure to attend the hearing and, in light of that evidence and our comments herein, shall determine whether or not a postponement should have been granted. The procedure for the conduct of hearing on the merits shall flow from that decision.

ORDER

The Referee's order dated October 24, 1988, and reconsidered November 9, 1988, is reversed. Claimant's hearing request is reinstated, and this case is remanded to the Referee for further proceedings consistent with this order. A client-paid fee, not to exceed $1,127, payable from the employer to its counsel, is approved.

March 28, 1990 Cite as 42 Van Natta 623 (1990)

In the Matter of the Compensation of
RICHARD L. BROOKS, Claimant
WCB Case No. 88-07184
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Thomas J. Dzieman (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

Claimant requests review of Referee Mirassou's order which dismissed claimant's request for hearing on the rate of his temporary disability compensation on res judicata grounds. On review, the issues are res judicata and rate of temporary total disability. We reverse.

FINDINGS OF FACT

The Board adopts the Referee's "Findings of Fact" through the fourth full paragraph on page two of the Opinion and Order with the following supplemented ultimate fact.

Claimant's rate of temporary total disability was incorrectly calculated because he regularly worked overtime and his overtime pay was not included.

CONCLUSIONS OF LAW AND OPINION

Res Judicata

The Referee dismissed claimant's hearing request stating that litigation of the issue of claimant's temporary total disability rate was barred by claim preclusion because the rate issue should have been litigated at a hearing in 1983. However, the Court of Appeals and the Board have subsequently held, under similar circumstances, that the narrow issue of the "correct wage rate" is an issue of fact, not a claim, and thus, the claimant is not barred by the "issue preclusion" aspect of res judicata from litigating the issue. Drews v. EBI Companies, 96 Or App 1 (1989); Vicente M. Taisacan, 41 Van Natta 1005 (1989). These cases are controlling here. Thus, claimant is not barred by res judicata.

Rate of Temporary Total Disability

The record contains a Supplemental Stipulation of Facts which sets forth the information necessary to correctly calculate claimant's benefits. We thus proceed to recalculate claimant's rate of temporary total disability.

Claimant worked 40 hours per week at a pay rate of $9.125. He also averaged 10 hours per week of overtime at one-and-one-half times his normal hourly rate. His weekly wage, therefore, averaged $501.88. His temporary total disability is equal to 66 2/3 percent of that amount, or $334.58. However, because that amount is above the "average weekly wage" on the date of injury, claimant is entitled to the "average weekly wage" ($261.32 at the date of injury) and any statutory increases to the temporary total disability rate. See ORS 656.210; 656.211.

ORDER

The Referee's order dated October 12, 1988 is reversed. The case is remanded to the SAIF Corporation for processing consistent with this order.

March 28, 1990 Cite as 42 Van Natta 624 (1990)

In the Matter of the Compensation of
CANDACE M. GRIFFIN, Claimant
WCB Case No. 87-05868
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Nichols and Crider.

Claimant requests review of Referee Tuhy's order that upheld the self-insured employer's denial of claimant's occupational disease claim for a bilateral forearm condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

Claimant, age 36 at hearing, worked for the self-insured employer for more than six years, during the last four of which she worked as a clerk/stenographer, first in market services and then in the customer office.

Based on the credible testimony of claimant and her former supervisor, Judith Sielicky, we find that although the types of tasks performed by claimant over the four-year period did not change significantly, the work load increased dramatically between 1984 and the end of 1986. The number of pages she typed per week more than doubled over the two-year period because she began working for six rather than just two supervisors. Beginning in early 1986, the average amount of daily typing time increased from about three to five or six hours.

Claimant worked on a keyboard that was located on her left hand side and was elevated to an uncomfortable position. Her terminal was located in the center of the work station. This set-up caused discomfort in the right hand and forearm. Claimant also experienced some neck tension, with pain on the left, from answering the phone and rotating her body at her workstation.

In April 1986, claimant began a course in massage. The class met one night a week through September. Claimant spent about 45 minutes per class doing massage. Claimant pursued class work in preparation for getting a massage

license thereafter. Most of the class work was academic. Claimant did a little massage on her own to practice her skills.

Claimant first noticed pain in both forearms and the back of her hands in January or February, 1986. The pain became acute in October 1986. At that time claimant sought treatment from Dr. Blodgett, D.C. He treated her with massage and trigger point therapy.

On November 3, 1986, she filed a claim for pain, aching and tension in both hands and forearms. The claim was deferred.

At Dr. Blodgett's direction, claimant's typing was limited to three hours per day in January 1987. Her symptoms diminished but did not disappear. In February, her typing work resumed its prior dimensions. Her symptoms immediately increased. When the workload was reduced again, her pain situation again improved.

Claimant was examined on referral from Dr. Blodgett by Dr. Silver, a neurosurgeon. She was also examined, at the request of the self-insured employer, by Dr. Nathan, a hand specialist, in February 1988. In addition, she was examined by Dr. Hauge, a hand surgeon, in April 1987. Thereafter, claimant treated with Dr. Hauge.

On March 2, 1987, the claim was denied.

Claimant's pain is caused by an inflammatory process such as tendinitis.

Claimant's symptoms at the time of hearing were considerably diminished. She suffers bilateral arm pain when typing. Housework also causes her symptoms to increase.

Claimant had no problems with either her forearms or her hands prior to 1986.

FINDINGS OF ULTIMATE FACT

Claimant's work activities are the major contributing cause of her bilateral forearm and hand pain.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant had failed to establish a causal connection between her work and her bilateral condition. He was troubled by the inability of Drs. Silver and Nathan to firmly diagnose the condition. Moreover, he relied on the opinions of Drs. Silver and Nathan, rather than on that of Dr. Hauge, because he believed that Dr. Hauge did not take a history of claimant's off-the-job activities. The Referee erred.

First, we have found that claimant suffered from an inflammatory process, probably extensor tendinitis. We made this finding based on the opinion of Dr. Hauge, who examined claimant at her own request. We note that this is the same diagnosis which Dr. Silver suggested might prove correct given his failure to find any neurological abnormality. In any event, it is not a necessary predicate to compensability that the medical experts know the exact mechanism of injury or disease. See Robinson v. SAIF, 78 Or App 581 (1986). It is simply necessary that there be persuasive evidence that the primary cause of the disease is exposure at work.

Second, unlike the Referee, we find the opinion of Dr. Hauge more persuasive than those of Drs. Silver and Nathan. We do so for several reasons. Contrary to the Referee's opinion, Dr. Hauge did discuss off-work activities with claimant. Indeed, claimant specifically suggested to him that her massage might have contributed to the causation of the condition. (Ex. 20.) However, Dr. Hauge apparently rejected this hypothesis because claimant's massage activities were so limited in duration. We note that Dr. Nathan had also concluded that claimant's pain was unrelated to her massage work because the onset of her symptoms preceded the commencement of the massage class and her symptoms exacerbated after the class was over. (Ex. 16.) Moreover, Dr. Hauge treated claimant over a period of months and was able to observe claimant's response to variation in workload and to treatment. Finally, he, unlike Drs. Silver and Nathan, understood that claimant's workload had increased over the years. For these reasons, we defer to his opinion that claimant's condition was caused by her work activities.

Inasmuch as Dr. Hauge attributed claimant's condition to her work activities and not to any non-work cause, we have found that the major contributing cause of her condition is her work activities. The claim is, therefore, compensable.

ORDER

The Referee's order dated December 15, 1987, is reversed. The self-insured employer's denial of March 2, 1987, is set aside and the claim remanded to the self-insured employer for processing according to law. For services at hearing and on review, claimant's attorney is awarded an assessed fee of $2,300, to be paid by the self-insured employer. The Board approves a client-paid fee, not to exceed $1,290.50, payable by the self-insured employer to its counsel. In so doing, we note that Board authorization is not required for costs incurred by counsel for the employer.

In the Matter of the Compensation of
MICHAEL D. OWINGS, Claimant
And, In the Matter of the Compliance of
WILLAMINA ASSEMBLY OF GOD CHURCH, Employee
WCB Case Nos. 89-03324 & 89-04845
ORDER DENYING MOTION TO DISMISS
Gatti, et al., Claimant Attorneys
Norman Harper, Attorney
Gail Gage (Saif), Defense Attorney

The SAIF Corporation has moved for an order dismissing the alleged noncomplying employer's request for Board review of the Referee's order on the grounds that the employer should have appealed directly to the Court of Appeals. We deny the motion.

FINDINGS OF FACT

The alleged noncomplying employer requested a hearing concerning the Department's Order of Noncompliance. In addition, claimant and the employer requested a hearing regarding SAIF's acceptance, as processing agent for the employer, of claimant's December 14, 1988 low back and left knee injury claim. Finally, claimant also filed a hearing request concerning a denial of claimant's aggravation claim for his low back condition issued by SAIF, as insurer for the employer under a 1986 injury claim.

Following a hearing, the Referee issued an order and reconsideration order which reached the following conclusions. The Referee concluded that the employer was noncomplying when claimant sustained his December 1988 injury. Therefore, the Department's Order of Noncompliance was affirmed. SAIF's acceptance, as processing agent for the employer, was upheld insofar as it pertained to claimant's left knee injury but set aside insofar as it concerned claimant's current low back condition. Finally, SAIF's denial of claimant's low back condition, as insurer for the employer under the 1986 injury claim, was upheld insofar as it pertained to claimant's aggravation claim, but set set aside insofar as it concerned claimant's medical services claim.

The Referee's findings and conclusions were contained in one order, which carried both WCB Case numbers. The employer requested Board review within 30 days of the Referee's December 5, 1989 order, as abated and reconsidered January 8, 1990.

CONCLUSIONS OF LAW

When an order declaring a person to be a noncomplying employer is contested at the same hearing as a matter concerning a claim pursuant to ORS 656.283 and 656.704, the review thereof shall be as provided for a matter concerning a claim. ORS 656.740(4)(c). Matters concerning a claim under ORS 656.001 to 656.794 are those matters in which a worker's right to receive compensation, or the amount thereof, are directly in issue. ORS 656.704(3).

Here, the hearing before the Referee was not limited to the Department's noncompliance order. Instead, the order also concerned the compensability of, and responsibility for, claimant's low back and left knee conditions. Since these issues addressed by the Referee's order directly affected claimant's right to compensation, review of the order shall be conducted as provided for a matter concerning a claim. ORS 656.704(3); 656.740(4)(c). Such a procedure necessarily involves Board review of the Referee's order pursuant to ORS 656.289(3) and 656.295. Donna M. Hooper, 41 Van Natta 373 (1989).

Accordingly, the motion to dismiss is denied. As a result of this motion, the briefing schedule shall be revised as follows. SAIF's and claimant's respondent's briefs shall be due 14 days from the date of this order. The alleged noncomplying employer's reply brief shall be due 7 days from the date of mailing of the latest timely submitted respondent's brief.

IT IS SO ORDERED.

March 28, 1990 Cite as 42 Van Natta 627 (1990)

In the Matter of the Compensation of
SERGIO Z. SALINAS, Claimant
WCB Case No. 88-11206
ORDER ON REVIEW (REMANDING)
Jeff Carter, Claimant Attorney
Tooze, Shenker, et al., Defense Attorneys

Reviewed by Board Members Crider and Brittingham.

Claimant requests review of Referee Seifert's order that: (1) refused to admit Exhibit 19; and (2) affirmed a Determination Order that awarded no unscheduled permanent disability for injury to the neck and low back. On review, the issues are evidence, remand and extent of permanent partial disability. We reverse and remand.

FINDINGS OF FACT

Claimant was compensably injured on October 12, 1987, when he was hit on the head by a board.

The claim was accepted. It was closed by Determination Order of June 17, 1988 without permanent disability.

Claimant timely requested hearing. The hearing was scheduled for September 23, 1988.

Exhibits were exchanged.

On the day before hearing, claimant's attorney received a report from Dr. Jansen, claimant's treating physician. Claimant's attorney notified counsel for the self-insured employer of the receipt of the report and read the report to him by telephone.

Claimant offered the exhibit at hearing. It was marked Ex. 19. The self-insured employer objected to receipt of the exhibit on the ground that "it results in material prejudice and surprise to the carrier and that there is no good cause for the failure to obtain and disclose this exhibit at an earlier time."

The Referee rejected the exhibit on the grounds that claimant had no good reason for failing to produce the exhibit at an earlier date.

ULTIMATE FINDING OF FACT

Claimant disclosed Dr. Jansen's September 22, 1988, report to the self-insured employer within seven days of its receipt.

CONCLUSIONS OF LAW AND OPINION

The Referee, in his written order, excluded Exhibit 19 as untimely. In so doing, he relied on former OAR 438-07-015(6).

Claimant contends that former OAR 438-07-015(6) allows a referee discretion to exclude an exhibit only when it has not been timely disclosed under former OAR 438-07-015(4). He is correct.

All exhibits which are disclosed within the time provided for by the rules are admissible. Former OAR 438-07-015(6) provides for consideration of the reasons for late disclosure of an exhibit and of prejudice to the opposing party as a result of the late disclosure only if the disclosure is in fact untimely under the rules. If the disclosure is late in the sense that it was disclosed on the eve of hearing but was not untimely under the rules, then the remedy for potential prejudice to the opposing party is not to exclude the exhibit but rather to allow time for cross-examination or rebuttal.

Former OAR 656-07-015(4) provided:

> "Documents acquired after the initial exchanges shall be provided to the other parties within seven (7) days after the disclosing party's receipt of the documents. A party's failure to comply with this section may result in the same sanctions provided in sections (2) and (3) above."

The referenced sections allowed the Referee to exclude documents not timely disclosed. Claimant disclosed Dr. Jansen's report the day it was received. Therefore, the disclosure was timely. The Referee had no discretion to exclude the exhibit because it was late. See Dolores P. Hoffman, 42 Van Natta 549 (1990).

We will remand the case for receipt of Exhibit 19. The Referee may allow the self-insured employer to cross-examine the author of the exhibit or to rebut it as is appropriate under the rules. The Referee shall then enter a new, appealable order addressing the issue of extent of permanent disability.

ORDER

The Referee's order dated October 20, 1988, is reversed. The case is remanded to the Presiding Referee. The Presiding Referee shall appoint a referee who shall undertake further proceedings consistent with this opinion. The Board authorizes a client-paid fee, not to exceed $1,352, payable by the self-insured employer to its counsel.

March 28, 1990 Cite as 42 Van Natta 629 (1990)

In the Matter of the Compensation of
GEORGE A. SMITH, Claimant
WCB Case No. 88-04237
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Cowling & Heysell, Defense Attorneys

Reviewed by Board Members Nichols and Brittingham.

The self-insured employer requests review of Referee Myers' order granting permanent total disability in lieu of a Determination Order awarding no unscheduled permanent partial disability in addition to the 40 percent (128 degrees) previously awarded. On review, the issue is extent of permanent disability, including permanent total disability. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant was not permanently and totally disabled on the basis of the medical factors alone. The Referee however concluded that claimant was totally disabled because he was limited to sedentary work and according to the testimony of Mr. McNaught, a vocational counselor, there were no sedentary jobs that the claimant was capable of doing.

Both Dr. Shachner and Dr. Sharrer, who have been claimant's treating physicians, have indicated that claimant is capable of performing work in the sedentary to light range. Claimant is capable of performing some work, consequently he can only be found permanently and totally disabled if 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 397,399 (1985).

Claimant has worked with vocational counselors to assist his return to work. In February 1988, he attended a work evaluation program where it was determined that he had the physical abilities and skills to perform certain jobs. Before the hearing claimant was approved for an authorized training program although it had not been started. At hearing, vocational experts testified regarding claimant's employability. We find vocational expert Mihayl more persuasive. He believes that there are sedentary to light duty jobs that claimant can do and that fall within his physical restrictions as indicated by the medical reports. Mr. McNaught, the other vocational expert, opined that claimant was not employable because of the limits claimant placed on his physical activity rather than those indicated by the medical experts. We find the medical reports of claimant's limitations, which are consistent with the work evaluation report, to be more persuasive than claimant's perception of his limits.

Claimant had told his vocational counselor that there were certain jobs he could do, i.e. meter reader; however he felt it would only be worthwhile to work if he earned more than $8 per hour which he would need to meet his living expenses. The expected wage rate is not treated the same in evaluating an injured worker for permanent total disability purposes as it is for vocational assistance purposes. The purpose of awarding permanent total disability benefits is to maintain an injured worker, not restore him to his pre-injury wage. Walter R. Searles, 41 Van Natta 627 (1989). Given that claimant is not physically permanently and totally disabled and that there are jobs claimant is capable of doing that are within his physical limitations, we find that claimant is not entitled to an award of permanent total disability.

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

The medical evidence indicates that claimant is moderately impaired from this injury to his shoulder and neck. There have been specific limitations placed on the claimant because of this injury. Additionally, claimant has pain which further limits his activity. After considering the impact claimant's age, education, work experience and adaptability have on his loss of earning capacity, we conclude that an award of 70 percent (224 degrees) unscheduled permanent disability is appropriate for this injury.

ORDER

The Referee's order dated July 6, 1988 is reversed. In lieu of the Referee's award and in addition to the prior awards of 40 percent (128 degrees) unscheduled permanent disability, claimant is awarded 30 percent (96 degrees) unscheduled permanent disability, giving him a total award to date of 70 percent (224 degrees) unscheduled permanent disability for the injury to his neck and shoulder. Claimant's attorney is awarded 25 percent of the increased compensation created by this order, payable directly to claimant's attorney, not to exceed $3,000. The employer is permitted to credit attorney fees paid pursuant to the Referee's award against the attorney fee awarded herein.

In the Matter of the Compensation of
BOBBY L. AUSTIN, Claimant
WCB Case No. 87-17300
ORDER ON REVIEW
Olson, Rowell & Walsh, Claimant Attorneys
Cowling & Heysell, Defense Attorneys

Reviewed by Board Members Cushing and Myers.

Claimant requests review of that portion of Referee Brown's order which upheld the insurer's denial of claimant's aggravation claim for his back condition. Although the insurer has not formally cross-requested review, in its respondent's brief, the insurer argues that claimant's aggravation claim was not filed prior to the expiration of claimant's five-year aggravation rights. On review, the issues are jurisdiction and aggravation. We dismiss.

FINDINGS OF FACT

Claimant compensably injured his low back in August 1976. His claim was accepted by the insurer as nondisabling. No Determination Order issued. In February 1979, claimant received additional medical treatment for his back condition and filed an aggravation claim of his 1976 injury. The insurer denied claimant's aggravation claim and claimant requested a hearing. In January 1980, by Opinion and Order, a Referee set aside the insurer's aggravation denial. That order was subsequently affirmed by the Board.

In July 1982, a Determination Order issued awarding claimant 10 percent unscheduled permanent disability for his low back condition. Claimant requested a hearing. Prior to the hearing, the parties entered into a disputed claims settlement in which the parties stipulated that claimant's low back problems were unrelated to claimant's August 1976 compensable injury.

In June 1987, claimant suffered a recurrence of low back pain and filed an aggravation claim. The insurer issued its denial of the claim in January 1988. Claimant requested a hearing on the denial.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant's aggravation claim had been filed in a timely manner. We disagree. Further, the Referee concluded that claimant had not met his burden of proving that his current need for treatment is related to his 1983 industrial injury. We do not reach this issue because of our determination on the timeliness issue.

Claimant is entitled to claim reopening under ORS 656.273(4) for worsened conditions resulting from the compensable injury. This worsening may be temporary or permanent. Smith v. SAIF, 302 Or 396 (1986). Furthermore, this "worsening" must be established prior to the expiration of claimant's aggravation rights. Perry v. SAIF, 93 Or App 631 (1988), rev'd on other grounds 307 Or App 654, on remand 99 Or App 52, n. 2 (1989).

Jurisdiction

The insurer argues that the Referee lacked jurisdiction to hear the aggravation issue because claimant's aggravation rights had expired. We agree.

In 1975, ORS 656.273(4) provided,

> "(4)(a) Except as provided in paragraphs (b) and (c) of this subsection, the claim for aggravation must

> be filed within five years after the first determination made under subsection (3) of ORS 656.268.
>
> (b) If no determination was made, the claim for aggravation must be filed within five years after the date of injury.
>
> (c) If a nondisabling injury did not become disabling within at least one year from the termination of medical services, the claim for aggravation must be filed within five years from the date of injury rather than the date of any determination issued in the claim."

Here, the date of claimant's injury is August 1976. Claimant's claim for that injury was accepted by the insurer as nondisabling. At the time of claimant's 1976 injury, no statute required closure of a nondisabling claim. See Webb v. SAIF, 83 Or App 386, 390 (1987). Here, no notice of closure or determination order issued. Thus, ORS 656.273(4)(b) applies.

Claimant's claim for aggravation must have been filed within five years of the date of injury. Claimant's current "aggravation" claim was filed in 1987. Therefore, we conclude that claimant's "aggravation" claim was outside the five-year period. Consequently, the Referee was without jurisdiction to consider the claim.

Aggravation

Because we find that the Referee lacked jurisdiction to hear the merits of the "aggravation claim", we do not reach this issue.

ORDER

The Referee's order dated June 3, 1988, is reversed in part and affirmed in part. Claimant's hearing request is dismissed insofar as it pertained to claimant's "aggravation" claim. The remainder of the Referee's order is affirmed. A client-paid fee, not to exceed $553, payable by the insurer to its counsel, is approved.

March 29, 1990 Cite as 42 Van Natta 632 (1990)

In the Matter of the Compensation of
CHERYL L. COBB, Claimant
WCB Case No. 88-12563
ORDER ON REVIEW
Charles Woods, Claimant Attorney
Gail M. Gage (Saif), Defense Attorney

Reviewed by Board Members Howell and Perry.

Claimant requests review of Referee Daron's order which: (1) awarded claimant interim compensation; (2) assessed a penalty and related attorney fee for the SAIF Corporation's alleged unreasonable failure to pay interim compensation; (3) upheld SAIF's denial of claimant's claim for her injuries sustained in a car accident; and (4) declined to assess penalties and attorney fees for alleged unreasonable denial. On review, the issues are compensability, interim compensation, penalties and attorney fees.

We affirm and adopt the order of the Referee with the following supplementation and modification.

Claimant did not work May 2, and May 3, 1988 due to her accident related injuries. She returned to work on May 4, 1988. She worked her regular schedule until June 10, 1988 when she was terminated for reasons unrelated to her injury.

A claimant is entitled to temporary disability compensation pending acceptance or denial of a claim for a disabling injury if she "leaves work" within the meaning of ORS 656.210. Bono v. SAIF, 298 Or 405, 408-10 (1984); see also Jones v. Emanuel Hospital, 280 Or 147, 150-52 (1977). Such compensation, called "interim compensation" for convenience, is due beginning 14 days after the date upon which the employer or its insurer receives notice or knowledge of the claimant's claim. ORS 656.262(4). However, no disability payment is recoverable for temporary total disability suffered during the first three calendar days after the worker leaves work as a result of the compensable injury unless the total disability continues for a period of 14 days or the worker is an inpatient in a hospital. ORS 656.210(3).

Claimant is not entitled to temporary disability (interim) compensation because she was off work only two days due to her accident-related injuries.

ORDER

The Referee's order dated November 30, 1988 is modified to the extent that it awarded interim compensation. It is otherwise affirmed.

March 29, 1990 Cite as 42 Van Natta 633 (1990)

In the Matter of the Compensation of
GLENDA R. COOPER, Claimant
WCB Case No. 88-14027
ORDER ON REVIEW
Lawrence C. Klang, Claimant Attorney
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Cushing and Gerner.

The insurer requests review of Referee Hoguet's order which set aside its denial of claimant's occupational disease claim for bilateral carpal tunnel syndrome. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

Claimant began working full-time for the employer in July 1985 as a deburrer. The job entailed the use of an air gun, weighing approximately five pounds, which is used to finish metal parts. The air gun vibrated when in use. Claimant alleges that she suffered hand and wrist pain accompanied by numbness in her fingers while performing this job. Claimant did not report to her employer that she suffered any pain, she did not seek medical treatment, nor did she file a claim.

After three months, claimant worked for that same employer as a machinist for the next two and one half years. She alleges that her hand pain subsided with this position. She was able to perform her duties without difficulty and did not file a claim.

Claimant next worked, beginning in April 1988, as a packager for the employer. Claimant alleges her hand and wrist symptoms recurred. She first sought treatment in May 1988 from Dr. Ploss, M.D., for arm symptoms, and then filed an occupational disease claim for her left and right arm and hand condition.

Ploss referred claimant to Dr. Brown, neurologist, who began treating claimant in June 1988. Claimant reported to Brown that her symptoms had continued for three years. Brown diagnosed bilateral carpal tunnel syndrome and rendered no independent opinion regarding the cause of claimant's condition.

Brown referred claimant to Dr. O'Keefe, orthopedist, who performed release surgery on claimant.

In July 1988, claimant was evaluated by Dr. Button, orthopedist, hand and upper extremities specialist and independent medical examiner.

In August 1988, the insurer denied claimant's occupational disease claim for bilateral carpal tunnel syndrome. Claimant requested review.

Claimant has a family history of diabetes, obesity, possible hypertension and poor fluid retention, each of which possibly contribute to the development of carpal tunnel syndrome.

Claimant has failed to prove that her work activities were the material cause of her bilateral carpal tunnel syndrome.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant had proven her occupational disease claim. In doing so, the Referee relied on claimant's testimony and the opinion of Dr. O'Keefe. 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 filed her workers' compensation claim in May 1988, and her last exposure to working conditions, which she alleges caused her bilateral carpal tunnel syndrome, was in July 1988. Accordingly, the occupational disease law, which became effective January 1, 1988, is applicable.

To be compensable, claimant's occupational disease must fall within one of the three subsections of ORS 656.802(1). Here, claimant alleges that her hand and wrist pain began while working as a deburrer, which required repetitive wrist movement, that the pain subsided while working as a machinist, and then recurred while working as a packager. We conclude that this 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 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). We find that she has not met her burden.

The Referee found claimant to be credible. Claimant relates wrist and hand pain to her work activities which began in August 1985. Although claimant's credible testimony concerning causation is probative, it may not be persuasive when the claim involves a complex medical question. See Uris v. Compensation Department, 247 Or 420, 424 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985).

The record establishes that claimant has a history of diabetes, obesity, possible hypertension and poor fluid retention. Button, the independent medical examiner, reported that each of these conditions are likely causes or contributing factors of claimant's carpal tunnel syndrome. Under these circumstances, we

find that the issue of whether claimant's work exposure was a material cause of her bilateral carpal tunnel syndrome is a complex medical question, requiring expert medical evidence. See Uris, supra; Kassahn, supra.

Neither claimant's treating physician, Ploss, nor her neurologist, Brown, rendered an opinion regarding the cause of claimant's carpal tunnel condition. Button, independent medical examiner, specifically reported in July 1988 that he did not believe that there was a causal relationship between claimant's employment activities and the development of her carpal tunnel syndromes.

The only physician to relate claimant's work activities to her carpal tunnel condition is O'Keefe. O'Keefe, after reviewing medical reports of Drs. Ploss, Brown, Button and himself, reported that "it appears that all parties agree that the onset of [claimant's condition] was causally related to her work activities in approximately August of 1985." However, after our review of the same medical records, neither Ploss, Brown nor Button made any such conclusion. We find the opinion of O'Keefe to be based on an erroneous premise that seriously undermines his own conclusions. Therefore, we are not persuaded by his opinion.

Consequently, as there is no persuasive medical evidence in the record to establish that claimant's bilateral carpal tunnel syndrome is causally related to her work activities, we conclude that claimant has failed to meet her burden of proof.

ORDER

The Referee's order dated November 25, 1988, is reversed. The insurer's denial of claimant's bilateral carpal tunnel syndrome is reinstated and upheld. The Referee's $1,200 attorney fee award is reversed.

March 29, 1990 Cite as 42 Van Natta 635 (1990)

In the Matter of the Compensation of
RANDY G. FISHER, Claimant
WCB Case No. 88-12648
ORDER ON REVIEW
Merrill Schneider, Claimant Attorney
David Ray Fowler (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

Claimant requests review of those portions of Referee Hoguet's order which: (1) declined to reclassify claimant's injury as disabling; and (2) declined to assess penalties and associated attorney fees for alleged unreasonable claim processing. On our own motion we consider whether we have jurisdiction over the issue of claim classification. See Southwest Forest Ind. v. Anders, 299 Or 205, 208 (1985). On review, the issues are jurisdiction, proper classification of this claim, penalties and associated attorney fees. We modify and affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Temporary Disability

SAIF initially accepted this claim as a nondisabling injury on June 23, 1988. Claimant requested a hearing on July 26, 1988, contending that his injury

had been misclassified as nondisabling. He argued at hearing that his injury was actually disabling, thus entitling him to benefits for temporary partial disability and temporary total disability.

Rather than requesting a hearing, however, the statute provides that a claimant has a "right to object to a decision that the injury . . . is nondisabling by requesting a determination thereon pursuant to ORS 656.268." ORS 656.262(6)(b).

ORS 656.268(8) provides:

> "Upon receipt of a request made pursuant to ORS 656.262(6) or subsection (3) of this section, the Department of Insurance and Finance shall determine whether the claim is disabling or nondisabling. A copy of such determination shall be mailed to all interested parties in accordance with subsection (6) of this section."

ORS 656.270 requires that each such determination advise the parties of their right to request a hearing thereon. Thus, while ORS 656.283 states that a hearing may be requested by any party at any time regarding any question concerning a claim, the statutes relating to nondisabling injuries provide that a claimant must first exhaust the remedy provided under ORS 656.268(8) by submission of the matter to the Department for determination before he may request a hearing on the question of reclassification of his claim. See Anthony A. Bono, 35 Van Natta 1, 6-7, rev'd on other grounds Bono v. SAIF, 66 Or App 138 (1983).

Because we find that claimant did not exhaust his remedy under ORS 656.268(8) by requesting a determination from the Department before requesting a hearing, the Hearings Division and the Board lack jurisdiction to address the proper classification of his claim.

Penalties and Attorney Fees

Claimant contends he is entitled to a penalty and associated attorney fee because SAIF's claims examiner possessed evidence of time loss but ignored that evidence. See ORS 656.262(10) and 656.382(1). Given the information before the claims examiner, we are not persuaded that SAIF's conduct was unreasonable.

ORDER

The Referee's order dated October 26, 1988 is affirmed as to the issue of penalty and attorney fee. The order is modified as to the question of claim classification. Claimant's request for hearing in that regard is dismissed.

March 29, 1990 Cite as 42 Van Natta 636 (1990)

In the Matter of the Compensation of
YVONNE F. FITTS, Claimant
WCB Case No. 86-07926
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Myers and Gerner.

The insurer requests review of Referee McCullough's order which: (1) set aside the insurer's partial denial of a psychological condition; (2) set aside

the insurer's partial denial of medical services for a syncopal episode; (3) set aside the insurer's denial of compensability of an exercise bicycle; and (4) granted claimant an award for permanent total disability. The insurer also contests certain evidentiary rulings made by the Referee in his Opinion and Order. On review, the issues are compensability of the psychological condition, compensability of the syncopal episode, compensability of the exercise bicycle, extent of disability, and the propriety of the Referee's evidentiary rulings. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following supplementation. Dr. Foulke did not explain with particularity why claimant required an exercise bicycle when the majority of workers with similar impairments do not.

CONCLUSIONS AND OPINION

We adopt the Referee's "Opinion and Conclusions" with the exception of the section titled "Compensability of the Exercise Bike."

We conclude that claimant has failed to sustain her burden of proving the compensability of the exercise bicycle because the only two reports justifying the compensability of the exercise bicycle are from Dr. Foulke and they do not explain with particularity why claimant needs the exercise bicycle when the majority of workers with similar impairments do not need such a bicycle. OAR 436-10-040(8).

ORDER

The Referee's order dated November 10, 1988 is affirmed in part and reversed in part. That portion of the Referee's order which set aside the insurer's denial of July 2, 1987, the denial of the exercise bicycle, is reversed. The denial is reinstated and upheld. The assessed fee awarded by the Referee is reduced by $250. The balance of the Referee's order is affirmed. Claimant's attorney is awarded an assessed fee of $850, to be paid by the insurer. The Board approves a client-paid fee, not to exceed $3,381.25, to be paid by the insurer to its attorney.

March 29, 1990 Cite as 42 Van Natta 637 (1990)

In the Matter of the Compensation
JACQUELINE D. HANES, Claimant
WCB Case No. 88-11146
ORDER ON REVIEW
Ronald A. Fontana, Claimant Attorney
Barbara Brainard (Saif), Defense Attorney

Reviewed by Board Members Brittingham and Nichols.

The SAIF Corporation requests review of Referee Schultz's order that: (1) set aside a Determination Order and remanded the claim to Closing and Evaluation; and (2) awarded temporary total and temporary partial disability benefits. Claimant cross-requests review, contending that she is entitled to additional temporary disability benefits. On review, the issues are remand to Closing and Evaluation and temporary disability compensation. We reverse.

FINDINGS OF FACT

Claimant is a 46-year-old administrator who was employed with SAIF's insured until she was terminated on January 13, 1986 for reasons unrelated to her

compensable claim. On June 19, 1987, claimant filed an occupational disease claim for "cumulative mental stress with physical symptoms due to increasing workload, budgetary problems, change of position and termination of employment." The date of onset of her occupational disease was listed as May 31, 1985. Her claim was initially denied and later found compensable by Referee Ebner's order of April 20, 1988.

SAIF submitted a 1502 form on April 25, 1988 indicating that the claim had been accepted as nondisabling. On June 8, 1988, the claim was submitted for closure and a Determination Order issued on June 27, 1988 awarding claimant neither temporary nor permanent disability.

Claimant was examined by her family physician, Dr. Glasser, in April 1986 for physical problems which could have been related to her stress claim. Dr. Glasser did not treat claimant for her psychiatric problems and did not authorize time loss for her physical problems.

Claimant did not seek professional psychiatric or psychological treatment.

Claimant did not return to employment following her January 13, 1986 termination from SAIF's insured until July 1986. This position was terminated in August 16, 1986. Claimant then applied for and received unemployment benefits, acknowledging that she was able to and was actively seeking work. Claimant subsequently worked for a period self-employed as a housekeeper. On February 20, 1988, she accepted a position as a manager with a new employer, and remained employed in this capacity until September 19, 1988.

On September 2, 1987, claimant was examined at the request of SAIF by Dr. Turco. His diagnosis was adjustment reaction with elements of fatigue. Dr. Turco did not authorize time loss.

FINDINGS OF ULTIMATE FACT

Claimant's compensable stress condition is nondisabling.

CONCLUSIONS OF LAW AND OPINION

The Referee found that no physician had authorized time loss nor had claimant sought psychiatric care. The Referee concluded however, that these factors were not fatal to claimant's claim and concluded that based upon claimant's testimony she was temporarily disabled from January 14, 1987 through September 2, 1987. We disagree.

Whether claimant is entitled to temporary disability depends on whether a preponderance of the evidence indicates that claimant was disabled during the period she requested time loss. Botefur v. City of Creswell, 84 Or App 627 (1987). We conclude that claimant has failed to meet her burden.

No time loss was authorized by any physician. Claimant's family physician, Dr. Glasser, did not treat claimant for her employment related stress and authorized no time loss. Furthermore, the only psychiatric evidence in the record is that of Dr. Turco. Dr. Turco concluded that claimant was psychiatrically stationary and capable of working on a regular full-time basis. Dr. Turco found that while claimant could have possibly been disabled from her job with SAIF's insured he could not determine when she would have been capable of returning to regular work. His suggestion that claimant was disabled from work at the time she was terminated is primarily based on information basically obtained through claimant's statements that she could not perform the job when terminated and for some time thereafter. The remainder of this record, which includes

other employments as well as receipt of unemployment benefits, does not support claimant's statements that she was continuously disabled during this period of time even on a partial basis.

In this case, the record is devoid of any evidence of claimant's inability to work due to her compensable injury other than her testimony. Under these circumstances, we find claimant's testimony insufficient to meet her burden of proving an inability to work. Therefore, we conclude that claimant is not entitled to temporary total or temporary partial disability. We reverse the Referee and reinstate the Determination Order of June 27, 1988.

ORDER

The Referee's order of October 25, 1988 is reversed. The June 27, 1988 Determination Order is reinstated and affirmed.

March 29, 1990 Cite as 42 Van Natta 639 (1990)

In the Matter of the Compensation of
ROSEMARY J. HARREL, Claimant
Own Motion No. 89-0709M
OWN MOTION ORDER
Phil H. Ringle, Jr., Claimant Attorney
SAIF Legal Department, Defense Attorney

The SAIF Corporation has submitted to the Board claimant's claim for an alleged worsening of her January 27, 1982 industrial injury. Claimant's aggravation rights have expired. SAIF has accepted responsibility for the current medical services, including hospitalization for a deep vein thrombosis. SAIF does not recommend reopening of her claim contending the hospitalization merely represents an ongoing waxing and waning of her current condition.

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 hospitalization. "Worsening" means a pathological or symptomatic exacerbation resulting in increased loss in use or function.

Claimant was compensably injured in 1982. The same year, she had a total right knee replacement. She suffered post-operative deep vein thrombosis. She re-injured her knee in 1986. The claim was reopened.

The claim was closed by Determination Order on September 19, 1989. At that time, claimant's knee was stiff, swollen and painful. Claimant was limited in her ability to walk, climb, squat and kneel due to her knee pain. However, she was able to do at least sedentary work and to do most household tasks.

On November 11, 1989, claimant was hospitalized with increased symptoms. She suffered from deep vein thrombosis in the right leg. SAIF has apparently agreed to pay for her hospitalization.

We conclude that claimant suffered an exacerbation of her condition coupled with greater disability than at the time of the last award when the

thrombosis condition flared. She was hospitalized as a result. Therefore, her condition worsened. See Gwynn v. SAIF, 304 Or 345 (1987); Edward D. Lucas, 41 Van Natta 2272 (1989). SAIF's contention that a condition worsens only if claimant is totally disabled for more than 14 days is incorrect.

Accordingly, claimant's claim is reopened with temporary disability benefits to commence the date she was hospitalized. 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.

Claimant's condition worsened and her claim is reopened within the time for appeal of the 1989 Determination Order. Therefore, this claim must be reclosed under ORS 656.268 rather than ORS 656.278. Carter v. SAIF, 52 Or App 1027 (1981), Therefore, when appropriate, the claim shall be submitted to Evaluation Section or closed by the insurer as is appropriate under ORS 656.268 rather than pursuant to OAR 438-12-055.

Finally, SAIF is allowed to offset time loss paid beyond the medically stationary date against any future award of permanent disability.

IT IS SO ORDERED.

In the Matter of the Compensation of
ROY E. HUBBARD, Claimant
WCB Case No. 88-10506
ORDER ON REVIEW
Ormsbee & Corrigall, Claimant Attorneys
Cowling & Heysell, Defense Attorneys

Reviewed by Board Members Cushing and Myers.

The self-insured employer requests review of that portion of Referee Nichols' order which set aside its denial of claimant's occupational disease and/or injury claim for his neck and shoulder strain condition. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

The Referee found that there was no specific event which occurred at claimant's employment which would be the basis for an industrial injury claim. Thus, the Referee analyzed claimant's claim for his neck and shoulder strain condition as an occupational disease claim. 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 his neck and shoulder condition. He filed his workers' compensation claim that same month. Accordingly, the occupational disease law, which became effective January 1, 1988, is applicable.

To be compensable, 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 "spreader", a position which involves repetitive shoulder and arm movement while lifting. 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 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). We find that he has met his burden.

Claimant injured his neck and upper back in a 1981 automobile accident. The pain symptoms associated with that injury continued to worsen until 1986, when claimant was diagnosed with a C6-7 disc herniation and underwent a laminectomy performed by Dr. Golden. Claimant's pain symptoms never completely resolved.

In March 1988, after working three months as a spreader, claimant returned to Golden, reporting that his current work, which involved consistent repetitive arm and shoulder movements, caused an exacerbation of his neck and shoulder condition. Golden conservatively treated claimant. Claimant then sought treatment from Dr. Vancho, his original treating chiropractor since the 1981 accident. Vancho initially restricted claimant's work activities to modified duties, but because no modified work was available, Vancho released claimant from work.

Vancho diagnosed claimant's condition as "cervical-thoracic strain, superimposed on cervical disc syndrome and post laminectomy C6-7." In his July 1988 report, Vancho reported that the pathology of claimant's condition had not worsened to a reasonable degree but had worsened temporarily due to his current working conditions. In the same question and answer report, Vancho indicated that claimant's "employment activities . . . [were] an independent, significant, contributing cause of [claimant's] worsening." We find the opinion of Vancho persuasive.

Therefore, since there is no other medical evidence to the contrary, we find that claimant's repetitive work exposure is a material contributing cause of his current neck and back condition. His occupational disease claim is compensable.

ORDER

The Referee's order dated November 30, 1988, is affirmed. For services on Board review, claimant's counsel is awarded a reasonable assessed fee of $750. A client-paid fee, not to exceed $382, payable by the insurer to its counsel, is approved.

March 29, 1990 Cite as 42 Van Natta 641 (1990)

In the Matter of the Compensation of
PAULA J. KERNS, Claimant
And, In the Matter of Complying Status of
PAULA GUIDO-LEE, dba
DANA'S HOUSEKEEPING, Employer
WCB Case Nos. 87-13554 & 87-13553
ORDER ON REVIEW
Schwabe, et al., Attorneys
Saif Legal Department, Defense Attorney

Reviewed by Board Members Howell and Speer.

The alleged noncomplying employer, Paula Guido-Lee, dba Dana's Housekeeping, requests review of Referee Schultz's order that: (1) found that

claimant was a subject worker; (2) upheld the SAIF Corporation's acceptance of the alleged noncomplying employer's denial of claimant's claim for a left knee injury; and (3) affirmed the Department's Proposed and Final Order which found the employer to be a noncomplying employer. On review, the issue is whether claimant is a subject worker. We reverse in part and affirm in part.

FINDINGS OF FACT

The Board adopts the Referee's findings of fact as set forth in the "Stipulated Facts" section of the Opinion and Order, with the following supplementation.

Dana's Housekeeping regulated the amount per hour that claimant could charge her clients and claimant was paid on an hourly basis. If claimant's schedule was not filled by regular customers within 8-12 weeks, claimant was likely to be terminated. Dana's reviewed weekly the following week's offers and the individual client's comments about the housekeepers.

ULTIMATE FINDINGS OF FACT

Claimant engaged to furnish services for remuneration and was subject to the direction and control of Dana's Housekeeping.

Claimant worked for Dana's Housekeeping as a domestic servant in private homes.

CONCLUSIONS OF LAW AND OPINION

Compensability

The Referee found that claimant was a subject worker and Dana's Housekeeping (Dana's) was a subject employer for purposes of the Worker's Compensation Act. We find that claimant was a "worker" as defined by ORS 656.005(27). The statute provides that:

> "'Worker'" means any person, including a minor whether lawfully or unlawfully employed, who engages to furnish services for a remuneration, subject to the direction and control of an employer...." ORS 656.005(27).

A written contract existed between Dana's and claimant. Dana's and claimant had entered into an agreement whereby Dana's agreed to offer housekeeping contracts to claimant and claimant agreed to return clients' weekly commissions to Dana's.

Employee status exists when objective factors indicate that the employer had the right to control the details of the employee's work. In distinguishing between an employee and an independent contractor, the principal factors showing employment are the direct right or exercise of control, the method of payment, the furnishing of equipment and the right to terminate. Woody v. Waibel, 276 Or 189 (1976).

Dana's controlled when and where claimant would work, as it offered housekeeping contracts from individual homeowners as the contracts became available. Claimant was paid on an hourly basis and the amount per hour that she charged had been previously set by Dana's.

In its "Housekeeper Rules", Dana's provided that claimant's rate per hour would be affected by the number of regular or repeat customers that filled her schedule. Dana's further provided that if claimant's schedule was not

"frozen", or filled by regular customers within 8-12 weeks, the relationship would "likely be terminated." Dana's also reviewed weekly the next week's offers and the individual client's comments about the housecleaners. Under the circumstances, we therefore conclude that claimant was a worker who was subject to the direction and control of Dana's.

The employer argues that claimant is a nonsubject worker under ORS 656.027, which provides:

> "All workers are subject to ORS 656.001 to 656.794 except those nonsubject workers described in the following subsections:
>
> (1) A worker employed as a domestic servant in or about a private home. For the purposes of this subsection 'domestic servant' means any worker engaged in household domestic service."

The employer contends that because claimant was performing housekeeping services in private homes, she falls within the exemption and is not a subject worker for purposes of the Workers' Compensation Act. To support its argument, the employer compares 656.027(1) with the following subsection that excludes:

> "(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." ORS 656.027(2) (Emphasis added).

The employer argues that because 656.027(1) does not include the emphasized language, the legislature intended to focus on the nature of the work and exclude all domestic servants, regardless of who supervised, controlled or benefited from the work.

The Referee found that the legislative intent of the exemption was to relieve non-business homeowners of the burden of providing workers' compensation coverage for their employees. The Referee speculated that the more probable reason for a difference in language between the two subsections was that housekeeping services such as Dana's were not viable business entities at the time the legislation was enacted, while gardening and maintenance businesses were commonplace.

In the construction of statutes, Oregon courts cannot insert what has been omitted nor omit what has been inserted. ORS 174.010; see So. Sea Auto Auction v. W. Cas., 41 Or App 707, 711 (1979). Using similar rationale, we decline to speculate as to legislative motives or to read into ORS 656.027(1) language from another subsection. We find that under the plain language of the statute, claimant was employed as a domestic servant in or about private homes and she was, therefore, excluded from the workers' compensation coverage provisions generally. ORS 656.005(25). Neither does ORS 656.029(1) provide coverage because it excludes individuals exempted by ORS 656.027. Claimant's injury was, therefore, not compensable under Workers' Compensation Law.

Subjectivity

ORS 656.023 provides that every employer employing one or more subject workers in the state is subject to ORS 656.001 to 656.794. Dana's staff in Oregon consisted of one office manager. Therefore, our finding that claimant was excluded from workers' compensation coverage does not preclude us from find

ing that Dana's is nonetheless a subject employer. The alleged noncomplying employer has the burden to prove that it was not a subject employer and that the Department's order finding it to be subject and noncomplying was incorrect. ORS 656.740(1). The employer has failed to do so. The Department's Proposed and Final Order which found Dana's to be a noncomplying employer is affirmed.

ORDER

The Referee's order dated May 24, 1988 is reversed in part and affirmed in part. That portion of the order finding claimant to be a subject worker is reversed. The SAIF Corporation's acceptance of claimant's injury claim is set aside. That portion which affirmed the Department's Proposed and Final Order of noncompliance is affirmed. A client-paid fee, payable from the noncomplying employer to its counsel, not to exceed $2,130, is approved. Francesconi & Associates, Claimant Attorneys

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March 29, 1990 Cite as 42 Van Natta 644 (1990)

In the Matter of the Compensation of
HARLAN L. REETZ, Claimant
WCB Case No. 87-19473
ORDER ON REVIEW
Haugh, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Gerner and Cushing.

The insurer requests review of those portions of Referee Heitkemper's order which: (1) found that claimant's request for hearing was timely; and (2) set aside its denial of claimant's claim for a jaw and dental injury. On review, the issues are timeliness and compensability. We reverse.

FINDINGS OF FACT

On May 14, 1987, claimant filed an 801 form alleging that he had sustained an injury to his head and teeth. The 801 alleges that the injury occurred a day prior. Claimant did not seek treatment for this injury until May 27, 1987. On July 15, 1987, the insurer sent a denial of claimant's claim by registered mail at a Bend address. On the same day, a second copy of the denial was mailed to claimant by regular mail. Both denials were sent to the address listed on claimant's 801 form.

In the latter part of July 1987, claimant moved to a different section of Bend. At that time, he left a forwarding address for a Portland residence. He made arrangements with some friends to have his mail forwarded to the Portland address. Claimant moved from Bend to Portland in September 1987.

Claimant treated with Dr. Boni, dentist, between May 27, 1987 and December 1987. This treatment included the placement of crowns on claimant's injured teeth in September 1987. By letter dated December 21, 1987, claimant requested a hearing on the July 1987 denial.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant had established good cause for the untimely filing of his request for hearing. We disagree.

Claimant has 60 days to request a hearing on a denial, or 180 days if good cause for the failure to request within the 60 days is shown. ORS 656.319(1).

The test for determining if good cause exists has been equated to the standard of "mistake, inadvertence, surprise or excusable neglect" recognized under former ORS 18.160 and present ORCP 71B(1). Anderson v. Publishers Paper Co., 78 Or App 513, 517, rev den 301 Or 666 (1986). Claimant has the burden of proving good cause. Cogswell v. SAIF, 74 Or App 234 (1985).

The Referee found claimant to be a credible witness. Although we generally defer to a Referee's finding of credibility, we decline to do so in this case. We find claimant's testimony to be vague and inconsistent and therefore give it little weight. See Davies v. Hanel Lumber Co., 67 Or App 35 (1985).

Claimant testified that following the injury, his face was so swollen that he could not speak and was spitting out blood. However, the employer's nurse, who filled out the 801 form the following day testified that claimant had no difficulty speaking and had no swelling. Further, despite testifying that he was in extreme pain, claimant did not seek treatment for approximately two weeks and continued to work during this period.

Claimant initially testified that he moved from the address listed on the 801 form in the later part of July 1987. He later testified that he moved in mid-July 1987. Further, claimant had his mail forwarded to a Portland address even though he continued to live in Bend until September 1987. Claimant testified that he notified his employer of the new address after he quit working for the employer in August 1987, however he offers no corroboration for this testimony. Further, claimant testified that after he left work in August 1987, he misrepresented his status to obtain unemployment benefits which he ultimately had to return. Finally, although claimant testified that he first learned of the denial on December 4, 1987, he did not request a hearing until his letter dated December 21, 1987.

These circumstances indicate that claimant has not been totally candid nor has he acted in a manner which indicated a diligent pursuance of his claim. His failing to leave an effective current address, his failing to check with anyone regarding his claim from time to time, and his failing to immediately appeal his denial upon his alleged first receipt of it, all indicate a neglect of his claim. This neglect, based upon the totality of the evidence, is not excusable. We conclude that claimant has not established good cause for his untimely request for hearing.

As we have found that claimant's request for hearing was untimely, we do not reach the compensability issue.

ORDER

The Referee's order dated July 8, 1988, as amended July 20, 1988, is reversed. Claimant's request for hearing is dismissed. The Referee's award of a $2,000 attorney fee to claimant's counsel is reversed. A client-paid fee, not to exceed $1,300, is approved, payable by the insurer to its counsel.

March 29, 1990 Cite as 42 Van Natta 645 (1990)

In the Matter of the Compensation of
WAYNE A. SCHMIDT, Claimant
WCB Case Nos. 88-10806 & 88-10805
ORDER ON REVIEW
Heiling & Morrison, Claimant Attorneys
Cowling & Heysell, Defense Attorneys

Reviewed by Board Members Nichols and Brittingham.

Claimant requests review of that portion of Referee Higashi's order that affirmed two Determination Orders that did not grant claimant any permanent partial disability for the injuries to his neck, shoulders and right upper

extremity which occurred on January 22, 1987 and February 17, 1987. The issue on review is extent of scheduled and unscheduled permanent partial disability. We modify.

FINDINGS OF FACT

We adopt the Referee's findings.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant had no disability to the left shoulder but did have disability to the right shoulder; however, because his loss of earning capacity did not exceed the 25 percent unscheduled permanent disability he had been awarded for a prior 1986 injury, the Referee did not grant claimant any disability award for the 1987 injuries. We disagree with this analysis. If claimant has any impairment from the 1987 injuries, he is entitled to an award of permanent disability for his loss of earning capacity due to those injuries.

There is no medical evidence which would support a finding of permanent impairment for the left shoulder which was injured in February 1987. However, we agree with the Referee that there is evidence that the claimant does have permanent disability to the right shoulder. He has increased pain and decreased range of motion due to the first 1987 injury to his right shoulder. Prior to the 1987 injuries, claimant was able to work as a log truck driver and was able to throw wrappers over the load. Since those injuries, he has not been able to resume driving log truck primarily because of this limitation. He has, however, returned to work for this employer, driving chip truck.

Dr. Womack examined claimant in June 1988 and found that his condition had not changed since he had previously examined him in June 1987. He did however find claimant had some loss of motion of the shoulder and some weakness. The findings of this report do indicate claimant has additional disability beyond what was reported in October 1986, prior to closure of his 1986 injury. Dr. Womack's report refers to the left shoulder; however, we agree with Dr. Tyson, the treating chiropractor, that the doctor meant to refer to the right shoulder and arm. Dr. Tyson, basically concurred with Dr. Womack's report.

Based on the medical evidence and upon claimant's testimony, we find claimant has mild right shoulder impairment from the January 1987 injury. We have found claimant's disability to be the result of the injury in January rather than February because at the time of the second incident, claimant still had complaints and limitations with his right shoulder.

An award of unscheduled permanent partial disability for loss of earning capacity is based on physical impairment and the relevant social and vocational factors set forth in former OAR 436-30-380 et seq. Although not determinative, claimant's continued employment reduces the impact those various factors have had on his earning capacity. After considering these factors, we conclude that an award of 10 percent (32 degrees) unscheduled permanent disability adequately compensates claimant for the January 1987 injury to his right shoulder.

Claimant also seeks an award of scheduled permanent disability for the right upper extremity. The criteria for determining an award of disability for a scheduled member is loss of use or function. Prior to the injury in question, claimant had problems and complaints relative to his right arm. The medical evidence does not indicate that this injury has resulted in any additional permanent disability to claimant's right arm. We consider the question of extent of disability where there is evidence of preexisting impairment, to be a complex

question that must be addressed by expert medical evidence. Based on the evidence in this record, we are unable to find that claimant has sustained any loss of use or impairment to his right upper extremity.

ORDER

The Referee's order dated October 4, 1988 is affirmed in part and modified in part. That portion of the order which declined to award claimant unscheduled permanent partial disability for the right shoulder injury which occurred in January 1987 is modified to grant claimant an award of 10 percent (32 degrees) unscheduled permanent disability. The remainder of the order is affirmed. 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 Board approves a client-paid fee, not to exceed $473.50, payable by the insurer to its counsel.

March 29, 1990 Cite as 42 Van Natta 647 (1990)

In the Matter of the Compensation of
JOYCE STUART, Claimant
WCB Case No. 88-10869
ORDER ON REVIEW
Svoboda & Associates, Claimant Attorneys
Kate Donnelly (Saif), Defense Attorney

Reviewed by Board Members Perry and Speer.

Claimant requests review of that portion of Referee Livesley's order that upheld the SAIF Corporation's denial of claimant's occupational disease claim on the ground the claimant was a sole proprietor who had failed to elect coverage pursuant to ORS 656.128. On review, the issue is coverage. 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.

ORS 656.419(5) provides that coverage of an employer under a guaranty contract continues until cancelled or terminated as provided by ORS 656.423 or 656.247. Under ORS 656.427(1), an insurer that issues a guaranty contract or a surety bond to an employer may terminate liability on its contract or bond, as the case may be, by giving the employer and the director written notice of termination. A notice of termination shall state the effective date and hour of termination.

SAIF's May 19, 1986 notice of cancellation advised claimant that her workers' compensation insurance with SAIF would be cancelled at midnight, June 30, 1986. At hearing, claimant testified that she received SAIF's notice of cancellation. We therefore agree with the Referee's conclusion that claimant's policy which provided personal election was effectively cancelled on June 30, 1986.

ORDER

The Referee's order dated October 12, 1988 is affirmed.

In the Matter of the Compensation of
KOREY B. TAYLOR, Claimant
WCB Case No. 88-15995
ORDER ON REVIEW
Saif Corporation, Insurance Carrier

Reviewed by Board Members Howell and Speer.

Claimant, pro se, requests review of Referee Michael Johnson's order that authorized the SAIF Corporation to suspend all temporary total disability benefits while claimant is incarcerated. On review, the issue is entitlement to temporary total disability benefits during incarceration. We reverse.

The Board received a letter from claimant asking that his appeal request be dropped until his period of incarceration is over. We interpret this as a request to postpone consideration of his request for review. Because his objective cannot be realized, we do not interpret the request as a formal withdrawal and, thus, proceed to the merits.

FINDINGS OF FACT

The Board adopts the Referee's "Findings of Fact" through paragraph number 4 on page two of the Opinion and Order.

CONCLUSIONS OF LAW AND OPINION

The Referee, citing Cutright v. Weyerhaeuser Co., 299 Or 290 (1985), found that claimant was no longer part of the work force because of his incarceration and, thus, was not entitled to temporary disability as compensation for lost wages. We disagree.

The Court of Appeals recently held that a claimant who is temporarily totally disabled as a result of a compensable injury is entitled to continued temporary total disability benefits, despite incarceration, until claim closure or until he is medically stationary and released to regular work. Forshee & Langley Logging v. Peckham, 100 Or App 717 (March 14, 1990). Here, claimant originally left the workforce as a direct consequence of his compensable injury. He was not medically stationary, nor was he released for work when incarcerated. His claim has not been closed pursuant to ORS 656.268. Accordingly, claimant is entitled to continued temporary disability benefits. Id.

ORDER

The Referee's order dated December 29, 1988 is reversed. The SAIF Corporation is directed to process this claim in accordance with this order.

In the Matter of the Compensation of
PATRICIA S. THOMPSON, Claimant
WCB Case No. 88-11132
ORDER ON REVIEW
Olson, et al., Claimant Attorneys
Gary Wallmark (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

Claimant requests review of Referee Foster's order which upheld the SAIF Corporation's partial denial of claimant's claim for her low back condition. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

Claimant sustained an injury to her low back in August 1976. She treated with Dr. Hanson, M.D., who diagnosed a low back strain. Her claim was accepted by SAIF and was closed by a 1978 Determination Order which awarded no permanent disability.

In 1983 claimant sought treatment for her low back. She reported to Dr. Tilden, D.C., that it had been two-and-a-half to three years since she had experienced any trouble. Claimant reported that her recent symptoms arose after her legs gave out beneath her and she fell while fishing. In September 1983, SAIF denied claimant's current treatment because it was "for a condition not related to her accepted claim." The matter was resolved by a disputed claim settlement approved in March 1984.

In April 1987, claimant began to treat with Dr. Kelly, D.C., who diagnosed chronic lumbosacral, sacroiliac and thoracic sprain/strain syndrome. Claimant was examined by Dr. Tilden in January 1988. She reported to Dr. Tilden that she had undergone no treatment from 1984 until 1986. She further reported that her back had been fine until two years before when it began to hurt again.

Claimant made a second claim for an aggravation of her accepted condition. SAIF issued a denial of claimant's current condition and related treatment and the matter was settled by a second disputed claim settlement approved in February 1988. The 1988 settlement provided that claimant's current medical condition was not related to the August 1976 injury.

In April 1988, Dr. Kelly reported that claimant's compensable condition had worsened. SAIF issued a denial on May 5, 1988, on the basis that claimant's condition was unrelated to her compensable claim.

ULTIMATE FINDING OF FACT

Claimant's condition as of the date of hearing was the same condition subject to the February 1988 disputed claim settlement.

CONCLUSIONS OF LAW AND OPINION

The Board adopts the Referee's conclusions of law and opinion as set forth in the "Findings and Opinion" section of the order, with the following supplementation.

The doctrine of res judicata precludes litigation of claims and issues previously adjudicated. North Clackamas School District v. White, 305 Or 48, 50, modified 305 Or 468 (1988). The rule of claim preclusion is that if a claim is litigated to final judgment, the judgment precludes a subsequent action between the same parties on the same cause of action or any part thereof. Restatement (Second) of Judgments, Sec. 17-19, 24 (1982); see also Carr v. Allied Plating Co., 81 Or App 306, 309 (1986).

A Referee's order approving a disputed claim settlement is a final "judgment" within the meaning of the above rule. See Proctor v. SAIF, 68 Or App 333 (1984); Floyd D. Mitchell, 41 Van Natta 1456 (1989). Because claimant's condition remains unchanged and because claimant is claiming the same medical services for that condition, we conclude that claim preclusion applies in this case and claimant cannot relitigate the compensability of claims for chiropractic treatment of the conditions that were settled by the prior disputed claims settlements. See Liberty Northwest Ins. Corp. v. Bird, 99 Or App 560 (1989).

ORDER

The Referee's order dated October 11, 1988 is affirmed.

In the Matter of the Compensation of
ARTEMIO VERGARA, Claimant
WCB Case No. 88-11579
ORDER ON REVIEW (REMANDING)
Aller & Morrison, Claimant Attorneys
Tom Dzieman (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

Claimant requests review of Referee Mongrain's order which found that claimant's claim for a hernia condition was barred for untimely filing. On review, the issue is timeliness of claimant's hernia condition claim. We reverse and remand.

FINDINGS OF FACT

For purposes of addressing the timeliness issue, we accept the following as fact.

Claimant, 24 years old at hearing, experienced a sharp pain in his right groin in May 1987 while he was carrying wood at work. At the time he experienced the pain, claimant was a new employee and he did not know the location of the work area because his crew frequently moved from mountain to mountain.

Claimant, who speaks virtually no English, did not tell his co-workers or his employer that he had felt a pain. His symptoms subsided and claimant remained at his job with the employer until June 1988, when he experienced more groin symptoms and became aware of a lump. Claimant treated with Dr. Yeo, who diagnosed a right inguinal hernia. On June 17, 1988, claimant underwent surgery for his hernia condition.

It was not until early June 1988 that claimant informed the employer of the May 1987 incident. The denial was solely based upon the alleged untimeliness of the claim. At hearing, the parties agreed to preserve any issues involving the underlying compensability of the claim.

SAIF issued a denial on June 23, 1988. The denial was solely based upon the alleged untimeliness of the claim. At hearing, the parties agreed to preserve any issues involving the underlying compensability of the claim.

CONCLUSIONS OF LAW AND OPINION

Under ORS 656.265, an injured worker must give written notice of the accident to the employer not later than 30 days after the accident. Failure to give notice bars a claim unless: (1) the employer had actual knowledge of the injury or had not been prejudiced by failure to receive the notice; (2) the employer had begun payments as required by statute; or (3) notice was given within one year after the date of the accident and the worker establishes good cause for failure to give notice within 30 days.

The Referee found that claimant did not give proper notice of his injury and the employer had been prejudiced by the untimely notice. The Referee found that the employer would not be able to investigate the incident that had allegedly occurred over one year ago. He concluded that prejudice was obvious, based upon claimant's inability to: (1) place the incident within a more specific time than one month; (2) more precisely identify the location where the injury occurred, and (3) identify the co-employee with whom he was working at the time. We do not agree that the employer has shown prejudice in this case.

The employer bears the burden of proving that there has been prejudice from untimely notice. Inkley v. Forest Fiber Products Co., 288 Or 337 (1980). The passage of time is not sufficient to show prejudice; the employer must prove some actual prejudice. Ford v. SAIF, 71 Or App 875, rev den 299 Or 118 (1985).

The court reversed a Board case in which we found that the employer had been prejudiced because it was unable to investigate the accident scene and could not conduct an independent medical examination (IME). Grimes v. SAIF, 87 Or App 597 (1987). The court found that the job site had been covered within one month of the incident, so the employer could not have investigated the location in any event. In addition, the court held that the employer's inability to conduct an IME to determine whether the surgery was necessary, had nothing to do with the compensability of the claim. Id.

In the present case, as none of claimant's co-workers witnessed the May 1987 incident, we are unable to discern how SAIF would have benefited by locating the job site where claimant first experienced symptoms. We conclude that it is not enough for SAIF to show that it was more difficult to investigate the incident because the job site could not be located. SAIF must further show that inability to locate the site prejudiced its ability to determine compensability of the claim.

SAIF has not argued that a more expedient independent medical examination would have produced different or additional evidence than the exam performed in 1988. SAIF is also unable to contend that the passage of time has dimmed the memories of witnesses to the incident. In fact, SAIF argues only that specific indications of prejudice are unnecessary where the existence of prejudice is apparent from the record as a whole. See William B. Rice, 37 Van Natta 1289 (1985). Here, the existence of prejudice to the employer is not apparent from the record. We conclude that the employer has not met its burden of proving that there has been actual prejudice from untimely notice. We therefore reverse the Referee on the issue of timeliness.

As a result of the parties' stipulation, the only issue litigated at hearing was the timeliness of the claim. Accordingly, because compensability was not litigated at hearing, we remand the case for further development of the record. See ORS 656.295. The Referee is instructed to proceed in any manner that will achieve substantial justice. ORS 656.283(7).

ORDER

The Referee's order dated November 2, 1988 is reversed. The case is remanded to Referee Mongrain for further proceedings consistent with this order.

March 30, 1990 Cite as 42 Van Natta 651 (1990)

In the Matter of the Compensation of
WILLIAM V. BELLAMY, Claimant
WCB Case No. 87-19055
ORDER ON REVIEW
Burt, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Myers and Cushing.

The insurer requests review of those portions of Referee Foster's order which: (1) admitted into evidence the reports of claimant's out-of-state doctors who did not submit to cross-examination; and (2) set aside the insurer's

medical services denial for surgery of claimant's L3-4 disc herniation as unrelated to a compensable 1975 low back injury. The insurer requests remand or, in the alternative, seeks exclusion of documents. On review, the issues are admissibility of documents, remand and compensability. We reverse.

Preliminary Matters

The Referee formally admitted exhibits 1 through 76 and exhibit 75A. (Tr. 1; O & O p. 1). He did not formally admit exhibits 77 through 82. However, he made reference to some of these exhibits in his opinion, and the parties make reference to these exhibits in their briefs. The documents are included in the record as certified by the Referee to us under ORS 656.295(3). We presume that the Referee intended to admit them into the record and that he did so sub silentio. P.D. Hildebrandt, 40 Van Natta 2057 (1988). Therefore, we consider them a part of the record for the purposes of our review. ORS 656.295(5).

Admissibility of Documents

The Referee, without explanation, admitted a report from claimant's doctor, Mattheis, identified as exhibit 75A. The insurer alleges that this report, authored on October 28, 1987, was not disclosed until closing arguments on October 7, 1988 and therefore argues it is inadmissible because it was discovered late, citing former OAR 438-07-015(3). Aside from the insurer's assertion, however, there is no evidence in the record to support the argument that the document was disclosed late. The record was not reopened to take evidence in the form of testimony or stipulated fact as to when the document was first received by claimant or his counsel, nor when it was first provided to the insurer. Without this information it is impossible to rule upon the admissibility of the document under former OAR 438-07-015(3). While we might be persuaded to remand the case to the Referee because of this incomplete development of the record, see ORS 656.295(5), we do not do so in this case because the document is excludable from the record on another basis.

The insurer moved at the beginning of hearing to cross-examine Drs. Adams, Stuart, Stinson and Mattheis. (Tr. 1-2). This motion was allowed but the requested cross-examination did not occur. Again, there is no evidence as to why the requested cross-examinations did not occur. However, in their briefs, both parties assert that the cross-examinations did not occur because the doctors demanded that their outstanding medical bills be paid and, in the cases of Adams and Stinson, that they receive up front payment of deposition costs in the amount of $400 and $500 respectively. The certified record of the Referee also contains correspondence from the parties with additional assertions to this effect. We may review this information. ORS 656.295(3); 656.295(5). Based on the representations of the parties in their briefs before the Board and on their representations to the Referee in their correspondence, we find that the depositions did not occur because the doctors refused to submit to cross-examination without prepayment of all outstanding medical bills and, in the cases of Adams and Stinson, prepayment of deposition charges in excess of those allowed by fee schedule. (See Ex. 80); see also OAR 436-10-090(20) (which sets deposition charges at $300 for the first hour and $100 per hour thereafter).

Our rules require the authors of medical reports to submit to cross-examination. Former OAR 438-07-005(3) provides in part:

> "The reports of any medical or vocational expert who has refused to make herself or himself available for cross-examination shall be excluded from the record unless good cause is shown why such evidence should be received."

We find that under these facts doctors Mattheis, Adams and Stinson have effectively refused to make themselves available for cross-examination. Out-of-state medical providers must cooperate with the reporting requirements of Oregon's Workers' Compensation Law. ORS 656.252; See Reynaga v. Northwest Farm Bureau, 300 Or 255, 259 (1985). We find that this duty extends to cooperation with the rules of practice and procedure and with proceedings conducted by the Hearings Division or the Board. ORS 656.726(4). The duty to submit to cross-examination by out-of-state medical providers is one mandated by statute. ORS 656.310(2). By demanding payment of outstanding medical bills as well as excessive up front deposition fees, the out-of-state doctors have not submitted to cross-examination. Id; former OAR 438-07-005(3).

Under our rule, failure to submit to cross-examination is excused if the other party can show "good cause" why the authored reports should be admitted. Claimant offers no explanation for the doctors' refusal to submit to cross-examination save for unwillingness to do so without complete payment of their medical bills, which bills are the very heart of the litigation requiring cross-examination in the first place. This reason is not "good cause."

Claimant argues that the Board must "balance" the insurer's right to cross-examination with the harm to claimant that would result from exclusion of the documents. Neither the statute nor the rules require a balancing of such interests. Indeed, the controlling statute requires medical providers to consent to cross-examination:

> "The contents of medical, surgical and hospital reports presented by claimants for compensation shall constitute prima facia evidence as to the matter contained therein; so, also, shall such reports presented by the insurer or self-insured employer, provided that the doctor rendering medical or surgical reports consents to submit to cross-examination." ORS 656.310(2). (Emphasis added.)

Furthermore, claimant has the right to choose his own attending doctor. ORS 656.245(3); Reynaga, supra. Claimant has it within his power to choose attending doctors who agree to cooperate with Oregon's Workers' Compensation Law. We will not deprive the insurer of its right to cross-examination because claimant exercises his right and chooses noncooperative doctors. Nor is the insurer required to invoke extra-territorial process in order to enforce its right to cross-examination, as claimant suggests. Such an action would negate the requirement that the medical providers "consent" to cross-examination and it would undermine the charge to provide a fair administrative system that reduces the adversary nature of the proceedings. ORS 656.012(2)(b).

Accordingly, because Drs. Mattheis, Adams and Stinson have refused to consent to cross-examination, we grant the insurer's motion and exclude their authored documents offered by claimant. Exhibits 75A, 78, and 79 are excluded.

Remand

Because of our resolution of the admissibility of documents question, remand to the Referee is not necessary. We proceed to review the merits of the case.

FINDINGS OF FACT

Claimant originally injured his low back while working as a labor foreman for the insured on September 29, 1975. Claimant's claim was first closed by

Determination Order dated August 1, 1977, which awarded 10 percent unscheduled disability. Thereafter, the claim was reopened a number of times.

Claimant first sought care from Dr. Poulson, orthopedic surgeon, in November of 1978. On March 20, 1979, Poulson performed a bilateral laminotomy and partial excision of lumbosacral disc at L5-S1. Claimant moved to North Carolina in late 1979 and sought care from Dr. Stinson, orthopedic surgeon. Poulson reevaluated claimant in July 1984 and January 1986. Claimant has experienced pain and radicular complaints since the original injury. Claimant reinjured his back in September 1987 while helping his wife clean the freezer of their business; the North Side Bar. This injury caused a disc herniation at L3-4. The L3-4 disc herniation and resulting medical services are not causally related to the original 1975 industrial injury.

CONCLUSIONS OF LAW AND OPINION

The uncontroverted medical opinion of Dr. Poulson is that the disc herniation at L3-4 is not causally related to the original accepted injury of September 1975. Poulson's opinion contained in 28 pages of deposition testimony is objective, clear, cogent, based on complete information and is persuasive. Earl M. Brown, 41 Van Natta 287, 291 (1989). As the former attending doctor, his opinion is entitled to considerable deference, especially since he examined the claimant close to the time of injury. See Kienow's Food Stores v. Lyster, 79 Or App 416 (1986); Stedman v. Garrett Freightlines, 67 Or App 129 (1984). We are persuaded by his opinion.

In the alternative, were we to have upheld the admission of exhibits 75A, 78 and 79, we would nonetheless reach the same result in this case. Poulson's opinion is far more persuasive than are the opinions of the other doctors. Stewart's opinion in exhibit 78 is that the 1979 surgery for claimant's injury increased the stress placed on the remaining discs and caused disc degeneration at L3. His opinion is without any explanation and was effectively rebutted by Poulson who opined in his deposition that a fusion would have increased the stress on the other discs, but the surgical procedure performed in 1979 would not. (Ex. 82-15).

Adams' opinion expressed in exhibit 79 is both based on an erroneous fact and is speculative. Adams believed that the 1979 procedure was at the same level as the new disc; accordingly, he concluded the present problem "may be" related. Adams' opinion is wholly unpersuasive. Gormley v. SAIF, 52 Or App 1055, 1060 (1981).

Mattheis' opinion is only that this is a "recurrent" disc. He expresses no opinion on causal relationship to the original 1975 injury. (Ex. 75A). His opinion is not persuasive either. Accordingly, even based on the entire record, claimant would still have failed to prove a causal relationship between his current need for medical services and the new disc herniation to the original 1975 injury. The insurer's denial would still be upheld.

ORDER

The Referee's order dated December 5, 1988 is reversed. The insurer's December 3, 1987 denial is reinstated and upheld. Claimant's attorney fee award of a $2,000 is reversed. The Board approves a client-paid fee, not to exceed $1,765.50, payable by the insurer to its counsel.

In the Matter of the Compensation of
DAVID B. CARTER, Claimant
WCB Case Nos. 88-11104 & 88-11105

In the Matter of the Compensation of
MARVIN L. COAKLEY, Claimant
WCB Case Nos. 88-15315, 88-15316, 88-15317, 88-10956 & 88-10957
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Kate Waldo (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

Claimants, in this consolidated proceeding, request review of Referee Quillinan's order that upheld the SAIF Corporation's denial of their claims for mileage reimbursement for trips to their treating physician pursuant to OAR 436-60-050(4). On review, the issue is reimbursement for travel expenses. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings and make the following additional finding. SAIF's denial, dated August 31, 1988, denied only future mileage expenses for trips to claimants' treating physician for treatment resulting from the compensable injuries.

CONCLUSIONS OF LAW

A claim may be made on the insurer for reimbursement of transportation costs to visit the attending physician pursuant to OAR 436-60-050(4). Claims must be promptly paid or denied. OAR 436-10-100. If denied, the worker may request a hearing. ORS 656.245(2).

An insurer may not deny its future responsibility for payment of medical services (and related transportation costs) for a previously accepted claim. See ORS 656.245(1); Evanite Fiber Corp. v. Striplin, 99 Or App 353 (1989).

In the present case SAIF's denial said, "As of the date of this letter, we will no longer pay mileage expenses to [the treating physician]." Such a denial is void because it improperly denies prospective medical service claims rather than existing claims.

ORDER

The Referee's order, dated October 21, 1988, is reversed. SAIF's denial of transportation expenses is set aside. For services at hearing and on review concerning this issue, claimants' attorney is awarded a reasonable fee of $1,500, to be paid by SAIF.

In the Matter of the Compensation of
MARK E. COPE, Claimant
WCB Case No. 88-13186
ORDER ON REVIEW
Merrill Schneider, Claimant Attorney
Roberts, et al., Defense Attorneys

Reviewed by Board Members Myers and Cushing.

Claimant requests review of that portion of Referee Mulder's order which upheld the insurer's denial of medical services for chiropractic care. Although

the insurer has not formally cross-requested review, in its respondent's brief the insurer argues that the expert testimony of Dr. Belhumeur taken at hearing should be excluded. On review, the issues are admissibility of expert testimony and compensability of medical services. We affirm.

Evidentiary Matter

The Referee admitted the testimony of Dr. Belhumeur taken at hearing, despite the failure to give proper disclosure of an expert witness before hearing. The Referee found there was no material prejudice to the employer. We agree. Former OAR 438-07-015(6). The testimony was properly admitted.

FINDINGS OF FACT

Claimant sustained a compensable injury to his right shoulder and neck on October 6, 1986 while working as a custodian for the employer. Beginning in April 1987 claimant sought care from Dr. Belhumeur, chiropractor. Belhumeur treated conservatively with chiropractic adjustments, manual traction and ultrasound therapy. A cervical myelogram showed no evidence of disc protrusion nor disc compression.

Belhumeur declared claimant medically stationary on May 13, 1988 with 15 to 25 percent permanent "disability." He recommended continued chiropractic care of approximately 4 to 8 treatments per month for claimant's symptoms.

Claimant underwent an independent medical examination for both physical and psychiatric evaluation by Western Medical Consultants on May 20, 1988. The Consultants found no measurable impairment and a "paucity" of objective physical abnormalities. They noted inconsistencies on examination and functional overlay. They noted that claimant's frequent chiropractic care was "reinforcing" his chronic pain behavior, especially in light of his own admission that the treatments did not last for longer than 5 hours or so. The Consultants recommended a cessation of further treatment of all kind.

The insurer denied claimant's continuing need for medical care and services on August 29, 1988. Claimant appealed the denial.

Claimant has a minimal physical impairment limiting repetitive heavy work. He exaggerates his complaints. Chiropractic care up to the date of hearing was detrimental to claimant's well being in that it created a psychological dependency and increased his chronic pain behavior.

CONCLUSIONS OF LAW AND OPINION

The Referee upheld the insurer's denial of medical services. We agree.

The Western Medical Consultants were comprised of three doctors: Klecan, psychiatrist, Staver, orthopedist, and Duncan, chiropractor. The Consultants opined that continued care was contra-indicated inasmuch as it reinforced detrimental pain behavior and reinforced claimant's maladaptive psychological response of somatization. The Consultants recommended a cessation of all further medical care.

Belhumeur continued to express the opinion that his treatment was appropriate and necessary. He explained that claimant's complaints were consistent throughout his entire course of treatment. We usually defer to the opinion of the attending doctor on the reasonableness and necessity of medical care. However, in this instance we do not do so. At no time does Belhumeur acknowledge the existence of exaggeration or pain behavior, nor does he recognize even the

possibility of psychological dependency because of continued care. This lack of recognition undermines the factual basis of his opinion. Joanne L. Seelig, 41 Van Natta 1665, 1667 (1989). Without this recognition, he does not attempt to explain why his continued care does not serve to perpetuate this detrimental psychological state. Without such an explanation, Belhumeur's opinion is without logical force as it is conclusory and nonresponsive to the essential criticism of his continued care. We do not defer to his opinion. Earl M. Brown, 41 Van Natta 287, 291 (1989).

Instead, we rely upon the thorough and well-reasoned opinions of the Consultants. See Marshall v. Boise Cascade, 82 Or App 130, 133 (1986). This reliance is also based, in part, upon the specialized knowledge of the psychiatrist, Klecan, who by training is a more qualified source to comment upon the adverse psychological effects of continued medical care. Earl M. Brown, supra; Ellen L. Hamel, 40 Van Natta 1226 (1988). Therefore, we conclude that claimant's medical care until the date of hearing was not reasonable and necessary. Hollie J. Rahim, 42 Van Natta 415 (1990).

ORDER

The Referee's order dated November 25, 1988, is affirmed. The Board approves a client-paid fee, not to exceed $1,253.50, payable by the insurer to its counsel.

In the Matter of the Compensation of
HAROLD H. GAROUTTE, Claimant
WCB Case No. 88-14094
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Paul Mackey, Defense Attorney

Reviewed by Board Members Nichols and Brittingham.

The self-insured employer requests review of that portion of Referee Tenenbaum's order that granted permanent total disability effective June 2, 1988, whereas a Determination Order awarded 70 percent (224 degrees) unscheduled permanent disability for a low back condition. The issue on review is extent of unscheduled permanent disability, including permanent total disability. We reverse.

FINDINGS OF FACT

We adopt the Referee's Findings on permanent total disability with the exception of the last sentence of the third paragraph and all of the fourth paragraph on page four of the order and supplement as follows:

We find that claimant has not made reasonable efforts to obtain employment.

CONCLUSIONS OF LAW AND OPINION

To prove his entitlement to permanent total disability, claimant must establish that he is unable to perform any work at a gainful and suitable occupation. Claimant is not totally incapacitated on a physical or medical basis. He does have considerable physical impairment; however, his treating physician has released him to sedentary work.

Consequently, claimant can prevail only by proving that he falls within the so called "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 physical condition and certain nonmedical factors, such as age, education, work experience, adaptability to nonphysical labor, mental capacity and emotional conditions. Clark v. Boise Cascade Corp., 72 Or App 397, 399 (1985).

The statute requires that the claimant show that he is willing to seek regular gainful employment and has made reasonable efforts to obtain such employment. ORS 656.206(3). The claimant, however, can be excused from this requirement if it can be shown that such effort to obtain employment would be futile. Welch v. Bannister Pipeline, 70 Or App 699, 701 (1984), rev den 298 Or 470 (1985).

The Referee found that claimant was permanently and totally disabled on an odd lot basis. She based her decision in part on the fact that claimant's preinjury wage of $10.00 per hour would make a minimum wage job not suitable. She further found that under those circumstances, claimant had made reasonable efforts to find employment.

The Board has held in Walter R. Searles, 41 Van Natta 627 (1989), that 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. We find that the Referee erred in relying on the wage rate of the potential jobs available to claimant as a sufficient basis why he did not need to make any further job search.

The Referee did make a finding that claimant has transferable skills and we agree. Since the last closure in this matter, claimant has moved out of state with the knowledge that to do so would curtail the vocational assistance available to him. Since the move to Boise, claimant has made no contacts with employers regarding potential employment. Under these circumstances we do not believe claimant has made reasonable efforts to obtain employment. We do not find claimant to be permanently and totally disabled.

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

Claimant's treating physician has released him to do sedentary work although he does have significant physical impairment. Claimant has a high school education and his general learning ability is in the high average range. Evidence from the vocational rehabilitation counselor, who testified at hearing, indicates that there are jobs available that the claimant could do. Taking all the factors, that affect the loss of earning capacity, into consideration we find that the claimant's loss of earning capacity to be 70 percent.

ORDER

The Referee's order dated November 16, 1988, as amended December 8, 1988, is reversed and the award of 70 percent (224 degrees) unscheduled permanent disability granted by the Determination Order issued on July 26, 1987 is reinstated.

In the Matter of the Compensation of
CHARLES M. KEPFORD, Claimant
WCB Case No. 88-05447
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Acker, et al., Defense Attorneys

Reviewed by Board Members Howell and Speer.

Claimant requests review of that portion of Referee Baker's order that: (1) declined to grant permanent total disability; and (2) increased claimant's unscheduled permanent disability for a back condition from 35 percent (112 degrees) as awarded by Determination Order, to 75 percent (240 degrees). On review, the issue is permanent total 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 Conclusions of Law and Opinion, with the following supplementation.

Claimant relies on the opinion of Mr. Byron McNaught, his vocational expert, to establish that he is not employable. Mr. McNaught testified that claimant could not perform work that required sitting or standing for an eight-hour day. He further testified that he did not believe claimant would be able to deal well with the stress of working with people. Mr. McNaught concluded that claimant was not employable for those reasons, in addition to claimant's age, lack of education and lack of transferable skills.

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). Mr. McNaught's testimony included medical opinions regarding claimant's physical limitations. He also testified to claimant's psychological state and the manner in which it would preclude claimant from obtaining employment. To the extent that Mr. McNaught's conclusion is based upon his assessment of claimant's medical and psychological conditions, we do not find his opinion persuasive.

ORDER

The Referee's order dated October 27, 1988 is affirmed. A client-paid fee payable from the self-insured employer to its counsel, not to exceed $1,102, is approved.

In the Matter of the Compensation of
BRECK D. MEYER, Claimant
WCB Case No. TP-90006
THIRD PARTY DISTRIBUTION ORDER
Cummins, et al., Claimant Attorneys
Michael O. Whitty (Saif), Defense Attorney

Claimant has petitioned the Board for resolution of a conflict concerning the "just and proper" distribution of proceeds from a third party settlement. See ORS 656.593(3). Specifically, the dispute pertains to whether the cost of

an engineering report should be included in the "third party" lien of the SAIF Corporation, as a paying agency. We conclude that this expense is not lienable.

FINDINGS OF FACT

In June 1989, claimant suffered a compensable injury when a chemical purification device he was operating exploded. Some of the hot liquid which spewed from the device landed on him, resulting in burns primarily to his right arm.

Shortly thereafter, SAIF hired an independent engineer to inspect the purification device and to issue a report. Following completion of his investigation, the engineer issued his report on July 14, 1989.

On July 31, 1989, claimant, through his legal counsel, notified SAIF that he intended to bring suit against the manufacturer of the purification device. Claimant's counsel also requested copies of claimant's file.

Thereafter, SAIF provided a copy of claimant's file. Included with these materials was a copy of the engineer's report and accompanying photographs.

On December 28, 1989, a settlement of claimant's cause of action was achieved. The settlement was for $10,000, which would be paid to claimant in the following manner. Claimant would receive an initial $5,000 payment, followed by monthly installments of $1,000 commencing February 1, 1990 and continuing for the next 4 months.

SAIF has approved the settlement. It has incurred $645.87 in temporary disability payments and $829.48 in medical costs. In addition, SAIF has spent $1,115.32 for the engineering evaluation and report.

Contending that its engineering expenses were a legal cost of the third party action, SAIF seeks reimbursement from the third party settlement. Claimant does not contest SAIF's entitlement to recover its temporary disability and medical expenses. However, he objects to SAIF's assertion that it should be reimbursed for the engineering report.

CONCLUSIONS OF LAW

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).

In addition to its temporary disability and medical expenses, SAIF contends that the engineering report is a recoverable cost from claimant's third party settlement. We disagree.

We have previously held that claim evaluation reports are analogous to litigation reports and, as such, not properly includable in a paying agency's lien against a third party recovery. Carolyn J. Gant, 39 Van Natta 471 (1987); Darrell L. Rambeau, 37 Van Natta 144 (1986); Shawn Cutsforth, 35 Van Natta 515,

517 (1983). The cost of such reports is the responsibility of the party that requested it. Cutsforth, supra, page 517.

Here, SAIF hired the engineer to investigate the purification device and to provide a report. It makes no contention that this evaluation was conducted for claims management purposes. Rather, it asserts that the expense is a reimbursable legal cost incurred in pursuit of a third party recovery.

Yet, reimbursable legal costs for a third party recovery are those which are reasonably and necessarily incurred during the litigation of the third party action. Thomas Lund, 41 Van Natta 1352, 1356 (1989). These costs are either incurred by the attorney bringing the action or as expressly advanced by the paying agency to the worker.

As previously discussed, the engineering report was produced solely at the direction of SAIF with neither the knowledge nor consent of claimant or his counsel. Inasmuch as this cost was not incurred by the attorney litigating the third party action or expressly advanced by the paying agency to the worker, we conclude that it is not reimbursable from the third party settlement.

We turn to the distribution of proceeds.

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, we find no persuasive reason to depart from the aforementioned approach.

The distribution statutes do not discuss the allocation of proceeds from a third party "structured" settlement. However, we have previously concluded that the "proceeds" of a third party settlement encompass not only immediate cash payments, but also the purchase of an annuity. Ralph W. Schemmel, 40 Van Natta 951 (1988). We have further held that those "total proceeds" shall be apportioned in accordance with the statutory distribution scheme. Schemmel, supra; Dick A. Cole, 40 Van Natta 1021, 1023 (1988). In other words, the proceeds shall be initially applied to claimant's attorney fee and litigation costs, then to claimant's statutory one-third share, next to the paying agency's lien, with any remaining proceeds distributed to claimant. See ORS 656.593(1).

Here, the total settlement is $10,000, which, following an initial $5,000 lump sum payment, is to be paid in five $1,000 monthly installments. Ordinarily the proceeds of a structured settlement are divided based on the total present value of the settlement. See Ralph W. Schemmel, supra. Inasmuch as no annuity was purchased for the payment of monthly installments, we have no evidence of the present value of the total award. Nevertheless, the installments are to be paid shortly after the initial distribution such that the present value is not substantially less than the face value of the obligation. Therefore, we conclude that the "total proceeds" of the third party settlement equal $10,000.

Thus, in accordance with the Schemmel rationale, the total proceeds shall be distributed as follows.

Settlement	$10,000.00
Atty. Fee (1/3)	3,333.33
Litigation Costs	168.00
Subtotal	$ 6,498.67
Claimant's Share (1/3)	$ 2,166.22
Subtotal	$ 4,332.45
SAIF's Lien	$ 1,475.35
Remainder to claimant	$ 2,857.10

As previously noted, the initial payment on this $10,000 settlement is $5,000. From this amount, claimant's total attorney fee and litigation costs shall first be deducted. ORS 656.593(1)(a). The remainder of the $5,000 shall be distributed to claimant as partial payment toward his one-third statutory share of $2,166.22. ORS 656.593(1)(b). The following monthly $1,000 installments shall be distributed in a manner that initially satisfies the remaining balance of claimant's aforementioned $2,166.22 share and then SAIF's $1,475.35 lien. ORS 656.593(1)(b), (c). Thereafter, the remaining payment(s) shall be distributed to claimant. ORS 656.593(1)(d).

Accordingly, claimant's counsel is directed to distribute the proceeds of the third party settlement in the manner detailed above, which we hold constitutes a "just and proper" distribution. See ORS 656.593(3).

IT IS SO ORDERED.

In the Matter of the Compensation of
MARY E. MILLET, Claimant
WCB Case No. 88-12459
ORDER ON REVIEW
Merrill Schneider, Claimant Attorney
Tooze, et al., Defense Attorneys

Reviewed by Board Members Nichols and Brittingham

Claimant requests review of Referee Quillinan's order that upheld an aggravation denial for a low back condition that was issued on July 14, 1988. Claimant also requests this matter be remanded to the Referee for admission and consideration of Exhibit 73 which the Referee excluded. The issues on review are evidence, remand, and compensability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following supplementation:

On the day of the hearing, claimant received a report from Dr. King and submitted a copy of that report to the insurer and the Referee. The insurer objected to the admission of that document and it was excluded.

CONCLUSIONS OF LAW AND OPINION

The Referee refused to admit Dr. King's report (Exhibit 73) because she felt claimant could have obtained it prior to the day of the hearing because Dr. King was the treating chiropractor and had been for some time.

We agree with claimant that the Referee erred in not admitting that document. Claimant submitted the exhibit within seven days of receiving it and thus complied with the requirements of former OAR 438-07-015(4). The Referee had no discretion to exclude the exhibit. William G. Mattison, 41 Van Natta 2331 (1989).

Having decided that Exhibit 73 must be admitted, we now turn to the insurer's request for remand. The Board may remand a case if it determines that the case has been improperly, incompletely or otherwise insufficiently developed or heard by the Referee. ORS 656.295(5). Although evidence was improperly excluded, the unadmitted document is in the record. The Board need not remand to admit evidence in the record that was excluded by the Referee. Edward Morgan, 34 Van Natta 1590 (1982). However, we would remand if it would be unfair to consider the evidence without giving the insurer an opportunity to rebut.

Dr. King opined that claimant's condition in May 1988 was materially related to his compensable 1987 injury. We find that although this report from Dr. King was his only report on the question of the relationship of claimant's denied condition and the accepted January 1987 injury, the admission of that report is not prejudicial to the insurer because both Dr. Hathaway and Dr. Hopkins were present and testified at the hearing on that same issue. Consequently, we decline to remand and Exhibit 73 will be considered in addressing this matter on the merits.

We adopt the Referee's opinion with the following supplementation:

The Referee was persuaded by the testimony of Dr. Hathaway and Dr. Hopkins, that claimant had suffered a new off-the-job injury in May 1988 when her low back complaints returned. We agree. We do not find the last minute report of Dr. King to be persuasive in this matter. Although Dr. King treated claimant for a considerable period of time, we find his report to be in conflict with other of his own reports regarding causation. He admitted at one time that the 1987 incident was minor. In Exhibit 73 he acknowledges that the 1988 incident which was a similar type activity was also minor. Generally, the treating physician's opinion is given greater weight; however, in this matter we decline to do so. We find the testimony of Dr. Hathaway and Dr. Hopkins to be more well reasoned and complete, and thus find their opinions to be persuasive. We find that the 1987 accepted injury was not a material contributing factor to claimant's need for medical care and/or disability in May 1988, which is the result of a new off-the-job injury.

ORDER

The Referee's order dated November 1, 1988 is affirmed. The Board approves a client-paid fee, payable from the insurer to its counsel, not to exceed $1,962.

March 30, 1990 Cite as 42 Van Natta 663 (1990)

In the Matter of the Compensation of
WARD C. NEIHART, Claimant
Own Motion No. 85-0418M
OWN MOTION ORDER ON RECONSIDERATION
Malagon, et al., Claimant Attorneys
Cowling & Heysell, Defense Attorneys

The insurer initially submitted to the Board claimant's claim for an alleged worsening of his April 2, 1979 low back and neck injury. By Order on

Review, issued December 5, 1986, the Board upheld the insurer's denial of compensability of claimant's current low back and neck condition. By Own Motion Order, issued the same date, the Board denied the request for own motion reopening in light of the adverse compensability ruling. The Court of Appeals then reversed the Board's Order on Review and remanded the matter to the Hearings Division. By Opinion and Order, issued October 11, 1988, Referee Foster set aside the insurer's denial of compensability. We have affirmed the Referee's ruling in our Order On Review, issued this date. We now reconsider our earlier own motion determination in light of this decision.

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.

The insurer raises a number of challenges to own motion reopening. First, it contends that reopening is barred by an October 9, 1985 Stipulation and Order of Settlement. However, the record does not contain sufficient evidence to determine whether that settlement involved the same set of operative facts as the present own motion matter. See Million v. SAIF, 45 Or App 1097 (1980). Accordingly, the insurer has not established that reopening is barred by the stipulation.

The insurer next contends that claimant has not sustained a worsening of his condition. We disagree. To establish a "worsening" within the meaning of ORS 656.278(1)(a), claimant must show increased symptoms or a worsened underlying condition resulting in a diminishment of earning capacity. Smith v. SAIF, 302 Or 396 (1986). 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).

Claimant's last award of compensation was by Disputed Claim Settlement, dated September 3, 1982. By Opinion and Order, issued April 6, 1984, Referee Seifert upheld the insurer's denial of a prior aggravation claim, and that order became final as a matter of law. Accordingly, as a matter of law, claimant's condition had not worsened as of April 6, 1984, and claimant must establish a worsening since that date.

We conclude that claimant has met his burden of proof. Dr. Smith, the treating surgeon, opined that claimant's condition progressively worsened over the period April 1984 through December 21, 1984. We defer to his well-reasoned opinion. Accordingly, we conclude that claimant has experienced an exacerbation since the last arrangement of compensation. Based on claimant's testimony that he left work in November 1984 because of his symptoms, we also conclude that his exacerbation resulted in diminished earning capacity. Moreover, as a result of this exacerbation, claimant was hospitalized for surgery on June 23, 1986. Accordingly, claimant has demonstrated a compensable aggravation.

The insurer also contends that claimant has retired and, therefore, is not entitled to temporary disability compensation under Cutright v. Weyerhaeuser, 299 Or 290 (1985). We disagree. The insurer relies on claimant's testimony in March 1986 that he quit working because of his injury. However,

claimant's testimony indicates that he would be willing to work and seek work if it were not for his compensable condition. See Dawkins v. Pacific Motor Trucking, 308 Or 254 (1989). Moreover, the insurer has not submitted any information regarding claimant's current condition and work status. Under these circumstances, we are not persuaded that claimant has retired from the labor force within the meaning of Cutright.

Finally, claimant contends that he was hospitalized for conservative treatment in February 1986. However, the record contains no medical documentation of this treatment. The first documentation of inpatient treatment is on June 23, 1986, when claimant was hospitalized for surgery. We reopen claimant's claim as of that date.

Accordingly, claimant's claim is reopened with temporary disability benefits to commence June 23, 1986. The insurer shall pay temporary disability compensation until claimant becomes medically stationary and the claim is closed, or claimant returns to regular work at the regular wage, whichever is earlier. When appropriate, the claim shall be closed by the insurer 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.

March 30, 1990 Cite as 42 Van Natta 665 (1990)

In the Matter of the Compensation of
ELSIE C. RIOS, Claimant
WCB Case Nos. 87-11814 & 87-01430
ORDER ON REVIEW
Francesconi & Associates, Claimant Attorneys
Schuyler T. Wallace, Jr., Defense Attorney
Randolph Harris (Saif), Defense Attorney

Reviewed by Board Members Nichols and Brittingham.

The SAIF Corporation requests review of those portions of Referee's Menashe's order that: (1) set aside its aggravation denial of claimant's rheumatoid arthritis condition; and (2) upheld GAB Business Service's "new injury" denial of the same condition.

The Board affirms the order of the Referee.

ISSUES

1. Whether claimant's aggravation claim is barred as untimely.

2. Whether claimant's current rheumatoid arthritis condition is compensable.

3. Whether SAIF or GAB is responsible for claimant's current rheumatoid arthritis condition.

FINDINGS OF FACT

Claimant, a 46 year old paralegal, began working for SAIF's insured in November 1977. Shortly thereafter, she began experiencing pain in her hands and feet. She consulted Dr. Brookhart, M.D.. Brookhart diagnosed rheumatoid arthritis and apparently prescribed anti-inflammatory medication. Claimant's

arthritis condition became disabling in April 1978 and claimant quit working for SAIF's insured.

Claimant filed an industrial injury claim against SAIF's insured in June, 1980. SAIF classified her injury as nondisabling and timely denied her claim. Claimant appealed. Although a prior referee upheld SAIF's denial, the Board, in May 1981, reversed the prior referee and ordered SAIF to accept claimant's claim.

Subsequently, SAIF requested that the Evaluation Division close claimant's claim. A Determination Order issued on November 10, 1982, awarding periods of temporary disability. In addition, the Determination Order stated that a claim for additional compensation had to be filed within five years from February 28, 1978.

In June, 1983, the parties entered into a stipulation and settlement, which awarded claimant 15 percent (48 degrees) permanent unscheduled disability for her rheumatoid arthritis condition. At this time, claimant was experiencing low back pain but was able to perform full time sedentary work.

Claimant began working for GAB's insured, a legal services provider, in May 1986. In July 1986, she experienced a flare-up of her rheumatoid arthritis involving her shoulders, wrists, hands and knees. As a result, Dr. Kappes, her treating physician, released her from her sedentary job. Claimant was totally disabled and remained so for four months, when she was released back to her sedentary work.

Claimant filed an aggravation claim against SAIF's insured and a "new injury" claim against GAB's insured. In May 1987 claimant was examined by Dr. Montanaro, M.D.. A few days later, SAIF denied responsibility for her then current rheumatoid arthritis condition. In August 1987 GAB apparently issued a denial of responsibility for the same condition. Claimant requested a hearing on the denials. At the hearing, both insurers' attorneys raised the additional issue of compensability.

FINDINGS OF ULTIMATE FACT

Claimant's claim was filed within five years of her first claim determination.

Claimant's last arrangement of compensation was the June 1983 Stipulation.

As a result of her return to work for GAB's insured in July 1986, claimant experienced a symptomatic exacerbation of her compensable arthritis condition. That exacerbation resulted in diminished earning capacity below the level fixed at the time of the June 1983 stipulation. Claimant's exacerbation resulted in at least 14 consecutive days of temporary total disability.

Claimant's employment with GAB's insured did not independently contribute to her arthritis condition.

CONCLUSIONS OF LAW AND OPINION

Timeliness of Aggravation Claim

As best we understand, SAIF argues that because it initially "deemed" claimant's condition as nondisabling in "February 1978" claimant had only five years thereafter to file an aggravation claim (i.e., until February 1983). See former ORS 656.262(12) and former ORS 656.273(4)(b). Since claimant did not

file an aggravation claim before that date, SAIF asserts that her claim is barred as untimely. We do not agree.

Although SAIF initially classified claimant's claim as nondisabling as part of its denial, the Board subsequently set aside SAIF's denial. In so doing, the Board ordered SAIF to accept claimant's claim and to process it pursuant to former ORS 656.268. Claimant's arthritis had become disabling in April 1978. Nothing in the Board's order suggests that it intended to set aside only a portion of SAIF's denial. Accordingly, we conclude that the Board's order set aside SAIF's denial in toto (i.e., including the classification of claimant's injury as nondisabling).

Moreover, former ORS 656.262(12) has no application to this case. Former ORS 656.262(12) provides, inter alia, that a worker has one year from the date of his injury to submit a claim that a nondisabling injury has become disabling. In our view, however, that statute is intended to apply only to accepted claims. Thus, when a worker's claim is accepted as a nondisabling injury, he has one year from the date of his injury to submit a claim that his injury has become disabling.

To interpret former ORS 656.262(12) otherwise, as SAIF suggests, would lead to the pointless requirement that a worker request reclassification of his claim from nondisabling to disabling even though his claim has been denied. Yet, reclassifying a denied claim from nondisabling to disabling would be of no value to a worker. That is, until and unless a worker's claim is found compensable and, thereby, ordered accepted, he is entitled to no benefits under his claim regardless of whether his injury is classified as nondisabling or disabling.

Here, claimant's claim was denied. His proper remedy, therefore, was to seek acceptance of his claim by requesting a hearing. He did so. On Board review, the Board set aside SAIF's denial and ordered it to accept claimant's claim.

Turning to former ORS 656.273(4)(b), that statute expressly applies only to situations where "no determination was made . . . ." It has no application in the present case where claimant timely appealed a denied claim, the Board ordered SAIF to accept the claim as disabling, and a Determination Order then issued.

Compensability of Aggravation Claim

To establish an aggravation, claimant must show a worsening of her compensable arthritis 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. If the last arrangement of compensation anticipated future exacerbations accompanied by a diminished earning capacity, claimant must also prove: (1) that her earning capacity was diminished longer or in greater degree than was anticipated; or (2) that her 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 Referee found, and we agree, that the medical evidence establishes that claimant's rheumatoid arthritis flared up in July 1986 to the point where she became physically unable to continue working at her sedentary job. By contrast, at the time of the June 1983 Stipulation, claimant was able to work at that job full time. We are therefore persuaded that claimant has sustained a

symptomatic exacerbation resulting in diminished earning capacity below the level fixed at the time of the last arrangement of compensation.

Moreover, claimant was released from sedentary work by Dr. Kappes in 1986 for four months. Claimant credibly testified that she was unable to perform her sedentary job during that period. Accordingly, we are persuaded that claimant was temporarily totally disabled for at least 14 consecutive days.

In light of these circumstances, we conclude that claimant has proven a compensable aggravation. See Ronald K. Hobbs, 41 Van Natta 2327 (1989); Kurt E. Kral, 42 Van Natta 129 (1989).

Responsibility

Turning to the question of responsibility, in Hensel Phelps Construction v. Mirich, 81 Or App 290, 294 (1986), the court announced that unless a "new injury" independently contributes to a worker's disability (i.e., causes a pathological worsening of his underlying condition) then the worker has sustained a mere recurrence of symptoms, which remains the responsibility of the first employer.

Here, there is no persuasive evidence of an independent contribution that would shift responsibility away from SAIF. The medical evidence points to a symptomatic flare-up of claimant's rheumatoid arthritis condition. Although that flare-up rendered her less able to work, it did not result in a pathological worsening of her underlying condition. In fact, in its Appellant's Brief, SAIF states:

> "Dr. Kappes repeatedly and emphatically testified that claimant's 1986 flare up was merely symptoms [sic] of a chronic disease in its natural progression. He stated [that] there was no evidence of a fundamental change in the disease course. Nor was there any material deterioration of the rheumatoid arthritis. Rather[,] Dr. Kappes has described claimant as fitting into a well established group of people who experience a predictable pattern of up and down symptoms."

Accordingly, we agree with the Referee's conclusion that SAIF remains responsible for claimant's arthritis condition.

ORDER

The Referee's order, dated December 31, 1987, is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,500 to be paid by the SAIF Corporation. The Board approves a client-paid fee, payable from GAB Business Services to its attorney, not to exceed $1,043.50.

In the Matter of the Compensation of
CHARLES W. WHEELER, Claimant
WCB Case No. 87-13235
ORDER ON REVIEW
Brian R. Whitehead, Claimant Attorney
Kevin L. Mannix, Defense Attorneys

Reviewed by Board Members Myers and Gerner.

The insurer requests review of Referee Huff's order which set aside its denial of claimant's aggravation claim for a thoracic strain. It contends that: (1) the Referee lacked jurisdiction to hear the case; and (2) claimant has not sustained an aggravation. On review, the issues are jurisdiction and aggravation. We find that the Referee had jurisdiction, however we reverse on the aggravation issue.

FINDINGS OF FACT

Claimant sustained a compensable thoracic injury in November 1986. The insurer accepted the claim as nondisabling. In December 1986 claimant sought treatment at an Emergency Room for pain symptoms. Thereafter, claimant was treated with physical therapy and painkillers.

On February 27, 1987, the insurer issued a Notice of Closure which awarded temporary disability benefits from December 5, 1987 through February 26, 1987. Claimant did not return to work until May 1987 due to economic reasons. After approximately a week at work, claimant began to experience increased pain and symptoms. Claimant was released from work on June 15, 1987 and thereafter filed an aggravation claim with the insurer.

On August 10, 1987, the insurer issued a denial of claimant's aggravation claim.

On October 2, 1987, a Determination Order issued which affirmed the insurer's February 1987 Notice of Closure.

FINDINGS OF ULTIMATE FACT

The October 2, 1987 Determination Order was the last arrangement of compensation.

CONCLUSIONS OF LAW AND OPINION

Jurisdiction

The insurer contends that the Referee lacked jurisdiction to decide the merits of claimant's aggravation claim due to the subsequent Determination Order. We disagree.

Here, claimant filed an aggravation claim in mid-1987. The insurer issued a denial in August 10, 1987 which denied claimant's aggravation claim. The propriety of the insurer's denial was a matter concerning a claim because it put claimant's right to receive compensation directly in issue. ORS 656.704(3); SAIF v. Zorich, 94 Or App 661, 664 (1989). Accordingly, the Referee had jurisdiction to address claimant's aggravation claim. ORS 656.708.

Aggravation

The Referee concluded that claimant had sustained an aggravation of his compensable thoracic condition. We disagree.

At the outset, we note that the October 2, 1987 Determination Order is not in the record. However, the Board may take administrative notice of facts "capable of accurate and ready determination by resort to sources whose accuracy cannot be reasonably questioned." ORS 40.065(2); Groshong v. Montgomery Ward, 73 Or App 403 (1985). This authority includes Determination Orders. See Leslie G. Mullenix, 41 Van Natta 2068 (1989).

Accordingly, we take administrative notice of the October 2, 1987 Determination Order.

In order 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 he is more disabled, i.e., less able to work, since the last arrangement of compensation.

In the instant case, it is first necessary to decide what constituted claimant's last arrangement of compensation. Subsequent to the Referee's order, we issued our decision in Eugene P. Nelson, 42 Van Natta 240 (1990). In Nelson, we held that where a carrier's Notice of Closure is affirmed or modified by a subsequent Determination Order, the date of issuance of the Determination Order becomes the effective date of claim closure.

Here, the insurer issued its Notice of Closure in February 1987. The Notice of Closure was affirmed by the October 2, 1987 Determination Order. Accordingly, for the purposes of the aggravation issue, the October 2, 1987 Determination Order is claimant's last arrangement of compensation. Id.

Turning to the merits, claimant alleges that his compensable condition worsened in June 1987. Assuming arguendo that claimant's compensable condition did in fact worsen, the worsening took place prior to the October 1987 Determination Order. There is no persuasive evidence which suggests that claimant's condition worsened following the October 1987 Determination Order. Accordingly, we conclude that claimant has not established that his compensable thoracic condition worsened after his last arrangement of compensation.

ORDER

The Referee's order dated October 14, 1987 is reversed. The insurer's denial is reinstated and upheld. The Referee's $1,400 attorney fee award to claimant's counsel is reversed. A client-paid fee, not to exceed $1,755, payable from the insurer to its counsel, is approved.

In the Matter of the Compensation of
MOHAMMAD ZARIFI, Claimant
WCB Case No. 86-08558
ORDER ON REVIEW
Samuel A. Hall, Jr, Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Brittingham, Nichols and Perry.

Claimant requests review of Referee Michael Johnson's order that dismissed his hearing request for lack of standing and jurisdiction. On review, the issues are standing, jurisdiction and attorney fees. We conclude that the

Referee should have addressed claimant's hearing request. However, we hold that claimant is not entitled to the relief he seeks.

FINDINGS OF FACT

In March 1983, claimant and his attorney signed a retainer agreement for legal representation in a workers' compensation matter. The agreement included the following language: "On extent of permanent disability claims . . . where additional compensation is gained . . . the fee for services shall be limited to 25 percent of the additional compensation gained . . . ."

Claimant's workers' compensation claim proceeded to hearing, with the referee affirming a Determination Order award of 35 percent unscheduled permanent disability. Claimant requested Board review seeking an increased award of permanent disability. By order dated May 7, 1986, the Board awarded an additional 15 percent permanent disability and a related attorney fee. In regard to the attorney fee, the Board stated: "Claimant's attorney is allowed a fee in the amount of 25 percent of the increased compensation awarded under this order."

In its brief on review in the present case, the insurer acknowledged that its customary practice, and that of the industry as a whole, is to pay out-of-compensation fees directly to the claimant's attorney. Nevertheless, following the Board's May 1986 order, the insurer issued a check to claimant on June 4, 1986 for the full amount of the additional compensation awarded by the Board, including the out-of-compensation fee. It made no separate payment to claimant's attorney, and claimant did not forward the fee to the attorney. As a result, the attorney filed a hearing request on June 16, 1986 regarding the insurer's failure to pay him the out-of-compensation fee awarded by the Board.

At the time claimant's attorney filed this hearing request, he was not aware that the insurer had issued a check to claimant for the full amount of the increased compensation award. The attorney did not discover this fact until February 3, 1987, when the insurer contacted him regarding the hearing request. Claimant's attorney wrote claimant, explaining the situation and requesting reimbursement of the attorney fee. On June 17, 1987, claimant informed his attorney by letter that he had spent the entire amount of the insurer's payment and had no means of reimbursing the attorney for the out-of-compensation fee.

On September 23, 1987, claimant's attorney and the insurer agreed to submit this matter on stipulated facts in lieu of proceeding to hearing. The Referee dismissed the matter for lack of standing and jurisdiction.

FINDINGS OF ULTIMATE FACT

Claimant did not agree to payment of the out-of-compensation fee directly to his attorney. The Board did not order the insurer to pay the out-of-compensation fee directly to claimant's attorney.

CONCLUSIONS OF LAW AND OPINION

Standing/Jurisdiction

Claimant contends that the Referee erred in dismissing his hearing request on standing and jurisdictional grounds. We agree.

A claimant's attorney has standing to request review on an attorney fee issue. See Amfac, Inc. v. Garcia-Maciel, 98 Or App 88 (1989). Payment of an out-of-compensation attorney fee is a matter concerning a claim and within the

jurisdiction of the Hearings Division and the Board. ORS 656.283 and 656.704(3). See Ronald L. Warner, 40 Van Natta 1082, affirmed on recon, 40 Van Natta 1194 (1988). The fact that the fee in this case will be paid to claimant's attorney does not deprive the Referee of jurisdiction. Id.

Accordingly, we reverse the Referee's dismissal of claimant's hearing request.

Entitlement To Out-of-Compensation Fee

On the merits, claimant contends that the insurer is obligated to reimburse his attorney for the out-of-compensation fee it misdirected to claimant. The record contains sufficient information for the Board to rule on this issue. Accordingly, we decline to remand the case to the Referee and we address this issue on review. See ORS 656.295(5).

It was at one time our position that an insurer is under no legal obligation to pay an out-of-compensation fee directly to a claimant's attorney. See Douglas D. Dutton, 39 Van Natta 1123 (1987). See also Joe Holmes, Jr., 36 Van Natta 601 (1984). More recently, however, we took a contrary position and ordered an insurer to reimburse an attorney for an out-of-compensation fee mistakenly forwarded to a claimant. See Joseph Sexton, 40 Van Natta 331 (1988). We take this opportunity to reexamine this issue. We conclude that the statutory provisions and rules applicable in this case do not obligate the insurer to reimburse claimant's attorney for the misdirected attorney fee.

Under former ORS 656.388(3), any claim for legal services approved by the Board ". . . shall, in the manner and to extent fixed by the . . . [B]oard . . . be a lien upon compensation." See Verban v. State Ind. Acc. Com., 168 Or 394 (1982). Under former OAR 438-47-080, "[t]he Board may, with consent of claimant, order payment of [an attorney fee awarded from permanent disability] directly to the attorney. . . ." Under former OAR 438-47-010((5), "[a]ttorney fees in the amount allowed or approved by . . . the Board . . . shall be paid out of the compensation award except as otherwise specifically provided. A fee allowed or approved in accordance with [OAR 438-47-000 to 438-47-095] is a lien upon the compensation, if any, awarded."

After reviewing the applicable law, we conclude that a potential lien is created when an out-of-compensation attorney fee is awarded. However, the lien is not perfected and enforceable until the requirements of former OAR 438-47-010(5) and 438-47-080 are satisfied.

Here, the Board's May 7, 1986 order stated that "[c]claimant's attorney is allowed a fee in the amount of 25 percent of the increased compensation awarded under this order." The Board did not order direct payment of the fee to the attorney. Moreover, there is nothing in the record to persuade us that claimant consented to such direct payment. Under these circumstances, claimant's attorney did not have an enforceable lien against the permanent disability award. Accordingly, the insurer is under no obligation to reimburse claimant's attorney for the misdirected attorney fee. Accord Douglas D. Dutton, 39 Van Natta 1123 (1987); Joe Holmes, Jr., 36 Van Natta 601 (1984). We disavow our holding in Joseph Sexton, supra, to the extent it is inconsistent with this decision.

ORDER

The Referee's order dated December 10, 1987 is reversed. The insurer shall not be responsible for reimbursing claimant's attorney for the misdirected attorney fee. The Board approves a client-paid fee, not to exceed $727.50, payable by the insurer to its counsel.

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IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Phillip E. Ledbury, Claimant.

LEDBURY,
Petitioner,

v.

MONTGOMERY WARD & CO.,
Respondent.

(WCB 87-03490; CA A60016)

Judicial Review from Workers' Compensation Board.

Argued and submitted October 13, 1989.

C. Rodney Kirkpatrick, Portland, argued the cause for petitioner. With him on the brief was Kirkpatrick & Zeitz, Portland.

William D. Peek, Portland, argued the cause for respondent. On the brief were Ridgway K. Foley, Jr., P.C., and Schwabe, Williamson & Wyatt, Portland.

Before Graber, Presiding Judge, and Riggs and Edmonds, Judges.

GRABER, P. J.

Affirmed.

GRABER, P. J.

Claimant petitions for review of the Workers' Compensation Board's decision to deny benefits. He argues that the order is not supported by substantial evidence, that the Board improperly failed to adhere to the referee's findings on credibility, and that the Board relied on allegedly inaccurate and irrelevant evidence. We affirm and write only to discuss the second issue.

Claimant alleges that he sustained a work-related injury on July 15, 1986. He did not file a claim until February, 1987. ORS 656.265 requires that a claim be filed within 30 days of the accident or within one year of the date of the accident if "good cause for failure to give notice within 30 days after the accident" is shown.

Claimant testified that he called his employer two days after the accident to request a claim form and that the personnel manager told him that he had to report in person within 48 hours to file the form. He was unable to report in person within 48 hours and testified that employer's instruction was the reason for his late filing. The personnel manager testified that she had no specific recollection but that the company's records showed no contact from claimant with employer on July 17, 1986. Because no record was made and because all such contacts are supposed to be recorded, she maintained that claimant could not have called on that day.

She also testified that employer's normal business practice was to mail a claim form to an employe who could not come in to get it or to allow another person to pick up the form for the employe.

The referee found that "[c]laimant's credible testimony established that he attempted to file the claim in a timely manner, but he was unable to do so because someone, at the employer's office, convinced him that the claim was barred because of [a] supposed 48-hour limit." The Board reviewed *de novo* and reversed. It stated:

> "After reviewing his testimony, we find claimant not credible for three reasons. First, as discussed above, his testimony is not consistent with the employer's attendance records. Second, although claimant testified that he told all of his doctors that his injury occurred on the job, their reports and chart notes prior to July, 1987, do not reflect that history. Dr.

> Franks received history from claimant that he developed pain 'with no known inciting cause.' Dr. Crumpacker, who saw claimant in consultation with Franks, reported that claimant's history 'goes back to July [1986] when he awoke in the middle of the night one night to have severe cramping pain in his left calf.' The only medical report that mentions work activities was issued by Franks in July, 1987, after he received additional history from claimant's attorney. That history was not included in the record and remains unknown.
>
> "Finally, claimant testified that he was laid off work after filing his claim on February 16, 1987. Based on that allegation, he filed a complaint against the employer with the Bureau of Labor and Industries. Claimant's testimony was contravened by his supervisor, Mr. Hayden. Hayden testified that he informed claimant on February 14, 1987 that he would be placed on a floating work schedule due to a reduction in work hours. Ms. Peterson testified likewise. Claimant later resigned, citing his work schedule as the reason.
>
> "Given our credibility finding, we decline to accept claimant's testimony that he attempted to file a claim in July, 1986."

Claimant argues that the Board was not free to disagree with the referee's credibility determination unless it followed, in its *de novo* review, the same reasoning that we followed when we formerly exercised *de novo* review. He cites, for example, *Condon v. City of Portland,* 52 Or App 1043, 629 P2d 1324, *rev den* 291 Or 662 (1981), and *Hannan v. Good Samaritan Hosp.,* 4 Or App 178, 471 P2d 831, 476 P2d 931 (1970), *rev den* (1971). The Board is not required to use the same criteria that we did. All that is required is that, if the Board reverses a referee's finding on credibility, it "state precisely what it found to be the facts and * * * explain how those facts [led] to its conclusion." *See Lewis v. Employment Division,* 66 Or App 303, 307, 673 P2d 1376 (1984).[1]

In the present case, the Board identified three factors that led it to disbelieve claimant's testimony. The Board

[1] We note that our cases did not require us, on *de novo* review, to accept a referee's credibility finding. *See e.g., Johnson v. Spectra Physics,* 77 Or App 1, 712 P2d 125 (1985), *rev'd on other grounds* 303 Or 49, 733 P2d 1367 (1987).

explained why it disagreed with the referee and made its own findings. There is substantial evidence in the record to support those findings, and the Board's reasoning from them to

its conclusion is not irrational or unsound. *See Armstrong v. Asten-Hill Co.*, 90 Or App 200, 752 P2d 312 (1988).

Affirmed.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of Audie Wilson, Claimant.
LIBERTY NORTHWEST INSURANCE CORPORATION,
Petitioner,
v.
SAIF CORPORATION,
Respondent.
(WCB 87-17907; CA A49975)

Judicial Review from Department of Insurance and Finance.

Argued and submitted June 2, 1989.

Stafford J. Hazelett, Portland, argued the cause and filed the brief for petitioner.

John A. Reuling, Jr., Assistant Attorney General, Salem, argued the cause for respondent. With him on the brief were Dave Frohnmayer, Attorney General, Virginia L. Linder, Solicitor General, and Katherine H. Waldo, Assistant Attorney General, Salem.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

DEITS, J.

Reversed and remanded with instructions to order respondent to reimburse petitioner $1,360.87.

DEITS, J.

Petitioner Liberty Northwest Insurance Corporation (Liberty) seeks review of a contested case order issued by the Department of Insurance and Finance[1] denying its request for an order requiring SAIF to pay it $1,360.87, the amount of

[1] Under ORS 656.726(3), the director of the department is charged with the administration, regulation and enforcement of ORS 656.001 to ORS 656.794. The director has delegated his authority to carry out the statutes, rules and bulletins relating to employer coverage to the department's Workers' Compensation Division. ORS 656.704(2); OAR 436-50-002; OAR 436-50-006; OAR 436-50-008; OAR 436-50-010; and OAR 436-50-020.

interim compensation paid by Liberty to a worker before it denied responsibility for his injury. We reverse.

The claimant was injured on June 27, 1986, while an employe of Gold Dust, a business that provides temporary help to other employers. Gold Dust was insured by SAIF at the time of the injury. The claimant was working as a temporary employe at Cornett Lumber Company when he was injured. On July 7, 1986, he went to work for Cornett, which is insured by Liberty. Claimant first sought medical treatment for the June 27 injury on July 8, 1986. In the medical forms that he filled out, he named Cornett, rather than Gold Dust, as his employer at the time of the injury. Consequently, claimant's medical providers reported the claim to Liberty, Cornett's insurer. Liberty paid interim compensation from July 11 until August 29, 1986, when it formally denied responsibility. It continued to pay compensation until September 26. Claimant also filed a workers' compensation claim against Gold Dust. SAIF did not pay interim compensation.

On August 29, 1986, Liberty requested an order under ORS 656.307 determining responsibility for the claim. Liberty notified SAIF of its request. SAIF took no action and did not respond to requests by the Workers' Compensation Division to explain the status of the claim until October 17, 1986, when it formally accepted the injury as disabling. SAIF then made a lump sum payment directly to the worker for interim compensation and temporary total disability for the period from July 11 to September 26, 1986. SAIF did not inform Liberty of the payment. As a consequence of SAIF's actions, the claimant received double payments for that period.

In September, 1987, Liberty requested an order from

the department requiring SAIF to reimburse it $2,138. The department denied the request for compensation on the ground that it lacked authority to order reimbursement without an ORS 656.307 order. Liberty requested a hearing. After the hearing, the department denied reimbursement for the compensation that Liberty had paid from July 11 to August 29, 1986. It did, however, order SAIF to reimburse Liberty $777.64 for payments made by Liberty after its denial through September 26.

The issue is whether the department has the authority to order SAIF to reimburse Liberty for the interim compensation that it paid. Liberty argues that the department has the authority under ORS 656.307[2] to order adjustments

[2] *Former* ORS 656.307(1) provided:

"Where there is an issue regarding:

"(a) Which of several subject employers is the true employer of a claimant worker;

"(b) Which of more than one insurer of a certain employer is responsible for payment of compensation to a worker;

"(c) Responsibility between two or more employers or their insurers involving payment of compensation for two or more accidental injuries; or

"(d) Joint employment by two or more employers,

"the director shall, by order, designate who shall pay the claim, if the claim is otherwise compensable. Payments shall begin in any event as provided in ORS 656.262(4). When a determination of the responsible paying party has been made, the director shall direct any necessary monetary adjustment between the parties involved. Any failure to obtain reimbursement from an insurer or self-insured employer shall be recovered from the Administrative Fund."

between insurers in cases where responsibility is an issue. SAIF contends that that statute does not provide authority, because a determination of responsibility must be made *by the department* before there is authority to order reimbursement.

Liberty invoked the ORS 656.307 process by filing a request for a determination of responsibility under that statute. It turned out not to be necessary for the department to make a determination of responsibility, because SAIF accepted responsibility for the claim before a determination was made. We conclude that the fact that the department did not make the responsibility determination itself does not preclude it from ordering monetary adjustments between insurers. The pertinent language of the statute provides that "[*w*]*hen a determination of the responsible paying party has*

been made, the department shall direct any necessary monetary adjustment * * *." ORS 656.307(3). (Emphasis supplied.) The statute does not require that the department make the determination of responsibility before adjustments may be ordered, but merely that a determination be made. Here, a determination of responsibility was made when SAIF accepted responsibility.[3]

Statutes should be construed with a view to effecting the overall policy that they are intended to promote. *Wimer v. Miller,* 235 Or 25, 30, 383 P2d 1005 (1963). Our interpretation of ORS 656.307 is consistent with the policy of the workers' compensation law to encourage employers and insurers to take a pay-and-then-ask approach to claims, ORS 656.262; to require cooperation between insurers, OAR 436-60-180(4), (5) and (11) and OAR 436-60-200; to provide sanctions for delay or unreasonable denial in the payment of benefits, ORS 656.262(10) and ORS 656.382(1); and to discourage double recovery of benefits by claimants. ORS 656.210. We hold that the department has the authority to order SAIF to reimburse Liberty for the interim compensation that it paid.

Reversed and remanded with instructions to order respondent to reimburse petitioner $1,360.87.

[3] The administrative rules also do not require that the determination of responsibility be made by the department. OAR 436-60-190(2) does not make direction of an adjustment contingent on an order, but on the fact that the responsible paying party has been determined. In OAR 436-60-190(4), it is recognized that parties may determine between themselves who the responsible party is and, thereafter, a monetary adjustment may be made.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Shelley F. Hempel, Claimant.

HEMPEL,
Petitioner,

v.

SAIF CORPORATION et al,
Respondents.

(WCB No. 86-15537; CA A50911)

Judicial Review from Workers' Compensation Board.

Argued and submitted September 18, 1989.

Thomas Cary, Eugene, argued the cause for petitioner. With him on the brief was Coons & Cole, P.C., Eugene.

John T. Bagg, 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.

JOSEPH, C. J.

Affirmed.

JOSEPH, C. J.

Claimant seeks review of a Workers' Compensation Board order dismissing her claim. The Board ruled that she had not established good cause for failing to request a hearing within 60 days after the denial of her claim. ORS 656.319(1). We affirm, but on a ground different from the Board's.

Claimant was employed as a lumber grader in Bend during 1985 and 1986. In 1985, she noticed a pain in her right wrist. In January, 1986, she noticed a sharp increase in the pain. She reported the problem to the plant nurse and was treated. She missed no work. She was discharged in May, 1986, for reasons unrelated to her wrist. She was diagnosed as having tenosynovitis in June, 1986. Her doctor filed a report with SAIF in July, 1986, and she began receiving interim compensation. SAIF sent claimant a letter dated September 4, 1986, denying compensability. Claimant knew that a request for hearing had to be filed with the Board no later than 60 days from the date of the denial. The 60th day would be November 3, but she calculated that the 60th day would be November 4. On October 30, 1986, she wrote a letter to the Board requesting a hearing. Instead of mailing it, she gave the letter to a friend to deliver personally to the Board on November 4, 1986. The friend did not get to Salem on that day but mailed the letter on November 5. It was received by the Board on November 7.

The referee concluded that claimant's miscalculation of the last day of the period was the cause of the untimely filing and was not excusable; the Board concluded that the friend's failure to deliver the request on November 4 was dispositive and that it was not excusable neglect.

Claimant has the burden to establish good cause for failure to file timely. *Anderson v. Publishers Paper Co.*, 93 Or App 516, 518, 763 P2d 398 (1988). Good cause in this context means "mistake, inadvertence, surprise or excusable neglect," as those terms are used in ORCP 71B(1). *Barr v. EBI Companies*, 88 Or App 132, 137 n 4, 744 P2d 582 (1987). We agree that claimant did not show good cause for filing her request after the 60-day time period had expired, but we do not agree with the Board. Claimant failed to show good cause for miscalculating the filing deadline as November 4, instead of November 3. It does not matter why her friend did not mail

the notice until November 5, because the notice would have been late had she delivered it on the day on which she was told to deliver it, November 4.

Claimant knew that the notice had to be filed within 60 days of the date after the denial. No one and no thing led her to believe anything different, and no supervening event occurred to cause her to miscalculate. *Cf. Voorhies v. Wood, Tatum, Mosser*, 81 Or App 336, 725 P2d 405, *rev den* 302 Or 342 (1986) (claimant misled by insurer's representative).

Affirmed.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

GORDINEER,
Appellant,
v.
BELLOTTI et al,
Respondents.
(16-88-04775; CA A50175)

Appeal from Circuit Court, Lane County.

Pierre Van Rysselberghe, Judge.

Maurice Merten, Judge.

Argued and submitted September 11, 1989.

David C. Force, Eugene, argued the cause and filed the briefs for appellant.

Randall Thwing, Eugene, argued the cause for respondent Alice Bellotti dba H&B Trucking. On the brief were Sidney E. Thwing, and Thwing & Thwing, Eugene.

John R. Faust, Jr., Portland, argued the cause for respondent Insurance Company of North America, a foreign corporation. On the brief were Mildred J. Carmack, James G. Huegli, and Schwabe, Williamson & Wyatt, Portland.

Before Joseph, Chief Judge, and Newman and Deits, Judges.

JOSEPH, C. J.

November 15, 1988, judgment for defendant Bellotti vacated; September 30, 1988, judgment dismissing claim against defendant Bellotti reversed and remanded; judgment of dismissal for INA affirmed.

104 Gordineer v. Bellotti

JOSEPH, C. J.

In 1979, plaintiff sustained an injury while working for H&B Trucking. Insurance Company of North America (INA), H&B's workers' compensation carrier, accepted his claim and paid temporary total disability for almost two years, at which time defendants told him that his benefit rate would be reduced and that an additional amount would be held to recover an alleged overpayment. On appeal, the Workers' Compensation Board found that he had been a part-time employee and allowed the offset for overpayment. We affirmed without opinion. *Gordineer v. H&B Trucking et al,* 63 Or App 382, 663 P2d 1313 (1983).[1]

In 1987, plaintiff sought an own-motion action by the Board, ORS 656.278, to modify its former finding that he had been a part-time employe at the time of the injury and to reinstate the original temporary total disability benefit rate. The Board declined. He then filed this declaratory judgment action in which he alleged that defendant Bellotti had been a co-owner of H&B Trucking with Cecil Hunt and that, after Hunt's death in 1981, she became sole owner. He alleged that, as a result of her "false, fraudulent and perjurious" testimony and business records submitted in the compensation hearing, he had lost compensation and had suffered emotional distress. He sought a declaration that his action was not subject to the exclusive workers' compensation remedy and that he was entitled to damages.

On September 30, 1988, a judgment of dismissal for failure to prosecute, ORCP 54B(3), was entered on plaintiff's claims against Bellotti. Plaintiff and Bellotti agree that the judgment was entered in error, because plaintiff had in fact served her with a summons and complaint and, on September 29, she had filed a motion to dismiss that was pending on the date of dismissal. On October 21, the trial court granted INA's motion to dismiss and entered a judgment pursuant to ORCP 67B. On October 31, plaintiff filed a notice of appeal from the judgments of September 30 and October 21. On November 15,

[1] Plaintiff entered into a stipulated settlement regarding an alleged psychiatric condition in July, 1985, which also increased unscheduled permanent partial disability on his accepted claim.

the trial court entered a purported judgment granting Bellotti's motion to dismiss. Plaintiff then attempted to file a supplemental notice of appeal to include that judgment.[2]

Plaintiff's October 31 notice of appeal deprived the trial court of jurisdiction to enter the November 15 judgment on Bellotti's motion to dismiss. ORS 19.033. That judgment is a nullity and is vacated.

Bellotti argues that the September 30 judgment was a judgment without prejudice, ORCP 54B(4), and that, therefore, it was not appealable. That argument has been answered contrary to her position. *Gearhart v. Employment Division,* 99 Or App 601, ___ P2d ___ (1989). She also contends that the judgment is not appealable, because plaintiff failed to move to set it aside pursuant to ORCP 71, which permits a trial court to relieve a party from a judgment because of mistake, inadvertance, surprise or excusable neglect. Although, in an instance like this, a Rule 71 motion would be a more efficient use of judicial resources, neither the rules nor the appeal statutes require a motion before an appeal may be taken. The judgment was entered due to error, and we reverse and remand as to Bellotti.[3]

Plaintiff argues that the trial court erred in declaring that his claim against INA was subject to the exclusivity provisions of ORS 656.018.[4] His position is that the wrongs alleged in this action did not arise out of his compensable injury but, rather, were post-injury intentional torts for which he can bring a civil action. Plaintiff states the issue too narrowly. It is not whether the wrongs arose out of his compensable injury or were post-injury, but whether they were matters

"concerning a claim," for which the decision and review provisions of workers' compensation law are exclusive. ORS 656.704(3); ORS 656.708; *SAIF v. Johnson,* 99 Or App 64, 67, 781 P2d 374 (1989); *Hayden v. Workers' Compensation Dept.,* 77 Or App 328, 713 P2d 612 (1986); *SAIF v. Harris,* 66 Or App 165, 672 P2d 1384 (1983), *rev den* 298 Or 334 (1984).

Plaintiff relies on *Crosby v. SAIF,* 73 Or App 372, 699 P2d 198 (1985), in which the plaintiff alleged that the defendants had conspired to divest him unlawfully of his right to workers' compensation benefits and to terminate him unlawfully. Plaintiff misunderstands *Crosby.* There was no

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[2] On February 24, 1989, we ordered the appeal to proceed on the original notice.

[3] We do not reach plaintiff's assignment of error that the trial court erred in dismissing his claim against Bellotti on his motion to dismiss.

[4] ORS 656.018(1)(a) provides:

"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."

issue in that case about the exclusivity of the workers' compensation procedures. SAIF's contention (which we rejected) was that, because the plaintiff's allegations arose out of his termination after he had filed a workers' compensation claim, the remedies for discrimination under ORS chapter 659 were exclusive. More fundamentally, the misconduct alleged in *Crosby* had nothing to do with the disposition of the plaintiff's compensation claim.[5]

Here, in contrast, plaintiff alleges damages that arose directly out of a workers' compensation proceeding in which the amount of compensation was in issue. He alleged that Bellotti furnished false and perjured testimony and evidence in the hearing at which the overpayment claim was in issue and that, as a result of that, he suffered a loss of temporary total disability benefits to which he was entitled.[6] Attacking a claim for general and punitive damages in addition to a claim

for loss of compensation does not alter the nature of his cause of action. He seeks to overturn a workers' compensation decision, and the trial court was correct in holding that the remedies in the workers' compensation law are exclusive.[7]

Plaintiff argues that he is without any recourse, because the Board considers that it is without jurisdiction to issue any own-motion order that would overturn an earlier decision. *See* ORS 656.278(5). Plaintiff misstates the Board's order on his request for exercise of own-motion jurisdiction. The Board did not conclude that it was without jurisdiction. Rather, it declined to exercise that jurisdiction to disturb a decision rendered by the referee and affirmed by the Board and this court.[8]

Plaintiff also seems to contend that, if he does not get the relief that he seeks from the tribunal with jurisdiction,

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[5] Plaintiff is not aided by *Nicholson v. Blachly*, 305 Or 578, 753 P2d 955 (1988), where the Supreme Court held that the workers' compensation exemption from liability for an employer and the employer's insurer did not extend to vocational rehabilitation organizations that had contracted to provide assistance under the Workers' Compensation Law. In our opinion in *Nicholson*, we had held that the plaintiff could not pursue his contract and tort claims against his employer, *Nicholson v. Blachly*, 86 Or App 645, 740 P2d 220 (1987), because the Workers' Compensation Department has jurisdiction over all matters concerning claims. On review in the Supreme Court, the plaintiff abandoned his claim against the employer.

[6] Plaintiff is unclear as to what tort he alleged. As his counsel stated at oral argument, the conduct was "fraud, deceit or whatever you want to call this kind of conduct * * *." In his complaint, plaintiff states conclusorily that he was damaged by INA's "fraud and misrepresentation" but he does not allege facts that show that INA conspired or participated in preparing the allegedly false testimony and evidence. Insofar as plaintiff's complaint states facts, it alleges perjury on the part of Bellotti. Perjury is not an intentional tort in and of itself, but it may constitute fraud intrinsic in a proceeding. *See O.-W.R. & N. Co. v. Reid*, 155 Or 602, 609, 65 P2d 664 (1937).

[7] Plaintiff contends that the circuit court could not dismiss the case, because he is entitled to a declaration of his rights under ORS 28.020. *See Lewis v. Miller*, 197 Or 354, 251 P2d 876 (1952); *Reynolds v. State Board of Naturopathic Exam.*, 80 Or App 438, 722 P2d 739 (1986). However, the requirement that the circuit court make a declaration, as opposed to dismissing an action, is not applicable in this situation, where the court is without jurisdiction to consider the subject matter as to which a declaration is sought.

[8] We note that Oregon courts have declined to overturn judgments on the basis of intrinsic fraud in a proceeding, acknowledging that there must be an end to litigation. *See Larson v. Heintz Const. Co. et al*, 219 Or 25, 345 P2d 835 (1959); *Watson v. State of Oregon*, 71 Or App 734, 737, 694 P2d 560 (1984), *petition for review withdrawn* 299 Or 204 (1985).

that is, the Board, it cannot be said to be the sole source of relief. The fact that an exclusive tribunal's decision has become final does not mean that another tribunal therefore obtains jurisdiction. Just because plaintiff's only recourse was the workers' compensation system does not mean that he had no recourse.

November 15, 1988, judgment for defendant Bellotti vacated; September 30, 1988, judgment dismissing claim against defendant Bellotti reversed and remanded; judgment of dismissal for INA affirmed.

198 — January 17, 1990 — No. 21

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Juanita J. Morrow, Claimant.

MORROW,
Petitioner,

v.

PACIFIC UNIVERSITY et al,
Respondents.

(86-06758; CA A50479)

Judicial Review from Workers' Compensation Board.

Argued and submitted September 18, 1989.

Karen M. Werner, Eugene, argued the cause and filed the brief for petitioner.

Kate Waldo, Assistant Attorney General, Salem, argued the cause for respondents. With her 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.

Reversed and remanded for further proceedings not inconsistent with this opinion.

200 — Morrow v. Pacific University

DEITS, J.

Claimant seeks review of an order of the Worker's Compensation Board upholding SAIF's denial of her claim for compensation. She argues that the Board erred in holding that her claim is for an occupational disease rather than an occupational injury and that, under either standard, her condition is compensable. We reverse and remand.

Claimant, age 58, was employed by Pacific University as an office manager in its optometry clinic. She had worked there for seven years. She had surgery in 1977 to clip a rup-

tured brain aneurysm. Six months later, a fall caused the clip to loosen, and she underwent surgery again. She sought no further medical treatment for the aneurysm. Since the time of that surgery, she has suffered nausea, headaches, high blood pressure and occasional light-headedness.

On January 21, 1986, claimant was told by her supervisor that her job title was going to be changed from "office manager" to "operational supervisor." She was unhappy with the change and viewed it as a demotion. Later the same day, her supervisor and one of the university's vice presidents met with her to discuss some variances between bookkeeping entries and actual deposits. She was not accused of theft. However, after interviewing her, the supervisor told her that she was being suspended immediately without pay for mismanagement. Claimant was very upset by the events of the day and left immediately. She has difficulty remembering what happened that night and the next day, but she apparently became disoriented, missed her bus stop on the way home and did not know whether it was day or night. The next evening, her apartment manager found her in a confused state and took her to a hospital. The examining doctor stated in his report that she had complained of a severe headache and nausea and that she was lethargic, but oriented. She was hospitalized from January 23 to January 30, 1986.

The medical experts were not able to provide a certain diagnosis. Dr. Smith, claimant's treating neurosurgeon, believed that there were several possible explanations. He thought that the most likely causes of her condition were an unwitnessed seizure or a hysterical disassociative state. Smith

indicated that the earlier brain injury made her more susceptible to seizure activity and that her state when she was admitted to the hospital was consistent with a seizure. The other potential causes that he thought were somewhat likely were a disassociative state or a transient global amnesia. He testified that it is a reasonable medical probability that the emotional stress from the job incident was connected to a seizure or disassociative state and that, if what she suffered was a global transient amnesia, the emotional trauma could only have played a minor role. Dr. Brown, another neurologist who reviewed claimant's medical file in June, 1986, thought that the angiogram taken at the time of the incident indicated the possibility of two distinct aneurysms. He did not believe that there could be a relationship between the earlier ruptured brain aneurysm, claimant's stress from the incident at work and the disability.

The referee concluded that the medical evidence was based on presumptions and guesses that would not support a conclusion that claimant's condition is compensable. The Board affirmed the referee, but on a different ground. It held that claimant's condition, which it identified as a "brain aneurysm and its sequela [*sic*]," is an occupational disease rather than an occupational injury. It then concluded that claimant had not proved that her work activities were the

major contributing cause of her disability and, that, therefore, she had not established a compensable occupational disease.

Claimant first argues that the Board erred in concluding that her claim should be treated as an occupational disease claim rather than an injury claim.[1] We agree. Oregon has adopted the distinction between an "injury" and a "disease" explained in 1B Larson, *Worker's Compensation Law* § 41:31:

> " '* * * What set[s] occupational diseases apart from accidental 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] gradual rather than sudden in onset.* * *' "

James v. SAIF, 290 Or 343, 348, 624 P2d 565 (1980); *Donald Drake Co. v. Lundmark,* 63 Or App 261, 266, 663 P2d 1303 (1983), *rev den* 296 Or 350 (1984).

The Board concluded that that test was satisfied:

> "Here, claimant underwent a rather high degree of on-the-job stress on January 21, 1986. Within a span of only a few hours, her job title was changed which she viewed as a demotion, and later she was given an immediate suspension under accusation of mismanagement. Moreover, she had recently sought medical attention for high blood pressure and was treated with a diuretic for several days. Considering the unusually stressful events of January 21, 1986 coupled with the recent treatment for high blood pressure, we find that *claimant's aneurysm and resulting amnesia [sic] was not unexpected.*
>
> "Moreover, the aneurysm condition was not sudden in onset. Although claimant was emotionally upset following her job suspension on January 21, 1986, she left work in no apparent physical distress. She caught a bus and rode it to her apartment. That evening she spoke on the telephone with a friend. Some time between the time of that telephone call and the next evening, she became disoriented and lost track of time. On January 23, 1986, she was taken to a hospital. We find that the onset of claimant's aneurysm condition *was not 'sudden.'*
>
> "Accordingly, in our view, the present case should be analyzed as a *claim for occupational disease,* rather than for injury." (Emphasis supplied.)

The Board's conclusion that claimant's recent problems with high blood pressure made her condition "not unexpected" is in error. There is no evidence that high blood pressure or the problems claimant suffered on January 21 were risks inherent in her work. *See O'Neal v. Sisters of Providence,* 22 Or App 9, 537 P2d 580 (1975). Although she appar-

[1] It is unclear whether claimant initially filed the claim as an occupational disease or as an occupational injury. On the claim form, she indicated that the claim was for a "brain aneurism [sic] and seizure." SAIF acknowledged the claim "for an industrial injury to your brain" and denied her "condition diagnosed as brain aneurysm." At the hearing, claimant's attorney stated that she was not seeking compensation for the pre-existing aneurysm, but for the episode for which she was hospitalized in 1986.

ently did suffer from stress, there is no evidence that her work duties subjected her to ongoing stress. Since the time of her brain surgeries in 1977, she had sought no medical treatment for that condition. The Board's conclusion that claimant's

problems in January were not unexpected is not supported by substantial evidence.

We next consider the Board's conclusion that claimant's condition did not occur suddenly. In order to be considered "sudden," a condition must occur "during a short, discrete period, rather than over a long period of time." *Donald Drake Co. v. Lundmark, supra,* 63 Or App at 266. It is not necessary that the injurious event be an instantaneous happening with a traumatic, sudden cause. The Board's conclusion that claimant's condition was not sudden is also not supported by substantial evidence.

Accordingly, we conclude that the Board erred in considering claimant's claim as being for an occupational disease. On remand, the Board should view the claim as one for an injury and determine if claimant's job was a material contributing cause of her disability. *Harris v. Albertson's Inc.,* 65 Or App 254, 257, 670 P2d 1059 (1983).

Reversed and remanded for further proceedings not inconsistent with this opinion.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Dennis J. Harvey, Claimant.

HARVEY,
Petitioner,
v.
LOU SURCAMP LOGGING et al,
Respondents.

(TP-88028; CA A50832)

Judicial Review from Workers' Compensation Board.

Argued and submitted September 19, 1989.

James L. Edmunson, Eugene, argued the cause for petitioner. On the brief were Christopher D. Moore and Malagon, Moore & Johnson, Eugene.

Christopher B. Marks, Portland, argued the cause for respondents. With him on the brief was MacMillan & Scholz, Portland.

Before Graber, Presiding Judge, and Riggs and Edmonds, Judges.

RIGGS, J.

Affirmed.

RIGGS, J.

Claimant seeks review of a Workers' Compensation Board third party order, challenging the Board's method of distributing the proceeds from the settlement of his third party claim. We review for substantial evidence and errors of law and affirm.

Claimant was injured on a third party's premises while performing his work duties. Liberty Northwest Mutual (Liberty), employer's insurer, accepted the claim. It then requested that claimant elect either to pursue his third party action himself or to assign it to Liberty. ORS 656.583. Liberty's election notice, sent to claimant by certified mail in March, 1986, stated:

> "This letter will constitute an *election notice.* You have two alternatives: You may elect to recover damages yourself or you may elect to sign [*sic*] your third party rights to [Liberty]. If you assign your rights to [Liberty], or do not elect at all, you lose all rights and voice in the handling and settlement of this claim. You have 60 days by law to advise us *in writing* as to whether or not you will pursue the third party action yourself." (Emphasis in original.)

Claimant did not respond to the letter. In February, 1987, Liberty sent another letter stating that it assumed that claimant was assigning his third party rights and that Liberty should pursue the action itself. In several later contacts with Liberty, claimant indicated that he did not wish to pursue the action himself. He stated that he had pursued an earlier, similar third party claim himself and had recovered only $500 and that it had been a "big hassle."

Liberty reached a tentative settlement with the third party. It asserted a lien, ORS 656.580, that exceeded the amount of the settlement. Consequently, under ORS 656.591(2), claimant would receive none of the proceeds. The third party refused to execute the settlement agreement without claimant's consent, which claimant withheld. Liberty petitioned the Board for a third party order resolving the dispute pursuant to ORS 656.587.[1]

At issue was whether the proceeds should be distributed under ORS 656.591(2) or ORS 656.593(1). Liberty contended that claimant's failure to notify it within 60 days of the election notice, as required by ORS 656.583, operated to assign his third party claim to Liberty as a matter of law and that the proceeds of the settlement of that claim should there-

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[1] Liberty asserts that the Board had jurisdiction of this dispute under ORS 656.587, which provides, in pertinent part:

> "Any compromise by the worker or other beneficiaries or the legal representative of the deceased worker of any right or action against an employer or third party is void unless made with the written approval of the paying agency or, in the event of a dispute between the parties, by order of the board."

ORS 656.587 does not confer jurisdiction in this situation, because it applies to a compromise "by the worker or other beneficiaries or the legal representative of the deceased worker." The compromise at issue was negotiated *by* Liberty. The Board did have jurisdiction, however, under ORS 656.704(1), because this dispute involves "matters concerning a claim." *See EBI v. Cooper,* 100 Or App ____, ____ P2d ____ (1990).

fore be distributed under ORS 656.591(2). Claimant contended that the election was invalid, because he did not clearly understand his rights and was fearful that he would lose his medical coverage if he elected to pursue the third party claim himself. Therefore, he argued, the proceeds should be distributed according to ORS 656.593, as if he had pursued the action himself. Under that distribution he would receive one third of the proceeds from the settlement after deduction of costs and attorney fees.

The Board held that claimant had effectively assigned his claim because he did not wish to pursue it himself, that the assignment was valid and that the proceeds should therefore be distributed under ORS 656.591(2). In reaching its conclusion, the Board considered the election form sent to claimant, a statement claimant made to Liberty's claim representative that he did not wish to "mess with" a third party action and several interoffice documents noting similar communications. The only contrary evidence was claimant's affidavit, which the Board found provided only weak support for his argument that he did not understand the implications of an assignment and was fearful of losing medical benefits. The Board's determination is supported by substantial evidence.

Affirmed.

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246 January 17, 1990 No. 28

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of James A. Cooper, Claimant.

EBI COMPANIES,
Petitioner,

COOS CURRY ROOFING,
Employer,

v.

COOPER,
Respondent.

(WCB TP-87022; CA A50167)

Judicial Review from Workers' Compensation Board.

Argued and submitted September 8, 1989.

Patric J. Doherty, Portland, argued the cause for petitioner. With him on the brief was Rankin, VavRosky, Doherty, MacColl & Mersereau, Portland.

James C. Coffey, North Bend, argued the cause for respondent. With him on the brief was Stebbins & Coffey, North Bend.

Before Graber, Presiding Judge, and Riggs and Edmonds, Judges.

EDMONDS, J.

Affirmed.

EDMONDS, J.

EBI seeks review of a Workers' Compensation Board order that held that claimant was entitled to rescind his election, made pursuant to ORS 656.591, to assign his third party action to EBI and that the proceeds of the third party settlement should be redistributed pursuant to ORS 656.593(1).[1] We affirm.

Claimant suffered a compensable injury in November, 1981. In June, 1982, he was involved in an off-the-job accident that caused increased pain and new symptoms. He pursued an aggravation claim and elected to assign his third party rights arising from the accident to EBI, pursuant to ORS 656.591.[2] EBI settled that action in April, 1986, and

the proceeds were distributed pursuant to ORS 656.591(2). In the distribution, claimant received nothing.

In October, 1987, claimant petitioned the Board for a third party order pursuant to ORS 656.593 to redistribute the recovery in the third party action. Claimant contended that EBI had induced him to assign his claim by fraud or misrepresentation. The Board concluded that the assignment was

[1] ORS 656.593(1) provides:

"(1) If the worker or the beneficiaries of the worker elect to recover damages from the employer or third person, notice of such election shall be given the paying agency by personal service or by registered or certified mail. The paying agency likewise shall be given notice of the name of the court in which such action is brought, and a return showing service of such notice on the paying agency shall be filed with the clerk of the court but shall not be a part of the record except to give notice to the defendant of the lien of the paying agency, as provided in this section. The proceeds of any damages recovered from an employer or third person by the worker or beneficiaries shall be subject to a lien of the paying agency for its share of the proceeds as set forth in this section and the total proceeds shall be distributed as follows:

"(a) Costs and attorney fees incurred shall be paid, such attorney fees in no event to exceed the advisory schedule of fees established by the board for such actions.

"(b) The worker or the beneficiaries of the worker shall receive at least 33-1/3 percent of the balance of such recovery.

"(c) The paying agency shall be paid and retain the balance of the recovery, but only to the extent that it is compensated for its expenditures for compensation, first aid or other medical, surgical or hospital service, and for the present value of its reasonably to be expected future expenditures for compensation and other costs of the worker's claim under ORS 656.001 to 656.794. Such other costs include assessments for reserves in the Insurance and Finance Fund, but do not include any compensation which may become payable under ORS 656.273 or 656.278.

"(d) The balance of the recovery shall be paid to the worker or the beneficiaries of the worker forthwith. Any conflict as to the amount of the balance which may be retained by the paying agency shall be resolved by the board."

[2] ORS 656.591 provides:

"(1) An election made pursuant to ORS 656.578 not to proceed against the employer or third person operates as an assignment to the paying agency of the cause of action, if any, of the worker, the beneficiaries or legal representative of the deceased worker, against the employer or third person, and the paying agency may bring action against such employer or third person in the name of the injured worker or other beneficiaries.

"(2) Any sum recovered by the paying agency in excess of the expenses incurred in making such recovery and the amount expended by the paying agency for compensation, first aid or other medical, surgical or hospital service, together with the present worth of the monthly payments of compensation to which such worker or other beneficiaries may be entitled under ORS 656.001 to 656.794, shall be paid such worker or other beneficiaries."

invalid and ordered redistribution of the proceeds as if claimant had maintained his own third party action pursuant to ORS 656.593.

Although it is not raised by the parties, we decide as a threshold issue whether the Board had jurisdiction and the authority to order that claimant's election be rescinded and the proceeds be redistributed. This dispute involves "matters concerning a claim under ORS 656.001 to 656.794," because the worker's right to receive compensation is directly in issue. ORS 656.704(1), (3). The paying agency's right to distribution of third party recoveries is derived from its responsibility for compensation, and the amount distributed is determined in part by the amount of compensation paid. *See Schlect v. SAIF*, 60 Or App 449, 455, 653 P2d 1284 (1982). ORS 656.591 gives the Board jurisdiction over the parties and the subject matter of an election by a worker to assign his third party claim to a paying agency. The Board's authority to order rescission of an election fraudulently obtained flows from the exercise of that jurisdiction, because an election that was induced by fraud is, in fact, no election.

The Board stated:

> "In *Ebbtide Enterprises v. Tucker*, 303 Or 459, 464[, 738 P2d 914] (1987), the Court held that, in order to support a recision of an earlier acceptance, the insurer must show that the decision to accept the claim 'could reasonably have been affected' if the true facts had been known. The insurer is not required to show that it in fact would have denied the claim

> with the correct information. *Newport Elks Club v. Hays*[, 92 Or App 604, 607, 759 P2d 327, *rev den* 307 Or 245 (1988)]."
>
> "Applying this standard to the third party matter before us, we conclude that claimant need only show that the election form was misleading and that his decision to assign his rights to the paying agency 'could reasonably have been affected' if the true facts had been known. Claimant need not prove that he was, in fact, misled into assigning his third party action to the paying agency. *See Newport Elks Club v. Hays, supra*, 92 Or App at 607.
>
> "We find that the election form is misleading. Option 'A' and Option 'B', read together, strongly imply that in order to continue receiving benefits under his compensable claim, claimant had to elect Option 'B'. Both parties agree that this is not a correct statement of the law. *Moreover, it is readily apparent that claimant's election could have been influenced by the knowledge that he did not need to assign his third party action to the paying agency in order to continue to receive his workers' compensation benefits.*[3] We conclude that, absent a defense on the part of the paying agency, claimant is entitled to rescind his prior election." (Emphasis supplied.)

EBI does not argue that the Board applied the wrong

[3] Although the emphasized wording is confusing, in the context of all of the Board's findings, we understand the sentence to say that, *if* claimant had known that he did not need to assign his claim in order to continue to receive benefits, his election might have been different.

legal standard when it held that the claimant must show that his election could reasonably have been affected by the misleading language in the notice. Rather, it argues that the Board erred in refusing to resolve an underlying credibility dispute between claimant and the claims representative and in basing its decision on the language of the election form, because claimant did not rely on it. It points to the fact that claimant called petitioner after receiving the election form notice. Petitioner's claims representative and claimant disagree about what the representative said in that conversation. Petitioner suggests that OAR 438-11-045(2), which provides that testimonial evidence in third party disputes shall be by "deposition, affidavit or written interrogatories," and ORS

656.593(3)[4] require the Board to resolve the credibility dispute as a matter of law.

Nothing in ORS 656.593(3) or OAR 438-11-045(2) prohibits the Board from considering the conflicting testimony of the claimant and the claims representative to be in equipoise or from relying on the election notice language as the determinative factor. There is substantial evidence to support the Board's finding that the election notice could have affected claimant's election. Although claimant testified that, after receiving the election form, he called the claims representative and "asked what the letter meant," thereafter he signed the election form and returned it to petitioner. It is just as reasonable to infer that the conversation with the claims representative did not obviate the misleading language of the election form as it is to infer that it did. Therefore, the Board did not err.[5]

Affirmed.

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[4] ORS 656.593(3) provides:

"A claimant may settle any third party case with the approval of the paying agency, in which event the paying agency is authorized to accept such a share of the proceeds as may be just and proper and the worker or the beneficiaries of the worker shall receive the amount to which the worker would be entitled for a recovery under subsections (1) and (2) of this section. Any conflict as to what may be a just and proper distribution shall be resolved by the board."

[5] Petitioner's other arguments do not merit discussion.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of
Larry K. Rose, Claimant.

MERCER INDUSTRIES et al,
Petitioners - Cross-Respondents,

v.

ROSE,
Respondent - Cross-Petitioner,
and

AMERICAN BUILDING MAINTENANCE et al,
Respondents - Cross-Respondents.

(86-16120, 86-03158; CA A51112)

Judicial review from Workers' Compensation Board.

Argued and submitted November 13, 1989.

Patric J. Doherty, Portland, argued the cause for petitioners - cross-respondents. With him on the brief were E. Kimbark MacColl and Rankin, VavRosky, Doherty, MacColl & Mersereau, Portland.

Karen M. Werner, Eugene, argued the cause and filed the brief for respondent - cross-petitioner.

Eric Roland Miller, Portland, argued the cause for respondents - cross -respondents. With him on the briefs was Terrall & Miller, Portland.

Before Graber, Presiding Judge, and Riggs and Edmonds, Judges.

EDMONDS, J.

Affirmed on petition; reversed and remanded on cross-petition for further proceedings not inconsistent with this opinion.

EDMONDS, J.

Mercer Industries seeks review of an order of the Workers' Compensation Board that assigned responsibility to it for claimant's condition. Claimant seeks cross-review of the Board's order that he was not entitled to employer paid attorney fees. We affirm without discussion on the petition[1] and reverse on the cross-petition.

Claimant initiated a hearing under *former* ORS

[1] Detailing the facts that the Board relied on would not aid the Board or the bar. There is substantial evidence to support the Board's decision.

656.307 to determine whether American Building Maintenance (American) or Mercer was responsible for claimant's disability. Both employers agreed that claimant was entitled to compensation but disputed which was responsible for his present condition. Claimant took the position that his most recent employer, Mercer, was responsible on the ground that he had suffered a new injury. A finding that Mercer was responsible would entitle claimant to a higher time-loss rate and, in turn, greater compensation. The referee assigned responsibility to American and denied attorney fees to claimant. On review, the Board assigned responsibility to Mercer but refused to award attorney fees to claimant. The Board stated that *SAIF v. Phipps,* 85 Or App 436, 737 P2d 131 (1987), had been overruled *sub silentio* by subsequent cases and, instead, relied on *Short v. SAIF,* 305 Or 541, 546-47, 754 P2d 575 (1988), as support for its denial of fees. In *Phipps* and *Petshaw v. Farm Bureau Ins. Co.,* 76 Or App 563, 569, 710 P2d 781, *rev den* 300 Or 722 (1986), we held that the test to determine if attorney fees should be awarded is whether claimant's attorney "actively litigated" the issue of responsibility.

Short v. SAIF, supra, holds that there is no statutory provision for circuit court review of the Board's determination of attorney fees when the only compensation issue is the extent of disability, rather than whether a claimant's condition was caused by an industrial injury. We do not read *Short* to overrule *SAIF v. Phipps, supra, sub silentio.* The Board also cited *Cascade Corporation v. Rose,* 92 Or App 663, 759 P2d 1127 (1988); *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); and *Anfora v. Liberty Communications,* 88 Or App 30, 744 P2d 265 (1987), for its conclusion that *Phipps* had been overruled. To the contrary, those cases apply *Phipps* and *Petshaw,* and the only differences are factual. *Phipps* remains authoritative. *See also Dilworth v. Weyerhaeuser Co.,* 95 Or App 85, 92, 767 P2d 484, *rev den* 307 Or 658 (1989). Accordingly, we remand to the Board for a determination of whether claimant's attorney's participation constituted "active litigation" and for appropriate further proceedings.

Affirmed on petition; reversed and remanded on cross-petition for further proceedings not inconsistent with this opinion.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Carol A. Fisher, Claimant.

SAIF CORPORATION et al,
Petitioners,

v.

FISHER et al,
Respondents.

(87-12543, 87-15218; CA A48762)

Judicial Review from Workers' Compensation Board.

On respondent Fisher's motion to dismiss filed December 21, 1988.

Robert K. Udziela, and Pozzi, Wilson, Atchison, O'Leary & Conboy, Portland, for respondent Fisher.

No other appearances on motion.

Before Rossman, Presiding Judge, and Newman and Edmonds, Judges.

EDMONDS, J.

Motion to dismiss denied; judicial review dismissed on the court's own motion.

EDMONDS, J.

Claimant has moved to dismiss SAIF's petition for judicial review as untimely. She argues that SAIF was required and failed to file an amended petition for judicial review. We deny claimant's motion but dismiss on our own motion, because there is no final order from which SAIF can seek review.

On May 18, 1988, the Workers' Compensation Board issued an order reversing the referee and determining that claimant's condition was compensable. On June 9, 1989, SAIF filed with the Board a "REQUEST FOR ABATEMENT AND RECONSIDERATION." On June 16, 1988, SAIF filed a petition for judicial review. On June 17, 1989, the Board issued an "ORDER OF ABATEMENT" which, *inter alia,* stated, "To provide sufficient time to reconsider the request, we withdraw and abate our Order on Review in this case, effective this date." On July 20, 1989, the Board issued an "ORDER WITHDRAWING ABATEMENT ORDER," which, after noting that SAIF had filed a petition for judicial review before the Board had issued its order of abatement, stated: "We decline to withdraw our May 18, 1988 Order on Review." SAIF did not thereafter file a new or amended petition for judicial review.

Claimant has moved to dismiss on the ground that,

under ORS 183.482(6),[1] the June 17 abatement order triggered a requirement that SAIF file an amended petition, which it did not do. The significance of whether ORS 183.482(6) applies to workers' compensation cases is that it requires the filing of an amended petition for judicial review if an agency withdraws the original order for which judicial review was sought. If an amended petition is not filed, the petition must be dismissed

for lack of jurisdiction. *Knapp v. Employment Division,* 67 Or App 231, 677 P2d 738 (1984). In *Fisher v. SAIF,* 76 Or App 656, 711 P2d 162 (1985), *rev den* 300 Or 605 (1986), we held that ORS 183.482(6) does apply to judicial review of workers' compensation decisions, because ORS 183.315(1) does not explicitly exclude it.[2] However, it is not necessary to apply ORS 183.482(6) to decide this case.

In the absence of a statutory provision limiting its authority to do so, an agency has plenary authority to decide matters committed to it by the legislature. That authority includes the authority to withdraw an order and to reconsider the decision embodied in the order. The Workers' Compensation Board has been granted the authority by the legislature to decide claims. ORS 656.295. With one exception, there is nothing in ORS 656.295 limiting the power of the Board, after having issued a decision on a claim, to withdraw it. The exception is in subsection (8) of ORS 656.295:

> "An order of the board is final unless within 30 days after the date of mailing of copies of such order to the parties, one of the parties appeals to the Court of Appeals for judicial review pursuant to ORS 656.298. The order shall contain a statement

[1] ORS 183.482(6) provides, in relevant part:

> "(6) At any time subsequent to the filing of the petition for review and prior to the date set for hearing the agency may withdraw its order for purposes of reconsideration. If any agency withdraws an order for purposes of reconsideration, it shall, within such time as the court may allow, affirm, modify or reverse its order. If the petitioner is dissatisfied with the agency action after withdrawal for purposes of reconsideration, the petitioner may file an amended petition for review and the review shall proceed upon the revised order."

ORAP 5.35 implements ORS 183.482(6). The Board did not comply with the provisions of the rule when it issued its June 17 order withdrawing the May 18 order on review.

[2] The legislative history of House Bill 2900, Or Laws 1987, ch 884, making significant changes in the Workers' Compensation Law, may relate to the holding in *Fisher.* Section 12a of HB 2900 replaced certain provisions in ORS 656.298(6) regarding the scope of this court's review in workers' compensation cases with this provision: "Review shall be as provided in ORS 183.482(7) and (8)." The fact that HB 2900 adopted specific subsections of ORS 183.482 is some evidence of legislative intent to exclude the application of the remaining subsections of ORS 183.482, including the one relevant here, ORS 183.482(6). That conclusion is bolstered by the fact that, as originally introduced, HB 2900 would have adopted ORS 183.482 *in toto.* HB 2900 was amended in committee to adopt only subsections (7) and (8). Senator Hill explained that "there is a lot in ORS 183.482 that is redundant and not appropriate to apply to this procedure—ORS 183.482 language is redundant to procedure provided in the workers' compensation law. The elements to be included are those contained in (7) and (8)." Tape Recording, Senate Committee on Labor, June 9, 1987.

ORS 183.482(6) is not redundant of anything in ORS chapter 656, because chapter 656 does not contain any provision for the Workers' Compensation Board to reconsider its orders and does not deal with the effect of a petition for judicial review on the Board's ability to reconsider an order. Apart from his statement, there is no evidence that Senator Hill or any other legislator intended to overrule the specific holding of *SAIF v. Fisher, supra,* that ORS 183.482(6) applies to judicial review of workers' compensation decisions.

explaining the rights of the parties under this subsection and ORS 656.298."

We hold that the Board has the authority to withdraw an

order for the purpose of reconsideration at the request of a party or on its own motion, provided that it does so before the order becomes final under ORS 656.295(8).

The question then arises whether the fact that a petition for judicial review has been filed affects the authority of the Board to withdraw an order for reconsideration if the Board acts before the order becomes final. The answer is no. There is no provision in either ORS chapter 656 or ORS chapter 183 that limits the authority of the Board to reconsider an order *before* it becomes final, regardless of whether a petition for judicial review has been filed. ORS 19.033(1),[3] which expressly limits the jurisdiction of a trial court after a notice of appeal has been filed, does not apply.

We need not decide whether, when the Board has exercised its authority to withdraw an order before it has become final, a party who had already filed a petition for judicial review is required to file a new or amended petition after the Board issues a new order, because the Board did not issue a new, reviewable order here. The Board did not redecide the case after granting reconsideration, as it was obligated to do. This case remains pending before the Board, because the Board has not issued a decision on reconsideration.

Because claimant's motion to dismiss is premised on the contention that SAIF failed to petition for judicial review of the July 20 order, we deny that motion. We dismiss this judicial review on our own motion, because there is no final order.

Motion to dismiss denied; judicial review dismissed on the court's own motion.

[3] ORS 19.033(1) provides:

"(1) When the notice of appeal has been served and filed as provided in ORS 19.023, 19.026 and 19.029, the Supreme Court or the Court of Appeals shall have jurisdiction of the cause, pursuant to rules of the court, but the trial court shall have such powers in connection with the appeal as are conferred upon it by law and shall retain jurisdiction for the purpose of allowance and taxation of attorney fees, costs and disbursements or expenses pursuant to rule or statute. If the trial court allows and taxes attorney fees, costs and disbursements or expenses after the notice of appeal has been served and filed, any necessary modification of the appeal shall be pursuant to rules of the appellate court."

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
James A. Ross, Claimant.

ROSS,
Petitioner,

v.

FLIGHTCRAFT, INC., et al,
Respondents.

(WCB 87-15924; CA A60060)

Judicial Review from Workers' Compensation Board.

Argued and submitted November 13, 1989.

Robert Wollheim, Portland, argued the cause for petitioner. With him on the brief was Welch, Bruun and Green, Portland.

Stafford J. Hazelett, Portland, argued the cause and filed the brief for respondents.

Before Graber, Presiding Judge, and Riggs and Edmonds, Judges.

GRABER, P. J.

Affirmed.

GRABER, P. J.

Claimant seeks review in this workers' compensation case. We review for substantial evidence and errors of law, ORS 656.298(6), and affirm.

The referee set aside employer's denial of compensability on claimant's occupational disease claim. On *de novo* review, the Workers' Compensation Board reversed. It concluded that claimant had failed to prove by a preponderance of the evidence, *see Hutcheson v. Weyerhaeuser,* 288 Or 51, 55-56, 602 P2d 268 (1979), that his employment was the major contributing cause of his hearing loss. *See former* ORS 656.802(1)(a); *Dethlefs v. Hyster Co.,* 295 Or 298, 310, 667 P2d 487 (1983).

Claimant first argues that the Board reversed "the referee without making a sufficient final order for this court to review." In *Johnston v. James River Corporation,* 91 Or App 721, 722, 756 P2d 696 (1988), we held that, "[w]hen the Board reverses, adequate judicial review requires specific findings in the Board's opinion substantiating its contrary conclusion." Here, the Board found that claimant had been exposed to noise off the job, as well as on the job. It noted that he had presented no expert opinion concerning the cause of his hearing loss, because his treating physician offered no opinion on that issue. The Board also found that the audiometric test results that demonstrated claimant's hearing loss did not establish a causal relationship. Although it found claimant's

testimony credible, it reasoned that his testimony was "insufficient to establish the necessary causal relationship in this medically complex claim[,]" citing *Kassahn v. Publishers Paper Co.*, 76 Or App 105, 109, 708 P2d 626 (1985), *rev den* 300 Or 546 (1986). Those findings and that reasoning were adequate to substantiate a conclusion contrary to that of the referee. *See Johnston v. James River Corporation, supra,* 91 Or App at 722. The order is sufficient for judicial review. *See Johnston v. James River Corporation, supra; Armstrong v. Asten-Hill Co.*, 90 Or App 200, 207, 752 P2d 312 (1988).

Claimant's second assignment of error is that "the Board erred in holding that claimant's hearing loss was not compensable." The Board applied the correct legal standard. It made sufficient findings, all of which are supported by substantial evidence. ORS 183.482(8)(c); *Armstrong v. Asten-Hill Co., supra,* 90 Or App at 206. Its reasoning from the facts to the conclusion is not unsound.

Affirmed.

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410 February 14, 1990 No. 56

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of
Charles M. Kepford, Claimant.
WEYERHAEUSER COMPANY,
Petitioner,
v.
KEPFORD,
Respondent.
(87-02846; CA A60272)

In Banc*

Judicial Review from Workers' Compensation Board.

Argued and submitted October 20, 1989; resubmitted in banc January 10, 1990.

Paul L. Roess, Portland, argued the cause for petitioner. With him on the brief was Acker, Underwood, Norwood & Hiefield, Portland.

James L. Edmunson, Eugene, argued the cause for respondent. On the brief were Christopher D. Moore and Malagon, Moore & Johnson, Eugene.

BUTTLER, J.

Reversed in part and remanded for reconsideration of penalty, excluding consideration of employer's failure to pay benefits; otherwise affirmed.

Joseph, Chief Judge, concurring in part; dissenting in part.

Rossman, J., dissenting.

* Warren, J., not participating.

BUTTLER, J.

Employer seeks review of a Workers' Compensation Board order requiring it to pay claimant temporary total disability benefits from February 20, 1981, the date of the onset of his disability.

Claimant, age 63 at the time of the hearing, has not worked since February 20, 1981, when he left his job because of back pain. He underwent surgery in October, 1981, and sought compensation for an aggravation of a 1974 compensable injury. Employer denied the claim, whereupon claimant filed a new claim based on an occupational disease theory. Employer also denied that claim. A referee and the Board upheld the denials. Claimant sought review in this court only on the occupational disease claim.

Meanwhile, in November, 1982, claimant began receiving Social Security disability benefits retroactive to August, 1981. In May, 1983, at the suggestion of employer, claimant applied for and received employer provided disability retirement benefits retroactively to 1981. In January, 1986, we held that the occupational disease claim was compensable and remanded the claim to the Board for a determination of the extent of disability. *Kepford v. Weyerhaeuser Co.*, 77 Or App 363, 713 P2d 625, *rev den* 300 Or 722 (1986).

After our decision, employer submitted for closure the aggravation claim, rather than the occupational disease claim on which we had based our decision. It has not paid any benefits for time loss to this date, reasoning that claimant has been retired and, therefore, is not entitled to them. Claimant sought a hearing. At the time of the hearing in this proceeding, claimant had not been declared medically stationary and had not been released for work. He had, however, apparently withdrawn from the work force by May, 1983, at the latest, when he applied to employer for retirement benefits.

The Board, in affirming the referee, ordered employer to process the claim as an occupational disease claim and to pay claimant time loss from the date of the onset of disability until the claim is closed. It also assessed a penalty for employer's refusal to pay benefits for temporary total disability. The question is whether claimant is entitled to benefits for temporary total disability for the time after he began

receiving Social Security disability and retirement benefits from employer.

In *Cutright v. Weyerhaeuser Co.*, 299 Or 290, 702 P2d 403 (1985), the worker had voluntarily withdrawn from the work force for reasons unrelated to his compensable injury *after* the claim had been closed and before he filed an aggravation claim. The court stated that one who retires voluntarily from the work force is no longer to be compensated for time loss under the Workers' Compensation Law. It went on to say that payment of temporary total disability compensation is intended to provide wage replacement and that one who has voluntarily retired from the labor market cannot lose wages and is not, therefore, entitled to benefits for temporary total disability.

After *Cutright*, we decided several cases involving entitlement to benefits after retirement and, relying on *Cutright*, held that a person who has retired is not entitled to temporary total disability benefits. *Dawkins v. Pacific Motor Trucking*, 91 Or App 562, 756 P2d 60 (1988), *reconsideration granted and former opinion adhered to* 93 Or App 349, 762 P2d 329, *rev'd* 308 Or 254, 778 P2d 497 (1989); *Sykes v. Weyerhaeuser Company*, 90 Or App 41, 750 P2d 1171 (1988); *Karr v. SAIF*, 79 Or App 250, 719 P2d 35, *rev den* 301 Or 765 (1986). However, in each of those cases, like *Cutright*, the facts showed that the worker had retired *after* the initial closure of his claim and *before* the filing of an aggravation claim, but we did not rely on those facts, because *Cutright* did not appear to focus on them. None presented the question of the effect of a worker's retirement during the processing, and before closure, of a claim, *i.e.*, during the time when the employer would otherwise be obligated to pay benefits for temporary total disability.

It was not until the Supreme Court, on review of *Dawkins v. Pacific Motor Trucking, supra*, that the court focused on the significance of the time of a claimant's withdrawal from the work force on the claimant's entitlement to temporary total disability benefits arising out of an aggravation.[1] The court reiterated its holding in *Cutright v.*

Weyerhaeuser Co., supra, and then considered the principal question presented: What constitutes a withdrawal from the work force that will preclude a claimant's entitlement to temporary total disability benefits for an aggravation? It concluded:

> "To receive temporary total disability upon aggravation of a work-related injury, the claimant must be in the work force *at the time* of the aggravation. *Cutright v. Weyerhaeuser Co., supra.* A claimant is deemed to be in the work force if:
>
> "a. The claimant is engaged in regular gainful employment; or
>
> "b. The claimant, although not employed at the time, is willing to work and is making reasonable efforts to obtain employment, *Cutright v. Weyerhaeuser Co., supra, see* ORS 656.206(3); or
>
> "c. The claimant 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. *Cf. SAIF v. Stephen*, 308 Or 41, 47-48, 774 P2d 1103 (1989)." 308 Or at 258. (Emphasis supplied.)

Dawkins makes it clear that the critical time for determining whether a claimant has withdrawn from the work

[1] The court stated:

"Our inquiry focuses on whether claimant had withdrawn from the work force *at the time of the aggravation* of his prior work-related injury." (Emphasis supplied.) 308 Or at 257.

force is at the time of his disability.[2] It also makes it clear that, even though a claimant has applied for and received disability benefits from Social Security and disability retirement benefits from his union *before* his disability, he may be entitled to temporary total disability benefits if he can show that he fulfilled the requirements of criterion (c) at the time of his disability.[3]

Here, claimant was working and was, therefore, a member of the work force when he became disabled by his occupational disease. It matters not that he retired or had withdrawn from the work force after that time. Under

Dawkins, he need not show that he remained in the work force. Because he was entitled to receive benefits for temporary total disability at that time, he was entitled to continue to receive them until he became medically stationary and was released for work, ORS 656.325(5),[4] *Fazzolari v. United Beer Distributors,* 91 Or App 592, 757 P2d 857, *rev den* 307 Or 236 (1988), at which time employer was entitled to close his claim. ORS 656.268. We agree with the Board that employer, having been ordered to accept the occupational disease claim, should have processed it as if it had been accepted from the outset and should have paid benefits accordingly, including benefits for temporary total disability, to the date of claim closure. *Vip's Restaurant v. Krause,* 89 Or App 214, 748 P2d 164, *on reconsideration* 91 Or App 472, 756 P2d 47, *rev den* 306 Or 414 (1988).

Employer also contends that the Board should not have assessed a penalty for its failure to pay benefits for temporary disability for the time after claimant had retired because, in the light of the advice that it had received from its legal counsel that benefits for temporary total disability are not payable to a retired worker, it did not act unreasonably. We agree that, in view of some confusion in the state of the law at that time, employer's conduct in that respect was not unreasonable. However, the Board assessed the penalty on other grounds as well, including employer's failure to characterize the claim as disabling and its failure to submit the occupational disease claim to the Evaluation Division for closure. We remand to the Board for reconsideration of the penalty in the light of our decision.

Reversed in part and remanded for reconsideration of penalty excluding consideration of employer's failure to pay benefits; otherwise affirmed.

[2] Although *Dawkins* involved an aggravation of a work-related injury, we perceive no reason why the court would view a post-injury or post-occupational disease withdrawal from the work force differently. The parties do not dispute the Board's finding that claimant left work on February 20, 1981, on account of his disability. We treat that date as the "date of injury."

[3] In *Dawkins,* the court remanded the case to the Board to determine whether the claimant had satisfied criterion (c), even though he was receiving Social Security and retirement benefits at the time of his aggravation.

[4] ORS 656.325(5) provides:

> "Notwithstanding ORS 656.268, an insurer or self-insured employer shall cease making payments pursuant to ORS 656.210 and shall commence making payment of such amounts as are due pursuant to ORS 656.212 when an injured worker refuses wage earning employment prior to claim determination and the worker's attending physician, after being notified by the employer of the specific duties to be performed by the injured worker, agrees that the injured worker is capable of performing the employment offered."

JOSEPH, C. J., concurring in part; dissenting in part.

I concur with the lead opinion that claimant is entitled to total temporary disability benefits.

I dissent from the lead opinion in respect to the penalty assessed against employer for failure to pay temporary disability benefits. The lead opinion says that it was not unreasonable for employer to rely on the advice of its counsel that it was not required to pay benefits because claimant had retired. In the face of ORS 652.268, employer had no right to rely on bad legal advice. Its conduct in that respect was, therefore, unreasonable. The Board properly assessed the penalty.

Graber, J., joins in this opinion.

ROSSMAN, J., dissenting.

I dissent.

The way I see it, workers' compensation is for "workers."[1] Claimant is not a "worker." Therefore, claimant is not entitled to compensation.[2] End of case.[3]

Accordingly, I dissent.[4]

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[1] Perhaps the reason that I find this case so bothersome is that it epitomizes how worker's compensation, which was intended to be an understandable and straightforward system, has been transformed into a complicated, legalistic maze.

[2] The purpose of the Workers' Compensation Act is to provide wage replacement and medical benefits for *workers* who sustain compensable injuries. *Cutright v. Weyerhaeuser Co.*, 299 Or 290, 296, 702 P2d 403 (1985). Because "a person who has withdrawn from the work force has lost no wages," the person is not entitled to temporary total disability payments. *Karr v. SAIF*, 79 Or App 250, 253, 719 P2d 35, *rev den* 301 Or 765 (1986). In this case, it is undisputed that claimant had retired by May, 1983. It follows that, having ceased to be a worker, he became ineligible to receive temporary total disability benefits at that time.

[3] It is difficult to be too critical of the majority, because *Dawkins v. Pacific Motor Trucking*, 308 Or 254, 778 P2d 497 (1989), supports the conclusion that a claimant may be considered to be in the work force, notwithstanding retirement. Nevertheless, the opinion is disturbing in that it directs an employer to pay benefits to claimant for the same time period during which he received payment from Social Security and employer's retirement plan. In my view, *Dawkins* should be distinguished on the basis that it did not involve a claimant who had accepted retirement benefits from his employer. The fact that claimant in this case has done so proves that he is no longer willing to work and has permanently withdrawn from the workforce.

[4] I agree with the majority that, given the ongoing confusion in the state of the law regarding when a retired worker is entitled to benefits for temporary total disability, the employer did not act unreasonably when it failed to pay claimant for the time after he retired. Therefore, assuming that claimant was entitled to the benefits, the Board should not have assessed it a penalty. I would not reach that issue, however, because, in my view, the Board should not have required the employer to pay the benefits in the first place.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Marcia M. McKellips, Claimant.

LIBERTY NORTHWEST INSURANCE CORPORATION et al,
Appellants,

v.

McKELLIPS,
Respondent.

(8807-04068; CA A60996)

Appeal from Circuit Court, Multnomah County.

Donald H. Londer, Judge.

Argued and submitted January 12, 1990.

Stafford J. Hazelett, Portland, argued the cause and filed the brief for appellants.

No appearance for respondent.

Before Graber, Presiding Judge, and Riggs and Edmonds, Judges.

PER CURIAM

Reversed.

PER CURIAM

The only issue in this workers' compensation case is claimant's entitlement to attorney fees. After a hearing, a referee published an order. Employer sought Board review but withdrew its request before the Board considered the case. The Board dismissed the request for review and held:

> "The request for an attorney fee is denied. Where an insurer's or employer's request for Board review is dismissed prior to a decision on the merits, claimant is not entitled to an attorney fee. *Agripac, Inc. v. Kitchel,* 73 Or App 132[, 698 P2d 69] (1985) * * *." (Other citations omitted.)

Claimant appealed the denial of attorney fees to the circuit court, ORS 656.388(2), which awarded fees. Employer appeals, and we reverse.

The Board correctly held that claimant cannot receive fees under ORS 656.382(2),[1] because the Board did not

[1] 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."

[2] ORS 656.386(1) provides, in pertinent part:

> "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."

make the finding that the statute requires to support an award of fees. *Agripac, Inc. v. Kitchel, supra.* Neither does ORS 656.386(1)[2] allow the award, because the referee did not deny benefits, claimant did not request Board review, and claimant did not "finally prevail." *Shoulders v. SAIF,* 300 Or 606, 616, 716 P2d 751 (1986). "Attorney fees may only be awarded in workers' compensation cases if they are authorized by statute." *SAIF v. Peoples,* 59 Or App 593, 596, 651 P2d 1359 (1982). There is no such authority.

Reversed.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Robert D. Armstrong, Claimant.

ASTEN-HILL COMPANY et al,
Petitioners,

v.

ARMSTRONG,
Respondent.

(WCB No. 86-02776; CA A51176)

Judicial Review from Workers' Compensation Board.

Argued and submitted September 18, 1989.

Paul L. Roess, Portland, argued the cause for petitioners. With him on the brief was Acker, Underwood, Norwood & Hiefield, Portland.

Arthur P. Klosterman, Salem, argued the cause for respondent. With him on the brief was The Law Offices of Brian R. Whitehead, Salem.

Before Joseph, Chief Judge, and Newman and Deits, Judges.

JOSEPH, C. J.

Reversed and remanded for reconsideration.

JOSEPH, C. J.

Employer seeks review of an order of the Workers' Compensation Board affirming the referee's decision that claimant's chronic rhinitis condition was worsened by his working environment and is, therefore, compensable. Reviewing for substantial evidence, we reverse and remand. ORS 656.298(6); ORS 183.482(8).

Claimant worked for employer as a weaver for seven years. He was exposed to dust and fibers from the milling of asbestos, cotton, fiberglass and acrylic materials. Employer no longer uses asbestos and cotton fibers, but 20 to 50 percent of the material presently used is fiberglass or acrylic, and particles are released into the air from those substances.

Claimant has a history of hay fever, allergic rhinitis, pneumonia and bronchitis. He is allergic to house dust and has an increased tendency to catch colds and flu, because his children bring home viruses. He rides a bicycle in cold weather, and that aggravates his symptoms. His home is drafty and, during the winter, its average temperature is 60 degrees. He heats the house with firewood and cuts the wood himself. He once cut firewood for commercial sale for approximately 4 months but quit on his doctor's advice. He suffers from chronic rhinitis, an inflammation of the nasal mucosa characterized by post nasal drainage, sneezing, nasal itching and nasal congestion.

Claimant last worked for employer in December, 1985. In January, 1986, he took a 30-day medical leave of absence. On January 24, 1986, he filed a claim for compensation for nosebleeds and headaches, alleging that those symptoms were caused by the working conditions. Employer denied the claim. Claimant requested a hearing on the compensability of the nosebleeds only. The referee found that the work environment had worsened the rhinitis. The Board reversed. On review, we remanded because, under recent amendments to the Workers' Compensation Law, its order was inadequate for our review. *Armstrong v. Asten-Hill Co.*, 90 Or App 200, 752 P2d 312 (1988). On remand the Board found the claim compensable.

At issue is whether claimant's rhinitis worsened in late 1985 and early 1986 and, if so, whether his work exposure

was the major contributing cause. *Devereaux v. North Pacific Ins. Co.*, 74 Or App 388, 391, 703 P2d 1204, *rev den* 300 Or 162 (1985). The medical evidence was in conflict as to whether an aggravation of symptoms, *i.e.*, nosebleeds, increased congestion and nasal drainage, reflected a worsening of the underlying disease. A worsening of symptoms alone is not compensable. *Stupfel v. Edward Hines Lumber Co.*, 288 Or 39, 602 P2d 264 (1979).

The Board relied on expert opinions from Dr. Parosa and Dr. Montanaro. Parosa stated that an increase in symptoms results from a pathological change in the nasal tissue and is symptomatic of a worsening of the underlying condition.

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[1] The Board stated:

"* * * His testimony regarding the correlation between an increase in symptoms and a worsening of the underlying condition is ambiguous. Early in his testimony he stated:

" 'Well, I feel that . . . irritant exposures, either in the workplace or away from the workplace, may result in a significant worsening of — of symptoms. Symptoms do not imply that there are underlying *significant* pathologic changes. We have individuals who have runny noses, sneezing, who, if you go in and look at them have *very little* in the way of pathologic changes. If you biopsy that tissue, it would not show any *significant* pathologic changes.' (Emphasis added [by the Board]).

"Later in his testimony, Dr. Montanaro opined 'that a change in a physiologic condition from minute to minute or day to day may not result in a *long term* change in a disease or a condition. . . .' (Emphasis added [by the Board]).

"* * * * *

"We conclude, however, based upon the foregoing, that Dr. Montanaro was of the opinion claimant did suffer a worsening of his condition albeit a worsening that was neither 'significant' nor 'long term.' "

Montanaro stated that day to day symptomatic changes may mean that there have been physiological changes but does not reflect a change in the underlying disease process. The Board, however, read his testimony as saying that the disease process has worsened.[1] Having read both experts' testimony to say that both agreed, it concluded that the condition had worsened. The Board also concluded, partly on the basis of its characterization of Montanaro's testimony, that the working conditions were the major cause of the worsening.

The Board substantially misstated Montanaro's testimony.[2] The only reasonable reading is that he said that it

was clear that only claimant's symptoms, not the underlying, pre-existing condition, had worsened. Because of that misstatement, we cannot say whether there is substantial evidence to support the Board's conclusion on compensability. *See Armstrong v. Asten-Hill Co., supra,* 90 Or App at 206. Because we cannot know what the Board would have concluded about claimant's condition if it had not misread Montanaro's testimony unreasonably, we must again remand for reconsideration.

Reversed and remanded for reconsideration.

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[2] Montanaro also testified:

"I think that—that the [work] environment itself was not a high risk involve—environment leading to any further material worsening of * * * that underlying condition * * *.

"* * * * *

"I feel a condition is—that a condition, as we use it in this arena, is a pathologic event, a disease process, if you will. I feel an individual may have symptoms in which you can see physiologic alterations in which a disease process or a pathologic process has not taken place.

"* * * * *

"Q. Okay, now, I note on page five of your report you said that 'the exposure at Asten-Hill resulted [in] only a temporary aggravation of symptoms and would not be related to his present condition.'

"A. That's correct."

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Robert W. Ashley, Claimant.

ASHLEY,
Petitioner,

v.

UNIVERSITY OF OREGON et al,
Respondents.

(WCB No. 86-11499; CA A50458)

Judicial Review from Workers' Compensation Board.

Argued and submitted September 18, 1989.

David C. Force, Eugene, argued the cause and filed the brief for petitioner.

John A. Reuling, Jr., Assistant Attorney General, Salem, argued the cause for respondents. 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.

PER CURIAM

Affirmed.

PER CURIAM

Claimant seeks review of an order of the Workers' Compensation Board that dismissed his claim for penalties and attorney fees for lack of jurisdiction. We affirm.

SAIF did not pay benefits that the Board ordered it to pay claimant and to reimburse his private health care provider. Claimant requested a hearing to enforce the Board's order; he also sought penalties and attorney fees. At the hearing, SAIF agreed to pay a penalty and attorney fees for its delay in compensating claimant. It did not, however, concede that its delay in reimbursing the health care provider was unreasonable. The referee agreed that that delay was not unreasonable and denied penalties and attorney fees. Claimant appealed that decision to the Board, which concluded that it, and the referee, lacked jurisdiction over the reimbursement issue and dismissed the appeal.

Claimant's right to compensation was not affected by the delayed payment to the health care provider. Therefore, the reimbursement dispute was not a "matter * * * concerning a claim." Neither the Hearings Division nor the Board has jurisdiction over matters that do not concern a claim. ORS 656.704(3); *Lloyd v. Employee Benefits Ins. Co.*, 96 Or App 591, 594, 773 P2d 798 (1989); *see also Howard v. Liberty Northwest Ins.*, 94 Or App 283, 765 P2d 223 (1988).

Affirmed.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Carol J. Knapp, Claimant.
WEYERHAEUSER COMPANY,
Petitioner,
v.
KNAPP,
Respondent.
(WCB 86-02762; CA A60802)

Judicial Review from Workers' Compensation Board.

Argued and submitted December 11, 1989.

Daniel M. Spencer, Coos Bay, argued the cause for petitioner. With him on the brief was Foss, Whitty, Littlefield & McDaniel, Coos Bay.

Michael R. Stebbins, North Bend, argued the cause for respondent. With him on the brief was Stebbins & Coffey, North Bend.

Before Graber, Presiding Judge, and Riggs and Edmonds, Judges.

GRABER, P. J.

Reversed and remanded.

GRABER, P. J.

This workers' compensation case is before us for the third time.[1] We take the facts from our opinion in *Knapp v. Weyerhaeuser Co.*, 93 Or App 670, 672-73, 763 P2d 746 (1988), *rev den* 307 Or 326 (1989):

> "From January to September, 1983, while working for employer, claimant experienced back pain and saw Dr. Bert for treatment and medication. In September, she was laid off from her job for reasons unrelated to her back. She continued to receive treatment and, in August, 1984, underwent back surgery. On October 4, 1984, employer denied a claim for an occupational disease. Claimant sought a hearing, at which she testified that, because of her back problem, she had not worked for wages after September, 1983. In an order dated June 20, 1985, the referee determined that the claim, including the back surgery of August 23, 1984, was compensable. He reversed employer's denial but did not remand the case to employer for payment of compensation. The Board affirmed. Employer did not pay benefits for temporary total disability, apparently reasoning, in reliance on *Cutwright v. Weyerhaeuser Co.*, 299 Or 290, 702 P2d 403 (1985), that, because claimant had been laid off since September, 1983, she was not entitled to any benefits for time loss.

[1] In the first review, we affirmed the Board's order of June 17, 1986, without opinion. *Weyerhaeuser Company v. Knapp*, 85 Or App 220, 736 P2d 230 (1987). That order required employer to pay temporary total disability benefits from the date when claimant's treating physician authorized time loss.

"Claimant sought another hearing. The evidence showed that, after she was laid off, she looked for work and drew unemployment compensation from September, 1983, until July, 1984, and that her doctor had authorized time loss from June 22, 1984. On October 11, 1985, another referee ordered employer to pay temporary total disability benefits, offset by any unemployment compensation that claimant had received, from June 22, 1984, 'until termination * * * is appropriate.' The Board affirmed that order on June 17, 1986.

"In the meantime, on November 22, 1985, employer wrote to claimant, advising her that it had just learned that she had reported to the Employment Division that she had earnings of $785 for the period from April 29, 1984, through July 22, 1984. The letter went on to state that claimant's treating physician apparently had had no knowledge of the work resulting in those earnings and that the clinical evidence showed that

claimant experienced a worsening of her back condition during the same period. Because claimant's treating physician had testified that claimant's worsened back condition was the result, in part, of off-the-job activity, employer reasoned that work claimant may have performed from April 29, 1984, to July 22, 1984, contributed to the condition for which surgery was performed in August, 1984. Accordingly, employer denied responsibility for the condition it had been ordered by the first referee to accept in 1984.

"Claimant received the denial on November 23, 1985. Her attorney received a copy on November 25, 1985. He read it on December 2, 1985, and understood it to be a denial, but did not file a request for hearing until February 24, 1986. The Board, affirming the second referee, dismissed the request for hearing as untimely, because claimant had not established good cause."

We reversed and remanded on the ground that employer could not mount a "collateral challenge to a final order of the Board." 93 Or App at 673.

On remand, the Board assessed a penalty, because it found employer's denial to have been unreasonable. The order provides:

"For its unreasonable conduct, the employer shall also pay claimant a penalty equal to 25 percent of the temporary disability compensation due under this order."

Employer seeks review. Its sole argument is that the Board lacked authority to impose a penalty on amounts that will become due after the date of the order until claim closure. We agree and reverse and remand for a recalculation of the penalty.

ORS 656.262(10) provides:

"If the insurer or self-insured employer unreasonably delays or unreasonably refuses to pay compensation, or unreasonably delays acceptance or denial of a claim, the insurer or self-insured employer shall be liable for an additional amount up to 25 percent of *the amounts then due* plus any attorney fees which may be assessed under ORS 656.382." (Emphasis supplied.)

The "amounts then due" for employer's unreasonable denial were the amounts of compensation due when the denial was

set aside. *See Wacker Siltronic Corporation v. Satcher,* 91 Or App 654, 658, 756 P2d 679 (1988).

Claimant argues, first, that ORS 656.262(10) authorizes the penalty to be based on all amounts due, that is, on "temporary total disability benefits until claim closure." That reading fails to give effect to the word "then." Second, claimant asserts that employer's interpretation does not result in a penalty that is large enough to compensate for "the wrong done." Whether or not claimant is correct, the Board is limited to exercising the authority that the legislature has granted it. Moreover, if employer has complied with the Board's most recent order, it will not have unreasonably delayed or denied the payments that became due after the date of the order.

Reversed and remanded.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Donald S. Wincer, Claimant.

INDEPENDENT PAPER STOCK et al,
Petitioners,

v.

WINCER,
Respondent.

(WCB 86-0406M; CA A50113)

Judicial Review from Workers' Compensation Board.

Argued and submitted November 13, 1989.

Jerald P. Keene, Portland, argued the cause for petitioners. With him on the brief was Roberts, Reinisch & Klor, P.C., Portland.

Nelson R. Hall, Portland, argued the cause for respondent. With him on the brief was Pozzi, Wilson, Atchison, O'Leary & Conboy, Portland.

Before Graber, Presiding Judge, and Riggs and Edmonds, Judges.

RIGGS, J.

Reversed and remanded.

RIGGS, J.

Employer seeks review of a Workers' Compensation Board order on reconsideration, arguing that, as a result of 1987 statutory amendments, the Board has no authority to award permanent disability benefits on its own motion after January 1, 1988. We reverse and remand.

In June, 1976, claimant filed a back injury claim that was accepted in January, 1977. The claim was closed and reopened several times from 1977 until January, 1985. In July, 1986, the referee found that claimant had exhausted his rights to request further openings and benefits and that he would need to pursue additional benefits under the Board's own motion jurisdiction. ORS 656.278. In August, 1986, pursuant to an own motion order, the claim was reopened, effective December, 1985.

Claimant was declared medically stationary as of January, 1988, and in July, 1988, the Board issued an own motion order awarding him "permanent total disability commencing January 20, 1988." In September, 1988, the Board issued an order on reconsideration, adhering to its previous decision.

In the order on reconsideration, the Board recognized that, under the current version of ORS 656.278, "our Own Motion authority is limited to granting temporary disability * * * [and] we lack authority to award permanent partial or permanent total disability." However, it awarded claimant permanent disability benefits, reasoning that the current version of the statute does not apply. Citing OAR 438-12-018, the Board concluded that, because the claim was open before the January 1, 1988, changes became effective, "claim closure was conducted in accordance with the law and rules in effect on the date the claim was ordered reopened."

Employer argues that the Board erred in awarding claimant permanent total disability after January 1, 1988, the operative date of the 1987 amendments that deprived it of the authority to make such an award. It also argues that the Board's reliance on OAR 430-12-018 was improper, because the rule impermissibly exceeds statutory authority. We agree with both contentions.

Previously, ORS 656.278 contained broad language

that authorized the Board, on its own motion, to "[m]odify, change or terminate former findings, orders or awards if in its opinion such action is justified."[1] ORS 656.278(1)(a). In 1987, the legislature amended the statute by adding additional limiting language abolishing the Board's authority to award permanent disability benefits on own motion claims.[2] Or Laws

[1] Previously, ORS 656.278(1) provided:

"Except as provided in subsection (5) of this Section, the power and jurisdiction of the Board shall be continuing, and it may, upon its own motion, from time to time, modify, change or terminate former findings, orders or awards if in its opinion such action is justified."

[2] Currently, ORS 656.278(1) provides:

"Except as provided in subsection (5) of this Section, the power and jurisdiction of the Board shall be continuing, and it may, upon its own motion, from time to time, modify, change or terminate former findings, orders or award if in its opinion such action is justified in those cases in which:

"(a) there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. In such cases, the Board may authorize the payment of temporary disability compensation from the time the worker is actually hospitalized or undergoes outpatient surgery until the worker's condition becomes medically stationary, as determined by the board; or

"(b) the date of injury is earlier than January 2, 1966. In such cases, in addition to the payment of temporary disability compensation, the Board may authorize payment of medical benefits."

1987, ch 884, § 37. The operative date of the amendment was January 1, 1988, "[n]otwithstanding ORS 656.202."[3] Or Laws 1987, ch 884, § 62.[4] To implement the statutory changes, the Board adopted new administrative rules effective December, 1987. OAR 438-12-018, in pertinent part, provides:

> "These rules apply only to claims in which a request for compensation under the Board's own motion is made on or after January 1, 1988. *All claims reopened under ORS 656.278 on*

> *or before December 31, 1987 shall be continued and closed by the Board under the laws and rules in effect on the date the claim was ordered reopened.*" (Emphasis supplied.)

ORS 656.202 embodies the general rule that we look to the law in effect at the time of the claim, unless there is a clear legislative directive to do otherwise, which there is here. By specifically providing that the amendment to the own motion statute become operative "notwithstanding ORS 656.202," the legislature expressly intended that the Board's authority to award permanent disability cease after January 1, 1988, despite the statute that generally preserves the application of the law in effect at the time of a claim. By promulgating OAR 438-12-018, the Board exceeded its authority.

Oregon Laws 1987, chapter 884, section 62, also provides that amendments to certain listed statutes "shall apply to all claims which become medically stationary on or after January 1, 1988," and excludes the amendment to ORS 656.278.[5] The Board's promulgation of OAR 438-12-018 circumvents that exclusion. Consequently, we conclude that the rule is impermissible, and the Board erred in relying on it to award claimant permanent disability. The Board lacked own motion authority to make a permanent disability award, "commencing January 20, 1988."

Reversed and remanded.

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[3] ORS 656.202(2) provides:

> "Except as otherwise provided by law, payment of benefits for injuries or deaths under [the Workers' Compensation Act] * * * shall be continued as authorized, and in the amounts provided for, by the law in force at the time the injury giving rise to the right of compensation occurred."

[4] Oregon Laws 1987, chapter 884, section 62, provides, in pertinent part:

> "(1) *Notwithstanding ORS 656.202, amendments by this Act to* ORS 656.245, 656.254, 656.262, *656.278,* 656.298, 656.388, 656.538, 656.622, 656.794 and Sections 17, 18, 28, 29, 30, 31, 33 and 41 of this Act *become operative January 1, 1988.*" (Emphasis in original.)

In *Armstrong v. Asten-Hill Company,* 90 Or App 200, 204 n 3, 752 P2d 312 (1988), we noted that "[t]he apparent purpose of [§ 62(1)] is to avoid the possible application of ORS 656.202 to cases subject to the 1987 Act's amendments."

[5] Oregon Laws 1987, chapter 884, section 62(2), provides, in pertinent part:

> "For the purposes of ORS 656.202, amendments by this Act to ORS 656.218, 656.268, 656.283, 656.295 and 656.319 shall not be considered to be the payment of benefits and shall apply to all claims which become medically stationary on or after January 1, 1988."

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Michael J. Harvey, Claimant.

HALLMARK FISHERIES et al,
Petitioners,

v.

HARVEY,
Respondent.

(87-06987; CA A61323)

Judicial Review from Workers' Compensation Board.

Argued and submitted January 12, 1990.

Paul L. Roess, Portland, argued the cause for petitioners. With him on the brief was Acker, Underwood, Norwood & Hiefield, Portland.

James L. Edmunson, Eugene, argued the cause for respondent. With him on the brief was Malagon, Moore & Johnson, Eugene.

Before Graber, Presiding Judge, and Riggs and Edmonds, Judges.

PER CURIAM

Affirmed.

PER CURIAM

Employer seeks review of an order of the Worker's Compensation Board awarding claimant temporary total disability (TTD) benefits. Claimant injured his back while working for employer. He filed a claim and received TTD. He returned to work before his claim was closed, but was fired for smoking marijuana on the work site two days later. On March 5, 1987, while still unemployed, claimant was declared by his treating physician to be physically unable to work, due to his work-related injury.

Employer argues that the Board's order is inadequate for judicial review, because there was no finding of a "worsening" which, according to employer, is required to trigger reinstatement of TTD. Proof of a subsequent "worsening" is required only after a claim has been initially closed. ORS 656.273; *Rodgers v. Weyerhaeuser Company*, 88 Or App 458, 460, 745 P2d 820 (1987). Claimant was working for employer when he suffered the disabling injury. As of March 5, he was entitled to TTD until he became medically stationary and was released for work. *See Weyerhaeuser Company v. Kepford*, 100 Or App 410, ___ P2d ___ (1990).

Affirmed.[1]

[1] Employer also argues that there is not substantial evidence to support the Board's findings. We disagree.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Nina C. Griggs, Claimant.

PARKVIEW NURSING HOME et al,
Petitioners,

v.

GRIGGS,
Respondent.

(87-09271; CA A60771)

Judicial Review from the Workers' Compensation Board.

Submitted on record and briefs January 12, 1990.

Patric J. Doherty, Karli L. Olson and Rankin, VavRosky, Doherty, MacColl and Mersereau, Portland, filed the brief for petitioners.

Glen J. Lasken and Vick & Gutzler, Portland, filed the brief for respondent.

Before Graber, Presiding Judge, and Riggs and Edmonds, Judges.

PER CURIAM

Affirmed.

PER CURIAM

Employer seeks review of an order of the Board that affirmed the referee's order setting aside a denial of claimant's aggravation claim. Employer argues that the referee abused his discretion in excluding from evidence a medical report that conflicted with an earlier report written by the same doctor regarding the compensability of claimant's injury. The referee ruled that employer had not shown "good cause" within the meaning of *temporary* OAR 438-07-005(4)[1] to justify an untimely filing of the report.

Although employer filed the report the day after it was received, it offered no explanation of why the doctor did

[1] *Temporary* OAR 438-07-005(4) provided:

"At the hearing the referee may in his or her discretion allow admission of additional medical reports or other documentary evidence not filed as required by (3) above. In exercising this discretion, the referee shall determine if good cause has been shown for failure to file within the prescribed time limits."

not provide the report in time for employer to file it on time.[2] We will not reverse a discretionary decision of an administrative officer, unless the officer exceeded the delegated range of discretion. *See* ORS 183.482(8)(b)(A). The referee acted within his discretion.

Affirmed.

[2] Under *temporary* OAR 438-07-005, employer was required to file the report at least twenty days before the hearing. At the hearing, counsel for employer stated:

> "[T]he Notice for Hearing was sent out on July 16th; our office contacted [the doctor], scheduling an appointment to meet with him. We met with him. We wrote to him on August 14th * * *. We advised him at that time that the hearing was scheduled for September 15th, and we requested a response by August 24th so the documents could be submitted; it was not received until last week [September 9]. And our position is we made a good faith effort, once it was sent on an expedited basis, to get our report in on [*sic*] a timely fashion."

When the referee asked counsel if there was "any explanation" as to why the doctor did not respond within the requested time frame, counsel responded:

> "I did not personally talk to him to know. I had someone call his office to inquire as to the whereabouts of the report when it came to my attention I hadn't received it."

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Ted W. Peckham, Claimant.

FORSHEE & LANGLEY LOGGING et al,
Petitioners,

v.

PECKHAM,
Respondent.

(WCB 86-00033; CA A60518)

Judicial Review from Workers' Compensation Board.

Argued and submitted December 11, 1989.

H. Scott Plouse, Medford, argued the cause and filed the brief for petitioners.

Karen M. Werner, Eugene, argued the cause and filed the brief for respondent.

Before Graber, Presiding Judge, and Riggs and Edmonds, Judges.

RIGGS, J.

Affirmed.

RIGGS, J.

Employer seeks review of a Workers' Compensation Board order on reconsideration that awarded temporary total disability benefits to an incarcerated claimant who was neither released for work nor medically stationary. We affirm.

Claimant, a timber faller, injured his back in a logging accident on September 22, 1983. One week later, his physician took him off work, and claimant began to receive temporary total disability compensation. On October 3, 1984, claimant was incarcerated in a correctional facility, where he remained until June 9, 1985. During that entire time, he was neither medically stationary nor released for regular work. While incarcerated, he continued to receive temporary total disability benefits.

Claimant's claim was closed by a December 15, 1985, determination order that declared him medically stationary as of November 15, 1985, and awarded him 15 percent permanent partial disability. The determination order did not award temporary total disability for the period that he was incarcerated and authorized employer to offset the disability payments that claimant had received during that time.

Claimant contended that he was entitled to TTD benefits while he was incarcerated and requested a hearing. The referee, relying on *Cutright v. Weyerhaeuser,* 299 Or 290, 702 P2d 403 (1985), affirmed the denial of benefits for the time that he was jailed, reasoning that, because he was unavailable for work, he had no loss of wages and was, therefore, not entitled to temporary disability payments. The Board affirmed, noting that temporary total disability is wage replacement for "workers," as defined by ORS 656.005(27),[1] and concluding that an incarcerated individual has withdrawn from the work force. In its order on reconsideration, the Board reversed itself and held that claimant was entitled to temporary disability benefits.

720 Forshee & Langley Logging v. Peckham

On review, the employer argues by analogy to the retired worker in *Cutright v. Weyerhaeuser, supra,* that claimant was not a "worker" and was not entitled to temporary disability because, as an incarcerated individual, he was unavailable for work and, therefore, did not sustain a loss of wages.

In *Cutright,* the Supreme Court held that a claimant who voluntarily retires and permanently withdraws from the work force for reasons unrelated to the injury, after the claim is closed and before filing an aggravation claim, is not entitled to temporary total disability benefits for an aggravation, because the claimant is no longer a "worker" at the time of filing. Here, claimant was a "worker" when he filed his initial claim. He injured his back while engaged in regular gainful employment. His departure from the workforce was the direct consequence of the disabling effects of that compensable injury. As we recently stated in *Kepford v. Weyerhaeuser,* 100 Or App 410, 414, ___ P2d ___ (1990):

[1] ORS 656.005(27), provides:

"'Worker' means any person, including a minor whether lawfully or unlawfully employed, who engages to furnish services for a remuneration, subject to the direction and control of an employer and includes salaried, elected and appointed officials of the state, state agencies, counties, cities, school districts and other public corporations, but does not include any person whose services are performed as an inmate or ward of a state institution."

> "*Dawkins* [*v. Pacific Motor Trucking*, 91 Or App 562, 756 P2d 60 (1988), *on reconsideration*] makes it clear that the critical time for determining whether a claimant has withdrawn from the workforce is at the time of the disability. * * * Here, claimant was working and was, therefore, a member of the workforce when he became disabled by his occupational disease. It matters not that he retired or had withdrawn from the workforce after that time. Under *Dawkins*, he need not show that he remained in the work force. *Because he was entitled to receive benefits for temporary total disability at that time, he was entitled to continue to receive them until he became medically stationary and was released for work* * * * at which time employer was entitled to close his claim." (Citations omitted; emphasis supplied.)

Employer's argument ignores the fact that, despite claimant's incarceration, he was never medically stationary or released for work during the time that he was jailed. Claimant's medical condition precluded his employment, even if he had not been incarcerated. Under those circumstances, there is no authority to terminate temporary disability benefits. *Northrup King & Co. v. Fisher*, 91 Or App 602, 757 P2d 855, *rev den* 307 Or 77 (1988); *see also Fazzolari v. United Beer Distributors*, 91 Or App 592, 595, 757 P2d 857, *on reconsideration* 93 Or App 103, 761 P2d 6, *rev den* 307 Or 236 (1988).

It is the legislature's province to restrict the ability of incarcerated individuals to collect workers' compensation and, in some situations, it has done so. *See* ORS 655.515(1).[2] We decline employer's suggestion that we create additional exceptions that have no basis in the statute.

Claimant was temporarily totally disabled as a result of a compensable injury throughout the time that he was incarcerated, and he was entitled to temporary disability compensation. ORS 656.268(1).[3] Accordingly, TTD benefits paid were not an overpayment, and an offset is improper.

Affirmed.

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[2] ORS 655.515(1) provides:

> "No benefits, except rehabilitation services, shall accrue to the inmate until the date of release from confinement and shall be based upon the condition of the inmate at that time."

[3] ORS 656.268(1) provides, in pertinent part:

> "Claims shall not be closed nor temporary disability compensation terminated if the worker's condition has not become medically stationary."

In *Fazzolari v. United Beer Distributors, supra*, we stated: "The statute does not permit unilateral termination of temporary total disability benefits, unless the claimant is *both* medically stationary and released for work." 91 Or App at 595. (Emphasis in original.)

IN THE SUPREME COURT OF THE
STATE OF OREGON

In the Matter of the Compensation of
Charles I. Spear, Claimant.

STATE OF OREGON, DEPARTMENT OF JUSTICE,
INMATE INJURY FUND,
Petitioner on Review,

v.

SPEAR,
Respondent on Review.

(WBC No. 86-02003; CA A46205; SC S36091)

In Banc

On review from the Court of Appeals.*

Argued and submitted September 6, 1989.

Christine Chute, Assistant Attorney General, Salem, argued the cause for petitioner. With her on the brief were Dave Frohnmayer, Attorney General and Virginia L. Linder, Solicitor General, Salem.

No appearance for respondent.

VAN HOOMISSEN, J.

The decision of the Court of Appeals and the order of the Workers' Compensation Board are affirmed.

* Judicial review from an order from the Workers' Compensation Board. 94 Or App 677, 767 P2d 928 (1989).

VAN HOOMISSEN, J.

The issue is whether the Inmate Injury Act, ORS 655.505 *et seq.*, incorporates the attorney fees provisions of the Workers' Compensation Law, ORS chapter 656. The Department of Justice, which administers the Inmate Injury Fund, contends that it does not. The Court of Appeals held that it does. *Dept. of Justice v. Spear,* 94 Or App 677, 767 P2d 928 (1989). We affirm.

Claimant is an inmate at the Oregon State Penitentiary. While employed there, he was assaulted and injured by another inmate. When he filed a claim for benefits, the Department of Justice denied his claim on the ground that his injury was not work related. On appeal, a referee found that claimant's injury was compensable. The Department appealed to the Workers' Compensation Board, which affirmed the referee and also awarded claimant $550 attorney fees for services on Board review. The Court of Appeals affirmed. In upholding claimant's attorney fees award, the Court of Appeals relied on *Johnson v. SAIF,* 267 Or 299, 516 P2d 1289 (1973). The Department now appeals only the award of attorney fees.[1]

The Department contends that the Board has no authority to award attorney fees on Inmate Injury Act claims, arguing that *Johnson* was wrongly decided. Alternatively, the Department contends that *Johnson* has been superseded by the subsequent repeals of *former* ORS 656.301(2)[2] and *former* 655.420,[3] statutes which the Department argues this court relied upon in *Johnson*.

In *Johnson*, we concluded that "the legislature intended to incorporate into the [Inmate Injury Act] * * * all of the procedural and remedial rights extended to injured workmen, with certain reservations necessitated by the unique position of the inmate." 267 Or at 302. We held that the incorporated rights included all of the Workmen's Compensation Act provisions relating to judicial review of inmate claims. 267 Or at 303. Normally, this court will not reconsider

its prior interpretation of a statute, especially when the legislature has acquiesced in that interpretation over a long period of time. Accordingly, we decline to review *Johnson* on its merits.

The Department argues that *Johnson* was decided on the authority of *former* ORS 656.301(2) and *former* ORS 655.420 and that because both statutes have since been repealed, *Johnson* is no longer viable. We disagree. The Department has misread this court's opinion in *Johnson*.

In *Johnson*, we explained:

> "The purpose of the reference in ORS 655.525[4] to ORS 656.283 - ORS 656.304 was to identify the sections of the Workmen's Compensation Act setting out the hearing procedures and the scope of review *and was not intended to exclude other provisions in another part of the Workmen's Compensation Act under the heading of Legal Representation dealing with attorney's fees (ORS 656.386 and ORS 656.388) among other things.*" 267 Or at 303. (Emphasis added).

ORS 655.520 overcomes the general rule that attorney fees are not recoverable absent a statute or contractual provision authorizing such fees[5] by incorporating into the Inmate Injury Act *all* of the consistent provisions of ORS 656.001 to 656.794, including ORS 656.382(2), *infra*, which provides for an award of a claimant's attorney fees when an employer appeals and loses.

Johnson was decided in 1973. *Former* ORS 656.301(2) was repealed in 1977, and *former* ORS 655.420 was repealed in 1979. Therefore, we examine whether the repeal of those stat-

[1] The referee awarded claimant's attorney $1,400 in fees "paid out of and not in addition to compensation." Those fees are not at issue in this appeal.

[2] *Repealed*, Or Laws 1977, ch 804, § 55.

[3] *Repealed*, Or Laws 1979, ch 814, § 1.

[4] ORS 655.525 provides:

"An inmate or the beneficiary of the inmate may obtain review of action taken on the claim as provided in ORS 656.283 to 656.034."

[5] *See Samuel v. Frohnmayer*, 308 Or 362, 366, 779 P2d 1028 (1989); *Stelljes/Dumler v. State Board of Parole*, 307 Or 365, 368, 769 P2d 177 (1989); *but see Deras v. Myers*, 272 Or 47, 65-66, 535 P2d 541 (1975) (equity court may award attorney fees without specific authority).

utes demonstrates any legislative intent to reverse our holding in *Johnson.*

Looking first at *former* ORS 655.420, we find that persons covered by *former* 655.405 to 655.450 (mentally retarded minors injured in special training program) are now

"workers" for the purposes of the Workers' Compensation Law. *See* ORS 656.033(1). It is clear that the legislature intended no change in the ability of such minors to claim and receive attorney fees. Therefore, the repeal of *former* ORS 655.420, which we cited in *Johnson* only by analogy, proves nothing in the context of this case.

Former ORS 656.301(2) involved SAIF or employer appeals from the *circuit court:*

> "In case of an appeal by the State Accident Insurance Fund or employer from an adverse decision of the circuit court, if the judgment of the circuit court is affirmed, the claimant shall be allowed attorney fees to be fixed by the court and to be paid by the party initiating the appeal, in addition to the compensation."

When the legislature removed circuit court review from the workers' compensation scheme, *former* ORS 656.301 became surplusage.[6] We conclude that the repeal of *former* ORS 656.301 proves nothing in the context of this case.

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[7] 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."

That statute is incorporated into the Inmate Injury Act by ORS 655.515 and 655.520(1). *Johnson v. SAIF, supra.*

The decision of the Court of Appeals and the order of the Workers' Compensation Board are affirmed.

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[6] The Department cites no legislative history, and we are aware of none, to support its argument that the repeal of *former* ORS 656.301 was intended to undermine our holding in *Johnson.* Had the legislature intended to reverse our holding in *Johnson,* we think it would have said so.

[7] The Department does not argue that it is not an "employer" for the purposes of this claim.

IN THE SUPREME COURT OF THE
STATE OF OREGON

In the Matter of the Compensation of
Reyes S. Garcia, Claimant.

GARCIA,
Respondent on Review,

v.

BOISE CASCADE CORPORATION,
Petitioner on Review.

(WCB No. 85-15946; CA A46569 ; SC S35840)

On review from the Court of Appeals.*

Argued and submitted July 6, 1989.

Susan A. Bischoff, Salem, argued the cause for petitioner on review. On the petition for review were Robert R. Trethewy, and Garrett, Seideman, Hemann, Robertson & DeMuniz, P.C., Salem.

Quintin B. Estell, Salem, filed the response and argued the cause for respondent on review.

Before Peterson, Chief Justice, and Linde,** Carson, Jones, Gillette and Fadeley, Justices.

CARSON, J.

The decision of the Court of Appeals is reversed. The case is remanded to the Court of Appeals for proceedings consistent with this opinion.

* Judicial review from order of Workers' Compensation Board. 94 Or App 362, 765 P2d 1245 (1988).

** Linde, J., retired January 31, 1990.

CARSON, J.

In this workers' compensation case, the Court of Appeals concluded that the referee's findings of fact, which were affirmed by the Workers' Compensation Board, are not supported by substantial evidence. *Garcia v. Boise Cascade Corp.*, 94 Or App 362, 765 P2d 1245 (1988). Substantial evidence supports a finding when the record, viewed as a whole, permits a reasonable person to make the finding. ORS 183.482(8)(c).[1] Because we conclude that the Court of Appeals did not correctly apply the substantial evidence standard of review, we reverse its decision and remand the case to the Court of Appeals.

In 1985, claimant injured his back while working at employer's mill pulling sheets of veneer off a conveyor belt or "greenchain," a task claimant described at his deposition as

[1] ORS 183.482(8)(c) provides:

"The court shall set aside or remand the order if it finds that the order is not supported by substantial evidence in the record. Substantial evidence exists to support a finding of fact when the record, viewed as a whole, would permit a reasonable person to make that finding."

"light" work. Claimant sought workers' compensation for his degenerative back condition. At the hearing, claimant introduced a letter from Dr. Munson, his treating physician, stating that "heavy lifting" at claimant's job was "a major if not the major contributing factor aggravating [claimant's degenerative back condition]." The referee discounted Dr. Munson's opinion because "the record indicates that claimant's work did not involve heavy lifting" and because Dr. Munson "was unaware of the claimant's actual work history." The referee then concluded "that the claimant has not met his burden of establishing that the work activities for this employer were the major contributing cause of his degenerative back condition."[2] The Board affirmed the referee's decision. The Court of Appeals disagreed with the referee and the Board, concluding that the referee erred in discounting Dr. Munson's opinion. 94 Or App at 365.

The Court of Appeals came to this conclusion on the

ground that the referee's findings—that claimant's work did not involve heavy lifting and that Dr. Munson was unaware of claimant's work history—are not supported by substantial evidence in the record. 94 Or App at 365. The court observed that claimant "worked several years, including the years 1983 to 1985, 'pulling greenchain' for employer, a job that the record reveals requires substantial lifting as well as pulling, bending and twisting." 94 Or App at 365. The court also stated that Dr. Munson had treated claimant since 1973 and so could not have been unaware of claimant's work history. 94 Or App at 365. The Court of Appeals formerly would have reviewed *de novo, see former* ORS 656.298(6) (1985), thus permitting the court to make its own findings. Since 1987, however, the court has been required to review for substantial evidence. Or Laws 1987, ch 884, § 12a; ORS 183.482(8)(c) and 656.298(6). As stated above, substantial evidence supports a finding when the record, viewed as a whole, permits a reasonable person to make the finding. ORS 183.482(8)(c). A court must "evaluate the substantiality of supporting evidence by considering *all* the evidence in the record." *Younger v. City of Portland,* 305 Or 346, 356, 752 P2d 262 (1988). (Emphasis added.) That is, the court must evaluate evidence against the finding as well as evidence supporting it to determine whether substantial evidence exists to support that finding. If a finding is reasonable in light of countervailing as well as supporting evidence, the finding is supported by substantial evidence. *See Armstrong v. Asten-Hill Co.,* 90 Or App 200, 206, 752 P2d 312 (1988).

Here, the Court of Appeals did not evaluate all the evidence to determine whether a reasonable person could have made the findings that the referee and the Board made on the evidentiary record. Instead, the court concluded that certain

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[2] Claimant initially sought compensation on alternative theories that his degenerative condition was an occupational disease or that, as to his herniated disc, it was the result of an industrial injury. The referee concluded that claimant had not met his burden on the injury alternative. Claimant has not pursued his industrial injury claim.

evidence supported findings different from those reached by the referee and that the referee (and the Board) thus erred. The Court of Appeals effectively has substituted its view of the evidence, contrary to ORS 183.482(8)(c). That was an incorrect application of the substantial evidence standard of review.

The twist in this case was a negative finding by the referee (and the Board). That is, purportedly based on the evidence, the referee "discounted" the opinion of Dr. Munson

that the heavy lifting was "a major if not the major contributing factor aggravating [claimant's degenerative back condition]." Once the opinion of Dr. Munson was discounted, the referee concluded that claimant had failed to carry his burden of establishing a compensable claim.

In cases where evidence is rejected or disregarded by the referee, and such action purports to be based on facts, it is appropriate for the reviewing court to examine whether the referee's decision to disregard or discount evidence in the record is supported by substantial evidence. Put another way: An assertion of a finding of fact as part of an explanation for disregarding evidence is subject to attack if that fact relied upon is not, itself, supported by substantial evidence.

Here, the referee, in support of his conclusion to discount Dr. Munson's opinion testimony, relied on an explanation that "the record indicates that claimant's work did not involve heavy lifting" and that Dr. Munson "was unaware of the claimant's actual work history." The Court of Appeals, after stating that the foregoing findings were not supported by the evidence (the correct test), reversed the Board because it found that some evidence *did* suggest that claimant's work required substantial lifting, pulling, bending and twisting, and that Dr. Munson *was* aware of claimant's work history. Essentially, the Court of Appeals held that there was substantial evidence supporting claimant's position. Even if true, that is irrelevant. The appropriate question was not whether substantial evidence supported claimant's claim, but whether substantial evidence supported the referee's decision.

The evidence in this case conflicts: Claimant's job might or might not have been the major contributing cause of claimant's degenerative back condition, pulling veneer might or might not be considered heavy work, and Dr. Munson might or might not have understood claimant's work history. Rather than reviewing the record to determine if substantial evidence supported the referee's order, which, in this case, necessitated an examination for substantial evidence to support the referee's decision to disregard Dr. Munson's opinion, the Court of Appeals reexamined the record and simply reached a contrary conclusion. That was error.

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 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).

The issue was not raised before the referee at the hearing. Neither the Board nor the Court of Appeals addressed it. We assume that the Board ignored this issue either because it deemed the issue waived or because the Board determined that claimant did not satisfy a prerequisite to the operation of the rule—that claimant's degenerative back condition was caused by *any* place of employment. Presumably, the Court of Appeals did not reach this issue either because it determined that the claim was compensable by this employer or because it, too, deemed the issue waived. Depending upon the decision on remand, this issue may, or may not, properly be deemed revived.

The decision of the Court of Appeals is reversed. The case is remanded to the Court of Appeals for proceedings consistent with this opinion.

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