# VAN NATTA'S WORKERS' COMPENSATION REPORTER

VOLUME 42

(Pages 1511-2288)

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

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

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**CITE AS**

42 Van Natta ____ (1990)

In the Matter of the Compensation of
**ERNEST A. BROWN, Claimant**
WCB Case No. 88-05082
ORDER ON REVIEW
Dean Heiling, Claimant Attorney
Rankin, et al., Defense Attorneys

Reviewed by Board Members Gerner and Cushing.

The self-insured employer requests review of Referee Baker's order which set aside its denial of claimant's aggravation claim for his current low back condition. On review, the issue is aggravation. We affirm.

## FINDINGS OF FACT

Claimant experienced a compensable low back injury on January 22, 1985 while lifting a heavy press roll. He had no prior back injuries or disabilities. The claim was accepted on February 4, 1985.

On March 20, 1985, Dr. Kendrick, surgeon, performed a microdiskectomy at L2-3 on the right. A disc bulge was found and incised, and all disc material was removed.

Claimant continued to experience severe back pain. In May 1985 claimant felt abnormal sensations in the right leg. In July 1985 he attempted to return to modified work for the same employer. In September 1985 claimant experienced severe low back pain, with pain and numbness in the right leg and some pain in the left leg.

On April 22, 1986, claimant complained of back pain across the belt line and occasional pain radiating into the foot. Dr. Kendrick found claimant stationary with moderate impairment and activity restrictions.

The claim was closed by Determination Order of May 7, 1986 with an award of 25 percent (80 degrees) for unscheduled permanent partial disability.

In July 1986 claimant moved to Wyoming, where he operated a large rubber tire loader. Claimant had no work accident or incident in Wyoming.

On March 10, 1987, claimant returned to Dr. Kendrick because of increased symptoms with his low back. Thereafter, claimant began treating with Dr. Peterson, surgeon. A July 28, 1987 MRI study showed advanced lumbar degenerative disc disease with a central small fragment of herniated nucleus pulposus at L2-3 and generalized osteophytosis producing some encroachment upon the L4 and 5 neuroforamina on the right. Physical therapy provided only temporary relief.

A January 1988 electromyogram yielded findings consistent with of right L5 radiculopathy. On March 25, 1988, claimant's aggravation claim was denied. The employer contended that the current problems were not related to the January 1985 work injury.

Claimant's January 1985 compensable injury has continued to be a material contributing factor in claimant's current back problems. His work activities in Wyoming did not independently contribute to claimant's disability.

## CONCLUSIONS OF LAW AND OPINION

The Referee set aside the employer's aggravation denial of claimant's back condition, reasoning that the medical evidence showed a worsening of claimant's back condition. We agree.

To establish a compensable aggravation under ORS 656.273(1), claimant must prove: (1) a worsening of his condition since the last award or arrangement of compensation; and (2) a material causal connection between the worsening and the compensable condition. Stepp v. SAIF, 78 Or App 438 (1986).

The employer is apparently not contesting that claimant is worse, but only that the worsening is not due in material part to the compensable 1985 injury. We therefore turn to the issue of material causation.

The Referee found that claimant was credible. Yet, considering claimant's prior medical history, the issue of whether claimant's current back condition is causally related to the 1985 compensable back injury is a complex medical question. Thus, although claimant's credible testimony is probative, the resolution 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 106, 109 (1985).

Dr. Peterson, claimant's treating physician, reported that claimant's back pain eventually returned following the May 1985 surgery. (Ex. 58). After reviewing claimant's current MRI exam, which revealed advanced degenerative disc disease and a herniation at L2-3, Peterson concluded that he was treating claimant for a back condition derived from the January 1985 compensable injury. (73A-1). He referred claimant to Dr. Freeman for evaluation.

Dr. Freeman, neurosurgeon, opined that claimant suffered from marked nerve root compromise in the L3-5 and S1 distributions, which was consistent with the MRI findings. (Ex. 60-2). Freeman also concluded that claimant's current low back condition was related to his compensable injury. (Ex. 60-2; 76-1).

Dr. Rosenbaum, surgeon, performed an independent medical examination. Initially, Rosenbaum could not exclude the possibility that claimant's compensable 1985 injury also involved his lower nerve roots. (Ex. 71-4). Subsequently, Rosenbaum found the 1985 incident and the L5 or S1 nerve root distribution to be a separate condition. (Ex. 74-1). Eventually, Rosenbaum conceded there was some evidence of L5 or S1 radiculopathy condition attributable to the compensable injury, however it was not enough to change his opinion. (Ex. 77-34). Finally, Dr. Rosenbaum diagnosed degenerative spine disease and a superimposed radiculopathy. (Ex. 77-40). Because of this vacillation regarding the causal connection between the compensable 1985 injury and claimant's current low back condition, we do not find Rosenbaum's medical opinion to be persuasive.

Dr. Snodgrass, neurologist, at first agreed that claimant's compensable condition had materially worsened from the time of his 1986 claim closure. (Ex.63-4). Dr. Neitling, orthopedist, concurred with this initial opinion. Id. Thereafter, Snodgrass concurred with Rosenbaum, concluding that claimant's current back condition should not be considered part of the original 1985 injury because there were significant difference in the levels involved. (Ex. 75). Considering the conclusory nature of this change of opinion, we do not find Dr. Snodgrass's opinion to be persuasive.

We find Dr. Peterson's opinion as claimant's treating physician, to be thorough and well reasoned. Somers v. SAIF, 77 Or App 259 (1986); Weiland v. SAIF, 64 Or App 810 (1983). This opinion was also shared by Dr. Freeman, who authored a reasoned opinion based on a review of claimant's MRI findings. Moreover, even Rosenbaum conceded that there was evidence pointing towards a L5 or S1 radiculopathy condition. Based on this medical evidence claimant has established that his current worsened low back condition is causally related to his compensable 1985 injury.

The employer also contends that while working in Wyoming, claimant suffered an injury, which in turn aggravated his condition. Because no claim was filed in Wyoming, the employer asserts that responsibility can be shifted away from the employer. See Miville v. SAIF, 76 Or App 603, 607 (1985). We disagree. There is no evidence that claimant's work activities in Wyoming independently contributed to his low back condition. Consequently, it was unneccessary for claimant to file an out-of-state claim. Accordingly, Miville, supra, is not applicable in this situation. See Harry W. Clark, 38 Van Natta 1271 (1986).

ORDER

The Referee's order dated December 19, 1988 is affirmed. Claimant's attorney is awarded $1,762.50 for services on Board review, to be paid by the insurer. A client-paid fee, not to exceed $2,421, payable from the employer to its counsel, is approved.

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In the Matter of the Compensation of
**PEGGY H. MORROW, Claimant**
WCB Case No. 89-00364
ORDER ON REVIEW
Quintin B. Estell, Claimant Attorney
Stafford J. Hazelett, Defense Attorney

Reviewed by Board Members Gerner and Myers.

Claimant requests review of Referee Brazeau's order that: (1) awarded 12 percent (38.4 degrees) unscheduled permanent disability for a back injury, whereas a Determination Order awarded no permanent disability; and (2) found claimant's condition medically stationary on July 27, 1988. On review, the issues are the extent of unscheduled permanent disability and the medically stationary date. We modify.

FINDINGS OF FACT

The Board adopts the Referee's Finding of Fact, as our own, except the findings that "Dahlstrom ultimately released claimant to return to regular work on December 20, 1988," and "Claimant has lost 12 percent of her earning capacity as a result of her compensable injuries."

Instead, we find the following:

Claimant's preinjury physical capacity was to do medium work. After her compensable injury, Dr. Dahlstrom released her to return to modified work with restrictions in a light to medium capacity. (Ex. 23). Claimant returned to modified work with a subsequent employer, worked for approximately one month, and then quit for reasons unrelated to her compensable injury.

Claimant has sustained 15 percent loss of earning capacity resulting from her compensable injury.

CONCLUSIONS OF LAW AND OPINION

Medically Stationary Date

We adopt the Referee's Conclusions of Law, as set forth in the "Conclusions and Opinion" portion of the order, with respect to the issue of when claimant's condition became medically stationary.

Extent of Unscheduled Permanent Disability

The Referee found that claimant had returned to regular work, did not assess values for claimant's age, education and adaptability, and concluded that claimant sustained 12 percent loss of earning capacity resulting from her compensable injury. We agree that claimant suffers permanent impairment resulting from her compensable injury. However, we do not find that claimant has returned to regular work.

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

Age

The appropriate value for claimant's age of 41 years is 1. Former OAR 436-35-290.

Education

Claimant has a 10th grade education and a GED. Therefore, claimant's value for formal education is 0. Former OAR 436-35-300(3). Claimant has successfully performed the work of a housekeeper during the ten years preceding the date of injury. The specific vocational preparation (SVP) for a housekeeper is 3. Thus, the appropriate value for skills is 3. Former OAR 436-35-300(4). There is no documentation demonstrating competence in a specific vocational pursuit. Therefore, the appropriate value for claimant's training is 1. Former OAR 436-35-300(5). After adding claimant's values for education together, we find that the appropriate total value for education is 4.

Adaptability

An adaptability value for a claimant who is unable to return to his or her usual and customary work (See former OAR 436-35-270(3)(a)) and who has returned to modified work is determined from a matrix of values at former OAR 436-35-310(3)(a). That matrix compares the physical capacity of the claimant's usual and customary work with the physical capacity required by the modified work. This is true even though claimant may have the physical capacity to do heavier work than is required by the modified employment. Physical capacities are not defined by the "standards" generally. We utilize those definitions contained in former OAR 436-35-310(4)(a)-(d).

In this case, claimant's usual and customary work required the physical capacity to do medium work. Claimant's modified work required a medium to light physical capacity. Therefore, the appropriate adaptability value is 1.5. Former OAR 436-35-310(3)(a).

Impairment

The Referee based his impairment rating on a November 1987 medical report authored by Dr. Poulson, referring physician. (Ex. 4). The insurer contends that the August 1988 medical report completed by Dr. Bolin, independent medical examiner, within one month from the time claimant's condition became medically stationary, is a more appropriate report upon which to base claimant's range of motion findings. (Ex. 13). We agree for the reason asserted by the insurer.

Claimant's relative cervical range of motion findings include 20 degrees retained extension (for a value of 1) and 30 degrees retained left lateral flexion (for a value of 1). Former OAR 436-35-360 (2) through (5). Claimant's dorsolumbar range of motion findings do not equate to values ratable under the standards. Former OAR 436-35-360 (6) through (9).

Therefore, claimant's total impairment resulting from loss of spinal range of motion is 2.

The Referee did not award any impairment value for disabling pain. Former OAR 436-35-320(1)(a) provides that pain can result in loss of use or function. When it does, it is rated based on the loss of use or function which results and no additional value is allowed for pain alone. Daniel M. Alire, 41 Van Natta 752 (1989).

Here, we find that claimant's disabling pain has prevented her from returning to her usual and customary work. Additionally, it prevents her from lifting more than 40 pounds. Therefore, we find that claimant suffers 5 percent disabling pain resulting from her compensable injury.

Claimant's disabling pain value (5) is combined with her loss of range of motion findings (2), for a total impairment value of 6.9.

Computation of Unscheduled Disability

Having determined each value necessary to compute claimant's permanent disability under the "standards," we proceed to that calculation. When claimant's age value (1) is added to his education value (4) the sum is 5. When that value is multiplied by claimant's adaptability value (1.5) the product is 7.5. When that value is added to claimant's impairment value (6.9), the result is 14.4 percent unscheduled permanent partial disability. Former OAR 436-35-280(7). That disability figure is rounded to the next higher whole percentage. Former OAR 436-35-280(7). Claimant's unscheduled permanent disability under the "standards" is, therefore, 15 percent.

ORDER

The Referee's order dated April 18, 1989, is modified. In addition to the Referee's award of 12 percent (38.4 degrees) unscheduled permanent disability, claimant is awarded 3 percent (9.6 degrees) unscheduled permanent disability, for a total award to date of 15 percent (48 degrees). Claimant's attorney is awarded 25 percent of the increase in compensation created by this order, payable directly to the attorney. However, the total fees awarded by the Referee and Board orders shall not exceed $3,800.

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July 2, 1990 Cite as 42 Van Natta 1515 (1990)

In the Matter of the Compensation of
**ELIZABETH A. SCUDDER, Claimant**
WCB Case No. 89-01346
ORDER ON REVIEW
Black, et al., Claimant Attorneys
Thomas A. Andersen, Defense Attorney

Reviewed by Board Members Cushing and Gerner.

Claimant requests review of that portion of Referee Neal's order which awarded no additional temporary disability over that awarded by the Determination Order. On review, the issue is temporary disability.

The Board affirms and adopts the order of the Referee with the following supplementation.

There is no evidence in this case, other than claimant's testimony, that she was disabled from October 1987 to December 9, 1987. Claimant did not seek medical assistance for much of that period of time and her treating doctor would not indicate that she was disabled prior to the first time he saw her in December. Considering these circumstances, we find claimant's contention unpersuasive in establishing that she was, in fact, unable to work prior to her December 1987 examination. See Avalos v. Bowyer, 89 Or App 546, 550 (1988).

ORDER

The Referee's order dated April 26, 1989 is affirmed.

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In the Matter of the Compensation of
**RICHARD L. SPROUL, Claimant**
WCB Case No. 88-22469
ORDER ON REVIEW
Gastineau & Smith, Claimant Attorneys
Cowling & Heysell, Defense Attorneys

Reviewed by Board Members Cushing and Gerner.

The insurer requests review of Referee Brown's order that increased claimant's unscheduled permanent disability award for a low back injury from 16 percent (51.2 degrees), as awarded by a Determination Order, to 30 percent (96 degrees). On review, the issue is extent of unscheduled permanent disability. We modify.

FINDINGS OF FACT

Claimant compensably injured his low back in May 1988. He treated with both Dr. Dunn, II, M.D., and Dr. Ewald, M.D. An MRI revealed degenerative changes at L4-5, L5-S1 and L3-4.

Claimant was initially released to return to light work, but after returning to work, his low back pain symptoms increased. He returned to Ewald, who noted back spasms and decreased range of motion, and was again released from work.

In October 1988, the Western Medical Consultants performed an independent medical examination. Later that month, Dunn again released claimant to return to modified work and found him medically stationary as of October 4, 1988. A November 14, 1988 Determination Order awarded claimant 16 percent (15.2 degrees) unscheduled permanent disability. Claimant requested a hearing.

Claimant, 32 years of age at hearing, has a 10th grade education and no GED. His highest specific vocational preparation (SVP) during the ten years preceding the date of injury was as an edge operator, for an SVP of 6. He has no documented training or certification demonstrating competence in any specific vocational pursuit.

Claimant's work at the time of his compensable injury required the physical capacity to do heavy work. Since the injury, he has been released to return to light work.

As a direct result of claimant's compensable injury, he now has a clinically significant unoperated disc derangement at L5-S1 and an L4-5 disc bulge.

He suffers no ratable loss of range of motion impairment resulting from the compensable injury.

Claimant is unable to return to his usual and customary work, given his release to return to light duty work. He has not returned to work, but has been offered work within his treating physician's restrictions.

CONCLUSIONS OF LAW AND OPINION

The Referee increased claimant's unscheduled permanent disability from 16 percent to 30 percent. We modify.

Because claimant's condition became medically stationary in October 1988, and his claim closed in December 1988, the "standards" adopted effective July 1, 1988, (former OAR 436-35-001 et seq), as amended by temporary rules effective August 19, 1988, apply to the rating of claimant's permanent partial disability. Former OAR 436-35-270 through 436-35-440 apply to the rating of unscheduled permanent partial disabilities. Former OAR 436-35-270(1).

Age

The appropriate value for claimant's age of 32 years is 0. Former OAR 436-35-290.

Education

Claimant has not returned to his usual and customary work. He has a 10th grade education and no GED. Therefore, the appropriate value for claimant's formal education is 1. His highest SVP during the ten years prior to the date of injury was 6 as an edge operator (DOT # 667.682-058). Therefore, the appropriate value for skills is 2. Former OAR 436-35-300(4). He has no documented training. Therefore, the appropriate value for training is 1.

Claimant's total education value is 4.

Adaptability

The Referee found that claimant had not returned to work nor had he been offered bona fide work. As a result of this finding, the Referee analyzed claimant's adaptability under former OAR 436-35-310(4). The insurer contends that claimant's adaptability should be analyzed under former OAR 436-35-310(3)(b), contending that claimant had been offered work within his restrictions. We agree with the insurer and assign an adaptability value under former OAR 436-35-310(3)(b).

The determination of whether claimant's adaptability is rated under former OAR 436-35-310(3)(b) or (4) depends solely on whether claimant was offered work that the attending physician agrees is within the worker's physical capacity. If the answer to this question is yes, then claimant's adaptability is rated under subsection (3)(b).

The record establishes that claimant was offered work within the restrictions set by claimant's treating physician. (Tr. 36-37). However, because claimant failed to pass a drug test, he was not given that particular job. Rather, the employer offered and claimant accepted and completed a five-week drug rehabilitation program. (Tr. 21-24).

The fact is that claimant was offered a job within the physical restrictions placed upon him by his treating physician, thereby satisfying former OAR

436-35-310(3)(b). Claimant's failure to satisfy a condition of employment, passing a drug test, does not mean that the offer was not made in good faith. Further, claimant's failure to pass the drug test has nothing whatsoever to do with his compensable injury.

While the Referee found that the failure of the drug test and claimant's participation in an employer-sponsored drug rehabilitation program was a withdrawal of the offer, we do not. It is claimant's burden to prove extent of disability. ORS 656.266. Furthermore, claimants are encouraged to make reasonable efforts to reduce their disabilities. ORS 656.325(3).

Because claimant's independent actions which prevented his actual acceptance of the offer do not detract from the fact that the offer was made, and because those actions were not in any way associated with the compensable injury, we find that a job offer within claimant's working restrictions was made. Consequently, claimant's adaptability value is based on former OAR 436-35-310(3)(b).

The record establishes that claimant's job at the time of his compensable injury required him to do heavy work. After the injury, claimant was released to return to light work. Therefore, the appropriate adaptability value for a claimant who has gone from heavy to light work is 2.5. Id.

Impairment

Claimant has not suffered any ratable loss of spinal range of motion. (Ex. 10). Therefore, no value is assessed for loss of range of motion. He does have, however, a clinically significant unoperated disc derangement at L5-S1, and a bulging disc at L4-5. Therefore, a value of 4 is given for each of these disc conditions. Former OAR 436-35-350(2). Claimant's total impairment is 8.

Computation of Unscheduled Disability

Having determined each value necessary to compute claimant's permanent disability under the "standards," we proceed to that calculation. When claimant's age value 0 is added to his education value 4 the sum is 4. When that value is multiplied by claimant's adaptability value 2.5 the product is 10. When that value is added to claimant's impairment value 8 the result is 18 percent unscheduled permanent partial disability. Former OAR 436-35-280(7). Claimant's permanent disability under the "standards" is, therefore, 18 percent.

Disability Outside the Standards

The Referee found that claimant had proven by clear and convincing evidence that his compensable injury caused limitations in his ability to repetitively twist, crawl, bend, etc. As a result, the Referee awarded claimant an additional 4 percent permanent disability outside the standards. We disagree.

We find that such limitations have already been taken into consideration under our adaptability analysis under the standards. That analysis considers claimant's physical capacity to do work and his limitations caused by his compensable injury. Therefore, we find that these limitations do not equate to additional disability outside the standards.

Further, we conclude that there is no clear and convincing evidence that claimant suffers additional permanent disability not already found by an application of the standards.

ORDER

The Referee's order dated March 27, 1989, is modified. In lieu of the Referee's award and, in addition to the November 14, 1988 Determination Order award of 16 percent (51.2 degrees) unscheduled permanent disability, claimant is awarded 2 percent (6.4 degrees) unscheduled permanent disability, for a total of 18 percent (57.6 degrees) unscheduled permanent disability. A client-paid fee, not to exceed $392.50, payable by the insurer to its counsel, is approved.

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In the Matter of the Compensation of
**TOM B. TALMAGE, Claimant**
WCB Case No. 88-17651
ORDER ON REVIEW
Stafford J. Hazelett, Defense Attorney

Reviewed by Board Members Myers and Cushing.

Claimant, pro se, requests review of Referee Miller's order which declined to set aside a Disputed Claims Settlement entered into by claimant and the insurer. On review, the issue is validity of the Disputed Claims Settlement. 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.

In the Disputed Claim Settlement, claimant agreed to allow the insurer's denial of his low back injury to remain in force. In consideration of claimant's agreement, the insurer paid claimant a lump sum of money.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant was bound by the Disputed Claim Settlement on the basis that he had not timely appealed it. Although we agree with this result, we modify the Referee's reasoning.

The Disputed Claim Settlement did contain a notice of appeal rights. This notice, however, related to the insurer's denial which was incorporated within the document. It did not pertain to an appeal of the Disputed Claim Settlement. Therefore, whether claimant complied with the time limitations of the denial are not relevant to the resolution of this case.

The issue at hand is whether claimant is bound by the terms of the Disputed Claims Settlement. 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). This includes settlement of a previously accepted claim in some limited circumstances. See former OAR 430-09-010(3)(a). We regard vacating prior settlements to be an extraordinary remedy to be granted sparingly only in the most extreme situations. Manuel R. Boyd, 42 Van Natta 515, 516 (1990); Mary Lou Claypool, 34 Van Natta 943, 946 (1982).

In the instant case, claimant was represented by counsel and indicated that he had read and understood the agreement. His sole reason for questioning the validity of the document was his understanding that he could accept the lump sum and then also appeal the denial. In effect, he signed the document,

accepted the benefits therefrom with the unexpressed intent to deny it later and seek additional benefits. Under these circumstances, we conclude that claimant has not established extraordinary circumstances necessary to set aside the Disputed Claim Settlement. Accordingly, we decline to set the agreement aside.

ORDER

The Referee's order dated February 21, 1989, is affirmed.

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July 3, 1990 Cite as 42 Van Natta 1520 (1990)

In the Matter of the Compensation of
**SHIRLENE HANSON, Claimant**
Own Motion No. 90-0163M
OWN MOTION ORDER
Francesconi, et al., Claimant Attorneys
Saif Legal Department, Defense Attorney

Claimant has submitted to the Board her request for own motion relief for an alleged worsening of her May 7, 1975 industrial injury. Claimant's aggravation rights have expired. The SAIF Corporation has not submitted a recommendation on whether or not to reopen claimant's claim. OAR 438-12-025. Moreover, SAIF has not issued a written acceptance or denial of the responsibility and/or compensability of claimant's current right knee condition. Claimant has not responded to the Board's request for evidence regarding her entitlement to temporary disability benefits.

Under ORS 656.278(1)(a), we may exercise our own motion authority and reopen a claim for additional temporary total disability compensation when we find that there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. Here, the condition for which claimant underwent surgery and now requests own motion relief remains in de facto denied status. Consequently, we are not authorized to reopen her claim at this time. Should claimant's circumstances change and SAIF accept responsibility for her condition, she may again seek own motion relief.

Accordingly, claimant's request for own motion relief is denied.

IT IS SO ORDERED.

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July 3, 1990 Cite as 42 Van Natta 1520 (1990)

In the Matter of the Compensation of
**SIGRID C. PARKER, Claimant**
WCB Case No. 88-13005
ORDER ON REVIEW
Charles Maier, Claimant Attorney
Gail Gage (Saif), Defense Attorney

Reviewed by Board Members Nichols and Brittingham.

The SAIF Corporation requests review of that portion of Referee Foster's order that awarded a $550 assessed fee for late acceptance or denial of an aggravation claim. On review, the issue is entitlement to 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. SAIF received the aggravation claim on May 5, 1988. On May 17, 1988 the claims representative noted facts, in a medical report, which led him to believe that claimant's disc herniation could have been caused by a tire changing incident unrelated to the compensable injury. Dr. Flamming, the treating physician, however, advised him that claimant had not suffered a new injury. That report was received on May 31, 1988. The representative then scheduled an independent medical examination -- for a date more than 60 days after the filing of the claim. The timing of the examination was further delayed by claimant's inability to travel. SAIF apparently first interviewed claimant about the tire changing incident on July 26, 1988, more than 60 days following the filing of the claim.

SAIF's delay of 48 days beyond that allowed for acceptance or denial of a claim was unreasonable. We further find that the delay constituted unreasonable resistance to the payment of compensation. In so finding, we take administrative notice of the fact that the aggravation claim was ultimately declared compensable by stipulation.

The case was litigated under the expedited claim service. Claimant's counsel did not submit a statement of services within 15 days of the conclusion of the proceeding before the Referee. The Referee nonetheless awarded a penalty-related fee of $550.

CONCLUSIONS OF LAW AND OPINION

SAIF's delay in accepting or denying the claim was unreasonable. The statute provides 60 days for accepting or denying a claim. SAIF took 108 days in this case. SAIF did not even interview claimant or schedule an independent medical examination until after the 60-day period had expired. Its conduct was unreasonable.

SAIF contends that the Referee erred in awarding a fee because claimant's counsel performed no services to procure acceptance or denial of the claim. That, if true, is irrelevant. Claimant's counsel is entitled to a fee not for procuring acceptance or denial following SAIF's delay but for vindicating claimant's interest by achieving an adjudication that SAIF's conduct was unreasonable. Counsel has certainly provided services in that regard, including but not limited to requesting a hearing and representing claimant at hearing.

SAIF also argues that counsel is not entitled to an attorney fee because he filed no statement of services (SOS). Claimant's attorney does not address SAIF's contention. We agree with SAIF and conclude that no attorney fee should have been awarded.

Former OAR 438-15-010(5) provided that,

> "Except as otherwise provided in these rules, an assessed fee or client paid fee shall not be authorized by a referee...unless the attorney requesting authorization for payment of the fee files a statement of services on a form prescribed by the Board..."

No exception is provided in these rules which would specifically exclude the necessity of claimant's attorney filing an SOS in expedited claims proceedings.

Inasmuch as counsel never filed a statement of services, he was entitled to no fee for establishing SAIF's resistance to the payment of compensation. Therefore, we reverse.

ORDER

The Referee's order dated September 28, 1988, is reversed in part and affirmed in part. The Referee's award of a $550 penalty-related fee is reversed. The remainder of the order is affirmed.

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In the Matter of the Compensation of
**DONALD H. WOOD, Claimant**
WCB Case No. 88-09280
ORDER ON REVIEW
David C. Force, Claimant Attorney
Nancy Marque (Saif), Defense Attorney

Reviewed by Board Members Crider and Brittingham.

Claimant requests review of those portions of Referee Livesley's order that: (1) upheld a denial of reimbursement for travel expenses associated with a followup visit to the Arizona surgeon who performed an elbow surgery; and (2) concluded that the SAIF Corporation had correctly calculated claimant's temporary total disability compensation. On review, the issues are medical services and temporary total disability compensation. We reverse in part and affirm in part.

FINDINGS OF FACT

Claimant suffered a compensable elbow injury in August 1983. He continued to work for the employer off and on until October 1984. Dr. Schachner performed ligament release surgery in March 1985 and Dr. Butters performed an arthroscopy procedure a year later.

Claimant vacationed in Arizona, and while he was there he experienced more problems with his elbow. He began treating with Dr. Joseph in Arizona, and in December 1986 Dr. Joseph performed another surgery for radial nerve decompression and radial head replacement. Dr. Joseph expected claimant to return for annual checkups. Both Dr. Butters and Dr. Redfield, claimant's treating physician in Oregon since December 1986, recommended followup with Dr. Joseph in Arizona. Claimant requested that SAIF pay for his Arizona treatment. SAIF paid claimant's doctor bills but refused to pay claimant's travel expenses to Arizona.

While claimant worked for the employer, he had the use of a van, which he took home at night. He was told in 1980 that he could use the van for personal business, provided he got permission before he took the vehicle on a long trip. In January 1984 claimant was told to leave the van at the workplace at night. At the same time, he received a $200 per month raise. The value to claimant of the use of the van was $200 per month.

FINDINGS OF ULTIMATE FACT

Claimant's personal use of a van was part of his wages.

Travel to the treating doctor in Arizona was reasonable and necessary.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant's return to his attending physician in Arizona was merely for his own peace of mind and was not reasonable and necessary. The Referee, citing ORS 656.245 and OAR 436-60-050(4), stated that because a claimant residing in Oregon cannot choose a treating physician outside of Oregon, that no right to reimbursement exists for travel to that physician under the rules.

SAIF does not dispute the medical treatment itself, but contends that the right to travel expenses arises not from the statute but from the rules, and that the applicable rule permitting a claimant to choose an out-of-state doctor, OAR 436-60-050(5), does not allow for reimbursement of travel expenses. We disagree.

A claimant is entitled to medical services when out of state under ORS 656.245. Reynaga v. Northwest Farm Bureau, 300 Or 255 (1985). Moreover, reasonable travel expenses resulting from treatment of an on-the-job injury are "services", and are compensable. ORS 656.245(1); Francoeur v. SAIF, 17 Or App 37 (1974). OAR 436-60-050(5) simply permits an insurer to object to the claimant's choice of an out-of-state doctor, which only then permits the insurer to limit payment for treatment or services. Id. Here, SAIF made no objection to claimant's choice of an Arizona doctor. Therefore, SAIF cannot limit payment for services. Id.

Furthermore, there is no evidence supporting the Referee's finding that the checkups with the Arizona physician were merely for claimant's peace of mind. SAIF approved the Arizona doctor as claimant's treating surgeon for his compensable injury. Both of claimant's local doctors recommended that he receive followup care by the Arizona doctor. Accordingly, we conclude that the checkups were reasonable and necessary. Therefore, because the medical services were reasonable and necessary and since SAIF did not object to claimant's out-of-state attending physician, SAIF must reimburse claimant for his mileage.

Calculation of Temporary Total Disability Compensation

The Referee found that claimant failed to prove his temporary total disability compensation was incorrectly calculated. The Referee concluded that the value of claimant's personal use of the employer's van should not be included as part of claimant's wages. Claimant contends that the use of a company van, at a value to him of $200 per month, should have been compensated as part of the replacement of his wages under ORS 656.210(26). We agree.

The Referee reasoned that because claimant acknowledged that he requested permission to use the van in extraordinary situations, doubt was cast on his claim that he had exclusive personal use of the vehicle. The Referee relied on the testimony of witnesses who were not present at the time claimant was assigned the van when he made the finding that the $200 wage adjustment granted in January 1984 was part of a routine review of salaries. We rely instead on the testimony of the partner-owner, who was also the manager of the employing company in 1980 when claimant began work, regarding the use of the van arrangement.

Both claimant and the partner-owner testified that claimant was provided with round-the-clock use of a company van because he was on call and had no vehicle of his own. The manager was aware that claimant made weekend trips in the vehicle, although both agreed that claimant would ask permission to use the van for an extraordinary personal use, such as using it for a vacation, or his honeymoon. Claimant was to maintain the vehicle, while the company was to pay for the maintenance.

On January 1, 1984, claimant was given a salary increase of $200 per month. At the same time, he was required to leave the van at the office. Claimant testified that he was told the $200 raise was to compensate him for the use of the van. SAIF offered no evidence of a lower or different value.

On this record, we are persuaded that the value of the van to claimant was $200 per month, and that the use of the van was part of claimant's wage at the time of his 1983 injury. SAIF should include the value of the van in claimant's wages for purposes of calculating temporary disability benefits.

ORDER

The Referee's order dated January 3, 1989 is reversed in part and affirmed in part. The portion upholding the SAIF Corporation's denial of travel reimbursement is reversed. The denial is set aside and the claim is remanded to SAIF for further processing. SAIF shall recalculate claimant's temporary total disability compensation consistent with this order. The remainder of the Referee's order is affirmed. For services at hearing and on review regarding the medical services issue, claimant's attorney is awarded an assessed fee of $625, payable by SAIF. Claimant's attorney is allowed an approved fee in the amount of 25 percent of the increased compensation awarded by this order, not exceeding $3,800, payable by SAIF directly to claimant's attorney.

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July 5, 1990 Cite as 42 Van Natta 1524 (1990)

In the Matter of the Compensation of
**B. J. CRANE, Claimant**
Own Motion No. 88-0466M
OWN MOTION ORDER ON RECONSIDERATION
Rex Q. Smith, Claimant Attorney
Shelley K. Edling, Defense Attorney

Claimant requests reconsideration of our June 13, 1990, Own Motion Order which denied his request for additional permanent disability benefits on the ground that we no longer have the statutory authority to award such benefits. Claimant argues that the legislature's 1987 amendments to ORS 656.278, which removed the Board's own motion authority to award permanent disability benefits after January 1, 1988, violates both the federal and state constitutional provisions prohibiting state action impairing the obligation of contracts.

The Board has considered claimant's constitutional argument and finds it to be without merit. Accordingly, claimant's request for reconsideration is denied. The parties' rights of reconsideration and appeal shall continue to run from the date of our June 13, 1990, order.

IT IS SO ORDERED.

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July 5, 1990 Cite as 42 Van Natta 1524 (1990)

In the Matter of the Compensation
**DESI R. DAVIS, Claimant**
WCB Case No. 88-21770
ORDER ON REVIEW
Gastineau & Smith, Claimant Attorneys
Cowling & Heysell, Defense Attorneys

Reviewed by Board Members Myers and Cushing.

The insurer requests review of that portion of Referee Brown's order which declined to authorize the insurer to offset its overpayment against any future award of permanent disability. On review, the issue is offset. We reverse.

FINDINGS OF FACT

Claimant compensably injured his left knee in April 1987. Claimant has no ratable impairment in her left knee as a result of this compensable injury.

A June 24, 1988 Determination Order closed claimant's left knee injury claim, awarding temporary disability only. She was awarded temporary total disability from April 18, 1987 through April 19, 1987 and temporary partial disability from April 20, 1987 through May 21, 1987. Her condition was medically stationary on May 5, 1988.

The insurer overpaid claimant $5,208.27.

CONCLUSIONS OF LAW AND OPINION

The Referee declined to authorize the insurer to offset its overpayment against any future awards of permanent disability because the insurer did not supply claimant with an accounting or submit evidence proving the amount of the offset. We disagree.

At hearing, the insurer requested an offset against permanent disability for overpaid temporary disability. The Referee concluded that there was insufficient evidence of an overpayment and denied the request.

With its request for reconsideration, the insurer submitted records establishing an overpayment of $5,208.27. On reconsideration, the Referee found that the insurer had never supplied claimant with an accounting. Further, because the Referee found that the amount of the overpayment proven by those records was inconsistent with earlier figures, such as that found on the official notice of hearing submitted by the insurer, the Referee again declined to grant an offset against future permanent partial disability.

The Referee relied on former OAR 436-60-170(2), which provides that the insurer shall explain to the claimant, in writing: (1) the reason for the overpayment; (2) the amount of the overpayment; and (3) the method of recovery of the overpayment. Reasoning that the rule required an "accounting" from the insurer prior to obtaining authorization to recover an overpayment, the Referee declined the insurer's request for an offset.

We disagree with the Referee's conclusion that the aforementioned rule requires an "accounting." Moreover, considering that the admitted copies of the insurer's cancelled checks, which were submitted by the insurer and furnished to claimant's counsel, were introduced in a proceeding designed to determine whether the insurer should be permitted to recover an overpayment, we conclude that the requirements of former OAR 436-60-170(2) have been met.

Based on the copies of the cancelled checks from the insurer, we hold that the insurer has established an overpayment of temporary disability of $5,208.27. Therefore, we conclude that the insurer is entitled to an offset of overpaid temporary disability against any future awards of permanent disability. See Berliner v. Weyerhaeuser Company, 92 Or App 264 (1988)(Offset authorization continues in effect until revoked or overpayment wholly recovered.) James D. Shirk, 41 Van Natta 90, 92 (1989).

ORDER

The Referee's order dated March 24, 1989, as reconsidered on April 4, 1989, is affirmed in part and reversed in part. That portion of the order which declined to authorize an offset is reversed. The insurer is allowed an offset of temporary disability paid ($5,208.27) against future awards of permanent disability on this claim, if any. The remainder of the Referee's order is affirmed. A client-paid fee, not to exceed $337.50, payable by the insurer to its counsel, is approved.

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In the Matter of the Compensation of
**EDYTHE P. EGGLESTON, Claimant**
WCB Case No. 89-17565
ORDER ON REVIEW
Richard F. McGinty, Claimant Attorney
Tooze, et al., Defense Attorneys

Reviewed by Board Members Howell and Speer.

Claimant requests review of Referee Holtan's order that increased her scheduled permanent disability award for a right foot (ankle) injury from 5 percent (6.75 degrees), as awarded by a Determination Order, to 8 percent (10.80 degrees). Claimant moves the Board for remand for the introduction of evidence not admitted at hearing. In its brief, the insurer contends that claimant failed to mitigate the effects of her injury. On review, the issues are remand and extent of scheduled permanent disability. We affirm.

FINDINGS OF FACT

The Board adopts the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Remand

The Referee declined to assign an impairment value to claimant's limited range of motion which occurred when she wore her ankle brace. Claimant asserts that, because she used a temporary brace until the day before hearing, she did not have adequate time to develop evidence regarding her new brace and the effects of any limitations she experiences from its use.

We may remand a case to the Referee if we find that the record has been "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(5). To merit remand 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).

We agree with the Referee that impairment values assigned by OAR 436-35-190 are determined by the active range of motion of claimant's injured ankle without bracing. See OAR 436-35-010(3).

Under the circumstances, we conclude that the record has been completely and sufficiently developed to determine permanent disability under the applicable standards. Accordingly, claimant's request for remand is denied.

Scheduled permanent disability

The Referee found that claimant had diminished range of motion in her right ankle and he awarded 3 percent scheduled permanent disability in addition to the 5 percent previously awarded by Determination Order. Neither party disputes that claimant is entitled to the scheduled permanent disability awarded by the Referee under the standards.

The Referee found that claimant had not established by clear and convincing evidence that her permanent disability award under the standards is inadequate. We agree.

A scheduled disability rating outside the standards must be supported by clear and convincing evidence. ORS 656.283(7). "Clear and convincing evidence" means that the truth of the facts is highly probable. The evidence must be free from confusion, fully intelligible and distinct. Riley Hill General Contractor, Inc. v. Tandy Corp., 303 Or 390, 407 (1987). In examining for clear and convincing evidence, the record is viewed as a whole. Thomas L. Swanger, 42 Van Natta 887 (1990).

On review, claimant contends that her testimony that she cannot bend her foot down or to either side while wearing her brace, establishes her lost range of motion due to the brace. She also argues that the Referee was able to observe her demonstrated limited range of motion.

We conclude that the issue of the effect of a brace on claimant's permanent impairment due to her injury is in part a medical question. That is, while the brace may reduce motion, it presumably provides a net benefit to claimant by reducing pain or instability, by increasing her ability to repetitively use her ankle or through some other benefit(s).

We agree with the Referee that claimant has not provided sufficient evidence pertaining to the use of the brace or its effect on claimant's range of motion. Under the circumstances, we are not convinced that she has shown an entitlement to additional scheduled disability.

Finally, we have previously held that the mere fact that claimant wears a brace does not necessarily constitute clear and convincing evidence that disability is greater than the award to which claimant is entitled under the standards. See Kirk A. Shira, 42 Van Natta 1011 (1990).

Based upon our examination of the record as a whole, we find that claimant has not shown that it is highly probable that her award under the standards is inadequate. She has failed to show clear and convincing evidence that her disabilities are greater than indicated by the Referee's application of the standards.

Mitigation of damages

The insurer argues that claimant is not entitled to a disability award outside the standards because she has failed to mitigate the effects of the injury. Because we have already concluded that claimant has not proven that her disability is greater than the 8 percent to which she is entitled under the standards, we do not reach the issue of mitigation.

ORDER

The Referee's order dated February 7, 1990 is affirmed.

In the Matter of the Compensation of
**WAYNE GENTRY, Claimant**
Own Motion No. 85-0347M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Nichols & Bogardus, Claimant Attorneys

Claimant has requested review of the insurer's Notice of Closure dated May 8, 1990, which terminated the payment of temporary disability benefits as of April 26, 1990, and declared him medically stationary as of May 7, 1990. By correspondence dated May 22, 1990, the insurer advised that it rescinded its closure of the claim because claimant underwent surgery that is related to the 1975 injury. Notwithstanding that rescission, claimant now requests a penalty and attorney fees for the insurer's allegedly unreasonable processing of his claim.

By Own Motion Order issued January 27, 1987, the Board reopened claimant's claim for the payment of temporary disability benefits "until closure pursuant to ORS 656.278." At the time of the order, ORS 656.278 and the rules promulgated thereunder did not permit an own motion insurer to close a claim or terminate temporary disability benefits without prior authorization by the Board. Although the current own motion law permits an insurer to close a claim and terminate benefits without prior Board authorization, it does not apply to claims reopened prior to January 1, 1988. See OAR 438-12-018. Here, the insurer did not have prior Board authorization for either claim closure or the termination of benefits. We find, therefore, that its processing of this claim resulted in an unreasonable delay in the payment of compensation. We assess a penalty equal to 10 percent of the amounts of temporary disability compensation due from April 27, 1990, through May 22, 1990. See ORS 656.262(10). Claimant's attorney is awarded a penalty-related attorney fee of $100. See ORS 656.382(1).

Because claimant's attorney was instrumental in obtaining additional temporary disability benefits, we ordinarily would approve a reasonable attorney fee payable out of claimant's increased compensation. See OAR 438-15-080. However, the attorney retainer agreement signed by claimant sometime in June, 1985, provides that "any and all attorney fees that may be awarded will be paid in addition to and not out of any benefits obtained for claimant." Because that agreement is controlling, we decline to approve a fee payable out of claimant's increased compensation.

IT IS SO ORDERED.

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In the Matter of the Compensation of
**FRANK D. GRAY, Claimant**
Own Motion No. 90-0356M
OWN MOTION ORDER

The self-insured employer has voluntarily reopened the above claim pursuant to ORS 656.278. Claimant's aggravation rights expired May 2, 1979. It asks the Board to authorize reimbursement from the Reopened Claims Reserve.

We find that claimant's compensable condition has worsened requiring inpatient or outpatient surgery, or other treatment requiring hospitalization. We, therefore, have the authority to award temporary disability benefits commencing November 2, 1989, the date of claimant's hospitalization or outpatient surgery. See ORS 656.278(a). Accordingly, reimbursement of these monies to the insurer is appropriate. The self-insured employer shall continue paying temporary total disability benefits until one of the following events first occurs:

(1) claimant is medically stationary and claim is closed; (2) claimant returns to regular or modified work; (3) the attending physician gives claimant a written release to return to regular employment; or (4) the attending physician gives claimant a written release to return to modified work, such employment is offered in writing to claimant and claimant fails to begin such employment. 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.

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In the Matter of the Compensation of
**DONALD L. HALL, Claimant**
WCB Case No. 88-07407
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Rankin, et al., Defense Attorneys

Reviewed by Board Members Howell and Speer.

Claimant, pro se, requests review of Referee Mulder's order which upheld the insurer's partial denial of his claim for an ear condition, including tinnitus. In its brief, the insurer contends that the issue of claimant's ear condition and tinnitus is barred by res judicata pursuant to a Disputed Claim Settlement. On review, the issues are res judicata and compensability. We affirm.

## FINDINGS OF FACT

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

## CONCLUSIONS OF LAW AND OPINION

With regard to the merits of claimant's tinnitus claim, the Board adopts the Referee's "Conclusions of Law and Opinion." However, we note that, if we were to have accepted claimant's statements concerning the onset of his tinnitus condition, the claim would have been barred by claim preclusion. If accepted, claimant's testimony would establish that the tinnitus claim arose out of the same set of operative facts giving rise to the final judgment between these same parties on his hearing loss claim. See Tana L. Wilson, 40 Van Natta 476 (1988).

## ORDER

The Referee's order dated February 23, 1989 is affirmed.

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In the Matter of the Compensation of
**DEWEY A. LOGUE, Claimant**
WCB Case No. 88-19684
ORDER ON REVIEW
Stebbins & Coffey, Claimant Attorneys
Cummins, et al., Defense Attorneys

Reviewed by Board Members Gerner and Myers.

The self-insured employer requests review of that portion of Referee Brown's order that awarded claimant temporary disability benefits from May 19, 1986 through the date of the Referee's order. On review, the issue is temporary disability benefits. We affirm.

## FINDINGS OF FACT

The Board adopts the Referee's Findings of Fact, as set forth in the "Findings" and "Ultimate Findings of Fact" portions of the order, as our own, with the following supplementation.

In Dewey A. Logue, 42 Van Natta 431 (1990), the Board affirmed an August 1, 1988 Opinion and Order which set aside Weyerhaeuser Company's denial of claimant's aggravation claim for a right knee osteoarthritis condition and upheld Wausau's Insurance Company's denial of the same condition.

At hearing, the parties stipulated to the following:

(1) Claimant was entitled to temporary total disability from November 18, 1985 through May 19, 1986;

(2) Claimant retired as of May 19, 1986;

(3) After being taken off work in October 1985, claimant was at no time released to return to regular work by any treating physician; and

(4) As of the date of hearing, the aggravation claim for the osteoarthritic knee condition had not been closed or submitted for closure.

## CONCLUSIONS OF LAW AND OPINION

The Board adopts the Referee's Conclusions of Law, as set forth in the "Opinion" portion of the order, with the following supplementation.

Claimant's entitlement to temporary disability benefits after May 19, 1986 is at issue. The employer contends that because claimant retired on May 19, 1986, he was not entitled to temporary disability benefits after that date. We disagree.

Claimant's aggravation claim was opened on November 19, 1985. Claimant retired May 19, 1986. The parties stipulated that cliamant had not been released to return to regular work, nor had the claim been closed. Therefore, we find that claimant is entitled to temporary disability benefits from May 19, 1986 through February 24, 1989, the date of the Referee's order. See Weyerhaeuser Co. v. Kepford, 100 Or App 410 (1990).

## ORDER

The Referee's order dated February 24, 1989, as reconsidered on March 24, 1989, is affirmed. For services on Board review, claimant's attorney is awarded a reasonable assessed fee of $500, to be paid by the employer. A client-paid fee, not to exceed $1,932, payable by the employer to its counsel, is approved.

In the Matter of the Compensation of
**DONALD REED, Claimant**
Own Motion No. 88-0523M
OWN MOTION ORDER REFERRING FOR FACTFINDING HEARING
Roger D. Wallingford, Claimant Attorney
Saif Legal Department, Defense Attorney

Claimant requests review of the SAIF Corporation's April 20, 1989, Notice of Closure which declared him medically stationary as of January 16, 1989. SAIF terminated claimant's temporary total disability benefits as of January 22, 1989. Claimant contends that claim closure is premature because he is not medically stationary. He also contends that he was not paid the proper rate of temporary disability benefits and requests that SAIF be assessed a penalty and attorney fee.

By order dated May 17, 1989, we directed SAIF to provide claimant with the employer's payroll records for 1981 and 1982. However, SAIF only provided claimant with a copy of a single-page summary of an employee's wage earnings and deductions for three quarters. Neither the employee nor the employer is named on the summary, and many of the entries on the summary are illegible. Furthermore, whereas claimant represents that he regularly worked five days a week, the employer contends that he only worked three days a week.

We conclude that the rate of claimant's temporary disability benefits is a matter that should be referred for a factfinding hearing. The referee shall take evidence concerning the daily wage that claimant was earning on the date of his injury in 1982, and the number of days that he was regularly employed on a weekly basis. The referee shall then make a recommendation regarding the appropriate rate of claimant's temporary total disability benefits. The referee shall also recommend whether SAIF should be assessed a penalty and related attorney fee for its allegedly unreasonable refusal to pay compensation.

Accordingly, this own motion matter is referred for a factfinding hearing. At the conclusion of the hearing, the referee shall forward to the Board his/her recommendation. Thereafter, we shall issue an order in this own motion matter.

IT IS SO ORDERED.

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In the Matter of the Compensation of
**DEBRA A. SMITH, Claimant**
WCB Case No. 88-17862
ORDER ON REVIEW
Burt, et al., Claimant Attorneys
Stafford Hazelett, Defense Attorney

Reviewed by Board Members Howell and Speer.

The insurer requests review of Referee Irving's order which: (1) found that claimant had established good cause for an untimely filing of a hearing request; and (2) set aside the insurer's denial of claimant's claim for her right wrist condition. On review, the issues are timeliness of the hearing request and compensability. We reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Timely Request for Hearing

The Referee found that claimant had established good cause for her untimely request for hearing. We do not 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, confers jurisdiction 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, 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). 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 June 16, 1988 denial until October 13, 1988, giving as her reason reliance on the oral statements of the insurer's employee that additional information was required and the fact that the insurer had set an appointment for an independent medical examination after the 60-day limit had expired. However, the employee did not mislead claimant by telling her that her claim would be accepted either upon receipt of the additional information or after the statutory time for requesting a hearing had passed. We conclude that claimant's reliance on the statements of the insurer's employee did not constitute mistake, inadvertence, surprise, or excusable neglect under ORCP 71B(1). Thus, claimant has failed to establish good cause. See Diane T. Lindholm, 42 Van Natta 447 (1990).

Because we do not find that claimant had good cause for her untimely request for a hearing, we lack jurisdiction to reach the issue of compensability of her claim.

ORDER

The Referee's order dated March 17, 1989 is reversed. Claimant's request for hearing is dismissed. The insurer's denial is reinstated. The Referee's award of an assessed attorney fee of $1,650 is reversed.

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In the Matter of the Compensation of
**BRYAN THOMPSON, Claimant**
WCB Case No. 88-20553
ORDER ON REVIEW
Gatti, Gatti, et al., Claimant Attorneys
Cowling & Heysell, Defense Attorneys

Reviewed by Board Members Howell and Speer.

Claimant requests review of those portions of Referee Higashi's order that: (1) upheld the insurer's "de facto" denial of claimant's medical services claim for massage therapy from November 1987 through May 1988; and (2) declined to assess penalties and attorney fees for an alleged unreasonable failure to

timely pay or deny her massage therapy bills. In its brief, the insurer argues that claimant's medical services claim for message therapy rendered prior to March 14, 1988 is barred by the doctrine of merger. On review the issues are medical services, penalties and attorney fees, and res judicata.

The Board affirms in part and modifies in part.

## FINDINGS OF FACT

We adopt the Referee's "Findings" with the following supplementation and correction.

From November 1987 until September, 1988, the massage therapist treated claimant in her own office. (Tr. 11). From September 6, 1988, the massage therapist treated claimant in Dr. Tryon's office. (Exs. 60, 61; Tr. 11, 14). Dr. Tryon's office and the massage therapist's office are in the same building, one floor apart. (Tr. 10; Exs. 51A, 56).

At a May 11, 1988 hearing regarding the same compensable injury, claimant litigated the issues of premature closure, extent of permanent partial disability, and penalties and attorney fees for the employer's late payment of temporary disability benefits and the failure to pay for an exercise bicycle. (Ex. 58).

The last time the insurer paid a massage therapy bill for claimant was in February 1988. (Tr. 11). At the time of the February 9, 1989 hearing, there was a total amount due and owing of $432 for massage therapy for claimant's compensable condition. (Tr. 13-14). The amount due since treatments began to be given in Dr. Tryon's office on September 6, 1988 is $210. (Exs. 60, 61; Tr. 11-14).

## CONCLUSIONS OF LAW AND OPINION

### Res Judicata

At hearing the insurer argued that claimant was precluded from asserting a claim for the massage therapy bills because claimant had failed to raise the issue at the May 1988 hearing when there were massage therapy bills due and owing for more than 60 days. The Referee in the present case held that the massage services from November 1987 through May 1988 were not compensable and, therefore, the issue of whether claimant waived his right to contest the "de facto" denial after proceeding to hearing in May without raising the issue, was moot. The insurer now argues that claimant is precluded from continuing to assert the massage therapy claim, not because of the rules of res judicata or collateral estoppel, but because claimant lost the right to assert the claim through the doctrine of merger.

The term "res judicata" is generally used in a broad sense to include merger, issue preclusion, claim preclusion and bar. See Restatement, Second, Judgments (1980). The doctrine of merger pertains to the extinguishment of a claim in a judgment for plaintiff; bar -- the extinguishment of a claim in a judgment for defendant; and issue preclusion -- the effect of the determination of an issue in another action between the parties on the same claim (direct estoppel) or a different claim (collateral estoppel).

The term "res judicata" has been utilized to refer to the preclusive effect on a claim ("claim preclusion") and on an issue ("issue preclusion"). North Clackamas School Dist. v. White, 305 Or 48, 50, modified 305 Or 468 (1988). Claim preclusion bars claims "which were or could have been litigated in the prior proceeding." See Consolidated Freightways v. Poelwijk, 81 Or App 311, 315 (1986).

Issue preclusion bars "relitigation of issues actually litigated and determined, if their determination was essential to the prior order." Id.; see State Farm Fire & Casualty v. Reuter, 299 Or 155, 158 (1985).

What we have in the present case is a "claim preclusion" issue. Claimant proceeded to hearing on May 11, 1988 on premature closure, extent of permanent disability and the insurer's late payment of temporary disability benefits and failure to pay for an exercise bike. (Ex. 58). At the time of hearing claimant's massage therapy bills from November 1987 up to the time of the hearing had not been paid by the insurer -- a "de facto" denial. For the res judicata/claim preclusion argument to be successful, it must be established that the claim for medical services in the form of massage therapy was raised and finally adjudicated in the prior hearing involving the same parties; or that if the claim was not actually raised in the prior hearing, that it could have been raised under the same set of operative facts. Restatement, Second, Judgments, 24(2); see also Dean v. Exotic Veneers, Inc., 271 Or 188, 192-93 (1975); Carr v. Allied Plating Co., 81 Or App 306, 310 (1986); Taylor v. Baker, 279 Or 139 (1977); Gerald W. Lewis, 41 Van Natta 1946 (1989). The operative facts for the holding on premature closure, permanent partial disability, and the late payment of temporary disability benefits and failure to pay for an exercise bike were not the same for a claim on a "de facto" denial of medical services in the form of massage therapy. Accordingly, claimant was not precluded from asserting a claim for the massage therapy. We turn to the merits of the massage therapy claim.

Medical Services Claim

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). Claimant's submission of billings for massage therapy prescribed by his attending physician is a claim for "other related services" under OAR 436-10-005(17), and also "physical restorative services" under ORS 656.245. Terrance A. Benboe, 42 Van Natta 298 (1990); Jeanette M. McMichael, 40 Van Natta 1131, 1132 (1988). At the time claimant received the massage treatment, OAR 436-10-050(2) required that the massage therapist "work under the direct control and supervision of the attending physician." "Direct control and supervision" means that the attending physician is 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).

The Referee held that the massage therapist was not under the direct supervision and control of the physician who prescribed the services. The massage therapist and claimant's treating physician have independent offices. The rule, the validity of which is not challenged, is clear. Prior to September 1988, the attending physician and the massage therapist were not "on the same premises." Therefore, the pre-September 6, 1988 services are not compensable. As the Referee stated, after September 1988, when the massage therapist began to treat claimant in the physician's office, there is no question of compensability of the massage therapy treatments.

Penalty and Attorney Fee

The insurer neither denied nor accepted claimant's massage therapy bills/claim. The record indicates that the insurer had a reasonable doubt that the massage therapy was performed in compliance with OAR 436-10-005(9) -- all of the billings came from the massage therapist with her letterhead and there was no indication of the special arrangements between Dr. Tryon and the therapist until clarification was clearly made in February 1989. (Ex. 60A).

However, the insurer should have issued an acceptance or denial within 60 days of receipt of claimant's massage therapy claim dating back to November 1987. ORS 656.262(6). The insurer had a duty to issue a timely acceptance or denial without regard to the merits of the claim. Because the insurer did not timely accept or deny, we conclude that the employer did act unreasonably, that such conduct was an unreasonable resistance to the payment of compensation pursuant to ORS 656.382(1), and assess a penalty and related attorney fee. ORS 656.262(10). Pursuant to our decision affirming that the massage therapy bills from November 1987 until September 6, 1988 are not compensable, a penalty of 25 percent is assessed against the amount due and owing for the bills from September 6, 1988 until 60 days prior to the February 9, 1989 hearing. Claimant's attorney is entitled to a reasonable, insurer-paid attorney fee of $100 for services in connection with the insurer's failure to pay compensation in regard to the message therapy.

ORDER

The Referee's order, dated March 1, 1989, as supplemented March 3, 1989, is affirmed in part and modified in part. Claimant is awarded a penalty of 25 percent of the compensation due for the massage therapy between September 6, 1988 and December 11, 1988. Claimant's attorney is awarded a $100 penalty-related assessed fee. Claimant's attorney is also awarded an assessed fee of $300, to be paid by the insurer, for prevailing on the medical services issue on review.

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July 5, 1990 Cite as 42 Van Natta 1535 (1990)

In the Matter of the Compensation of
**THERMAN TUTTLE, Claimant**
WCB Case No. 88-10186
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Speer and Howell.

Claimant requests review of Referee St. Martin's order which found that he was not a subject worker. On review the issue is subjectivity. We affirm.

FINDINGS OF FACT

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

Claimant was paid $12.00 per hour; claimant was given gasoline and mileage allowance. (Ex. 1, 16; Tr. 36). Claimant was paid by personal check. (Tr. 66). Claimant did not file a tax withholding form. (Tr. 69). No amounts were withheld from claimant's pay check for benefits, social security or taxes. (Tr. 36, 63). Claimant presented himself to Orion Homes, Inc. as a licensed, bonded and insured independent contractor in the State of Oregon. (Tr. 22, 27, 57 and 78). Claimant has worked for other building companies as an independent contractor. (Tr. 65).

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant was not a subject worker, but rather an independent contractor, at the time he was injured. We agree.

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 worker's services. ORS 656.005(27). The test requires an application of the traditional "right to control" analysis. Woody v. Waibel, 276 Or 189, 196 (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.

Control

Although claimant argues that he worked from 8-5 each day for Orion Custom Homes, Inc. ("employer"), claimant also testified that he continued to run his own businesses while working for the employer. Claimant presented himself as and has previously worked as a licensed and bonded subcontractor with the State of Oregon doing business under his own company name. (Tr. 22, 27, 57, 78). Claimant's labor for the employer was performed pursuant to an oral contract while he continued to operate his own company. (Tr. 13, 49, 88). The evidence indicates that claimant's schedule with the employer was very flexible, and that he was simply required to get the requested work done well in a reasonable time.

There was minimal contact between the employer and claimant. The employer specified the desired results of assigned projects but exercised no control over the details of claimant's work. Claimant worked only one week for the employer before the injury. During that time, claimant was building a deck for the employer and spoke with one of the employers only one time regarding the progress of construction of this deck. (Tr. 62). Claimant was not supervised.

The evidence does not support a finding that the employer either exercised control, or had the right to control, claimant's work performance.

Method of Payment

Claimant argues that because he had not been paid when the accident occurred, the method of payment is an "irrelevant" factor and should not be considered. We disagree.

Claimant was paid $12.00 per hour. Claimant submitted a very detailed, itemized bill to the employer for the services he rendered. (Tr. 29, 30; Ex. 16). Claimant was paid by check made payable to him personally; claimant did not file a withholding form with the employer, therefore, no taxes or benefits were withheld.

Equipment

Claimant furnished all of his own equipment and tools necessary for performance of his contracted labor. (Tr. 14, 19). Materials were paid for by the employer. (Tr. 37). The fact that claimant supplied his own equipment supports an independent contractor relationship.

Right to Terminate

Claimant and the employer established the terms of their agreement orally. Such a contract is a binding contract for services and does not fall within the Statute of Frauds. Once claimant agreed to perform the work, he was contracturally obligated to complete the task or risk damages. The employer was

similarly obligated to allow claimant to complete his tasks, or risk damages. The employer was not in a position to terminate the contract with claimant at will. This is a typical contractor/subcontractor relationship and does not denote a subject employee/employer relationship.

We conclude that the factors considered above regarding the traditional "right-to-control" test support finding that claimant is an independent contractor and not a "subject worker."

ORDER

The Referee's order, dated January 23, 1989, is affirmed.

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July 6, 1990 Cite as 42 Van Natta 1537 (1990)

In the Matter of the Compensation of
**IOLA P. CARR, Claimant**
Own Motion No. 89-0730M
SECOND OWN MOTION ORDER ON RECONSIDERATION
Peter O. Hansen, Claimant Attorney
Roberts, et al., Defense Attorneys

The insurer requests reconsideration of the Board's Own Motion Order dated January 19, 1990, as reconsidered June 18, 1990, which reopened claimant's claim for the payment of temporary disability benefits commencing November 11, 1989. The insurer contends that temporary disability benefits should have commenced as of November 30, 1989, the date of surgery. The insurer also requests that we order claimant to release information concerning dates of employment subsequent to surgery so that it may determine whether benefits should be paid for temporary partial or temporary total disability. Finally, the insurer requests Board authorization to offset overpaid temporary disability benefits against the current award of temporary disability.

We find that claimant did not have surgery until November 30, 1989. Therefore, we amend our previous orders to award temporary disability benefits commencing as of that date. Additionally, we direct claimant to furnish the insurer with employment information concerning the wages earned and the dates and hours worked subsequent to the November 30, 1989, surgery. The insurer's obligation to pay temporary disability compensation is suspended until within 14 days after its receipt of such information.

By stipulation dated June 20, 1989, the insurer preserved its overpayment of temporary disability benefits in the amount of $9,924.60. The insurer now requests that the overpayment be deducted from temporary disability benefits awarded under our previous orders. We decline to do so, however, because overpaid temporary disability benefits may only be deducted from future awards of permanent disability. See Buddy Tillman, 41 Van Natta 239 (1989); William J. Dale, 39 Van Natta 632 (1987); Harold D. Bates, 38 Van Natta 992 (1987). The insurer's request for an offset against temporary disability benefits is denied.

Accordingly, our Own Motion Order dated January 19, 1990, as reconsidered June 18, 1990, is abated and withdrawn. On reconsideration, as amended and supplemented herein, we adhere to and republish our June 18, 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
**FRED E. SMITH, Claimant**
Own Motion No. 90-0238M
OWN MOTION ORDER ON RECONSIDERATION
Pozzi, et al., Claimant Attorneys
Saif Legal Department, Defense Attorney

Claimant requests reconsideration of the Board's Own Motion Order issued May 7, 1990, which denied his request for own motion relief on the ground that his compensable low back condition does not require surgery or hospitalization for treatment. Claimant contends that his treatment, which consisted of a myelogram and pain injections, qualifies both as surgeries and hospitalizations. We disagree.

Under our own motion authority, we may award temporary disability benefits in those cases where 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). We interpret "surgery" to be an invasive procedure undertaken for a curative purpose and which is likely to temporarily disable the worker. Here, there is no persuasive evidence in the record that the myelogram or facet injections, in and of themselves, resulted in or were likely to result in temporary disability. Accordingly, neither of those procedures qualify as "surgeries" within the meaning of ORS 656.278(1)(a). Moreover, because neither procedure required an overnight stay, we do not regard either as "hospitalization" sufficient to justify claim reopening. Accordingly, claimant's request for reconsideration is denied.

IT IS SO ORDERED.

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In the Matter of the Compensation of
**MARY A. THOMAS, Claimant**
WCB Case No. 88-21547
ORDER ON REVIEW
Max Rae, Claimant Attorney
Gary Wallmark (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

Claimant requests review of that portion of Referee Michael Johnson's order which upheld the SAIF Corporation's denial of claimant's claim for an adrenal supplement as a medical service under ORS 656.245(1). On review the issue is medical services. We affirm.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact."

CONCLUSIONS OF LAW AND OPINION

The Referee held that OAR 436-10-040(7) precluded reimbursement to claimant for the stereotrophic adrenal dietary supplement she was taking as an anti-inflammatory for her compensable condition. OAR 436-10-040(7) provides:

> "Dietary supplements - such as minerals and vitamins are not reimbursable unless a specific compensable dietary deficiency has been clinically established in the injured worker..."

Claimant argues that the rule is invalid because it is inconsistent with ORS 656.245(1) and limits her right to obtain reasonable and necessary medical services causally related to her compensable claim. Further, claimant argues that the Director lacks authority to limit medical treatment under OAR 436-10-040(7).

Effective January 1, 1988, subsection (4) was added to ORS 656.245 which gives the Director broad authority to regulate what types of medical treatment are compensable. OAR 436-10-040(7) was repromulgated in September 1988. The rule is one which, under ORS 656.245(4), involves delegation of policy making authority. We review to determine whether the policy evidenced by the rule is within the legislative delegation. Springfield Ed. Ass'n v. School Dist., 290 Or 217 (1980). Claimant has failed to persuade us that the rule exceeds the delegated authority.

Claimant argues that the Director, prior to the repromulgation of OAR 436-10-040(7) in September 1988, was under the obligation to seek the advice of a committee or professional licensing board pursuant to ORS 656.245(4) and because the Director did not mention having been so advised regarding the substance of OAR 436-10-040(7), the rule was repromulgated improperly. This argument is not well-taken. Claimant cites Floyd L. Wiebe, 37 Van Natta 1295 (1985), in support of her argument that the Director does not have the authority to issue a rule with the scope of OAR 436-10-040(7). However, we noted in Wiebe that in promulgating OAR 436-10-040(7), "the Department had the benefit of the participation of an Advisory Committee on Medical Care...," and we inferred that the Committee took an active role in helping the Department to determine when vitamin therapy is reasonable and necessary. Wiebe, supra, at 1297.

In the present case, claimant has not shown that the Director acted outside his delegated authority in promulgating OAR 436-10-040(7), that adoption of the rule was by illegal process or that application of the rule in this case is inconsistent with ORS 656.245 and the Workers' Compensation Act.

ORDER

The Referee's order, dated March 15, 1989, is affirmed.

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In the Matter of the Compensation of
**KELLY V. CURTIS, Claimant**
WCB Case Nos. 88-19699 & 89-01969
ORDER ON REVIEW
Vick & Gutzler, Claimant Attorneys
Mitchell, Lang & Smith, Defense Attorneys
Thomas Anderson (Saif), Defense Attorney

Reviewed by Board Members Nichols and Brittingham.

Scott Wetzel Services, Inc. requests review of Referee Mulder's order that: (1) set aside its denial of claimant's aggravation claim for a low back 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 Referee's findings of fact subject to the following modifications and supplementations. We do not adopt the Referee's finding that

claimant, while employed by SAIF's insured, carried several tons of 40 pound concrete blocks. Rather, on September 30, 1988, claimant carried approximately 50 to 60 of these concrete blocks. Also, we do not adopt the finding that claimant lifted up to 225 pounds while working for a metals company in 1987; claimant lifted objects weighing up to 100-125 pounds on this job, with the average weight being from 30 to 60 pounds.

As a result of claimant's compensable 1984 low back injury with Scott Wetzel's insured, he has received an unscheduled permanent disability award of 22.5 percent.

FINDINGS OF ULTIMATE FACT

Claimant's work activities with SAIF's insured did not independently contribute to a worsening of his underlying low back condition.

CONCLUSIONS OF LAW AND OPINION

The Referee held that Scott Wetzel remained responsible for claimant's current low back condition. On review, Scott Wetzel disputes the Referee's responsibility finding. We agree with the Referee's conclusion, based on the following reasoning.

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 low 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, Scott Wetzel, has failed to show by a preponderance of the evidence that claimant's employment with SAIF's insured independently contributed to a worsening of claimant's underlying low back condition. See Linda L. Wise, 42 Van Natta 115 (1990).

Our conclusion is based on the following evidence. Claimant was examined by independent medical examiner Dr. Poulson, an orthopedic surgeon, in February, April and December 1986. Dr. Poulson diagnosed a degenerating lumbar disc, that would cause minimal pain without repetitive bending or lifting, but when claimant became active would cause recurrent and severe pain.

From December 1986 to September 1988 claimant did not receive medical care for his back condition. Claimant again experienced the onset of severe back pain on September 30, 1988, after carrying the concrete blocks while working for SAIF's insured.

Following the September 1988 injury, claimant was seen by Drs. Counts and Holbert. Both doctors found claimant's symptoms to have increased and relate the problem to the 1984 injury. Neither physician concluded that claimant's 1988 work incident/activity with SAIF's insured independently contributed to a worsening of the underlying condition.

After consideration of the aforementioned medical opinions, we conclude that claimant's work activities with SAIF's insured prompted an increase in his low back symptoms, but did not independently contribute to a worsening of his underlying low back condition. Therefore, Scott Wetzel, as carrier for claimant's compensable 1984 injury, remains responsible for claimant's low back condition.

ORDER

The Referee's order dated March 13, 1989 is affirmed.

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In the Matter of the Compensation of
**DIANE R. DOUGLAS, Claimant**
WCB Case No. 88-19222
ORDER ON REVIEW
Robert E. Nelson, Claimant Attorney
Roberts, et al., Defense Attorneys

Reviewed by Board Members Brittingham and Nichols.

Claimant requests review of Referee Bennett's order that declined to reinstate temporary total disability benefits after the insurer's reduction to temporary partial disability. The issue on review is temporary total disability compensation. We reverse.

FINDINGS OF FACT

Claimant sustained a compensable back injury on June 16, 1988. She subsequently received temporary total disability benefits. In September 1988, after obtaining claimant's physical limitations from the treating physician, the employer offered modified work within the light range to claimant.

The employer's September 13, 1988 offer letter did not satisfy all the requirements of the administrative rules. Missing was the requirement of specifying a beginning date and time as well as an ending date. The employer's offer asked claimant to call during business hours if she wanted to accept the modified job.

At the time of injury, claimant was a full time nurse aide on a day-time shift. The modified job offer consisted of light clerical duties during the four-hour period of 10:00 p.m. to 2:00 a.m.

In September 1988, the insurer reduced claimant's temporary total disability benefits to temporary partial disability when claimant refused the modified employment offer.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that the employer's failure to state a starting date and time should not nullify the employer's offer. We disagree. In accordance with Eastman v. Georgia Pacific Corp., 79 Or App 610 (1986) and Sharon A. Baucom, 38 Van Natta 869 (1986), the requirements of OAR 436-60-030(5) are to be strictly adhered to. Substantial compliance is not enough.

Here, contrary to Eastman, the Referee found compliance by conjecturing that the employer's request to have claimant call in to accept the job indicated

that a specific start date had not been set and thus, the requirements of the rule were met. We disagree. "Strict compliance" is necessary. See Eastman, supra. Furthermore, the employer's offer letter does not say to call in for starting and ending dates. Rather, it says to contact the employer "if you wish to accept the light duty position described in this letter..." (Exhibit 2). Accordingly, we conclude that the insurer did not properly reduce claimant's temporary disability benefits under the rule because it failed to strictly comply with all of the requirements of a written offer of employment. Eastman, supra.

ORDER

The Referee's order dated March 1, 1989 is reversed. Claimant is awarded temporary total disability benefits, effective the date the insurer reduced her temporary disability benefits to temporary partial disability, and continuing until these benefits can be properly terminated according to law. These benefits shall be offset by time worked and temporary disability benefits already paid during this period. 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.

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In the Matter of the Compensation of
**THOMAS A. FACHET, Claimant**
WCB Case No. 89-01493
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Tom Dzieman (Saif), Defense Attorney

Reviewed by Board Members Speer and Howell.

Claimant requests review of Referee Mongrain's order that increased his unscheduled permanent disability award for a low back injury from 4 percent (12.8 degrees), as awarded by a Determination Order, to 9 percent (28.8 degrees). On review, the issue is extent of unscheduled permanent disability. We modify.

FINDINGS OF FACT

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

The lifetime of the lathe blades lifted by claimant is about eight months. When the blades are new, they weigh between 85 and 90 pounds and claimant requires assistance when he lifts them. After the blades are worn down to 50 pounds or less, claimant occasionally lifts them by himself. Claimant is capable of performing work in the medium category.

CONCLUSIONS OF LAW AND OPINION

The Board adopts the Referee's "Opinion", with the following supplementation and modification.

The Referee assigned a value of 1 for claimant's adaptability. He based his conclusion on the fact that claimant had returned to modified work and could frequently lift up to 50 pounds. We modify.

Claimant has credibly testified that, at the beginning of his shift, he takes the blades out of a rack, sharpens them and then returns them to the rack. In addition, periodically during the day, he is sometimes required to install the blades. At the end of the day, claimant removes the blades for the next shift. The only blades claimant lifts by himself are the ones that weigh less than 50 pounds. The remainder of claimant's shift is spent performing other duties, such as operating machinery from a control booth.

Under the circumstances, we conclude that claimant occasionally, rather than frequently, lifts up to 50 pounds. Claimant performed work in the heavy category before his injury and now performs modified work in the medium category. Therefore, his adaptability value is 2. Former OAR 436-35-310(3)(a).

In the present case, the parties have not disputed the values assigned by the Referee for claimant's age, education and impairment. Using the uncontested values in conjunction with our assigned adaptability value, we proceed to compute claimant's permanent disability under the standards.

When claimant's age value, 1, is added to his education value, 4, the sum is 5. When that value is multiplied by claimant's adaptability value, 2, the product is 10. When that value is added to claimant's impairment value, 4, the result is 14 percent unscheduled permanent partial disability. Claimant's permanent disability under the "standards" is, therefore, 14 percent.

ORDER

The Referee's order dated May 5, 1989 is modified. In addition to the previous awards of 9 percent (28.8 degrees) unscheduled permanent disability, claimant is awarded 5 percent (16 degrees) for a total award to date of 14 percent (44.8 degrees) unscheduled permanent disability. Claimant's counsel is awarded 25 percent of the additional compensation created by this order. However, the total fees awarded by this order and the Referee's order shall not exceed $3,800.

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July 9, 1990 Cite as 42 Van Natta 1543 (1990)

In the Matter of the Compensation of
**CONNIE M. KRONE, Claimant**
WCB Case No. 89-07473
ORDER ON REVIEW (REMANDING)
Gatti, Gatti, et al., Claimant Attorneys
Callahan & Gardner, Attys., Attorneys
David Ray Fowler (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

Crawford Janitorial Service, a noncomplying employer, requests review of Referee Nichols' order which set aside as invalid its denial of the compensability of claimant's low back injury claim. On review, the issue is compensability. We remand.

FINDINGS OF FACT

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

By letter dated December 23, 1988, the Compliance Section referred claimant's injury claim to the SAIF Corporation for processing. SAIF

accepted a thoracolumbar spine strain, on behalf of the employer, on February 21, 1989, and notified the employer of this acceptance by letter dated the same day. The employer filed a request for hearing on April 19, 1989, within 60 days of SAIF's letter notifying it of acceptance but more than 60 days after referral of the claim to SAIF.

CONCLUSIONS OF LAW AND OPINION

The Referee in this case correctly anticipated the Court of Appeals' subsequent decision in Clark v. Linn, 98 Or App 393 (1989). In Clark, the court held that SAIF, and not the noncomplying employer, is responsible for processing claims against the noncomplying employer. Here, the Referee set aside the noncomplying employer's denial of claimant's claim. However, she did not take evidence on, or address, the noncomplying employer's request for hearing from SAIF's notice of claim acceptance.

Also, subsequent to the Referee's order in this case, the Board held that once SAIF has accepted a claim and more than 60 days have passed since the claim was referred to SAIF, the noncomplying employer may obtain a hearing regarding SAIF's acceptance but may not defeat the compensability of the claim without proving fraud, misrepresentation or other illegal activities capable of affecting acceptance. See Kristi L. Chase, 42 Van Natta 1247 (1990) (citing Bauman v. SAIF, 295 Or 788 (1983)).

Here, the noncomplying employer requested a hearing more than 60 days after the claim was referred to SAIF. Consequently, the noncomplying employer is entitled to a hearing but, in order to defeat compensability, must prove fraud, misrepresentation or other illegal activities capable of affecting acceptance. Accordingly, the case is remanded for a decision consistent with Kristi L. Chase, supra.

ORDER

The Referee's order dated August 21, 1989 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.

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In the Matter of the Compensation of
**LARRY L. McDOUGAL, Claimant**
WCB Case No. 89-07672
ORDER ON REVIEW
Charles D. Maier, Claimant Attorney
Rick Dawson (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

Claimant requests review of Referee Holtan's order that increased his unscheduled permanent disability award for a right shoulder and cervical injury from 18 percent (57.6 degrees), as awarded by a Determination Order, to 28 percent (89.6 degrees). On review, the issue is extent of unscheduled permanent disability. We modify.

FINDINGS OF FACT

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

In his right shoulder, claimant has retained 120 degrees abduction, 130 degrees forward flexion, 30 degrees backward extension and 80 degrees external rotation. Other right shoulder motions are normal (Ex. 24).

In the cervical area, claimant has retained 25 degrees flexion, 40 degrees extension, 30 degrees left and right lateral flexion and 60 degrees left and right rotation (Ex. 24).

Claimant's ability to sit, stand and carry has been limited by his injury. Claimant's ability to repeatedly use his right shoulder and to repeatedly use his neck have also been limited by his injury.

## CONCLUSIONS OF LAW AND OPINION

In determining the extent of claimant's permanent disability, the Referee applied the standards for evaluating permanent disability as adopted by the Director, pursuant to ORS 656.726(3)(f). See ORS 656.283(7). Specifically, the Referee applied the current version of OAR 436-35-001 et seq, the rules in effect at the time of the March 28, 1989 Determination Order. These are the rules which we apply as well.

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

### Age

The appropriate value for claimant's age of 32 years is 0. OAR 436-35-290(3).

### Formal education

The appropriate value for claimant's 10 years of formal education is 1. OAR 436-35-300(3)(b).

### Skills

OAR 436-35-300(4) adopts by reference the "SVP" (specific vocational preparation time) values assigned to various occupations by the Dictionary of Occupational Titles (DOT), published by the U.S. Department of Labor. The highest SVP level demonstrated by a claimant during the ten years prior to the date of hearing is used to determine a value for skills. OAR 436-35-300(4). Claimant's highest SVP during the ten years prior to the date of hearing was 3 as a farm laborer (DOT # 409.683-014). Therefore, the appropriate value for skills is 3. OAR 436-35-300(4).

### Training

"OAR 436-35-300(5) states:

> "Training: (a) For workers who do not have competence in some specific vocational pursuit, a value of plus one shall be allowed.
> (b) For workers who do have competence in some specific vocational pursuit, no value shall be allowed."

The "standards" do not define the term "specific vocational pursuit." Because we conclude that OAR 436-35-300(5) was intended to differentiate between those who have and those who have not acquired formal or on-the-job training sufficient to perform something other than entry level employment, we interpret "specific vocational pursuit" to mean employment other than an entry level position.

In this case, claimant has not obtained training which would provide him with competence in a specific vocational pursuit. He is, therefore, entitled to a value of 1 for training.

Adaptability

When, as a result of the compensable injury, claimant is not working and no employment has been offered, claimant's adaptability value is determined by his residual physical capacity, without regard to his physical capacity prior to the injury. See OAR 436-35-310(4). The Referee concluded that, because claimant could lift 19 pounds frequently and 38 pounds occasionally, he was able to perform jobs between the light and medium categories.

Claimant contends that OAR 436-35-270(3)(c) provides that only the attending physician's description of limitations of the worker may be used in determining claimant's work capacity. Claimant argues that his treating doctor's recommendation of light work precluded the Referee's finding that he was able to perform light to medium work.

We do not agree that the rule cited by claimant requires us to use only the attending doctor's estimates of limitations in determining claimant's work capacity. Rather, the rule states that a "physician's release" means written notification provided by the attending physician to the worker and the worker's employer releasing the worker to work and describing any limitations the worker has. The term "physician's release" also means the doctor has agreed that the worker is physically capable of performing a job that the employer has offered to the worker. See OAR 436-35-270(3)(c).

In those cases in which a claimant receives a "work offer" as defined in OAR 436-35-270(3)(d), the "physician's release" creates a rebuttable presumption that the claimant is capable of performing the work to which he or she is released. In that case, and absent evidence rebutting the presumption, the "physician's release" in conjunction with the physical requirements of the worker's "usual and customary work" [see OAR 436-35-270(3)(a)] determine the adaptability value under OAR 436-35-310(3). Where, as here, there is no "work offer," an adaptability value is determined by the claimant's physical capacity under OAR 436-35-310(4). And, while the attending physician's assessment of claimant's physical capacities are relevant evidence, they are not necessarily determinative.

The current "standards" do not require that an attending physician's assessment of a claimant's limitations be used in determining physical capacity. In arriving at a value for claimant's physical capacity, the Referee was entitled to use the evidence that he found to be most persuasive.

We agree with the Referee and conclude that claimant's physical capacity falls between the light and medium categories as defined in OAR 436-35-310(4). He is able to lift 19 pounds frequently and 38 pounds occasionally. That is more than is required of the light category but less than is required for the medium category. OAR 436-35-310(4)(b) & (c).

The "standards" provide a specific method of determining an adaptability value when a worker "can perform above the requirements of one category but has limited ability to sit, stand, etc." See OAR 436-35-310(4). Claimant's "actual tested capacity" demonstrates that he is capable of performing above the light category. The record also demonstrates that impairment from his injury limits claimant's ability to sit, stand and carry. We, therefore, find that the correct adaptability value is obtained by averaging the value for the strength category for which claimant qualifies (light) with the values for the categories immediately above (medium) and below (sedentary). The values of 1 for medium, 4 for light and 8 for sedentary average 4.3.

Impairment

The Referee concluded, the parties do not dispute, and we conclude that claimant is entitled to an impairment value of 5 percent for lost range of motion of the right shoulder. OAR 436-35-330. In addition, it is not disputed and we conclude that claimant is entitled to a value of 6 percent for lost range of motion in the cervical area. OAR 436-35-360.

Impairment value for chronic conditions limiting repetitive use of a body part

Claimant contends that he is entitled to more than 5 percent impairment for limited repetitive use of his right shoulder and cervical area. We agree.

OAR 436-35-320(4) provides that chronic conditions limiting repetitive use of an unscheduled body part shall be rated at 5 percent impairment of that part. The "standards" do not define a "body part." However, the "standards" do segregate and separately value various parts of the body. For example, a thumb (OAR 436-35-050), a finger (OAR 436-35-060), a forearm (wrist) (OAR 436-35-330), a shoulder (OAR 436-35-330), the thoracolumbar spine (OAR 436-35-360(6)-(9), the cervical spine (OAR 436-35-360(2)-(5)), and the heart (OAR 436-35-380) are each treated as a separate "body part" for determining ranges of motion and/or other values for impairment under the "standards." We conclude that a "body part" is one of the areas of the body that is dealt with as a separate unit or system by the standards.

In accordance with OAR 436-35-320(4), an injured worker is entitled to a 5 percent impairment value for loss of repetitive use of a body part. Thus, more than one 5 percent impairment value may be awarded if more than one "body part" has limited repetitive use due to a compensable injury or disease. See OAR 436-35-320(2).

We further find that an award of 5 percent impairment for chronic conditions limiting repetitive use of a body part is available whether or not a claimant is entitled to impairment values for any other conditions or restrictions. We reach this conclusion because we find no indication in the current standards that the 5 percent value is only available when a claimant either is or is not entitled to a value or values for other impairment.

In addition to the absence of limiting language within the standards, we note that OAR 436-35-010(7) and 436-35-320(4) are distinctive rules that provide for the valuing of a particular form of impairment. Those specific provisions control the general provision of OAR 436-35-005(1) which defines impairment as a decrease in the function of a body part or system as measured by a physician, according to the methods described in the American Medical Association Guides to the Rating of Permanent Impairment, 2nd Edition, copyright 1984 (emphasis added). Based upon these provisions, we conclude that, even though

claimant may or may not have impairment as defined generally, the rules specifically provide for an impairment value where there is a loss of repetitive use of a body part due to a chronic, injury-related condition.

In the present case, due to his chronic injury condition, claimant has difficulty repeatedly lifting his arm over his head. He also has decreased ability to repeatedly look to the left or right. Based on this chronic limited repetitive use of his right shoulder, claimant is entitled to an impairment value of 5 percent. OAR 436-35-320(4). Furthermore, claimant's chronic limited repetitive use of his neck, a separate body part, entitles him to an impairment value of 5 percent. OAR 436-35-320(4). The 5 percent impairment for limited repetitive use of claimant's right shoulder and the 5 percent impairment for limited repetitive use of his neck are combined with (not added to) other impairment values. OAR 436-35-320(2).

Unoperated disc bulge

The Referee found that claimant was not entitled to impairment values for either unoperated disc derangement or disc bulges under OAR 436-35-350(2). We agree that claimant is not entitled to a value for disc bulges or derangements based upon the following reasoning.

In April 1989, Dr. Kelley, D.C., reported that an MRI and a CT scan showed that claimant had mild central anulous bulging at C5-C6. In addition, Dr. Kelley reported that the tests indicated decreased nerve root filling at C4-C5 and C6-C7. Claimant contends that he is entitled to a value of 4 percent for each of the three areas in which a disc bulge or derangement is found. We disagree.

Dr. Kelley has not explained how claimant's decreased nerve root fillings are related to his symptoms or to a permanent impairment. Moreover, we find that none of the medical reports, including Dr. Kelley's, indicate that claimant's disc bulge or decreased nerve root sheath fillings are due to his compensable injury. Because claimant has failed to prove that the impairment of his cervical discs is due to his compensable injury, he is not entitled to unscheduled disability for his disc bulge or reduced nerve root fillings. ORS 656.214(5) and OAR 436-35-280.

Claimant's impairment values of 5, for his limited right shoulder motion, 6 for lost range of motion in the cervical area, 5 for limited repetitive use of his right shoulder and 5 for limited repetitive use of his neck are combined (not added) for a total impairment value of 19.4.

Computation of unscheduled disability.

Having determined each value necessary to compute claimant's permanent disability under the "standards," we proceed to that calculation. When claimant's age value, 0, is added to his education value, 5, the sum is 5. When that value is multiplied by claimant's adaptability value, 4.3, the product is 21.5. When that value is added to claimant's impairment value of 19.4, the result is 40.9 percent unscheduled permanent partial disability. OAR 436-35-280(7). That disability figure is rounded to the next higher whole percentage. OAR 436-35-280(7). Claimant's permanent disability under the "standards" is, therefore, 41 percent.

Neither party contends that claimant's permanent disability is more or less than the value provided for by application of the "standards."

ORDER

The Referee's order dated August 22, 1989, as reconsidered October 18, 1989, is modified. In addition to the Referee's award and the Determination Order award, claimant is awarded 13 percent (41.6 degrees), giving him a total award to date of 41 percent (131.2 degrees) unscheduled permanent disability for his neck and right shoulder injury. Claimant's attorney is awarded 25 percent of the increased compensation created by this order, payable directly to claimant's attorney by the SAIF Corporation. However, the total attorney fees awarded by the Referee and Board orders shall not exceed $3,800.

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July 9, 1990 Cite as 42 Van Natta 1549 (1990)

In the Matter of the Compensation of
**KENNETH L. MORRIS, Claimant**
WCB Case No. 88-08690
ORDER ON REVIEW
Wilbur C. Smith, Jr., Claimant Attorney
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Nichols and Brittingham.

Claimant requests review of Referee Mills' order that: (1) affirmed a Determination Order that did not award additional unscheduled permanent disability for a back injury beyond the 30 percent (96 degrees) claimant had previously been awarded; and (2) declined to award temporary total disability benefits. The issues on review are extent of unscheduled permanent partial disability and entitlement to additional temporary disability benefits. We affirm.

FINDINGS OF FACT

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

On May 16, 1985, and again on May 7, 1987, the treating physician, Dr. Grewe, concurred with the independent medical examiner's conclusion that claimant was medically stationary. The record reveals no evidence that claimant's medical status became unstationary between May 1985 and May 1987.

Dr. Grewe did not release claimant to his regular work on September 2, 1986. Rather, after considering claimant's return to his former job as a fork-lift operator, Dr. Grewe deferred a final decision pending an evaluation by the Work Tolerance Program. On November 28, 1986, following the Work Tolerance review of claimant's former job description, Dr. Grewe concluded that claimant was limited to light work.

In January 1987, the parties entered into a stipulation which resolved claimant's hearing request concerning some temporary disability and claims processing issues. The stipulation, which received referee approval, provided that claimant would receive temporary disability through September 2, 1986. The stipulation further stated that, upon issuance of a Determination Order, claimant could seek additional temporary disability beyond September 2, 1986. An April 15, 1987 Determination Order awarded temporary disability which terminated September 2, 1986.

## CONCLUSIONS OF LAW AND OPINION

Claimant asserts that he is entitled to temporary disability from September 2, 1986, through the date of the Determination Order dated April 15, 1987. The Referee concluded that claimant would be entitled to these benefits only if he was not medically stationary during this period. We agree; however, our opinion is based on a different legal analysis.

The parties' January 21, 1987, Stipulation, which terminated temporary total disability as of September 2, 1986, was essentially an agreement which approved the self-insured employer's termination of temporary disability benefit. See Fazzolari v. United Beer Distributors, 91 Or App 592 (1988). Thus, there was no unilateral termination of temporary total disability benefits. Instead, claimant agreed to the termination of his benefits. Under such circumstances, considerations of whether claimant was released to work or returned to regular work under a Fazzolari, supra, analysis are accordingly not germane to this discussion. This matter is decided solely on the substantive issue of when claimant became medically stationary, rather than on the claims processing aspects of former ORS 656.268(2). See Julie A Trujillo, 40 Van Natta 1892 (1988).

It is claimant's burden to prove by a preponderance of the evidence his entitlement to temporary disability. See Hutcheson v. Weyerhauser, 288 Or 51 (1979). Here, claimant must demonstrate that he was not medically stationary after September 2, 1986. Given that all medical evidence establishes claimant has been medically stationary since May 1985, he has not shown that he is substantively entitled to any temporary disability beyond what he has already received.

We turn to the permanent disability issue. The Referee was not persuaded that claimant sustained a loss of earning capacity in excess of his prior 30 percent permanent disability award. We agree.

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, 296 Or 505, 510 (1984).

Claimant has the burden of proving the extent of his disability. On de novo review, after considering claimant's relative youth, his average education, his recent retraining program, his work experience and his residual functional capacity in the mild impairment range, we are not persuaded that he is entitled to unscheduled permanent disability in excess of his 30 percent award.

## ORDER

The Referee's order dated January 13, 1989 is affirmed.

In the Matter of the Compensation of
**VICTOR PELL, Claimant**
WCB Case Nos. 88-08343, 88-13683, 88-14571 & 88-14572
ORDER ON REVIEW
Peter O. Hansen, Claimant Attorney
Schwabe, et al., Defense Attorneys
Acker, Underwood, et al., Defense Attorneys
Roberts, et al., Defense Attorneys
Julia Philbrook (Saif), Defense Attorney

Reviewed by Board Members Nichols and Brittingham.

Claimant requests review of Referee Fink's order that upheld denials of claimant's bilateral inguinal hernia condition issued by State Farm Insurance, the SAIF Corporation, AIAC and EBI Companies. On review, the issues are compensability and responsibility. 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 and Conclusions of Law" with the following comment.

One of claimant's contentions is that his hernia condition is the result of an injury during his participation in an ATP program under his accepted 1981 claim with State Farm. At hearing, State Farm argued that claimant did not file a timely claim for this alleged injury. The Referee did not adequately address this argument in his order.

A claimant is required to give the employer written notice of the claim within 30 days of the injury. ORS 656.265(1) and (2). Failure to give notice within this period bars a claim unless: (1) the employer had knowledge of the injury; or (2) the employer was not prejudiced by the failure to provide notice; or (3) the carrier has begun payments as required under ORS 656.001 to 656.794; or (4) notice is given within one year of the injury and the claimant had good cause for failing to give notice within 30 days. ORS 656.265(4)(a)-(d).

Here, medical reports in the record indicate that claimant's bilateral hernia condition was first diagnosed in June 1984, and again in late 1985. Claimant did not file a written claim or otherwise give the employer notice of the claim prior to 1988, even though the ATP program concluded in October 1985. None of the reports relate claimant's hernia condition to any work injury or work activity. Therefore, contrary to claimant's assertion, these reports would not constitute a claim for the condition or put the employer on notice of a possible work injury.

Furthermore, there is no evidence that the carrier had begun payments as provided under ORS 656.001 to 656.794. Thus, the claim is barred unless the employer was not prejudiced by the failure to give notice. The Referee concluded that the employer was prejudiced, and we agree.

Accordingly, this claim with State Farm was untimely, and the Referee was correct in dismissing the request for hearing.

## ORDER

The Referee's order dated February 17, 1989 is affirmed.

In the Matter of the Compensation of
**MARGARET BOATENG, Claimant**
WCB Case No. 88-21726
ORDER ON REVIEW
Bottini et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Brittingham and Nichols.

Claimant requests review of that portion of Referee Podnar's order that upheld the self-insured employer's denial of claimant's aggravation claim for her right shoulder. On review, the issue is aggravation. We affirm.

FINDINGS OF FACT

We adopt the Referee's "Findings", with the following supplementation.

Dr. Goodwin, M.D., released claimant to modified work in November 1986, recommending that she not use her hands above shoulder level for more than 2 hours in an 8 hour shift. Dr. Colville, orthopedist, released claimant to regular work, although he cautioned her that repetitive use of the right shoulder in forward elevation could cause the return of her symptoms.

On March 25, 1988, following a right shoulder flare-up earlier that month, claimant was released to light duty work, which included no overhead reaching. However, she returned to her regular work. In May 1988, claimant experienced a mid-back strain and right bicipital tendinitis that took her to the emergency room. Dr. Lewis, M.D., took her off work one week. Claimant returned to her regular work, and was off again on June 6, 1988 because of another right shoulder flare-up.

A June 23, 1988 independent medical examination by Dr. Dickson, M.D., found that claimant's June 1988 exacerbation was consistent with her medical history. He recommended that claimant be excluded from occupations requiring repetitive shoulder and wrist motions. After her shoulder symptoms subsided, Lewis prescribed a physical capacities evaluation. The evaluation recommended that claimant avoid repetitive reaching above chest height.

A Determination Order issued on December 1, 1988, with no additional award of permanent partial disability. Claimant filed an aggravation claim on December 15, 1988 which was denied on February 15, 1989.

Claimant requested a hearing on both the Determination Order and the aggravation denial. The two issues were initially consolidated for hearing. However, because claimant was eight months pregnant at the time of hearing and could not participate in a physical capacities evaluation, determination of her extent of disability was deferred by the Referee. Consequently, the aggravation denial was the only issue addressed by the Referee.

On February 15, 1989 Lewis reported that claimant had been medically stationary since November 4, 1988; that any activity involving repetitive motion of the right shoulder would cause a flare-up of symptoms; and that her symptomatic flare-up in mid-December 1988 did not prevent claimant from performing all work, but only repetitive work with the right shoulder.

Claimant's last award of compensation was the December 1, 1988 Determination Order.

## FINDINGS OF ULTIMATE FACT

Claimant sustained a symptomatic exacerbation of her right shoulder condition in mid-December 1988 that resulted in diminished earning capacity beyond the level fixed at the time of the December 1, 1988 Determination Order.

Claimant's exacerbation was anticipated by the December 1, 1988 Determination Order.

Claimant's exacerbation did not result in more than 14 consecutive days of total disability.

Claimant was not an inpatient in a hospital for treatment of her exacerbation.

## CONCLUSIONS OF LAW AND OPINION

### Aggravation

To establish an aggravation, claimant must show a worsening of her compensable shoulder 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 diminished 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 last arrangement of compensation was the December 1, 1988 Determination Order, not the December 1987 stipulation as claimant argues.

The Referee denied claimant's December 1988 aggravation claim on the basis that claimant's underlying condition had not worsened since her last arrangement of compensation, that she was not totally disabled, and that she had a condition which becomes increasingly symptomatic with repetitive use. In regard to the latter two findings, we understand the Referee to be reasoning that claimant did not sustain an aggravation as a matter of law because she did not have 14 consecutive days of temporary total disability, and because the flare-ups were anticipated by the last award of compensation.

Claimant maintains that the Referee applied the wrong analysis because he required a worsening of the underlying condition. Instead, claimant argues, she has established an aggravation because the symptoms of her shoulder condition have worsened to the extent that she was less able to work in December 1988 than in December 1987. The employer argues that claimant's flare-ups were not in excess of those anticipated, nor were they an actual worsening of her underlying condition.

Although we agree with the Referee's ultimate conclusion, we do so as a result of the following analysis.

### Symptomatic Exacerbation/Diminished Earning Capacity

The Referee incorrectly required a pathological worsening of the underlying condition. A symptomatic exacerbation is sufficient if it results in diminished earning capacity and is not anticipated by the last award of compensation.

Claimant was performing her regular work on the loader without restriction on December 1, 1988. On December 12, 1988, claimant consulted Dr. Lewis for shoulder pain. She asked to be taken off the loader because it hurt too much. Lewis gave her a note restricting her from regular work in order to prevent aggravation of her right shoulder by repetitive motion. The employer had no modified work available. Therefore, claimant has experienced a flare-up resulting in diminished earning capacity below the level fixed at the time of the last arrangement of compensation.

Whether the Prior Award Anticipated Waxing and Waning Symptoms

Evidence supporting a finding that waxing and waning symptoms were anticipated by the last arrangement of compensation includes documented history of repeated flare-ups. See Lance O. Glover, 42 Van Natta 256 (1990).

Drs. Wild, Colville and Goodwin opined in 1986 that claimant should avoid repetitive overhead arm movement because she had a tendency toward overuse syndrome. (Exs. 23, 50 & 52). Nevertheless, she returned to her regular work which required this type of activity. As a result, claimant has experienced repeated flare-ups since her initial claim in 1985. Following one such flare-up in 1986, claimant received a stipulated award of 10 percent permanent partial disability. There is no evidence of any permanent impairment to support that award, other than claimant's propensity to experience flare-ups. More recently, claimant had flare-ups of symptoms in July 1986 and in March, May, and June 1988. Examining doctors continued to opine that claimant would experience flare-ups if she continued in her regular work.

This history was available to the evaluator at the time of the last arrangement of compensation. Therefore, the last arrangement of compensation anticipated future periods of waxing and waning.

Whether the Current Exacerbation is Greater than Anticipated

Claimant's current flare-up is not greater than those anticipated. After each of claimant's prior flare-ups, she was restricted from work requiring repetitive overhead reaching. That is also the case with the present flare-up. This degree of restriction is precisely what was anticipated by Drs. Wild, Goodwin and Colville. As a result, claimant has not shown that her periods of flare-up are in excess of that anticipated by the prior award.

Whether the Exacerbation Resulted in 14 Days of Total Disability/Inpatient Hospitalization

Alternatively, claimant may prove aggravation by establishing that the exacerbations resulted in inpatient hospitalization or 14 days of total disability. See Gwynn v. SAIF, supra; Kurt E. Kral, 42 Van Natta 129 (1990). Claimant had no inpatient hospitalization and no total disability. Thus, she has not established a worsening as a matter of law.

Consequently, we find that claimant has not established a compensable worsening since the last arrangement of compensation. Accordingly, we affirm.

ORDER

The Referee's order dated April 10, 1989 is affirmed.

In the Matter of the Compensation of
**GLADYS B. BRITTON, Claimant**
WCB Case No. 88-14442
ORDER ON REVIEW
H. Adunni Warren, Claimant Attorney
Roberts, et al., Defense Attorneys

Reviewed by Board Members Cushing and Myers.

Claimant requests review of that portion of Referee Seymour's order that upheld the self-insured employer's denial of claimant's occupational disease claim for a mental stress condition. The employer cross-requests review of that portion of the order that assessed a penalty-related attorney fee for an alleged unreasonable denial. On review, the issues are compensability and attorney fees. We affirm in part, and reverse in part.

FINDINGS OF FACT

We adopt the Referee's "Finding of Fact."

CONCLUSIONS OF LAW AND OPINION

Compensability

We adopt the "Conclusions and Opinion" as set forth in the Referee's order with the following supplementation.

The Referee concluded that claimant's mental stress claim was not compensable. The basis for the Referee's decision was that he found that claimant's perceptions of what happened, and what actually happened, were two different things. Implicit in his decision is the finding that the corrective actions taken by claimant's supervisor were reasonable. We agree, and affirm that aspect of the Referee's order with the following comment.

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) & ORS 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. Deborah Andersen, 42 Van Natta 513 (1990); Donna E. Aschbacher, 41 Van Natta 1242 (1989); Ellen L. Crawford, 41 Van Natta 1257 (1989).

Here, claimant has not shown that her stress was materially caused by work related events that existed in a real and objective sense. Although some of the stress-causing conditions were real, others were either imagined or grossly exaggerated. The Referee found, and we agree, that most of claimant's stress resulted primarily from claimant's perception of the way she was treated by her supervisor. It was claimant's belief that her supervisor was subjecting her to harassment and excessive supervision in that the supervisor was "nit-picking." However, the incidents and events related by claimant to support this belief are unfounded.

As an example, claimant testified that the precipitating event to filing the claim was an incident whereby the supervisor created a "visual rumpus" in a hospital hallway which involved the supervisor flinging objects off another employee's housekeeping cart, as well as speaking harshly to the same co-

employee to the point he was reduced to physical tears. Claimant went on to describe that a physician asked her to intervene, and claimant attempted to do so. Shortly thereafter, confrontation between claimant and the supervisor in a "chute" room took place.

However, the supervisor's testimony was in direct contradiction to claimant's narrative account. Additionally, the testimony of the co-employee did not corroborate claimant's version on any point accept the fact that the supervisor did remove an open packet of paper towels and placed them in a trash can in order to comply with federal health regulations. And finally, although claimant testified to an additional witness to this event, a physician who was present in the hallway at the time, this witness was not produced. We are not persuaded that the events and conditions of claimant's employment which she contends occurred and produced stress occurred as related by claimant, and thus, exist in "a real and objective sense."

Additionally, we find no evidence that the supervisor's actions with regard to claimant were anything but reasonable corrective actions by her supervisor. The supervisor repeatedly and persuasively testified that she only pointed out to claimant work that needed to be done on the floor for which claimant was responsible for cleaning. Other than claimant's testimony, there was no evidence of the supervisor publicly disciplining claimant. Therefore, we further find the conduct of the employer to represent reasonable corrective actions. ORS 656.802(2)(b).

Accordingly, claimant has failed to establish by clear and convincing evidence that her work activities and exposures were a material contributing cause of her mental stress condition.

Attorney Fees

The Referee also concluded that the denial issued by the employer was unreasonable, despite his ultimate ruling that the claim was not compensable. Consequently, the Referee assessed a penalty-related attorney fee. ORS 656.262(10). The Referee reasoned that at the time the denial was issued the facts available to the claims adjuster indicated a compensable claim. We disagree.

The supervisor's description of the June 29, 1988 incident on the 801 refuted claimant's version of events. Therefore, the employer could have assumed that the history claimant provided to Dr. Denker was inaccurate as well, and that any resulting diagnosis and inference of causation was likewise unreliable. The 827 submitted by Dr. Denker does not relate causation of claimant's diagnosed stress syndrome. And Dr. Denker's chart note of July 1, 1988 was not received by the employer until July 25, 1988, after the denial had issued. Thus, the totality of the evidence in possession of the employer at the time it issued the denial for claimant's stress condition was sufficient to raise a legitimate doubt as the compensability of the claim. As long as an employer has a legitimate doubt of its liability, its conduct is not unreasonable. Norgard v. Rawlinsons, 30 Or App 999, 1003 (1977). Accordingly, we do not find that issuance of the employer's denial to be unreasonable.

Even assuming that we agree that the employer's conduct in denying claimant's mental stress claim was unreasonable, which we do not, claimant is not entitled to attorney fees. Here, we have found the mental stress claim noncompensable. Therefore, there has been no unreasonable resistance to the payment of compensation. Thus, no attorney fees may be assessed. See Ellis v. McCall Insulation, 308 Or 74 (1989); Lloyd L. Cripe, 41 Van Natta 1774 (1989). That portion of the Referee's order which awarded attorney fees is reversed.

ORDER

The Referee's order dated March 27, 1989, is affirmed in part, and reversed in part. The Referee's award of a $1,500 penalty-related attorney fee to claimant's counsel is reversed. The remainder of the Referee's order is affirmed.

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July 10, 1990 Cite as 42 Van Natta 1557 (1990)

In the Matter of the Compensation of
**DEBBIE L. BROWN, Claimant**
WCB Case No. 88-19187
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
H. Thomas Andersen (Saif), Defense Attorney

Reviewed by Board Members Howell and Perry.

Claimant requests review of Referee Livesley's order which affirmed a Determination Order awarding no additional scheduled permanent disability for claimant's left knee condition over a previous Determination Order and Stipulated Order award totalling 30 percent (45 degrees) scheduled permanent disability. On review, the issue is extent of permanent disability. We affirm.

FINDINGS OF FACT

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

Flexion in claimant's knee was to 143 degrees.

Claimant suffers disabling pain due to her compensable knee injury.

CONCLUSIONS OF LAW AND OPINION

The Board affirms the Referee with the following comments.

After the reopening of a claim for an aggravation, claimant must demonstrate a worsening of the condition in order to be awarded additional permanent disability. Stepp v. SAIF, 78 Or App 438 (1986).

Assuming that claimant's knee is worse, we are required by law to rate under the "standards." In this case, the "standards" adopted effective July 1, 1988, (former OAR 436-35-001 et seq), as amended by temporary rules effective August 19, 1988, apply to the rating of claimant's permanent partial disability. Former OAR 436-35-010 through 436-35-260 apply to the rating of scheduled permanent partial disabilities. Former OAR 436-35-010(1).

We note that claimant has 143 degrees of retained flexion of her left knee. Accordingly, she is entitled to an award of 1.7 percent disability for loss of use or function of her left knee.

Additionally, we conclude that claimant is entitled to an award of 10 percent disability for disabling pain. See Daniel Alire, 41 Van Natta 752 (1989).

Combining the 1.7 percent disability for loss of flexion of the knee with the 10 percent value for disabling pain, we arrive at 11.5 (rounded to the

nearest 1/10th). That figure is rounded upward to the next whole number for a total of 12 percent disability.

Claimant has previously received an award under the guidelines of 30 percent (45 degrees) scheduled permanent disability for her left knee condition. We do not find that claimant has met her burden, by clear and convincing evidence, of showing that she has lost greater than 30 percent of the use and function of her left knee. Accordingly, the Determination Order is affirmed.

ORDER

The Referee's order dated May 3, 1989 is affirmed.

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July 10, 1990 Cite as 42 Van Natta 1558 (1990)

In the Matter of the Compensation of
**VERA A. GRAY, Claimant**
WCB Case Nos. 88-14728 & 88-05923
ORDER OF ABATEMENT
George W. Sohl, Claimant Attorney
Cowling & Heysell, Defense Attorneys

Claimant has submitted a letter in response to our June 11, 1990 Order on Review that reversed a Referee's order which had set aside the insurer's aggravation denial. Asserting that she wishes to "continue the fight", claimant seeks a "continuance" to enable her to consult fully with her counsel. Under these circumstances, we treat such a submission as a motion for reconsideration.

In order to allow sufficient time to consider the motion and to preserve the parties' rights of appeal, we abate and withdraw our June 11, 1990 order. A copy of claimant's letter is being provided to the insurer, who is requested to file a response to the motion within ten days. Thereafter, we shall take this matter under advisement.

IT IS SO ORDERED.

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July 10, 1990 Cite as 42 Van Natta 1558 (1990)

In the Matter of the Compensation of
**LINDA J. HASSLEN, Claimant**
WCB Case No. 88-20402
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
Cowling & Heysell, Defense Attorneys

Reviewed by Board Members Speer and Howell.

The self-insured employer requests review of Referee Schultz' order which: (1) set aside its denials of claimant's medical services claim for acute lumbar strain; and (2) assessed a penalty and associated attorney fee for its alleged unreasonable denials. On review the issues are compensability and penalties and attorney fees.

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

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" and make the following additional finding. The employer's denials dated October 25, 1988 and November 15, 1988, are prospective denials. (Exs. 42, 44A).

CONCLUSIONS OF LAW AND OPINION

The Referee set aside the employer's denials, concluding that the employer's denials are "back-up" denials under Bauman v. SAIF, 295 Or 788 (1983), and that claimant's compensable injury is a material factor in her current need for medical treatment. Although we agree that the employer's denial must be set aside, we do so without reaching the merits.

An employer may not prospectively deny medical services. See ORS 656.245(1); Evanite Fiber Corp. v. Striplin, 99 Or App 353 (1989). Here, the employer's October 25, 1988 denial reads, in relevant part:

> "Medical treatment needs for your current condition should more appropriately be provided under any group health insurance you may have." (Ex. 42).

The November 15, 1988 denial reads, in relevant part:

> "The employer must respectfully deny responsibility for your current treatment needs and/or any disability as compensably related to this injury or your work activity at the employer." (Ex. 44A).

Both these denials are prospective in nature. Neither is addressed to specific medical services rendered or claimed. It appears that the employer has accepted all medical service claims filed through October 25, 1988 and the denials simply purport to deny any and all future medical benefits. Accordingly, they shall be set aside.

ORDER

The order of the Referee, dated March 31, 1989, is affirmed. For services on review concerning the compensability isuue, claimant's attorney is awarded an assessed fee of $700, to be paid by the employer.

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July 10, 1990 Cite as 42 Van Natta 1559 (1990)

In the Matter of the Compensation of
**RONALD HAWKINS, Claimant**
WCB Case No. 88-19698
ORDER ON REVIEW
Vick & Gutzler, Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Speer and Howell.

The insurer requests review of that portion of Referee Podnar's order which found that claimant was a subject worker. On review, the issue is subjectivity. We affirm.

FINDINGS OF FACT

The Board adopts the Referee's "Findings".

## CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant was an employe and his injury was compensable under workers' compensation law. We agree that claimant was an employe and we base our conclusion on the following reasoning.

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 656.005(13) and (27). The factors to be considered under the traditional test of the right to control include: (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 at will without liability. Woody v. Waibel, 276 Or 189 (1976).

Evidence of actual control supports a finding of an employer-employe relationship. However, absence of evidence of the actual exercise of control does not require an independent contractor finding.

In the present case, the employer inspected the project and was present during much of the construction. He went over blueprints with claimant and instructed claimant to make changes when they were required. When claimant needed materials, he made a list and submitted it to the employer, who purchased the materials. Although the employer was not present to oversee all details of the work, we conclude that he both exercised control and had the right to control claimant's services.

Claimant earned $150 per day and was paid a total of $500 every two weeks. Hourly wages are evidence of an employer/employe relationship. Bernards v. Wright, 93 Or App 192 (1988). Payment on a continuing basis suggests employe status rather than independent contractor status. See e.g. Henn v. SAIF, 60 Or App 587, 592 (1982).

Although claimant provided his own truck and some of his own tools, he also used tools supplied by the employer. Claimant supplied a variety of small hand tools, such as a drill and hammer, but he used the employer's welder, dump truck, scoop tractor, brooms and shovels and additional small tools.

Finally, the employer and claimant had a verbal agreement in regard to the construction project. The employer testified that, after the injury, he continued to keep claimant on the payroll although he was not required to do so. We conclude that, under the circumstances, the employer could terminate claimant's employment without liability, a factor that supports a finding of employe rather than independent contractor.

The employer's exercise of control over claimant, his right to control claimant's work, payment of wages, employer's provision of some tools and all materials and the employer's ability to terminate claimant's employment without liability are all factors indicative of employe status. We therefore conclude that the Referee correctly found that claimant was a subject worker within the meaning of the Workers' Compensation Act.

## ORDER

The Referee's order dated April 13, 1989 is affirmed. For services on review, claimant's counsel is awarded an assessed fee of $870, payable by the insurer.

In the Matter of the Compensation of
**DAVID E. LINDSEY, Claimant**
WCB Case No. 88-20076
ORDER ON REVIEW
Merrill Schneider, Claimant Attorney
Shelly K. McIntyre (Saif), Defense Attorney

Reviewed by Board Members Howell and Perry.

Claimant requests review of those portions of Referee Knapp's order that: (1) found that claimant's low back injury claim was not prematurely closed; and (2) increased claimant's unscheduled permanent disability award for his low back condition from 7 percent (22.4 degrees), as awarded by Determination Order, to 10 percent (32 degrees). On review, the issues are premature closure and, alternatively, extent of unscheduled permanent disability. We affirm.

## FINDINGS OF FACT

The Board adopts the Referee's "Findings of Fact," with the exception of the finding of a lifting limit of 15 pounds. We find that claimant has a lifting capability of between 25 and 50 pounds. (See Exs. 4D-3, 10-1-2, 11-1, 13-7, 16-1, Tr. 13).

## CONCLUSIONS OF LAW AND OPINION

We adopt the Referee's "Conclusions of Law and Opinion" with the following supplementation.

Claimant contends that his adaptability factor should be +4, in the light category. We disagree. His adaptability factor is dependent upon his physical capacity to lift. Former OAR 436-35-310(4). As we have found above, claimant can lift between 25 and 50 pounds, placing him in the medium or heavy category.

The Referee averaged the medium and light adaptability values, +1 and +4, because of claimant's difficulty with continued back usage and prolonged positions. However, that version of the rule applicable here provides for averaging only when the worker's physical capacity, measured by his lifting capabilities, falls between two categories. Id. In this case, averaging has no impact because the value assigned for both the medium and heavy categories is +1.

Claimant also contends that he experiences disabling pain. He argues that he has proven such pain by clear and convincing evidence. Claimant need not meet such a burden. All factfinding under the standards is made upon a preponderance of the evidence. Michelle Griffith, 40 Van Natta 2086, 2089 (1988). Disabling pain may be considered in determining permanent disability under former OAR 436-35-320(1)(a), when it results in loss of use or function. Claimant testified that he suffers constant back pain, which limits his ability to stand, sit and walk. (Tr. 17-19; see also, Ex. 7-3). Based on his testimony, we conclude that he has proven an additional 3 percent impairment, due to his disabling pain. See Daniel M. Alire, 41 Van Natta 752 (1989).

### Impairment

The ratings for claimant's multiple residuals are combined for a total body part rating. Former OAR 436-35-360(11). When, as here, impairment results from disabling pain, the pain impairment value is combined with other body part impairment values. The 5 percent impairment value for a disc lesion and reduced

extension is combined with the 3 percent value for disabling pain for a total impairment of 7.85 percent. Id.

Calculation of Standards Disability

The value for age is added to the total for education. (0+2=2). This sum is multiplied by the value for adaptability. (2X1=2). This product is then added to the total impairment value (7.85) to reach the extent of disability. (9.85). This number is rounded to the next higher whole number. Former OAR 436-35-280(7). Claimant's total disability under the standards is 10 percent, as determined by the Referee.

The Referee found no clear and convincing evidence that claimant's degree of impairment is greater than indicated by the standards. We agree.

ORDER

The Referee's order dated March 17, 1989 is affirmed.

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In the Matter of the Compensation of
**SHARON E. MACK, Claimant**
WCB Case No. 89-03883
ORDER ON REVIEW (REMANDING)
Burt, et al., Claimant Attorneys
Bottini, et al., Defense Attorneys

Reviewed by Board Members Myers and Cushing.

Claimant requests review of Referee Howell's order which dismissed her request for hearing as barred under the doctrine of res judicata. On review, the issue is whether claimant's aggravation claim for a neck condition is barred by the doctrine of res judicata. We reverse and remand.

FINDINGS OF FACT

On August 21, 1985, claimant filed a claim alleging that on August 15, 1985 she injured her "back, legs, neck and ankles" while working on a belt picking beans. In the description of injury, claimant wrote "got back and neck pain and legs acked (sic), ankles starting swelling." Dr. Azhar initially saw claimant for these complaints. However, over the next several months, claimant's symptoms and treatment focused on the low back. In December 1985, Dr. Azhar did note that claimant had injured both her low back and her neck.

On January 13, 1986, the employer's processing agent issued a denial of the claim. The parties agree that the denial was intended to deny both the neck and the low back injuries.

Claimant requested a hearing to protest the denial. The case was heard on December 10, 1986 by Referee M. Johnson. At hearing, Referee Johnson characterized the issue as "the correctness of a denial dated January 13, 1986...." However, in his Opinion and Order of April 3, 1987, Referee Johnson stated the issue as:

> "Compensability of claimant's current low back condition. Claimant challenges a January 13, 1986 denial in which the employer denied the compensability of claimant's low back condition on the basis that the condition did not arise out of or in the course and scope of her employment." (emphasis in original).

In the "order" portion of his Opinion and Order, Referee Johnson stated:

> "The January 13, 1986 denial is disapproved, and the claim is remanded to the employer for acceptance as a compensable claim and for the provision of all benefits to which the worker is entitled...."

The Board reviewed Referee Johnson's order and affirmed on September 30, 1988. The Order on Review also characterizes the denial as being a denial of "claimant's low back injury claim."

On January 13, 1989, claimant saw Dr. Radecki and complained of neck pain which had existed since the 1985 injury, but which had worsened in the previous month. An MRI revealed moderate disc herniation at C6-7. Dr. Radecki proposed surgery.

On February 11, 1989, Dr. Reynolds, claimant's treating physician, requested reopening on the basis that the cervical problem represented a worsening of the cervical problems which had existed since the 1985 injury. On February 14, 1989, the employer's processing agent denied an aggravation claim on the basis that the current medical treatment was not "materially related to your alleged injury of August 15, 1985...."

## CONCLUSIONS AND OPINION

The Referee concluded that claimant could have asserted a claim for injury to her neck in the hearing before Referee Johnson and because she did not do so and because she did not request that Referee Johnson or the Board consider that issue on reconsideration, she has waived the neck claim and that claim is precluded under the doctrine of res judicata. We disagree.

The Supreme Court has held that the doctrine of res judicata has two aspects; "claim preclusion" (formerly called res judicata) and "issue preclusion" (formerly called direct estoppel or collateral estoppel). North Clackamas School District v. White, 305 Or 48, on recon 305 Or 468 (1988).

The key elements of claim preclusion are: (1) the same parties (or those in privity); (2) the same claim (or a second claim arising from the same transaction or series of connected transactions out of which the first claim arose); and (3) a valid and final judgment on the first claim. Jimmy M. Campoz, 42 Van Natta 903 (1990). The key elements of issue preclusion are: (1) the same parties; (2) a valid and final judgment; (3) actual litigation of an issue of fact or law; and (4) a determination of that issue which is essential to the judgment. Campoz, supra at 904.

We conclude that claimant is not barred from raising the neck claim under either the doctrine of claim preclusion or the doctrine of issue preclusion. Issue preclusion does not apply because there is no evidence in this record that the parties in the hearing before Referee Johnson actually litigated the factual or legal issue of whether the neck condition was caused by the injury which Referee Johnson and the Board found to be compensable.

Claim preclusion does not apply because this claim for a neck condition is not the same claim nor does it arise out of the same transaction or series of transactions as the claim which was litigated before Referee Johnson. "The res judicata effect [of a] denial is limited to the conditions denied as they existed on or before the date of the denial." George W. Jordan, 41 Van Natta 2072, 2073 (1989). At the time of the denial litigated before Referee Johnson, claimant's primary condition was a low back condition. She had previously had some neck complaints, but the main problem was the low back. Even if claimant were somehow precluded from arguing that her neck condition as it existed at the time of the first denial was related to the compensable injury, she could not be precluded from proving that her compensable condition worsened to the point that it became a material cause of her neck condition. Jordan, supra. However, claimant actually prevailed in the hearing on the first denial; therefore, if there were some preclusive effect on the neck condition, it would be against the employer and not against claimant.

We conclude that claimant is not precluded from litigating the merits of whether her current neck condition is compensable. Accordingly, we vacate the Referee's order and remand this case to the Presiding Referee to assign to a Referee to hold a hearing and to decide this case on the merits.

IT IS SO ORDERED.

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July 11, 1990 Cite as 42 Van Natta 1564 (1990)

In the Matter of the Compensation of
**HAZEL P. FLORY, Claimant**
WCB Case Nos. 85-15107 & 85-15106
ORDER ON RECONSIDERATION
Sharp & Durr, Claimant Attorneys
Thomas Sheridan (Saif), Defense Attorney
Stafford Hazelett, Defense Attorney
Beers, et al., Defense Attorneys

On May 11, 1990, we issued an Order of Abatement stating that we had decided to reconsider our April 26, 1990 Order on Review. In that order, we declined to award an assessed fee for services rendered at hearing and on review concerning the carpal tunnel claim to be paid by Liberty Northwest Insurance Corporation. We declined to award an attorney fee because claimant's counsel had not filed a statement of services. Submitting a statement of services for her counsel's efforts at hearing and on Board review, claimant seeks an attorney fee.

After reviewing the statement of services and considering the factors set forth in OAR 438-15-010(6), we award claimant's attorney a reasonable assessed fee of $1,800 for services at hearing and Board Review concerning the carpal tunnel claim, to be paid by Liberty Northwest.

Claimant also seeks an attorney fee for services rendered on review concerning the neck and shoulder claim. Yet, as a result of our decision that the SAIF Corporation, rather than Liberty Northwest (the appealing party), is responsible for the claim, claimant's compensation has been reduced because Liberty Northwest's temporary disability rate is higher than SAIF's. Inasmuch as claimant's compensation concerning the neck and shoulder claim has been reduced as a result of our order, she is not entitled to an attorney fee pursuant to ORS 656.382(2).

Accordingly, our April 26, 1990 order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our April 26, 1990 order in its entirety. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

**Board Member Crider, concurring in part and dissenting in part.**

The Board republishes our earlier opinion and, in addition, awards claimant an attorney fee.

I concur in those portions of the Board's order that assign responsibility for claimant's carpal tunnel syndrome to Liberty Northwest and award attorney fees for services at hearing and on review with respect to that issue. I dissent, however, with respect to the assignment of responsibility for the back, neck and shoulder conditions and, consequently, to the denial of an attorney fee for services regarding assignment of responsibility for those conditions.

The majority finds that evidence regarding the contribution of claimant's employment while EBI and Liberty Northwest were on the risk is in equipoise. That is, although it is clear that claimant symptoms became worse such that she became more disabled as a result of work activity while Liberty Northwest was on the risk, the majority is unable to determine whether or not those work activities caused a worsening of the underlying condition. When evidence regarding causation of a compensable condition is in equipoise, responsibility must be assigned to the last employment which was capable of causing the condition. Boise Cascade v. Starbuck, 296 Or 238 (1984); Champion International v. Castilleja, 91 Or App 556 (1988).

Where, as here, the claimant has worked throughout for the same employer, the same principle applies to assignment of responsibility between insurers. See Inkley v. Forest Fiber Products Co., 288 Or 337 (1980). Asssuming that the majority is correct when it states that the evidence regarding causation is in equipoise, it erred in assigning responsibility to the earlier insurer. I dissent for the reasons stated in Linda Wise, 42 Van Natta 115 (1990)(Board Member Crider, dissenting).

If the Referee correctly assigned to Liberty Northwest, claimant is also entitled to fees for defending that order on review.

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July 11, 1990 Cite as 42 Van Natta 1565 (1990)

In the Matter of the Compensation of
**BILL R. HARRISON, Claimant**
WCB Case No. 89-00791
ORDER ON REVIEW
Brown & Tarlow, Claimant Attorneys
Williams, et al., Defense Attorneys

Reviewed by Board Members Howell and Speer.

Claimant requests review of Referee Higashi's order which increased his unscheduled permanent disability award for a low back injury from 2 percent (6.4 degrees), as awarded by Determination Order, to 18 percent (57.6 degrees). On review, the issue is extent of unscheduled permanent disability. We affirm.

FINDINGS OF FACT

With the exclusion of his "Findings" regarding claimant's modifying his work, we adopt the Referee's "Findings" with the following supplementation.

Claimant is 57 years old, a high school graduate with no vocational training. Claimant has been an edgerman for 21 years. (Ex. 18-2).

Claimant reported on his "801" form that he had hurt his hip and leg in the fall. (Ex. 2). The initial treating physician diagnosed his condition as "Trochanteric bursitis." (Ex. 3). In April 1987, claimant's pain was centered in his left lumbar spine radiating into his buttocks and down into his thigh. (Ex. 4). By June 1987, his pain was "almost completely resolved ... some intermittent sciatica in the left leg ... (which) will come and go and is not dependent upon his activity." (Ex. 4).

After the accident, claimant returned to his usual and customary work. (Ex. 10-3). Because of continued pain, claimant had nerve root decompression surgery on August 17, 1988. (Ex. 14). Subsequent to the surgery, claimant returned to his usual and customary work with limitations regarding repeated bending, twisting, and lifting more than 10 lbs. (Ex. 18; Tr. 18). Claimant's usual and customary work does not require him to bend or twist nor lift more than 10 lbs. (Tr. 19 & 20). Loss of function due to the February 27, 1987 injury is minimal. (Ex. 18-4). Due to degenerative arthritis and disc disease, which are not related to his compensable injury, claimant's total loss of function of the back is mild. (Ex. 18-4).

Claimant was medically stationary on November 2, 1988. The Determination Order issued December 21, 1988. (Ex. 26).

CONCLUSIONS OF LAW AND OPINION

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

For purposes of determining injury-related permanent partial disability, ORS 656.283(7) and 656.295(5) require application of the standards for the evaluation of disabilities adopted by the director pursuant to ORS 656.726(3)(f)(A). Those "standards" in effect on the date of the Determination Order from which the hearing was requested control the evaluation of permanent partial disability. OAR 438-10-010.

In this case, the "standards" adopted effective July 1, 1988, (former OAR 436-35-001 et seq), as amended by temporary rules effective August 19, 1988, apply to the rating of claimant's permanent partial disability. Former OAR 436-35-270 through 436-35-440 apply to the rating of unscheduled permanent partial disabilities. Former OAR 436-35-270(1).

The determination of permanent partial disability under the standards is made by determining the appropriate values assigned by the standards to the claimant's age, education, adaptability and impairment. Once established, the values for age and education are added and the sum is multiplied by the appropriate value for adaptability. The product of those two figures is then added to the appropriate value for impairment to yield the percentage of claimant's unscheduled permanent disability. Where the worker has returned to his usual

and customary work, no value is assigned for age, education (skills and training), and adaptability to perform a given job. Former OAR 436-35-290(1)(b), OAR 436-35-300(1)(b), and OAR 436-35-310(1)(b).

Claimant contends that he should be considered to have returned to "modified" work because sometimes he must ask for assistance from other workers due to his limitations stemming from his compensable condition and he is prevented from voluntarily substituting on another shift (double shift for extra salary) that requires lifting more than 10 lbs., bending and twisting. Therefore, claimant argues, if he is rated as having returned to "modified" work, he should receive values under the standards for age, education, training and adaptability. We have considered claimant's testimony regarding his current work activities and do not find that his current work activities constitute "modified" work for purposes of applying the standards. Claimant has returned to usual and customary work and no values shall be assigned for age, education and adaptability.

Claimant has sustained permanent spinal impairment due to his compensable injury:

General Spinal Impairment

Claimant had nerve root decompression surgery on August 17, 1988 -- a laminotomy and foraminotomy. (Ex. 14). Claimant is entitled to an impairment value of 1 percent under the category intervertebral disc lesion. Former OAR 436-35-350(2).

Impairment of Spinal Range of Motion

Claimant is entitled, under the standards, to an impairment value for lost spinal motion. Former OAR 436-35-360. Claimant's retained forward flexion is 85 degrees, for a value of .5 percent. Former OAR 436-35-360(6). His retained extension is 25 degrees, for a value of .5 percent. Former OAR 436-35-360(7). He is entitled to no impairment values for lost lateral flexion or rotation. Former OAR 436-35-360(8) & (9).

The values for lost motion in claimant's spine are added (not combined) to obtain a single value of 1. Former OAR 436-35-360(10).

Loss of Use Due to Pain

Disabling pain can result in loss of use or function and when it does, an impairment value may be assessed, even though the standards do not provide for a value range for impairment attributable to disabling pain. Former OAR 436-35-010(2) and OAR 436-35-320(1)(a); Daniel M. Alire, 41 Van Natta 752, 757 (1989). Since the surgery claimant is restricted to lifting no more than 10 lbs. and is limited when he bends or twists his back. (Ex. 18-4). Claimant can not do many of the personal activities he was accustomed to doing prior to the injury such as painting his house, refinishing furniture, and playing with his grandchildren. We conclude that the Referee correctly awarded 15 percent permanent impairment for claimant's disabling pain.

To obtain a total spinal impairment value, we combine (not add), the impairment values for surgery, pain and lost motion for a total of 16.69 percent. Former OAR 436-35-280(7). This figure is rounded up to the next higher whole number. Former OAR 436-35-280(7). We find that claimant is entitled to an unscheduled permanent disability award under the standards of 17 percent.

Claimant further contends that clear and convincing evidence exists that the degree of his permanent disability is more than the entitlement indicated by the standards. ORS 656.283(7). After our de novo review of the record, we find that claimant has not established that his disability exceeds 17 percent.

The Referee awarded 16 percent unscheduled permanent disability in addition to the 2 percent awarded by the December 21, 1988 Determination Order. Because the insurer has not requested a reduction in the Referee's award, we affirm the Referee's order.

ORDER

The Referee's order, dated May 4, 1989, is affirmed.

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In the Matter of the Compensation of
**SHARON A. IPOX, Claimant**
WCB Case No. 88-21792
ORDER ON REVIEW
Vick & Gutzler, Claimant Attorneys
Beers, et al., Defense Attorneys

Reviewed by Board Members Howell and Speer.

Claimant requests review of Referee Quillinan's order which increased claimant's unscheduled permanent disability award for a low back injury from 4 percent (12.8 degrees), as awarded by Determination Order, to 7 percent (22.4 degrees). On review, the issue is extent of unscheduled permanent disability. We affirm.

FINDINGS OF FACT

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

Claimant's usual and customary job is driving a school bus twice a day, morning and afternoon. (Tr. 10). In order to work more hours, claimant could substitute and has substituted on other bus "runs" in addition to her own morning and afternoon "runs." (Tr. 42). It was on one of these additional bus "runs" -- a "wheelchair run" -- that claimant was injured in February 1987. The "wheelchair run" is not a "run" where lifting is normally required -- there is a mechanized lift in the bus for the wheelchairs. (Tr. 10, 30). Dr. Moore, D.C., claimant's treating chiropractor, returned claimant to work with a lifting restriction of 20 pounds on March 2, 1987. (Ex. 5). Claimant returned to her usual and customary work and completed her regular work year through June 12, 1987. (Ex. 14; Tr. 12, 14, 31, 42). Claimant's usual and customary work did not include the "special ed runs" when lifting would be required. Prior to the injury, she had driven a "special ed run" only one time as a substitute. (Tr. 31).

CONCLUSIONS OF LAW AND OPINION

The determination of permanent partial disability under the standards is made by determining the appropriate values assigned by the standards to the claimant's age, education, adaptability and impairment. Once established, the

values for age and education are added and the sum is multiplied by the appropriate value for adaptability. The product of those two figures is then added to the appropriate value for impairment to yield the percentage of claimant's unscheduled permanent disability. Where the worker has returned to her usual and customary work, no value is assigned for age, education (formal education, skills and training), or adaptability. Former OAR 436-35-290(1)(b), OAR 436-35-300(1)(b), and OAR 436-35-310(1)(b).

The Referee found that claimant's injury-related impairment did not interfere with the performance of her "present" job. The Referee also held that claimant's lifting restriction could impair claimant's ability to gain and hold suitable employment in the general labor market. Based upon this latter finding, the Referee held that claimant had returned to "modified work" and evaluated claimant's disability under the standards on this basis. We disagree with the Referee's approach.

The facts in the record do not support a finding that claimant returned to "modified" work. Claimant returned to her usual and customary work. Whether claimant remains capable of performing other employment is not relevant to the question whether she has returned to her usual and customary work.

We also note that both parties rely on "strength" requirements not in the record, but as set forth in the Dictionary of Occupational Titles (DOT). We are not at liberty to rely upon such information. See Groshong v. Montgomery Ward Co., 73 Or App 403 (1985). The "standards" adopt by reference only the specific vocational preparation (SVP) times for jobs listed in the DOT. Former OAR 436-35-300(4).

On review, claimant disputes only the Referee's adaptability finding. However, because claimant returned to her usual and customary work, no value is assigned for adaptability. Because the insurer does not request a reduction in the Referee's award, we affirm the Referee's order.

ORDER

The Referee's order, dated April 10, 1989, is affirmed.

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July 11, 1990 Cite as 42 Van Natta 1569 (1990)

In the Matter of the Compensation of
**SIGRID C. PARKER, Claimant**
WCB Case No. 88-13005
ORDER ON RECONSIDERATION
Charles Maier, Claimant Attorney
Gail Gage (Saif), Defense Attorney

On its own motion, the Board has decided to reconsider its Order on Review in the above-captioned matter, issued July 3, 1990. In that order, we reversed the Referee's award of a $550 penalty-related fee because counsel for claimant had not filed a statement of services as required by former OAR 438-15-010(5). On reconsideration, we note that this rule was repealed effective July 1, 1990, and was not in effect at the time of our July 3, 1990 order. OAR 438-15-010, WCB Admin. Order 7-1990. Consequently, we affirm the penalty-related fee awarded by the Referee, notwithstanding the fact no statement of services was filed.

Accordingly, our July 3, 1990 order is abated and withdrawn. The Referee's order, dated September 28, 1988, is affirmed.

IT IS SO ORDERED.

In the Matter of the Compensation of
**FRANKIE J. VOTH, Claimant**
WCB Case No. 89-02152
ORDER ON REVIEW
Welch, Bruun & Green, Claimant Attorneys
Stafford Hazelett, Defense Attorney

Reviewed by Board Members Cushing and Myers.

The insurer requests review of that portion of Referee Neal's order which set aside the insurer's denial of claimant's right hand injury claim. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

Claimant was a disc jockey in a tavern. On December 15, 1988, the lounge manager told claimant to turn the music volume down. A few minutes later, claimant deliberately drew back his right arm, thrust his hand through the juke box glass and cut his hand.

We adopt the Referee's finding that claimant was not a credible witness.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant deliberately pushed his hand through the juke box. Nonetheless, finding that there was no evidence that claimant intended to injure himself, the Referee set aside the insurer's denial. We disagree.

If a worker intentionally causes his own injury, that injury is not covered under the Workers' Compensation Act. ORS 656.156(1); Brian J. Brown, 42 Van Natta 261 (1990). The test for determining whether claimant's injury is compensable is: (1) whether claimant condition was the result of his own conscious, volitional act; and (2) whether he had knowledge of the consequences of the act. See James G. Wesley, 40 Van Natta 1841, 1844 (1988).

There was a gap of several minutes between the time claimant's supervisor told him to lower the music's volume and when he heard the sound of breaking glass. (Tr. 12). During that period claimant paced back and forth in front of the "DJ Booth." (Tr. 15). Claimant then pulled his right arm back and pushed his hand through the glass. (Tr. 18, 15).

These circumstances persuade us that claimant consciously and of his own volition thrust his right hand through the juke box glass. We infer that claimant recognized the consequences of taking such an action. In other words, he knew that by thrusting his hand through the glass it was likely that he would cut his right hand. Consequently, we find claimant intentionally caused injury to himself, and is therefore not entitled to workers' compensation benefits. See ORS 656.156(1).

ORDER

The Referee's order dated May 4, 1989 is reversed in part and affirmed in part. The insurer's denial is reinstated and upheld. The Referee's attorney fee award of $1,500 is reversed. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
**ROBERT F. WALTERS, Claimant**
WCB Case No. 88-18141
ORDER ON REVIEW
Westmoreland & Shebley, Claimant Attorneys
David Lillig (Saif), Defense Attorney

Reviewed by Board Members Speer and Howell.

Claimant requests review of Referee Galton's order which affirmed two Determination Orders that awarded a total of 37 percent (118.4 degrees) unscheduled permanent disability for a back condition and awarded no scheduled permanent disability for his right arm. On review, the issues are extent of unscheduled and scheduled permanent disability. We affirm.

## FINDINGS OF FACT

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

Claimant's injury occurred on May 13, 1986. Claimant made a claim on the "801" form for a "bruised back." There is no mention of an arm injury. (Ex. 4). The physician's report, a few days after the injury, states that claimant's pain was in his midback (midthoracic), upper lumbar and left side. (Ex. 4A).

On August 1, 1986, claimant reported that his pain was predominantly in the right shoulder. (Ex. 4A-2). On September 2, 1986, claimant reported that his pain was in his left shoulder. (Ex. 4A-3). On August 1, claimant had a "normal exam" and was told that he could go back to modified work -- light duty. (Ex. 4A-2). In mid-August, claimant began to complain of low back pain. (Ex. 4A). On August 22, claimant was told that he could go back to regular work in about 10 days -- that his physical exam did not preclude him from working. (Ex. 4A-2, 4A-3). At the time of hearing, claimant had not returned to work. (Tr. 10).

Claimant complained to Emanuel Hospital Pain Center of "widespread body pain, including neck, thoracic, right arm and left leg pain." (Ex. 26-1).

Claimant's pain is significantly affected by psychosocial influences, his somatic focus, and long term depression. (Exs. 26-3 & 27-1). Claimant missed many appointments with vocational and rehabilitation therapists and was not motivated to take part in a pain reducing or rehabilitation program. (Exs. 26-4, 28, 29). Claimant's psychological condition was neither caused nor worsened by his compensable injury.

Claimant was medically stationary on May 6, 1988. His claim was closed by Determination Order on August 17, 1988. (Exs. 58, 61).

## CONCLUSIONS OF LAW AND OPINION

The Referee concluded from his observations of claimant's attitude, appearance and demeanor at hearing, that claimant was not credible. We defer to the Referee's determination. Humphrey v. SAIF, 58 Or App 360, 363 (1982), Bush v. SAIF, 68 Or App 230 (1984).

Scheduled Permanent Disability - Right Arm

The Referee found that claimant sustained no injury to his right arm as a consequence of his compensable injury. We affirm and adopt the Referee's conclusion and opinion regarding claimant's claim for his right arm condition.

Unscheduled Permanent Disability

Claimant contends on review that he is entitled to more disability under the standards because he suffers from a psychological condition causally related to his compensable injury which was not considered in the evaluation of his disability.

The Referee held that claimant had failed to carry his burden of proof that his psychological condition was causally related to his compensable injury. We agree and adopt the Referee's conclusion and opinion on this issue. Accordingly, we rate claimant's permanent disability without consideration of his psychological condition.

In this case, the "standards" adopted effective July 1, 1988, former OAR 436-35-001 et seq, apply to the rating of claimant's permanent partial disability. Former OAR 436-35-270 through 436-35-440 apply to the rating of unscheduled permanent partial disabilities. Former OAR 436-35-270(1).

The determination of permanent partial disability under the "standards" is made by determining the appropriate values assigned by the "standards" to the claimant's age, education, adaptability and impairment. Other than claimant's testimony regarding his pain, which the Referee and we have found to be not credible, claimant presents no evidence regarding permanent impairment due to his back condition, e.g., surgery, fractures, ankylosis, disc lesions, or lost range of motion. Because claimant presents no persuasive evidence to establish permanent impairment due to his compensable injury, he has failed to prove that he is entitled to permanent disability under the "standards" or by clear and convincing evidence. It is unnecessary for us to address the values for age, education and adaptability under the standards. Former OAR 436-35-280(1). The insurer does not request a reduction in the disability award, therefore, we affirm the Referee.

ORDER

The Referee's order, dated March 6, 1989, is affirmed.

In the Matter of the Compensation of
**PRISCILLA O. DEAN, Claimant**
WCB Case No. 88-19737
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Rankin, et al., Defense Attorneys

Reviewed by Board Members Nichols and Brittingham.

Claimant requests review of that portion of Referee Higashi's order that upheld the self-insured employer's denial of claimant's occupational disease claim for a respiratory condition. On review, the issue is compensability. We affirm.

## FINDINGS OF FACT

We adopt the Referee's "FINDINGS," with the following corrections and supplementation:

### Corrections

Paragraph 5 on page 3: Claimant has chronic rhinosinusitis, an infection of the nose and paranasal sinuses, not an infection of the supporting system of the lung.

Paragraph 7 on page 3: The medications used for treating claimant's high blood pressure were ruled out as a possible cause of her respiratory condition.

### Supplementation

Claimant had been in good health until 1986, when she noticed the onset of rhinorrhea (runny nose), fever, cough, chest tightness, and shortness of breath. After being taken off work and treated with antibiotics she improved somewhat, but worsened upon her return to work. She continued to have intermittent episodes of cough, chest pain and fever during the fall and winter of 1986-87. In early 1988, she had an increase in nasal congestion and rhinorrhea and in June 1988 complained to her treating doctor of worsening pulmonary and sinus congestion when at work. She was taken off work for the second time in September 1988, but had no dramatic improvement in her symptoms. At the time of hearing claimant had significant exertional dyspnea (difficulty breathing) after walking on the level carrying heavy objects or after climbing one flight of stairs. She also had intermittent non-productive cough and chest tightness, nasal and sinus congestion, bifrontal headaches, and a foul taste in her mouth.

Claimant's last work exposure was on January 20, 1989.

Claimant wore no respiratory protection until January 1988, when she began wearing surgical masks, a charcoal filter respiratory protective device, and safety goggles. There was no mechanical ventilation in the workplace until about July 1988, when an exhaust fan was installed in claimant's work area.

Claimant was also exposed at work to caustic soda, cellulose nitrate, regular and unleaded gasoline, glycerin, silicone additives, and Chevron thinners. All these substances, as well as those identified in the "FINDINGS", are potentially irritating to the respiratory tract.

Claimant has never smoked and seldom drinks alcohol. She has no animals. No non-work activities have been identified that might have contributed to her condition.

FINDINGS OF ULTIMATE FACT

Claimant has an underlying infectious sinusitis which predisposes her to experience symptoms from exposure to respiratory irritants in her workplace.

Claimant has an occupational irritant reaction of the upper and lower airway.

Claimant has no occupational lung disease.

Claimant's current symptoms are the result of infectious sinusitis or occupational irritant reaction, both equally plausible explanations for claimant's condition.

CONCLUSIONS OF LAW AND OPINION

Because claimant's last exposure to working conditions involving fumes and vapors was January 20, 1989, we analyze her claim under the occupational disease law, ORS 656.802(1)(a)-(c), which became effective January 1, 1988. See Johnson v. SAIF, 78 Or App 143, rev den 301 Or 240 (1986); Donna E. Aschbacher, 41 Van Natta 1242 (1989). Claimant argues that she has an occupational disease under either ORS 656.802(1)(a) or (c). We first address the claim under (c).

Claimant maintains that compensability of her condition can be established under ORS 656.802(1)(c) if her work exposure to fumes and vapors was a material contributing cause of her need for medical services. The Referee concluded that claimant had no occupational disease under (c) because he found no evidence of an injury, wound or pathological change that resulted from claimant's irritation reactions. We find both analyses misconstrue the statute. Subsection (c) is limited to overuse traumas. It does not apply to claimant's condition, which is due to exposure to fumes and vapors, the subject of ORS 656.802(1)(a).

As a result, if claimant is to establish that she has an occupational disease, she must do so under (a) and, therefore, must meet the burden of showing that her work exposure was the major contributing cause of the onset or pathological worsening of her condition. See Ronald V. Dickson, 42 Van Natta 1102 (1990). This is a complex medical question. The resolution of this issue turns largely on an analysis of the medical evidence. Kassahn v. Publishers Paper Co., 76 Or App 105, 109, rev den 300 Or 546 (1986).

The Referee found that claimant had no occupational lung disease under ORS 656.802(1)(a), because she had no scarring in the lungs or their supporting structure. He based his opinion on the reports and testimony of Dr. Montanaro, M.D., a specialist in occupational lung disease and occupational asthma.

Claimant argues that the opinion of Dr. Morton, M.D., an occupational health specialist, should be accepted over that of Dr. Montanaro. Based on the results of tests that showed claimant had oxygen desaturation and diminished defusion capacity, Dr. Morton inferred that claimant has a diffusion barrier in her lungs due to diffuse scarring caused by breathing irritant gases.

In finding that claimant did not have an occupational lung disease, the Referee stated that he accepted Montanaro's explanation that it was probable that claimant had an infection of the supporting system of the lung of unknown causation. We disagreed. Montanaro actually said that claimant had chronic rhinosinusitis, an infection of the nose and paranasal sinuses, not an infection of the supporting system of the lung. Montanaro opined that claimant's lower

respiratory tract symptoms were caused by post-nasal drainage from the upper respiratory tract. This paranasal problem is of unknown cause. Montanaro's opinion was supported by that of Dr. Medak, M.D., who independently concluded that claimant had a chronic sinus infection, of non-occupational origin, which can cause both upper and lower respiratory tract symptoms.

In addition, Montanaro and Medak each opined that claimant had a separate problem, an irritant reaction due to industrial exposure, which also causes cough, irritated throat, nasal and sinus congestion, and intermittent headache. Although Montanaro did not feel that there was any obvious disease or condition caused by exposure to these occupational irritants, he opined that claimant's underlying infectious condition predisposed her to experience symptoms from exposure to respiratory irritants in her workplace.

We are not persuaded by Dr. Morton's conclusory opinion. X-rays revealed no scarring. Dr. Montanaro testified that there were multiple causes of oxygen desaturation and diminished defusion capacity, including drugs, tumors, inflammation, and infection. Yet, Morton inferred that scarring was present without addressing the x-ray evidence or other possible causes of the test results. Instead, we defer to the well-reasoned opinion of Dr. Montanaro.

Based on his opinion, we find that claimant's symptoms are a result of either her noncompensable infectious sinus condition or exposure to respiratory irritants in her workplace. Even if claimant's symptoms are due in part to workplace irritants, her claim is not compensable. There is no evidence that the workplace irritants were the major contributing cause of the onset or the pathological worsening of claimant's condition. Consequently, claimant's condition is not compensable, regardless of the actual cause. Accordingly, we uphold the denial.

ORDER

The Referee's order dated February 27, 1989 is affirmed.

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July 13, 1990 Cite as 42 Van Natta 1575 (1990)

In the Matter of the Compensation of
**LEROY W. EARP, Claimant**
WCB Case No. 89-03540
ORDER ON REVIEW (REMANDING)
Dennis S. Martin (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

Claimant, pro se, requests review of Referee Daughtry's order that dismissed his hearing request concerning the SAIF Corporation's denial of his claim for an October 1961 injury on the ground that the claim, filed in January 1989, was untimely. Contending that the Referee erred in dismissing his hearing request, claimant asserts that his claim is compensable. We hold that claimant is entitled to present his claim at a hearing. Consequently, we reverse the Referee's dismissal order and remand for a hearing.

FINDINGS OF FACT

In January 1989 claimant filed an injury claim with SAIF. Claimant contended that he had suffered a "gash" to his "skull" while working for Columbia Fence Company in October 1961.

SAIF denied the claim. It based its denial on several grounds. First, a search of the State Industrial Accident Commission records did not contain any 1961 injury claim from claimant. Second, SAIF had been unable to establish that it insured claimant's alleged 1961 employer. Third, SAIF asserted that claimant was required to report the injury to his employer within 30 days of the incident. Finally, SAIF contended that it had been prejudiced by the untimely filing of claimant's injury claim.

Claimant requested a hearing. In response, SAIF moved for dismissal of the hearing request. Citing the existing statutes in 1961, SAIF argued that claimant was required to file his claim within one year from the date of accident. Since the claim had been filed some 27 years after the accident, SAIF contended that the claim was untimely and should be dismissed.

CONCLUSIONS OF LAW

Relying on the existing statutes in 1961, the Referee reasoned that he lacked authority to consider the merits of claimant's injury claim. Thus, concluding that the claim was untimely filed, the Referee granted the motion to dismiss. We disagree with the Referee's conclusion that claimant is not entitled to a hearing.

At the time of claimant's alleged 1961 injury, a worker in a nonfatal case was required to file his claim within a maximum period of one year from the time of the accident. ORS 656.274(1). The aforementioned statute was repealed in 1965. Or Laws 1965, Chapter 285, 95.

Under present law, an injured worker must give written notice of the accident to the employer not later than 30 days after the accident. See ORS 656.265(1). Failure to give such 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. ORS 656.265(4)(a), (b), & (c).

The determinative question becomes which law applies to this situation. In other words, is it the law in effect at the time of the alleged injury or the law in effect at the time of the claim. For the following reasons, we conclude that it is the latter.

Except as otherwise provided by law, payment of benefits for injuries or death 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. ORS 656.202(2). However, this statute is not an absolute proscription against retroactive application of workers' compensation statutes. Rather, the statute is generally applied to deny retroactive application of legislation that alters the amounts and availability of benefits under the Workers' Compensation Act. See Barrett v. Union Oil Distributors, 60 Or App 483, 486-87 (1982); SAIF v. Mathews, 55 Or App 608, rev den 292 Or 825 (1982). In determining whether statutes should have retroactive effect, the courts have generally given retroactive effect to workers' compensation statutes which change the time within which claimants must assert their rights. Argonaut Insurance Companies v. Eder, 72 Or App 54, 56 (1985); Barrett, supra; Holden v. Willamette Industries, 28 Or App 613 (1977).

Here, the statutes in question concern the time for filing a claim for benefits. Current ORS 656.265 effects the time, as well as circumstances, within which claimants must file their claims. As previously noted, the courts

have generally given retroactive effect to such statutes. See Argonaut Insurance Companies v. Eder, supra. Perceiving no basis for holding that the legislature did not intend the workers' compensation general rule of retroactivity to apply, we conclude that ORS 656.265 is applicable.

Consequently, claimant is entitled to present his case at hearing. At that time, evidence can be produced pertaining to claimant's injury claim. This evidence may include, but is not limited to: (1) the date the claim was filed; (2) whether the employer had workers' compensation coverage at the time of the alleged injury and, if so, with whom; (3) whether the employer had knowledge of the alleged injury; (4) whether SAIF has been prejudiced by claimant's apparent failure to provide timely notice of the claim; and (5) any other questions concerning the compensability of the injury claim.

ORDER

The Referee's order dated November 14, 1989 is reversed. This matter is remanded to the Presiding Referee with instructions to refer this case to a Referee who will conduct a hearing consistent with this order.

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July 13, 1990 Cite as 42 Van Natta 1577 (1990)

In the Matter of the Compensation of
**WILLIAM W. GILLIS, Claimant**
WCB Case Nos. 88-16658, 88-21450 & 88-21451
ORDER ON REVIEW
Gary G. Jones, Claimant Attorney
Stafford Hazelett, Defense Attorney
Marcus K. Ward, Defense Attorney
Kate Donnelly (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

Liberty Northwest Insurance Company (Liberty) requests review of Referee Seifert's order which: (1) set aside its denials of claimant's occupational disease claim for bilateral carpal tunnel syndrome; (2) upheld the SAIF Corporation's denials, on behalf of Triple K Cutting and on behalf of Bethel Corporation, of the same condition. On review, the issue is responsibility. We affirm.

FINDINGS OF FACT

Claimant has worked in the woods since 1945. In August 1987, he began working for Mill Company Logging, Liberty's insured. His job was to sort logs and mark them with a branding iron. Branding the logs required repetitive, forceful motions of the wrist.

Claimant first noticed right wrist symptoms in October 1987. He worked for Liberty's insured until approximately June 13, 1988. On July 28, 1988, claimant filed an 801 form with Liberty's insured, indicating numbness in the right hand. He noted the onset as "late winter-1988" [sic]. That claim was denied by Liberty. Claimant had attempted to file a claim earlier but, because of processing mix-ups with the employer, he was not successful. He did not see a doctor because he was not covered by insurance.

Between late June and September 9, 1988, claimant worked for Triple K Cutting, SAIF's insured. His duties there required use of a chain saw which did not affect his wrist as log branding had.

Claimant next worked for Bethel Logging, also insured by SAIF, between September 26 and October 9, 1988. His job was to load logs with an hydraulic shovel. On October 13, 1988, claimant went back to work for Triple K Logging and remained there until January 1989. At none of the jobs after Liberty's insured did claimant observe any change in his wrist symptoms.

During a period of lay off from work, on September 12, 1988, claimant first saw a doctor about his condition. Nerve conduction studies on September 20, 1988 indicated severe right carpal tunnel syndrome and moderate to severe left carpal tunnel syndrome.

Claimant's bilateral carpal tunnel condition was caused by his employment activities with Liberty's insured. Claimant's employment activities with SAIF's insureds did not independently contribute to a worsening of his condition.

## CONCLUSIONS OF LAW AND OPINION

The Referee relied on the medical opinion of Dr. Woolpert who concluded that claimant's current symptoms were due to his employment at Liberty's insured and, thus, found Liberty to be responsible. We agree.

Liberty argues that, because it was not on the risk at the time claimant first sought medical treatment, it is not responsible. Citing Bracke v. Baza'r, 293 Or 239 (1982), Liberty claims that the onset of disability occurred long after employment with its insured, thus relieving Liberty of responsibility. Liberty would be correct had it not been for the fact that claimant has proved actual causation as a result of his employment with Liberty's insured. Claimant has not relied on the last injurious exposure rule. See Bracke, supra.

Neither Dr. Jewell nor Dr. Woolpert were claimant's treating physician. Because the opinions of the two doctors are conflicting, we rely on the most well-reasoned for our conclusion. Somers v. SAIF, 77 Or App 259 (1986). As the Referee did, we rely on Dr. Woolpert's analysis of the causation of claimant's condition.

Dr. Woolpert noted that claimant was diagnosed as having "severe carpal tunnel syndrome" on September 20, 1988. By history, Woolpert noted that claimant had a continuation of symptoms that began with his work at Liberty's insured, but the symptoms were not worsened while working at Triple K. Moreover, the type of work claimant performed at Triple K involved less repetitive use of his right wrist. We note the fact that claimant had worked for Triple K only approximately five weeks before this severe carpal tunnel syndrome was diagnosed.

Dr. Woolpert found claimant to be an intelligent historian concerning his wrist condition. He stated that claimant noted atrophy of his thumb prior to his work with Triple K Logging. This atrophy is consistent with the severity of claimant's carpal tunnel syndrome as was noted by tests on September 20, 1988.

In addition, Dr. Woolpert noted that claimant had severe degenerative joint disease of the right carpal tunnel area. He concluded that, even though claimant's degenerative condition may have predisposed him to carpal tunnel problems, the use of the branding hammer while employed by Liberty's insured was the major factor contributing to claimant's condition.

Finally, we note claimant's credible testimony that the onset of his symptoms occurred during his employment with Liberty's insured, and that those symptoms did not worsen during his subsequent employments.

We are persuaded that claimant's work for Liberty's insured was the cause of his carpal tunnel syndrome. Accordingly, it is not necessary to rely on the last injurious exposure rule to assign responsibility. Bracke, supra at 245.

ORDER

The Referee's order dated April 28, 1989 is affirmed.

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July 13, 1990 Cite as 42 Van Natta 1579 (1990)

In the Matter of the Compensation of
**FAYE E. HARRIS, Claimant**
WCB Case No. 88-21359
ORDER ON REVIEW
Scott M. McNutt, Claimant Attorney
H. Thomas Andersen (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer

The SAIF Corporation requests review of Referee Mongrain's order that set aside its partial denial of claimant's current low back condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

In 1968 claimant sustained a compensable low back injury. SAIF accepted the claim. Five months after her injury, she underwent surgery for a herniated disc. A 1969 Determination Order granted claimant 15 percent unscheduled permanent disability.

In 1970, Dr. Smith, M.D., reported that claimant had developed narrowing of the L-3 disc space. In 1970, Dr. Williams, orthopedic surgeon, noted persistent low back pain of uncertain etiology with progressive narrowing of the L-3 interspace. In 1973, claimant was diagnosed with residual low back and right leg pain.

A 1974 stipulation increased claimant's unscheduled permanent disability award to 45 percent.

In 1986, claimant was diagnosed as having acute low back pain, probably secondary to low back strain. Claimant was also diagnosed with mild disc space narrowing at L1-2 and L3-4.

In 1987, claimant filed a claim with Combined Insurance Company, stating that her back "went out" when she leaned over a bed at a friend's house.

In September 1988, Dr. Meece, D.O., diagnosed lumbar spine sprain. In November 1988, Western Medical Consultants examined claimant and diagnosed degenerative joint disease at L5-S1, degenerative disc disease at C4-5 and C5-6 and pre-spondylolysis at L-5 bilateral. Ex. 19.

Dr. Meece's September 1988 report to SAIF diagnosed lumbar spine sprain/strain and stated that claimant had bridging symptoms since her 1968

injury. Dr. Meece recommended treatment three times per week and requested treatment authorization from SAIF.

In December 1988, SAIF denied that claimant's current low back condition was related to her 1968 injury.

## CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant's current low back condition was materially related to her compensable injury of 1968. He concluded that, although claimant had not sought medical treatment for almost 13 years, her credible testimony that she continued to suffer ongoing symptoms provided the evidence necessary to link her current condition to her prior injury. We do not agree with the Referee's conclusion that claimant has proven that her condition is materially related to her 1968 injury.

Although claimant credibly testified that she continued to suffer back symptoms after her 1968 injury, we are not convinced that such testimony is sufficient to connect the initial injury to her current condition. Claimant has sustained an intervening injury and suffers from degenerative disc disease. Therefore, the issue of whether her back condition is related to her 1968 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 Department, 247 Or 420, 426 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985).

In November 1988, the Western Medical Consultants took x-rays of claimant's cervical spine and found degenerative disc disease at the C4-5 and C5-6 levels. X-rays of claimant's lumbar spine showed degenerative joint disease at L5-S1. The Consultants opined that claimant's current symptoms were caused by degenerative changes in the lumbar spine, which were the consequences of normal aging, rather than the result of her 1968 injury.

In February 1989, Dr. Abbott, M.D. (claimant's treating physician since 1985), opined that claimant's current problem was directly related to her 1968 injury. Dr. Abbott reported that following her 1986 hospitalization, claimant had almost a year of good relief from pain, but had since suffered from recurrence.

Although Dr. Abbott has related claimant's current condition to her compensable injury, we do not find his opinion to be persuasive. Dr. Abbott has not explained why he believes claimant's back problems are related to her 1968 injury. Moreover, in reaching his conclusion, Dr. Abbott has not considered claimant's 1987 back injury nor the objective findings of degenerative disc disease. Under the circumstances, we conclude that claimant has not proven by a preponderance of the evidence that her current back condition is related to her compensable 1968 injury.

## ORDER

The Referee's order dated April 6, 1989 is reversed. The Referee's award of a $1,600 assessed attorney fee is reversed. The SAIF Corporation's denial is reinstated and upheld.

In the Matter of the Compensation of
**DEAN P. HOLDAHL, Claimant**
WCB Case No. 88-14588
ORDER ON REVIEW
Brown & Tarlow, Claimant Attorney
Rick Dawson (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

The SAIF Corporation requests review of Referee Garaventa's order that increased claimant's unscheduled permanent disability award for a low back injury from 12 percent (38.4 degrees), as awarded by a Determination Order to 17 percent (54.4 degrees). On review, the issue is extent of unscheduled permanent disability. We modify.

FINDINGS OF FACT

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

Claimant was employed by a woodwork company for a short time following graduation from high school. After that position he worked in the employer's machine and welding shops. For the ten years prior to his injury, claimant's highest SVP was 7 for his work as a machinist.

Claimant does not have documented competence in a specific vocational pursuit.

Claimant's usual and customary work is in the medium strength category. Claimant has returned to modified work and is currently capable of occasionally lifting 50 pounds or more. He regularly lifts up to 50 pounds.

Claimant has an unoperated disc derangement with clinically-related residual symptoms, at the L4-5 level.

Claimant had a left L5-S1 laminectomy and single discectomy.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant was entitled to 5 percent impairment for disabling pain, in addition to a prior Determination Order award of 12 percent. We modify.

In this case, the "standards" adopted effective July 1, 1988, former OAR 436-35-001 et seq, apply to the rating of claimant's permanent partial disability. Former OAR 436-35-270 through 436-35-440 apply to the rating of unscheduled permanent partial disabilities. Former OAR 436-35-270(1).

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

Age

The appropriate value for claimant's age of 29 years is 0. Former OAR 436-35-290.

Formal education

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

Skills

Former OAR 436-35-300(4) adopts by reference the "SVP" (specific vocational preparation time) values assigned to various occupations by the Dictionary of Occupational Titles (DOT), published by the U.S. Department of Labor. The highest SVP level demonstrated by a claimant during the ten years prior to the date of injury is used to determine a value for skills. Former OAR 436-35-300(4). Claimant's highest SVP during the ten years prior to the date of injury was 7 as a machinist (DOT # 600.280.022). Therefore, the appropriate value for skills is 1. Former OAR 436-35-300(4).

Training

SAIF argues that the Referee erred by finding that claimant was entitled to a value of 1 because he did not have training in a specific vocational pursuit. SAIF contends that claimant's high school shop classes constitute training in the field of mechanical work. We disagree.

OAR 436-35-300(5)(a) provides that if no documentation (demonstrating competence in some specific vocational pursuit) is provided, a value of 1 shall be allowed. SAIF has not provided evidence of a certificate, diploma or degree demonstrating claimant's competence in the vocation of machinist. See Jack E. Emerald, 42 Van Natta 1161 (1990).

Claimant has no documented training. Therefore, the appropriate value for training is 1. Former OAR 436-35-300(5). Claimant's total education value is 2, the formal education value plus the skills value plus the value for training. Former OAR 436-35-300(6).

Adaptability where claimant has returned to modified work

An adaptability value for a claimant who is unable to return to his or her usual and customary work [See former OAR 436-35-270(3)(a)] but who has returned to modified work is determined from a matrix of values at former OAR 436-35-310(3)(a). That matrix compares the physical capacity of the claimant's usual and customary work with the physical capacity required by the modified work. This is true even though claimant may have the physical capacity to do heavier work than is required by the modified employment. Physical capacities are not defined by the "standards" generally. We utilize those definitions contained in former OAR 436-35-310(4)(a)-(d).

SAIF argues that the Referee incorrectly found that claimant frequently lifted 30 to 40 pounds all day which therefore meant that he was capable of medium work. Claimant testified that he lifted 100 pounds although he tried not to consistently do so. Claimant also testified that he lifted 50 pounds "pretty regularly" and that he was able to pick that weight up and "work with it."

Under the circumstances, we conclude that claimant has returned to modified work in the medium or heavier category. As claimant's previous usual and customary work required work in the medium category, claimant is entitled to a value of 1 for adaptability. Former OAR 436-35-310(3)(a).

Impairment

The final element necessary to determine disability under the "standards" is the impairment value. For an unoperated disc derangement at the L4-5 level of the spine, with clinically-related residual symptoms, claimant is entitled to an impairment value of 4 percent. Former OAR 436-35-350(2). For a left L5-S1 laminectomy and single discectomy, claimant is entitled to an impairment value of 5 percent. Former OAR 436-35-350(2). The impairment values for claimant's disc derangement and laminectomy are added to obtain a single "intervertebral disc lesion" value. Michael E. Crist, 42 Van Natta 1093 (1990). In this case the sum of the impairment values for intervertebral disc lesion is 9 percent.

The Referee awarded claimant a value for pain which has resulted in a loss of use and function. We agree. Former OAR 436-35-320(1)(a) provides that pain can result in loss of use or function. When it does, it is rated based on the loss of use or function which results and no additional value is allowed for the pain alone. See Daniel M. Alire, 41 Van Natta 752 (1989).

In this case, the Referee found that claimant credibly testified that he has burning and aching pain in his low back and shooting pain in the left leg and buttock. Claimant's pain has caused him to limit or eliminate several off-work activites such as yard work, basketball and cutting firewood. Claimant's ability to lift, carry, walk, sit and run has been diminished because of his disabling pain. We agree with the Referee that claimant is entitled to an award of 5 percent for disabling pain.

The impairment values for claimant's intervertebral disc lesion are combined (not added) with the impairment value for his disabling pain to obtain a single impairment value. Former OAR 436-35-360(11). Here, 9 percent and 5 percent combine to a value of 13.55 percent.

Computation of unscheduled disability

Having determined each value necessary to compute claimant's permanent disability under the "standards," we proceed to that calculation. When claimant's age value, 0, is added to his education value, 2, the sum is 2. When that value is multiplied by claimant's adaptability value, 1, the product is 2. When that value is added to claimant's impairment value, 13.55, the result is 15.55 percent unscheduled permanent partial disability. Former OAR 436-35-280(7). That disability figure is rounded to the next higher whole percentage. Former OAR 436-35-280(7). Claimant's permanent disability under the "standards" is, therefore, 16 percent.

ORDER

The Referee's order dated November 22, 1988 is modified. In lieu of the Referee's award and in addition to the Determination Order award of 12 percent (38.4 degrees) unscheduled permanent disability, claimant is awarded 4 percent (12.8 degrees) for a total to date of 16 percent (51.2 degrees) unscheduled permanent disability for his low back injury.

In the Matter of the Compensation of
**ROBERT A. LUSK, Claimant**
WCB Case Nos. 88-10360, 88-10361 & 88-10362
ORDER ON REVIEW
Bennett & Durham, Claimant Attorneys
Roberts, et al., Defense Attorneys
Roy W. Miller (Saif), Defense Attorney
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Speer and Howell.

Aetna Casualty Company requests review of Referee Peterson's order that: (1) set aside its denial of responsibility for claimant's occupational disease claim for bilateral hearing loss and directed it to accept the claim through June 23, 1986; (2) set aside CNA Insurance Company's "de facto" denial of the same claim and directed that CNA accept the claim as of December 22, 1987; and (3) awarded claimant an assessed attorney fee payable equally by Aetna and CNA. In its brief, CNA contends that the Referee's assessed attorney fee award is excessive and should be reduced. On review, the issues are responsibility and attorney fees. We affirm in part and modify in part.

## FINDINGS OF FACT

We adopt the Referee's "Findings of Fact," with the following supplementation and modification.

Claimant was last employed by CNA's insured between November 16, 1987 and November 19, 1987.

The onset of claimant's permanent disability had occurred by June 23, 1986, while claimant was employed by Aetna's insured.

Claimant's work exposure after June 23, 1986, while employed by CNA's insured, caused additional permanent disability and independently contributed to a worsening of his condition.

## CONCLUSIONS OF LAW AND OPINION

### Responsibility

Responsibility for claimant's occupational disease rests, in the first instance, with the last potentially causal employer prior to the onset of disability. Bracke v. Baza'r, 293 Or 239, 248 (1982). Liability for the disease is fixed when the disease arises. Id. at 250. When, as here, the disability occurs first in the form of a permanent disability, the "onset of disability" is when the permanent disability manifests itself. Inez Horsey, 42 Van Natta 331, 332 (1990). The existence of claimant's permanent hearing loss was first established by a June 23, 1986 hearing test. (Exs. 2, 15-3). Aetna's insured was the last potentially causal employer prior to the onset of disability. Consequently, Aetna is responsible for the hearing loss suffered by claimant through June 23, 1986.

Claimant's hearing loss had worsened by December 22, 1987. (Exs. 3, 15-9). Uncontradicted evidence indicates that claimant's work exposure after June 23, 1986, while employed by CNA's insured, independently contributed to the worsening of his condition. (Ex. 15-9). In this regard, claimant's worsened condition is established by a second hearing test on December 22, 1987. Consequently, CNA's insured is responsible for claimant's worsened condition, commencing November 16, 1987, the date claimant began working for its insured.

In reaching these conclusions we note that the record clearly and quantifiably identifies claimant's permanent disability prior to his work activities with CNA's insured. Under such circumstances, claimant has successfully established the degree to which Aetna's and CNA's insured have been responsible for causing his occupational disease. Thus, use of the last injurious exposure rule is not necessary. See Runft v. SAIF, 303 Or 493, 502 (1987); Boise Cascade Corp. v. Starbuck, 296 Or 238, 244 (1983).

Attorney Fees

CNA argues that the Referee's attorney fee award of $1,800 is excessive. In support of this argument, it contends that claimant's compensation was not at risk because compensability was conceded. We disagree.

No ".307" order issued in this case by the time of the hearing. Under such circumstances, we have held that claimant's right to compensation is at risk against all potentially responsible carriers. Margaret A. Smith, 41 Van Natta 272, 274 (1989); See Ronald A. Warner, 40 Van Natta 1082, 1194 (1988).

Considering the relevant factors, we conclude that the Referee's award is reasonable. OAR 438-15-010(6). Because we find both insurers responsible, we also find the Referee's apportionment of the fee to be appropriate.

ORDER

The Referee's order dated December 16, 1988, as amended February 3, 1989, is affirmed in part and modified in part. The claim with CNA Insurance Company is ordered accepted as of November 16, 1987. We affirm the remainder of the order.

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July 13, 1990 Cite as 42 Van Natta 1585 (1990)

In the Matter of the Compensation of
**GEORGE A. RANKINS, Claimant**
WCB Case Nos. 88-07900 & 88-07899
ORDER ON REVIEW
Drakulich, et al., Claimant Attorneys
Cummins, et al., Defense Attorneys

Reviewed by Board Members Cushing and Myers.

The self-insured employer requests review of that portion of Referee Lipton's order that granted permanent total disability, whereas a Determination Order had awarded 65 percent (208 degrees) unscheduled permanent disability for a low back injury and 10 percent (13.5 degrees) scheduled permanent disability for loss of use or function of the left foot. In his brief, claimant requests review of that portion of the Referee's order that upheld the employer's denial of claimant's current cervical condition. On review, the issues are permanent total disability and compensability. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" as supplemented below.

Claimant's compensable 1986 injury materially contributed to claimant's current cervical condition and need for medical treatment.

## CONCLUSION OF LAW AND OPINION

### Compensability

The Referee upheld the employer's denial of claimant's current cervical condition. The Referee concluded that claimant's current cervical condition was unrelated to the lumbar back condition. We are in agreement with this portion of the Referee's opinion. However, the Referee also found that the compensable 1986 injury did not materially contributed to the current cervical condition. Specifically, he found increased symptoms insufficient to establish compensability for current treatment. We disagree with this portion of the Referee's analysis.

A claimant must establish by a preponderance of the evidence that the industrial injury was a material contributing cause of the existing disability. Harris v. Albertson's Inc., 65 Or App 254 (1983). Claimant is entitled to treatment for the disabling results of a compensable injury, even if claimant has a preexisting condition, and this preexisting condition continues to contribute to the disability. Jameson v. SAIF, 63 Or App 553 (1983). The compensable injury need not be the sole cause or the most significant cause of the need for treatment, but must be material. Van Blokland v. Oregon Health Sciences University, 87 Or App 694 (1987).

On October 16, 1986, claimant was working for the employer when he slipped and fell injuring his neck, shoulder, and left arm. Claimant filed a claim, which was accepted. The record does not indicate the date or terms of the acceptance. The claim was closed by Determination Order, dated December 7, 1987, and granted no permanent partial disability.

On March 31, 1988, the employer denied claimant's current cervical condition. The basis for the denial was that claimant's current cervical condition was not related to claimant's employment, but was related to a long standing preexisting degenerative disc disease in the cervical spine.

Claimant testified that prior to the compensable 1986 fall his cervical condition was asymptomatic. However, since the fall he has had a chronic problem with pain in the cervical area. Considering claimant's preexisting condition, we conclude that the issue of whether this current cervical condition is materially related to the compensable 1986 injury is a complex medical question. Hence, while claimant's testimony is probative, the resolution of this case largely turns on medical evidence. See Uris v. Compensation Dept., 247 Or 420 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105 (1985).

The medical record corroborates claimant's testimony in that it reveals that this preexisting condition predated the October 16, 1986 injury. The record also shows that even though claimant's degenerative disc disease preexisted the compensable injury, it was for the most part, asymptomatic. It was not until after the fall that claimant's cervical back condition became symptomatic and became a chronic problem for claimant.

In March 1987, claimant's then treating physician, Dr. Malos, diagnosed claimant's chronic neck pain resulting from cervical spondylosis and degenerative cervical disc disease, and opined that the 1986 fall may have exacerbated the condition, but was not entirely responsible for it. Dr. Kaldwell, claimant's present treating physician, felt the compensable 1986 injury "substantially aggravated" the cervical condition. He found that the compensable 1986 injury caused claimant to become symptomatic and limited claimant from overhead lifting, repetitive use of his left shoulder and cervicodorsal region, and precluded him from heavy work. Dr. Kaldwell noted that prior to the fall

claimant had not had significant problems in this area of his body. A consulting orthopedist, Dr. Hoppert, also concluded the 1986 fall aggravated the preexisting cervical condition.

In contrast, independent medical examiners have consistently concluded that claimant's cervical problems are related to a preexisting degenerative condition. Both the Orthopaedic Consultants in June 1987, and Dr. Rosenbaum in December 1986, so held. However, the contribution of claimant's degenerative cervical condition to his current cervical condition is not in dispute. Because these opinions fail to address the effect of the compensable 1986 injury, we give them less weight than that of claimant's treating physicians, as well as Dr. Hoppert.

We find that the compensable 1986 injury was a material contribution to claimant's current cervical problems. Claimant's preexisting susceptibility to this type of difficulty does not defeat claimant's claim. Even though no doctor used the "magic words" of material contributing cause, the evidence as a whole supports compensability of claimant's current cervical condition. McClendon v. Nabisco Brands Inc., 77 Or App 412, 416 (1986). We find that the evidence establishes that, although claimant did have a preexisting condition, the compensable 1986 injury materially contributed to the onset of chronic pain. Claimant has met his burden of proof, his claim is compensable. Accordingly, the March 31, 1988 denial is set aside.

We further find that setting aside the denial for claimant's cervical condition does not prevent rating extent of permanent disability. At the time of hearing claimant's cervical claim was in a closed status. Further, there was no contention at hearing by either party that, in the event the cervical condition was found compensable, it would be inappropriate for the Referee to proceed with a determination concerning the extent of claimant's permanent disability. Consequently, we proceed to determine whether claimant's cervical condition was medically stationary as of the date of hearing.

A Referee should not rate permanent disability if the claimant is not medically stationary at the time of hearing or the claim is in open status. Harmon v. SAIF, 54 Or App 121 (1981). "Medically stationary" means that no further material improvement would reasonably be expected from medical treatment, or the passage of time. The question of whether claimant was medically stationary at the time of hearing is a matter of medical evidence, which can be circumstantial as well as direct. Harmon, supra.

Claimant's treating physician, Dr. Kaldwell, in his Janaury 20, 1988 report, stated that claimant's cervical condition was medically stationary and nonsurgical. He also indicated that claimant's treatment for the condition for the past several months prior had been palliative only. Dr. Hoppert, in his February 6, 1988 report, stated that he had nothing more to offer claimant in the way of treatment, and would see him on an "as needed basis" only. Accordingly, we find claimant's cervical condition at the time of hearing to be medically stationary. Thus, it is permissible for us to proceed with a determination concerning the extent of claimant's permanent disability. See Harmon, supra.

Permanent Total Disability

In light of the above discussion, we find claimant has permanent impairment attributable to the compensable cervical condition. Claimant's impairment primarily consists of loss of range of motion in the neck. However, we further find that even without consideration of his cervical impairment, claimant is permanently totally disabled.

Thus, we adopt the "Opinion" as set forth in the Referee's order with respect to his conclusions regarding permanent total disability with the following exception. The Referee relied, at least partially, on the finding that the testimony and opinions of John Lipnicki were not credible. We disagree with that finding.

When credibility of a witness is based upon evidence in the record and the substance of a witness' testimony, a reviewing body is capable of evaluating a witness. Coastal Farm Supply v. Hultberg, 84 Or App 282 (1987). We therefore, proceed to evaluate the substance of Mr. Lipnicki's testimony, and find no basis for the finding that his opinions lacked credibility. However, despite our consideration of Lipnicki's opinion, we conclude that the preponderance of the evidence establishes claimant is entitled to permanent total disability.

## ORDER

The Referee's order dated November 22, 1988, as reconsidered December 16, 1988, is affirmed in part, and reversed in part. The employer's denial of claimant's cervical condition is set aside and the claim is remanded to the employer for processing according to law. The remainder of the Referee's order is affirmed. For services at hearing and on review regarding the compensability issue, claimant's attorney is awarded an assessed fee of $2,000, payable by the employer. For services on review concerning the permanent total disability issue, claimant's attorney is awarded $750, to be paid by the employer.

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In the Matter of the Compensation of
**MIKE A. MARTELL, Claimant**
WCB Case No. 88-17421
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Thomas E. Ewing (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

Claimant requests review of those portions of Referee Bennett's order that: (1) upheld the SAIF Corporation's denial of his occupational disease claim for a stress-related condition; and (2) found SAIF's denial to be unreasonable, but no compensation due upon which to base an assessed penalty. On review, the issues are compensability and penalties and attorney fees. We reverse in part and affirm in part.

## FINDINGS OF FACT

We adopt the Referee's "Findings of Fact," except for the last sentence of the "Findings of Ultimate Fact." We supplement the Referee's factual findings as follows. During his last year of employment at the Portland Habilitation Center (PHC), claimant was subject to an inconsistent and unpredictable federal inspector and a nonsupportive supervisor. His dealings with these people caused stress, which led to his mental condition and resulting disability. These stressors are conditions of employment which are neither inherent in every working situation nor reasonable job performance evaluation actions by the employer.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant had not met his burden of proving that he suffers from a work-related mental condition, because he decided that claimant's alleged stressors either did not exist in a real and objective sense or were reasonable job performance evaluation action. In reaching these conclusions, the Referee relied in part on the following credibility findings: "I believe in fact that claimant has been a credible witness, and that he has attempted to be honest. I also believe, however, that his recollection is often selective and suspect. . . ." The Referee found as credible three of claimant's former supervisors who testified concerning the content of personal conversations with claimant. He then decided that claimant's lack of memory regarding these conversations cast "doubt on whether the events to which he testified existed in a real and objective sense." The Referee also listed alleged inconsistencies between claimant's testimony and the treating psychiatrist's reports. We conclude that the Referee effectively treated claimant as an unreliable witness. We disagree with his credibility findings and conclusions based thereon.

The Referee did not make expressly demeanor-based credibility findings. When credibility findings are based on an objective evaluation of the witnesses' testimony, we are in as good a position as the Referee to evaluate their credibility. International Paper Co. v. McElroy, 101 Or App 61 (1990); Coastal Farm Supply v. Hultberg, 84 Or App 282 (1987).

The substance of personal conversations between claimant and his supervisors is not relevant to this claim. Moreover, we find claimant's lack of memory regarding these conversations no more significant than his former supervisors' interest in defending their previous conduct. More importantly, we find that claimant's testimony regarding his stressors is materially consistent with his doctors' histories. We conclude that claimant is credible.

Turning to the merits, we next consider whether claimant has sustained his burden of establishing that work-related stress was a material contributing cause of his current mental disorder.

"Occupational disease[s]" include any mental disorder arising out of and in the course of employment and which requires medical services or results in physical disability or death. ORS 656.802(1)(b). However, a mental disorder is not compensable:

(a) Unless the employment conditions producing the mental disorder exist in a real and objective sense.

(b) Unless the employment conditions producing the mental disorder are conditions other than conditions generally inherent in every working situation or reasonable disciplinary, corrective or job performance evaluation actions by the employer, or cessation of employment.

(c) Unless there is a diagnosis of a mental or emotional disorder which is generally recognized in the medical or psychological community.

(d) Unless there is clear and convincing evidence that the mental disorder arose out of and in the course of employment. ORS 656.802(2).

Dr. Gerson, treating psychiatrist, diagnosed claimant's condition as "adjustment disorder with depressed mood." (Ex. 12a-4). He specifically concluded that claimant's employment was the direct cause of his mental disorder. (Ex. 22-20). Dr. Turco, psychiatrist, diagnosed the same condition as "adjustment reaction with some somatic features." (Ex. 15a-4). Turco noted

that claimant's psychiatric condition is recognized in the medical community. (Ex. 15c-1). He also opined that claimant's off-the-job stressors "were not the predominant issue. . . ." (Ex. 15a-5). There is no evidence to the contrary. We conclude that claimant suffers from a diagnosed psychiatric condition and that the diagnosis is recognized in the medical community. We also conclude that, assuming that the stressors perceived by claimant were real, there is clear and convincing evidence that claimant's mental disorder arose out of and in the course of his employment at PHC.

Claimant identified two primary stressors toward the end of his employment: pressure resulting from unpredictable and inconsistent conduct by Ms. Kennedy, federal inspector; and being understaffed and overworked at the 511 Building. The Referee found that "except for [Kennedy's conduct which] involved reasonable disciplinary, corrective, or job performance evaluation action, the employment conditions producing the mental disorder did not exist in a real and objective sense." We disagree.

Ms. Kennedy succeeded Mr. Cornet as federal inspector. Mr. Cornet had been demanding, however, unlike Ms. Kennedy, he had given claimant a chance to correct problems. (Tr. 123, 124). Claimant testified that Kennedy would "say one thing and do another." (Tr. 124). He felt that he could not trust her (Tr. 112), that she pressured him, which caused considerable stress. (Tr. 139). Dr. Weiner, initial attending physician, reported claimant's stress "arising from ambiguous and impossible job requirements." (Ex. 19-3). The Referee found that Kennedy was unpredictable and inconsistent, in that "[s]he would occasionally indicate that things were okay and then file a report indicating that there was in fact a problem." Nevertheless, the Referee decided that Ms. Kennedy's conduct was more in the nature of enforcement of performance standards (not unreasonable) than a compensable stressor. In reaching this conclusion, he stated that claimant's examples were anecdotal, rather than specific, and that Dr. Gerson did not list the "pickiness" of federal inspectors "as of particular importance." (See Ex. 22-17). We note, however, Dr. Gerson did report that claimant suffered stress due to increasing pressure at work. (Ex. 22-13-14, 16).

Mr. Bustamante succeeded Mr. Pisarsky as claimant's supervisor. Claimant testified that it was a "different game" under the former, as if he was no longer "allowed to have deductions." (Tr. 112-113). As we have noted, the Referee found Kennedy's conduct to be strict performance enforcement, rather than real and objective stressors. He also found "no solid evidence" of lack of support from claimant's supervisors.

Claimant's co-workers provide evidence supporting a contrary conclusion. Mr. Johnson, who also worked under both Cornet and Kennedy, testified that he got along better with the former. He said Kennedy was "unpredictable and antagonistic," and that this was stressful. (Tr. 41, 42). He said that the Portland Habilitation Center (PHC) was understaffed, causing stress. (Tr. 44). He also said that the management style changed after Mr. Pisarsky died, and that the new style caused stress. Then, he said employees had no one to go to with problems. He specifically cited Bustamante for failing to provide support. (Tr. 47, 48). Johnson stopped working at PHC because of the changes in working conditions.

Ms. Kennedy's inconsistent and unpredictable behavior as a stressor is established by claimant's testimony. His testimony is corroborated by that of co-workers, regarding Ms. Kennedy's aforementioned characteristics, as well as the stressful unsupportiveness of Mr. Bustamante, supervisor.

We do not decide whether claimant was subject to additional work stressors, because we find that claimant has proven, by a preponderance of the evidence, that inconsistent conduct by Kennedy was, alone, a material contributing cause of his mental condition and disability.

The remaining question is whether inconsistent management is a condition inherent in every working situation or reasonable job performance evaluation action. The Referee found this stressor not inherent, a finding he said he made without evidence in the record. We find evidence in the record supporting his finding. Dr. Gerson treated other people who worked at PHC. He opined that conditions there would be stressful for anyone. (Ex. 22-30). Gerson was in a position to compare PHC's work environment with others, as well as PHC employees' responses with each other's. He concluded, based on his professional experience, that conditions at PHC were not of a type inherent in every working situation. (Ex. 22-30-33). We agree.

We conclude that claimant has met his burden of proving by a preponderance of the evidence that he suffers from a work related mental condition. His claim is compensable.

The Referee found SAIF's denial unreasonable, because the only evidence it had unequivocally stated that the claim was work-related. We agree. Claimant is entitled to a penalty of 25 percent of amounts then due. ORS 656.262(10).

ORDER

The Referee's order dated March 24, 1989 is reversed in part and affirmed in part. That portion of the Referee's order that upheld the SAIF Corporation's denial of claimant's claim for a stress-related condition is reversed. The claim is remanded to SAIF for processing according to law. That portion of the order which declined to assess a penalty is reversed. Claimant is awarded 25 percent of all compensation then due at the time of SAIF's denial for unreasonable refusal to pay compensation. The remainder of the Referee's order is affirmed. For services at hearing and on Board review concerning the compensability issue, claimant's attorney is awarded a reasonable fee of $5,000, to be paid by the SAIF Corporation.

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July 16, 1990 Cite as 42 Van Natta 1591 (1990)

In the Matter of the Compensation of
**JUANITA J. MORROW, Claimant**
WCB Case No. 86-06758
ORDER ON REMAND
Peter O. Hansen, Claimant Attorney
Raymond Smitke (Saif), Defense Attorney

This matter is before the Board on remand from the Court of Appeals. Morrow v. Pacific University, 100 Or App 198 (1990). The court has reversed our prior order which upheld the SAIF Corporation's denial of claimant's claim for compensation stemming from a period of disorientation and amnesia. Disagreeing with our analysis of the claim as an occupational disease, the court has instructed us to analyze the claim as an injury. We proceed with our reconsideration.

FINDINGS OF FACT

We adopt the "Findings of Fact" contained in our November 3, 1988 order, with the following supplementation. At hearing, the parties agreed that claimant's claim is for compensation stemming from her period of disorientation and amnesia. (Tr. 5).

Claimant's stress at work is a material contributing cause of her disability and need for medical services for her disorientation and amnesia.

CONCLUSIONS OF LAW AND OPINION

The parties do not disagree about what happened to claimant at work on January 21, 1986. They also apparently do not dispute that perceived demotion, accusation of mismanagement, suspension without pay and being asked to leave the premises constitute traumatic stressful events on that day. The question is whether claimant's disability and need for medical treatment for a period of disorientation and amnesia, following these events, is compensably related to her work. The court has instructed that we analyze this claim as an injury.

In injury cases, a claimant must establish by a preponderance of the evidence that the industrial injury was a material contributing cause of her disability or need for medical services. Hutcheson v. Weyerhaeuser, 288 Or 51 (1979); 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). A preexisting susceptibility, if she has one, does not defeat her claim. Preston v. Wonder Bread, 96 Or App 613 (1989).

Accordingly, claimant must prove that the potentially injurious incident, that is, her stress at work on January 21, 1986, materially contributed to her disorientation and amnesia and need for treatment. Considering claimant's prior history of an aneurysm, surgeries, high blood pressure, and lightheadedness, we conclude that the issue of whether claimant's disability and need for medical services for a period of disorientation and amnesia are causally related to her stress at work is a complex medical question. The resolution of this issue largely turns on an analysis of the medical evidence. Uris v. Compensation Department, 247 Or 420, 426 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985).

Dr. Brown, neurologist, reviewed claimant's file, "relative to the relationship between a ruptured intracranial aneurysm and her work," in April 1986. (Ex. 44). Finding the 1977 aneurysm inexplicably different in size from the "clipped" aneurysm described in 1986, Brown did not have an opinion regarding the relationship between the 1977 condition, claimant's stress at work and her current disability. However, he stated that aneurysms are not generally ruptured because of high blood pressure or stress.

We are not persuaded by Brown's opinion for several reasons. First, his statement that aneurysms are generally unrelated to high blood pressure or stress is conclusory and unexplained. Moe v. Ceiling Systems, 44 Or App 429, 433 (1980). Second, his opinion appears to be based on the erroneous assumption that claimant currently has a ruptured aneurysm. Yet, although a 1986 arteriography indicates an aneurysm with a slipped clip, it was not considered operable and there was no indication of bleeding. Furthermore, Dr. Smith, claimant's treating neurologist, noted that the aneurysm is still present, but there was no evidence that it had changed since her second craniotomy in 1977.

(Ex. 36-1). Finally, it is not the compensability of an aneurysm that is the issue before us, but the compensability of disorientation and amnesia.

We find the opinion of Dr. Smith, as claimant's treating physician, to be persuasive. See Weiland v. SAIF, 64 Or App 810, 814 (1983). Smith's initial diagnosis was amnesia attributable to an uncertain etiology. (Ex. 30-3). Later, Smith explained that only a limited number of possibilities could cause a period of amnesia. (Ex. 45-5). He then considered each possibility, in light of claimant's particular circumstances.

As a result of claimant's documented brain injury resulting from her 1977 aneurysm and "clipping" surgery, Smith opined that claimant was at an increased risk of developing epilepsy. (Ex. 30-4). Noting that her condition upon admittance was consistent with a postictal state, Smith stated that there was "about a 10 percent chance of developing epilepsy as a result of a stroke or a cerebral aneurysm causing a hemorrhage, or even just the presence of a large mass, in this case an aneurysm in the brain." (Ex. 45-13). Acknowledging that "[claimant] certainly was very upset by events at work" (Ex. 30-4), Smith identified stress as a precipitant of seizure in persons predisposed to seizures. (Ex. 45-38). Rejecting the possibility of a concussion or intoxication, Smith suggested that claimant's period of amnesia may have been triggered by stress alone. (Ex. 45-15). There is no evidence of off-work stressors. Smith also noted that it was not unusual for epilepsy to develop years after a brain injury. (Ex. 45-14).

Admitting that a primary diagnosis would be an "educated guess," Smith concluded as follows:

> "So, in summary, I think it is medically probable that there is a connection between the emotional stress that she experienced from work that day and whatever happened that triggered this period of amnesia, be it an epileptic seizure or whatever." (Ex. 45-15).

He further opined that:

> "[T]he emotional stress at work was a material, contributing factor, if not the only cause, but at least a contributing factor to the development of the seizure or whatever event it was that triggered the amnesia." (Ex. 26-27).

In conclusion, we are persuaded by Dr. Smith's well-reasoned opinion. See Somers v. SAIF, 77 Or App 259 (1986). In this regard, we note that Smith, claimant's treating neurologist, is a specialist in the field of epilepsy and has based his opinion on an accurate history. We also note that Smith's inability to assign a diagnostic label does not amount to a failure of proof where it is known to a medical probability that the condition is work related. Tripp v. Ridge Runner Timber Services, 89 Or App 355 (1988).

Accordingly, we hold that claimant has established that stress at work was a material contributing cause of her period of disorientation amnesia and related need for treatment. The SAIF Corporation's denial is set aside and the claim remanded to SAIF for processing in accordance with law. For services rendered at all prior forums, claimant's attorney is awarded $4,500, to be paid by SAIF. See ORS 656.388(1).

IT IS SO ORDERED.

In the Matter of the Compensation of
**LARRY J. POWELL, Claimant**
And, in the Matter of the Complying Status of
**ANGELL TRANSPORT, INC.,**
**Cynthia Angell, Individually, Employer**
WCB Case Nos. 88-18212 & 88-18213
ORDER OF DISMISSAL
Martin J. McKeown, Claimant Attorney
Cummins, et al., Defense Attorneys
Andrea Kemper, Assistant Attorney General

The Department of Justice, on behalf of the Department of Insurance and Finance (DIF), requests review of Referee Danner's order that set aside a Proposed and Final Order that found the employer to be noncomplying. On review, the issue is whether benefits paid from the Industrial Accident Fund by the SAIF Corporation under ORS 656.054 should terminate by operation of law upon the Referee's finding that claimant was not a subject worker at the time of injury. We dismiss the request for review for lack of jurisdiction.

## FINDINGS OF FACT

The Department of Insurance and Finance published a "Proposed and Final Order; Notice", declaring the employer to be a noncomplying employer on August 31, 1988.

SAIF accepted the claim and notified the employer on September 12, 1988. The employer requested a hearing on the Proposed and Final Order on September 23, 1988. The employer also requested a hearing on SAIF's claim acceptance on October 17, 1988.

The sole issue at hearing was the "Proposed and Final Order; Notice." Claimant, SAIF, and the Workers' Compensation Division, Department of Justice, each waived appearance at hearing. Counsel for the alleged noncomplying employer stated at hearing that the only issue was the "Proposed and Final Order; Notice."

The Referee stated in the "Conclusions and Opinion" portion of the order that SAIF, having accepted the claim, must continue to be responsible.

The Referee's order language states in pertinent part:

"IT IS ORDERED that the Proposed and Final Order; Notice, dated August 31, 1988, in the matter of the compliance of Angell Transport, Inc., be set aside and held for naught."

The Referee's order concludes in part:

"NOTICE TO ALL PARTIES: If you are dissatisfied with this Order, you may request review by the Workers' Compensation Board. . . . ."

## CONCLUSIONS OF LAW AND OPINION

If any party requests a hearing on a 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). 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).

In this case, compensability was not in issue at hearing. Although the employer requested hearings on noncompliance and compensability, the only issue actually litigated was noncompliance. Claimant, the Department and SAIF waived appearance. Furthermore, the Referee did not address the issue of compensability in his order language. The Referee ordered only that the Proposed and Final Order issued on August 31, 1988 be set aside. The Referee's compensability discussion in the "Conclusions and Opinion" section of the order is not binding.

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 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.

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July 18, 1990 Cite as 42 Van Natta 1595 (1990)

In the Matter of the Compensation of
**MYRON D. CARLSON, Claimant**
WCB Case No. 88-20944
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
Meyers & Radler, Defense Attorneys

Reviewed by Board Members Cushing and Myers.

The self-insured employer requests review of Referee Mulder's order which set aside its denial of claimant's occupational disease claim for his umbilical hernia condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

Claimant worked for the employer as a "machinist", a position which involves potentially repetitive and physically demanding lifting.

Claimant first noticed his symptoms while unloading groceries from a shopping cart, when he leaned over the handle of the cart. (Tr. 11, 14). He felt a lump and tenderness in the umbilical cord area. (Tr. 14). This incident occurred off the job.

On September 20, 1988, claimant submitted an 801 form regarding the hernia condition. (Ex. 1, 3). Shortly thereafter, he sought medical treatment from Dr. Ward, internist. The employer denied claimant's hernia condition, contending that the condition was not the result of his employment activities. (Ex. 4).

On October 28, 1988, claimant had his hernia condition surgically repaired by Dr. Huntwork. Dr. Grout, surgeon, had a complete and accurate history of claimant's medical condition. Drs. Ward, internist, and Huntwork, treating surgeon, did not have a complete and accurate history of claimant's medical condition.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant had suffered a compensable occupational disease claim pertaining to his hernia. 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's last work exposure which could have caused his hernia condition occurred during September and October 1988. (Ex. 1; Tr. 14). Accordingly, the new occupational disease law which became effective January 1, 1988, is applicable. Donna E. Aschbacher, 41 Van Natta 1242 (1989).

To be compensable under the new law, claimant's occupational disease must fall within one of the three subsections of ORS 656.802(1). Here, claimant worked for the employer as a "machinist", a position which involves potentially repetitive and physically demanding 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).

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

Here, there is no evidence that claimant's repetitive actions at work caused the hernia. Claimant first noticed the lump on his stomach during an off work incident when he leaned across a grocery cart. It was after this off work incident, that claimant sought medical attention.

Dr. Grout opined that claimant's hernia condition was not related to work. (Ex. 10-1). Grout based his opinion on an understanding of claimant's on and off work activities, including the shopping cart incident. We find Dr. Grout's opinion to be persuasive, because it was based on claimant's complete medical history. See Miller v. Granite Construction, 28 Or App 473 (1977).

On the other hand, Dr. Ward concluded that the most likely cause of claimant's hernia condition was heavy lifting related to his employment. (Ex. 8). However, Ward's opinion does not indicate any knowledge of claimant's off work activities, including the shopping cart incident and the onset of his hernia symptoms. In evaluating medical opinions, we give weight to those that are well reasoned and based on complete information. See Somers v. SAIF, 77 Or App 259 (1986). Dr. Ward's recitation does not indicate any knowledge of the shopping cart incident. Therefore, we are unable to find that Ward had a complete and accurate understanding of claimant's condition and its relationship to past and current activities. Consequently, his opinion regarding causation lacks persuasiveness. See Miller v. Granite Construction, supra.

Dr. Huntwork concluded that claimant's work activities were the likely cause of his hernia condition. However, Huntwork subsequently conceded that claimant had not mentioned the shopping cart incident and onset of the hernia condition. Moreover, Huntwork acknowledged that he was unaware of claimant's off work activities. Inasmuch as Dr. Huntwork's opinions are also based on an incomplete history, his opinion regarding causation lacks persuasiveness. See Miller v. Granite Construction, supra.

In conclusion, we are not persuaded that claimant's repetitive work activity was a material cause of his hernia condition or its symptoms. Accordingly, we hold that his occupational disease claim is not compensable.

ORDER

The Referee's order dated April 14, 1989, as republished May 8, 1989, is reversed. The self-insured employer's denial is reinstated and upheld. The Referee's attorney fee award of $1,700 is reversed.

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In the Matter of the Compensation of
**KYUNG B. DEBLOCK, Claimant**
WCB Case No. 88-19433
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Cushing and Myers.

The insurer requests review of Referee Shebley's order that: (1) set aside its denial of claimant's medical services claim for a motorized cart; and (2) assessed penalties and related attorney fees for an alleged untimely denial. The issues on review are medical services and penalties and attorney fees. We reverse.

FINDINGS OF FACT

Claimant, age 53 at time of hearing, received a compensable injury to her left foot on September 11, 1986. Thereafter, claimant developed reflex sympathetic dystrophy and currently suffers intractable pain from possible causalgia in her left lower extremity.

Claimant's treating orthopedic surgeon is Dr. Zimmerman. In May 1988, at claimant's request, Dr. Zimmerman sought authorization from the insurer for the purchase of a motorized cart. He did not give a medical or treatment purpose for this recommendation other than claimant's subjective feeling that she was "a prisoner in her own home." (Exhibit 17).

Claimant also received ongoing treatment at a pain center where both the attending physician, Dr. Renhold, and the treating clinical psychologist, Dr. Pierce, opposed claimant using a motorized cart because it was contrary to claimant's treatment objectives.

Supporting the medical opinion of the pain center is a report from a consulting physician, Dr. Cohen, who did not find a motorized scooter medically necessary.

The insurer, by letter of January 12, 1989, denied claimant's request for a motorized cart. Claimant requested a hearing.

ULTIMATE FINDINGS OF FACT

The electric cart requested by Dr. Zimmerman was not a reasonable and necessary medical service. The denial was issued approximately eight months after Dr. Zimmerman's initial request. The insurer did not unreasonably resist the payment of compensation.

CONCLUSIONS OF LAW AND OPINION

Medical Services Claim

The Referee set aside the insurer's denial of claimant's request for a motorized cart. The Referee concluded that the cart was more akin to a prosthetic appliance than to an item of furniture which is covered by former OAR 436-10-040(7). Rather than analyze this matter under the administrative rule, we apply ORS 656.245(1). Therefore, claimant must establish that the request for an electric cart is a "reasonable and necessary" medical service. We hold that she has not satisfied her burden of proof.

The carrier must provide, for the life of the worker, reasonable and necessary medical services required by the compensable injury. Former ORS 656.245(1). Claimant has the burden of proving that the treatment is reasonable and necessary. McGarry v. SAIF, 24 Or App 883, 888 (1976). To prove reasonableness and necessity for the electric cart, claimant must establish that the use of such a cart would likely to be of curative, palliative, preventative or restorative benefit. See generally, West v. SAIF, 74 Or App 317, 320-21 (1985).

On our de novo review of the medical and lay evidence, we are not persuaded that the reports and testimony provided in support of claimant's request, establish that a motorized cart is a reasonable and necessary medical service.

Claimant's treating orthopedist, Dr. Zimmerman, gave no medical or treatment justification for an electric cart. Rather, Dr. Zimmerman sought authorization from the insurer for the purchase of a motorized cart solely upon claimant's request. Zimmerman supported his request by saying, "I really have nothing else to suggest." (Exhibit 17). In his final report, Dr. Zimmerman opined that an electric go-cart was superior to using crutches or a walker. However, once again Zimmerman provided no medical bases or persuasive reasoning for his recommendation. Instead, Dr. Zimmerman stated, "[a]gain, this a subjective answer and not a medical one." (Exhibit 20).

In contrast to the opinion offered by Dr. Zimmerman, the medical opinions to the contrary are persuasive. Following Dr. Zimmerman's referral, claimant received treatment at a pain center. Dr. Renholds, the attending physician for the pain center, reported that claimant was making progress in her tolerance for standing and walking. Because of these physical gains, he did not feel any type of motorized cart should be supplied to claimant: "[c]learly she does need to walk on her foot, despite the pain. Part of the treatment for reflex sympathetic dystrophy is simply - activity." (Exhibit 19A, 3-4). Dr. Pierce, claimant's clinical psychologist at the pain center, was similarly concerned that a motorized scooter "would reinforce the patient role - her image of herself as totally disabled. Therefore, our focus would be on increasing her standing and walking tolerances." (Exhibit 19A, 23). Further support for these medical opinions comes from a consulting physician, Dr. Cohen, who did not consider a motorized scooter medically necessary. (Exhibit 21).

In the face of the aforementioned persuasive contrary medical evidence, Dr. Zimmerman's conclusory opinion is insufficient to meet the reasonable and necessary standard. Accordingly, we uphold the insurer's denial of the request for a motor scooter.

Penalties and Attorney Fees

The Referee ordered a penalty equal to 25 percent of the cost of the electric cart because the insurer's denial was issued more than 60 days as allowed

by ORS 656.262(6) and (10). Although we agree that the denial was untimely, we find that penalties and attorney fees are not assessable.

Because there was a claim for medical services, the insurer had a duty to accept or deny it within 60 days. Billy J. Eubanks, 35 Van Natta 131 (1983). However, as a result of our decision, there were no "amounts then due" upon which to base a penalty. Consequently, no penalty is assessable. An attorney fee may be awarded, pursuant to ORS 656.382(1), if an insurer unreasonably resists the payment of compensation, whether or not there are "amounts then due." Lloyd L. Cripe, 41 Van Natta 1774 (1989). However, in light of our decision that the claim is not compensable, there has been no unreasonable resistance to the payment of compensation. Accordingly, no penalties and attorney fees may be assessed.

ORDER

The Referee's order, dated March 3, 1989 is reversed. The insurer's denial dated January 12, 1989 is reinstated and upheld. The Referee's attorney fee awards of $2,400 and $150 are reversed.

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July 19, 1990 Cite as 42 Van Natta 1599 (1990)

In the Matter of the Compensation of
**ROSEMARY GOINS, Claimant**
WCB Case No. 88-16121
ORDER ON REVIEW
Robert E. Nelson, Claimant Attorney
Roberts, et al., Defense Attorneys

Reviewed by Board Members Cushing and Myers.

Claimant requests review of those portions of Referee Bennett's order which upheld the self-insured employer's denial of an industrial injury claim for a back injury. Claimant also seeks to remand the case to the Hearings Division to consider additional evidence. The employer, in its brief, cross-requests review of those portions of the Referee's order which awarded an attorney fee for late denial of the claim.

ISSUES

The first issue is whether claimant timely filed a request for review. This issue was resolved by Order Denying Motion to Dismiss dated August 11, 1989 which we incorporate by this reference. Resolution of this issue also resolves the sole issue in WCB Case No. 89-01512. The issue in that case is whether claimant's letter of January 20, 1989 was a request for review of WCB Case No. 88-16121 or a new request for hearing. Because we have held that it was a request for review, Referee Tenenbaum was correct in dismissing WCB case No. 89-01512. Accordingly, we are simultaneously issuing an order on review affirming Referee Tenenbaum in WCB Case No. 89-01512.

The next issue is whether the case should be remanded to consider additional evidence. Claimant seeks remand arguing that the proffered evidence establishes that she is a poor historian rather than a not credible witness as the Referee held.

On the merits, the principle issue is whether claimant has proven a compensable injury.

Finally, the employer contends that the Referee erred when he awarded an attorney fee for the employer's late denial. It contends that no compensation was delayed; therefore no attorney fee is due.

## MOTION TO REMAND

Claimant has moved for remand and has submitted several documents which he seeks to have admitted on remand. We consider these documents solely for the purposes of deciding the motion to remand.

The Referee concluded that claimant was not a credible witness. He based that finding on inconsistencies between claimant's testimony at hearing and the history which claimant gave to various physicians immediately after the alleged injury. He concluded that because claimant's testimony was inconsistent with the medical reports, he could not rely on her testimony that the alleged incident actually occurred.

Claimant now seeks remand to admit reports from a pain center program which claimant entered after the Referee's order. These reports indicate that claimant has a poor memory and cognitive deficits.

We deny the motion to remand. Claimant has made no showing that information concerning her poor memory and cognitive deficits was not obtainable at the time of hearing. The mere fact that claimant did not enter the particular program where this evaluation took place until after the hearing is not sufficient to establish that this evidence was not obtainable.

Furthermore, even if this evidence were unobtainable at the time of hearing, we conclude that it would not tend to support claimant's case. The Referee found claimant not credible and, therefore, did not rely on her testimony. This evidence tends to support the conclusion that claimant's testimony is not reliable.

## FINDINGS OF FACT

We adopt the Referee's findings of fact.

## CONCLUSIONS OF LAW AND OPINION

We adopt the Referee's opinion on the issue of compensability.

On the issue of the attorney fee, we reverse. The parties stipulated that the employer was late in denying the claim; however, they also stipulated that no compensation was delayed by the late denial. Accordingly, claimant's attorney is not entitled to an attorney fee for the late denial. Lloyd L. Cripe, 41 Van Natta 1774 (1989).

## ORDER

The Referee's order of January 6, 1989 is reversed in part and affirmed in part. That portion of the order which awarded claimant's attorney a penalty-related attorney fee of $150, is reversed. The balance of the order is affirmed.

In the Matter of the Compensation of
**JANET K. KRAXBERGER, Claimant**
WCB 89-02046
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Spears, et al., Defense Attorneys

Reviewed by Board Members Gerner and Cushing.

Claimant requests review of Referee Seymour's order which upheld the self-insured employer's partial denial of claimant's medical services claim for chiropractic treatment in excess of two times per month. On review, the issue is reasonableness and necessity of chiropractic treatment. We reverse in part and affirm in part.

FINDINGS OF FACT

In February 1987, claimant sustained a compensable injury to her right shoulder. In June 1987, she began treating with Dr. McMahon, chiropractor, for her compensable injury. In September 1987, the employer denied chiropractic treatment on the basis that it was unrelated to her compensable injury. In March 1988, an earlier referee set aside the employer's denial finding a compensable relationship between the injury and the chiropractic treatment.

Claimant has not worked since March 1988. Between March 1988 and January 1989, she treated with Dr. McMahon an average of eight times per month. On January 18, 1989, the employer issued a denial which stated inter alia:

> "For these reasons [the employer] believes your current chiropractic treatment is palliative, not curative, and we therefore will no longer pay for chiropractic treatment in excess of two per month."

Following the denial, claimant limited her treatment with Dr. McMahon to two times per month. At the time of the January 18, 1989 denial, the employer had an outstanding balance of $570 billed by Dr. McMahon for claimant's treatment.

CONCLUSIONS OF LAW AND OPINION

The Referee upheld the employer's denial of chiropractic treatment in excess of two times per month. We disagree insofar as the denial pertains to future treatments.

Prospective denials are impermissible. A carrier may not deny its future responsibility for payment of medical services for a previously accepted claim. ORS 656.245(1); Evanite Fiber Corp. v. Striplin, 99 Or App 353 (1989).

In the instant case, the employer's denial stated that it would "no longer pay for chiropractic treatment in excess of two times per month." The denial purports to address all post-January 18, 1989 chiropractic treatment in excess of two times per month. Such a denial is prospective and must be set aside.

However, the denial also denies claimant's current chiropractic treatment and at the time the denial issued, there was an outstanding balance of $570 owed to Dr. McMahon for chiropractic treatment. Since claimant's current chiropractic care was also put into issue by the denial, we may decide the reasonableness and necessity of chiropractic treatment up until the date of the denial. See Hollie J. Rahim, 42 Van Natta 415 (1990).

A claimant is entitled to all reasonable and necessary curative or palliative medical treatment required for recovery from a compensable injury or for relief of pain. ORS 656.245(1); Wetzel v. Goodwin Bros., 50 Or App 101 (1981). For example, chiropractic treatment, on an as-needed basis, is compensable where it is necessary to relieve severe pain and permit claimant to work. West v. SAIF, 74 Or App 317, 320-21 (1985).

Here, Dr. McMahon, who has treated claimant extensively since June 1987, opined that chiropractic treatment in excess of two times per month was essential to claimant's well-being in that it reduced her pain and increased her range of motion.

Yet, Dr. McKillop reported that claimant experienced only temporary relief from chiropractic treatment and opined that she was not in need of any formal treatment plan. Dr. Tilden also noted that claimant experienced temporary relief following chiropractic treatment, but opined that such treatment was not reasonable or necessary.

Finally, claimant testified that she experiences temporary relief from pain and some marginal increase in range of motion following chiropractic treatment. She further testified that she has not worked since March 1988.

We conclude that claimant has not established that treatment in excess of two times per month is reasonable or necessary. In reaching this conclusion, we rely on the opinions of Drs. McKillop and Tilden as well as claimant's testimony. See West, supra.

We note parenthetically that the employer cites Gordon D. Garrett, 41 Van Natta 334 (1989), in support of its contention that its denial is not prospective. Subsequent to our decision in Garrett, however, the Court of Appeals issued its opinion in Striplin, supra. The instant case is controlled by Striplin.

ORDER

The Referee's order dated May 24, 1989, is reversed in part and affirmed in part. The self-insured employer's denial is set aside, in part, as prospective. For services at hearing and on review concerning the prospective denial issue, claimant's counsel is awarded a reasonable assessed fee of $700, payable by the self-insured employer. The self-insured employer's denial is upheld with regard to treatment in excess of two times per month through January 18, 1989. The remainder of the Referee's order is affirmed.

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In the Matter of the Compensation of
**LARK A. WEIDENHAFT, Claimant**
WCB Case No. 88-21061
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Beers, et al., Defense Attorneys

Reviewed by Board Members Gerner and Cushing.

The insurer requests review of that portion of Referee Livesley's order that increased claimant's unscheduled permanent disability award for a back injury from 16 percent (51.2 degrees) to 30 percent (96 degrees). On review, the issue is extent of unscheduled permanent disability. We modify.

## FINDINGS OF FACT

Claimant compensably injured his low back in October 1983. He received conservative treatment from Dr. McHolick, M.D., who diagnosed a herniated lumbar disc. In January 1984, claimant underwent an L5-S1 laminectomy and diskectomy. His claim was closed by an October 5, 1984 Determination Order which awarded 10 percent unscheduled permanent disability.

In November 1987, claimant returned to McHolick complaining of increased back pain. McHolick referred him to Dr. Serbu, M.D.

In February 1988, after a myelogram revealed a recurrent disc herniation, claimant underwent a second laminectomy at the L5-S1 level performed by Serbu. One month later, claimant returned to modified light duty work. His condition was found medically stationary in June 1988 and his claim was closed by a November 8, 1988 Determination Order which awarded a total of 16 percent unscheduled permanent disability. Claimant requested a hearing.

Claimant, 29 years of age at hearing, is a high school graduate. He has worked in the sheet metal industry practically his entire adult life. The specific vocational preparation (SVP) for a sheet metal worker is 7. Claimant has completed a four-year sheet metal apprentice program but has not received his journeyman's certificate.

The physical capacity required to do claimant's at-injury employment was in the heavy category. Since his injury, he has returned to permanent modified work in the light category.

Claimant's permanent impairment includes lost range of motion in forward lumbosacral flexion, two surgeries involving the same disc and disabling pain.

## CONCLUSIONS OF LAW AND OPINION

The Referee found by clear and convincing evidence that claimant suffered 30 percent loss of earning capacity resulting from his compensable back injury. We disagree and modify the award.

Because claimant's condition became medically stationary in June 1988, and his claim closed in November 1988, the "standards" adopted effective July 1, 1988, (former OAR 436-35-001 et seq), as amended by temporary rules effective August 19, 1988, apply to the rating of claimant's permanent partial disability. Former OAR 436-35-270 through 436-35-440 apply to the rating of unscheduled permanent partial disabilities. Former OAR 436-35-010(1).

### Age and Education

The appropriate value for claimant's age of 29 is 0. Former OAR 436-35-290(3). He is a high school graduate. Thus, the appropriate value for his formal education is 0. Former OAR 436-35-300(3). His highest SVP during the preceding ten years from the date of injury is a 7, for a skills value of 1. Former OAR 436-35-300(4). Claimant has no documented training. Therefore, the value for claimant's training is 1. Former OAR 436-35-300(5). The total value for claimant's age and education, therefore, is 2.

### Adaptability

Claimant has returned to modified light duty work. The physical capacity required of his at-injury job was in the heavy category. Therefore, the appropriate value for claimant's adaptability is 2.5, for going from heavy to light work. Former OAR 436-35-310(3)(b).

Impairment

Claimant suffers from decreased range of motion. Specifically, he has retained 60 degrees lumbar flexion, for an impairment value of 3. Former OAR 436-35-360(6).

Additionally, claimant has undergone two laminectomies at the L5-S1 level. He is entitled to a single impairment value for his surgical procedures unless there is evidence that he suffered a greater degree of impairment as a result of the second procedure. See Claudia J. Percy, 42 Van Natta 1209 (May 29, 1990). We find no such evidence in this case. Therefore, claimant is entitled to a 5 percent value for his laminectomy and diskectomy at the L5-S1 level. Former OAR 436-35-350(2).

Finally, disabling pain, when it results in loss of use or function, is ratable under the standards. Former OAR 436-35-270; Daniel M. Alire, 41 Van Natta 752 (1989). After our review of the record, we find that with any strenuous exertion, exacerbations result causing increased back pain and resulting loss of use or function. Therefore, we find that claimant suffers 5 percent disabling pain resulting from his compensable back injury.

After combining claimant's impairment values, disabling pain (5), loss of range of motion value (3) and surgical value (5), claimant's total impairment value is 12.46.

Computation of Unscheduled Disability

Having determined each value necessary to compute claimant's permanent disability under the "standards," we proceed to that calculation. When claimant's age and education values are added, the sum is 2. When that value is multiplied by claimant's adaptability value (2.5), the product is 5. When that value is added to claimant's impairment value (12.46), the result is 17.46 percent unscheduled permanent partial disability. Former OAR 436-35-280(7). That disability figure is rounded to the next higher whole percentage. Former OAR 436-35-280(7). Claimant's permanent disability under the "standards" is, therefore, 18 percent.

Disability Outside the Standards

After an analysis of claimant's testimony, the medical and lay evidence, including a vocational expert's report, the Referee found clear and convincing evidence that claimant suffered 30 percent loss of earning capacity resulting from his compensable injury.

As we have already found, claimant suffers 18 percent unscheduled permanent disability under the standards. In making this determination, we have considered both claimant's testimony and the medical and lay evidence in the record.

The remaining question, then, is whether there is clear and convincing evidence that claimant suffers impairment greater than that found under the standards. In support of this contention, claimant argues that the vocational expert's report represents such clear and convincing evidence. We disagree.

Mihayl, claimant's vocational expert, authored one report. After our de novo review of that report, we do not find Mihayl's opinion, with respect to claimant's loss of earning capacity, to be persuasive.

In making this determination, we note that Mihayl's opinions relate solely to possible future actions or activities on the part of claimant, i.e., "should [claimant] need to leave this employer for any reason, he will not find similar employers in his skills trade waiting to employ him with open arms." (Ex. 24). Given the speculative and conditional nature of Mihayl's report, we do not find Mihayl's opinion to be persuasive evidence that claimant suffers disability outside the standards. Furthermore, we do not find any other evidence that claimant suffers permanent disability greater than that found under the standards.

Accordingly, we conclude that claimant suffers 18 percent permanent disability resulting from his compensable back injury.

ORDER

The Referee's order dated April 25, 1989, is modified. In lieu of the Referee's increased award, and in addition to the November 8, 1988 Determination Order award of 16 percent (51.2 degrees) unscheduled permanent disability, claimant is awarded 2 percent (6.4 degrees) unscheduled permanent disability, for a total of 18 percent (57.6 degrees) unscheduled permanent disability.

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In the Matter of the Compensation of
**DAVID E. WORTHEN, Claimant**
WCB Case No. 88-22458
ORDER ON REVIEW
Lynne W. McNutt, Claimant Attorney
Foss, et al., Defense Attorneys

Reviewed by Board Members Cushing and Gerner.

The insurer requests review of Referee Higashi's order that increased claimant's unscheduled permanent disability award for a right shoulder injury from 7 percent (22.4 degrees), as awarded by a Determination Order, to 23 percent (73.6 degrees). On review, the issue is extent of unscheduled permanent disability. We modify.

FINDINGS OF FACT

Claimant, 29 years of age at hearing, compensably injured his right shoulder on January 8, 1987 while pulling a cable around a log. He returned to his regular work after one week's rest, and then continued to work until February 25, 1987. At that time, he began treating with Dr. Smith, orthopedist.

Approximately one month later, after conservative treatment and physical therapy, claimant was released to return to his regular work.

After approximately one week on the job, claimant's pain symptoms increased. He again was released from work, by Smith, and treated conservatively. On April 22, 1987, claimant returned to light work "chasing."

In late May 1987, claimant began working 30-hour work weeks as a timber bucker, requiring heavy work. After working several weeks as a bucker, claimant's pain symptoms returned. Smith continued conservative treatment until August 1987, at which time claimant stopped treating with Smith.

Three months later, in October 1987, claimant began treating with Dr. Holbert, orthopedist. Holbert prescribed conservative treatment, including cortisone shots, and then recommended surgery.

On February 2, 1988, claimant underwent right shoulder surgery. He made a rapid recovery and his condition was found medically stationary on March 18, 1988. On March 23, 1988, Holbert released claimant to return to regular work without restrictions.

A July 1, 1988 Determination Order awarded claimant 7 percent unscheduled permanent disability. Claimant requested a hearing.

Claimant is a high school graduate with no documented training in any specific vocational pursuit. During the last ten years preceding the date of injury, his work activities included logging, reforestation, landscaping and changing tires. His highest specific vocational preparation (SVP) is in logging, with an SVP of 3.

Claimant's work at the time of injury required the physical capacity to do heavy work. He is now capable of performing heavy work, and has been released to return to his regular work. However, he has not returned to the work activities he was performing at the time of his compensable injury.

Claimant suffers some disabling pain resulting from his compensable right shoulder injury.

CONCLUSIONS OF LAW AND OPINION

Finding that claimant suffered a permanent loss of earning capacity resulting from right shoulder surgery and disabling pain with repeated overhead arm activities, the Referee awarded claimant an additional 16 percent unscheduled permanent disability, for a total of 23 percent permanent disability. We modify.

Because claimant's condition was medically stationary on March 18, 1988 and because his claim for that condition was closed by Determination Order on July 1, 1988, the "standards" adopted effective July 1, 1988, (former OAR 436-35-001 et seq), apply to the rating of claimant's permanent partial disability. Former OAR 436-35-270 through 436-35-440 apply to the rating of unscheduled permanent partial disabilities. Former OAR 436-35-270(1).

Contending that claimant has been released to, and has returned to, his usual and customary work, the insurer asserts that he is not entitled to a rating under the standards for age, education and adaptability. We disagree.

Claimant was released to his regular work activities without restrictions by Dr. Holbert, his treating surgeon. (Ex 20). Moreover, claimant has returned to the work force performing heavy physical work activities. However, there is no indication that claimant was either extended an offer to return to his usual and customary work activity as a choke setter or actually returned to such a position. Under such circumstances, claimant is entitled to be rated under the standards. See former OAR 436-35-290(2)(b); 436-35-300(2)(b); 436-35-310(2)(b). We proceed with our evaluation.

The appropriate value for claimant's age of 29 years is 0. Former OAR 436-35-290(4). The appropriate value for claimant's 12 years of formal education is 0. Former OAR 436-35-300(3)(a).

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

highest SVP during the ten years prior to the date of injury was 3 as a log bucker. Therefore, the appropriate value for skills is 3. Id.

Claimant has no documented training in any specific vocational pursuit. Therefore, the appropriate value for training is 1. Former OAR 436-35-300(5)(a). Claimant's total education value is 4, the formal education value plus the skills value plus the value for training. Former OAR 436-35-300(5)(sic).

We turn to adaptability. An adaptability value for a claimant who is unable to return to his or her usual and customary work [see former OAR 436-35-270(3)(a)], but who has returned to modified work is determined from a matrix of values at former OAR 436-35-310(3)(a). That matrix compares the physical capacity of claimant's usual and customary work with the physical capacity required by the modified work. This is true even though claimant may have the physical capacity to do heavier work than is required by the modified employment. Physical capacities are not defined by the "standards" generally. We utilize those definitions contained in former OAR 436-35-310(4)(a)-(d).

Here, claimant's usual and customary work as a choke setter required the physical capacity to do heavy work. Claimant's subsequent work activities as a tree planter, brush clearer, and deckhand also required a heavy physical capacity. Therefore, the appropriate adaptability value is +1. Former OAR 436-35-310(3)(a).

Concerning claimant's permanent impairment, the medical records establish that his right shoulder range of motion is normal. Therefore, no value is assessed for loss of range of motion. Former OAR 436-35-330(1)-(12). Claimant has undergone a resection of the acromion, for a value of 5. Former OAR 436-35-330(14). Therefore, the appropriate value for claimant's right shoulder surgery is 5.

Pain, which results in loss of use or function, may also be considered in determining permanent impairment under OAR 436-35-320(1)(a). See Daniel M. Alire, 41 Van Natta 752 (1989).

The Referee found that claimant suffers 15 percent disabling pain with repeated overhead arm activities. While we agree that claimant does suffer some disabling pain resulting from his compensable injury, we do not find that such pain is as great as that found by the Referee.

As we have earlier found, claimant is capable of performing heavy physical work activities. In addition, claimant chops and stacks cords of wood, which requires substantial overhead activities. Because we find that claimant is capable of performing substantial overhead activities, we do not find that he suffers 15 percent disabling pain with these activities.

We do find, however, that claimant suffers some disabling pain caused by excessive heavy work. Under such circumstances, we conclude that claimant suffers 5 percent disabling pain resulting from his compensable shoulder injury. Alire, supra. Claimant's disabling pain value (5) is combined with his surgery value (5) for a total impairment value of 9.75. Former OAR 436-35-280(7).

Having determined each value necessary to compute claimant's permanent disability under the "standards," we proceed to that calculation. When claimant's age value (0) is added to his education value (4) the sum is 4. Former OAR 436-35-280(4). When that value is multiplied by claimant's adaptability value (1), the product is 4. Former OAR 436-35-280(6). When that value is

added to claimant's impairment value (9.75) the result is 13.75 percent unscheduled permanent disability. Former OAR 436-35-280(7). That disability figure is rounded to the next higher whole percentage. Id. Claimant's permanent disability under the "standards" is, therefore, 14 percent.

ORDER

The Referee's order dated April 21, 1989, is modified. In lieu of the Referee's award, and in addition to the Determination Order award of 7 percent (22.4 degrees) unscheduled permanent disability, claimant is awarded 7 percent (22.4 degrees) unscheduled permanent disability, for a total of 14 percent (44.8 degrees) unscheduled permanent disability.

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In the Matter of the Compensation of
**HOWARD A. HOWES, Claimant**
Own Motion No. 90-0253M
OWN MOTION ORDER
Emmons, et al., Claimant Attorneys

The insurer has submitted to the Board claimant's claim for an alleged worsening of his May 27, 1981 industrial injury. Claimant's aggravation rights have expired. The insurer has accepted responsibility for the surgery and recommends that claimant's claim be reopened for the payment of temporary disability benefits.

Currently, litigation is pending in WCB Case No. 89-09915. Claimant has appealed a Determination Order issued December 16, 1988, contending that he is permanently and totally disabled.

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

We are persuaded that claimant's compensable injury has worsened requiring surgery. Accordingly, claimant's claim is reopened with temporary disability benefits to commence February 7, 1990, the date he 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. 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.

In addition, WCB Case No 89-00915 may proceed to hearing. The Referee should rate permanent disability based on claimant's condition at the time of hearing if he is medically stationary at that time. Pauline Travis, 37 Van Natta 194 (1985); Jeffrey Barnett, 36 Van Natta 1636 (1984). If claimant is not medically stationary at the time of hearing, the Referee should rate permanent disability as of the date claimant was last medically stationary. Pauline Travis, supra.

IT IS SO ORDERED.

In the Matter of the Compensation of
**RICHARD R. KOEHL, Claimant**
WCB Case No. TP-89047
THIRD PARTY DISTRIBUTION ORDER
John Mayfield, Claimant Attorney
Stoel, et al., Defense 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). Specifically, the dispute pertains to the agency's entitlement to its "third party" lien from the settlement proceeds. We conclude that the paying agency is entitled to a share of the proceeds and that a distribution in accordance with ORS 656.593(1) is "just and proper."

FINDINGS OF FACT

In February 1988, claimant suffered a compensable injury when injured in a motor vehicle accident. The paying agency accepted the claim and provided compensation. To date, the agency has incurred actual claim costs totalling $1,263.04. Since the claim has been closed without permanent or temporary disability awards, these costs entirely consist of medical bills.

Claimant engaged legal counsel to explore the possibility of bringing suit against the driver of the other vehicle. In August 1989, claimant's counsel advised the paying agency that a settlement between claimant and the third party had been reached. In addition, the paying agency was assured that the settlement proceeds were sufficient to provide the agency with complete reimbursement of its lien for actual claim costs. Such an arrangement was acceptible to the paying agency.

Despite repeated attempts to recover its share of the third party settlement, the paying agency has received nothing from claimant. A distribution of $1,263.04 from the third party settlement to the paying agency is "just and proper."

CONCLUSIONS OF LAW

If a worker receives a compensable injury due to the negligence or wrong of a third party not in the same employ, the worker shall elect whether to recover damages from the third person. ORS 656.578. The proceeds of any damages recovered from the third person by the worker shall be subject to a lien of the paying agency for its share of the proceeds. ORS 656.593(1). "Paying agency" means the self-insured employer or insurer paying benefits to the worker or beneficiaries. ORS 656.576.

Here, claimant sustained a compensable injury as a result of the negligence or wrong of a third person. The claim was accepted by the employer, who has provided compensation. Inasmuch as the employer has paid benefits to claimant as a result of a compensable injury, we conclude that it is a paying agency. ORS 656.576.

Furthermore, upon claimant's election to seek recovery against the third party, the provisions of ORS 656.593 become applicable. Consequently, portions of the third party settlement proceeds became subject to the paying agency's lien for its "just and proper" share. See ORS 656.593(3).

Having concluded that the paying agency is entitled to a share of the settlement proceeds, we proceed to determine a "just and proper" distribution.

After the deduction of attorney fees, litigation costs, and claimant's statutory 1/3 share, the paying agency shall be paid and retain the balance of the third party recovery to the extent that it is compensated for its expenditures for compensation, first aid or other medical, surgical or hospital service, and for the present value of its reasonably to be expected future expenditures for compensation and other costs of the worker's claims under ORS 656.001 to 656.794. See ORS 656.593(1)(c). Such other costs do not include any compensation which may become payable under ORS 656.273 or 656.278. Id. The balance of the recovery shall be paid to the worker or beneficiaries. ORS 656.593(1)(d).

If the worker settles the third party claim with paying agency approval, the agency is authorized to accept as its share of the proceeds "an amount which is just and proper", provided that the worker receives at least the amount to which he is entitled under ORS 656.593(1) and (2). ORS 656.593(3); Estate of Troy Vance v. Williams, 84 Or App 616, 619-20 (1987). Any conflict as to what may be a "just and proper distribution" shall be resolved by the Board. ORS 656.593(3).

The statutory formula for distribution of a third party recovery obtained by judgment, ORS 656.593(1), is generally applicable to the distribution of a third party recovery obtained by settlement. Robert L. Cavil, 39 Van Natta 721 (1987). As previously noted, we generally apply the statutory formula for distribution of a third party judgment to the distribution of proceeds from a third party settlement. Robert L. Cavil, supra. 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. Consequently, we turn to the question of whether the paying agency has established its lien for actual claim costs.

In response to the paying agency's contention that it has not received reimbursement for its $1,263.04 in claim costs, claimant has not disputed the agency's entitlement to such a recovery from the settlement proceeds. Instead, claimant's counsel asserted that claimant would be providing copies of cancelled checks demonstrating that full reimbursement had already been achieved. Yet, no further response nor copies of cancelled checks from claimant have been received in the more than two months since the aforementioned representation.

Under such circumstances, we conclude that the paying agency has established that it incurred $1,263.04 in claim costs and that it is entitled to full reimbursement of these expenses from the third party settlement proceeds. We further hold that a distribution of $1,263.04 of the third party settlement proceeds to the paying agency would be "just and proper." See ORS 656.593(3).

Accordingly, claimant is directed to pay to the paying agency $1,263.04, which shall constitute its "just and proper" share of the third party settlement.

IT IS SO ORDERED.

In the Matter of the Compensation of
**RICK D. BRADY, Claimant**
WCB Case No. 88-17624
ORDER ON REVIEW
Emmons, et al., Claimant Attorneys
Cummins, Brown, et al., Defense Attorneys

Reviewed by Board Members Myers and Gerner.

The insurer requests review of Referee McCullough's order that set aside its denial of claimant's right carpal tunnel syndrome surgery. On review, the issue is compensability of medical services. We affirm.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" as supplemented below.

Claimant's off work activities are not injurious practices.

CONCLUSIONS OF LAW AND OPINION

We adopt the Referee's "Opinions and Conclusions" as supplemented below.

The insurer argues that claimant has engaged in injurious practices which extinguishes his workers' compensation benefits. For authority, the insurer cites ORS 656.156 and OAR 436-60-110. As the proponent of the proposition, it is the insurer's burden to demonstrate that claimant engaged in injurious practices. Hutchenson v. Weyerhaeuser, 288 Or 51 (1979). We do not find claimant has engaged in either an intentional act to injure himself, nor do we find claimant has engaged in injurious practices.

There is no evidence of any conscious volitional act on the part of claimant to injure himself. Accordingly, we do not find any intentional injury as required by ORS 656.156(1). See James G. Wesley, 40 Van Natta 1841 (1988).

Nor is there persuasive evidence that claimant has engaged in any injurious practices which tend to imperil or retard recovery of the compensable injury. ORS 656.325(2). The insurer construes claimant's off work activities of chopping fire wood, mowing grass, and various other activities as injurious practices sufficient to deny claimant medical services for his accepted claim.

Claimant's unrebutted and credible testimony indicated that on occasion he cut wood for home use in order to supply a wood stove. Further, claimant testified that he has on occasion mowed the lawn of his grandparents. Claimant also testified that when his grandparent's well went dry he helped haul water with his father, and dug a ditch for the purpose of laying pipe. And finally, claimant testified that on occasion he assisted friends on construction projects by essentially running errands. All of these projects apparently were sporadic, of short duration, and without pay. Thus, we do not find the nature of these activities and the manner in which they were performed injurious practices.

Dr. Ellison, claimant's treating physician, testified that claimant's off work activities would be expected to "affect" claimant's pathological process. However, he did not state that these activities were injurious to claimant, nor did he indicate that claimant should refrain from engaging in them. Additionally, Dr. Ellison had concurred with both independent medical examiners, Doctors Woolpert and Button, in their recommendation that claimant return to regular work in order to see if claimant's symptoms would be exacerbated sufficiently to justify surgery. We have difficulty in understanding why work activity as a

landscaper/groundskeeper would be beneficial for claimant for diagnostic purposes, while off work activities as described by claimant are to be considered injurious practices. Based upon the totality of the medical evidence we decline to find that claimant's off work activities were injurious practices.

Accordingly, on a factual basis alone, the insurer has failed to meet his burden of proof in demonstrating claimant's off work activities were injurious practices which tended to imperil or retard claimant's recovery. However, even assuming claimant had engaged in injurious practices, which we do not find, the insurer's remedy was to request the Director to suspend benefits, not to unilaterally terminate medical services. See ORS 656.325(2); OAR 436-60-110(1) & (4).

ORDER

The Referee's order dated April 28, 1989 is affirmed. For services on Board review, claimant's attorney is awarded an assessed fee of $500, to be paid by the insurer.

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July 24, 1990 Cite as 42 Van Natta 1612 (1990)

In the Matter of the Compensation of
**DALE W. EBERLY, Claimant**
WCB Case No. 88-21003
ORDER OF ABATEMENT
Merrill Schneider, Claimant Attorney
Schwabe, et al., Defense Attorneys

The Board has received claimant's motion for reconsideration of our Order on Review, dated June 26, 1990.

In order to allow sufficient time to consider the motion, the above noted order is abated and withdrawn. The insurer is requested to file a response to claimant's motion within ten days. Thereafter, this matter shall be taken under advisement.

IT IS SO ORDERED.

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July 24, 1990 Cite as 42 Van Natta 1612 (1990)

In the Matter of the Compensation of
**DAVID G. GARRISON, Claimant**
WCB Case Nos. 88-02197 & 88-09152
ORDER ON REVIEW
Burt, Swanson, et al., Claimant Attorneys
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Cushing and Gerner.

Claimant requests review of Referee Borchers' order which: (1) upheld the self-insured employer's denials of claimant's aggravation and medical services for his current back condition; and (2) upheld the employer's denial of claimant's "new injury" claim for claimant's current back condition. On review, the issues are medical services, aggravation and compensability. We affirm.

FINDINGS OF FACT

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

## CONCLUSIONS OF LAW AND OPINION

### Medical Services

The Referee upheld the employer's medical services denial, reasoning that claimant had not established a causal connection between the June 1986 compensable injury and his medical treatment for his current treatment. We agree.

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.

Inasmuch as claimant suffers from a preexisting back condition, we conclude that the issue of causal relationship between claimant's compensable injury and his current back condition is a complex medical question. Thus, while his testimony is probative, the resolution of this issue primarily turns on medical evidence. Kassahn v. Publishers Paper Co., 76 Or App 259, 263 (1986). Claimant has failed to meet his burden.

Dr. Tilden, chiropractor, compared 1983 and September 1986 radiographs. He concluded that the degenerative changes in claimant's back condition predated the June 1986 compensable injury. Tilden found no worsening of claimant's degenerative joint disease related to claimant's compensable injury. (Ex. 30). On the other hand, Dr. Tiley, surgeon, concluded that claimant's disc degeneration at L4-5 was related to the June 1986 compensable injury. (Ex. 29).

In evaluating medical opinions, we give weight to those that are well-reasoned and based on complete information. See Somers v. SAIF, 77 Or App 259 (1986). Unlike the opinions authored by Dr. Tilden, Dr. Tiley's opinion does not indicate any knowledge of claimant's 1983 radiographs. Under such circumstances, we do not consider Tiley's opinion to have been based on a thorough understanding of claimant's prior medical history. Consequently, his opinion regarding causation lacks persuasiveness. See Miller v. Granite Construction Co., 28 Or App 473, 476 (1977).

Dr. Kelley, chiropractor, also opined that claimant's current back condition was related to the June 1986 compensable injury. However, he provided no reasoning as to the causal connection between claimant's compensable injury and his current back condition. Considering the conclusory nature of Kelley's opinion, we do not find it to be persuasive. See Moe v. Ceiling Systems, 44 Or App 429 (1980).

Based on the aforementioned reasoning, Dr. Tilden had the most thorough and well-reasoned medical analysis of claimant's condition. Consequently, we accord greater weight to his opinion. Somers v. SAIF, supra. Accordingly, claimant has not met his burden for showing a causal relationship between the June 1986 compensable injury and his current need for medical treatment.

### Aggravation

The Referee upheld the employer's denial for claimant's aggravation claim for his low back condition. We agree that the denial should be upheld, but for different reasons.

Before addressing the question of whether claimant's condition has worsened, we must determine what date represents the last arrangement of compensation. The Referee found that the effective date of the last arrangement of compensation was November 25, 1987. We disagree.

Claimant signed the stipulation on November 18, 1987. The employer signed the stipulation on November 20, 1987. On November 25, 1987, the Referee signed the stipulation. We have previously held that as between the date of the Referee's order and the date of the final opportunity to present evidence, the latter date is the appropriate date from which to establish a worsening. Larry H. Erbs, 42 Van Natta 98 (1990); Joseph R. Klinsky, 35 Van Natta 332, 333-34, aff'd mem. 66 Or App 193 (1983).

Applying the aforementioned analysis to the present case, we conclude that the appropriate date from which to establish a worsening is the date claimant signed the stipulation. This date would represent claimant's final opportunity to present evidence concerning his condition. Thus, we find that the appropriate date from which to establish a worsening would be November 18, 1987.

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 296 (1986). Following our review of the record, we are persuaded that claimant's compensable condition has not worsened since November 18, 1987, the last arrangement of compensation. In reaching this conclusion, we rely upon our previous reasoning that claimant's current back condition is not causally related to his June 1986 compensable injury.

New Injury

We adopt the Referee's opinion that claimant did not suffer a compensable "new injury" on November 18, 1987. Consequently, the employer's denial of claimant's "new injury" claim is upheld.

ORDER

The Referee's order dated November 17, 1988 is affirmed.

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July 24, 1990 Cite as 42 Van Natta 1614 (1990)

In the Matter of the Compensation of
**CAROL J. KNAPP, Claimant**
WCB Case No. 86-02762
ORDER ON REMAND
Stebbins & Coffey, Claimant Attorneys
Foss, et al., Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Weyerhaeuser Company v. Knapp, 100 Or App 615 (1990). The court has reversed our order in Carol J. Knapp, 41 Van Natta 851 (1989), that assessed a penalty for the self-insured employer's unreasonable denial "equal to 25 percent of the temporary disability compensation due under this order." The compensation awarded by our prior order included temporary total disability "effective June 22, 1984, and continuing until such compensation can be lawfully terminated, subject to the previously approved offset in unemployment benefits, wages earned, and temporary disability previously received." Concluding that we lacked authority to impose a penalty based on amounts that would come due after

the date of our order until claim closure, the court has remanded for a recalculation of the penalty. We proceed with our recalculation.

Amounts "then due" for a carrier's unreasonable denial are the amounts of compensation due when the denial is set aside. See Weyerhaeuser Company v. Knapp, supra; Wacker Siltronic Corporation v. Satcher, 91 Or App 654, 658 (1988). Therefore, in accordance with the court's mandate and the aforementioned holdings, we assess a penalty for the employer's unreasonable denial based on the amounts then due on April 25, 1989, the date we set aside the employer's denial.

Accordingly, the employer is assessed a penalty equal to 25 percent of the temporary disability which was due, as a result of our April 25, 1989 order, between June 22, 1984 and April 25, 1989.

IT IS SO ORDERED.

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In the Matter of the Compensation of
**PENNI L. MUMM, Claimant**
WCB Case No. 88-02137
ORDER ON REVIEW (REMANDING)
David C. Force, Claimant Attorney
Dennis Ulsted (Saif), Defense Attorney

Reviewed by Board Members Crider and Nichols.

Claimant requests review of Referee Young's order that upheld the SAIF Corporation's denial of her claim for aggravation and medical services for abdominal pain. Claimant has requested that this matter be remanded for the taking of additional evidence. On review, the issues are remand, aggravation and medical services. The motion for remand is granted.

## FINDINGS OF FACT

On December 1, 1985, claimant suffered a compensable injury to the low back. The claim was closed August 7, 1986. Claimant, however, continued to be treated with medications, including ibuprofen. Her treating physician is Dr. Mossberg, M.D.

In May 1988, claimant was twice hospitalized with severe abdominal pain. The first admission was on May 22, the second on May 26.

By letter of September 2, 1988, SAIF denied a claim for aggravation and medical services on the ground that claimant's abdominal condition was not related to the compensable injury.

Claimant filed a request for hearing, challenging the denial, on February 12, 1988. Simultaneously, claimant requested that SAIF provide copies of all medical documents and other information relating to the claim.

SAIF produced a number of documents, including documents pertaining to claimant's May 26, 1988 admission to the hospital.

The hearing commenced on December 16, 1988. Testimony was taken and documents received. The hearing was continued to enable claimant's attorney to

cross-examine the author of a medical report submitted on the eve of hearing and to enable SAIF's attorney to procure a medical report on the compensability issue from Dr. Mossberg.

Before the reconvening of the hearing, in January 1989, claimant's attorney telephoned SAIF's attorney to advise him that it appeared that the hospital records that SAIF had produced at that time were incomplete inasmuch as they failed to explain claimant's initial hospital admission. SAIF's attorney agreed to instruct the claims examiner to look into the matter. In early February 1989, the examiner advised claimant's attorney that she had provided him with copies of all hospital records involved in the case.

The hearing was reconvened on April 7, 1989. Additional exhibits were received. The parties agreed to waive cross-examination of medical experts. Oral argument was taken, and the record was closed.

The Referee issued his order on April 12, 1989, upholding SAIF's denial.

Thereafter, claimant demanded her medical records from the Eugene Clinic and the hospital. Among the documents she received were a number of documents which SAIF had not produced, among them Dr. Mossberg's chartnotes of May 25, 1988 and June 13, 1988, relating to claimant's treatment for abdominal pain; a report authored by Dr. Binder, M.D., who consulted concerning claimant's abdominal condition during her May 22, 1988 hospitalization; Dr. Binder's May 23, 1988 operative report; and the May 25, 1988 discharge report of Dr. Strutin, M.D., the physician who first admitted her to the hospital.

The documents obtained by claimant after hearing are relevant to the question of compensability. They are of the type routinely provided by providers to insurers.

## FINDINGS OF ULTIMATE FACT

The record is incompletely developed without the documents obtained by claimant after hearing.

The documents were not obtainable with the exercise of due diligence at the time of hearing.

## CONCLUSIONS OF LAW AND OPINION

Should we determine that a case has been improperly, incompletely, or otherwise insufficiently developed, we may remand to the Referee for further evidence taking, correction, or other necessary action. ORS 656.295(5). To merit remand, it must be established that the evidence relevant to the issues raised in the remand request was unobtainable with due diligence before the hearing. See Bernard L. Osborn, 37 Van Natta 1054, 1055 (1985), aff'd mem. 80 Or App 152 (1986).

Claimant contends that the omission of the aforementioned documents from the record renders it incompletely developed. She argues that the omission was occasioned, not by dilatory conduct on her part, but by the failure of the medical reporting and discovery process to make them available to her timely. SAIF responds that the records existed at the time of the hearing and that claimant could have obtained them from the medical care providers. Therefore, SAIF contends that the documents were obtainable with due diligence. SAIF further asserts that remand is not appropriate in this case because it did not have the

newly discovered evidence in its files prior to hearing and consequently that it is without fault.

Although the record does not establish that the newly discovered evidence was in SAIF's possession at the time of hearing, we nonetheless conclude that claimant exercised due diligence when claimant not only made a standard request for claims information but also queried SAIF concerning the apparent incompleteness of the records which had been disclosed pursuant to the request. We hold that due diligence does not always require that the claimant request records directly from medical providers who are required by rule to submit reports to the insurer; it is sufficient that claimant seek disclosure of records from the insurer.

We have previously held that a claimant is entitled to remand for the taking of additional evidence when he discovers, after hearing, medical reports which, although in the insurer's possession, were not timely disclosed. Lance E. Leavitt, 40 Van Natta 393 (1988); Marvin L. Moustachetti, 40 Van Natta 106 (1988). Although we discussed the "fault" aspect of those situations, the core of our rationale in those cases was our conclusion that claimant is entitled to rely on the insurer to obtain medical reports.

OAR 436-10-030, which was promulgated under authority granted by ORS 656.252(1), requires medical care providers, including treating, consulting and examining physicians, to regularly submit reports to insurers. The Director's rules further provide that workers and their representatives shall generally obtain copies of those reports from the insurer although they may obtain them directly from the provider "upon payment of an appropriate charge for copies." OAR 436-10-030(10). Both the Director's rules and the Board's rules consequently require the insurer to disclose such reports to the worker.

If a claimant's attorney cannot be assured that he is exercising due diligence in obtaining medical reports when he relies on the disclosure provisions of the rules, then claimant's attorneys will be forced routinely to request documents directly from providers. This would needlessly increase the burden of reporting on medical care providers and increase the costs of litigation to the parties. We decline to create this situation. Therefore, we hold that remand is appropriate when claimant has not obtained relevant medical reports, without which a record is insufficiently developed, pursuant to a request to the insurer, provided that the reports are of the type that should have been submitted to the insurer. This principle holds even where, as here, the insurer is without fault.

Accordingly, the Referee's order is vacated. This case is remanded to the Presiding Referee with instructions that it be assigned to a referee with instructions to reopen the record and to reconsider this matter in light of this additional evidence.

## ORDER

The Referee's order of April 12, 1989 is vacated. This matter is remanded to the Presiding Referee for further action consistent with this order.

In the Matter of the Compensation of
**DONALD REED, Claimant**
Own Motion No. 88-0523M and 90-0357M
OWN MOTION ORDER AND OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Roger D. Wallingford, Claimant Attorney
SAIF Legal Department, Defense Attorney

Claimant requested review of the SAIF Corporation's April 20, 1989, Notice of Closure which declared him medically stationary as of January 16, 1989. SAIF terminated claimant's temporary total disability benefits as of January 22, 1989. Claimant contended that claim closure was premature because he is not medically stationary. He also contended that he was not paid the proper rate of temporary disability benefits and requested that SAIF be assessed a penalty and attorney fee. By order issued July 5, 1990, the Board referred the issue of the rate of temporary disability benefits for a factfinding hearing; however, the Board neglected to address the issue of premature claim closure. We shall now address that issue in this order. In addition, SAIF submits to the Board claimant's most recent claim for another alleged worsening of the February 8, 1982, industrial injury. Should the Board uphold SAIF's April 20, 1989, closure of the claim, SAIF recommends denial of claim reopening on the grounds that no surgery or hospitalization was required for the most recent worsening and that claimant is no longer in the work force.

We turn first to the issue of premature claim closure. By letter dated January 27, 1989, Dr. Gray stated that he last saw claimant on January 16, 1989, and that his condition at that time was "stable" and "stationary." On February 17, 1989, Dr. Gray again declared claimant medically stationary as of January 16, 1989. There is no evidence to the contrary. Therefore, we find that claimant became medically stationary on January 16, 1989, and conclude that SAIF properly closed the claim. Accordingly, we affirm SAIF's April 20, 1989, Notice of Closure.

We turn now to claimant's current request for claim reopening. Under our own motion authority, we may award temporary disability benefits in only those cases where 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). On February 28, 1990, claimant was admitted to the hospital overnight for a lumbar myelogram and CT scan and an epidural steroid injection. However, the evidence does not persuade us that the hospitalization was required for a worsening of claimant's compensable injury. Rather, it appears that the purpose of the hospitalization was to test and treat a continuing condition. The hospital's progress note on February 28, 1990, diagnosed "[r]ecurrent sciatica" and reported claimant's history of lumbar pain radiating into the right leg "for several years." Absent persuasive medical evidence of a material worsening of claimant's condition requiring the hospitalization, we are not authorized to grant claimant's request for reopening and the issue of whether claimant was in the workforce is moot. Accordingly, the request for own motion relief is denied.

In the Matter of the Compensation of
**ANTHONY E. COCHRANE, Claimant**
WCB Case No. 88-01975
ORDER ON REVIEW
Charles D. Maier, Claimant Attorney
Garrett, et al., Defense Attorneys

Reviewed by Board Members Gerner, Myers and Cushing.

Claimant requests review of those portions of Referee Myzak's order that: (1) declined to order payment of an approved attorney fee from an earlier Referee's order; and (2) declined to assess a penalty and attorney fee for the employer's alleged unreasonable refusal to pay the approved fee. The issues on review are whether the employer complied with the prior Referee's order, penalties and attorney fees. We affirm in part and reverse in part.

## FINDINGS OF FACT

Claimant was awarded temporary total disability from March 16, 1987 through July 24, 1987 by Determination Order dated September 16, 1987. However, in the course of claims processing, claimant had already been paid temporary total disability from March 16, 1987 through September 10, 1987. Claimant requested a hearing on the Determination Order. The employer made no request for recovery of overpaid temporary disability benefits.

By Opinion and Order dated January 19, 1988, claimant was awarded temporary total disability from July 24, 1987 through September 9, 1987, and an additional 10 percent unscheduled permanent partial disability. Claimant's attorney was awarded 25 percent of the amount of temporary total disability compensation awarded for the period July 24, 1987 through September 9, 1987.

## CONCLUSIONS OF LAW AND OPINION

Claimant argues that the Referee, in effect, reversed the attorney fee awarded by the earlier referee. We agree.

Referee Foster, in the prior order awarded 10 percent unscheduled disability. He also ordered:

> "Claimant is hereby granted temporary total disability for the period July 24, 1987 through September 9, 1987. Claimant's attorney is granted 25 percent of the additional temporary disability, to a maximum of $750." (emphasis added).

The employer properly paid temporary disability benefits pending the issuance of the Determination Order. However, the Determination Order fixed claimant's substantive entitlement to temporary disability benefits only through July 23, 1987. Thus, at the time of the hearing before Referee Foster, claimant was not substantively entitled to the temporary disability benefits for the period between July 24, 1987 and September 9, 1987. Those benefits were, thus, potentially subject to an offset against the permanent disability which Referee Foster awarded. The effect of Referee Foster's order was to establish claimant's substantive entitlement to those temporary disability benefits and thus to defeat any claim to an offset by the employer. In other words, as a result of Referee Foster's order, claimant became entitled to additional temporary disability benefits.

OAR 438-15-045 provides:

> "If, after a hearing requested by the claimant, the referee awards additional compensation for temporary disability the referee shall approve a fee of 25 percent of the increased compensation, but not more than $1,050, to be paid out of the increased compensation."

Based on the fact that Referee Foster awarded additional temporary disability benefits, claimant's attorney was entitled to a fee out of those benefits. The employer should have paid that attorney fee.

Furthermore, OAR 438-15-085(2) provides:

> "An attorney fee which has been authorized under these rules to be paid out of increased compensation awarded by a referee, the Board or a court shall not be subject to any offset based upon a prior overpayment of compensation to the claimant."

Here, Referee Foster authorized an attorney fee pursuant to rule, to be paid out of the increased temporary disability compensation he awarded. The employer essentially offset against that fee the temporary disability it had previously paid to claimant. This violates OAR 438-15-085(2). See Weyerhaeuser v. Sheldon, 86 Or App 46 (1987).

The employer argues that claimant did not actually receive any "additional" temporary disability due under Referee Foster's order from which to pay a fee. We disagree.

The temporary disability was originally paid as a matter of procedural right until a determination order issued. However, the first substantive entitlement to benefits was not secured until Referee Foster awarded those benefits. Claimant's attorney was instrumental in securing that substantive award. Claimant's attorney was entitled to 25 percent of those substantive benefits and was actually awarded that 25 percent by the referee.

We conclude that claimant's attorney was, and still is, entitled to the original 25 percent approved fee awarded by Referee Foster.

Penalties and Attorney Fees

Penalties and attorney fees may be assessed for, inter alia, an employer's unreasonable refusal to pay compensation. ORS 656.262(10); ORS 656.382(1). The employer's actions in this case were wrong, but not unreasonable. It had a legitimate doubt, from a legal standpoint, whether or not Referee Foster's order required payment of an attorney fee from monies that had already been paid claimant where the employer had not requested recovery of the overpayment. Norgard v. Rawlinson, 30 Or App 999 (1977). We conclude the employer did not unreasonably resist the payment of compensation.

ORDER

The Referee's order, dated April 26, 1988, is reversed in part and affirmed in part. That portion which declined to order the employer to pay claimant's attorney an approved fee equal to 25 percent of the temporary disability from July 24, 1987 through September 9, 1987 is reversed. The employer

is hereby ordered to pay claimant's attorney 25 percent of this period of temporary disability without regard to the prior payment of this compensation to claimant. That portion of the Referee's order that declined to assess penalties and attorney fees is affirmed.

**Board Member Cushing, dissenting:**

I respectfully dissent.

The employer, in the instant case, had waived its claim for overpayment of time loss, but the majority holds that though a "procedural guarantee" it did not equate to a "substantive entitlement" for claimant, a distinction without a difference. The majority, in approving payment of an attorney fee for time loss already paid, has substituted a technical analysis for a practical application of the Workers' Compensation law.

Claimant's attorney, the real party in interest, who processed the requests for hearing and review, stipulated that claimant had received payment prior to Referee Foster's Opinion and Order; and testified that the request was inequitable (Tr. 4).

In summary, I believe that the use of the system to obtain attorney fees in cases such as this is contrary to ORS 656.012 and is far removed from the goals of those who enacted the Workers Compensation law in 1913.

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July 25, 1990 Cite as 42 Van Natta 1621 (1990)

In the Matter of the Compensation of
**The Beneficiaries of JOSEPH J. HAHN, Deceased**
WCB Case No. 88-21730
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 its denial of claimant's benefits. The insurer also contends that the Referee erred in refusing to reopen the record to admit a medical journal article which was published after the record closed. On review, the issues are the correctness of the Referee's evidentiary ruling and compensability.

We affirm and adopt the Referee's order with the following supplementation on the evidentiary issue:

At hearing, the insurer's expert, Dr. Goodall, postulated that decedent's clostridial myonecrosis may have been caused by clostridial bacteria entering claimant's bloodstream through the gastro-intestinal tract rather than through a work-related burn in the chest or shoulder. Claimant's attorney cross-examined him from medical literature which made little mention of clostridial infections occurring through the gastro-intestinal system and little mention of this occurring in diabetics such as decedent. Dr. Goodall admitted that if decedent actually had a burn as described by claimant and other witnesses, then he would agree with Dr. Kimbrough that the burn was the likely portal of entry for the clostridial bacteria.

The Referee found that claimant and the other lay witnesses were credible. Based on that finding, she found that decedent had suffered work related burns

on the chest and shoulder and that those burns were the likely portal of entry for the clostridial bacteria. We agree with and adopt those findings.

After the Referee issued her Opinion and Order, the insurer moved to re-open the record:

> "[A] new article published on May 15, 1989, establishes that clostridial myonecrosis (gas gangrene) has been documented in patients with the only precipitating factor being diabetes mellitus. This article did not exist prior to the Hearing and therefore could not have been produced as evidence. As it supports Dr. Goodall's testimony in an area wherein you determined that his testimony was not persuasive, however, it is highly relevant information which should be taken into consideration. The employer/insurer therefore moves that you re-open the record for consideration of this article, and, if appropriate, depositions of Drs. Goodall and Kimbrough concerning the impact of this article on their opinions."

The Referee, by Order after Reconsideration dated June 8, 1989, denied the motion. The insurer now moves to remand to the Referee to reopen the record to admit the medical article in question, or in the alternative, that we take official notice of that article.

We conclude, however, that the Referee did not err in declining to reopen the record to admit this article. Under normal circumstances a medical article is not admissible as substantive evidence of the matters asserted therein. It is hearsay evidence of which a lay person has little indicia of reliability and may lack the ability to interpret. Such an article, offered alone, is usually only admitted if it forms the basis for an admitted expert opinion. In this case, because the article was written after the hearing, it was not offered as the basis for an admitted expert's testimony. The insurer really wishes the Board, or the Referee, to take official notice of the accuracy of the contents of this article. This is a matter which is subject to reasonable dispute; therefore, it is not a proper matter for official notice. Therefore, we deny the motions to remand and to take official notice.

We note further that even if we were to consider this article, it would not affect our decision. The critical factual issue in this case is whether decedent actually burned his chest and shoulder at work. The Referee so found and we agree. Even Dr. Goodall, the insurer's expert, agreed that if decedent burned his chest, then the burns were a likely portal of the infection.

## ORDER

The Referee's order dated May 12, 1989, as reconsidered June 8, 1989, is affirmed. For services on Board review, claimant's attorney is awarded an assessed fee of $2,500, to be paid by the insurer.

In the Matter of the Compensation of
**LaREE L. KUSCHEL, Claimant**
WCB Case No. 88-21260
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
Cowling & Heysell, Defense Attorneys

Reviewed by Board Members Cushing and Myers.

The insurer requests review of Referee Higashi's order which set aside its "de facto" denial of claimant's current chiropractic treatment for her neck and back complaints. On review, the issue is medical services. We reverse.

## FINDINGS OF FACT

Claimant experienced a compensable injury on April 7, 1983, to her upper back and neck. Her claim was closed by an April 6, 1984 Determination Order. Claimant was found medically stationary on March 15, 1984.

Claimant experienced no spinal symptoms between November 26, 1984 and January 21, 1985.

On April 2, 1987, the insurer denied claimant's aggravation claim, contending that claimant's current back and neck complaints were not the result of the April 7, 1983 compensable injury. An October 21, 1987 Opinion and Order found that claimant failed to prove that her current complaints were related to her industrial injury.

Thereafter, claimant continued to receive the same chiropractic treatments to the same body parts. The insurer refused to pay for these treatments, contending that the treatments remained in denied status. Claimant requested a hearing.

## CONCLUSIONS OF LAW AND OPINION

The Referee found claimant's medical services were compensable, reasoning they were reasonable and necessary, and related to the 1983 compensable injury. We disagree.

The insurer stated that this case does not present "an issue of res judicata or collateral estoppel." However, it argues that the "identical question" was previously addressed and answered in the earlier Referee's October 1987 order. Under such circumstances, we conclude that notwithstanding the insurer's statement that res judicata and collateral estoppel are not at issue, the substance of its argument is that claimant's current medical services claim is not compensable because neither his condition nor his treatment are different than they were in October 1987 when the same issue was previously litigated. Consequently, we proceed with our determination as to whether claimant is precluded from asserting her current medical services claim.

When a claim for medical services is reasserted after being once denied, the question is whether the claimant's condition has changed so as to have created a new set of operative facts that previously could not have been litigated. See Liberty Northwest Ins. Corp. v. Bird, 99 Or App 560 (1989); Argonaut Ins. Co. v. Rush, 98 Or App 730 (1989); Kepford v. Weyerhaeuser, 77 Or App 363, rev den 300 Or 722 (1986).

Here, claimant's medical treatment was the identical treatment that she received from 1986 through 1987, which in turn was found unrelated to the 1983 compensable injury by the earlier Referee's October 1987 order. In reaching this conclusion, we rely upon the following reasoning.

Claimant received the same treatment following the October 1987 order as was given in 1986 and 1987. Dr. Rethwell, chiropractor, concluded that claimant did not experience a new condition. Moreover, claimant testified that Dr. Rethwell's treatment had not changed since October 1987, and that he continued to treat the same parts of her body.

Inasmuch as there is no evidence that claimant's chiropractic treatments have changed or that claimant's neck, shoulder and upper back conditions have changed, we conclude that claimant's condition is not different from the time of the earlier Referee's October 1987 order.

Based on the medical evidence and claimant's testimony, we have found that claimant's condition did not change. Accordingly, we hold that claimant's medical services claim is not compensable. See Liberty Northwest Ins. Co. v. Bird, supra; Brenda M. Hinkle, 42 Van Natta 993 (1990).

## ORDER

The Referee's order dated April 4, 1989 is reversed. The insurer's denial is reinstated and upheld. The Referee's attorney fee award of $2,000 is reversed.

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In the Matter of the Compensation of
**SALLY A. RAY, Claimant**
WCB Case No. 88-15319
ORDER ON REVIEW
Coons & Cole, Claimant Attorneys
Cooney, et al., Defense Attorneys

Reviewed by Board Members Cushing & Gerner.

Claimant requests review of those portions of Referee Gruber's order which refused to admit exhibit 168 post-hearing, and found that claimant's claim had not been prematurely closed. On review, the issues are admissibility of evidence and premature claim closure. We affirm.

## FINDINGS OF FACT

We adopt the Referee's findings of fact as our own with the following supplementation. The hearing on this claim was conducted and the record closed on November 30, 1988. Subsequent to the closure of the record, the employer sent claimant to Dr. J. Thompson for an Independent Medical Examination (IME). The exam took place on January 9, 1989, with the doctor's report being issued on January 16, 1989. Upon receipt of the report from the employer, claimant sought a reopening of the hearings record. The request to reopen the record was denied in an order by the Referee on February 8, 1989. The opinion and order was issued on February 8, 1989.

CONCLUSIONS OF LAW AND OPINION

Admission of Evidence

Claimant contends that the Referee erred in not reopening the record for admission of further evidence. We disagree.

OAR 438-07-025(1) allows a Referee discretion to reopen the record for consideration of new material evidence. OAR 438-07-025(2) provides that a party moving for reconsideration must provide an explanation why such new evidence could not have reasonably been discovered and produced at the hearing.

Claimant requested that the Referee reopen the record, sixty-three days after hearing, for submission of a medical report from an IME that had not taken place prior to the closure of the hearings record. Claimant contended that she had first learned of the evidence after the record had closed because the examination had not taken place prior to the hearing.

We conclude that the Referee did not abuse his discretion in declining to reopen the record. Claimant's explanation is not sufficient to establish that the proffered medical evidence could not have been reasonably procured, generated, or produced at the time of hearing through the exercise of due diligence. Claimant had the opportunity, and responsibility, to develop the medical evidence necessary to meet her burden of proof prior to the hearing. The medical evidence in question was not even requested at the time of the closure of the hearing's record, nor did claimant's counsel request that the record be held open to procure that additional evidence. Under these circumstances, the Referee was within his discretion in declining to reopen the record for the admission of further evidence.

Premature Closure

We adopt the Referee's Conclusion and Reasoning on this issue as our own.

ORDER

The Referee's order dated February 8, 1989, as reconsidered on March 21, 1989, is affirmed.

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July 25, 1990 Cite as 42 Van Natta 1625 (1990)

In the Matter of the Compensation of
**DAVID W. SOUDERS, Claimant**
WCB Case No. 88-19104
ORDER ON RECONSIDERATION
Merrill Schneider, Claimant Attorney
Tooze, et al., Defense Attorneys

Claimant requests reconsideration of our June 27, 1990 Order on Review that set aside a Determination Order which had reclassified claimant's hearing loss claim from nondisabling to disabling.

On reconsideration, claimant argues that the procedures followed in

this case were not proper. He contends in this regard that the insurer's challenge of the reclassification to disabling was premature and, therefore, inappropriate. Moreover, with his motion for reconsideration, claimant includes additional evidence which was not before us at the time of our review. We do not agree with claimant's contentions. To the contrary, we conclude that this matter was processed in accordance with the statutory scheme.

The insurer initially classified the claim as nondisabling in December 1987. ORS 656.262(6)(a). By letter date June 30, 1988, claimant requested a redetermination of the claim as disabling. ORS 656.268(8). A Determination Order subsequently issued which classified the claim as disabling. The insurer requested a hearing challenging this classification. Contrary to claimant's contention, the insurer's challenge was not premature. Rather, the insurer's challenge was contemplated and authorized by statute. ORS 656.268(8) and (6). As mandated by statute, we based our review of the Referee's decision upon the record submitted to us. ORS 656.295(5). Based upon that record, we concluded that claimant failed to prove that his compensable hearing loss claim was compensable.

In sum, we conclude that the procedure followed in this case was proper. Accordingly, the request for reconsideration is granted and our prior order withdrawn. On reconsideration, subject to the foregoing supplementation, we adhere to and republish our June 27, 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
**JUANITA ALLEN, Claimant**
WCB Case No. 88-10169
ORDER ON REVIEW
Francesconi & Associates, Claimant Attorneys
Merrily McCabe (Saif), Defense Attorney

Reviewed by Board Members Crider and Brittingham.

Claimant requests review of Referee Brazeau's order that: (1) held that claimant is procedurally entitled to temporary total disability compensation for the period April 19, 1988 through May 26, 1988, but that since she was medically stationary as of February 4, 1988, the SAIF Corporation is not required to pay that compensation; (2) declined to assess a penalty and attorney fee for SAIF's alleged unreasonable unilateral termination of benefits; (3) set aside a Determination Order which awarded 10 percent (32 degrees) unscheduled permanent partial disability for her low back condition; and (4) authorized SAIF to offset permanent partial disability compensation paid pursuant to the Determination Order against future awards of permanent disability. On review, the issues are temporary disability compensation, extent of unscheduled permanent partial disability, offset, penalties and attorney fees. We reverse in part and affirm in part.

FINDINGS OF FACT

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

The May 26, 1988 Determination Order found claimant medically stationary as of April 25, 1988 and awarded temporary disability compensation through that date.

Pursuant to a letter written by claimant's attorney to the SAIF claims examiner, SAIF had notice that the modified job offer had been withdrawn as of May 19, 1988.

FINDINGS OF ULTIMATE FACT

SAIF's termination of temporary total disability benefits was unreasonable.

Claimant was medically stationary on February 4, 1988, but was not released for regular work at that time.

Claimant has no permanent impairment of her low back and thus has suffered no loss of earning capacity due to the compensable low back injury.

CONCLUSIONS OF LAW AND OPINION

Temporary Disability

SAIF terminated claimant's temporary disability payments as of April 19, 1988. A May 26, 1988 Determination Order closed the claim with an award of temporary disability benefits through April 25, 1988. Claimant contended at hearing that she was entitled to temporary disability benefits through the date of the May 26, 1988 Determination Order and sought an order requiring payment through that date subject to offset of any benefits paid for the period after claimant became medically stationary. SAIF contended that it was entitled to terminate temporary disability benefits on April 19, 1988, the date claimant failed to report for work.

The Referee rejected SAIF's contention, finding that claimant did not refuse the job offer when she was called away on a family emergency and advised the employer she could not report to work as scheduled. We adopt the Referee's reasoning in that regard. (Conclusions and Opinion, Part 1). Nevertheless, the Referee declined to award additional temporary disability benefits based on his finding that claimant was medically stationary on February 4, 1988, prior to the termination of temporary disability benefits. The Referee reasoned that because claimant was substantively entitled to temporary disability benefits through that date only, no additional award should be made.

On review, claimant argues that she was not medically stationary until May 3, 1988, when Dr. Flaming, her treating osteopath, released her to work on a trial basis. We agree with the Referee's finding that claimant was medically stationary on February 4, 1988. However, we disagree with his conclusion that this precluded an award of temporary disability benefits after that date.

The insurer has a duty to pay temporary disability until the claim is closed or the claimant is medically stationary and is released to regular work. Fazzolari v. United Beer Distributors, 91 Or App 592. Here, claimant had been released for work on a trial basis only. Therefore, claimant is procedurally entitled to temporary disability benefits through the date of claim closure. The benefits must be paid. Accordingly, the Referee is reversed with regard to this issue.

Penalties and Attorney Fees

The Referee found that SAIF strictly complied with the provisions of OAR 436-60-030(5) in terminating claimant's temporary disability because, as far as SAIF's representative knew, claimant had refused the employer's offer of modified employment. Therefore, the Referee reasoned that the termination of temporary disability compensation was not unreasonable.

Claimant argues that SAIF unreasonably terminated her temporary disability, entitling her to penalties and attorney fees.

We have affirmed the Referee's ruling, which is not challenged by SAIF on review, that claimant, having been called away on a family emergency, did not refuse the job offer when she advised her employer that she could not report for work as scheduled. Nevertheless, SAIF's claims examiner testified that she was unaware of this and, on the basis of a report that claimant had failed to report for work, terminated temporary disability compensation. The Referee concluded that SAIF did not act unreasonably given the information available. We disagree.

Any information that the employer has is "charged" to the insurer. Here, the employer knew by April 18, 1988 that claimant had been called away on a family emergency. We find that, with that constructive knowledge, SAIF's termination of temporary total disability benefits was unreasonable. Moreover, SAIF actually knew by May 19, 1988 that the modified job offer had been withdrawn. This constitutes a second basis for a finding that SAIF's termination of temporary disability benefits was unreasonable. Accordingly, we reverse the Referee's finding and assess penalties and attorney fees for SAIF's unreasonable termination of temporary disability benefits.

Medically Stationary Date

SAIF contended at hearing that claimant was medically stationary on February 4, 1988, rather than on April 25, 1988, as provided by Determination Order. The Referee agreed. Claimant contends that she was not medically stationary until May 3, 1988, the date Dr. Flaming reported that claimant was medically

stationary. We adopt the Referee's reasoning in his Conclusions and Opinion, Part 4, paragraphs 2 and 3. However, we have also concluded that claimant is procedurally entitled to temporary total disability benefits through May 26, 1988, the date of the Determination Order. We will, therefore, award benefits through that date, but allow SAIF to offset payments made for the period after February 4, 1988 against future awards of permanent disability.

Extent/Offset of Overpaid Permanent Disability

The Board affirms and adopts the Referee's Conclusions and Opinion regarding these issues.

ORDER

The Referee's order dated September 22, 1988 is reversed in part and affirmed in part. In addition to the temporary disability compensation awarded by the May 26, 1988 Determination Order, claimant is awarded temporary disability benefits for the period April 26, 1988 through May 26, 1988. The SAIF Corporation is allowed to offset the temporary total disability benefits paid from February 4, 1988 through May 26, 1988 against any future award of permanent disability compensation. SAIF shall pay to claimant a penalty equal to 25 percent of the temporary disability benefits due under this order. For services regarding the penalty issue, claimant's attorney is awarded a fee of $200, payable by SAIF. Claimant's attorney is allowed an approved fee in the amount of 25 percent of the increased compensation awarded by this order, not exceeding $750, payable by SAIF directly to claimant's attorney out of that compensation. The remainder of the order is affirmed.

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July 26, 1990 Cite as 42 Van Natta 1629 (1990)

In the Matter of the Compensation of
**RONALD CARIAS, Claimant**
WCB Case No. 88-20358
SECOND ORDER ON RECONSIDERATION
Francesconi & Associates, Claimant Attorneys
Carrol J. Smith (Saif), Defense Attorney

The SAIF Corporation requests review of that portion of our June 22, 1990 Order on Review, as reconsidered July 13, 1990, that awarded claimant's attorney an assessed fee for successfully prevailing against SAIF's appeal from the Referee's order which set aside its "de facto" denial of claimant's claim for an inguinal hernia. SAIF contends that claimant is not entitled to an assessed fee because the retainer agreement filed with the Board is in Spanish, rather than in English. In support of its motion, SAIF relies upon ORS 1.150, which requires that "[e]very writing in any action, suit or proceeding in a court of justice of this state, or before a judicial officer shall be in English * * *."

SAIF's argument is without merit. The statute relied upon by SAIF, ORS 1.150, is limited by its terms to judicial proceedings. Here, the proceeding is an administrative one before an administrative agency of this state. ORS 1.150 does not apply. If SAIF is concerned about the content of claimant's retainer agreement, it may obtain a translation of that document.

Accordingly, the request for reconsideration is granted. Our prior orders are withdrawn. Subject to the foregoing supplementation, we adhere to and republish our June 22, 1990 order, as reconsidered July 13, 1990. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
**ANDREW R. COMEAU, Claimant**
WCB Case Nos. 88-12279 & 88-12278
ORDER ON REVIEW
W. D. Bates Jr., Claimant Attorney
Beers, et al., Defense Attorneys
H. Thomas Andersen (Saif), Defense Attorney

Reviewed by Board Members Crider and Nichols.

EBI Companies requests review of Referee Seymour's order which: (1) set aside its denial of claimant's aggravation claim for a left shoulder condition; and (2) upheld the SAIF Corporation's denial of claimant's aggravation claim for the same condition. On review, the issues are compensability and responsibility. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact, as contained in his "Findings of Fact" and "Conclusions and Opinion" sections, with the following exceptions. The Referee stated that claimant's first compensable injury occurred in July 1986. In fact, it occurred in January 1986. In addition, the Referee found that there was really no discussion of surgery after the first compensable injury, or indeed, after the second compensable injury. However, the record establishes that claimant's treating orthopedic surgeon, Dr. Butters, did discuss surgical as well as non-surgical options with claimant after both the first and second compensable injuries.

In addition, we supplement with the following. Dr. Butters advised against shoulder stabilization surgery after the first compensable injury, and recommended surgery after the second compensable injury. There was some damage to claimant's left shoulder with each of the compensable injuries. The second compensable injury was more traumatic than the first.

FINDINGS OF ULTIMATE FACT

Claimant's injuries with SAIF's insured and EBI's insured were each a material contributing cause of claimant's left shoulder condition and current need for medical treatment.

Claimant's injury with EBI's insured independently contributed to claimant's left shoulder condition and current need for treatment.

CONCLUSIONS OF LAW AND OPINION

Claimant sustained left shoulder injuries with SAIF's insured in January 1986, and with EBI's insured in August 1987. The claim currently at issue before the Board is for claimant's condition and need for surgery following an off-work dislocation of his left shoulder in April 1988.

A .307 order issued following the August 1987 injury with EBI's insured; EBI accepted responsibility for the claim by stipulation, signed April 8, 1988.

At hearing and on review, both EBI and SAIF disavow compensability of and responsibility for claimant's current need for surgery. The Referee found that, as claimant's need for surgery was exactly the same at hearing as it was when the April 1988 stipulation issued, neither insurer could contest compensability of surgery, only responsibility for surgery. He then assigned responsibility to

EBI, reasoning that it had accepted responsibility under the April 1988 stipulation. We affirm the Referee's ultimate conclusion regarding EBI's responsibility. However, we do so for different reasons.

Pursuant to the April 1988 stipulation, the insurers only agreed that the August 1987 injury was compensable and EBI's responsibility. Following the stipulation, the 1987 injury claim was closed April 18, 1988. The present claim is for claimant's current condition following yet another dislocation in April 1988--not the condition at the time of the August 1987 injury. Consequently, both insurers have the right to litigate compensability and responsibility for this condition.

Compensability

When compensability and responsibility are both at issue, as here, the threshold issue is compensability. Runft v. SAIF, 303 Or 493, 498-99 (1987); Elizabeth Coomer, 41 Van Natta 2300, 2302 (1989). Claimant bears the burden of proving by a preponderance of the evidence that an industrial injury materially contributed to his disability or need for medical treatment. Milburn v. Weyerhaeuser Co., 88 Or App 375, 378 (1987).

The January 1986 injury with SAIF's insured, and the August 1987 injury with EBI's insured, each resulted in a left shoulder dislocation which required reduction under general anesthesia. In deposition, Dr. Butters testified that there was some damage to the shoulder with each compensable dislocation. He further stated that if claimant had not suffered these dislocations, there would be no need for surgery. His testimony was unrebutted.

Therefore, we find that claimant has established a material causal contribution from each of his injuries. Consequently, we conclude that claimant has established the compensability of his current left shoulder condition.

Responsibility

Claimant has sustained two compensable injuries to the same body part followed by a new period of disability. Responsibility rests with the insurer that last independently contributed to claimant's condition and need for surgery. There is a rebuttable presumption that responsibility rests with EBI, the insurer at the time of the last work-related injury. Boise Cascade v. Starbuck, 296 Or 238 (1984); Industrial Indemnity v. Kearns, 70 Or App 583 (1984); Linda L. Wise, 42 Van Natta 115 (1990).

EBI asserts that claimant's post-1987 injury status was the same as his pre-1987 injury status, so that the 1987 injury did not result in a permanent worsening of claimant' left shoulder condition. Therefore, EBI contends that the 1987 injury did not independently contribute to claimant's current condition, and that SAIF, and not EBI, is responsible. However, the testimony of Dr. Butters, taken in its entirety, establishes that although it is difficult to specify which injury caused exactly what and how much damage, the second injury did independently contribute to claimant's left shoulder condition and current need for surgery.

It was Dr. Butter's unrebutted testimony that there was some damage to claimant's left shoulder after each compensable injury. He further noted that had the compensable injuries not occurred, there would have been no decision to perform surgery. Finally, he stated that significant trauma would cause a worsening of claimant's shoulder condition, and that the 1987 injury was more traumatic than the 1986 injury.

Further, claimant testified that he was able to use his shoulder efficiently after the 1986 injury and even performed manual labor, but was unable to return to this level of activity after the 1987 injury.

Accordingly, the record establishes that the 1987 injury with EBI's insured independently contributed to claimant's current condition. Consequently, EBI is the responsible insurer.

ORDER

The Referee's order dated March 27, 1989 is affirmed. Claimant's attorney is awarded an assessed fee of $550, to be paid by EBI Companies.

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In the Matter of the Compensation of
**WANDA L. DRYDEN, Claimant**
WCB Case No. 88-03476
ORDER ON REVIEW
Quintin B. Estell, Claimant Attorney
Gary Wallmark (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

The SAIF Corporation requests, and claimant cross-requests, review of that portion of Referee Higashi's order which granted permanent and total disability, whereas a Determination Order did not increase claimant's unscheduled permanent disability award beyond the 10 percent (32 degrees) she had previously received. On review, the sole issue is permanent total disability. We affirm.

FINDINGS OF FACT

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

Claimant's compensable injury is a material cause of her current psychological condition.

Claimant was 46 years old at the time of hearing. She has a ninth grade education and her primary work experiences were that of cocktail waitress and bartender. Claimant entered a vocational rehabilitation program which was terminated in 1982 because she had to drop out of school under doctor's orders. School pressure worsened claimant's mental condition and the long hours of sitting caused an increase in physical symptoms.

Claimant is physically restricted to sedentary work, however, she is not released to return to any type of work due to her mental status. Claimant's permanent impairment, as a result of her compensable injury, pain syndrome, and depression/anxiety, renders her permanently incapacitated from regularly performing work at a gainful and suitable occupation. It would be futile for claimant to look for work. But for her compensable injury, claimant would be willing to seek regular, gainful employment.

CONCLUSIONS OF LAW AND OPINION

The Board adopts the Referee's "Conclusion and Opinion" with the following comments.

Claimant testified that she was very healthy, strong and active before the work injury. (Tr. 21). Immediately after the assault at work she was fired without explanation. (Tr. 28). Then for a period of time she was under surveillance by SAIF and had several disturbing encounters with an investigator. Following these run-ins, she began having anxiety attacks and developed hypertension. (Tr. 32-36).

Since the accident, claimant reports that she has pain under her left arm; neck swelling; knots in her neck and left shoulder; knotting and soreness in her mid-back; low back pain; and constant radiating chest pain. She also has frequent headaches that may last three days. The more "upset" she becomes the greater the pain. Any amount of activity hurts her neck and the left side of her face goes numb. She is no longer able to do things with her grandchildren and she can only do limited housework and yard work. If she exerts herself for more than a couple hours she must lie flat on her back. Claimant is only able to drive for very short periods of time. (Tr. 41-56). Based on demeanor, the Referee found claimant entirely credible. We defer to this finding. Coastal Farm and Supply v. Hultberg, 84 Or App 282 (1987).

The Referee concluded that claimant is medically and physically permanently and totally disabled and that this status was established as of July 28, 1988. We agree.

Claimant received a compensable injury on June 12, 1980, when she was assaulted by a customer while working as a bartender. Subsequently claimant developed a chronic pain syndrome associated with the compensable injuries. Eventually this led to depression and anxiety which only intensified her pain syndrome. The combination of claimant's chronic pain syndrome and current psychological status have rendered her permanently totally disabled if her psychological condition is related to the compensable injury.

Therefore, whether claimant is entitled to an award of permanent total disability turns on whether her compensable injury was a material contributing cause of a worsening of her preexisting psychological condition. Marilyn F. Gosnell, 42 Van Natta 593 (1990).

Claimant's treating osteopath, Dr. Gordon, and attending psychiatrist, Dr. Hofeldt, are in complete agreement that there is a causal link between the compensable injury and claimant's current disabling psychiatric status. (Exs. 9, 10, 12, 13, 22D, 29). However, an independent psychiatrist, Dr. Glass, is not convinced there is a causal relationship. (Exs. 18 and 32).

Dr. Glass diagnoses claimant as having an adjustment reaction with mixed features of depression. He also feels that, predating the compensable injury, claimant had a passive/aggressive personality disorder with features of depression, anxiety, somatic preoccupation and hysterical embellishment of symptoms. (Ex. 18, p. 5). While Dr. Glass does not clearly say that the industrial injury prompted the manifestation of claimant's preexisting personality disorder, neither does he reject this position.

Dr. Glass suggests that the other physicians established a relationship between the industrial accident and claimant's current psychiatric condition by focusing on the pain component, whereas he highlighted the secondary gain element. (Ex. 32, pp. 36-37 and Tr. at 81). However, he only "sort of" disagreed with the medical opinions that the conversion hysteria was directly related to the industrial injury. (Ex. 32, p. 47). In fact, Dr. Glass concurred that there were psychophysiologic factors involved in claimant's pain, and that the industrial accident was one of a number of elements manufacturing the claimant's symptoms. "I wouldn't totally ascribe the subsequent course of

events to the industrial injury. I would ascribe the subsequent course of events to this woman's personality disorder and emotional vulnerability." (Ex. 32, pp. 48-49; Emphasis added).

Like the Referee, we are not persuaded by Dr. Glass' opinion and conclude that his testimony does not overcome the treating physician presumption. When, as it is here, the medical evidence is divided, greater weight is given the opinion of the treating physicians, unless there are persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810 (1983). We reject SAIF's argument that expert analysis, rather than expert external observation, is required in this case and therefore no special deference should be given the treating physician. Allie v. SAIF, 79 Or App 284 (1986).

We conclude that expert external observation is very important in evaluating claimant's psychiatric condition and its relationship to her long-standing physical complaints. Dr. Gordon, claimant's attending orthopedist, saw her almost 300 times for the compensable injury and resulting pain syndrome and he is in a better position to comment on claimant's sincerity and the causation factor than a one-time consultant. Because of Dr. Gordon's first-hand exposure to and knowledge of claimant's condition, the Referee properly gave his opinion great weight. Argonaut Ins. v. Mageske, 93 Or App 698, 702 (1988). Furthermore, Dr. Gordon's opinion on the causal link between the injury and claimant's current psychiatric status is confirmed by Dr. Hofeldt, claimant's treating psychiatrist.

We hold that the preponderance of well-reasoned medical opinion establishes that claimant's compensable injury prompted a pain syndrome and psychological reaction which worsened claimant's underlying psychiatric condition.

The Board also takes administrative notice that an earlier Referee, in a January 1985 Opinion and Order, found claimant's depression treatments compensable and this determination was affirmed by the Board. (Exs. 3B and 6).

Finally, we are persuaded that claimant demonstrated her willingness to return to work and her participation in vocational rehabilitation was reasonable under ORS 656.206(3). (Exs. 3AA3 and 10). Any further attempts to participate in vocational rehabilitation or to seek other employment would be futile given the extent and nature of her impairment. Accordingly, we conclude that claimant is entitled to permanent total disability benefits.

ORDER

The Referee's order dated November 21, 1988, as amended December 8, 1988, is affirmed. For services on review, claimant's attorney is awarded an assessed attorney fee of $750, to be paid by the SAIF Corporation.

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In the Matter of the Compensation of
**GEORGE L. MARTIN, Claimant**
WCB Case No. 88-21345
ORDER ON REVIEW
Max Rae, Claimant Attorney
David Smith (Saif), Defense Attorney

Reviewed by Board Members Brittingham and Nichols.

Claimant requests review of Referee Brazeau's order which awarded claimant 15 percent (48 degrees) unscheduled permanent disability for his neck, upper

back and left shoulder conditions, whereas a Determination Order awarded him no unscheduled permanent disability. On review, the issue is extent of permanent partial disability. We affirm.

FINDINGS OF FACT

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

Claimant returned to heavy work, drawing bales of hay, following his injury. Claimant was released to return to medium work.

CONCLUSIONS OF LAW AND OPINION

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

We agree with the Referee that claimant is entitled to a +1 adaptability value. The Referee found that claimant had not returned to his usual and customary work and was not working at the time of the hearing, but had been released by Salem Hospital's Industrial Medicine Program to medium work. Accordingly, the Referee found claimant was entitled to a value of +1 under former OAR 436-35-310(4)(b).

Claimant argues that he should be awarded an adaptability value of +2 pursuant to former OAR 436-35-310(3)(a). That rule provides that, in cases where a claimant is unable to return to his usual and customary work but has returned to modified work, the value factor is based upon the difference between the physical capacity necessary to perform his usual and customary work and the physical capacity required to perform the claimant's modified employment.

In this case claimant did not return to his usual and customary work. However, claimant returned to other heavy work (i.e. drawing bales of hay). Therefore, claimant would only be entitled to a +1 adaptability value under the matrix at former OAR 436-35-310(3)(a). Therefore, under either matrix claimant is entitled to a value of +1. See former OAR 436-35-310(3)(a); 436-35-310(4)(b).

ORDER

The Referee's order dated March 10, 1989, as reconsidered March 22, 1989, is affirmed.

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July 26, 1990 Cite as 42 Van Natta 1635 (1990)

In the Matter of the Compensation of
**GARY D. MOSER, Claimant**
WCB Case No. 88-15380
ORDER ON REVIEW
Parks, Allen, et al., Claimant Attorneys
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Brittingham and Crider.

Claimant requests review of those portions of Referee Fink's order that: (1) affirmed a Determination Order which awarded claimant a total of 53 percent (79.5 degrees) scheduled permanent disability for loss of use or function of the right leg (knee), and no unscheduled permanent partial disability for his low back; and (2) upheld the insurer's denial of claimant's low back herniated disc condition. On review the issues are extent of scheduled and unscheduled permanent partial disability and compensability. We affirm.

## FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" with the exception that we do not adopt the last three paragraphs of findings. We make our own "Ultimate Findings of Fact".

## ULTIMATE FINDINGS OF FACT

Claimant has sustained a 53 percent loss of use or function in the right knee as a result of his compensable knee injury.

## CONCLUSIONS OF LAW AND OPINION

### Scheduled Permanent Disability

Claimant's right knee condition became medically stationary in August 1988. The Determination Order issued on September 15, 1988.

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

For purposes of determining injury-related permanent partial disability, ORS 656.283(7) and 656.295(5) require application of the standards for the evaluation of disabilities adopted by the director pursuant to ORS 656.726(3)(f)(A). Those "standards" in effect on the date of the Determination Order from which the hearing was requested control the evaluation of permanent partial disability. OAR 438-10-010.

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

In this case, the "standards" adopted effective July 1, 1988, (former OAR 436-35-001 et seq), as amended by temporary rules effective August 19, 1988, apply to the rating of claimant's permanent partial disability. Former OAR 436-35-010 through 436-35-260 apply to the rating of scheduled permanent partial disabilities. Former OAR 436-35-010(1).

The Referee found that claimant was entitled to an award of 53 percent scheduled disability under the standards. We agree under the following analysis.

The Referee properly awarded a 44 percent range of motion value for retained flexion of about 25 degrees, and 0 for loss of extension based on the fact that claimant's right knee extends to within a couple of degrees of full extension. Former OAR 436-35-220(1) and (2). Under former OAR 436-35-230(4)(c), which applies to the rating for meniscectomy, the award of 5 percent based on the February 1983 partial medial meniscectomy is appropriate. Under former OAR 436-35-220(4), 44, the sum of each rating for decreased motion, is then combined with 5, resulting in a value of 46.8 percent.

We find that claimant is entitled to an award of 10 percent due to weakness or atrophy under former OAR 436-35-230(5). Dr. McKillop, an orthopedic surgeon, performed an independent medical examination of claimant in April 1987, and found that claimant suffered from weakness and atrophy of the thigh. (Ex. 98-7,8). We note that an independent medical examination of claimant was performed by Medical Consultants Northwest in May 1988. They found that claimant had a 50 percent loss of use of the right knee for work-related tasks, that his right thigh was smaller than the left, and that his lower extremity strength was adequate. (Ex. 131-4, 5). We do not credit the Consultants' view that claimant's strength was adequate, considering their "loss of use" and thigh findings, and particularly given Dr. McKillop's view that claimant had suffered weakness.

Claimant argues that he is entitled to an additional award for disabling pain. We disagree. Subsequent to the Referee's order, we concluded that in cases where pain is disabling (i.e. where it results in a loss of use or function), we may assign a value under the standards that represents claimant's loss of use or function based upon disabling pain. See Daniel M. Alire, 41 Van Natta 752 (1989); former OAR 436-35-320(1)(a). However, based upon the record in this case, we do not find that claimant's minimal pain resulted in a loss of function beyond that caused by loss of range of motion and weakness and atrophy. Medical reports reflect that claimant's knee pain "bothers him only mildly" (Ex. 131), or not at all. (Ex. 82). Based on claimant's testimony, his pain seems to be related to range of motion (Tr. 21), and weakness. (Tr. 25).

The value for weakness or atrophy, 10, is combined with 46.8 (the combination of the values for lost range of motion and for partial meniscectomy), and the result is 52.3 percent scheduled permanent disability. That disability figure is rounded to the next higher one percent step. Former OAR 436-35-010(6). Claimant's permanent disability under the "standards" is therefore 53 percent.

Denial of Herniated Disc

Claimant argues that Bauman v. SAIF, 295 Or 788 (1983), precludes the insurer from denying his disc herniation. We disagree.

In September 1987 claimant's treating physician, Dr. Berselli, an orthopedic surgeon, related claimant's low back pain to a chronic musculoskeletal strain problem, related to his right knee problem. In a November 1987 stipulation, the insurer agreed that it would rescind its denial and "...accept claimant's present need for low back care as being materially related to claimant's April 14, 1982 right knee injury." Claimant's claim for a herniated disc did not arise until February 1988. Thus, the disc condition had not previously been accepted. Therefore, the insurer was not precluded from issuing a denial of that condition. See Johnson v. Spectra Physics, 303 Or App 49 (1987); Weyerhaeuser Co. v. Warrilow, 96 Or App 34 (1989).

Claimant also argues that his herniated disc condition is related to his compensable right leg condition. He relies on Dr. Berselli who noted that claimant's abnormal gait due to his knee pathology most probably caused a degeneration of the L4-5 disc. However, Berselli unequivocally concluded that a February 1988 lifting incident at claimant's home caused the herniated disc. He did not opine that the herniation was related to the degeneration. Consequently, claimant has failed to prove that his herniated disc condition is causally related to claimant's compensable leg condition. Therefore, we uphold the insurer's denial of the herniated disc condition.

Unscheduled Permanent Disability

In February 1988, claimant experienced increased low back pain following a noncompensable lifting incident that was diagnosed as a herniated lumbar disc. Although claimant experienced low back complaints prior to the February 1988 incident, the record does not establish that he has sustained permanent impairment as a result of his compensable injury. Instead, Dr. Berselli found the cause of claimant's low back and left hip pain to be the uncompensable herniation at L4-5. Therefore, claimant has failed to establish that he suffered any permanent impairment to his low back as a result of the compensable knee injury. Accordingly, we conclude he is not entitled to an award of permanent disability for his low back condition.

ORDER

The Referee's order dated January 26, 1989 is affirmed.

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In the Matter of the Compensation of
**RALPH A. NEELEY, Claimant**
WCB Case No. 88-16694
ORDER ON REVIEW
Vick & Gutzler, Claimant Attorneys
Carrol J. Smith (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

Claimant requests review of Referee Danner's order that: (1) declined to grant permanent total disability; (2) awarded 37 percent (118.4 degrees) unscheduled permanent disability for a low back condition; and (3) awarded 10 percent (15 degrees) scheduled permanent disability for loss of use or function of the left leg and 5 percent (7.5 degrees) scheduled permanent disability for loss of use or function of the right leg, whereas a Determination Order had awarded 36 percent (115.2 degrees) unscheduled permanent disability for a low back condition and 5 percent (7.5 degrees) for loss of use or function of each leg. On review, the issue is permanent total disability, or alternatively, extent of permanent partial disability, scheduled and unscheduled. We affirm in part and modify in part.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact," with the following supplementation. Claimant retains 58 degrees flexion of his thoracolumbar spine. (Ex. 21-8).

CONCLUSIONS OF LAW AND OPINION

Permanent Total Disability

We adopt the Referee's discussion of this issue.

Permanent Partial Disability

A Determination Order dated August 28, 1987 awarded claimant 25 percent unscheduled permanent disability for his low back injury. A second Determination order issued on September 16, 1988, resulting in a total award of 36 percent (115.2 degrees) unscheduled disability and five percent (7.5 degrees) scheduled disability for loss of use or function of each leg.

In this case, the "standards" adopted effective July 1, 1988, (former OAR 436-35-001 et seq), as amended by temporary rules effective August 19, 1988, apply to the rating of claimant's permanent partial disability. Former OAR 436-35-010 through 436-35-260 apply to the rating of scheduled permanent partial disabilities. Former OAR 436-35-010(1). Former OAR 436-35-270 through 436-35-440 apply to the rating of unscheduled permanent partial disabilities. Former OAR 436-35-270(1).

Scheduled Disability

The Referee awarded 10 percent scheduled disability for claimant's left limp, citing former OAR 436-35-230(6)(b)(A). He awarded 5 percent for weakness in the right leg, citing OAR 436-35-230(5)(a). The Evaluation Division had previously awarded 5 percent for each leg, based on sensory changes and disabling pain. (Ex. 18-2).

Former OAR 436-35-230(6)(b)(A) allows a rating for a limp only if it is caused by vascular disease. Claimant does not have vascular disease. Consequently, we cannot value his left limp on this basis. However, because of pain, claimant's "[s]tance and gait are antalgic with a severe limp on the left side." (Ex. 20-2). We conclude that he suffers from disabling pain in his left leg. We find that a 10 percent scheduled award for disabling pain is appropriate. See Michelle Griffith, 40 Van Natta 2086, 2089 (1988), and Daniel M. Alire, 41 Van Natta 752 (1989).

The record does not persuasively establish that claimant suffers permanent disability in his right leg. However, because the SAIF Corporation does not seek a reduction, we do not disturb the 5 percent award.

Unscheduled Disability

The Referee found claimant entitled to 37 percent (118.4 degrees) unscheduled permanent disability for his low back condition. We modify.

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

In the present case, the parties do not dispute the values assigned by the Referee for claimant's age, education and adaptability. We therefore accept those values and discuss only the issue of impairment.

The Referee allowed 2 percent for claimant's loss of flexion in his thoracolumbar spine. However, the most current objective medical findings of claimant's loss of range of motion from his compensable injury are found in Dr. Sears' November 1, 1988 report. Dr. Sears indicated that claimant retains 58 degrees of flexion, rated at 3 percent under former OAR 436-35-360(6). When 3 percent is added to the other spinal range of motion findings, the result is 13 percent. Claimant is also entitled to one percent for his laminectomy without discectomy. Former OAR 436-35-350(2).

Claimant contends that he is entitled to an additional award for disabling pain in his low back which is not taken into account by the values assigned for surgery and lost range of motion. (Tr. 40-48). We agree. See Daniel M. Alire, supra.

Claimant's back pain limits his ability to lift, carry, push, pull, squat, kneel or bend. (Ex. 15-1). His pain is worsened by sitting or standing (Ex. 1), and by walking, bending and stair climbing. (Ex. 15-6). He suffers from pain, which persists for days, following minimal work activities. (Ex. 13-1). In this regard, we note doctors' observations that claimant's pain behavior is very much consistent with his verbal rating of pain. (Exs. 15-5 & 21-6). There is no evidence of malingering, functional overlay, hysteria, somatic preoccupation or secondary gain. (Exs. 15-5 & 21-6). We conclude that claimant has proven entitlement to an additional 20 percent impairment value for disabling pain which is not otherwise accounted for by the "standards."

Claimant's impairment values of 13 percent (for loss of range of motion); 1 percent (for surgery); and 20 percent (for disabling pain) are combined, resulting in a total impairment value of 31.1 percent. Former OAR 436-30-360(11).

Computation of Unscheduled Disability

As we have noted, claimant's education and adaptability values are not disputed. When the sum of the age value and the education value is multiplied by the adaptability factor, the result is 24, as determined by the Referee. This product is added to the impairment value of 31.1. The sum, 55.1, is rounded to the next higher whole number, 56. Former OAR 436-35-280(7). Claimant's total unscheduled disability is 56 percent.

ORDER

The Referee's order dated December 30, 1988 is affirmed in part and modified in part. In addition to the Referee's increased award giving a total award of 37 percent (118.4 degrees) unscheduled disability, we award 19 percent (60.8 degrees), for a total award to date of 56 percent (179.2 degrees) unscheduled permanent disability. The remainder of the Referee's order is affirmed. Claimant's attorney is awarded 25 percent of the increased compensation created by this order. However, the total fee awarded by the Referee's order and this order shall not exceed $3,800.

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July 26, 1990 Cite as 42 Van Natta 1640 (1990)

In the Matter of the Compensation of
**PAMELA A. PERRY, Claimant**
WCB Case No. 88-20836
ORDER ON REVIEW
Cynthia Cumfer, Claimant Attorney
Chelsea Mohnike (Saif), Defense Attorney

Reviewed by Board Members Nichols and Brittingham.

Claimant requests review of those portions of Referee Knapp's order that affirmed a Determination Order which: (1) awarded 5 percent (1.2 degrees) scheduled permanent disability for loss of use or function of the right index finger; and (2) awarded no unscheduled permanent disability for a neck and mid back condition. On review, the issue is extent of both scheduled and unscheduled permanent partial disability. We modify in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" with the following exceptions. A Determination Order issued November 25, 1988, not 1985 as the Referee found.

The Referee found that claimant is limited to 15 minute counseling sessions, whereas she formerly conducted 45 minute sessions. We, instead, find that claimant is now limited to 50 minute counseling sessions, whereas she formally conducted 60 minute sessions. In addition, we supplement with the following findings.

Claimant suffers from disabling pain of the neck and mid back which restricts her ability to work. Claimant experiences pain on a daily basis which affects her concentration. She has increased symptoms with prolonged sitting and standing. She is unable to lift more than 25 pounds.

Claimant was medically stationary as of September 29, 1988.

FINDINGS OF ULTIMATE FACT

Claimant has sustained a 14 percent loss of use or function of her right index finger as a result of her compensable injury.

Claimant has sustained a 5 percent loss of earning capacity as a result of her compensable neck and mid back injuries.

CONCLUSIONS OF LAW AND OPINION

Here, claimant was medically stationary as of September 29, 1988, and the Determination Order issued November 25, 1988. The Referee correctly noted that if a claimant became medically stationary after January 1, 1988 and his or her claim was closed on or after July 1, 1988, a subsequent determination by a referee or the Board of the claimant's permanent partial disability must be made pursuant to ORS 656.283(7) and 656.295(5), respectively. OAR 438-10-005 and Michelle Griffith, 40 Van Natta 2086 (1988).

For purposes of determining injury-related permanent partial disability, ORS 656.283(7) and 656.295(5) require application of the standards for the evaluation of disabilities adopted by the director pursuant to ORS 656.726(3)(f)(A). The Referee further noted that those "standards" in effect on the date of the Determination Order from which the hearing was requested control the evaluation of permanent partial disability. OAR 438-10-010. However, the Referee did not specify which "standards" he was applying.

As the Determination Order in this case issued November 25, 1988, the "standards" adopted effective July 1, 1988, (former OAR 436-35-001 et seq), as amended by temporary rules effective August 19, 1988, apply to the rating of claimant's permanent partial disability. Former OAR 436-35-010 through 436-35-260 apply to the rating of scheduled permanent partial disabilities. Former OAR 436-35-010(1). Former OAR 436-35-270 through 436-35-440 apply to the rating of unscheduled permanent partial disabilities. Former OAR 436-35-270(1). Therefore, on review, these are the standards which we apply.

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

Scheduled Disability

The Referee affirmed the Determination Order award of 5 percent for loss of use or function of the right index finger. On review, claimant alleges that

she is entitled to an increased award for loss of sensation of the right index finger. We agree claimant is entitled to more than a 5 percent award.

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

As a consequence of her compensable unscheduled cervicothoracic impairment, claimant has some loss of sensation of her right index finger. Claimant alleges that her finger is completely numb from the top of the finger to the knuckle. However, there is no medical evidence supporting that degree of loss. Rather, the reports of Dr. Leopold, claimant's treating osteopathic physician, and two independent medical examinations indicate that claimant has sustained only a decrease to pinprick sensation in the radial side of the proximal phalanx of the right index finger. The appropriate value for this partial loss of sensation of the index finger is 14 percent. Former OAR 436-35-110(1)(a). There is no other impairment of the index finger.

Accordingly, we conclude that claimant has demonstrated a 14 percent loss of use or function of her right index finger.

Unscheduled Disability

The Referee found that claimant had not established permanent back and neck impairment. Specifically, he found that claimant did not have pain that was related to her work injury which resulted in loss of use or function. We disagree.

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

Impairment

Relying on an impairment rating submitted by Dr. Leopold, claimant argues that she should be awarded 10 percent disability for her thoracic spine impairment, and 35 percent disability for her neck impairment. The essence of claimant's argument is that she is entitled to an award for lost earning capacity as a result of disabling pain. In that regard, claimant contends that the standards do not allow a value for pain resulting in loss of earning capacity, so that they are inconsistent with ORS 656.214(5). We disagree.

Former OAR 436-35-010(2)(a) provides that pain can result in loss of use or function. When it does, it is rated based on the loss of use or function which results and no additional value is allowed for pain alone. The Board in Daniel M. Alire, 41 Van Natta 752 (1989) held that, inasmuch as the standards do not provide for a value range for impairment attributable to disabling pain, the Board on de novo review can consider the evidence and award the claimant a value that adequately compensates her for her loss of use or function attributable to disabling pain.

We proceed to the rating of claimant's impairment. 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, there are such reasons not to defer to the opinion of Dr. Leopold. The doctor's rating was based in part on claimant's residual index finger impairment, and we already have rated that impairment separately under the applicable scheduled disability standards. Further, Dr. Leopold does not have equal expertise in rating disability as compared to the Western Medical Consultants and Dr. Pasquesi.

Finally, Dr. Leopold's findings of impairment are inconsistent with the other medical opinions contained in the record. The record documents, and claimant does not allege otherwise, that she has full range of neck and shoulder motion and normal grip strength of the upper extremities. Cervical and thoracic myelograms were negative. The objective findings establish that claimant has only mild impairment which is primarily related to her preexisting, noncompensable obesity and underlying arthritis.

Accordingly, in this case, we defer to the medical opinions of the Western Medical Consultants and Dr. Pasquesi which are both well-reasoned and based on complete information. Somers v. SAIF, 77 Or App 259, 262 (1986); see Hammons v. Perini Corp., 43 Or App 299, 302 (1979). They found that claimant has sustained mild impairment as a result of her injury.

Based on their opinions and claimant's testimony, we are persuaded that claimant has sustained mild impairment in her neck, shoulders, and mid back attributable to disabling pain. Specifically, claimant experiences pain on a daily basis and continues to take pain medication. She is unable to lift more than 25 pounds and has increased symptoms with prolonged sitting and standing. This pain limits the length of claimant's regular counseling sessions. We consider a value of 5 percent for disabling pain in this particular case to be reasonable. This represents claimant's total unscheduled impairment value.

Age, Education, Adaptability

Claimant has returned to her at-injury job. For workers who have returned to their usual and customary work, the factors of age, education, and adaptability shall be given no value. Former OAR 436-35-290(2)(b); former OAR 436-35-300(2)(b); and former OAR 436-35-310(2)(b). Claimant contends that the cited administrative rules are contradictory to ORS 656.214(5), which predicates rating of permanent partial disability on loss of earning capacity, and therefore, are invalid. Claimant argues that the statute requires an award for lost earning capacity in the broad field of general occupations, as well as the job at injury. We do not find claimant's argument to be persuasive.

Either party may establish that the record, as a whole, constitutes clear and convincing evidence that the degree of permanent partial disability suffered by the claimant is more or less than the entitlement indicated by the "standards." ORS 656.283(7) and 656.295(5). Under certain circumstances, these provisions may authorize an award outside the standards where a claimant returns to the job at injury but is less able to compete in the general labor market.

We conclude, therefore, that the age, education and adaptability standards cited above are valid, and we apply them in this case. Accordingly, the appropriate value for claimant's age, education, and adaptability is 0.

Computation of Unscheduled Disability

Having determined each value necessary to compute claimant's permanent disability under the "standards," we proceed to that calculation. As discussed above, claimant is not entitled to a value for age, education and adaptability. Therefore, she is entitled to an award based solely on her 5 percent impairment value. Accordingly, claimant has 5 percent unscheduled permanent disability under the standards. Former OAR 436-35-280(7).

Disability Outside the Standards

As discussed above, claimant contends that her loss of earning capacity, as measured by her ability to obtain and hold gainful employment in the general labor market, is greater than that provided for under a strict application of the standards. Claimant asserts, and the record establishes, that claimant is limited from performing her prior work in a factory and as a waitress, as well as other jobs in the general labor market that require the ability to lift greater than 25 pounds and to walk and stand for prolonged periods of time.

However, we have already considered these limitations in assigning claimant a value of 5 percent under the standards for disabling pain. To be clear and convincing, evidence must establish that the truth of the asserted fact is "highly probable." Riley Hill General Contractor, Inc. v. Tandy Corp., 303 Or 390, 402 (1987). On this record, we do not find that claimant has proven by clear and convincing evidence that she suffers permanent disability greater than that awarded under the standards.

ORDER

The Referee's order dated March 22, 1989 is reversed in part, modified in part and affirmed in part. Claimant is awarded 5 percent (16 degrees) unscheduled permanent disability for her neck and mid back conditions. In addition to the Referee's award of 5 percent (1.2 degrees) scheduled permanent disability, claimant is awarded 9 percent (2.16 degrees), for a total award of 14 percent (3.36 degrees) scheduled permanent disability for loss of use or function of the right index finger. Claimant's attorney is awarded an approved fee of 25 percent of the increased disability compensation awarded by this order, not to exceed $3,800, payable directly to claimant's attorney. The remainder of the order is affirmed.

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July 26, 1990 Cite as 42 Van Natta 1644 (1990)

In the Matter of the Compensation of
**QUIRT E. RISLEY, Claimant**
WCB Case No. 89-01087
ORDER ON REVIEW
Vick & Gutzler, Claimant Attorneys
Tom Dzieman (Saif), Defense Attorney

Reviewed by Board Members Brittingham and Nichols.

Claimant requests review of that portion of Referee Brown's order that upheld the SAIF Corporation's denial of claimant's injury/occupational disease claim for his low back condition. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

ULTIMATE FINDINGS OF FACT

We adopt the Referee's ultimate findings of fact.

CONCLUSIONS OF LAW AND OPINION

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

The Referee found that claimant had failed to prove that his condition was either the result of an occupational disease or an injury. Under either theory claimant's burden is to prove by a preponderance of the evidence that his low back condition arose out of and in the course of his employment, and that his alleged work-related injury or work exposure was the material contributing cause to his need for treatment or resulting disability. See ORS 656.005(7)(a); 656.802(1)(c); Donna E. Aschbacher, 41 Van Natta 1242 (1989).

We agree with the Referee that the record is devoid of any evidence which would suggest that claimant's low back condition is the result of an occupational disease. Accordingly, we find that claimant has failed to establish that his low back condition is compensable as an occupational disease.

Therefore, claimant must prove that his alleged work injury in early February 1988 was the material contributing factor to his low back symptoms and need for treatment. We find that claimant has failed to meet his burden. The hospital emergency room, where claimant was seen on February 10, 1988, attributes claimant's low back pain to his splitting wood the night before. Claimant did not seek medical treatment again for his low back symptoms until October 8, 1988, at which time he was examined by Dr. Srch, chiropractor. Dr. Srch did not render an opinion as to the causation of claimant's low back condition other than a "check-the-box" response on the First Medical Report. We find this opinion is conclusory and without any explanation. Marshall v. Boise Cascade, 82 Or App 130, 133 (1986). Additionally, we have adopted the Referee's finding that claimant was not a credible witness; therefore, we are unable to rely on claimant's testimony to establish the causation of his low back condition. Accordingly, we find that claimant has failed to prove that his work was a material contributing factor to his need for treatment or resulting disability.

ORDER

The Referee's order dated April 26, 1989 is affirmed.

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July 26, 1990 Cite as 42 Van Natta 1645 (1990)

In the Matter of the Compensation of the Beneficiaries of
**DONALD E. THOMAS, (Deceased), Claimant**
WCB Case Nos. 87-17184 & 88-02638
ORDER ON REVIEW
Brown & Tarlow, Claimant Attorneys
John Motley (Saif), Defense Attorney
Gary G. Jones, Attorney

Reviewed by Board Members Howell and Speer.

The SAIF Corporation, on behalf of A-1 Sandblasting and Steam Cleaning Co. (A-1), requests review of those portions of Referee Michael Johnson's order which: (1) found it responsible for claimant's widow's benefits; and (2) upheld SAIF's denial of the same claim on behalf of Ross Bros. Construction Co. (Ross). SAIF, in its brief on behalf of Ross (Oregon), contends that claimant was not an

Oregon subject worker and that claimant's claim is not compensable in Oregon. Alternatively, if compensable in Oregon, SAIF, on behalf of Ross (Oregon), raises the issues of interim compensation and penalties and attorney fees. On review, the issues are compensability, responsibility, interim compensation and penalties and attorney fees. We vacate the Referee's order.

## FINDINGS OF FACT

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

Paragraph 6 should read that Ross was incurring penalties at the rate of $500 per day.

An employee of Ross accompanied claimant and another crew member, Sid Cornett Jr., normally an A-1 employee, to California. Sid Cornett Jr. was responsible for frequent contact with Ross in Oregon to report on the progress of the job.

## ULTIMATE FINDINGS OF FACT

Claimant's status on the date of his fatal injury was that of a loaned employee.

Claimant was a California worker on the date of his fatal injury.

## CONCLUSIONS OF LAW AND OPINION

### Responsibility

The Referee found that claimant was an employee of A-1. We disagree. We conclude that claimant was employed by Ross and that his employment arrangement was that of a loaned-servant.

Under the loaned-servant doctrine, when a general employer lends an employee to a special employer, the special employer becomes liable for workers' compensation only if:

"(a) the employee has made a contract of hire, express or implied, with the special employer;

(b) the work being done is essentially that of the special employer; and

(c) the special employer has the right to control the details of the work." 1C Larson, Workmen's Compensation Law 8-317, 48.00; see also Newport Seafood v. Shine, 71 Or App 119, 124 (1984).

Here, claimant understood that A-1 did not have a license to do the work in California and, because of that, he would have to fill out a W-4 form and be put on Ross' payroll. Claimant was paid by Ross and withholdings from his check were made and paid to Ross' California workers' compensation insurer in order to provide California workers' compensation coverage for him. Both claimant and Ross understood that claimant would be working for Ross in California. Both consented to that arrangement. We conclude that claimant and Ross entered into an implied employment contract.

Claimant was in California to do the sanding and painting portion of a bridge refurbishing job that Ross had contracted. At the time, Ross was late in

performing the contract and was incurring penalties at the rate of $500 per day. A-1 could not legally work on that job in California. The work being done by claimant was entirely that of Ross, the special employer.

Finally, Ross had the right to control the work performed by claimant. The specifications of the job were provided to the painting crew by Ross. One of the crew, Sid Cornett Jr., frequently checked with Ross in Oregon about the progress of the job. An employee of Ross accompanied the painters to California "to make sure that they were working and not sitting on their butt[s]."

For the above-mentioned reasons, we conclude that the three-part test has been met and that claimant was a loaned servant, in the employ of the special employer, Ross. Accordingly, Ross is liable for claimant's workers' compensation coverage.

Because we have concluded that claimant was in the employ of Ross, we must address the issue of whether he was an employee of Ross, Oregon or Ross, California. It is undisputed that claimant was an Oregon resident who entered into an employment agreement with Ross, while he was physically in Oregon, to sandblast and paint a bridge exclusively in California. He did not perform any work in Oregon for Ross before going to California and there was no expectation that he would perform any work in Oregon for this employer after he returned to Oregon. Claimant died while he was in California. We conclude that, under Oregon law, claimant was a California worker at the time of his death.

In order to receive Oregon workers' compensation benefits for an injury sustained in another jurisdiction, a worker must be employed in Oregon and become injured while temporarily out of Oregon incidental to the Oregon employment. ORS 656.126(1). Mere residence in Oregon is insufficient to make a worker an Oregon employee for the purposes of Workers' Compensation Law. Hollingsworth v. May Trucking, 59 Or App 531, 535 (1982).

The Board has previously held that to be an Oregon worker, subject to Oregon Workers' Compensation Law, out-of-state work must be incidental to work performed in Oregon for an Oregon employer and there must be proof of "an established employment relationship between [the worker] and this employer in Oregon before the out of state injury occurs." Steven A. Dancer, 40 Van Natta 1750 (1988), citing Daryl W. Hugulet, 37 Van Natta 1518, 1520 (1985). (Emphasis in original).

Here, as in Dancer, there was no established employment relationship between claimant and Ross in Oregon. Because claimant was never employed by Ross in Oregon and because no such employment was contemplated, his work for this employer in California was not incidental to Oregon employment. ORS 656.126(1) does not apply and claimant was not a subject worker under Oregon Workers' Compensation Law.

Because we have found that Oregon Workers' Compensation Law does not apply, and this claim should be pursued in California, we do not reach other issues.

## ORDER

The Referee's order dated April 6, 1989 is vacated. That portion which found A-1 responsible is reversed. The SAIF Corporation's denial on behalf of A-1 is reinstated and upheld. Claimant's remedy, if any, is under the workers' compensation laws of the State of California.

In the Matter of the Compensation of
**BOBBY G. TODD, Claimant**
WCB Case No. 88-20499
ORDER ON REVIEW
Kate Waldo (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

Claimant, pro se, requests review of Referee Podnar's order that: (1) found that his claim was not prematurely closed; and (2) declined to award permanent partial disability for his low back injury. In his brief, claimant requests remand for the taking of additional medical evidence. On review, the issues are remand, premature closure and permanent partial disability. We affirm.

FINDINGS OF FACT

The Board adopts the Referee's "Findings".

CONCLUSIONS OF LAW AND OPINION

The Board adopts the Referee's "Conclusions" with the following supplementation.

Remand

Claimant has requested remand for the taking of additional expert medical evidence. The Board may remand a case to the Referee if it determines that the record has been improperly, incompletely or otherwise insufficiently developed. ORS 656.295(5).

Claimant requests remand alleging that his attorney failed to inform him of evidence presented at hearing that adversely affected the outcome. With regard to this allegation, claimant has neither presented nor referred us to any evidence to support his contention that he was not properly represented. In addition, claimant has not shown that the record was improperly or incompletely developed. Accordingly, we decline to grant claimant's motion for remand.

Premature closure

The Referee found that claimant had not established that his claim was prematurely closed. We agree and we base our conclusion on the following reasoning.

ORS 656.005(17) provides that "medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. In order for claimant to establish that his claim was prematurely closed, he must prove that he was not medically stationary at the time the Determination Order issued on December 2, 1988.

In September 1988, Dr. Thomas, one of claimant's treating physicians, opined that claimant had a lumbosacral strain, and he placed him on a course of physical therapy and muscle relaxants. On October 10, 1988, on Dr. Thomas' referral, claimant was examined by Dr. Platt, M.D. Dr. Platt reported that claimant was taking medication as prescribed by Dr. Thomas. Claimant reported numerous complaints, including headache, chest pain, tinnitus, leg and back pain.

Dr. Platt diagnosed a history of left lumbar and dorsal strain and he reported multiple widespread symptoms without definite neurologic abnormalities.

He opined that claimant had probably developed a serious psychological interference with physical recovery that would make return to work efforts difficult.

Dr. Platt recommended follow-up with Dr. Thomas and he suggested that claimant might benefit from a brief course of physical therapy to learn home exercise for his upper and lower back areas. Dr. Platt reported that continued anti-inflammatory therapy for a time might be helpful, but he would not recommend it for any length of time.

On October 13, 1988, Dr. Thomas reported that he did not think there were any objective findings from claimant's examination.

On October 20, 1988, Dr. Thomas wrote that, in his opinion, claimant could work. He stated that he did not feel that claimant's on-the-job injury was significant. He also reported that, from an orthopedic viewpoint, claimant could return to work.

On October 26, 1988, Dr. Zimmerman, neurologist, reported that claimant's examination was totally normal. He planned to obtain electrical tests to provide further objective evaluation.

We do not agree that a need for further testing is indicative that claimant has not reached medically stationary status. See Edward L. Bateson, 42 Van Natta 439 (1990). (Suggested further CT scan and MRI testing, in and of itself, does not indicate that claimant is not medically stationary.) Additionally, we do not find that a recommendation of physical therapy necessarily renders a Determination Order premature. See e.g. William E. Hamilton, 41 Van Natta 2195 (1989). (Participation in a work hardening program does not necessarily indicate that further improvement could reasonably be expected.)

Claimant has failed to show that he was not medically stationary at the time of the December 2, 1988 Determination Order.

Unscheduled permanent disability

We agree with the Referee's conclusion that claimant has not shown that he is entitled to unscheduled disability.

Former OAR 436-35-280(1) provides:

> "There shall be no unscheduled disability if the injury did not result in impairment."

None of claimant's doctors, including his treating doctor, have opined that claimant is permanently impaired. In addition, we have found no evidence in the record of permanent impairment, therefore, the extent of permanent disability cannot be rated.

ORDER

The Referee's order dated March 13, 1989 is affirmed.

In the Matter of the Compensation of
**RALPH G. ALTON, Claimant**
WCB Case Nos. 89-02652, 89-02650, 88-19447, 88-19446 & 88-19445
ORDER ON REVIEW
Bennett & Durham, Claimant Attorneys
Nelson, et al., Defense Attorneys
Waggoner, et al., Defense Attorneys
David O. Horne, Defense Attorney
Jerome Larkin (Saif), Defense Attorney
Roberts, et al., Defense Attorneys

Reviewed by Board Members Speer and Howell.

The SAIF Corporation (Portland Wire) requests review of that portion of Referee Mills' order that assessed it attorney fees although another insurer was found to be responsible for claimant's condition. Alternatively, SAIF contends that the award of attorney fees is excessive. In his brief, claimant requests that the attorney fee award be increased. On review, the issue is attorney fees. 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 and Opinion," with the following supplementation. The Referee concluded that SAIF (Portland Wire) had placed claimant's compensability at issue when it contended that the claim was not timely. We agree. At hearing, SAIF placed claimant's compensation at risk and the Referee correctly assessed attorney fees on that basis.

Claimant contends that his counsel is entitled to an attorney fee for services on review. Inasmuch as attorney fees are not "compensation" within the meaning of ORS 656.382(2), claimant is not entitled to an attorney fee for successfully defending that award on review. Dotson v. Bohemia, Inc., 80 Or App 233 (1986); Saxton v. SAIF, 80 Or App 631 (1986).

ORDER

The Referee's order dated April 21, 1989 is affirmed.

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In the Matter of the Compensation of
**ANTONIO A. GUTIERREZ, Claimant**
WCB Case No. 88-12699
ORDER ON REVIEW (REMANDING)
Ralph M. Yenne, Claimant Attorney
Thomas Ewing, Assistant Attorney General

Reviewed by Board Members Cushing and Gerner.

Claimant requests review of Referee Daughtry's order that dismissed his request for hearing as premature. On review, the issue is the propriety of the dismissal. We remand.

FINDINGS OF FACT

Claimant compensably injured his right thumb on October 6, 1987, while working in the Industries program at the Oregon State Penitentiary. He filed a claim for that injury with the Department of Justice, Inmate Injury Fund. The

Fund accepted claimant's injury claim in November 1987 as a nondisabling injury and closed the claim without compensation or award. (Ex. A).

On July 19, 1988, claimant wrote a letter to the Department of Justice, indicating that it was his understanding that his injury claim had been closed. Claimant also noted that he was still seeking medical treatment for his thumb. The Department referred the letter to the Hearings Division, suggesting that the letter constituted a request for hearing.

The request for hearing was acknowledged by the Workers' Compensation Board on July 21, 1988. Pursuant to OAR 438-06-020, a telephone conference was scheduled for August 22, 1988. Claimant requested a postponement of the teleconference, as he was scheduled for thumb surgery on August 10, 1988.

On August 23, 1988, the Department moved to dismiss claimant's request for hearing as premature, citing ORS 655.520(2) and 655.515(1). Finding the reasons and grounds for the motion to be well-founded, the Referee dismissed claimant's request for hearing as premature. Claimant requested review of the Referee's Order of Dismissal.

## CONCLUSIONS OF LAW AND OPINION

Relying on ORS 655.515(1) and 655.520(2), the Referee dismissed claimant's request for hearing as premature. We disagree.

ORS 655.515 provides that "[n]o 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."

ORS 655.520(2) provides that, "[u]pon release of the inmate from confinement, the department shall reaffirm or modify its initial award in a manner appropriate to the condition of the inmate upon release."

Neither of these two statutes directly address claimant's request for hearing on the issue of whether or not his claim is disabling or nondisabling.

An inmate or the beneficiary of the inmate may obtain review of an action taken on the claim as provided in ORS 656.283 to 656.304. ORS 655.525. Here, in response to the Fund's acceptance of his claim as nondisabling and the closure of his claim, claimant requested a hearing.

Since claimant was seeking review of an action taken on his claim, he is entitled to be heard. ORS 655.525; see Robert S. Waterston, 41 Van Natta 2025, 2284 (1989). Therefore, in light of these facts, the Board concludes that the dismissal was improper.

We may remand to the Referee should we find that the record has been "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(5). Under the circumstances of this case, we conclude that remand is the appropriate action.

## ORDER

The Referee's order dated April 25, 1989, is vacated. This case is remanded to the Presiding Referee to assign to a Referee with instructions to schedule and convene a hearing concerning any and all matters raised by claimant's hearing request or any supplemental hearing requests.

In the Matter of the Compensation of
**KAREN E. SCHREITER-KOPACH, Claimant**
WCB Case No. 89-01068
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
Stafford J. Hazelett, Defense Attorney

Reviewed by Board Members Cushing and Myers.

The insurer requests review of Referee Hoguet's order which: (1) found that claimant's left thumb injury claim was not time-barred; (2) set aside its denial of claimant's medical services claim for treatment of her current left thumb condition; and (3) assessed a penalty and related attorney fee for an alleged unreasonable denial. On review, the issues are timeliness, medical services and penalties and attorney fees. We affirm.

## FINDINGS OF FACT

The Board adopts the Referee's Findings of Fact as our own, with the following supplementation.

Claimant's November 30, 1984 compensable injury is a material contributing cause of her current need for treatment of her left thumb.

## CONCLUSIONS OF LAW AND OPINION

### Untimely Notice

After finding that claimant's claim was for a "new injury," that the insurer had knowledge of claimant's left thumb injury, and finding no basis for prejudice, the Referee concluded that claimant's current claim was not time-barred. We agree that claimant's claim is not time-barred, but apply different reasoning.

The insurer argues that claimant's current claim is time- barred under ORS 656.265, contending that it did not receive notice of a left thumb injury until December 1988, thereby establishing prejudice. We disagree.

ORS 656.265 provides that,

> "(1) Notice of an accident resulting in injury . . . shall be given immediately by the worker . . . but not later than 30 days after the accident. . . .
>
> "(4) Failure to give notice as required by this subsection bars a claim under ORS 656.001 to 656.794 unless:
>
> "(a) the employer had knowledge of the injury . . . or the insurer . . . has not been prejudiced by failure to receive the notice. . . ." (emphasis added).

Here, the employer had notice of the accident immediately. Nothing in this statute requires notice of the particular injuries caused by the accident. It only requires notice of the accident itself.

Therefore, we conclude that claimant's current left thumb claim is not time-barred under ORS 656.265.

Compensability of Current Medical Services

Claimant contends that her current left thumb condition is a compensable consequence of her November 1984 compensable injury. We agree.

Claimant has an accepted claim for an industrial injury. It is well settled that the employer is liable for the natural consequences flowing from a compensable injury. Williams v. Gates McDonald & Co., 300 Or 278, 281 (1985); Pattitucci v. Boise Cascade Corp., 8 Or App 503, 507-08 (1972); Randolph P. Gaul, 42 Van Natta 592 (1990).

The only medical evidence in the record is that of claimant's treating physician, Dr. Isaacson. Isaacson treated claimant's thumb condition from 1983, when claimant suffered a noncompensable laceration to the bone of her left thumb, until the present.

The record establishes that on November 1984, while working as a security guard, claimant injured her head and left hand while attempting to apprehend a suspect. As a result of this incident, claimant's left thumb, which was healing from the initial noncompensable fusion surgery, suffered a contusion and was sprained, causing a delay in the union of the fusion. (Ex. 18). This delay in the union of the fusion caused the necessity for the second fusion performed on claimant's thumb in 1985. The compensability of this second fusion surgery is not at issue.

Finally, as a direct result of both fusion surgeries, claimant developed a bone spur at the interphalangeal joint fusion of the left thumb which required surgical removal. It is this surgical bone spur procedure and medical treatment that claimant contends is a compensable consequence of the November 1984 compensable injury. We agree.

In January 1989, Isaacson opined that claimant's November 30, 1984 left thumb injury materially worsened claimant's preexisting left thumb condition and caused the necessity for the second fusion surgery. (Ex. 18). Isaacson noted that claimant then developed a spur at the interphalangeal joint fusion of the thumb and that the spur was the reason for the most current surgery.

There is no evidence in the record, medical or lay, which contradicts Isaacson's opinion regarding the causal relationship between the November 1984 compensable injury and claimant's current thumb condition. Therefore, claimant has met her burden of proving that her compensable 1984 industrial injury is a material cause of her current condition.

Penalties and Attorney Fees - Unreasonable Denial

The Board adopts the Referee's Conclusions of Law, as set forth in the "Opinion" portion of the order, with respect to the issue of "Unreasonable denial."

ORDER

The Referee's order dated April 26, 1989, is affirmed. For services on Board review concerning the medical services claim, claimant's attorney is awarded a reasonable assessed fee of $650, payable by the insurer.

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

Claimant has requested reconsideration of our April 10, 1990 Order on Review that affirmed awards by Determination Order of scheduled and unscheduled disability for a head injury. In order to allow the SAIF Corporation sufficient time to respond to claimant's motion, we abated our order. Having received SAIF's response to claimant's motion, we now proceed to our review.

FINDINGS OF FACT

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

Claimant's condition as of the date of hearing was unchanged from his condition as of claim reopening in December 1987. As of the date of hearing, claimant continued to work in modified employment as a log loader operator.

CONCLUSIONS OF LAW AND OPINION

Claimant requested hearings from a July 1, 1987 Determination Order and a July 25, 1988 Determination Order. The July 1988 Determination Order resulted from a reopening of claimant's claim in December 1987. Those hearing requests were consolidated. At the September 9, 1988 hearing, claimant indicated that he wished to pursue only his appeal of the July 1987 Determination Order. The Referee heard and admitted evidence pertaining to claimant's condition as it existed prior to claim reopening in December 1987.

In our April 10, 1990 Order on Review, we stated that claimant's disability must be rated at the time of hearing. That fact, coupled with former OAR 438-10-005 (temp.), required application of the "standards" for evaluation of claimant's disability. We found, however, that claimant had failed to present evidence concerning his condition as it existed at the time of the hearing. Therefore, we concluded that claimant had failed to establish entitlement under the "standards" to a greater award of permanent disability than previously awarded.

On reconsideration, claimant asserts that we should remand his case for further evidence-taking on his condition as of the date of hearing. Alternatively, claimant argues that the record establishes that his condition at the time of hearing was unchanged from his condition as of December 1987. Consequently, claimant contends that the record contains sufficient evidence to rate his disability at the time of hearing under the "standards." SAIF agrees that the record is sufficiently developed to evaluate claimant's disability at hearing under the "standards." We agree. We proceed with that evaluation.

Unscheduled Disability

In this case, the "standards" adopted effective July 1, 1988, former OAR 436-35-001 et seq, apply to the rating of claimant's permanent partial disability. Former OAR 436-35-270 through 436-35-440 apply to the rating of unscheduled permanent partial disabilities. Former OAR 436-35-270(1).

The determination of unscheduled permanent disability under the "standards" is made by determining the appropriate values assigned by the

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

Age

The appropriate value for claimant's age of 28 years is 0. Former OAR 436-35-290.

Education

The appropriate value for claimant's 12 years of formal education is 0. Former OAR 436-35-300(3). Claimant's highest SVP during the ten years prior to the date of injury was 3, as a faller (DOT # 454.684-014). Therefore, the appropriate value for skills is 3. Former OAR 436-35-300(4). Claimant has no documented training. Therefore, the appropriate value for training is 1. Former OAR 436-35-300(5). Claimant's total education value is 4, the formal education value plus the skills value plus the value for training. Former OAR 436-35-300(6).

Adaptability

An adaptability value for a claimant who is unable to return to his or her usual and customary work [See former OAR 436-35-270(3)(a)] but who has returned to modified work is determined from a matrix of values at former OAR 436-35-310(3)(a). That matrix compares the physical capacity of the claimant's usual and customary work with the physical capacity required by the modified work. This is true even though claimant may have the physical capacity to do heavier work than is required by the modified employment. Physical capacities are not defined by the "standards" generally. We utilize those definitions contained in former OAR 436-35-310(4)(a)-(d).

In this case, claimant's usual and customary work required the physical capacity to do heavy work. Claimant's modified work involved operating a log loader. The Evaluation Section, apparently concluding that operation of a log loader required a physical capacity between medium and heavy, assigned a value of 1.5. SAIF agrees that 1.5 is the appropriate value. Claimant has not objected to this figure. Therefore, the adaptability value which we use is 1.5. Former OAR 436-35-310(3)(a).

Impairment

As a result of his skull fracture, claimant has experienced permanent damage to the brain. This damage is manifested by a minor loss of cognitive skills including diminished math, reading and comprehension skills. In addition, claimant's long-term memory abilities have been reduced. The criteria to be used in rating the impairment resulting from permanent organic brain damage are found at former OAR 436-35-395. Pursuant to that rule, organic brain damage is subdivided into four "classes" depending upon the degree of interference with daily living activities which results from that damage. Here, claimant is able to carry out most of the activities of daily living as well as before the injury. Accordingly, claimant's impairment is properly placed in the Class 1 rating. Given the degree of claimant's reduced cognitive abilities, we assign an impairment value within Class 1 of 15 percent.

Computation of Unscheduled Disability

Having determined each value necessary to compute claimant's unscheduled permanent disability under the "standards," we proceed to that calculation. When claimant's age value, 0, is added to his education value, 4, the sum is 4. When that value is multiplied by claimant's adaptability value, 1.5, the product is 6. When that value is added to claimant's impairment value, 15, the result is 21 percent unscheduled permanent partial disability. Former OAR 436-35-280(7). Claimant's unscheduled permanent disability under the "standards" is, therefore, 21 percent.

Neither party contends, nor does the record support a finding that claimant's permanent unscheduled disability is more or less than the value provided for by application of the "standards." See ORS 656.283(7). Considering claimant's prior awards totalling 21 percent unscheduled permanent disability, we find him entitled to no additional unscheduled award.

Scheduled Disability

Right leg

Former OAR 436-35-010 through 436-35-260 apply to the rating of scheduled permanent partial disabilities. Former OAR 436-35-010(1). Claimant is entitled to an award based upon recognized impairment values for permanent loss of use of his right leg.

Claimant's sole ratable impairment under the "standards" for his right lower extremity results from loss of sensation. In this regard, claimant has full range of motion and experiences no disabling pain. However, he has a partial loss of plantar sensation in the foot area. Exs. 12, 21. He is entitled to a value of 5 percent for this loss. Former OAR 436-35-200(1). Accordingly, claimant's permanent scheduled disability under the "standards" is 5 percent.

Either party may establish that the record, as a whole, constitutes clear and convincing evidence that the degree of permanent partial disability suffered by the claimant is more or less than the entitlement indicated by the "standards." ORS 656.283(7) and 656.295(5).

In addition to ratable loss of sensation in his right foot, claimant also suffers from a loss of position sense in his right leg, i.e., claimant is unable to determine the positioning of his right leg without actually looking at his leg. This loss of position sense makes it more difficult for claimant to climb, walk on uneven ground, and perform other similar activities. Moreover, claimant is prone to stumble over objects in his path. This unrebutted loss of position sense is not addressed by the "standards." Viewing the record as a whole, we conclude that claimant has established by clear and convincing evidence that his permanent scheduled right leg disability exceeds that arrived at by application of the "standards." We conclude that claimant is entitled to a total award of 20 percent scheduled disability for loss of use or function of his right leg. ORS 656.295(5); see Riley Hill General Contactor Inc. v. Tandy Corp., 303 Or 390, 407 (1987).

Right Arm

Claimant's sole ratable impairment under the "standards" for his right upper extremity results from loss of sensation in his right hand. Former OAR 436-35-110. We are persuaded in this regard that claimant has retained less than normal but more than protective sensation. Ex. 21. Accordingly, he is entitled to the following values for the fingers of his right hand: thumb - 16

percent; index finger - 24 percent; middle finger - 26 percent; ring finger - 27 percent; and little finger - 43 percent. When these values are converted to hand values and combined, in accordance with former OAR 436-35-120(4), a value of 20.2 percent of the hand is obtained. Former OAR 436-35-070. That value is rounded to the next higher whole percentage, or 21 percent of the hand. Former OAR 436-35-010(6). This impairment is equivalent to 16 percent of the arm. Former OAR 436-35-090.

Again, either party may establish that the record, as a whole, constitutes clear and convincing evidence that the degree of permanent partial disability suffered by the claimant is more or less than the entitlement indicated by the "standards." ORS 656.283(7) and 656.295(5).

In addition to ratable loss of sensation in his right hand, claimant also suffers from lessened manual dexterity of his right hand and a loss of position sense in his right arm, i.e. claimant is unable to determine the positioning of his right arm without actually looking at his arm. This loss of position sense makes it more difficult for claimant to use his right upper extremity to perform activities involving grasping and manipulating objects. This unrebutted loss of manual dexterity and position sense is not addressed by the "standards." Viewing the record as a whole, we conclude that claimant has established by clear and convincing evidence that his permanent scheduled right arm disability exceeds that arrived at by application of the "standards." We conclude that claimant is entitled to a total award of 25 percent scheduled disability for loss of use or function of his right arm. ORS 656.295(5); see Riley Hill General Contactor Inc. v. Tandy Corp., 303 Or 390, 407 (1987).

ORDER

The Referee's order dated November 18, 1988 is affirmed in part and modified in part. In addition to the award of scheduled permanent right leg disability made by Determination Order, claimant is awarded 10 percent (15 degrees), for a total award to date of 20 percent (30 degrees) scheduled permanent right leg disability. In addition to the award of 15 percent (28.8 percent) scheduled right arm disability, claimant is awarded 10 percent (19.2 percent), for a total award to date of 25 percent (48 degrees) scheduled right arm disability. The Referee's order is affirmed to the extent that it declined to award additional unscheduled permanent disability. Claimant's attorney is awarded a reasonable approved fee of 25 percent of the additional compensation resulting from this order in an amount not to exceed $3,000, payable directly to claimant's attorney.

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July 31, 1990 Cite as 42 Van Natta 1657 (1990)

In the Matter of the Compensation of
**GOLDIE M. AMES, Claimant**
WCB Case No. 88-22524
ORDER ON REVIEW
Stebbins & Coffey, Claimant Attorneys
H. Thomas Andersen (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

Claimant requests review of Referee Leahy's order that affirmed a Determination Order award of 19 percent (60.8 degrees) unscheduled permanent disability for a low back injury. On review, the issue is extent of unscheduled permanent disability. We affirm.

FINDINGS OF FACT

The Board adopts the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

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

On review, claimant does not contest her award under the standards, but she argues that there is clear and convincing evidence that she is entitled to a greater award of disability. She contends that the standards do not take into account her age of 46, her limited vocational experience and her high school degree. In addition, claimant argues that, due to decreased ankle reflex and numbness of the right foot, she is unable to stand for long periods of time. She contends that she has problems with her current job as a dishwasher because it involves prolonged standing.

Finally, claimant argues that a vocational expert, Mr. McNaught, testified that, in his opinion, bending and twisting restrictions preclude her from many medium level jobs. Mr. McNaught has reported that the vocational and medical factors indicate that claimant has a loss of 33 percent of her earning capacity.

We conclude that claimant's age, education, training, adaptability and skills have all been taken into consideration under an application of the standards; therefore, those factors do not necessarily constitute clear and convincing evidence that she was not adequately compensated. See Henry H. Stinnett, 42 Van Natta 1187 (1990) (Claimant's age, education and current strength did not equate to clear and convincing evidence as the factors had already been considered under the standards).

We are also not convinced that claimant's inability to stand to perform some jobs is indicative that she is entitled to additional compensation. Claimant's treating physician found that she had flat feet and bow legs and he did not believe that the conditions were related to her compensable back condition. We therefore do not take claimant's limited ability to stand into account in considering the adequacy of her award.

Finally, claimant argues that her vocational expert has testified that she is precluded from many jobs that require bending and twisting. Mr. McNaught concluded that, under the circumstances, claimant had lost approximately 33 percent of her earning capacity. We disagree.

Claimant argues that, before the injury she had 9 percent of the job market available to her, but after the injury only 6 percent of the market was available. We find claimant's argument to be without merit. Earning capacity is based upon not only the number of types of jobs a worker can perform, but also upon other factors such as wages, the number of hours and days worked in each job and the availability and number of jobs in a worker's hypothetically normal labor market. The testimony of claimant's vocational expert is not persuasive in this regard, as he has only considered one of the factors that comprise a worker's earning capacity. We therefore conclude that the vocational expert's opinion does not provide clear and convincing evidence that claimant's award of 19 percent unscheduled permanent disability was inadequate.

ORDER

The Referee's order dated May 16, 1989 is affirmed.

In the Matter of the Compensation of
**ROGER A. BAILEY, Claimant**
WCB Case Nos. 88-16900 & 88-14782
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Tom Ewing (Saif), Defense Attorney

Reviewed by Board Members Crider and Nichols.

Claimant requests review of Referee Lipton's order that: (1) required the SAIF Corporation to recalculate claimant's temporary disability rate based on a weekly wage of $203.98; (2) assessed a 25 percent penalty and attorney fee for unreasonable failure to timely disclose claims documents; and (3) declined to award a carrier-paid fee for unreasonable failure to include overtime in calculation of the rate of temporary disability. On review, the issues are rate of temporary disability compensation and attorney fees. We affirm in part, modify in part, and reverse in part.

FINDINGS OF FACT

Claimant was compensably injured on February 4, 1988 and August 12, 1988. The SAIF Corporation, as the insurer of the employer-at-injury, paid claimant temporary disability compensation in each claim based on an average weekly wage of $200. This figure was calculated based on information from the employer indicating that claimant was scheduled to work five days per week, eight hours per day, at a rate of $5.00 per hour.

At the time of the first injury, claimant was employed as a security guard by a service company. He apparently worked at varying locations. He was scheduled to work Thursday through Monday with Tuesday and Wednesday off. When he missed a scheduled day on account of illness, he was paid for eight hours. He often worked more than eight hours in a day and often worked on his scheduled days off. Although claimant worked a varying number of overtime hours, he worked overtime during every payroll period after that ending June 30, 1987 until the payroll period during which he was injured.

At the time of injury, claimant was paid $5.00 per hour for hours designated by the employer as regular hours and $7.50 per hour for hours designated by the employer as overtime hours. The record does not include any testimony concerning how hours were designated. It would appear, however, that claimant may have been paid at the overtime rate for hours in excess of 40 hours during the week commencing Sunday and ending Saturday. See Ex. 1.

During the 26 full payroll weeks preceding the February 4, 1988 injury -- that is, August 1, 1987 through January 31, 1988 -- claimant received a series of increases in hourly rate of pay. During the payroll period ending August 16 he was receiving $4.65 per hour; by the payroll period ending November 15 he was receiving $5.00 per hour. It would appear that the increases reflect some type of longevity or merit increase. There is no indication that at the time of injury claimant's job classification or wage rate varied from time to time.

FINDINGS OF ULTIMATE FACT

Claimant was hired to work five days per week. He regularly worked overtime, albeit for varying periods of time. During the 26 week period prior to the injury claimant worked an average of 41.4 hours per week at the regular rate and 13.82 hours per week at the overtime rate for an average weekly wage, at the rates payable at the time of injury, of $310.65.

SAIF unreasonably delayed and resisted the payment of compensation by failing to include overtime earnings in its temporary disability compensation payments.

## CONCLUSIONS OF LAW AND OPINION

### Rate of temporary disability compensation

The parties agree that SAIF erred when it failed to include overtime pay in its calculation of claimant's average weekly wage for purposes of computing claimant's temporary disability benefits. They further agree that the temporary disability rate

payable for the February 4 injury shall also apply to the later injury. Finally, they agree that the average weekly wage must be determined in accordance with OAR 436-60-020(7). They disagree, however, on the proper application of the rule.

The Referee concluded that because claimant's hours of work varied, his average weekly wage should be calculated based on his average earnings over the 26 weeks prior to the injury. OAR 436-60-020(7)(a) and (i). His opinion states that the parties have stipulated that claimant's total earnings for the 26 week period were $7,955.02; he divided that figure by 26, arriving at an average weekly wage of $305.96. He computed 2/3 of that rate to arrive at a TTD rate of $203.98. In his order, however, he directed SAIF to pay TTD at the rate of 2/3 of $203.98.

Claimant contends that the Referee is wrong in several regards. First, assuming that claimant's average weekly wage is as calculated by the Referee, the order should be modified to reflect that figure and not 2/3 of it. Second, claimant contends that he works five nine-hour shifts per week. Therefore, his average weekly regular wage is $225. Third, under OAR 436-60-020(7)(i), which applies to claimants who work overtime, claimant contends that inasmuch as claimant worked an average of 13.82 hours of overtime per week, his rate of compensation must be calculated as if he worked two full nine hour days of overtime each week in addition to the 45 regular hours.

We agree with claimant's first point. The Referee appears to have inadvertently required application of the statutory formula for calculation of the temporary disability rate to a figure which he had already reduced in accordance with the formula. We will modify the Referee's order to require that the statutory formula established in ORS 656.210 be applied to the average weekly wage and not to a figure which is 2/3 of the average weekly wage.

Nevertheless, while we disagree in a minor way with the Referee's analysis of the problem, we reject claimant's other arguments. We find no basis for claimant's assertion that claimant worked a nine-hour shift. While the employer's time records suggest that claimant very often worked 8 1/2 hours on scheduled workdays, there is no evidence that claimant's regular shift was either 8 1/2 or nine hours. The employer's time and payroll records, which are all that appear in the record, suggest that claimant worked an eight hour shift inasmuch as he was paid eight hours for days missed due to illness.

Claimant's contention that his average weekly wage should be calculated as if he worked 18 overtime hours, rather than 13.82, per week is equally unsupported. Claimant relies on the Director's rule which provides for compensation of workers employed with overtime as follows:

> "Overtime shall be considered only when worked on a regular basis. Overtime earnings shall be considered at the overtime rate rather than straight time....Example: If one day of overtime per month for a normally 40 hour a week worker, use 40 hours at regular wage and 2 hours at overtime wage; etc., to compute the weekly rate. If overtime varies in hours worked per day or week, use average as in subsection (a). One-half day or more will be considered a full day when determining days worked per week." (Emphasis supplied.)

OAR 436-60-020(7)(i). He argues that the rule means that a worker shall be credited for a full day of work when his average weekly overtime exceeds 1/2 the length of his regular shift. Since he worked an average amount of overtime that slightly exceeds 1 1/2 times his regular shift length, he believes he should be treated as if he worked 5 regular nine hour shifts plus 2 regular nine hour overtime shifts.

Although the purpose of the emphasized sentence is not transparent, the interpretation offered by claimant does violence to the general purpose of the rule which is to provide a formula for the average weekly wage which approximates what claimant would have earned had he not been injured. Claimant's reading would inflate the average weekly wage for no ascertainable reason. We conclude that the emphasized portion of the rule is intended to assist in determining how many days claimant is regularly employed for purposes of ORS 656.210 and is not intended for use in calculating average overtime hours. Therefore, we reject claimant's contentions.

Nevertheless, we conclude that, owing to the peculiar facts of this case, the Referee erred when, to calculate the average weekly wage, he averaged claimant's earnings rather than his hours for the 26 payroll weeks preceding the injury. We average earnings when a worker, at the time of injury, is employed to work varying shifts, hours or wages. OAR 436-60-020(7)(c). A worker, however, is entitled to compensation in accordance with his at injury wage. Thus, when a worker has been promoted during the weeks prior to injury, his average weekly wage is calculated based only on his wages since his promotion to the at-injury position. See Robert T. Moon, 39 Van Natta 370, 503 (1987), aff'd mem 91 Or App 186 (1988). Where, as here, claimant has been promoted only in the sense that he received a wage increase during the 26 week period without a change in job classification, his average wage is arrived at by first calculating his average regular and overtime hours and multiplying these figures by the regular and overtime hours to which claimant was entitled at the time of injury. This approach is consistent with OAR 436-60-020(7)(i) which provides for calculation of weekly regular hours and overtime hours before converting those hours to dollars and, by cross reference to OAR 436-60-020(7)(a), for use of a 26 week average when the amount of overtime varies from week to week. Finally, it more fairly approximates what claimant would have earned but for the compensable injury than does the Referee's approach.

Using the formula discussed above, we conclude that claimant worked an average of 41.4 hours of regular time and 13.82 hours of overtime each week. At the rate of pay in effect at the time of injury, he would have earned an average of $310.65. He was entitled to temporary disability compensation based on that average weekly wage.

Attorney fees

The Referee approved a fee payable to claimant's attorney out of the additional compensation obtained in this proceeding. He held that counsel is entitled to such a fee under OAR 438-15-045 and is not entitled by ORS 656.386(1) to a carrier-paid fee for overcoming a denial of a rejected case. The Referee was correct as far as he went. However, claimant correctly argues that a carrier-paid fee is appropriate in a case involving the rate of temporary disability compensation when claimant contends and proves that the insurer's miscalculation of the rate of temporary disability compensation is unreasonable. In such cases, the insurer has delayed and resisted compensation within the meaning of former ORS 656.262(10) and ORS 656.382(1). Therefore, a carrier-paid fee is appropriate. Herschel J. Thompson, 40 Van Natta 1670 (1988).

At hearing, claimant raised the issue of penalties and attorney fees for unreasonable carrier conduct related to the rate of temporary disability compensation. Tr. 3. The Director's rule and the case law clearly require the consideration of overtime earnings in calculation of the average weekly wage. Consequently, we conclude that SAIF's conduct was unreasonable. Therefore, claimant's attorney is entitled to a fee for services at hearing and on review regarding this issue. The fee, however, shall not be comparable in amount to that awarded in Thompson because, in this case, SAIF had conceded this basic error at the commencement of hearing; this proceeding was prolonged by claimant's attorney's pursuit of an interpretation of the Director's rules which we have rejected.[1]

ORDER

The Referee's order dated March 2, 1989, abated March 27, 1989, and republished April 20, 1989, is modified in part, reversed in part and affirmed in part. That portion of the order that required payment based on two thirds of $203.98 per week is modified to require payment based on $310.65 per week. Claimant's attorney is allowed an approved fee in the amount of 25 percent of the increased compensation awarded by this order, payable by the SAIF Corporation directly to claimant's attorney out of that compensation. The total out-of-compensation fee awarded at hearing and on review shall not exceed $3,800. For services at hearing and on review on the issue of SAIF's unreasonable failure to consider overtime earnings in calculating the rate of temporary disability compensation, claimant's attorney is awarded an assessed fee of $500, payable by SAIF. The balance of the order is affirmed.

1. Claimant seeks no additional penalty for this violation and we award none because the Referee has already awarded the maximum allowable penalty for another violation.

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In the Matter of the Compensation of
**JUDY C. BOWERS, Claimant**
WCB Case No. 88-12820
ORDER ON REVIEW
Malagon, Moore, et al., Claimant Attorneys
H. Thomas Andersen (Saif), Defense Attorney

Reviewed by Board Members Crider and Brittingham.

Claimant requests review of Referee Gruber's order which affirmed a Determination Order award of 5 percent (9.6 degrees) scheduled permanent disability

for loss of use or function of the right arm. On review, the issue is extent of scheduled permanent disability. We modify.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" and supplement with the following.

Claimant has disabling pain which restricts her ability to extend her right arm fully and to do repetitive activities required to drive, sew, knit or crochet.

Claimant became medically stationary as of June 16, 1988.

The Determination Order issued July 18, 1988.

FINDINGS OF ULTIMATE FACT

Claimant has sustained a 9 percent loss of use or function of her right arm as a result of her compensable injury.

CONCLUSIONS OF LAW AND OPINION

To establish the extent of claimant's permanent partial disability, the Referee properly applied the standards for the evaluation of disabilities adopted by the Director pursuant to ORS 656.726(3)(f)(A). Those are the standards we apply as well. Specifically, former OAR 436-35-010 through 436-35-260, the "standards" in effect at the time of the July 18, 1988 Determination Order, apply to the rating of scheduled permanent partial disabilities. OAR 438-10-010.

Disability Under the Standards

On examination, claimant has reduced grip strength, loss of right elbow range of motion, and pain. The Referee properly noted that claimant's loss of grip strength exists from prior carpal tunnel releases and is not a ratable part of her current claim.

The Referee affirmed the Determination Order award of 5 percent scheduled permanent partial disability for lost range of right elbow motion. On review, we calculate a different value. Claimant has right elbow range of motion from 5 degrees to 140 degrees. For 10 degrees loss of flexion, claimant is awarded a value of 3. Former OAR 436-35-100(1). For 5 degrees loss of extension, claimant is awarded a value of 1. Former OAR 436-35-100(2). These values are added for a total impairment value for lost elbow ranges of motion of 4 percent. Former OAR 436-35-100(6).

Additionally, claimant asserts that she is entitled to a value for loss of pronation and supination under former OAR 436-35-100(4). Dr. Butters, claimant's treating physician, notes that claimant has full forearm rotation, which claimant concedes is synonymous with pronation and supination. Nevertheless, claimant contends that Dr. Butters' report does not clearly measure pronation and supination, and is therefore, ambiguous. Claimant asks the Board to assign a value based on claimant's unrebutted testimony of pain and restricted activities.

We decline to do so. There is no medical evidence of loss of right arm pronation and supination. Thus, while claimant credibly testified to pain and restricted activities with right forearm rotation, by her testimony she did not

seek merely to clarify a medically verified loss, but to establish such a loss. Under these circumstances, we are unwilling to accept claimant's unsubstantiated testimony as to lost range of motion, and conclude that claimant has failed to establish a ratable loss of right forearm supination and pronation. See Darcy M. Greene, 42 Van Natta 1372 (1990); Dennis D. Reed, 42 Van Natta 873 (1990).

Claimant also contends that the Referee erred in not assigning a value under the standards for disabling pain. We agree.

Former OAR 436-35-010(2)(a) provides that pain can result in loss of use or function. When it does, it is rated based on the loss of use or function which results and no additional value is allowed for pain alone. The Board in Daniel M. Alire, 41 Van Natta 752 (1989) held that, inasmuch as the standards do not provide for a value range for impairment attributable to disabling pain, the Board on de novo review can consider the evidence and award the claimant a value that adequately compensates her for her loss of use or function attributable to disabling pain.

Here, we find that the preponderance of the evidence demonstrates that claimant has a loss of use or function in her dominant right arm attributable to disabling pain. Claimant has numbness and pain with extension of the arm which limit her ability to perform her prior restaurant work. Moreover, repetitive use of her right arm causes disabling pain which affects her ability to drive, sew, knit, and crochet. We consider a value of 5 percent in this particular case to be reasonable.

Having determined each value necessary to compute claimant's disability under the standards, we proceed to that calculation. When the total value for loss of right elbow range of motion (4 percent) and the value for disabling pain (5 percent) are combined, the result is 8.8 percent scheduled permanent disability. Former OAR 436-35-100(8). That disability figure is rounded up to the next higher whole percentage. Former OAR 436-36-010(6). Claimant's disability under the standards is, therefore, 9 percent for loss of use or function of her right arm.

Disability Outside the Standards

Either party may establish that the record, as a whole, constitutes clear and convincing evidence that the degree of permanent partial disability suffered by claimant is more or less than the entitlement indicated by the "standards". ORS 656.283(7) and 656.295(5). To be clear and convincing, evidence must establish that the truth of the asserted fact is "highly probable." Riley Hill General Contractor, Inc. v. Tandy Corp., 303 Or 390, 402 (1987).

Claimant contends that the standards do not adequately rate her limited repetitive use of her arm, and her problems with sewing, crocheting, driving an automobile, sitting and performing everyday chores.

Claimant asserts that subsequent amendments to the disability standards establish by clear and convincing evidence that her award, as granted pursuant to the standards, was inadequate. Specifically, she alleges that the "new" standards allow a rating for chronic conditions limiting repetitive use of a scheduled body part, such as claimant's restriction on repetitive use of her right arm. Therefore, claimant contends, the change in the rules is conclusive evidence that the earlier rules did not adequately and appropriately rate claimant's permanent disability. We disagree.

We previously have held that amendments to the standards merely establish that the disability standards were amended at a time following the closure of

the claimant's injury claim, and do not constitute clear and convincing evidence that the claimant's loss of earning capacity is greater than previously awarded. Joseph Anger, 41 Van Natta 827 (1989).

Moreover, we have already considered the limitations noted by claimant in assigning a value under the standards for lost range of motion and disabling pain. Claimant has not presented clear and convincing evidence that her award under the standards does not adequately compensate her for her lost use and function.

Accordingly, we conclude that claimant is entitled to an award of 9 percent for scheduled permanent disability for loss of use of function of her right arm.

ORDER

The Referee's order dated December 22, 1988 is modified. In addition to the Determination Order award of 5 percent (9.6 degrees) scheduled permanent disability, claimant is awarded 4 percent (7.68 degrees), giving her a total award to date of 9 percent (17.28 degrees) scheduled permanent disability for loss of use or function of the right arm. Claimant's attorney is awarded an approved fee of 25 percent of the increased scheduled disability compensation awarded by this order, not to exceed $3,800, payable directly to claimant's attorney.

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July 31, 1990 Cite as 42 Van Natta 1665 (1990)

In the Matter of the Compensation of
**JOE E. COUEY, Claimant**
WCB Case No. 89-01690
ORDER ON REVIEW
Coons & Cole, Claimant Attorneys
Kevin L. Mannix, Defense Attorney

Reviewed by Board Members Speer and Howell.

Claimant requests review of Referee Garavanta's order that upheld the self-insured employer's denial of claimant's occupational disease claim for his asthma condition. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact," with the following supplementation. Claimant suffers from reactive airways disease (asthma). That disease preexisted his employment at James River Corporation as demonstrated by objective spirometry testing and a history of chest tightness and wheezing with upper respiratory infections. (See Exs. 2, 3, & 22).

CONCLUSIONS OF LAW AND OPINION

The legislature amended the occupational disease statute, ORS 656.802, effective January 1, 1988. Because claimant's last work exposure which could have contributed to a worsening of his condition occurred in October 1988, we find that this case should be analyzed under the new statute. Johnson v. SAIF, 78 Or App 143, 148, rev den 301 Or 240 (1986); Donna E. Aschbacher, 41 Van Natta 1242 (1989).

ORS 656.802(1)(a) requires that claimant establish that his work exposure was the major contributing cause of a worsening of his preexisting asthma

condition. Weller v. Union Carbide, 288 Or 27, 36 (1980); Donna E. Aschbacher, supra.

The Referee found that claimant had not carried his burden. We agree. In reaching this conclusion, we are persuaded by the weight of the medical evidence that, during his employment at James River Corporation, claimant suffered an exacerbation of symptoms which did not affect his preexisting disease process. (See Exs. 22-6, 24-1-2, 25-3 & 27). In this regard, we adopt the Referee's analysis of the medical evidence.

ORDER

The Referee's order dated May 18, 1989 is affirmed.

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July 31, 1990 Cite as 42 Van Natta 1666 (1990)

In the Matter of the Compensation of
**STOKES R. CROTTS, JR., Claimant**
WCB Case No. 88-02377
ORDER ON REVIEW
Ralph M. Yenne, Claimant Attorney
Stafford J. Hazelett, Defense Attorney

Reviewed by Board Members Gerner and Myers.

Claimant requests review of that portion of Referee McCullough's order which granted the insurer an offset for temporary disability benefits paid while claimant was incarcerated. On review, the issue is entitlement to temporary disability benefits. We reverse.

FINDINGS OF FACT

Claimant sustained a compensable injury to his neck, back, left elbow and head in July 1986. Claimant was incarcerated during the period from February 26, 1987 through July 30, 1987. During this period, the insurer paid claimant temporary disability benefits.

Claimant was medically stationary as of July 30, 1987. His claim was closed by a September 1987 Determination Order which awarded claimant temporary disability benefits from July 21, 1986 through July 30, 1987.

FINDINGS OF ULTIMATE FACT

Claimant was not medically stationary until July 30, 1987.

CONCLUSIONS OF LAW

The Referee concluded that claimant was not substantively entitled to temporary disability benefits from February 26, 1987 through July 30, 1987, as he was incarcerated during this time period. We disagree.

Subsequent to the Referee's order, the court has held that a claimant was substantively entitled to temporary disability benefits, while incarcerated, if he was not medically stationary and not released to regular work. Forshee & Langley Logging v. Peckham, 100 Or App 717 (1990).

Here, claimant was not medically stationary until July 30, 1987. Therefore, for the reasons cited in Peckham, supra, we conclude that claimant was

substantively entitled to temporary disability benefits from February 26, 1987 through July 30, 1987. Thus, those previously-paid benefits do not constitute an overpayment. Inasmuch as these benefits were not overpaid, the insurer is not entitled to offset them against any future award of permanent disability.

As a result of this order, claimant's temporary disability compensation has been effectively increased in that he has been found substantively entitled to temporary disability benefits from February 26, 1987 through July 30, 1987. Because these benefits have already been procedurally provided, claimant does not actually receive these benefits. Yet, such circumstances do not prevent claimant's attorney from receiving an attorney fee for his efforts in securing claimant's substantive entitlement to such benefits. See OAR 438-15-085(2); Anthony E. Cochrane, 42 Van Natta 1619 (1990).

ORDER

The Referee's order, dated June 7, 1988, is reversed in part and affirmed in part. That portion, which found that claimant was not substantively entitled to temporary disability benefits for the period from February 25, 1987 through July 30, 1987, and granted the insurer an offset for benefits paid during this period, is reversed. The Determination Order is reinstated and affirmed and no offset is authorized. Claimant's attorney is awarded 25 percent of the temporary disability benefits paid between February 25, 1987 and July 30, 1987, not to exceed $3,800. The remainder of the order is affirmed.

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July 31, 1990 Cite as 42 Van Natta 1667 (1990)

In the Matter of the Compensation of
**CARMEN M. CUDE, Claimant**
WCB Case No. 88-18881
ORDER OF DISMISSAL
Gleeson & Davis, Claimant Attorneys
Stafford J. Hazelett, Defense Attorney

Reviewed by Board Members Myers and Cushing.

The insurer requested review of Referee Tenenbaum's March 30, 1989 order. Claimant, pro se, cross-requested review of the Referee's order. Subsequently, the insurer withdrew its request for review, and moved for an order dismissing claimant's request for review for lack of jurisdiction. The issue on review is whether we have jurisdiction to consider claimant's cross-request. Because we conclude the cross-request for review is untimely, the insurer's motion is granted.

FINDINGS OF FACT

The Referee's order was issued on March 30, 1989. On April 13, 1989, the Board received the insurer's request for review of the order. On May 1, 1989, the Board received claimant's cross-request for review of the order. On June 27, 1989, the insurer withdrew its request for review.

ULTIMATE FINDINGS OF FACT

Claimant's cross-request for Board review was received by the Board more than 30 days after the issuance of the Referee's order and more than 10 days after the insurer submitted its request for Board review.

CONCLUSIONS OF LAW AND OPINION

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. When one party timely requests Board review, the other parties have at least the remainder of the 30-day period and, in any event, no less than 10 days within which to cross-request review. ORS 656.289(3). Here, claimant did not timely file a cross-request for Board review of the Referee's order within thirty days of its issuance, or within ten days of the insurer's request for Board review. Consequently, upon the withdrawal and dismissal of the insurer's request for review of the Referee's order, the 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, we cannot proceed to the merits.

We are mindful that claimant has cross-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. Finally, we are not free to relax a jurisdictional requirement, particularly in view of Argonaut Insurance Co. v. King, 63 Or App 847 (1983). See Alfred F. Puglisi, 39 Van Natta 310 (1987); Julio Lopez, 38 Van Natta 862 (1986).

Accordingly, the insurer's request for Board review is dismissed. Claimant's cross-request for Board review is likewise dismissed.

IT IS SO ORDERED.

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In the Matter of the Compensation of
**SHERRI L. DAFFRON, Claimant**
WCB Case No. 88-18793
ORDER ON REVIEW
Richard A. Sly, Claimant Attorney
Art Stevens (Saif), Defense Attorney

Reviewed by Board Members Crider and Nichols.

Claimant requests review of Referee Podner's order that: (1) upheld the SAIF Corporation's partial denial of a thoracic and lumbar spine condition; (2) found that the claim was not prematurely closed by an October 31, 1988 Determination Order; (3) upheld SAIF's denial of claimant's aggravation claim for left shoulder, neck, thoracic spine and lumbar spine conditions; (4) affirmed the portion of the Determination Order that awarded no unscheduled permanent disability for those conditions; and (5) declined to assess penalties and attorney fees for SAIF's alleged unreasonable issuance of a July 12, 1988 Notice of Closure, untimely denial of the claim for the thoracic and lumbar spine conditions, untimely denial of the aggravation claim, delay in payment of temporary partial disability compensation awarded by the Determination Order, and delay in payment of medical bills. On review, the issues are compensability, premature closure, aggravation, extent of unscheduled permanent partial disability, 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 additions and corrections.

The Referee found that the first notice SAIF had of claimant's aggravation claim was received October 14, 1988. We instead find that SAIF was on notice of claimant's lumbar and thoracic complaints on June 30, 1988, pursuant to Dr. Beeson's report of June 23, 1988.

The October 31, 1988 Determination Order set aside SAIF's July 12, 1988 Notice of Closure in its entirety and reclosed the claim.

SAIF wrote Dr. Beeson on September 26, 1988 requesting clarification of his billing for treatment of the shoulder and cervical-thoracic spine. Specifically, SAIF requested that Dr. Beeson separate the billings between the accepted shoulder and neck condition and the denied mid-back condition. SAIF received Dr. Beeson's explanation in late October or early November 1988.

As of October 28, 1988, there was an outstanding balance of $1,552 for Dr. Beeson's services through October 28, 1988. Dr. Beeson billed additional charges of $355 for services on November 16, 1988.

SAIF made partial payment for Dr. Beeson's services on December 23, 1988. It made further payment on January 19, 1989, in the amount of $1,101.00. This included payment for some services rendered prior to October 28, 1988, as well as services rendered November 16, 1988.

## FINDINGS OF ULTIMATE FACT

Claimant's thoracic and lumbar complaints are unrelated to her December 22, 1987 compensable injury.

Claimant was medically stationary on October 31, 1988, the date of the Determination Order.

Claimant's compensable condition did not worsen after October 31, 1988.

Claimant does not suffer from disabling pain or any other impairment as a result of her compensable injury.

Claimant's claim was prematurely closed by the July 12, 1988 Notice of Closure. SAIF's closure was unreasonable and delayed the payment of temporary total disability compensation.

The September 21, 1988 partial denial of claimant's thoracic and lumbar conditions issued more than 60 days after SAIF had notice of a claim for those conditions. This conduct was unreasonable. At the time of its denial, no compensation was "then due."

SAIF unreasonably delayed payment of medical bills from Dr. Beeson.

## CONCLUSIONS OF LAW AND OPINION

### Compensability of the Thoracic and Lumbar Condition

The Referee, relying on the testimony of independent medical examiner Dr. Duncan, D.C., held that any lumbar and thoracic problems claimant suffers are unrelated to claimant's compensable injury. We agree.

Claimant compensably injured her shoulder on December 22, 1987. The diagnosis was first degree acromial clavicular injury. She was treated by Dr. Zimmerman, M.D., who remained her treating physician until June 23, 1988. Zimmerman released claimant for regular work on January 4, 1988. On June 20,

1988, he reported that claimant had full range of motion of her neck, shoulders and lower back, and that she was medically stationary.

Three days after Dr. Zimmerman's June 20, 1988 report, claimant changed her treating physician to Dr. Beeson, D.C. He diagnosed chronic/mild cervical-thoracic sprain/strain, chronic/mild left shoulder sprain, and lumbar spine/hypomobility. In November 1988 Dr. Beeson opined that claimant's back pain was directly related to her injury. His theory was that claimant's latissimus dorsi muscle traumatized the thoracolumbar spine when the shoulder was injured.

On September 9, 1988, claimant was examined by a Western Medical Consultants panel which included Dr. Martens, orthopedist, and Dr. Duncan, D.C. X-rays of the AC joints and cervical area showed no abnormality. Dr. Martens diagnosed contusion strain left shoulder, resolved; recurrent strain cervico-thoracic spine, recovered; and anxiety tension state, unrelated. He opined that claimant's thoracic and lumbar complaints are unrelated to her December 22, 1987 compensable injury.

Dr. Duncan testified that Beeson was trying to stretch his theory too far in medical terms to conclude that claimant's shoulder injury was the cause of her spinal problems.

Although the Board generally gives greater weight to the conclusions of a treating physician, it will not do so when there are persuasive reasons to do otherwise. Weiland v. SAIF, 64 Or App 810, 814 (1983); Nancy E. Cudaback, 37 Van Natta 1580, withdrawn on other grounds, 37 Van Natta 1596 (1985), republished 38 Van Natta 423 (1986). Here, we find persuasive reasons not to defer to Dr. Beeson's opinion. The causation issue in this case turns on expert analysis, rather than external observation. Therefore, we do not give special credit to the evidence from treating physicians as opposed to other doctors. See Allie v. SAIF, 79 Or App 284 (1986); Hammons v Perini, 43 Or App 299 (1979). Dr. Martens' opinion is more consistent with claimant's history. In contrast, Dr. Beeson was unaware that claimant had been released for work by Dr. Zimmerman three days before she first saw Beeson.

On balance, we find Drs. Martens' and Duncan's analysis to be better reasoned and hence, more persuasive. Accordingly, we conclude that claimant's thoracic and lumbar complaints are unrelated to her compensable injury.

Premature Closure by October 31, 1988 Determination Order

The Referee found that Dr. Beeson's opinion that claimant was not medically stationary at the time of closure was not persuasive in light of contrary opinions by Dr. Zimmerman and the Western Medical Consultants. Accordingly, the Referee ruled that claimant had not established that her claim was prematurely closed by the October 31, 1988 Determination Order. Claimant, relying on Dr. Beeson's opinion, argues that she was not medically stationary and the claim, therefore, was prematurely closed. We disagree.

In order to establish that her claim was prematurely closed, claimant must demonstrate that she was not medically stationary on the date of closure. Scheuning v. J. R. Simplot & Co, 84 Or App 622, 625 (1987).

SAIF had notice from claimant's former treating physician, Dr. Zimmerman, that claimant had full range of motion of her neck, shoulders and low back and that she was medically stationary on June 20, 1988. Drs. Martens and Duncan concurred with Dr. Zimmerman's opinion by finding claimant medically stationary in their examination of September 9, 1988. Dr. Beeson's opinion that claimant

was not medically stationary on that date was based, in part, on claimant's non-compensable mid/low back condition. We, therefore, defer to the opinions of Martens and Duncan and conclude that claimant was medically stationary on or before September 9, 1988. Accordingly, the Referee is affirmed regarding this issue.

Aggravation

The Referee found that claimant had not proved aggravation by a preponderance of the evidence. We agree.

Claimant's last award of compensation was the Determination Order, issued October 31, 1988, which set aside the insurer's July 12, 1988 Notice of Closure. Therefore, claimant must show a worsening of her condition after October 31, 1988. The record is devoid of evidence of increased symptoms or diminished earning capacity as a result of claimant's compensable neck and shoulder condition. Smith v. SAIF, 302 Or 396 (1986); Edward D. Lucas, 41 Van Natta 2272 (1989). We conclude, therefore, that claimant has not established an aggravation of her condition.

Extent of Unscheduled Disability

The Referee held that claimant has not persuasively established that she suffers from permanent disability as a result of her compensable injury. We agree.

Claimant argues on review that Dr. Beeson's opinion establishes that she is restricted to light/sedentary work as a result of disabling pain, loss of repetitive use of her arms, neck and upper back, and lost range of motion of her left shoulder, neck and lumbar spine.

In support of her contention that she is entitled to an award for loss of repetitive use, claimant relies on OAR 436-35-320(4). As claimant became medically stationary after July 1, 1988, and the Determination Order issued on October 31, 1988, we apply the "standards" effective July 1, 1988, as amended by temporary rules effective August 19, 1988. This version of the standards did not assign a value for loss of repetitive use. OAR 436-35-320(4), on which claimant relies, did not become effective until January 1, 1989. Accordingly, we award no value under that rule.

We make no award for loss of range of motion because the opinions of Drs. Martens and Duncan persuade us that claimant has full range of motion of her shoulder, neck and low back, and that her mid and lower back complaints are unrelated to her compensable injury. They found no objective signs of impairment that would preclude claimant from returning to work and opined that claimant could return to work with no restrictions. They further opined that claimant's thoracic and lumbar complaints are not causally related to her 1987 injury.

We are not persuaded by Dr. Beeson's contrary opinion. Dr. Beeson related claimant's back problems up to the compensable shoulder injury, but offered no explanation for this opinion. Moreover, the lumbar ranges of motion reported by Dr. Beeson are all within normal limits. Finally, the losses in cervical and shoulder motion he reported were based on a November 16, 1988 examination, whereas Drs. Martens and Duncan found full range of motion on January 6, 1989. We defer to the more recent findings of Drs. Martens and Duncan. Similarly, we give little weight to Dr. Beeson's light/sedentary work restriction because it is based on his unpersuasive causation and range of motion findings.

Finally, we are not persuaded that claimant's pain has resulted in a loss of use or function. Claimant testified that while performing motions similar to the ones required for her job at injury she becomes stiff. She did not state that she could not perform these motions and, although she is not working outside the home, she continues to do wood carving in her garage. In light of these facts we find that while claimant may suffer from discomfort, she has not established that it causes impairment.

On this record, we conclude that claimant has not sustained any ratable impairment and is, therefore, not entitled to any unscheduled disability. Former OAR 436-35-280(1).

Penalty and Attorney Fee: Premature Closure by July 12, 1988 Notice of Closure

The Referee found that the claim was not prematurely closed by the July 12, 1988 Notice of Closure. He further concluded that the SAIF claims examiner did not act unreasonably in issuing the closure without investigating Dr. Beeson's June 23, 1988 Form 829, on which he indicated that claimant was not medically stationary. We disagree.

The Notice of Closure was set aside as premature by the Determination Order of October 31, 1988. SAIF did not cross-request a hearing on that ruling or otherwise challenge the ruling at hearing. Consequently, the July 12, 1988 Notice of Closure was issued prematurely, as a matter of law, and the Referee's finding to the contrary was in error.

The question, then, is whether penalties and attorney fees are due because the premature closure was unreasonable under ORS 656.262(10). This provision states:

> "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."

Here, although Dr. Zimmerman reported that claimant was medically stationary on June 20, 1988, claimant changed her treating physician to Dr. Beeson who indicated on June 23, 1988 that claimant was not medically stationary. This report was received by SAIF on June 30, 1988. What constitutes unreasonableness must depend on the particular facts and circumstances of each case. See Barrett v. Coast Range Plywood, 56 Or App 371 (1982). In this case, the SAIF claims examiner was not aware of Dr. Beeson's June 23, 1988 report when the Notice of Closure issued. However, internal routing delays do not excuse SAIF from its duty to close the claim in a reasonable manner; therefore, we find that Dr. Beeson's report should have been investigated before the claim was closed. Accordingly, we hold that SAIF's conduct was unreasonable and assess a penalty and attorney fees against the additional amounts of temporary disability compensation awarded by the Determination Order. Lester v. Weyerhaeuser Co., 70 Or App 307 (1984).

Penalty and Attorney Fee: Untimely Issuance of the September 21, 1988 Denial of Thoracic and Lumbar Conditions

The Referee found that the first information that SAIF had that claimant was claiming lumbar and thoracic problems were related to her injury was the Western Medical Consultants September 9, 1988 report. Consequently, he held that the September 21, 1988 denial of claimant's thoracic and lumbar complaints

was issued within 60 days of the claim and was therefore proper. Claimant argues that SAIF was on notice of claimant's complaints as of June 30, 1988 and that since more than 60 days passed before the denial was issued, it was untimely and penalties are therefore due.

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).

We find that the denial issued more than 60 days after SAIF had notice of claimant's complaints. On June 23, 1988, Dr. Beeson submitted an 829 Form which noted thoracic sprain and lumbar spine hypomobility and related these complaints to claimant's compensable injury. SAIF received this document on June 30, 1988 and so was on notice of claimant's thoracic and lumbar complaints as of that date. The denial did not issue until September 21, 1988. Thus, the denial issued more than 60 days after SAIF had knowledge of the claim. Therefore, SAIF's conduct was unreasonable.

However, ORS 656.262(10) provides for a penalty based upon a percentage of "amounts then due". Here, because there was no predenial medical verification of claimant's inability to work triggering a duty to pay temporary disability benefits, there was no compensation "then due". Silsby v. SAIF, 39 Or App 562 (1979). Therefore, a penalty is not authorized by law. Furthermore, because the claim is ultimately not compensable, the insurer did not unreasonably resist the payment of compensation. An attorney fee is, therefore, not authorized under ORS 656.382. Ellis v. McCall Insulation, 308 Or 74, (1989); Lloyd L. Cripe, 41 Van Natta 1774 (1989).

Penalty and Attorney Fee: Alleged Unreasonable Delay of Payment of Temporary Total Disability Due by Determination Order

Claimant argues that a penalty should be assessed against SAIF for untimely payment of temporary total disability benefits due under the October 31, 1988 Determination Order. In her testimony, the SAIF claims examiner acknowledged that claimant's temporary disability benefits were not timely paid. She explained that she sent claimant earnings letters in early November in an attempt to calculate the amount of her benefits. After receiving no response, the claims examiner sent claimant a speed letter on November 21, 1988. The claims examiner then received permission from claimant's attorney to contact claimant directly, which she did on November 30, 1988, at which time she learned claimant's wage. The temporary benefits were then paid on December 2, 1988. We do not find this delay to be unreasonable. Therefore, no penalties or fees are due.

Penalty and Attorney Fee: Alleged Unreasonable Delay in Paying Dr. Beeson's Medical Bills

The Referee, finding that SAIF paid Dr. Beeson's bills when he complied with SAIF's request for clarification of his treatment, held that there was no reason to assess a penalty and attorney fee. We disagree.

A medical bill is a claim and payment is due 60 days after the carrier has notice of the billing. ORS 656.262; Billy J. Eubanks, 35 Van Natta 131 (1983). For unreasonable delays in payment of compensation, the insurer is liable for up to 25 percent of amounts then due. ORS 656.262(10).

Here, the record indicates that SAIF received notice of Dr. Beeson's explanation for his billings in late October or early November 1988. Nevertheless, SAIF did not make full payment for services rendered prior to October 28, 1988 until January 19, 1989. Payment for these services was due at least by December 28, 1988 and was, therefore, untimely. SAIF has provided no explanation for delaying payment after it received Beeson's clarification. Payment for services rendered on November 16, 1988 was also delayed until January 19, 1989. That payment was untimely if SAIF received that billing prior to November 19, 1988.

In light of these facts, we find that SAIF unreasonably delayed payment of Dr. Beeson's medical bills. Accordingly, we reverse the Referee on this issue and assess a penalty and attorney fee.

ORDER

The Referee's order dated February 22, 1989 is reversed in part and affirmed in part. Claimant is awarded a penalty of 25 percent of the additional temporary disability compensation awarded by the October 31, 1988 Determination Order. As a penalty-related attorney fee, claimant's attorney is awarded $200, payable by the SAIF Corporation. SAIF shall also pay claimant a penalty equal to 25 percent of all billings for medical services rendered prior to November 16, 1988 that were not paid within 60 days of receipt, along with an associated insurer-paid attorney fee of $200, again payable by SAIF. The remainder of the order is affirmed.

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In the Matter of the Compensation of
**HAL L. FARNWORTH, Claimant**
WCB Case No. 89-02943
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Cowling & Heysell, Defense Attorneys

Reviewed by Board Members Gerner and Cushing.

Claimant requests review of Referee Brown's order that declined to award temporary total disability benefits from January 17, 1989 to April 26, 1989. On review, the issue is temporary disability benefits. We reverse.

FINDINGS OF FACT

Claimant sustained a compensable right inguinal hernia on August 15, 1988, which was accepted as nondisabling. Claimant continued to work, despite the hernia, through January 10, 1989. The following day a strike was called, and because so, claimant walked off the job. Claimant scheduled surgery prior to the strike date. He did not look for work from January 11, 1989 through January 16, 1989, in anticipation of his upcoming surgery.

On January 17, 1989, claimant underwent hernia repair surgery.

On January 23, 1989, the self-insured employer authorized surgery and the medical services related to the surgery, but denied temporary total disability, indicating that claimant had voluntarily removed himself from the labor market. (Ex. 5). Claimant requested a hearing.

On April 26, 1989, claimant's treating physician, Dr. Kremser, M.D., found claimant medically stationary and released him to return to his regular work.

At hearing, the parties stipulated that the employer agreed to reopen claimant's claim for surgery. (Tr. 3).

Claimant became disabled as a result of his compensable hernia on January 17, 1989, the date of surgery. As of that date, claimant had not removed himself from the work force.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant had voluntarily removed himself from the work force and concluded that claimant was not entitled to temporary total disability. We disagree.

First, we note that the parties stipulated at hearing that claimant's claim was "reopened" for surgery. Given this stipulation, we make the necessary assumption that claimant's nondisabling claim for his hernia was closed some time prior to his request for surgery. In the letter authorizing surgery, the employer specifically denied temporary total disability benefits.

There is no question that claimant's surgery and the medical services related thereto are compensable consequences of his compensable hernia condition. That issue is not contested. What is contested is claimant's entitlement to temporary total disability from the date of surgery until the date his treating physician found his condition medically stationary and released him to return to his regular work; i.e., January 17, 1989 to April 26, 1989.

Subsequent to the Referee's order, the Supreme Court stated that to receive temporary total disability, a claimant must be in the work force at the time of his disability. See Dawkins v. Pacific Motor Trucking, 308 Or 254, 258 (1989). Here, the Referee specifically found that claimant was not in the work force at the time of his disability (surgery). We disagree.

Claimant became disabled because of his compensable hernia on January 17, 1989, the date he had surgery. The issue, then, is whether, by that date, claimant had voluntarily withdrawn from the work force, thereby cutting off his right to temporary total disability.

The record establishes that claimant had scheduled surgery prior to the strike date, and that he underwent surgery less than one week after the strike date. Claimant also credibly testified that he was not certain that the strike would actually be called. Furthermore, the record establishes that approximately six weeks after his surgery, claimant began a work search. That work search included looking for work in other mills, in the insurance and real estate businesses and doing yard work. (Tr. 16).

Considering claimant's actions, including his setting of the surgery date prior to the strike date, his active work search approximately six weeks after the surgery, and the fact that claimant would have been required to take time off from work had the strike not been called, we conclude that at the time of claimant's disability he had not withdrawn from the work force.

Therefore, we conclude that claimant is entitled to temporary total disability benefits from the date of his surgery, January 17, 1989, until he was released to return to regular work and his condition found medically stationary, i.e., April 26, 1989. See ORS 656.268.

ORDER

The Referee's order dated June 9, 1989, is reversed. The self-insured employer's January 23, 1989 denial of temporary total disability benefits is set aside. Claimant is awarded temporary total disability from January 17, 1989 through April 26, 1989. Claimant's attorney is awarded 25 percent of the increased compensation created by this order, not to exceed $3,800.

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In the Matter of the Compensation of
**ANN M. GANDER, Claimant**
WCB Case No. 88-20234
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Saif Legal Department, Defense Attorney

Reviewed by Board Members Nichols and Brittingham.

Claimant requests review of Referee Danner's order that awarded 5 percent (16 degrees) unscheduled permanent disability for an injury to the low back, whereas a Determination Order had awarded no permanent disability. In its brief, the SAIF Corporation requests that the award be reduced to zero. On review, the issue is extent of unscheduled permanent disability. We modify.

FINDINGS OF FACT

Claimant, 31 years old at time of hearing and a registered nurse certified in psychiatric nursing, sustained a compensable low back injury on February 5, 1988. This was the second injury to the same location. At the time of injury, claimant performed administrative work and patient care, including physical restraint of unruly patients, at Dammasch State Hospital. About 50 to 80 percent of her time was spent in patient care, with the remaining time spent as nursing coordinator. Claimant currently has a similar position with a different employer, where she is no longer required to physically restrain patients. She now spends 25-30 percent of her time in patient care.

Claimant regularly takes muscle relaxants, pain medication, and anti-inflammatory medication because of pain and muscle spasms. She must restrict the length of time she can sit, stand or drive and often takes work home to avoid long hours of sitting at work. Claimant moved closer to work because she could not tolerate the low back pain caused by her former 25 minute commute. She can no longer sit up to play the piano, participate in sports, dance, or take lengthy drives. Her sleep is disturbed by pain.

Claimant is permanently restricted to work in the medium to light range.

Claimant is unable to return to her regular work, which entailed physical restraint of patients.

Claimant was treated by Dr. Medak, M.D.; and an independent medical examination was performed by Dr. Pasquesi, orthopedic surgeon.

Claimant became medically stationary on June 13, 1988, and her claim was closed on October 3, 1988.

Claimant experiences disabling low back pain which limits her ability to sit, stand or drive for extended periods, and which results in spasm with minimal activity.

## FINDINGS OF ULTIMATE FACT

Claimant sustained a 12 percent loss of earning capacity as a result of her compensable low back injury.

## CONCLUSIONS OF LAW AND OPINION

Claimant argues that the Referee failed to correctly apply the disability rating standards because he failed to award a value for anything other than claimant's impairment. SAIF argues that the Referee's award should be reduced to zero because application of the standards allows no value for claimant's age, education, or adaptability when there is no ratable impairment.

### Determining Which Standards Apply

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

For purposes of determining injury-related permanent partial disability, ORS 656.283(7) and 656.295(5) require application of the standards for the evaluation of disabilities adopted by the Director pursuant to ORS 656.726(3)(f)(A). The standards in effect on the date of the Determination Order from which the hearing was requested, control the evaluation of permanent partial disability. OAR 438-10-010.

Here, claimant became medically stationary on June 13, 1988, and the Determination Order is dated October 3, 1988. Therefore, the standards adopted effective July 1, 1988, (former OAR 436-35-001 et seq), as amended by temporary rules effective August 19, 1988, apply to the rating of claimant's permanent partial disability. Former OAR 436-35-270 through 436-35-440 apply to the rating of unscheduled permanent partial disabilities. Former OAR 436-35-270(1).

It is apparent from citations in the Referee's opinion that he applied the standards effective January 1, 1989 rather than those identified above. We must recalculate claimant's disability in light of the applicable standards. Our review is de novo on the hearing record. The underlying facts to which the standards are applied need only be established by a preponderance of the evidence.

### Determination of Unscheduled Permanent Disability

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

### Age

The appropriate value for claimant's age of 31 years is 0. Former OAR 436-35-290.

Education

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

Skills

Former OAR 436-35-300(4) adopts by reference the "SVP" (specific vocational preparation time) values assigned to various occupations by the Dictionary of Occupational Titles (DOT), published by the U.S. Department of Labor. The highest SVP level demonstrated by a claimant during the ten years prior to the date of injury is used to determine a value for skills. Former OAR 436-35-300(4). Claimant's highest SVP during the ten years prior to the date of injury was 7 as a General Duty Nurse (DOT # 075.374-010). Therefore, the appropriate value for skills is +1. Id.

Training

Claimant has documented training as a registered nurse with certification in psychiatric nursing. Therefore, the appropriate value for training is 0. Former OAR 436-35-300(5). Claimant's total education value is +1, the formal education value plus the skills value plus the value for training. Former OAR 436-35-300(5)(sic).

Adaptability Where Claimant Has Returned to Modified Work

SAIF argues that claimant's adaptability should be zero because she did not return to her regular work at the time of injury even though she was released to that work; or, in the alternative, that her return to modified work should not be rated at a value greater than +1. We are persuaded by claimant's uncontradicted testimony that she could not return to her regular work despite her release, because she could not continue to physically restrain unruly patients.

An adaptability value for a claimant who is unable to return to his or her usual and customary work but who has returned to modified work is determined from a matrix of values at former OAR 436-35-310(3)(a). That matrix compares the physical capacity of the claimant's usual and customary work with the physical capacity required by the modified work. This is true even though claimant may have the physical capacity to do heavier work than is required by the modified employment. Physical capacities are not defined by the standards generally. We utilize those definitions contained in former OAR 436-35-310(4)(a)-(d).

In this case, claimant's usual and customary work required the physical capacity to do medium work. Claimant's modified work required a light physical capacity. Therefore, the appropriate adaptability value is +2. Former OAR 436-35-310(3)(a).

Impairment

The Referee awarded claimant a total impairment value of 5 percent based on loss of repetitive use of her low back, relying on OAR 436-35-320(4). Under this provision, chronic conditions limiting repetitive use of an unscheduled body part shall be rated at 5 percent impairment of that part. However, this

provision did not become effective until January 1, 1989. The standards applicable in this case do not allow a value for conditions limiting repetitive use of an unscheduled body part. Therefore, we conclude that claimant is not entitled to any value under the standards for limited repetitive use of her low back.

Claimant contends that the Referee erred in not awarding a value under the standards for lost range of lumbar motion. Former OAR 436-35-360(6). She relies on Dr. Pasquesi's report that claimant flexed her lumbar spine to 30 degrees. However, the record does not establish that claimant is unable to fully flex her lumbar spine; rather, she is fearful of flexing more than 30 degrees because of the likelihood of triggering a muscle spasm. This does not establish a ratable loss of range of motion.

However, claimant is entitled to a value under the standards for loss of use or function resulting from disabling pain. Daniel M. Alire, 41 Van Natta 752 (1989). Accordingly, claimant is entitled to a value for disabling pain to the extent she limits her range of motion and other activity because of pain. Here, claimant's credible and uncontradicted testimony persuasively establishes that she suffers from disabling pain in her lower back which has permanently limited her ability to sit, stand, and drive. Further, she experiences disabling muscle spasms with minimal activity. Inasmuch as the standards do not provide for a value range for impairment attributable to disabling pain, we consider a value of 10 to be reasonable in this particular case.

Computation of Unscheduled Disability.

Having determined each value necessary to compute claimant's permanent disability under the standards, we proceed to that calculation. When claimant's age value 0 is added to her education value 1 the sum is 1. When that value is multiplied by claimant's adaptability value 2 the product is 2. When that value is added to claimant's impairment value 10 the result is 12 percent unscheduled permanent partial disability. Former OAR 436-35-280(1)-(7). Claimant's permanent disability under the standards is, therefore, 12 percent.

Disability Outside the Standards

Either party may establish that the record, as a whole, constitutes clear and convincing evidence that the degree of permanent partial disability suffered by claimant is more or less than the entitlement indicated by the standards. ORS 656.283(7) and 656.295(5). Claimant argues that she has established by clear and convincing evidence that she has suffered disabling pain, which should be considered outside the standards. We have already held that disabling pain is considered in determining the extent of permanent disability under the standards in effect for this case. Consequently, such pain is not evaluated separately by going outside the standards to establish by clear and convincing evidence that claimant's disability because of the pain is greater than the standards allow. See Daniel Alire, supra at 757.

Accordingly, because claimant has not proven by clear and convincing evidence that her disability exceeds that under the standards, we conclude that claimant is entitled to 12 percent unscheduled permanent disability for her low back condition as allowed by the standards.

ORDER

The Referee's order dated February 17, 1989 is modified. In addition to the Referee's award of 5 percent (16 degrees) unscheduled permanent disability, claimant is awarded 7 percent (22.4 degrees), giving her a total award to date

of 12 percent (38.4 degrees) unscheduled permanent disability for a low back injury. Claimant's attorney is awarded an approved fee in the amount of 25 percent of the increased compensation awarded by this order, not exceeding $3,800, payable by the SAIF Corporation directly to claimant's attorney. For services on review concerning SAIF's attempt to reduce claimant's award, claimant's attorney is awarded $500, to be paid by SAIF.

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In the Matter of the Compensation of
**HARLEY J. GORDINEER, Claimant**
WCB Case No. 88-14758
ORDER ON REVIEW
Vick & Gutzler, Claimant Attorneys
Dennis Ulsted (Saif), Defense Attorney

Reviewed by Board Members Nichols and Brittingham.

Claimant requests review of Referee Miller's order that: (1) set aside the SAIF Corporation's denial of his aggravation claim for a cervical, thoracic and lumbar spine condition; (2) closed the claim with an award of temporary total disability compensation through July 28, 1988; (3) affirmed the August 21, 1987 Determination Order which awarded no permanent disability; and (4) denied claimant's motion for reconsideration based on newly submitted evidence. On review the issues are jurisdiction, evidence, aggravation and propriety of the Referee's claim closure and extent ruling. We affirm in part and reverse in part.

## FINDINGS OF FACT

The Board adopts the Referee's "Findings," with the exception of the finding that claimant was medically stationary on July 28, 1988.

## FINDINGS OF ULTIMATE FACT

As a result of his June 6, 1988 exacerbation, claimant has sustained a worsening of his 1986 injury since the last arrangement of compensation. The 1986 injury materially contributed to that worsening.

## CONCLUSIONS OF LAW AND OPINION

### Aggravation

SAIF initially denied claimant's aggravation claim on the ground that claimant's condition had not worsened. In his opening statement at hearing, SAIF's counsel also argued that claimant's worsening was caused by a 1979 injury and, therefore, is unrelated to the 1986 injury.

The Referee concluded that claimant's condition had worsened and went on to address SAIF's alternative causation argument. On review, claimant contends that the Referee improperly assigned responsibility for the worsening to the 1979 injury. Claimant argues that the Referee did not have jurisdiction to rule on responsibility where that issue was not raised prior to hearing, and SAIF had not joined the insurer at risk for the 1979 injury. In the alternative,

claimant contends that the Referee erred in denying his motion to reconsider his ruling based on evidence submitted by claimant post-hearing.

Claimant has misinterpreted the Referee's order. The Referee, in fact, found a causal connection between the worsening and claimant's 1986 injury with SAIF and set aside SAIF's aggravation denial. The Referee expressly found that "[t]here is insufficient evidence . . . [to] conclude that claimant's exacerbation on June 6, 1988 was related to his 1979 injury instead of his 1986 injury." The Referee did not make a responsibility ruling. His remarks regarding disability attributable to the 1979 injury were made in reference to claimant's permanent disability following his recovery from the aggravation.

We affirm and adopt the Referee's ruling that claimant has sustained a compensable aggravation of his 1986 injury with SAIF. Consequently, we need not address the jurisdictional and evidentiary issues raised by claimant.

Claim Closure/Extent of Disability

The Referee found claimant medically stationary on July 28, 1988 and proceeded to close the claim and rate the extent of claimant's disability. The Referee awarded temporary total disability for the period June 6, 1988 through July 28, 1988, and concluded that claimant's current condition did not warrant an increase in permanent disability. On review, claimant argues that, under ORS 656.268, the Referee improperly closed the claim and rated the extent of claimant's disability, and that since closure was improper, SAIF must continue to pay temporary total disability benefits.

The issue of the extent of claimant's disability was raised by SAIF at hearing as an alternative issue if the Referee found that claimant had not suffered an aggravation of his condition. Since the Referee found that claimant had suffered an aggravation, the Referee improperly rated the extent of claimant's disability and closed the claim. As we have affirmed the Referee's aggravation ruling, the closure and extent issues are, likewise, not properly before the Board. Accordingly, we set aside the Referee's extent and claim closure ruling. See David A. Buswell, 42 Van Natta 123 (1990).

ORDER

The Referee's order dated December 16, 1988, as reconsidered January 6, 1989, is affirmed in part and reversed in part. We reverse those parts of the order that closed the claim, awarded temporary total disability compensation through July 28, 1988, and affirmed the August 21, 1987 Determination Order. The claim is remanded to the SAIF Corporation for further processing according to law. Claimant's attorney is awarded 25 percent of the increased compensation created by this order, not to exceed $750, payable directly to claimant's attorney. The remainder of the order is affirmed.

In the Matter of the Compensation of
**TONY GOMEZ, SR., Claimant**
WCB Case No. 88-14320
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Howell and Speer.

Claimant requests review of Referee Hoguet's order that dismissed his request for hearing as untimely. On review, the issues are whether claimant had "good cause" for failing to file his hearing request within 60 days of the self-insured employer's denial, and, if so, compensability. We affirm.

We adopt the Referee's "Findings of Fact" and those portions of his "Opinion" regarding jurisdiction, with the following comment. We agree with the Referee that EBI v. Lorence, 72 Or App 75, rev den 299 Or 118 (1985) is on point and instructive in this case.

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, confers jurisdiction 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, 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). 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 relies on Brown v. EBI Companies, 289 Or 455 (1980), contending that the negligence of the attorney's employee may be excusable neglect, where the lawyer's negligence would not be. We find that claimant's reliance on Brown is misplaced.

Brown is distinguished in Lorence, supra. In Brown, "[f]or some unknown reason, the attorney did not find out that the denial letter had reached his office until after the time for requesting a hearing had passed." Lorence, supra at 78. In Lorence, the attorney had the denial in his possession, delegated the task of filing the hearing request to an employee, then failed to make sure that it was filed on time. The Lorence court said, ". . . if a claimant's attorney had received the denial and failed to do anything, no good cause would exist." Id. The court found no substantial distinction between that situation and the facts of Lorence, and held that claimant had failed to establish good cause for his failure timely to file the request for hearing. Lorence was decided after the Supreme Court had adopted the definition for good cause contained in former ORCP 18.160. See Brown v. EBI Companies, supra.

We find that the facts of this case are substantially the same as those in Lorence. Like the court in Lorence, and for the same reasons, we find that claimant has failed to establish good cause for filing his request for hearing more that 60 days after the denial was mailed.

ORDER

The Referee's order dated May 18, 1989 is affirmed.

In the Matter of the Compensation of
**MARICE D. JACKSON, Claimant**
WCB Case No. 88-19869
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Cowling & Heysell, Defense Attorneys

Reviewed by Board Members Crider and Nichols.

Claimant requests review of Referee Myzak's order which affirmed a Determination Order awarding 16 percent (51.2 degrees) unscheduled permanent disability for injury to the mid and low back. On review, the issue is extent of unscheduled permanent partial disability. We affirm.

## FINDINGS OF FACT

The Board adopts the Referee's "Findings of Fact" and makes the following additional findings.

The at-injury employer offered claimant a modified job requiring light duty work which her attending physician agrees is within her physical capacity.

## FINDINGS OF ULTIMATE FACT

Claimant has sustained a 16 percent permanent loss of earning capacity as a result of her compensable injury.

## CONCLUSIONS OF LAW AND OPINION

Claimant was compensably injured while performing heavy work for the employer in October 1987. She was released to perform light duty work on March 30, 1988. The parties agree as to the values for age, education, training, and impairment, and only the adaptability value was and is in dispute.

The Referee found that the employer had offered a job to claimant which her attending physician agreed is within her physical capacity. Therefore, the Referee concluded that the adaptability value should be determined by the matrix set forth in OAR 436-35-310(3)(a). We agree, and adopt the Referee's "Opinion and Conclusion of Law" with the following comment and correction.

If a claimant became medically stationary after January 1, 1988, not 1989, and the claim was closed on or after July 1, 1988, a subsequent determination by a referee or the Board of the claimant's permanent partial disability must be made pursuant to ORS 655.283(7) and 656.295(5).

On review, claimant asserts that OAR 436-35-310(4)(c), and not 436-35-310(3)(b), applies to her situation and, therefore, based on her restriction to light work, the correct adaptability value is 4. In making this argument, claimant contends that there was no offer of suitable modified employment and, in the alternative, that she had five working days in which to accept or reject the offer, and that period had not elapsed at the time of hearing. We do not find claimant's argument to be persuasive.

On February 9, 1989, claimant met with her doctor, vocational rehabilitation counselor, and at-injury employer at her employer's place of business. At that meeting, the modified job was discussed, claimant's treating physician approved this job, claimant was presented with a three page description of the job and walked through the modified job duties, and she questioned her supervisor about different aspects of the job which she felt might be too strenuous

for her. Under these circumstances, we find that claimant's employer did make an offer of modified employment to claimant.

Moreover, under OAR 436-35-310(3)(b), acceptance is not a prerequisite to application of this provision. The rule only specifies that the employer make an offer. Therefore, we find that the employer's offer of employment was sufficient, and no further action on the part of the claimant was necessary for the provision to apply.

Accordingly, we find that the criteria for application of OAR 436-35-310(3)(b) are met. The correct adaptability value for a claimant who previously performed heavy work activity and has been offered suitable modified light work activity is 2.5, as delineated in the matrix in OAR 436-35-310(3)(a). Consequently, claimant's unscheduled permanent disability under the standards totals 16 percent.

ORDER

The Referee's order dated March 16, 1989 is affirmed.

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In the Matter of the Compensation of
**JUANITA J. JAMESON, Claimant**
WCB Case No. 88-19709
ORDER ON REVIEW
Parks & Ratliff, Claimant Attorneys
Michael L. Spencer, Attorney

Reviewed by Board Members Crider and Nichols.

The self-insured employer requests review of Referee Podnar's order that: (1) set aside its denial of claimant's claim for her low back condition; and (2) awarded claimant's attorney an assessed fee for prevailing over the denial at hearing. On review, the issues are compensability and attorney fees. We affirm.

FINDINGS OF FACT

The Board adopts the Referee's "Findings."

FINDING OF ULTIMATE FACT

Claimant's employment was a material contributing cause of her low back condition.

CONCLUSIONS OF LAW AND OPINION

Compensability

The Referee, finding that claimant's low back condition was sudden in onset, characterized the condition as an accidental injury and concluded that it is compensable. The employer argues on review that claimant's condition should be analyzed as an occupational disease and is not compensable as such. We do not necessarily agree with the Referee's analysis of claimant's condition as an injury. Nevertheless, we affirm the Referee's ultimate conclusion that claimant's claim is compensable.

The legislature amended the occupational disease statute, ORS 656.802, effective January 1, 1988. Since claimant's last exposure to work activity that

could have affected her condition occurred in 1988, we find that this case should be analyzed under the amended statute. Donna E. Aschbacher, 41 Van Natta 1242 (1989).

Claimant's claim is for conditions resulting from repetitive use of her back. Therefore, it must be assessed under former ORS 656.802(1)(c). This provision defines as one type of occupational disease:

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

The former statute does not require that the agent of the condition be one to which claimant is not ordinarily subjected or exposed other than during a period of regular actual employment therein. Claimant need only show that the work exposure was a material contributing cause of her increased symptoms. She need not establish that work exposure was the major contributing cause of them. Thus, whether claimant's condition is analyzed as an accidental injury or as an occupational disease, the standard remains the same. The employer's argument is therefore moot.

Like the Referee, we conclude that the record establishes a material relationship between claimant's symptoms and her work activity.

Dr. Viet opined on October 18, 1988 that claimant's back condition is causally related to her employment. His opinion is unrefuted on the record. Therefore, we defer to his opinion and concur in the Referee's ultimate conclusion that claimant has established a compensable claim.

Attorney Fees

The Referee awarded claimant's attorney an assessed fee for prevailing over the employer's denial at hearing. The employer argues that the fee award should be reversed because the award was made without regard to the employer's due process rights under the Oregon Constitution and the Fourteenth Amendment to the United States Constitution. The employer argues that due process requires notice and an opportunity to be heard on the amount of the fee award, but that the administrative rules do not provide for service of the statement of services on the employer's counsel, or for any process by which he may challenge the statement of services.

The employer's argument assumes that there is no duty under the rules to serve statements of service on opposing counsel. The employer is incorrect. OAR 438-05-046(2)(a) provides that "[a] true copy of any thing delivered for filing . . . shall be simultaneously [delivered] to each other party, or their attorneys." Furthermore, contrary to the employer's assertion, a statement of services can be challenged by a party on reconsideration, on Board review or on court appeal. Accordingly, we affirm the Referee's attorney fee award.

ORDER

The Referee's order dated March 9, 1989 is affirmed. For services on review concerning the compensability issue, claimant's attorney is awarded an assessed fee of $1,000, to be paid by the self-insured employer.

In the Matter of the Compensation of
**DAVID E. JOHNSTON, Claimant**
WCB Case No. 88-18610
ORDER ON RECONSIDERATION
Robert J. Guarrasi, Claimant Attorney
Dennis Ulsted (Saif), Defense Attorney

Claimant requests reconsideration of that portion of our July 5, 1990 Order on Review which approved an attorney fee equal to 25 percent of claimant's increased permanent disability compensation created by our order. Claimant seeks an assessed attorney fee. He contends that the SAIF Corporation sought, at the hearing level, reduction of claimant's unscheduled permanent disability award for an injury to claimant's back and that the Referee, thereafter, improperly reduced claimant's award. Consequently, claimant argues that he is entitled to an assessed attorney fee, for his services at hearing, payable by SAIF. We disagree.

If a claimant requests review of a Referee's order on the issue of temporary or permanent partial disability and the Board awards additional compensation, the Board shall approve a fee of 25 percent of the increased compensation, provided that the total of fees approved by the Referee and the Board shall not exceed $3,800. OAR 438-15-055(1). If a carrier requests a hearing seeking the reduction of compensation and the Referee does not reduce the compensation, the Referee shall award a reasonable assessed fee. OAR 438-15-065. In the event a carrier requests or cross-requests review of a Referee's order seeking the disallowance or reduction of compensation and the Board does not disallow or reduce claimant's compensation, the Board shall award a reasonable assessed fee. OAR 438-15-070.

Here, claimant requested Board review of the Referee's order, seeking an increase in his permanent disability award. Claimant's request was successful, inasmuch as we increased his compensation from the Referee's 28 percent unscheduled permanent disability award to 32 percent. Thus, as an attorney fee for his counsel's services, claimant's attorney was awarded 25 percent of any increased compensation created by our order, not to exceed $3,800. See OAR 438-15-055(1).

At the hearing level, SAIF did ask that claimant's 39 percent permanent disability award, as granted by the Determination Order, be reduced. The request was successful, since the Referee reduced claimant's award from 39 percent to 28 percent. Because claimant did not successfully defend against SAIF's request for reduction of his compensation at the hearing level, he is not entitled to an assessed fee. See ORS 656.382(2); OAR 438-15-065. Moreover, inasmuch as SAIF neither requested nor cross-requested Board review of the Referee's order, claimant is also not entitled to an assessed fee for services on review. See ORS 656.382(2); OAR 438-15-070. Instead, as previously discussed, any fee awarded to claimant is payable from any increased compensation created by our order. See ORS 656.386(2); OAR 438-15-055(1).

Accordingly, our July 5, 1990 order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our July 5, 1990 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
**BRUCE L. KLEIN, Claimant**
WCB Case Nos. 88-04718, 88-09710 & 88-13773
ORDER ON REVIEW
Olson, Rowell & Walsh, Claimant Attorneys
Gail Gage (Saif), Defense Attorney

Reviewed by Board Members Nichols and Crider.

The SAIF Corporation requests review of those portions of Referee Higashi's order that: (1) set aside its denial of claimant's aggravation claim and his occupational disease claim for a cervical condition; and (2) awarded an assessed attorney fee. On review, the issues are compensability 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:

Claimant experienced some minor neck pain prior to his November 7, 1985 compensable injury. It did not cause claimant to miss work or to seek medical treatment.

The neck pain that came on when claimant began his authorized training program was more severe than that which he had previously experienced. The increase in pain caused him to discontinue the training program. His treating physician, Dr. Carpenter, M.D., referred him to Dr. Gehling, M.D., for consultation.

On February 23, 1988, SAIF issued a denial of medical services for claimant's cervical pain on the grounds that claimant's cervical condition was unrelated to his November 7, 1985 compensable low back injury.

On March 21, 1988, claimant filed an occupational disease claim stating that neck and back pain came on as a result of his work in the authorized training program. SAIF denied this claim by letter dated March 17, 1989.

At hearing, claimant asserted the compensability of the neck condition on alternative theories.

## ULTIMATE FINDINGS OF FACT

We adopt the Referee's ultimate finding of fact except that we find that claimant's activity in the authorized training program, which involved repetitive use of his arms while working in an awkward posture, was a material contributing cause of a worsening of, rather than the onset of, the symptoms of his preexisting underlying neck condition.

## CONCLUSIONS OF LAW AND OPINION

We adopt the Referee's conclusions of law. See Donna E. Aschbacher, 41 Van Natta 1242 (1989). Nevertheless, we note that while the Referee discussed only the occupational disease claim in his Opinion and Conclusions, his order set aside the denial of the aggravation claim as well as the denial of the occupational disease claim. We supplement the Referee's order with the following aggravation analysis.

We are not persuaded that claimant's neck pain and disability was caused in material part by the compensable low back injury. We note that although claimant reported that his neck pain began several weeks after the back injury, he also reported to both the Western Medical Consultants and to Dr. LaFrance and testified at hearing that he had suffered neck pain prior to his low back injury; that pain was apparently brought on by overhead work at the employer's facility. We are unwilling to credit Dr. LaFrance's view, articulated in his March 13, 1989 report, that the 1985 injury contributed to the development of claimant's underlying cervical spondylosis. We give greater weight to the opinion of Dr. Gehling, neurologist, who treated claimant on referral. Dr. Gehling opined that the low back injury had nothing to do with the development of the underlying neck disorder. The pain that caused claimant's inability to participate in the rehabilitation program in 1989 is related to the underlying TOS and degenerative processes coupled with his ATP activities, but there is no indication that this disability was related in material part to the compensable back injury. Consequently, there is no basis for the Referee's order setting aside the denial of aggravation.

ORDER

The Referee's order dated May 9, 1989 is affirmed in part and reversed in part. That portion of the order that set aside the February 23, 1988 denial is reversed. The denial is reinstated and upheld. The balance of the order is affirmed. For services on review, concerning the occupational disease issue, claimant's attorney is awarded an assessed fee of $600, payable by the SAIF Corporation.

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In the Matter of the Compensation of
**DELMA R. OLSEN, Claimant**
WCB Case No. 88-22522
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Beers, et al., Defense Attorneys

Reviewed by Board Members Nichols and Brittingham.

Claimant requests review of Referee Leahy's order that upheld the insurer's denial of claimant's claim for temporary total disability benefits related to her lumbar fusion surgery. On review, the sole issue is entitlement to temporary total disability benefits. We affirm.

FINDINGS OF FACT

Claimant, 43 years old at the time of hearing, compensably injured her low back while working in a pharmacy stockroom on January 6, 1978. Dr. Samuel, D.C., diagnosed muscle strain. No time loss was awarded and claimant was treated conservatively. She continued her at-injury job until 1979, and then performed somewhat lighter employment until March 31, 1983. At that time she quit to get married and because her husband told her to quit because of her complaints of back problems. She has not worked since that time.

On June 17, 1983, treating physician Bert, orthopedist, reported that claimant continued to experience back and leg pain. Her condition aggravated in February 1984, and the claim was eventually reopened. In June 1984, Dr. Bernstein, M.D., recommended retraining claimant for lighter work. On February 15, 1985, claimant was independently examined by Dr. Martens, orthopedist. He

diagnosed chronic lower back strain and disc degeneration at L-5, S-1. On June 28, 1985, Dr. Bert released claimant to light work. The claim was eventually reclosed with an award of 20 percent unscheduled permanent disability for her low back condition.

On September 24, 1985, claimant was referred to vocational counseling to assist her return to work. On December 2, 1985, her vocational counselor reported that claimant's husband did not want her to participate in vocational rehabilitation and was opposed to claimant returning to work. On January 23, 1986, claimant reported to her vocational counselor that her husband was adamant that claimant not return to work. Claimant's vocational services were terminated pursuant to OAR 436-120-090(7), as she agreed that she was unavailable for such services.

On April 15, 1988, claimant underwent an independent psychological examination administered by Dr. Gardner, psychiatrist. Claimant stated that she was not looking for nor expecting to work.

On April 25, 1988, Dr. Samuel reported that claimant's back condition prevented her from working outside the home. On October 18, 1988, claimant had lumbar fusion surgery. On January 10, 1989, the insurer denied entitlement to temporary total disability benefits.

At hearing, claimant testified that she had looked for clerking jobs with some employers in the spring of 1986. She discussed her back problems with the potential employers. Claimant testified that she again looked for work around Christmas of the same year but was not hired. She did not look for work in 1987 because her back was worsening. Claimant indicated in her testimony that after her surgery she intended to return to work and had filed one written job application. Claimant's sister testified that she took claimant to four potential employers in the spring of 1986.

## FINDING OF ULTIMATE FACT

Claimant was not in the work force at the time her condition worsened.

## CONCLUSIONS OF LAW AND OPINION

Claimant is not entitled to temporary disability benefits if she was not in the work force at the time of her worsening. Cutright v. Weyerhaeuser, 299 Or 290 (1985). Claimant is deemed to be in the work force if: (1) she was engaged in regular gainful employment at the time of the worsening; (2) although not employed, she was making reasonable efforts to obtain employment; or (3) although willing to work, she was not looking for employment for reasons related to the compensable injury, where such efforts would be futile. Dawkins v. Pacific Motor Trucking, 308 Or 254 (1989).

The Referee found that claimant had removed herself from the work force and was not entitled to temporary disability benefits. On review, claimant relies on the fact that she left work, in part, because her husband told her to quit because of her back problems. Claimant contends that this establishes that she left work due to her back condition. She further contends that she searched for other work prior to her worsening.

The medical evidence establishes that claimant was at least capable of performing light work immediately prior to her worsening. Assuming, for the sake of argument, that the job she left in 1983 was beyond her limitations, she has not established that it would have been futile for her to seek less demanding employment. We are not persuaded that claimant conducted a serious work

search. She established only that she inquired with a few employers, and made only one written application. This search occurred on two days in 1986, and claimant has made no effort since then to find work. Furthermore, claimant agreed that she was unavailable for vocational services and they were terminated. Finally, she told psychiatrist Gardner in April 1988 that she was not looking for work or expecting to return to work. This persuades us that claimant was not willing to work immediately prior to her worsening.

In light of these facts, we find that claimant was not in the work force at the time of her worsening. Therefore, she is not entitled to an award of temporary total disability benefits. Accordingly, the Referee's order is affirmed.

ORDER

The Referee's order dated April 17, 1989 is affirmed.

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In the Matter of the Compensation of
**MICHAEL L. PAGE, Claimant**
WCB Case No. 82-08859
ORDER ON REVIEW
Royce, et al., Claimant Attorneys
Bullivant, et al., Defense Attorneys

Reviewed by Board Members Nichols and Brittingham.

Claimant requests review of those portions of Referee Michael Johnson's order that: (1) found that claimant's back injury claim was not prematurely closed; (2) found that claimant did not file a timely aggravation claim for his psychological condition and, therefore, did not address the compensability of claimant's psychological condition; (3) found that claimant's claim for a March 1985 fall during an Authorized Training Program was properly processed by the insurer as a claim for further medical services, rather than a "new injury" claim, and concluded that the March 1985 fall was not a "new injury"; (4) declined to assess penalties and attorney fees for the insurer's alleged unreasonable failure to process claimant's claim for the March 1985 fall as a "new injury", the insurer's alleged unreasonable submission of the claim for closure, and the insurer's alleged unreasonable failure to process a claim for the psychological condition; and (5) upheld the insurer's denial of claimant's chiropractic treatments. In the event the Board does not rule in claimant's favor regarding the premature closure issue and the claims for the March 1985 incident and the psychological condition, claimant requests review of the portion of the order that increased claimant's unscheduled permanent disability award for his back condition from 10 percent (32 degrees), as awarded by Determination Order, to 20 percent (64 degrees). On review, the issues are premature closure, claims processing, aggravation, compensability, medical services, extent of unscheduled permanent partial disability, penalties and attorney fees. We reverse in part and affirm in part, with supplementation.

FINDINGS OF FACT

Claimant, 36 years of age at hearing, sustained a compensable injury on May 23, 1979. He suffered low back and lower thoracic pain and treated with a chiropractor.

A May 23, 1980 Determination Order awarded claimant temporary total disability through May 5, 1980. By stipulation on December 18, 1980, claimant was awarded 8 percent unscheduled permanent disability.

Claimant began vocational rehabilitation on February 26, 1981. In his vocational assessment report, Dr. Loeb, psychologist, deferred diagnosis; recommended no long term in-depth therapy; and reported his impression of character disorder, "severe by history." He concluded: "referral to a psychiatrist for evaluation of a major tranquilizer should be considered." (Ex. 14-A-4). The insurer did not respond to this recommendation.

On June 1, 1982, a CT scan produced normal results. (Ex. 22). Dr. Kaesche, then treating orthopedist, diagnosed claimant's condition as lumbosacral sprain. (Ex. 23).

In October 1984, claimant began an Authorized Training Program (ATP). The insurer reopened the claim and began paying temporary disability. On March 6, 1985, claimant slipped and fell at his ATP job. The incident was reported to the insurer by Dr. Robinson, claimant's treating chiropractor, on a First Medical Report form. The date of injury was listed as March 6, 1985. (Ex. 68). Claimant reported the incident to his vocational provider on March 7. (See Ex. 70). Dr. Robinson removed claimant from work. Vocational services were suspended due to claimant's medical condition. (Ex. 72).

In April 1985, Dr. Robinson indicated that claimant needed further treatment. In this report he referenced the 1979 injury claim. (Ex. 71).

Drs. Stevens, orthopedic surgeon, and Mead, neuropsychiatrist, performed an independent medical examination on June 3, 1985. They found no material change (resulting from the March 1985 incident) since the 1979 injury, but recommended further testing to rule out thoracic outlet syndrome. (Ex. 79).

Dr. Robinson referred claimant to Dr. Nelson, osteopath. On July 12, 1985, Dr. Nelson noted an injury date of March 6, 1985. He opined that claimant was not medically stationary, and recommended testing to rule out cervical radiculopathy. (Ex. 80).

Dr. Kaesche, claimant's former treating orthopedist, found claimant medically stationary as of July 26, 1985, with some work restrictions. He reported that claimant did not have thoracic outlet syndrome. Although he opined that claimant's symptoms were such as those associated with carpal tunnel compression, he found no objective physical findings to substantiate that impression. (Ex. 82-4). He also noted claimant's report that his pain was worsened by the March incident. (Ex. 82-2). Nevertheless, Dr. Kaesche concluded that "[n]o further diagnostic testing is indicated at this time." (Ex. 82-1).

Dr. Robinson released claimant to modified work on August 23, 1985.

The insurer paid temporary disability benefits under the 1979 claim until August, 29, 1985, when a Determination Order issued. The Determination Order declared claimant medically stationary as of July 26, 1985. His unscheduled permanent disability award was increased to 10 percent. (Ex. 87A).

On December 10, 1985, Dr. Robinson asserted that claimant had never been medically stationary while in his care. (Ex. 140-1).

A December 12, 1985 Determination Order identified an error in the August 1985 Determination Order with respect to entitlement to temporary disability compensation and corrected it. It found claimant not medically stationary on

March 6, 1985 and again medically stationary July 26, 1985. (Ex. 116). The error had no effect on the medically stationary date.

Dr. Renholds, M.D., examined claimant in December 1985. In addition to physical complaints, Renholds found claimant severely overfocused, with anxiety and depression. Psychological counseling and, perhaps, anti-depressant medication was recommended. (Ex. 118-5).

In January 1986, Dr. Robinson reasserted that claimant was never medically stationary after the March 1985 incident. (Ex. 134).

Dr. Kaesche reevaluated claimant in January 1986, and reported that he suffered from depression and possible carpal tunnel syndrome. Dr. Kaesche stated that claimant had worsened since July 1985 "from the point of view that this man is very distraught with regard to his situation." (Ex. 126-3). Dr. Kaesche noted objective findings of normal posture, full range of motion of the cervical spine, normal alignment of the thoracic vertebrae, along with some tenderness in the lower lumbar area. He concluded that, based on information provided to him by claimant, Dr. Robinson's chiropractic treatments were not relieving his symptomatology. (Ex. 126).

Later in January 1986, without reexamination, Dr. Kaesche attributed claimant's psychological deterioration to a "worsening of a work related condition. . . which began in about 1979." He stated that he knew of no interceding injury between January 1983 and claimant's January 6, 1986 evaluation -- despite the fact that he had previously acknowledged the March 1985 incident. (Supra, at p.4. Compare Exs. 82 & 135).

During this time, claimant received chiropractic treatment from Dr. Robinson at a frequency of three times per week. On March 26, 1986, the insurer denied payment for his treatment with Dr. Robinson, contending that the treatment was neither reasonable nor necessary. (Ex. 138A).

On April 21, 1986, the Independent Chiropractic Consultants examined claimant and found him medically stationary with respect to his 1979 injuries. It also felt that he would benefit from psychological evaluation and counseling, noting "possible anxiety/depression stress syndrome." (Ex. 139-7).

On January 7, 1987, Dr. Robinson for the first time described claimant as medically stationary. He rated claimant moderately impaired. (Ex. 141).

On January 26, 1987, Dr. Worthington, clinical psychologist, evaluated claimant and opined that he was not psychologically stationary, describing him as temporarily totally disabled, based on his psychological condition. (Ex. 142-2).

On March 19, 1987, Dr. Reiter, psychologist evaluated claimant and concluded that claimant was probably then functioning much the same as he had before his first injury. (Ex. 144-8).

Claimant left school in the ninth grade, and left home at age 15. He is illiterate, has a history of violent behavior and may have dyslexia. At the time of injury, he was employed as a carpenter-framer.

## ULTIMATE FINDINGS OF FACT

No physician's report submitted before May 23, 1985 indicated that claimant suffered from a psychological condition related to his compensable injury.

Claimant's compensable injury was not a material cause of a worsening of his preexisting psychological condition.

The insurer's failure to process a claim for a psychological condition was not unreasonable.

Claimant does not have a psychological condition related to his compensable injury.

The insurer's failure to process claimant's "new injury" claim was unreasonable.

The March 6, 1985 incident at the "ATP" job independently contributed to a worsening of claimant's compensable condition.

Claimant's compensable condition was medically stationary as of the December 13, 1985 Determination Order.

Claimant has suffered 20 percent permanent loss of earning capacity due to his compensable injury.

Claimant's chiropractic treatments were not reasonable and necessary.

## CONCLUSIONS OF LAW AND OPINION

### Psychological Condition

#### Claims Processing/Penalties and Attorney Fees

Claimant contends that he made an aggravation claim for a psychological condition, and that the insurer's failure to accept or deny the claim is a "de facto" denial. He asks that this denial be set aside.

The Referee found that Dr. Loeb's February 26, 1981 report did not constitute an aggravation claim. We agree.

A physician's report which indicates a need for further medical services as a result of the compensable condition is a claim for aggravation. Former ORS 656.273(3); Haret v. SAIF, 72 Or App 668 (1985). A psychologist is a physician, as the term is defined in ORS 656.005(12). Crooke v. Gresham Transfer, 88 Or App 246 (1987).

In February 1981, Dr. Loeb, psychologist, evaluated claimant's psychological condition. He deferred diagnosis and declined to recommend long term in-depth therapy. He stated that claimant may have anxiety relative to his situation, but found no clear evidence. He also opined that claimant's character disorder "does not appear to be related to his industrial injury." The only mention of need for future treatment was: "A referral to a psychiatrist for evaluation of a major tranquilizer should be considered." (Ex. 14A-4).

Even if Dr. Loeb's report is construed to indicate a need for future medical services, an aggravation claim must indicate that the need is related to claimant's compensable condition. The report does not indicate a causal connection between the noted psychological condition and the compensable injury.

Claimant argues that other physicians' reports substantiate his claim for a psychological condition. The reports he refers to were produced after claimant's aggravation rights expired, May 23, 1985. Therefore, they do not constitute aggravation claims.

We conclude that claimant has not perfected a timely aggravation claim. Since there was no claim, there was nothing for the insurer to accept or deny. We find that the insurer's conduct in this instance was not unreasonable, and no penalties or attorney fees are assessed.

Merits of Psychological Claim

Claimant is entitled to continuing medical services for the residuals of his compensable injury, notwithstanding his failure to file a timely aggravation claim. Claimant contends that his psychological condition has worsened as a result of his industrial injury. Consequently, we must address the merits of his psychological claim, before considering whether or not he is medically stationary.

A claimant asserting the compensability of a psychological condition following an industrial injury must prove by a preponderance of the evidence that the compensable injury was a material cause of the condition, or if the mental condition predated the injury, that the injury worsened that preexisting condition. Jeld-Wen v. Page, 73 Or App 136, 139 (1985); Partridge V. SAIF, 57 Or App 163, 167, rev den 293 Or 394 (1982).

Considering claimant's multiple injuries and diagnoses, we conclude that the issue of whether claimant's psychological condition is materially related to his industrial injury is a complex medical question. The resolution of this issue largely turns on an analysis of the medical evidence. Uris v. Compensation Department, 247 Or 420, 426 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985).

As a preliminary matter, we consider claimant's reliability as a historian. Claimant contends that one cause of his current depression is chronic pain due to his injuries. Examining doctors have noted claimant's history of chronic pain since his first injury in 1979. Dr. Worthington, treating psychologist, concluded that claimant's "psychological condition is now interacting with his physical condition to the extent that his experience of chronic pain is psychologically worsened." (Ex. 142-5). However, we agree with the Referee's finding that claimant exaggerates his symptoms. This finding is corroborated by medical reports as early as 1981. (See Ex. 14A-3). Furthermore, claimant is intensely preoccupied with his physical symptoms. (Exs. 118-4 & 144-6-7). We conclude that claimant is not a reliable historian. Consequently, we do not rely on doctors' opinions which are based on claimant's reporting of his subjective complaints.

It is undisputed that claimant suffers from relatively severe depression and longstanding personality adjustment disorder. (See e.g., Ex. 144-7). It is also undisputed that claimant could benefit from psychological counseling. However, the medical evidence does not establish that claimant's psychological condition has worsened as a result of his industrial injuries. The medical evidence is divided regarding the contribution of claimant's work injury to his current psychological condition. When the medical evidence is divided, we give more weight to those medical opinions which are both well-reasoned and based on complete information. Somers v. SAIF, 77 Or App 259, 263 (1986).

Dr. Worthington, treating psychologist, reported claimant's depression and frustration over his loss of physical capacity. Worthington opined that claimant's sense of failure in new vocational areas contributed to his depression. (Ex. 146-2). Worthington noted that achievement in these areas was impossible for claimant, due to his developmental disabilities. We are not persuaded by Worthington's opinion for two reasons. First, the conclusion appears to be based solely on claimant's reporting of subjective complaints, which we

have found unreliable. Second, we find Worthington's conclusion outweighed by the opinions of Drs. Loeb and Reiter. See Weiland v. SAIF, 64 Or App 810 (1983).

In 1981, after claimant's first injury, Dr. Loeb, psychologist, noted claimant's severe character disorder, which he found unrelated to the injury. He also noted that, although claimant may have had some anxiety relative to his situation, he found no clear evidence of this. (Ex. 14-A-4). Based on his 1987 examination (after claimant's second injury), Dr. Reiter, psychologist, concluded that claimant has suffered psychological as well as developmental problems from a very early age. (Ex. 144-7). He further opined that "[claimant's] injury of 1979 and resulting problems, probably would have resolved if not for the pre-existence of premorbid psychological and developmental difficulties." (Id.) Reiter concluded that claimant is currently functioning "at a level probably not much different than prior to his first injury." (Ex. 144-8). We are persuaded by this thorough and well-reasoned opinion from a psychological specialist. See Somers v. SAIF, supra. We conclude that claimant has not established that his preexisting psychological condition worsened as a result of his industrial injury. Consequently, his current psychological condition is not compensable.

Claim For March 1985 Fall

Claims Processing/Penalties and Attorney Fees

Claimant contends that he made a "new injury" claim following his March 1985 fall, and that the insurer has "de facto" denied the claim by its failure to accept or deny in writing within 60 days.

The Referee found that claimant did not make a new injury claim following the March 6, 1985 incident. He reasoned that Dr. Robinson's First Medical Report was merely a request for authorization of further medical services. The Referee concluded that inasmuch as claimant's claim was already open and claimant was receiving temporary disability benefits, there was no reason to reopen the claim. We disagree.

Dr. Robinson reported claimant's slip and fall to the insurer with a Form 801 listing a date of injury of March 6, 1985. On March 7, claimant reported the injury to his vocational counselor, who apparently reported the incident to the insurer. (See Ex. 74). Either report constituted a claim for a new injury.

The first Medical Report described the March incident as a "traumatic" fall whereafter claimant suffered "acute" thoracocervical and lumbosacral sprain. (Ex. 68). We find that, upon receipt of this report, the insurer had sufficient knowledge of claimant's injury to lead a reasonable insurer to conclude that additional workers' compensation liability for a new injury was a possibility and that further investigation was appropriate. See Argonaut Insurance Company v. Mock, 95 Or App 1 (1989). The insurer's failure to accept or deny the claim as required by ORS 656.262 was unreasonable.

However, it appears that the insurer paid temporary disability compensation to claimant on an aggravation basis during the period in question. Consequently, there are no amounts then due upon which a penalty may be assessed. Unlike a penalty, an attorney fee can be awarded even though there are no amounts "then due," provided that the insurer has otherwise unreasonably resisted the payment of compensation. Cindi A. Cadieux, 41 Van Natta 2259 (1989). Here, we conclude that the insurer's failure to accept or deny claimant's "new

injury" claim constitutes an unreasonable resistance to the payment of compensation. Consequently, a reasonable attorney fee shall be assessed. ORS 656.262(10); 656.382(1).

"New Injury" v. Aggravation

An injury suffered during an authorized training program may be either an aggravation or a new injury. SAIF v. Partible, 98 Or App 244 (1989). This is so even where the incident will be the responsibility of the insurer on the initial injury no matter how characterized. Firkus v. Alder Creek Lumber, 48 Or App 251 (1980); Wood v. SAIF, 30 Or App 1103 (1977), rev. denied, 282 Or 189 (1978).

The insurer concedes that claimant's fall is compensable and that it is responsible. The only issue is whether the claim should be processed as an "aggravation" or a "new injury." The test for distinguishing an "aggravation" from a "new injury", where neither compensability nor responsibility is in dispute is:

> "Worsened symptoms of a compensable injury represent an aggravation, assuming all other requirements of an aggravation claim are met. A worker suffers a compensable new injury only if a subsequent incident or employment contributes to a worsening of the prior underlying condition."

See Teresa L. Walker, 41 Van Natta 2283, 2283-4 (1989).

Claimant's claim had been closed by Determination Order in May 1980. It had been reopened solely for vocational training, at which time claimant suffered another fall in March 1985. This fall produced an acute thoracocervical and lumbosacral sprain.

The May 1979 injury was to the mid and low back. Claimant soon reported neck pain as well (Exs. 6 & 11), and asserted that it had persisted since 1979.

Claimant later indicated to Dr. Kaesche, who treated him in 1982-84, that the neck problem stemmed from an automobile accident which occurred prior to the compensable injury. The neck pain resolved and was not reported from 1982-1984. The neck pain reemerged in acute and disabling form at the time of the March 1985 fall. As a result of the acute injury, claimant sought medical care and was taken off work.

We find that the March 1985 injury worsened claimant's underlying condition, based on Dr. Kaesche's opinion. Therefore, claimant has established that the March 6, 1985 incident independently contributed to a worsening of his underlying condition. Consequently, he has suffered a new injury.

Premature Closure

Medically Stationary Date

Claimant argues that the Evaluation Division prematurely closed his claim with the August 29, 1985 Determination Order. He contends that the Referee erroneously relied on a medical examiner rather than his treating physician to find that he was medically stationary. Claimant asks that the Determination Order be set aside.

The Referee noted that closure was based on Dr. Kaesche's report and that Kaesche was in at least as good a position as Dr. Robinson to determine whether claimant was medically stationary as of closure. The Referee observed that Kaesche was aware of the March 1985 incident. The Referee's opinion also relies on Drs. Stevens and Mead, who doubted that the March incident resulted in any material changes in claimant's condition. We agree with the Referee that the claim was not prematurely closed, based on different reasoning.

Claims shall not be closed nor temporary disability compensation terminated if the worker's condition has not become medically stationary. ORS 656.268(1). An injured worker is 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 no longer a need for continuing medical care. Maarefi v. SAIF, 69 Or App 527, 531 (1984). It is claimant's burden to establish that he was not medically stationary when the claim was closed. Berliner v. Weyerhaeuser, 54 Or App 624, 628 (1981); Dale R. Bennett, 40 Van Natta 843 (1988).

The medically stationary date is primarily a medical determination, based on competent medical evidence. Harmon v. SAIF, 54 Or App 121, 125 (1985). We evaluate claimant's condition and the reasonable expectation of improvement as of the date of closure. Alvarez v. GAB Business Services, 72 Or App 524 (1985).

The August 1985 Determination Order was replaced by another order issued in December of that year. Therefore, the propriety of the closure turns on whether claimant was medically stationary at the time of the December 1985 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, supra. 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).

The December 1985 Determination Order apparently relied on Dr. Kaesche's opinion that claimant was medically stationary on July 26, 1985. Claimant's treating chiropractor, Dr. Robinson, repeatedly and consistently opined that claimant was not medically stationary before January 7, 1987. When the medical evidence is divided, we give great weight to the conclusions of claimant's treating physician, absent persuasive reasons not to do so. Weiland v. SAIF, supra. In this case, we find persuasive reasons not to rely on Dr. Robinson's opinion regarding claimant's condition.

Throughout the period of his treatment, Dr. Robinson's reports are conclusory, with only two exceptions. (In an April 16, 1985 report he noted a 50 percent decrease in claimant's spinal range of motion and in a November 20, 1985 report, a 60 percent decrease.) We conclude that the majority of Dr. Robinson's opinions concerning claimant's condition are based on claimant's reporting of his discomfort. In this regard, we have agreed with the Referee's finding that claimant was not persuasive, "because he over-exaggerates his physical complaints and resultant difficulties." We also note claimant's admission that Dr. Robinson's treatments were not helping him. As a result, we accord Dr. Robinson's conclusory opinions little weight.

In January 1986, Dr. Kaesche examined claimant and noted objective findings of normal posture, full range of motion of the cervical spine, normal alignment of the thoracic vertebrae, along with some tenderness in the lower

lumbar area. We rely on Dr. Kaesche's thorough, well-reasoned opinion, and conclude that claimant was medically stationary by the time of the December 1985 Determination Order.

Penalties and Attorney Fees

Claimant contends that he is entitled to penalties and attorney fees because the insurer unreasonably submitted this claim for closure based on Dr. Kaesche's opinion. We disagree. The record does not suggest that the insurer failed to submit medical reports concerning claimant's condition to the Evaluation Division. Moreover, the reports submitted for evaluation support the view that claimant was medically stationary. Consequently, the insurer's conduct was not unreasonable. No penalty or attorney fee will be assessed.

Extent of Disability

We have found that claimant was medically stationary by December 1985, the date of the last determination order. Because we also find that claimant's medical condition did not change between claim closure and hearing, we proceed to consider the extent of claimant's permanent disability as of the date of hearing. See Gettman v. SAIF, 289 Or 609, 614 (1980).

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). After considering the aforementioned guidelines, we conclude that the Referee's award of a total of 20 percent unscheduled permanent disability accurately reflects the loss of earning capacity claimant has sustained as a result of his compensable back injury.

Chiropractic Treatments

On March 26, 1986, the insurer denied Dr. Robinson's treatment, on the basis that the treatment was not reasonable and necessary. (Ex. 138A) The insurer argued and the Referee held that coverage of continued chiropractic treatment was properly denied because its frequency was excessive. We agree with the result, but for different reasons.

Claimant is entitled to all reasonable and necessary medical services, curative or palliative, so long as they are for conditions resulting from the compensable injury. ORS 656.245(1); West v. SAIF, 74 Or App 317 (1985). Treatment is reasonable and necessary when it reduces claimant's pain and enables him to work. West, supra; Jose Ybarra, 40 Van Natta 5 (1988). It is claimant's burden to prove the reasonableness and necessity of treatment. McGarry v. SAIF, 24 Or App 1083 (1976).

On June 3, 1985, Drs. Stevens and Mead opined that chiropractic treatment was not appropriate "unless an extremely rapid short-term resolution of problems is noted." (Ex. 79-4). On January 29, 1986, Dr. Kaesche noted, based on information provided by claimant, that such treatment was not affording claimant any improvement in his symptomatology. (Ex. 135).

Dr. Robinson, treating chiropractor, opined that claimant would benefit from his continued treatment. We find Dr. Robinson's opinion, as treating chiropractor, outweighed by the thorough and well-reasoned opinions of Drs. Kaesche, Stevens, and Mead. See Somers v. SAIF, supra. Weiland v. SAIF, supra. In reaching this conclusion, we further note that the latter doctors'

opinions are corroborated by claimant's admission that chiropractic treatments were not helping him.

We conclude, therefore, that claimant has not met his burden of proof, and we affirm the Referee.

ORDER

The Referee's order dated August 5, 1987 is reversed in part and affirmed in part. The insurer's "de facto" denial of claimant's "new injury" claim for his March 1985 fall is set aside, and the claim remanded to the insurer for acceptance and processing in accordance with the law. For services at hearing and on review concerning this issue, claimant's attorney is awarded $2,500, to be paid by the insurer. The insurer's "de facto" denial of claimant's claim for further medical services related to his psychological condition is upheld. For services concerning the unreasonable failure to accept or deny the "new injury" claim, claimant's attorney is awarded a $500 attorney fee, to be paid by the insurer. The remainder of the Referee's order is affirmed.

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In the Matter of the Compensation of
**BONNIE J. PAYNE, Claimant**
WCB Case No. 88-18746
ORDER ON REVIEW
Dennis O'Malley, Claimant Attorney
Terrall & Miller, Defense Attorneys

Reviewed by Board Members Cushing and Gerner.

Claimant requests review of that portion of Referee Leahy's order that upheld the self-insured employer's denial of her occupational disease claim for bilateral epicondylitis and tremor conditions. On review, the issue is compensability. We affirm in part and reverse in part.

FINDINGS OF FACT

Claimant has a preexisting severe benign tremor condition commencing as early as 1953. Her treating physician for this condition is Dr. Wilson, M.D., whom she sees once a year for management of the benign tremor and review of prescriptive medicine.

On July 22, 1988, claimant received treatment from Dr. Postles, M.D., for bilateral elbow pain. She has not returned to her at-injury work, bus driving, since that date. One week later, claimant filed an occupational disease claim for tendinitis, contending that her work driving a bus caused a gradual onset of pain in both arms.

Claimant's work activities include repetitive motions of opening and closing the bus door, swinging and turning motions required in steering the bus and operating the controls on a repetitive basis.

In late August 1988, claimant received treatment for her bilateral elbow condition from Dr. Stewart, orthopedic surgeon.

In September 1988, two months after she began receiving medical treatment for her bilateral epicondylitis condition, claimant underwent an independent medical evaluation by Dr. Button, M.D.

In October 1988, the employer denied both the bilateral epicondylitis and tremor conditions. (Ex. 22). Claimant requested a hearing.

In November 1988, claimant was evaluated by Dr. Hazel, M.D., and Dr. Parvaresh, M.D.

Claimant's work activities driving a bus materially caused her bilateral epicondylitis condition.

Claimant does not have a diagnosed mental disorder.

## CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant failed to meet her burden of proving that her "current condition" was compensable as an occupational disease. However, we find that claimant suffers from two separate and distinct conditions: bilateral epicondylitis and tremors, both of which were denied in the October 1988 denial. First, claimant contends that her bilateral epicondylitis was caused by her work activities. Second, she contends that work-related stress caused a worsening of her preexisting benign tremor condition. We proceed to analyze each condition separately.

### Compensability of Bilateral Epicondylitis

Because claimant's last exposure to working conditions which could have caused her bilateral epicondylitis was in July 1988, the occupational disease law, which became effective January 1, 1988, is applicable. ORS 656.802; see Johnson v. SAIF, 78 Or App 143, rev den 301 Or 240 (1986). Further, because claimant's bilateral elbow pain began while working as a bus driver, which required repetitive twisting and turning of claimant's hands and arms, we conclude that her 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 increased symptoms or a worsening of her underlying condition. ORS 656.802(1)(c); Donna E. Aschbacher, 41 Van Natta 1242 (1989); Carole J. Damm, 42 Van Natta 225 (1990).

After our de novo review of the medical and lay evidence, we find that claimant's work activities, involving continuous and repetitive twisting and bending of claimant's arms and hands while driving a transit bus, are traumatic. See Joseph I. Vernaza, 42 Van Natta 1284 (1990); Dean A. Mintun, 42 Van Natta 1149 (1990); Mary L. Goudy, 42 Van Natta 1140 (1990).

In reaching this conclusion, we find that claimant's work driving a transit bus requires repeated opening and closing of the bus doors and swinging and turning motions to steer the vehicle. The process of opening and closing the bus doors involves claimant's left hand and arm and requires grasping or gripping of a lever that sticks out of the driver's side console. The lever is turned outward and laterally, and the wrist is then twisted outward in a counter-clockwise motion in an arc. (Ex. 27, Tr. 11-13). We find that such activities are repetitive in nature and traumatic. Therefore, based on claimant's credible description of her work activities, we find these repetitive activities to be traumatic.

The remaining question, then, is whether those work activities are a material cause of her bilateral epicondylitis.

Two physicians provided opinions regarding the causation of claimant's bilateral epicondylitis: Dr. Postles, M.D., claimant's treating physician; and Dr. Button, M.D., independent medical examiner.

The Board generally gives greater weight to the conclusions of a treating physician, unless there are persuasive reasons to do otherwise. Weiland v. SAIF, 64 Or App 810, 814 (1983); Nancy E. Cudaback, 37 Van Natta 1580, withdrawn on other grounds, 37 Van Natta 1596 (1985), republished 38 Van Natta 423 (1986). We find no persuasive reasons to do otherwise.

In January 1989, Postles, who treated claimant initially in July 1988 and continuously until present, opined that claimant's work activities were the "major contributing cause" of her bilateral epicondylitis. (Ex. 27). In reaching this opinion, Postles considered both claimant's work and nonwork activities. Therefore, we find his opinion to be persuasive. Weiland, supra.

In contrast to Postle's opinion, Button opined that claimant's "current condition" does not directly relate to her employment as a bus driver. (Ex. 18-3). Button evaluated claimant only once. Furthermore, at the time of evaluation, claimant had been off work for two months and her bilateral epicondylitis had already been treated during those same two months. (Ex. 18-3). Finally, Button's opinion does not distinguish between the epicondylitis condition and the tremor condition, both of which he evaluated. Under these circumstances, we give Button's opinion little weight.

Based on Postle's opinion, we find that claimant has met her burden of proving that her work activities were a material cause of her bilateral epicondylitis symptoms and condition.

Compensability of Benign Tremors

Claimant contends that work-related stressors during her last six months at work caused a worsening of her preexisting tremor condition. As such, she argues that her current tremor condition is compensable. We disagree.

Claimant's last exposure to work stressors which could have caused a worsening of her preexisting tremor condition was in July 1988. Therefore, the occupational disease law, which became effective January 1, 1988, is applicable. ORS 656.802; see Johnson v. SAIF, supra.

Therefore, to establish the compensability of her current tremor condition, it is claimant's burden to prove not only that her preexisting tremor condition has worsened, but also that stress at work was a material cause of such a worsening. ORS 656.802(1)(c); Donna E. Aschbacher, supra.

Claimant does not assert under which subsection of ORS 656.802 her condition should be found compensable. Therefore, we proceed to analyze her case under ORS 656.802.

ORS 656.802(1)(a) defines an occupational disease as one caused by toxic exposure. There is no contention or evidence to suggest that claimant's current tremor condition is caused by toxic exposure. Therefore, we find that her current tremor condition is not compensable under ORS 656.802(1)(a).

ORS 656.802(1)(c) defines an occupational disease as a "series of traumatic events." We have recently held that stress-related physical conditions are not compensable under ORS 656.802(1)(c). Ronald v. Dickson, 42 Van Natta 1102 (1990). However, the facts of the instant case are somewhat different than those found in Dickson.

In Dickson, the claimant alleged that he suffered from work-related stress which caused a physical condition. In the instant case, unlike Dickson, claimant alleges that work-related stress has worsened a preexisting condition, not caused a physical condition.

Our holding in Dickson stands for the proposition that stress-related physical conditions are not compensable under ORS 656.802(1)(c). The issue of whether the physical condition was caused by or worsened by the work-related stress is not the crucial factor in this instance. The crucial factor is whether or not the specific claimant is contending that his/her disability or need for medical treatment for a physical condition is caused by work-related stress.

We conclude that stress-related physical conditions, whether caused or worsened by the work-related stress, are compensable, if at all, under ORS 656.802(1)(b).

Consequently, since claimant contends that her work-related stress has caused a worsening of her tremor condition, we must analyze the compensability of her current tremor condition under ORS 656.802(1)(b).

ORS 656.802(1)(b) defines an occupational disease as:

> "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."

Here, however, claimant has not been diagnosed as having a "mental disorder." Therefore, claimant's tremor condition is not compensable under ORS 656.802(1)(b). Accordingly, we find that claimant's current tremor condition is not compensable.

ORDER

The Referee's order dated February 27, 1989, as supplemented March 14, 1989 and March 20, 1989, is affirmed in part and reversed in part. That portion of the Referee's order which upheld the self-insured employer's October 19, 1988 denial, insofar as it denied compensability of claimant's bilateral epicondylitis condition, is reversed. Claimant's bilateral epicondylitis condition is remanded to the employer for processing according to law. For services at hearing and on Board review concerning the compensability of claimant's epicondylitis condition, claimant's attorney is awarded a reasonable assessed fee of $2,000, payable by the employer. The remainder of the order is affirmed.

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In the Matter of the Compensation of
**DARLENE K. RIGGS, Claimant**
WCB Case No. 88-17209
ORDER ON REVIEW
Emmons, Kropp, et al., Claimant Attorneys
Cooney, et al., Defense Attorneys

Reviewed by Board Members Nichols and Brittingham.

Claimant requests review of those portions of Referee Emerson's order that: (1) upheld the self-insured employer's denial of claimant's claim for medical services for her back and shoulder condition; and (2) affirmed a Determination Order which awarded no permanent disability for that condition. On re

view, the issues are medical services and extent of unscheduled permanent partial disability. We affirm in part and reverse in part.

## FINDINGS OF FACT

The Board adopts the Referee's "Findings."

## FINDINGS OF ULTIMATE FACT

The self-insured employer's denial of claimant's medical services claim purported to deny all future treatment.

Claimant's back, shoulder and headache pain does not cause a loss of use or function.

## CONCLUSIONS OF LAW AND OPINION

### Medical Services

The Referee found that claimant's chiropractic treatments were neither reasonable nor necessary and upheld the self-insured employer's denial of those treatments. We reverse.

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).

Here, the insurer's denial stated that ". . . we will be unable to authorize additional manipulative and/or physical therapy after the date of this letter." As the self-insured employer has attempted to deny future responsibility for payment of medical services on an accepted claim, we hold that the denial is void. Evanite Fiber Corp. v. Striplin, supra. Accordingly, the denial is set aside.

### Extent of Unscheduled Disability

The Determination Order in this case issued on October 18, 1988. It awarded temporary disability, but no permanent disability. The Referee correctly applied the "standards" adopted effective July 1, 1988, as amended by temporary rules effective August 19, 1988, former OAR 436-35-001 et seq.

The Referee found that claimant suffered from no measurable impairment, so that he is not entitled to permanent disability. The Referee reasoned that, pursuant to former OAR 438-35-320(1)(a), pain is rated under the standards only if it results in loss of function, measured by loss of active ranges of motion. Finding that claimant had full range of motion of her affected body parts, the Referee held that she suffered from no impairment under former OAR 438-35-320(1)(a). On review, claimant contends she is entitled to a value under the standards for chronic pain which restricts the repetitive use of her back.

We agree with the Referee's ultimate conclusion that claimant has not sustained permanent impairment under the standards, but for different reasons. Claimant is entitled to a value under the standards for disabling pain that results in a loss of use of function -- whether or not the functional loss is otherwise measurable under the standards. Former 438-35-320(1)(a); Daniel M. Alire, 41 Van Natta 752 (1989). Claimant relies on treating chiropractor Grice's testimony that claimant suffers myofascial scarring and fibrosis of repair which sensitize the pain fibers in the muscles. Dr. Grice released

claimant to modified work only. On the other hand, Dr. Howell, osteopath, testified that any pain claimant suffers does not result in any loss of use or function.

We conclude there are persuasive reasons to defer to Dr. Howell's opinion over that of Dr. Grice. 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). Dr. Howell's well-reasoned opinion is supported by claimant's testimony that her physical condition is unchanged from her pre-injury status, she is able to do housework, and she refused a job offered by the employer at injury only because of a transportation problem and not her physical condition. Dr. Grice's opinion is not consistent with this testimony. Thus, we defer to Dr. Howell's opinion and conclude that claimant has not established that the pain she suffers is disabling. Accordingly, the Referee's order is affirmed on this issue.

Finally, claimant argues that Dr. Grice's opinion that claimant suffers from intersegmental loss of range of motion establishes that claimant suffers from disability which cannot be properly measured by the standards. We affirm and adopt the Referee's analysis on this issue.

ORDER

The Referee's order dated March 14, 1989 is reversed in part and affirmed in part. That part of the order upholding the self-insured employer's denial of medical services is reversed and the denial is set aside. The claim is remanded to the employer for further processing. The remainder of the order is affirmed. For services at hearing and on review regarding the denial of medical services, claimant's attorney is awarded an assessed fee of $1,500, to be paid by the employer.

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In the Matter of the Compensation of
**BURTON A. ROCHEFORT, Claimant**
WCB Case No. 88-14395
ORDER ON RECONSIDERATION
Callahan, et al., Claimant Attorneys
John Motley (Saif), Defense Attorney

On May 10, 1990, we issued an Order of Abatement in this matter stating that we had decided to reconsider our Order on Review of April 23, 1990. In our initial order, we affirmed Referee Seifert's order upholding the SAIF Corporation's denial of claimant's right foot arthritis. We based our decision on the fact the condition was not disabling and required only diagnostic services, as distinct from treatment. On reconsideration, claimant contends the condition is compensable under the court's analysis in Finch v. Stayton Canning Co., 93 Or App 168 (1988). We agree, disavow our prior position, and reverse the Referee.

FINDINGS OF FACT AND ULTIMATE FACT

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

Claimant received no treatment other than diagnostic services from either Dr. Miller or Dr. Fitchett. Neither doctor authorized time loss for claimant's arthritic condition; nor did they place any limitations on claimant's activities. Claimant quit his job with the school district for reasons unrelated to his arthritic foot condition.

## CONCLUSIONS OF LAW AND OPINION

Claimant experienced a work-related symptomatic worsening of a preexisting arthritic condition in the right ankle. Following diagnostic services, his treating physician did not feel that further treatment was appropriate; but he recommended a metatarsal bar or rocker bottom sole should claimant's symptoms increase further.

As claimant's last work exposure occurred in May 1988, we apply the occupational disease law that became effective January 1, 1988. The applicable section of that law is former ORS 656.802(1)(c) dealing with repetitive trauma. That provision defines an occupational disease as: "Any series of traumatic events or occurrences arising out of and in the course of employment which requires medical services or results in physical disability or death."

We agree with claimant's argument that this case is controlled by the court's opinion in Finch v. Stayton Canning Co., supra. The carrier in Finch denied the claimant's work-related carpal tunnel syndrome because the condition was not disabling and the claimant received no medical services other than diagnostic services. The Finch court set aside the denial, relying on ORS 656.005(8)(a), which defined a compensable injury as "an accidental injury * * * arising out of and in the course of employment requiring medical services or resulting in disability or death." The court noted that the statute made no distinction between diagnostic services and treatment. The court went on to hold that the diagnostic services at issue were compensable because the claimant suffered from a work-related occupational disease and the diagnostic services were necessary to determine what was wrong with her, notwithstanding the fact no treatment was recommended or rendered.

The applicable statutory language in Finch is essentially the same as in the present case, and we conclude that the rationale in Finch is equally applicable here. As in Finch, claimant has a work-related condition, i.e., a work-related symptomatic worsening of a preexisting condition; and diagnostic medical services were necessary to determine the nature of claimant's compensable symptoms and whether treatment was required. Accordingly, claimant's required medical service is within the meaning of former ORS 656.802(1)(c) and is, therefore, compensable. The Referee's order should be reversed.

## ORDER

The Referee's order, dated December 20, 1988, is reversed. The SAIF Corporation's denial of claimant' right foot condition is set aside, and the claim is remanded to SAIF for further processing according to law. For services at hearing and on review, claimant's attorney is awarded a $2,000 assessed attorney fee, payable by SAIF.

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July 31, 1990 Cite as 42 Van Natta 1705 (1990)

In the Matter of the Compensation of
**RON K. ROLLINS, Claimant**
WCB Case No. 89-00252
ORDER ON REVIEW
Burt, Swanson, et al., Claimant Attorneys
Rick Dawson (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

Claimant requests review of Referee Myers' order which upheld the SAIF Corporation's denial of his occupational disease claim for his psychological condition. On review, the issue is compensability. We affirm.

## FINDINGS OF FACT

The Board adopts the Referee's Findings of Fact.

## CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant's condition was not compensable because reasonable disciplinary actions, rather than overwork, caused claimant to seek psychological help. We agree.

ORS 656.802(1) provides, in part, that an occupational disease means:

> "(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."

ORS 656.802(2) provides that a mental disorder is not compensable under this chapter:

> "(a) Unless the employment conditions producing the mental disorder exist in a real and objective sense.
>
> "(b) Unless the employment conditions producing the mental disorder are conditions other than conditions generally inherent in every working situation or reasonable disciplinary, corrective or job performance evaluation actions by the employer, or cessation of employment.
>
> "(c) Unless there is a diagnosis of a mental or emotional disorder which is generally recognized in the medical or psychological community.
>
> "(d) Unless there is clear and convincing evidence that the mental disorder arose out of and in the course of employment."

The Referee found that claimant was not a satisfactory employee. Claimant had been disciplined for several incidents, most of which involved his failure to properly keep medical records or supervise client care. Complaints about claimant's performance were made by doctors, directors and staff. However, claimant argues that, if such events did occur, they were the result of the employer's overcrowded conditions and understaffing. Claimant contends that, under such circumstances, the employer's disciplinary process was not reasonable.

Claimant failed to note the weight gain of a diabetic client. He failed to monitor weight loss, lethargy or choking of a client. Claimant was counseled by his supervisor for his failure to give a client an injection. An assistant superintendent wrote claimant a disciplinary letter following an incident in which he failed to read and follow chart instructions. Claimant's supervisor testified that anyone who behaved in such a manner would have been reprimanded under the employer's rules. She also testified that claimant was never a good employee and his actions resulted in more supervision than other employees.

Claimant testified that he sought treatment because he felt that he was under pressure and stress. Claimant reported to Norwin Lowery, Ph.D., psychologist, that his stress was produced by his superiors' discriminatory practices, rather than "the nature of the work place." Dr. Lowery opined that claimant's mental and physical distress were directly related to his employment experiences as he had described them.

Dr. Turco, M.D., examined claimant and opined that he had experienced some depression and anxiety associated with a corrective work plan. Dr. Turco reported that claimant had repetitive problems getting along with supervisors.

We agree with the Referee's conclusion that disciplinary actions caused claimant to seek psychological help. We also agree that, under the circumstances, the disciplinary measures taken by the employer were reasonable. We conclude that claimant's current condition is primarily attributable to the employer's reasonable disciplinary process and is, therefore, not compensable.

ORDER

The Referee's order dated May 18, 1989 is affirmed.

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July 31, 1990 Cite as 42 Van Natta 1707 (1990)

In the Matter of the Compensation of
**WADE A. WEBSTER, Claimant**
WCB Case No. 88-14323
ORDER ON REVIEW
Malagon, Moore, et al., Claimant Attorneys
Nancy Marque (Saif), Defense Attorney

Reviewed by Board Members Crider and Nichols.

Claimant requests review of Referee Gruber's order which affirmed a Determination Order award of 5 percent (16 degrees) unscheduled permanent disability for a left shoulder injury. On review, the issue is extent of unscheduled permanent partial disability. We reverse.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" with the following exceptions. The Referee found that claimant was released to return to his regular work. However, following his February 1988 shoulder surgery, Dr. Lundsgaard, claimant's treating orthopedic surgeon, only released claimant to return to his modified post-injury groundskeeping job. Additionally, the Referee found that claimant could perform most of his previous employment activities. We, on the other hand, find that claimant cannot perform most of his prior jobs. He is limited to performing between light and medium level physical exertion.

We supplement with the following. Claimant's usual and customary work required medium and heavy level physical exertion, including lifting over 50 pounds and repetitive use of the upper extremities. As of the date of the hearing, claimant had returned to modified work as a groundskeeper which requires between light and medium level exertion, and allows claimant to work at his own pace.

Claimant is left-handed. Claimant has disabling pain which limits his ability to use his injured left shoulder to perform work-related activities. He is no longer able to lift over 50 pounds or use his upper extremities on a

repetitive basis, particularly overhead. He is also limited in his ability to engage in recreational and other activities.

FINDINGS OF ULTIMATE FACT

Claimant has sustained an 18 percent loss of earning capacity as a result of his compensable left shoulder injury.

CONCLUSIONS OF LAW AND OPINION

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

For purposes of determining injury-related permanent partial disability, ORS 656.283(7) and 656.295(5) require application of the standards for the evaluation of disabilities adopted by the director pursuant to ORS 656.726(3)(f)(A). Those "standards" in effect on the date of the Determination Order from which the hearing was requested control the evaluation of permanent partial disability. OAR 438-10-010. However, the Referee did not specify which "standards" he was applying.

In this case, claimant became medically stationary June 30, 1988, and the Determination Order issued September 6, 1988. Therefore, the "standards" adopted effective July 1, 1988, (former OAR 436-35-001 et seq), as amended by temporary rules effective August 19, 1988, apply to the rating of claimant's permanent partial disability. Former OAR 436-35-270 through 436-35-440 apply to the rating of unscheduled permanent partial disabilities. Former OAR 436-35-270(1). Accordingly, on review, these are the standards which we apply.

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

Consideration of the December 9, 1987 Determination Order

Claimant initially requested a hearing on a December 1987 Determination Order. The claim was reopened prior to hearing, and then reclosed by a September 6, 1988 Determination Order. Claimant's hearing request on that Determination Order was consolidated with the earlier hearing request.

The Referee based his extent rating on claimant's condition at the time of hearing. Claimant asserts that the Referee also should have considered his timely appeal from the earlier December 1987 Determination Order and analyzed his shoulder impairment under then applicable case law and the guidelines set forth in former OAR 436-30-380 et seq. However, disability is to be rated at the time of hearing. Gettman v. SAIF, 289 Or 609, 614 (1980); Emmons v. SAIF, 34 Or App 603 (1978).

We previously considered this issue in William J. Thomas, 42 Van Natta 841 (1990). There, a claimant also had requested review of two Determination Orders, one issued in 1987 before the effective date of the "standards" and one after. The Board held that even though the claimant had requested a hearing

from the earlier Determination Order, there was no reason to evaluate the claimant's permanent disability at any time other than at hearing. Likewise, in this case, we conclude that the Referee properly applied those "standards" in effect on the date of the September 6, 1988 Determination Order and rated claimant's impairment as of the November 1988 hearing.

Rating Unscheduled Disability Under the Amended Standards

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

Age

The appropriate value for claimant's age of 26 years is 0. Former OAR 436-35-290.

Formal Education

The appropriate value for claimant's 10 years of formal education and a GED is 0. Former OAR 436-35-300(3).

Skills

Former OAR 436-35-300(4) adopts by reference the "SVP" (specific vocational preparation time) values assigned to various occupations by the Dictionary of Occupational Titles (DOT), published by the U.S. Department of Labor. The highest SVP level demonstrated by a claimant during the ten years prior to the date of injury is used to determine a value for skills. Former OAR 436-35-300(4). Claimant's highest SVP during the ten years prior to the date of injury was 2 as a veneer grader (DOT # 569.587-010). Therefore, the appropriate value for skills is 4. Id.

Training

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

Adaptability

Claimant has been released to and has returned to modified work activity as a groundskeeper. An adaptability value for a claimant who is unable to return to his or her usual and customary work [See former OAR 436-35-270(3)(a)] but who has returned to modified work is determined from a matrix of values at former OAR 436-35-310(3)(a). That matrix compares the physical capacity of the claimant's usual and customary work with the physical capacity required by the modified work. This is true even though claimant may have the physical capacity to do heavier work than is required by the modified employment. Physical capacities are not defined by the "standards" generally. We utilize those definitions contained in former OAR 436-35-310(4)(a)-(d).

In this case, claimant's usual and customary work required the physical capacity to do medium and heavy work. Claimant's modified work requires between

light and medium physical capacity. Therefore, the appropriate adaptability value is 2.5. Former OAR 436-35-310(3)(a).

Impairment

Dr. Lundsgaard, claimant's treating orthopedic surgeon, documents that claimant has residual impairment consisting primarily of minimally reduced, but immeasurable, shoulder ranges of motion and disabling pain. His findings and opinions are unrebutted. The doctor notes that claimant has no appreciable atrophy of the shoulder girdle, excellent muscle strength, and no neurological compromise. Accordingly, other than disabling pain, claimant has no shoulder impairment for which a value may be assigned under the "standards." Former OAR 436-35-330(1) through 436-35-330(19) and OAR 436-35-010(2).

The Referee apparently did not assign any value for disabling pain under the standards. On review, claimant asserts that he is entitled to an award for disabling pain based on his demonstrated loss of use of his left shoulder. We agree.

Former OAR 436-35-010(2)(a) provides that pain can result in loss of use or function. When it does, it is rated based on the loss of use or function which results and no additional value is allowed for pain alone. The Board in Daniel M. Alire, 41 Van Natta 752 (1989) held that, inasmuch as the standards do not provide for a value range for impairment attributable to disabling pain, the Board on de novo review can consider the evidence and award the claimant a value that adequately compensates him for his loss of use or function attributable to disabling pain.

Here, we find that the preponderance of the evidence demonstrates that claimant has a loss of use or function in his dominant left shoulder attributable to disabling pain. Dr. Lundsgaard has opined that claimant has some residual impairment due to pain. Claimant has some slight limitation of abduction, external rotation, and internal rotation of his left shoulder which causes discomfort with repetitive use and overhead use. Claimant has returned to modified work as an apartment maintenance man doing groundskeeping and interior cleaning and painting. He works at his own pace. Claimant has pain after working one to two hours, requiring him to rest his shoulder or take pain medication.

In addition, claimant cannot cast fish, throw a football or baseball, swing a bat, dribble a basketball, or carry his 19 pound son. We consider a value of 5 percent in this particular case to be reasonable. This represents claimant's total unscheduled impairment value.

Computation of Unscheduled Disability

Having determined each value necessary to compute claimant's permanent disability under the "standards," we proceed to that calculation. When claimant's age value 0 is added to his education value 5, the sum is 5. Former OAR 436-35-280(4). When that value is multiplied by claimant's adaptability value 2.5, the product is 12.5. Former OAR 436-35-280(6). When that value is added to claimant's impairment value 5, the result is 17.5 percent. Former OAR 436-35-280(7). That disability figure is rounded to the next higher whole percentage. Id. Claimant's unscheduled permanent partial disability under the "standards" is, therefore, 18 percent.

Disability Outside the Standards

Claimant contends that the Director's rules do not adequately compensate him for his permanent disability relative to his left shoulder, and, therefore, the Referee should have found by clear and convincing evidence that his permanent partial disability exceeds that awarded under the standards. Claimant asserts, and the record establishes, that claimant is limited from performing his prior work in a veneer mill, as well as his other prior jobs that require the ability to lift up to 50 pounds and involve repetitive use of the shoulder in pulling, carrying, lifting, throwing, and overhead work.

However, we have already considered these limitations in assigning claimant a value under the standards for adaptability and disabling pain. On this record, we do not find that claimant has proven by clear and convincing evidence that he suffers permanent impairment outside the standards. We conclude, therefore, that an 18 percent award under the standards adequately compensates claimant for his lost earning capacity.

ORDER

The Referee's order dated December 27, 1988 is reversed. In addition to the Determination Order award of 5 percent (16 degrees) unscheduled permanent disability, claimant is awarded 13 percent (41.6 degrees), giving him a total award to date of 18 percent (57.6 degrees) unscheduled permanent disability for his left shoulder. Claimant's attorney is awarded an approved fee of 25 percent of the increased compensation awarded by this order, not to exceed $3,800, payable directly to claimant's attorney.

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July 31, 1990 Cite as 42 Van Natta 1711 (1990)

In the Matter of the Compensation of
**VICKIE C. WILEY, Claimant**
WCB Case No. 89-02368
ORDER ON REVIEW
Rick W. Roll, Claimant Attorney
Roberts, et al., Defense Attorneys

Reviewed by Board Members Cushing and Gerner.

Claimant requests review of those portions of Referee Neal's order which: (1) upheld the self-insured employer's denial of her occupational disease claim for a right hand (thumb) condition; and (2) declined to assess a penalty or related attorney fee for an alleged unreasonable denial. On review, the issues are compensability and penalties and attorney fees. We affirm.

FINDINGS OF FACT

We adopt the "Findings of Fact" as set forth in the Referee's order.

CONCLUSIONS OF LAW AND OPINION

Compensability

The Referee concluded that claimant had not established that her right hand (thumb) condition was compensably related to her work activities. Although we agree with this result, we modify the Referee's reasoning.

Before reaching claimant's occupational disease claim on its merits, it is first necessary to decide which version of former ORS 656.802(1) is applicable. This provision was revised by the legislature in 1987 and the revised version of former ORS 656.802(1) became effective January 1, 1988. Here, the injurious exposure alleged by claimant is the extensive use of her hand inherent in her job duties. Claimant continued to perform her job duties until October 1988 and thereafter sought medical treatment. Accordingly, we conclude that the occupational disease law, effective January 1, 1988, applies to claimant's claim. See Johnson v. SAIF, 78 Or App 143, 148, rev den 301 Or 240 (1986).

Dr. Erickson related claimant's condition to repetitive typing. Accordingly, claimant's condition is properly analyzed under former ORS 656.802(1)(c). See Ronald V. Dickson, 42 Van Natta 1102 (1990). To establish that her condition is compensable under subsection (1)(c), claimant need prove that her work exposure was a material contributing cause of either increased symptoms or a worsening of the underlying condition requiring medical services or resulting in disability. Donna E. Aschbacher, 41 Van Natta 1242 (1989).

Dr. Erickson opined that claimant's work activities, particularly typing, were the major contributing cause of her right thumb condition.

By contrast, Dr. Nathan opined that claimant's work activities did not contribute to her right thumb condition. He based his opinion on: (1) the fact that claimant had performed similar work for the previous ten years without any symptoms; (2) the fact that although claimant's work activities involved bilateral hand use, she only experienced symptoms in her non-dominant hand; and (3) the fact that claimant's work activities were not of sufficient force to produce the symptomatology of which she complained. In conjunction with Dr. Nathan, Dr. Aversano also opined that claimant's work activities were not causally related to her right thumb condition or symptoms.

We are persuaded by the opinion of Dr. Nathan and the supporting opinion of Dr. Aversano. Dr. Nathan offers a well reasoned explanation for his conclusion that claimant's work activities did not contribute to her right thumb condition or symptoms. Conversely, Dr. Erickson offers no explanation for his conclusion that claimant's symptoms are work-related. We do not find Dr. Erickson's opinion persuasive.

Accordingly, claimant has failed to established that her work activities were a material contributing cause of her right hand (thumb) condition or symptoms.

Penalties and Attorney Fees

We adopt the conclusions and reasoning concerning the penalty and attorney issue as set forth in the Referee's order.

ORDER

The Referee's order dated May 24, 1989, is affirmed.

In the Matter of the Compensation of
**JEFFERY R. WILLIAMS, Claimant**
WCB Case No. 88-17048
ORDER ON REVIEW
Robert L. Philmon, Claimant Attorney
Kengla, et al., Attorneys
Dennis Ulsted (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

Claimant requests review of those portions of Referee Scavera's order that: (1) found that he was not a subject worker; and (2) upheld the SAIF Corporation's denial of his claim for a low back injury. The noncomplying employer cross-requests review of that portion of the Referee's order that affirmed the Director's Proposed Order finding it to be a noncomplying employer. On review, the issues are compensability and noncomplying employer status. We affirm.

FINDINGS OF FACT

The Board adopts the Referee's "Findings."

CONCLUSIONS OF LAW AND OPINION

The Board adopts the Referee's "Conclusions and Opinion," with the following supplementation.

The Referee concluded that the employer had not timely filed a request for hearing on the issue of noncompliance and he therefore dismissed the request for hearing on that issue. In addition, the Referee affirmed the Proposed and Final Order of July 26, 1988. Because we find that the Referee properly dismissed the request for hearing, we conclude that he was without jurisdiction to affirm the Proposed and Final Order.

ORDER

The Referee's order dated February 6, 1989 is affirmed.

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In the Matter of the Compensation of
**RONALD D. WYTCHERLEY, Claimant**
WCB Case No. 88-19256
ORDER ON REVIEW
Dobbins & McCurdy, Claimant Attorneys
Parker & Bush, Attorneys
David Fowler (Saif), Defense Attorneys

Reviewed by Board Members Crider and Nichols.

The noncomplying employer requests review of Referee Podnar's order that set aside its denial of claimant's claim for a thoracolumbar strain. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact and take administrative notice that the Board has affirmed the dismissal of claimant's August 1, 1988 request

for hearing for failure to appear at the time and place scheduled for hearing. Ronald D. Wytcherley, 42 Van Natta 931 (1990).

FINDINGS OF ULTIMATE FACT

On August 3, 1988, the SAIF Corporation accepted claimant's claim for a March 14, 1988 injury, as processing agent for the noncomplying employer.

The denial of August 23, 1988 was issued by the noncomplying employer.

CONCLUSIONS OF LAW AND OPINION

The Referee set aside the noncomplying employer's denial of claimant's claim because it did not issue within 60 days of the claim's referral to SAIF for processing under ORS 656.054(2). He reasoned that any denial issued in excess of 60 days from referral was a "backup" denial, impermissible under Bauman v. SAIF, 295 Or 788 (1983). Since the claim for injury was filed and since the Referee's order was entered, the applicable law has been in a state of turmoil--making it difficult for the parties to know how to raise issues regarding the compensability of an injury alleged to have occurred by an employee of a noncomplying employer. We apply the law as it stands today and affirm for reasons somewhat different from those of the Referee.

When a claim is filed by an employee, the employer is found to be noncomplying and the claim is referred to SAIF for processing, only SAIF has the legal power to accept or deny the claim. Clark v. Linn, 98 Or App 393 (1989). If the noncomplying employer wishes to challenge the compensability of the claim, the employer must request a hearing under ORS 656.283. See Kristi L. Chase, 42 Van Natta 1247 (1990). Here, although the noncomplying employer initially requested a hearing, that request was withdrawn. The employer may not challenge compensability of a claim by issuing a denial.

The noncomplying employer correctly notes that claimant did not request a hearing within 60 days of the denial but did make his request within 180 days of the denial. Therefore, he would not ordinarily be entitled to a hearing absent a showing of good cause for late filing. ORS 656.319(1). Because, however, the denial was beyond the employer's power to issue and had no basis in law, claimant had no duty to timely request a hearing. Knapp v. Weyerhaeuser Co., 93 Or App 670, 674 (1988).

ORDER

The Referee's order dated February 27, 1989 is affirmed.

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In the Matter of the Compensation of
**MELINDA BARNETT, Claimant**
Own Motion No. 90-0289M
OWN MOTION ORDER ON RECONSIDERATION
Brian Welch, Claimant Attorney
SAIF Legal Department, Defense Attorney

Claimant requests reconsideration of the Board's June 20, 1990, Own Motion Order which denied her request for claim reopening on the ground that she has withdrawn from the work force. Claimant now contends that she was in the work force and requests additional time in which to submit supporting documentation.

Under Board rules, a motion for reconsideration shall be denied if not submitted to the Board in a timely manner. See OAR 438-12-065(2). In order to be timely, the motion for reconsideration must be submitted within 30 days of the date of mailing of the Board's order, or within 60 days of that mailing date if there was good cause for the failure to file a timely motion. Id. Here, claimant did not file her request for reconsideration until July 24, 1990, more then 30 days after the Board's order. Moreover, we do not find that there was good cause for the delay. Claimant states that she needs additional time due to physical limitations and difficulty in obtaining the necessary evidence. However, SAIF requested wage information from claimant on October 19, 1989, February 26, 1990, March 13, 1990, and, with their recommendation to deny claimant's temporary disability benefits, on May 16, 1990. Therefore, claimant has had several months to obtain the necessary evidence. Furthermore, claimant offers no reason for her delay in requesting reconsideration to obtain additional evidence.

Accordingly, the request for reconsideration must be denied.

IT IS SO ORDERED.

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In the Matter of the Compensation of
**LARRY M. BLISS, Claimant**
WCB Case No. 88-18448
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Nancy C. Marque (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

The SAIF Corporation requests review of that portion of Referee Seymour's order that awarded claimant temporary total disability benefits for the period January 18, 1988 to September 16, 1988. The issue on review is temporary disability compensation. We reverse.

## FINDINGS OF FACT

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

Between January 18, 1988 and September 16, 1988, claimant earned wages while performing modified employment. This employment consisted of sedentary work, including general oversight of his restaurant business. Claimant's wages during this period were at the rate of $2,000 per month. Claimant's at-injury wages were at the rate of $1,500 per month.

## CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant did not perform "substantial gainful work" and did not have "earned income from wages" after January 18, 1988. Therefore, the Referee concluded, claimant was entitled to temporary total disability benefits during the period in question. We do not agree.

Claimant's bar manager, Patricia Trim, credibly testified that claimant spent 2 to 3 hours per day working at the restaurant after January 1988. Claimant confirmed that he continued to work at the restaurant, albeit performing modified duties on a greatly reduced schedule. In this regard, the

modified work involved no lifting, but rather consisted of preparing banking transactions, making such transactions, and general oversight of the restaurant. We, therefore, conclude that claimant was performing work -- albeit modified and at significantly reduced hours -- between January and September 1988.

Because claimant engaged in modified work for wages, he is only entitled to receive temporary partial disability during that period. ORS 656.212; OAR 436-60-030(3). These temporary partial disability benefits are based on the difference between his regular wage and the wage he earned working at the modified work. OAR 436-60-030(1). If claimant's wage at the 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).

SAIF argues that claimant was receiving $2,000 per month in wages, an amount in excess of his wages at the time of injury. To arrive at this figure, SAIF notes that claimant reported quarterly wages to the IRS during the period in question of $6,000. Claimant argues that his bookkeeper reported this amount as wages merely for tax purposes, and that these sums were not in fact wages, but rather were "draws" against the corporate account to cover his living expenses.

We are not persuaded by claimant's characterization of the amounts he received as other than wages. In this regard, these amounts were reported as wages on claimant's W-2 form for federal income tax purposes. Taxes and amounts owed for social security were deducted from these amounts. We acknowledge that, as a result of our conclusion, claimant earned more for his modified work at significantly reduced hours than he earned prior to his injury while working full time. However, we note claimant's testimony that his salary prior to January 1988 similarly did not necessarily correspond to the number of hours he worked.

In sum, we conclude that claimant performed modified work during the period in question, and that he received wages in excess of his at-injury wages. Therefore, SAIF correctly did not pay him temporary disability compensation during this period.

ORDER

The Referee's order dated February 13, 1989 is affirmed in part and reversed in part. That portion of the Referee's order that found claimant to be entitled to temporary disability benefits during the period January 18, 1988 to September 16, 1988, is reversed. Claimant is entitled to no temporary disability benefits during this period. The remainder of the Referee's order is affirmed.

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August 2, 1990 Cite as 42 Van Natta 1716 (1990)

In the Matter of the Compensation of
**VERA A. GRAY, Claimant**
WCB Case Nos. 88-14728 & 88-05923
ORDER ON RECONSIDERATION
George W. Sohl, Claimant Attorney
Cowling & Heysell, Defense Attorneys

On July 10, 1990, we abated our June 11, 1990 Order on Review that had reversed a Referee's order which had set aside the insurer's aggravation denial. We took this action in order to consider claimant's motion for reconsideration.

The insurer was requested to file its response to the motion. Having received the insurer's response, we have proceeded with our reconsideration.

After considering claimant's contentions and following a further review of the record, we have nothing to add to our prior findings and conclusions. Accordingly, we adhere to and republish our June 11, 1990 Order on Review. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

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In the Matter of the Compensation of
**PRISCILLA M. McKOY, Claimant**
WCB Case No. 88-20361
ORDER ON REVIEW
Patrick K. Mackin, Claimant Attorney
Stafford J. Hazelett, Defense Attorney

Reviewed by Board Members Myers and Cushing.

Claimant requests review of Referee Shebley's order that: (1) found that claimant's condition was not medically stationary; and (2) dismissed claimant's request for hearing on a Determination Order, which had awarded 25 percent (80 degrees) unscheduled permanent disability for a back injury. Specifically, the Referee: (1) declined to grant permanent total disability for a back injury; and (2) declined to increase claimant's unscheduled permanent disability award. Claimant also requests: (1) temporary total disability from September 19, 1988, the date she contends that her condition became medically unstationary; (2) penalties and related attorney fees for an alleged unreasonable failure to pay interim compensation; and (3) penalties and related attorney fees for the insurer's alleged unreasonable failure to accept or deny claimant's aggravation claim timely. In its brief, the insurer: (1) moves to dismiss for want of jurisdiction; (2) moves to remand based upon new evidence; and (3) moves to strike from the record portions of claimant's appellant's brief. On review, the issues are extent of permanent disability including permanent total disability, penalties and attorney fees, jurisdiction, remand, and evidence. We reverse.

## PRELIMINARY MATTERS

### Motion to Dismiss

The insurer requests we grant its Motion to Dismiss for want of jurisdiction. Although the insurer does not provide us with argument, we assume it is the insurer's contention that because claimant has recently undergone surgery post-hearing and the insurer has reopened claimant's claim and begun paying temporary disability, that it is inappropriate for the Board to rate extent of permanent disability. We disagree this forum lacks jurisdiction.

Inasmuch as we find claimant medically stationary and her claim closed as of the date of hearing, we can proceed to rate extent of permanent disability. ORS 656.268(1); Raymond E. Pardee, 41 Van Natta 548 (1989). It is irrelevant that subsequent events post-hearing have apparently resulted in claimant presently not being medically stationary and her claim being in an open status. The insurer's Motion to Dismiss is denied.

Motion to Remand

In the alternative to its Motion to Dismiss, the insurer moves to remand to the Referee.

We may remand to the Referee should we find the record has been "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(5). Here, the new evidence the insurer seeks to have considered are medical reports which indicate claimant underwent low back surgery on May 9, 1989, as well as evidence that claimant's claim has been reopened.

However, as previously noted, the fact claimant underwent surgery on this date is not relevant. The hearing concerned the extent of claimant's permanent disability as it existed at the time of hearing. See Gettman v. SAIF, 289 Or 609 (1980). Claimant's medically stationary status was germane at the time of hearing on February 1, 1989, in order to rate extent of permanent disability. It is not relevant that subsequent to that hearing, but prior to Board review, claimant is no longer medically stationary, or that her claim is in an open status. We conclude that the record has not been improperly, incompletely or otherwise insufficiently developed and we decline to remand the matter for a new hearing. The insurer's Motion to Remand is denied.

Motion to Strike

The Referee in his Order Denying Reconsideration, refused to admit a report from Dr. Berkeley authorizing temporary disability from September 19, 1988 (Ex. 91). Claimant does not request review of this ruling. Nonetheless, claimant argues this exhibit in her appellant's brief, and thus, in essence requests the Board to consider it in its deliberations. We decline to do so. Consequently, the insurer's Motion to Strike is granted. Lines 6 to 10 at page 7 will be stricken from the appellant's brief that refers to the expunged exhibit 91, and will not be considered on review.

FINDINGS OF FACT

On March 2, 1986, claimant compensably injured her mid-back, neck, and left shoulder. The claim was accepted.

Claimant became medically stationary on January 15, 1987. A Determination Order dated February 20, 1987, awarded claimant temporary partial disability and 15 percent unscheduled permanent partial disability.

Claimant's condition aggravated on March 10, 1987, and the insurer began temporary disability payments. Claimant did not return to work after the spring of 1987.

In March of 1987, claimant's treating physician, Dr. Berkeley, recommended low back surgery at the L4-5 level. The insurer denied authorization for the surgery. Claimant requested a hearing. The issues at hearing were premature claim closure, an August 27, 1987 surgery denial, penalties and attorney fees, and, in the alternative, extent of permanent disability on a September 17, 1987 Determination Order. In February 1988, Referee McMurdo set aside the September 17, 1987 Determination Order and the August 27, 1987 surgery denial.

On May 2, 1988, Dr. Berkeley rescinded his surgery request due to the absence of objective findings from an April 1988 MRI report. Thus, surgery was not performed.

The claim was closed with a medically stationary date of May 2, 1988. A Determination Order issued June 22, 1988. Claimant was awarded temporary disability from March 10, 1987 through May 2, 1988, and unscheduled permanent partial disability of 25 percent.

The insurer requested a hearing concerning the June 22, 1988 Determination Order, challenging the award of temporary disability. Specifically, the insurer requested that the temporary disability awarded between March 10, 1987 through May 2, 1988 be modified to reflect temporary disability from March 10, 1987 through August 27, 1987. Claimant brought a cross-request on the issue of penalties and attorney fees for vexatious appeal. The issue of permanent disability was not raised by either party. In October 1988, Referee Thye affirmed the Determination Order and assessed a penalty and attorney fee. This order was not appealed.

On September 19, 1988, Dr. Berkeley reported a symptomatic flare-up of claimant's low back condition. A myelogram was performed in November 1988, demonstrating no abnormalities at the L4-5 level. Dr. Berkeley again requested authorization for surgery on December 2, 1988. The insurer authorized the surgery January 26, 1989, but did not begin payment of temporary disability.

In November 1988, claimant requested another hearing, raising the issue of permanent disability. The parties proceeded to hearing concerning the extent of permanent disability arising from the June 22, 1988 Determination Order. The hearing was held on February 1, 1989. The insurer defended arguing that it was inappropriate to rate claimant's permanent disability because she was not medically stationary. Claimant contended that she was medically stationary. The Referee agreed with the insurer that claimant was not medically stationary and declined to rate permanent disability. Claimant then requested reconsideration, arguing that if she were not medically stationary, then the Referee should admit a report from Dr. Berkeley (unadmitted Exhibit 91) and award time loss based on that report. The Referee denied the motion.

Claimant was 55 years old at hearing. She completed the 11th grade of high school, but has no GED. Claimant has no documented training.

Claimant has primarily been a housewife. However, she has also worked as a coupon sorter, cashier-checker, and janitress. Her job at injury was as a janitress.

Claimant cannot return to her job at injury as a janitress. Claimant cannot lift in excess of 10 pounds. She has limitations regarding lifting, bending, twisting, walking, standing, and sitting in excess or for long periods. Claimant is capable of sedentary work.

## ULTIMATE FINDINGS OF FACT

Claimant's compensable low back condition was medically stationary on May 2, 1988. Her condition remained medically stationary at the time of the February 1, 1989 hearing.

Claimant is not physically incapacitated to the extent that cannot regularly perform gainful and suitable employment.

Claimant is not foreclosed from gainful employment due to a combination of medical and nonmedical factors.

Claimant did not make reasonable efforts to find work, and a work search would not have been futile.

Claimant suffers a 40 percent unscheduled permanent disability for the loss of earning capacity due to her compensable injury.

CONCLUSIONS OF LAW AND OPINION

Procedural posture

At hearing, claimant asserted she was medically stationary and requested to go forward on the issue of the extent of permanent disability from the June 22, 1988 Determination Order. The insurer requested the hearing be deferred, contending that claimant was not medically stationary due to Dr. Berkeley's request for authorization of claimant's low back surgery. The insurer's motion was denied.

As an ultimate finding of fact, the Referee found that: (1) claimant's condition had worsened in or around September 1988; and (2) claimant was not presently medically stationary. Therefore, the Referee reasoned that rating extent of permanent disability would be premature. Accordingly, the Referee dismissed claimant's request for hearing. Claimant then requested reconsideration, asserting that if she were not medically stationary, then she was entitled to additional temporary disability benefits.

We disagree with the Referee's findings of fact and conclusions of law and reverse.

Res Judicata

Claimant's treating physician, Dr. Berkeley, found claimant's low back condition medically stationary on May 2, 1988. This date was used to close the claim by Determination Order dated June 22, 1988. The insurer requested a hearing on the award of temporary disability, alleging that the period of time granted by the Determination Order was incorrect and should have reflected a period of time from March 10, 1987 to August 27, 1987. Claimant cross-appealed requesting a penalty and related attorney fee for vexatious appeal. The issue of permanent disability was neither raised nor litigated. By Opinion and Order dated October 21, 1988, Referee Thye affirmed the temporary disability dates of March 10, 1987 through May 2, 1988, as per the Determination Order, and assessed a penalty and related attorney fee.

This case raises the question of whether the doctrine of "preclusion by former adjudication"[1] gives Referee Thye's Opinion and Order, preclusive effect.

The Court in Drews, summarized issue preclusion:

> "[I]issue preclusion...precludes future litigation on a subject issue only if the issue was 'actually litigated and determined' in a setting where 'its determination was essential to' the final decision reached....Issue preclusion applies to an issue of either fact or law." Drews, supra, slip op at 7.

1. In our recent decisions we have used the nomenclature "res judicata" to refer to this doctrine, but have adopted the nomenclature "claim preclusion" and "issue preclusion" to refer to the two branches of this doctrine. E.g. Jimmy M. Campoz, 42 Van Natta 903 (1990) and Tana Wilson, 40 Van Natta 476 (1988). The Supreme Court has just adopted the nomenclature "preclusion by former adjudication" to refer to the doctrine; however, it approves of the use of "claim preclusion" and "issue preclusion" to refer to the two branches of the doctrine. Drews v. EBI Companies, 310 Or 134, slip op at 5 (July 11, 1990).

The Court summarized claim preclusion with a quote from its earlier decision in Rennie v. Freeway Transport, 294 Or 319, (1982):

> "'[A] plaintiff who has prosecuted one action against a defendant through to a final judgment * * * is barred [i.e.,precluded] * * * from prosecuting another action against the same defendant where the claim in the second action is one which is based on the same factual transaction that was at issue in the first, seeks a remedy additional or alternative to the one sought earlier, and is of such a nature as could have been joined in the first action.' Rennie v. Freeway Transport, 294 Or 319, 323, 656 P2d 919 (1982)." Drews, supra slip op at 7.

The Drews Court noted that claim preclusion applies equally to defendants. It emphasized that claim preclusion does not require actual litigation of an issue of fact or law, nor does it require that the issue be essential to the result reached in the former adjudication; it does, however, require the opportunity to litigate that issue and a final determination. Drews, supra, slip op at 7. The Court noted that there are several exceptions to both claim and issue preclusion rules.

We conclude that claim preclusion does not apply. Although both the temporary disability claim which was litigated before Referee Thye and the permanent disability claim raised herein arise out of the same document, a Determination Order, they do not arise from the same operative facts. The facts relevant to the temporary disability claim are quite different than the facts relevant to the claim for permanent disability.

The correct principle to be applied is issue preclusion. Thus, only those material issues and determinative facts actually litigated and decided before Referee Thye have preclusive effect on the current litigation. In Referee Thye's hearing, claimant's period of temporary disability was in issue. The resolution of that issue could not be decided without establishing claimant's medically stationary date. The finding that claimant was medically stationary on May 2, 1988 was essential to that litigation.

Accordingly, as a matter of law, claimant was medically stationary on May 2, 1988. Claimant is precluded from contending that she was not medically stationary at that time. Claimant is not precluded from bringing an action on extent of permanent disability, as she has not yet had an opportunity to litigate this issue before any forum. Furthermore, she has timely filed a hearing request concerning the permanent disability issue. See ORS 656.268(6).

Aggravation claim and entitlement to interim compensation

This case comes to us in a peculiar procedural posture. The insurer attempted to prevent claimant from litigating extent of permanent disability by contending that claimant had become medically nonstationary (i.e. that claimant had aggravated). Claimant countered by arguing that she was medically stationary and, therefore, that it was appropriate to rate permanent disability. The Referee agreed with the insurer that claimant was not medically stationary (i.e. that claimant had compensably aggravated). Claimant then requested reconsideration arguing that if she were not medically stationary (i.e. had aggravated) then at the very least she was entitled to temporary disability benefits. On these peculiar facts, we conclude that an aggravation claim was raised and litigated and is now properly before us.

Claimant testified that her symptoms over the course of her disability have waxed and waned. However, on September 19, 1988, Dr. Berkeley reported that claimant was experiencing severe symptoms in her low back, with radiating pain to the left leg. In response he ordered a myelogram, which was accomplished in November 1988. Based upon his interpretation of the results of the myelogram, Dr. Berkeley requested authorization for low back surgery at L4-5.

Thus, Dr. Berkeley's conclusion that surgery was now required was due to the November 1988 myelogram. Yet, the myelogram report by radiologist, Dr. Adamson, states, "mild osseous hypertrophy at facet joints at the L5-S1 level without other abnormality seen." Dr. Adamson made no findings addressing the L4-5 level. However, when Dr. Berkeley interpreted the report, he found "discrete, but definite, in the L4-5 region, with some angulation and poor filling at the nerve root at this level, suggesting some distortion due to the facet hypertrophy and lateral recess stenosis." As such, we find an inconsistency between the myelogram report and Dr. Berkeley's interpretation that we cannot resolve without medical expertise.

Further, in February 1987 an MRI of claimant's lumbar back showed negative findings. But a myelogram done in March 1987 showed, "...the main lesion was observed at L4-5 on the left side with quite severe angulation and distortion of the nerve root due to the lateral recess stenosis and facet hypertrophy." Dr. Berkeley requested authorization for L4-5 surgery for claimant in March 1987. Later this request was withdrawn, as Dr. Berkeley felt treatment of claimant's cervical condition more important.

Again, in September 1987 through January 1988, Dr. Berkeley steadily maintained the need for L4-5 surgery. However, by May 2, 1988, he concluded surgery was not indicated as an MRI reported no abnormalities.

In light of the fact of the inconsistency concerning the latest myelogram, and in further consideration of the fact Dr. Berkeley has previously maintained equivocal positions regarding claimant's need for surgery, we are not persuaded by Dr. Berkeley's interpretation of the myelogram. Therefore, we do not rely on his conclusion that claimant required low back surgery at that time.

We also note there is no evidence of a diminishment of claimant's earning capacity as fixed by the last award of compensation. Claimant's last arrangement of compensation was the June 1988 Determination Order which granted her 25 percent unscheduled permanent disability for the low back. Claimant's closing examination from Dr. Berkeley dated May 2, 1988, concluded that L4-5 decompressive surgery was not indicated due to the absence of objective findings, and that further, "should claimant pursue a more sedentary and lighter job, she could carry on without surgical interference."

However, by comparison, neither Dr. Berkeley's chart note of September 19, 1988, nor his subsequent reports indicate that claimant's symptomatic exacerbation resulted in diminished earning capacity, or for that matter even an inability to work due to the September 1988 exacerbation, although the record shows claimant has not worked since the spring of 1987. Dr. Berkeley is silent on this point, and we will not assume facts not in evidence.

Based on the totality of evidence, we are not persuaded that claimant has sustained either a symptomatic exacerbation of her low back condition or a pathological worsening of her low back condition. Nor do we find that claimant's earning capacity was diminished below that fixed at the time of the June 1988 Determination Order. We find the medical record and lay testimony support a finding that claimant was medically stationary at the time of hearing and that she had not sustained a compensable aggravation in September 1988.

Additionally, there is no medical verification of claimant's inability to work due to the September 1988 exacerbation. We find no basis for the payment of interim compensation.

Penalties and related attorney fees

On appeal, claimant raises for the first time the issue of penalties and related attorney fees for failure to pay interim compensation and for failure to accept or deny a claim for aggravation within 60 days. When an issue is not raised at hearing and the record is closed, that issue will not subsequently be considered. Marvis v. SAIF, 45 Or App 1059 (1980); Richard C. Centeno, 41 Van Natta 617 (1989); Randy D. Johnson, 39 Van Natta 463 (1987). We have reasoned that to address an issue that was not raised at hearing would be fundamentally unfair. Gunther H. Jacobi, 41 Van Natta 1031 (1989). We decline to consider these issues on review.

Permanent Total Disability

Claimant contends that she is permanently and totally disabled. We disagree.

In order to establish permanent total disability, claimant must prove either that: (1) she is completely physically disabled and therefore precluded from gainful employment; or (2) her physical impairment, combined with a number of social and vocational factors, effectively prohibit gainful employment under the "odd-lot" doctrine. Welch v. Banister Pipeline, 70 Or App 699, 701 (1984); rev den 298 or 470 (1985); Wilson v. Weyerhaeuser, 30 Or app 403 (1977).

There is no evidence that claimant is permanently and totally physically incapacitated. In July 1987, claimant was examined by Western Medical Consultants. They found claimant medically stationary. They opined chronic pain in the neck and low back areas. They further concluded claimant's degree of impairment to be minimal. Dr. Berkeley noted reduced ranges of motion in claimant's lumbar back in September 1988. He also noted claimant's continuing disabling low back pain. We take into consideration claimant's reduced range of motion in her lumbar back, as well as her chronic disabling back pain, and find claimant's physical impairment is minimal.

Dr. Berkeley reported claimant was limited from standing and sitting for extended periods of time. Claimant also testified as to limitations concerning lifting, bending, walking, standing, and sitting long periods. She also testified to her inability to lift more than approximately 10 pounds. Dr. Berkeley indicated that claimant could not return to her previous work as a janitress and needed to seek more sedentary or light work. We find claimant's residual functional capacity to be in the sedentary range.

Accordingly, we conclude that claimant is not completely physically disabled and totally precluded from employment on medical grounds alone. We, therefore, determine whether claimant is permanently and totally disabled under the "odd-lot doctrine."

The nonmedical factors to be considered in an "odd-lot" analysis include age, education, adaptability to nonphysical labor, mental capacity and emotional condition, as well as the conditions of the labor market. Welch, supra, 70 Or App 701; Livesay v. SAIF, 55 Or App 390, 394 (1981). Because application of an "odd-lot" analysis presupposes some capacity for employment, an injured worker is statutorily required to be willing to work and to make reasonable efforts to find work, although the worker need not engage in job seeking activities that, in all

practicality, would be futile. ORS 656.206; SAIF v. Simpson, 88 Or App 638, 641 (1987); Welch, supra.

Claimant is 55 years old. She has an 11th grade education. She has no additional training. Claimant's work history consists of employment as a coupon sorter, cashier-checker, and janitress. Because of physical limitations, claimant can no longer return to her job as janitress. Claimant has not worked since the spring of 1987. Claimant testified that she has looked in the want ads for jobs, but otherwise she has attempted no other job search efforts. Claimant also has not been involved in meaningful vocational rehabilitation efforts. Claimant offered no vocational evidence that she is unable to regularly perform work at gainful and suitable employment.

In light of these facts, we find that claimant has not established permanent total disability status under the "odd-lot" doctrine. Consequently, she is not entitled to an award of permanent total disability.

Extent of permanent disability

In the alternative, claimant contends that her permanent partial disability award should be increased.

To prove entitlement to unscheduled disability, claimant must show by a preponderance of the evidence a permanent loss of earning capacity. See Hutcheson v. Weyerhaeuser, 288 Or 51, 56 (1979). The criteria for rating the extent of claimant's unscheduled permanent disability is the permanent loss of earning capacity due to the compensable injury. ORS 656.214(5). To determine claimant's permanent loss of earning capacity, we consider her physical impairment as reflected in the medical record, the testimony at hearing, and all the relevant social and vocational factors set forth in former OAR 436-30-380 et seq. We apply these rules as guidelines, not as restrictive mechanical formulas. See Harwell v. Argonaut Insurance, 296 Or 505, 510 (1984); Fraijo v. Fred N. Bay News Co., 59 Or App 260, 269 (1982).

After considering claimant's minimal permanent impairment and sedentary residual physical capacity attributable to her compensable injury, and in light of the relevant social and vocational factors described above, we conclude that an increase of 15 percent, for a total unscheduled permanent disability award of 40 percent provides appropriate and adequate compensation for claimant's permanent loss of earning capacity resulting from the compensable injury.

## ORDER

The Referee's order dated February 22, 1989, as reconsidered March 15, 1989, is reversed. Claimant's request for hearing is reinstated. The June 22, 1988 Determination Order is modified. In addition to the 25 percent (80 degrees) unscheduled permanent disability awarded by the Determination Order, claimant is awarded 15 percent (48 degrees) unscheduled permanent disability, giving her a total award of 40 percent (128 degrees) unscheduled permanent disability for a low back injury. Claimant's attorney is awarded 25 percent of the increased compensation created by this order, not to exceed $3,000. For services on Board review concerning the insurer's motions to dismiss, claimant's attorney is awarded an assessed fee of $300, payable by the insurer.

In the Matter of the Compensation of
**CASEY L. HIATT, Claimant**
WCB Case No. 88-18721
ORDER ON REVIEW
Coughlin, et al., Claimant Attorneys
Yturri, Rose, et al., Defense Attorneys

Reviewed by Board Members Cushing and Gerner.

The insurer requests review of those portions of Referee Menashe's order that: (1) affirmed that portion of a Determination Order which awarded claimant temporary disability from November 2, 1987 to November 9, 1987; (2) awarded additional temporary disability from February 22, 1988 through June 7, 1988; and (3) awarded 22 percent (70.4 degrees) unscheduled permanent disability for a neck and left shoulder injury, whereas a Determination Order awarded no permanent disability. In his respondent's brief, claimant asserts that the insurer's contention that a C7 fracture is not related to claimant's compensable injury is precluded by res judicata. On review, the issues are temporary disability, res judicata and extent of unscheduled permanent disability. We affirm.

## FINDINGS OF FACT

On May 5, 1987, claimant compensably injured his neck and left shoulder when he was hit on the head by the heel of a loader while working for his employer, a logging company. He first sought medical treatment for this injury on July 27, 1987. X-rays revealed a straightening of the normal lordosis, early and minimal spurring anteriorly at C5-6 and a fracture of the spinous process of C7.

On July 28, 1987, claimant began treating with Dr. Stephens, orthopedist, for neck, left shoulder, back and arm pain.

In October 1987, the Orthopaedic Consultants performed an independent medical evaluation.

The claim was closed on November 2, 1987 by a Notice of Closure, awarding temporary disability from July 28, 1987 through November 2, 1987. Claimant requested a hearing on the issues of premature and improper claim closure.

Dr. Stephens released claimant to return to work with no restrictions on November 9, 1987. After learning that his employer had no work available, claimant began working for another logging company. He worked for that employer until approximately February 18, 1988, when his symptoms increased and prevented him from working. He has not worked since that date.

On February 22, 1988, claimant received treatment for these increased symptoms from Dr. Fuchs, chiropractor. Two months later, Fuchs referred claimant to Dr. Kopp, orthopedist.

In June 1988, Dr. Hendricks, M.D., performed an independent medical evaluation.

On July 15, 1988, the insurer issued a denial of claimant's aggravation claim.

In August 1988, Dr. Misko, neurosurgeon, issued a medical report after reviewing claimant's medical reports and x-rays.

On September 15, 1988, a Determination Order issued, setting aside the November 2, 1987 Notice of Closure and awarding claimant temporary disability from July 28, 1987 through November 9, 1987. In late October 1988, claimant requested a hearing on the issues of aggravation, temporary disability and extent of permanent disability.

By Opinion and Order dated October 12, 1988, the November 2, 1987 Notice of Closure was also set aside. The claim was ordered to be reopened and submitted to the Evaluation Division for the issuance of a Determination Order.

In December 1988, the Orthopaedic Consultants performed a second independent medical examination.

Claimant, 27 years of age at hearing, has a high school diploma. He has no documented training. His past occupations include farming, welding and logging. His highest specific vocational preparation (SVP) is a 2, for logging.

The physical capacity required of claimant's work at-injury was in the heavy category. Claimant has been released to return to modified work with limitations including no heavy lifting, no repetitive mild lifting and no use of vibration tools. No offer of work has been made. Claimant is physically capable of performing work activities between the categories of light and medium.

## CONCLUSIONS OF LAW AND OPINION

### Temporary Disability Issues

The Board adopts the Referee's Conclusions of Law, as set forth in the "Opinion and Conclusions" portion of the order, with respect to the issues of premature closure and entitlement to temporary total disability, with the following supplementation.

The September 15, 1988 Determination Order awarding claimant temporary total disability from July 28, 1987 through November 9, 1987 is affirmed. Therefore, the insurer shall pay claimant temporary total disability for the week of November 2, 1987 through November 9, 1987.

### Res Judicata - Extent of Unscheduled Permanent Disability

The Board adopts the Referee's Conclusions of Law, as set forth in the "Opinion and Conclusions" portion of the order, with respect to the "Extent of Permanent Disability" issue, with the following supplementation.

The Referee found that the C7 fracture was compensably related to claimant's 1987 back injury claim and awarded claimant 3 percent for that fracture.

The insurer argues that the Referee erred in concluding that claimant's C7 spinous process fracture was caused by claimant's work related injury and in awarding permanent partial disability based upon that fracture.

Claimant argues that the insurer is barred by res judicata from raising this issue, contending that the earlier Referee's order necessarily determined that the C7 fracture is compensably related to claimant's compensable injury. In the alternative, claimant contends that he has met his burden of proving that the C7 fracture is related to his compensable injury and that the Referee correctly considered this fracture in determining the extent of permanent disability.

We agree with claimant that the insurer is barred from raising the issue of whether the C7 fracture is related to the compensable injury. However, the correct theory upon which to base the bar is issue preclusion.

In Drews v. EBI Companies, 310 Or 134 (July 11, 1990), the Court reiterated the concept of issue preclusion. Issue preclusion:

> ". . . precludes future litigation on a subject issue only if the issue was 'actually litigated and determined' in a setting where 'its determination was essential to' the final decision reached." North Clackamas School Dist. v. White, 305 Or 48, 53, modified 305 Or 468 (1988).

Here, on October 12, 1988, an earlier Referee found that x-rays taken on July 27, 1987 revealed a fracture of the C7 spinous process and concluded that claimant's claim had been improperly closed because there was "evidence of a C7 fracture which would indicate permanent disability." (Ex. 38). Consequently, after noting that, at the time, the insurer could not close a claim with a Notice of Closure where there was permanent disability, and noting that there was evidence of permanent disability based on the C7 fracture, the earlier Referee concluded that the claim was improperly closed and ordered the claim reopened for the issuance of a Determination Order.

We find that the issue of whether the C7 fracture was related to claimant's compensable back injury was essential to the final decision reached. Therefore, we conclude that the insurer is barred from raising this same issue on Board review.

ORDER

The Referee's order dated February 23, 1989, as republished April 24, 1989, is affirmed. For services on Board review, concerning the issues of temporary disability compensation and extent of unscheduled permanent disability, claimant's attorney is awarded a reasonable assessed fee of $1,000, payable by the insurer.

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August 3, 1990 Cite as 42 Van Natta 1727 (1990)

In the Matter of the Compensation of
**RAMI M. SHUREH, Claimant**
WCB Case No. 89-00381
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Cooney, et al., Defense Attorneys

Reviewed by Board Members Cushing and Gerner.

The insurer requests review of Referee Knapp's order that: (1) found the insurer had no authority to compel claimant's attendance at an independent medical examination; (2) set aside the Director's order suspending claimant's workers' compensation benefits for failing to attend a scheduled independent medical examination; and (3) assessed penalties and related attorney fees for alleged unreasonable claims processing for seeking the Director's suspension order. On

review, the issues are whether claimant was required to attend an independent medical examination, the propriety of the Director's order, and penalties and related attorney fees. We reverse.

## FINDINGS OF FACT

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

Claimant attended an independent medical examination on April 8, 1987 with the Western Medical Consultants. The examination was conducted by a panel consisting of Dr. Hogsdon and Dr. Ferguson. Dr. Hogsdon, an otolaryngologist, examined claimant's inner ear condition. Dr. Ferguson examined claimant's back condition. Both examinations were conducted on the same day and were sequential, but were held in different locations due to the need for specialized equipment.

Claimant was examined by his treating physician, Dr. Mirka, on February 18, 1988, upon the request of the insurer.

An independent medical examination was conducted by Dr. Duncan on February 19, 1988.

Dr. Mirka recommended to the insurer outside medical analysis of claimant's inner ear condition. The physicians he recommended all resided outside the state of Oregon. The closest physician was Dr. Mangham in Seattle, Washington.

On January 16, 1989, the insurer scheduled claimant to attend an independent medical examination with Dr. Mangham in Seattle, Washington. Claimant did not attend.

On January 17, 1989, the insurer requested the Director's consent to suspend claimant's workers' compensation benefits for failure to attend the scheduled January 16, 1989 independent medical examination. On February 15, 1989, the Director issued a suspension order.

## ULTIMATE FINDINGS OF FACT

At the time claimant was scheduled for the January 16, 1989 independent medical examination with Dr. Mangham, he had had two independent medical examinations.

## CONCLUSIONS OF LAW AND OPINION

The Referee found the insurer had exceeded the statutory limit of three independent medical examinations, and thus, had no authority to compel claimant's attendance at the scheduled independent medical examination on January 16, 1989 in Seattle, Washington. The suspension order was set aside, and the insurer ordered to reimburse claimant for any suspended benefits due from the date of suspension. We disagree.

The insurer is entitled to three independent medical examinations before

Director notification and authorization is required. Former ORS 656.325(1)(a) provides:

> "Any worker entitled to receive compensation under ORS 656.001 to 656.794 is required, if requested by the director, the insurer, or self-insured employer, to submit to a medical examination at a time and place and from time to time at a place reasonably convenient for the worker and as may be provided by the rules of the director. However, no more that three examinations may be requested except after notification to and authorization by the director. If the worker refuses to submit to any such examination, or obstructs the same, the rights of the worker to compensation shall be suspended with the consent of the director until the examination has taken place, and no compensation shall be payable during or for account of such period."

We find that at the time the insurer had scheduled claimant for his independent medical examination with Dr. Mangham in Seattle, claimant had had only two independent medical examinations.

Upon request of the insurer, the first examination was with the Western Medical Consultants on April 8, 1987. The purpose of the examination was to provide an independent medical assessment of claimant's ear condition and back condition. Because of the medical complexity of the conditions to be examined, a panel, consisting of two appropriate medical specialities, conducted the examination. Additionally, due to the need to utilize special equipment, the inner ear examination was held in Dr. Hogsdon's office. Although the two examinations were conducted in different locations and at different times, they were held on the same day, in sequential chronological order, for the same claim, and carried out under the auspices of the Western Medical Consultants. Under these facts, we find there was one multi-discipline independent medical examination conducted on April 8, 1987.

Claimant was also scheduled by the insurer for a February 18, 1988 examination with his treating physician, Dr. Mirka. The record reflects that at the time of the scheduled examination, claimant had established a doctor-patient relationship with Dr. Mirka. There is no evidence that, at the time of the scheduled examination, this relationship had been terminated. Furthermore, prior to this scheduled examination, claimant had missed two other regularly scheduled appointments with Dr. Mirka. Claimant has a duty to mitigate damages. Therefore, it was not improper for the insurer to require claimant to see his treating physician in order to ascertain the status of claimant's current inner ear condition. ORS 656.325(4). For these reasons, we decline to characterize the February 18, 1988 examination with Dr. Mirka as an independent medical examination.

Claimant's second independent medical examination was on February 19, 1988 with Dr. Duncan for his back condition. Thus, we find claimant has had two independent medical examinations. Accordingly, the insurer was entitled to a third independent medical examination. Former ORS 656.325(1)(a).

Turning to the selection of Seattle, Washington as the location for the scheduled January 16, 1989 independent medical examination, we find the actions

of the insurer to be reasonable. We note claimant's treating physician, Dr. Mirka, recommended to the insurer that it obtain expert medical analysis of claimant's inner ear condition. In that regard, he provided a short list of physicians qualified and equipped to evaluate this complex medical condition. In response, the insurer chose the physician geographically closest to claimant. All arrangements including travel and accommodations were made as required. ORS 656.325(1)(b); OAR 436-10-100. Thus, the medical record and lay testimony persuasively shows that the scheduling of the independent medical examination was reasonable. Claimant offered no valid reason for not attending.

We therefore find that the insurer had authority for requesting a suspension order from the Director. Former OAR 436-60-090. We further find that at the time the Compliance Section made its decision, it had the benefit of a complete record, including argument from both the insurer and claimant. Accordingly, we find issuance of the suspension order was reasonable and appropriate under the circumstances of this case. The Director's suspension order will be reinstated.

Penalties and related attorney fees

The Referee found the insurer had acted unreasonably in processing this claim by causing a suspension order to issue. In light of our conclusions above, we disagree.

We find the insurer has acted reasonably throughout and followed the statutory requisites as well as the administrative procedures in scheduling the January 16, 1989 independent medical examination, and in seeking an order suspending benefits from the Director.

ORDER

The Referee's order dated April 24, 1989, as reconsidered May 1, 1989, is reversed in its entirety. Claimant is directed to attend an independent medical examination as requested by the insurer in accordance with law. The Director's order suspending claimant's compensation is reinstated and upheld. Claimant's award of a penalty for unreasonable claims processing is reversed. Claimant's attorney fee award for unreasonable resistance to the payment of compensation of $300 is reversed.

In the Matter of the Compensation of
**MARK E. FULLER, Claimant**
WCB Case No. 87-12878
ORDER ON REVIEW
Brian R. Whitehead, Claimant Attorney
David O. Horne, Defense Attorney

Reviewed by Board Members Speer and Howell.

Claimant requests review of those portions of Referee Garaventa's order that: (1) upheld the insurer's denial of claimant's aggravation claim for his low back condition; (2) upheld the insurer's denial of further chiropractic treatment, and its denial of chiropractic treatment in excess of the Medical Director's guidelines; and (3) affirmed a Determination Order that awarded claimant 10 percent (32 degrees) unscheduled permanent partial disability for the low back. We affirm on the aggravation and extent issues and reverse with regard to the denial of further chiropractic care.

## ISSUES

1. Aggravation.

2. Chiropractic Treatment.

3. Extent of Permanent Partial Disability.

## FINDINGS OF FACT

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

The insurer's December 3, 1987 denial letter stated in part:

> "In addition, it does not appear that the chiropractic care now being rendered to you is reasonable or necessary as related to this industrial injury claim. ***. Due to the above, *** we must respectfully decline the payment of further chiropractic care as it appears to be unrelated to this industrial injury."

The insurer's denial letter dated December 4, 1987 stated in part:

> "In addition, the conclusion of both examiners is that no further medical treatment is necessary or reasonable on a curative basis. Any further chiropractic care would be on a palliative basis only. Please be advised that such care should be limited to two times per month unless the treating doctor cares to submit a report which will justify the need for treatment in excess of this treatment frequency. By copy of this denial letter to Kent J. Wilson, I am letting him know of our position in regards to treatment frequency."

As of December 3, 1987, there was an outstanding bill for treatment from Dr. Utter in the amount of $233.30. No other chiropractic services remained unpaid as of that date.

## CONCLUSIONS OF LAW AND OPINION

### Aggravation

Claimant contends that his condition worsened subsequent to the August 13, 1987 Determination Order; and, therefore, that he is entitled to additional compensation for aggravation of his compensable condition. ORS 656.273. It is unclear whether claimant asserts a pathological worsening or a symptomatic worsening of his condition. For purposes of establishing a compensable aggravation, "worsened conditions" may take the form of either a worsening of the underlying condition or a symptomatic worsening. Smith v. SAIF, 302 Or 396 (1986). If a worsening involves a symptomatic exacerbation, and if the prior award contemplated symptomatic exacerbations, then claimant must also prove that his increased symptoms lasted longer or were greater in degree than was anticipated and that, as a result, he suffered a diminished earning capacity; or that his worsened condition 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).

Here, Dr. Wilson took claimant off work for more than 14 days. If claimant was, in fact, unable to work, and if that disability resulted from a symptomatic worsening of claimant's compensable condition, then claimant would be entitled to a reopening of his claim for aggravation. The Referee concluded, however, that claimant did not establish "worsened conditions" after the August 13, 1987 Determination Order. We agree. See Perry v. SAIF, 307 Or 654 (1989) (worsening is a factual question). We adopt the Referee's discussion of this issue wherein she found Dr. Utter's opinion more persuasive than that of Dr. Wilson.

We note further that claimant's testimony may itself be sufficient to establish a compensable worsening. See Garbutt v. SAIF, 297 Or 148 (1984). However, such testimony must be reliable and credible. The Referee found in this regard that claimant's testimony was vague, unresponsive and inconsistent. We agree. We, therefore, conclude that claimant has failed to establish a compensable claim for aggravation.

### Denial of Chiropractic Treatment

The insurer issued two denials of chiropractic care. The first denial, dated December 3, 1987, denied "further" chiropractic care on the bases that it was neither reasonable and necessary nor causally related to the compensable claim. Claimant argues, in part, that the denial is impermissibly overbroad in that it denies future medical treatment. In this regard, a denial of all future medical treatment contravenes the provisions of ORS 656.245. Evanite Fiber Corporation v. Striplin, 99 Or App 353 (1989); Robert M. Bryant, 41 Van Natta 324 (1989).

We are not persuaded by the insurer's argument that, properly construed, its denial is other than a denial of future medical services. The only evidence of any unpaid bills as of December 3, 1987, is a bill for services by Dr. Utter in the amount of $233.30. The insurer conceded at hearing that this bill was not contested. Consequently, we conclude that no other chiropractic services remained unpaid as of that date. Under the circumstances, we are unable to construe the December 3, 1987 denial as anything other than an impermissible denial of future medical services.

On December 4, 1987, the day following its first denial, the insurer issued a second denial letter. In part, this letter denied further chiropractic care in excess of the Medical Director's guidelines of two treatments per month.

OAR 436-10-040(2). This denial can also only be read as denial of future medical benefits. Accordingly, the denial must be set aside as prospective. Striplin, supra; Bryant, supra.

Extent of Permanent Disability

We adopt the Referee's opinion on this issue.

ORDER

The Referee's order, dated March 10, 1988, is affirmed in part and reversed in part. That portion of the Referee's order that upheld the insurer's December 3 and 4, 1987 denials, insofar as they denied further chiropractic care, is reversed. The insurer's December 3 and 4, 1987 denials, insofar as they denied further chiropractic treatment, are set aside. The remainder of the Referee's order is affirmed. Claimant's attorney is awarded an assessed fee of $900 for his services at hearing and on Board review regarding the chiropractic denials issue.

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In the Matter of the Compensation of
**ROY I. CANNON, Claimant**
WCB Case Nos. 88-14294 & 88-05361
ORDER ON REVIEW
Coons & Cole, Claimant Attorneys
Schwabe, et al., Defense Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Cushing and Myers.

Claimant requests review of that portion of Referee Neal's order which: (1) upheld CIGNA's denials, on behalf of Babcock and Wilcox Construction Co., of claimant's occupational disease claim for asbestosis and chronic obstructive pulmonary disease (COPD) conditions; and (2) upheld CNA's denials, on behalf of Combustion Engineering, of the same conditions. In addition, claimant moves that we supplement the record with additional evidence. We treat this request as a motion to remand. On review, the issues are, remand, compensability and responsibility. We deny the motion, reverse in part and affirm in part.

FINDINGS OF FACT

Claimant worked as a welder and boilermaker from the age of 16. From 1950 until 1966 he constructed and repaired ships. During this period he was exposed to asbestos.

Following 1966, he worked as a boilermaker in mills. He was exposed to a lower amount of asbestos during this span.

Claimant repaired an old boiler for Babcock and Wilcox from September 22, 1987 through October 7, 1987. During this interval claimant was exposed to asbestos.

On October 26, 1987, claimant cleaned for Combustion Engineering. He was not exposed to asbestos.

Claimant smoked cigarettes for 25 years. He quit smoking in 1972. Claimant first noticed a shortness of breath in 1985; subsequently, his symptoms worsened.

On March 1, 1988, CIGNA issued its denial of claimant's asbestosis and lung condition, reasoning that neither was causally connected to claimant's employment with Babcock and Wilcox.

Claimant filed a claim with Combustion Engineering in June 1988. Combustion Engineering denied compensability and responsibility for claimant's lung condition at hearing, reasoning that claimant did not have a compensable occupational disease, and that even if he did, it was not responsible since claimant's last exposure to asbestos occurred while he was working for another employer.

Claimant suffers from an early form of asbestosis requiring periodic medical monitoring.

Claimant retired on July 1, 1988.

## CONCLUSIONS OF LAW AND OPINION

### Evidentiary Matters

On review, claimant moves to supplement the record with documents that show claimant filed a claim for exposure to asbestos fibers in Washington and that the claim was denied. We treat this motion as a request for remand.

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).

We find the record has been adequately developed. Moreover, the documents offered have no relevance to the determination of the issues presented because there has been no contention that claimant's work exposure while in Washington either caused or contributed to a worsening of his asbestosis condition. Therefore, the request for remand is denied.

### Asbestosis Condition

#### Compensability

To establish a compensable occupational disease, claimant has the burden of proving that his employment as a welder or boilermaker was the major contributing cause of the onset or a pathological worsening of a condition which required medical services or resulted in disability. See former ORS 656.802(1)(a); 656.804; former 656.005(8); Dethlefs v. Hyster Co., 295 Or 298 310 (1983); Blakely v. SAIF, 89 Or App 653, 656 (1988). Inasmuch as claimant has been exposed to asbestos fibers for an extended period of time, we conclude that the issue of whether claimant suffers from a compensable asbestosis condition to be a complex medical question. Thus, while his testimony is probative, the resolution of this case largely turns on medical evidence. Uris v. Compensation Dept., 247 Or 420 (1967); Kassahn v. Publishers Paper Co., 76 Or App 106, 109 (1985).

Dr. Edwards, a pulmonary and critical care specialist, opined that claimant had probably been exposed to asbestos while working as a boilermaker between 1950 and 1966. He diagnosed an early form of asbestosis. (Exs. 22, 9).

Dr. Miller, an occupational and environmental medicine specialist, opined that claimant's respiratory problems resulted from his 45-year history of exposure to welding fumes as a boilermaker and his 25-year history of exposure to asbestos in boiler repair and shipyard work. (Ex. 21). He, too, concluded that claimant suffered from early asbestosis and that he should be monitored on a regular basis. (Id., Ex. 23-2).

Likewise, Dr. Kilburn concluded that x-rays he had taken of claimant showed asbestosis of the lungs. (Ex. 4).

Only Dr. Ironside, a pulmonary specialist, opined that neither claimant's x-rays nor his physical examination reveal an asbestosis-related lung disease. (Ex. 16-3).

We find the opinions of Drs. Kilburn, Edwards and Miller to be persuasive, as compared to the opinion offered by Dr. Ironside. See Somers v. SAIF, 77 Or App 259 (1986). In reaching this conclusion, we note that Dr. Ironside possessed only copies of claimant's 1987 chest x-rays, and that he professed concern over the quality of those copies, which he referred to as "suboptimal". (Ex. 16-4). In addition, Dr. Ironside made no reference to claimant's March 21, 1988 x-ray. Moreover, Ironside agreed that claimant's abnormal pulmonary function tests were "consistent" with asbestosis, although he opined those tests were "nonspecific" in this case. Accordingly, we conclude that claimant suffers from an early form of asbestosis, the major cause of which was claimant's employment exposure to asbestos.

This case is distinguishable from the facts as presented in Brown v. SAIF, 79 Or App 205, rev den 301 Or 666 (1986). In Brown, the claimant was exposed to asbestos dust over a two-year period and thereafter became concerned that his health may have been compromised. He filed an occupational disease claim against his employer and underwent a number of medical examinations and tests which revealed no evidence of existing disease. Given these facts, the court held that claimant had not sustained a compensable occupational disease because there was no evidence of "any change in his physical condition" or "actual physical or mental harm". Id. at 208-90. Unlike the claimant in Brown, claimant in the present case has sustained actual damage to the tissues of his body. The damage will require regular medical evaluation. Claimant has proven, therefore, that his condition requires medical services. He has proven a compensable occupational disease. See Finch v. Stayton Canning Co., 93 Or App 168 (1988); Collins v. Hygenic Corp. of Oregon, 86 Or App 484 (1987).

Responsibility

Responsibility for occupational diseases is governed by the "last injurious exposure rule". Bracke v. Baza'r, Inc., 293 Or 239, 246 (1982); Cleo M. Riggs, 40 Van Natta 1133 (1988). This case involves the situation in which claimant has a series of employments, any one of which may have caused disability. Here, responsibility is 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, supra.

To shift responsibility to an earlier carrier or employer, the carrier or employer on the risk when claimant became disabled or sought medical treatment must establish that the work conditions while the prior carrier or employer was on the risk were the sole cause of the disease or that it was impossible for work conditions during the period when the last carrier or employer was on risk to have caused the disease. FMC Corp v. Liberty Mutual Ins. Co., 70 Or App 370 (1984), clarified 73 Or App 223 (1985). In order to shift responsibility to a later carrier or employer, the initially responsible carrier or employer must show that a later employment independently contributed to a pathological worsening of the condition.

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).

Here, the "triggering event" occurred when claimant was tested for asbestosis on December 12, 1987. Claimant's last exposure to asbestosis fibers which could have contributed to his respiratory condition occurred in September and October 1987, while he was working for Babcock and Wilcox. (Tr. 23-24). While working on a boiler at that time, claimant was exposed to asbestos, fiberglass, and other dust particles in the air. Babcock and Wilcox can shift responsibility only by proving that claimant's span of employment with them did not contribute to the cause or worsening of the asbestosis condition. Babcock and Wilcox failed to prove that it did not contribute to the asbestosis condition. Therefore, Babcock and Wilcox is responsible for claimant's early asbestosis condition.

Chronic Obstructive Pulmonary Disease (COPD)

The Referee found that claimant's pulmonary disease was not compensable, reasoning that claimant had not proven that his work activity was the major contributing cause of his disease. See Dethlefs, surpa. We agree.

Inasmuch as claimant had habitually smoked cigarettes in addition to his work exposure, the causal connection between the condition and on and off work activities is not clear. Therefore, we conclude that the issue of whether claimant experienced a compensable pulmonary condition is a complex medical question. Thus, while his testimony is probative, the resolution of this issue also largely turns on medical evidence. Uris v. Compensation Dept., supra; Kassahn v. Publishers Paper Co., supra.

Claimant's physicians agree that he suffers from chronic obstructive pulmonary disease (COPD). They disagree as to the cause of the lung condition.

Dr. Edwards and Ironside, both pulmonary specialists, agreed that claimant's lung condition was caused by his smoking cigarettes. (Exs. 9-3, 9a-2, 16a-3). They concluded that work exposure was possibly an aggravating factor. (Exs. 9a-2, 16a-3).

On the other hand, Dr. Miller reasoned that claimant's condition resulted from a combination of work exposure and smoking. Of the two causes, Miller concluded that smoking only played a contributory role. (Ex. 21-3).

In light of the medical evidence, we conclude that claimant has not shown that his employment as a welder or boilermaker was the major contributing cause

of the onset or a pathological worsening of his pulmonary disease. Consequently, this condition is not compensable.

Since we have not found claimant's pulmonary condition compensable, we do not address the issue of responsibility.

ORDER

The Referee's order dated January 20, 1989, as reconsidered March 2, 1989, is reversed in part and affirmed in part. That portion of the Referee's order which upheld CIGNA's denial insofar as it denied an asbestosis condition is reversed. CIGNA's denial of claimant's asbestosis condition is set aside and the claim is remanded to CIGNA for processing according to the law. The remainder of the Referee's order is affirmed. For services at hearing and on Board review regarding the compensability of his asbestosis condition, claimant is awarded an assessed attorney fee of $2,400, to be paid by CIGNA on behalf of Babcock and Wilcox.

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August 7, 1990 Cite as 42 Van Natta 1737 (1990)

In the Matter of the Compensation of
**ROBERT T. NELSON, Claimant**
WCB Case No. 88-14419
ORDER ON REVIEW
Brian R. Whitehead, Claimant Attorney
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Gerner and Cushing.

Claimant requests review of Referee Seymour's order which upheld the insurer's denial of claimant's cervical condition as an occupational disease and as a sequela of his compensable elbow injury. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

Claimant suffers from degenerative disc disease that predates his compensable injury.

At the time of the compensable injury, claimant was assistant manager of a gas station. His duties included setting shift schedules, pumping gas, and heavy lifting. (Tr. 9).

On January 13, 1987, claimant experienced symptoms in his right arm and neck when he picked up a five gallon grease bucket and carried it 70 feet. Subsequently, claimant felt numbness and pain in his right arm. (Ex. 12). Approximately two weeks later, claimant experienced neck pain. The right arm injury claim was accepted.

On July 14, 1988, the insurer denied claimant's claim for a cervical condition indicating that claimant's cervical condition was not related to the January 13, 1987 injury.

CONCLUSIONS OF LAW AND OPINION

Claimant contends that his cervical condition was compensable either as an occupational disease claim or as a sequela of his compensable elbow injury. The

Referee upheld the insurer's denial of claimant's cervical condition on both of these theories. We agree.

First, for an occupational disease claim, the date of "injury" is the date upon which the claimant was last exposed to the employment conditions which cause the disease. Johnson v. SAIF, 78 Or App 143, rev den 301 Or 240 (1986). Claimant's last work exposure which could have caused his cervical condition occurred on December 18, 1987. Accordingly, the occupational disease law which became effective January 1, 1988, is not applicable. Donna E. Aschbacher, 41 Van Natta 1242 (1989).

To establish the compensability of his cervical condition on an occupational disease theory, claimant has the burden of proving that his work activity for the employer was the major contributing cause of either the onset or worsening of his condition. See former ORS 656.802(1)(a); Dethlefs v. Hyster Co., 295 Or 298, 310 (1983); Blakely v. SAIF, 89 Or App 653, 656 (1988). "Major contributing cause" means an activity or exposure or combination of activities or exposures which contributes more to the onset or worsening than all other activities or exposures combined. See McGarrah v. SAIF, 296 Or 145, 166 (1983); Dethlefs v. Hyster Co. supra, 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).

Inasmuch as claimant suffers from a preexisting degenerative cervical condition, we conclude that the issue of causal relationship between claimant's work activities and his current cervical condition is a complex medical question. Thus, while his testimony is probative, the resolution of this issue primarily turns on medical evidence. Uris v. Compensation Department, 247 Or 420 (1967); Kassahn v. Publishers Paper Co., 76 Or App 259, 263 (1986). Claimant has failed to meet his burden.

Claimant suffers from a cervical condition which is caused by a preexisting arthritic condition. Almost all of the physicians opine that claimant's work activities are not related to his neck condition.

Dr. Hubbard, a neurosurgeon, diagnosed asymptomatic degenerative C5 disc disease. He did not comment on the causal connection between claimant's cervical condition and his work activities.

Dr. Spady, an orthopedic surgeon, interviewed and examined claimant in December 1987. He did not diagnose a symptomatic cervical condition. (Ex. 12).

Dr. Malos, a surgeon, examined claimant in May 1988. He concluded that claimant suffered from degenerative cervical changes. (Ex. 17-2).

Independent Medical Examiners Drs. Waldram, orthopedic surgeon, and Stolzberg, neurologist, examined claimant in June 1988. They concluded that claimant's neck condition "began years ago." (Ex. 22-3). Waldram and Stolzberg opined that it was not clear whether the December 1987 incident was related to the onset of neck symptoms. (Ex. 22-3).

Claimant was examined three times by Dr. Tiley, a surgeon. Tiley reported it was impossible to determine whether the temporary increases in claimant's neck symptoms were caused by work activity or a flare up of the disease process. Tiley concluded the cause of claimant's symptoms was a "gray area." (Ex. 33).

On the other hand, Dr. Shaw initially noted that claimant suffered from a degenerative disc condition that was not related to or caused by work. Shaw reported that claimant's work activity may have aggravated claimant's neck symptoms to the point where treatment was necessitated. Subsequently, in response to a letter from claimant's counsel, Shaw changed his opinion and reported that claimant's work activities were the major contributing cause of the worsening of the degenerative disc disease. (Ex. 32-1). Dr. Shaw premised the worsening of the underlying condition on the existence of a herniation or disc bulge. (Exs. 35-24, 25). Nonetheless, Shaw conceded there was no evidence of a disc herniation or bulge to a medical probability. (Ex. 35-25). Consequently, we find that Shaw failed to sufficiently explain his shift of opinion regarding claimant's neck condition. In light of his inconsistent opinion, we do not find Dr. Shaw persuasive. See Somers v. SAIF, 77 Or App 259 (1986).

In light of the medical evidence, we conclude that claimant has failed to prove by a preponderance of the evidence that his work activities worsened his previously asymptomatic degenerative neck condition. See Hutcheson v. Weyerhaeuser, 288 Or 51 (1979).

Secondly, for claimant's cervical condition to be compensable as a sequela to a compensable injury, claimant must prove that the elbow injury materially contributed to the cervical disability or need for treatment. See Hutcheson v. Weyerhaeuser, supra. In this case all the physicians state that the arm injury had no relationship to the cervical condition or at best, may have contributed. However, a mere possibility is not sufficient to meet claimant's burden of proof. See Gormley v. SAIF, 52 Or App 1055 (1981). Therefore, claimant has not met his burden of proving his elbow injury materially contributed to his cervical condition, and thus the cervical condition is not compensable as a sequela of the elbow injury.

Finally, since we have found claimant's cervical condition not to be compensable for the above reasons, we further find issuance of the insurer's denial not to be unreasonable.

ORDER

The Referee's order dated May 15, 1989, is affirmed.

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In the Matter of the Compensation of
**MARISOL VERDUZCO, Claimant**
WCB Case No. 88-13829
ORDER ON REVIEW
Garlock, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Gerner and Cushing.

Claimant requests review of Referee Lipton's order that: (1) upheld the self-insured employer's denial of claimant's tendinitis and cervicothoracic conditions; and (2) affirmed a Determination Order that awarded no scheduled permanent disability for the loss of use or function of her left index finger. On review, the issues are compensability, medical services, and extent of scheduled permanent disability. We affirm in part and reverse in part.

## FINDINGS OF FACT

The Board adopts the Referee's Findings of Fact as our own, with the following supplementation.

Claimant suffers some loss of use or function of her left index finger resulting from her compensable injury.

## CONCLUSIONS OF LAW AND OPINION

### Compensability

Claimant contends that her left wrist tendinitis and cervicothoracic conditions are related to her compensable left index finger injury. To prevail, claimant must establish that her compensable injury was a material cause of the wrist and cervicothoracic conditions.

The Referee concluded that claimant failed to meet that burden. We agree.

Claimant has an accepted claim for an industrial injury. It is well settled that the employer is liable for the natural consequences flowing from a compensable injury. Williams v. Gates McDonald & Co., 300 Or 278, 281 (1985); Pattitucci v. Boise Cascade Corp., 8 Or App 503, 507-08 (1972); Randolph P. Gaul, 42 Van Natta 592 (1990).

The record establishes that claimant suffered a fractured left index finger in March 1988. Her first complaints of wrist pain occurred in mid-May 1988, at the time she sought treatment from Dr. Phillips, chiropractor, two and one half months after the finger injury. Claimant's first complaints of cervicothoracic pain were in August 1988, five months after her left index finger injury.

Because of the length of time between the time of claimant's compensable left index finger injury and the first complaints of wrist and cervicothoracic pain, we find that the causation of claimant's condition is of sufficient medical complexity that we cannot decide it without expert opinion. Uris v. Compensation Department, 247 Or 420, 424-26 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985).

Claimant was treated by Dr. Sanders, her initial treating physician, and Dr. Phillips, chiropractor. She was evaluated by Dr. Nye, hand surgeon, and Dr. Howell, D.O.

Drs. Sanders, Nye and Howell agree that claimant's wrist and cervicothoracic conditions are not related to claimant's compensable finger injury.

Nye, a hand specialist, performed a thorough independent examination of claimant in June 1988, including an evaluation of all claimant's upper extremities. Nye noted a full range of motion of all upper extremities, including claimant's shoulder, elbow, wrist and hand, and specifically opined that it was not medically probable that claimant would have tendinitis or "any injury to the wrist or cervicothoracic area" resulting from a crush injury to the tip of the left index finger. (Ex. 21). Nye also opined, in an August 1988 report, that tendinitis "would be exceedingly rare" secondary to claimant's finger injury. (Ex. 18).

In October 1988, Sanders reported that claimant did not complain of tendinitis or cervicothoracic pain during the duration of his treatment of claimant

and noted that claimant's complaints outweighted physical findings. He also reported that this type of injury, finger fracture, generally heals within six weeks. In that same report, Sanders noted his agreement with Dr. Nye's August 1988 report. (Ex. 22).

Finally, in November 1988, Dr. Howell interviewed claimant and performed an independent medical examination. Howell noted claimant's comments that other than immersing her hand in water and prescribing medication, no other treatment was provided. Howell noted full range of motion in claimant's upper extremities and noted he agreed with Nye's August 1988 opinion. (Ex. 23).

The only physician to specifically relate claimant's wrist and cervicothoracic conditions to her compensable finger injury was Phillips.

Phillips did not begin treating claimant until two and one half months after the finger fracture. Phillips expounded three possible theories in relating claimant's current conditions to claimant's compensable finger injury: (1) left wrist tendinitis developing from not using the left hand; (2) muscular conditions developed from a yeast infection; or (3) claimant's activities during her brief return to work in April 1988. The Referee did not find these theories persuasive and neither do we. We adopt the Referee's conclusions with respect to Phillips' theories.

We find the opinions of Drs. Nye, Howell and Sanders to be more persuasive as they represent the more well-reasoned opinions. Somers v. SAIF, 77 Or App 259, 262 (1986); see Hammons v. Perini Corp., 43 Or App 299, 302 (1979).

Consequently, we find that the preponderance of the medical evidence, the opinions of Drs. Nye, Howell and Sanders, establish that claimant's wrist and cervicothoracic conditions are not compensably related to claimant's compensable finger injury.

Extent of Scheduled Permanent Disability

The Referee declined to award permanent disability, stating that the "greater weight of the persuasive medical evidence is that claimant has not suffered any impairment as a result of her distal phalanx fracture of the left index finger." We disagree.

To establish the extent of claimant's permanent disability, we apply the standards for evaluating permanent disability as adopted by the Director of the Department of Insurance & Finance pursuant to ORS 656.726(3)(f). See ORS 656.283(7). Specifically, we apply former OAR 436-35-000 et seq, which was effective at the time of the July 29, 1988 Determination Order.

The most current medical report in the record is that of Dr. Howell's November 1988 evaluation of claimant's finger condition. We have already found Howell's opinion to be persuasive in that it is thorough and well-reasoned. We use that same opinion in making our determination of the extent of claimant's scheduled disability.

Based on Howell's report, we find that claimant retains 65 percent of the distal interphalangeal joint, for a 3 percent loss of flexion. Former 436-35-060(1). We also find that she retains 90 degrees of motion at the proximal interphalangeal joint, for a loss of 6 percent. Former OAR 436-35-060(3).

Claimant contends that she is also entitled to an award for the "concomitant loss of opposition with the partially amputated thumb, pursuant to former OAR 436-35-040(2)(a)." We disagree. Claimant's partially amputated

thumb is not related to claimant's compensable left index finger injury. Therefore, such a loss of opposition is not considered in determining the extent of permanent disability regarding her left index finger.

Claimant also contends that she is entitled to an award for disabling pain. Former OAR 436-35-010(2)(a); Daniel Alire, 41 Van Natta 752, 757 (1989). However, after our review of the record, we find no basis for this contention. Therefore, we conclude that claimant is not entitled to an award for disabling pain.

The employer argues that the two figures for loss of flexion of the index finger should be combined, for a loss of nine percent. The employer then contends that, pursuant to former OAR 436-35-070(5), the value for the finger should be converted into a hand value. We agree that the figures should be combined, but disagree with the employer regarding the issue of conversion.

First, we note that former OAR 436-35-070(5) provides that "[l]oss of or loss of use of two or more digits may be converted to a value for loss in the hand. . ." Here, claimant suffers from only the loss of use of one digit. Therefore, former OAR 436-35-070(5) is inapplicable and conversion is not appropriate.

Second, we note that former OAR 436-35-060(7) provides that,

> "For multiple losses in any finger, first rate each loss separately. Then combine (do not add) these ratings to find the total impairment of the finger. Other findings, such as decreased sensation, would be combined with these ratings."

After combining the loss of flexion and motion figures, 6 and 3, we find that claimant is entitled to a 8.82 percent scheduled disability for the loss of use or function of her left index finger. This figure is then rounded to the next higher one percent step. Former OAR 436-35-010(6). Therefore, we conclude that claimant has suffered 9 percent permanent loss of use or function of her left index finger.

ORDER

The Referee's order dated July 10, 1989, is affirmed in part and reversed in part. Claimant is awarded 9 percent (2.16 degrees) scheduled permanent disability for the loss of use of her left index finger. Claimant's attorney is awarded 25 percent of the increased compensation created by this award. The remainder of the order is affirmed.

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In the Matter of the Compensation of
**JIMMY L. COONROD, Claimant**
WCB Case No. 89-01187
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
John Motley (Saif), Defense Attorney

Reviewed by Board Members Brittingham and Nichols.

The SAIF Corporation requests review of Referee Foster's order that set aside its denial of claimant's aggravation claim for his current left ankle condition. On review, the issue is aggravation. We reverse.

## FINDINGS OF FACT

Claimant sustained a compensable injury to his left ankle in a logging accident with SAIF's insured on September 26, 1984. At the time of hearing, claimant was 36 years old. The original injury was an ankle fracture. In August 1985, claimant was diagnosed as having left tarsal tunnel syndrome with probable mild sympathetic dystrophy. At that time, his treating osteopathic surgeon, Dr. Fritchett, performed a decompression of the left posterior tibial nerve root.

In December 1985, following claimant's recuperation from this procedure, Dr. Fritchett declared his ankle condition medically stationary and imposed permanent restrictions. Claimant was to permanently avoid walking on rough or uneven ground, and he was not to stand or walk in excess of three hours at a time.

On January 27, 1986, the claim was closed by Determination Order. Claimant received a scheduled permanent partial disability award of 10 percent for the left foot. On September 22, 1986, after claimant appealed this award, the parties stipulated to a 15 percent increase, for a total award of 25 percent scheduled permanent disability. This stipulation was the last arrangement of compensation.

Despite the medical restrictions placed on claimant, he attempted to return to logging jobs and predictably experienced an exacerbation of symptoms. Following the exacerbation, claimant's ability to stand and walk for prolonged periods was limited. He began wearing a knee brace in November 1988. Claimant filed an aggravation claim which was denied by SAIF on January 13, 1989.

## ULTIMATE FINDINGS OF FACT

Claimant's symptoms of pain, swelling, and burning in the left foot were exacerbated and resulted in at least a temporary loss of use or function greater than existed at the time of the stipulated award in September 1986.

Claimant's left ankle condition remains medically stationary; his exacerbation of symptoms has resulted in the same use and function limitations previously contemplated. Claimant's worsening of symptoms was contemplated by the last arrangement of compensation.

No evidence is presented that claimant's symptomatic flare-up resulted in inpatient treatment or disability for a period exceeding 14 days.

## CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant suffered a compensable aggravation of his left ankle condition. We disagree.

In order to demonstrate a compensable aggravation of his left foot, claimant has to have experienced increased loss of use since the last arrangement of compensation. International Paper Co. v. Turner, 84 Or App 248 rem 304 Or 354 (1987), on rem 91 Or App 91 (1988). Furthermore, the increased loss of use or function of the scheduled body part must be greater than that contemplated by the last award or arrangement. See e.g., Edward D. Lucas, 41 Van Natta 2272, 2277 (1989); Karen M. Schofield, 42 Van Natta 456 (1990).

The medical evidence is uncontroverted that claimant suffered an exacerbation of pain, swelling, and burning sensations in his left foot. (Exhibit 21). These symptoms resulted in at least a temporary loss of use or function greater

than existed at the time of the September 1986 stipulation. For example, claimant testified that following the return of these symptoms he could not stand as long and his range of walking decreased. (Tr 7-10). Claimant was supplied with a foot brace in November 1988, which is a further indication of loss of use. (Tr 10-11; Ex 12-4).

We next consider whether the last award of 25 percent scheduled permanent disability was predicated on an anticipated waxing and waning of claimant's symptoms. Here, claimant's primary symptomatology following the original fracture and also after the decompression surgery was pain, swelling, tingling and burning sensations in his left foot. To prevent flare-ups of these symptoms, claimant's treating physician told him to avoid walking on uneven or rough ground and not to stand or walk more than three hours at a time. These permanent restrictions were reiterated in a September 2, 1986 letter from Dr. Fritchett to claimant's attorney immediately before the last stipulated award. (Exhibit 19). As anticipated, when claimant attempted to return to jobs that exceeded these restrictions, he once again experienced symptoms of swelling and burning sensation of the left foot.

In this case, we assume that the parties considered all evidence available at the time they stipulated to an award of 25 percent scheduled permanent disability. International Paper Co., supra, 84 Or App at 251. The available evidence includes a report from Dr. Fritchett in which he restricted claimant from walking on uneven ground and standing for periods in excess of three hours. We infer from Dr. Fritchett's restrictions that he believed claimant's return to work involving these activities would cause a flare-up of his left ankle condition and result in periods of increased disability. See Noble J. Chasteen, 41 Van Natta 528, 529 (1989). Dr. Fritchett's opinion was unrebutted. Consequently, we conclude the September 1986 stipulation contemplated future flare-ups.

The remaining issue is whether or not the alleged periods of disability experienced by claimant exceeded those anticipated by the prior disability award. Id. at 530. If the period of disability resulting from a flare-up of symptoms exceeds 14 days, or if the flare-up requires inpatient hospitalization, the claimant has sustained an aggravation as a matter of law. Gwynn v. SAIF, 304 Or 345, 353 (1987); International Paper Co., supra, on rem 91 Or App at 94; Noble J. Chasteen, supra.

The record in this case reveals no evidence as to duration of disability or of any hospitalization due to claimant's exacerbation of symptoms. Moreover, the attending orthopedist, Dr. Fritchett, reported that claimant's exacerbated symptoms were primarily related to residuals of the compensable ankle injury and the fact that claimant did not follow through with the restrictions outlined three years earlier. Additionally, Dr. Fritchett indicated that there was no curative treatment, other than to continue with the previous restrictions. Supporting this medical opinion is an independent orthopedic evaluation by Dr. Van Olst, who agrees that claimant's condition remains medically stationary, and that there are no further treatments or curative benefits available, and that claimant's restrictions remain the same. No contrary medical findings were presented.

On this record, claimant has not proven that her exacerbation resulted in total disability in excess of 14 days, required in inpatient treatment, or otherwise exceeded that anticipated by the last arrangement of compensation. Accordingly, claimant has not established a compensable aggravation.

ORDER

The Referee's order, dated May 11, 1989, is reversed. The SAIF Corporation's denial is reinstated and upheld. The Referee's assessed attorney fee award of $500 is reversed.

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In the Matter of the Compensation of
**RILEY F. BEAN, Claimant**
WCB Case No. 88-17098
ORDER ON REVIEW
Malagon & Moore, Claimant Attorneys
Snarskis, Yager, et al., Defense Attorneys

Reviewed by Board Members Crider and Nichols.

The insurer requests review of those portions of Referee Brown's order that: (1) set aside the insurer's denial of claimant's aggravation claim for a back condition; and (2) held that claimant had timely filed his claim for aggravation rights. On review, the issues are aggravation and timeliness of filing. We reverse in part and affirm in part.

FINDINGS OF FACT

Claimant, a truck driver, sustained a compensable back injury on December 10, 1982. He had a prior history of low back problems and treatment, including a 1968 lumbar laminectomy at L4-5. On December 21, 1982, Dr. Dixon, M.D., performed a lumbar myelogram, which was consistent with mild disc herniation at L4-5. Claimant treated with Dr. Gell, rheumatologist, from July 1984 through August 1988.

The claim was first closed by Determination Order dated August 31, 1983. The claim was last closed by an October 13, 1987 Determination Order that awarded no permanent disability in addition to claimant's prior award of 25 percent unscheduled permanent disability for the low back. Claimant requested a hearing on the October 1987 Determination Order.

On February 10, 1988, claimant's current treating physician, Dr. Sutherland, neurosurgeon, found that claimant had disc bulging at all four lower lumbar disc spaces. On February 22, 1988, a hearing regarding the October 1987 Determination Order was held before Referee Melum. The record closed on the date of hearing. At that time, claimant was capable of performing modified work requiring no more than one continuous hour of sitting, standing and walking, and no more than four hours of each activity in an eight hour day. Referee Melum issued an order awarding an additional 40 percent unscheduled permanent disability for the low back, for a total of 65 percent.

Myelographic studies performed on May 6, 1988 indicated no change in the lumbar spine from the 1982 studies.

On May 11, 1988, Dr. Sutherland requested authorization to perform lumbar surgery. Pursuant to Dr. Sutherland's request, an independent medical examination was performed by the Western Medical Consultants on July 16, 1988. On August 29, 1988, Dr. Sutherland reported that claimant continued to experience pain in the lower back with cramping in the legs and tingling going down as far as the first toes. Dr. Sutherland requested that the claim be reopened and temporary disability benefits restored.

On September 1, 1988, Dr. Tennyson, neurosurgical consultant, reviewed claimant's records and the most recent myelograms.

On September 30, 1988, the insurer denied claimant's request for surgery and further temporary disability benefits.

FINDINGS OF ULTIMATE FACT

The insurer had notice of a request for additional treatment for a worsened condition related to the injury less than five years after August 31, 1983, when the claim was first closed.

Claimant has not suffered a worsening of his compensable condition since the February 22, 1988 hearing.

CONCLUSIONS OF LAW AND OPINION

The Referee held that claimant had filed an aggravation claim before his aggravation rights expired and had established an aggravation. We agree that the claim was filed timely, but reverse on the merits.

The Aggravation Claim

Claimant's claim was first closed by Determination Order dated August 31, 1983. Therefore, any claim for aggravation must have been filed prior to August 31, 1988. ORS 656.273.

A medical report will serve as a claim for aggravation if it puts the insurer on notice of the need for additional medical services for a worsened condition. Krajacic v. Blazing Orchards, 84 Or App 127 (1987). A surgery request is a classic example of such a claim, especially if coupled with new findings. See Haret v. SAIF, 720 Or App 668 (1985). On May 11, 1988, Dr. Sutherland requested authorization for surgery for a disc herniation related to the compensable condition. Although the record does not reflect when the insurer received the report, it does establish that on May 31, 1988, the insurer received a report from Dr. Gell responding to the recommendation and set up an independent medical examination for July 16, 1988, to evaluate the request. Although prior reports had noted disc bulges, none had suggested a herniation and none had proposed surgery. On this record, we find that the insurer had been notified, not later then May 31, 1988, that claimant's condition may have worsened requiring new, rather than ongoing, medical services. Consequently, we find that an aggravation claim was filed within the five year aggravation period.

Aggravation

The Referee, deferring to treating physician Sutherland's opinion, held that under the law of the case, claimant was capable of working as of the last arrangement of compensation in February 1988 but was not capable of working as of August 29, 1988, and thus had established an aggravation of his back condition.

In order to establish that he suffered an aggravation, claimant must show that he experienced a worsening of his condition since the last arrangement of compensation. Smith v. SAIF, 302 Or 396 (1986). "Worsening" within this context means increased symptoms, or a worsened underlying condition, resulting in a diminishment of earning capacity. Id. Here, the February 22, 1988 hearing was the last arrangement of compensation. Larry H. Erbs, 42 Van Natta 98 (1990); Joseph R. Klinsky, 35 Van Natta 332, 333-334, aff'd mem. 66 Or App 193 (1983).

After a de novo review of the record, we find that claimant has not established that his condition is currently worse than it was at the time of the last arrangement of compensation.

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

Here, we find persuasive reasons not to defer to the opinion of Dr. Sutherland, on whose August 29, 1988 report the Referee based his conclusion that claimant suffered an aggravation of his back condition. Dr. Sutherland, relying on a May 6, 1988 myelogram, felt that claimant suffered from a herniated disc and could not work. However, Sutherland offered no further analysis of claimant's condition. He did not compare claimant's condition before and after the February 22, 1988 hearing.

In contrast, Dr. Tennyson, after reviewing the medical record, explained that claimant's spine showed miniscule degenerative changes typical of postoperative changes following the type of lumbar surgery claimant underwent in 1968. Tennyson found no change between the 1982 and 1988 myelographic studies. He opined that there is no definite objective evidence of nerve root compression. Neurologist Kho, of the Western Medical Consultants, concurred with Dr. Tennyson. He found the May 6, 1988 myelogram to be within normal limits. We defer to the well-reasoned opinions of Drs. Tennyson and Kho.

Persuasive lay testimony may be probative of whether a worsening producing an increased loss of earning capacity has occurred. At hearing, claimant testified that his condition is worse than at the time of the last arrangement of compensation in that he cannot walk or climb ladders as well as he could previously. However, on cross-examination he stated that he continues to do a lot of walking. Moreover, claimant related to the Western Medical Consultants on July 16, 1988 that he could sit for one hour, stand for 30 to 40 minutes and drive for one hour. These are, essentially, the same subjective limitations claimant reported at the time of the February 22, 1988 hearing. Therefore, we do not find that claimant's testimony establishes a loss of earning capacity since the last arrangement of compensation.

ORDER

The Referee's order dated February 3, 1989, as reconsidered March 1, 1989, is reversed in part and affirmed in part. The insurer's denial is reinstated and upheld. The Referee's $1,500 attorney fee award concerning the aggravation denial is reversed. The remainder of the order is affirmed.

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In the Matter of the Compensation of
**LANE T. PLOTNER, Claimant**
WCB Case Nos. 88-22611 & 88-17778
ORDER ON REVIEW
Coons & Cole, Claimant Attorneys
H. Thomas Andersen (Saif), Defense Attorney
William Blitz, Defense Attorney

Reviewed by Board Members Crider and Brittingham.

Liberty Northwest Insurance Corporation requests review of Referee Danner's order that: (1) set aside its denial of an aggravation claim relating

to an August 3, 1988 authorization of temporary disability compensation; and (2) upheld the SAIF Corporation's denial of responsibility for claimant's current condition. On review, the issues are aggravation and scope of review. We reverse.

## FINDINGS OF FACT

Claimant was compensably injured as a result of a June 3, 1986 accident in which he was involved while employed as a truck driver for Liberty Northwest's insured. As a result, claimant suffered compression fractures and several of the vertebrae in the mid-back were fused. The claim was closed by Determination Order with an award of 30 percent unscheduled permanent disability and 14 months of temporary total disability compensation.

In March 1988 he was apparently involved in a chase and arrest and, thereafter, experienced back pain.

On June 21, 1988, claimant was involved in a second trucking accident while working for SAIF's insured. His initial complaints were of leg pain only. He suffered abrasions of the legs.

On July 12, 1988, SAIF accepted "contusion/swollen lower legs."

On August 3, 1988, claimant was seen by Dr. Bert, M.D. He was complaining of back pain. Dr. Bert diagnosed back strain following the two 1988 injuries. He authorized time loss. The report was sent to SAIF. On August 29, 1988, SAIF advised the Department of Insurance and Finance that it had reclassified the claim as disabling and begun paying temporary total disability.

Meantime, it appears that claimant's attorney requested that the 1986 claim be reopened on an aggravation basis commencing August 3, 1988. (Ex. 18). On September 27, 1988, Liberty Northwest denied the aggravation claim on the grounds that claimant's compensable condition had not worsened and, if it had, the 1988 compensable injury was the cause of the worsening.

Dr. Bert declared claimant medically stationary on September 16, 1988, and released him to return to his truckdriving work.

A Determination Order issued October 25, 1988, in the 1988 claim awarding temporary total disability only for the period August 3 through September 16, 1988.

On October 31, 1988, SAIF issued a denial stating that claimant's "dorsal lumbar condition is no longer causally related" to the 1988 compensable injury and is now related solely to the 1986 injury. Therefore, according to the denial, "we are unable to accept responsibility for any treatment and/or disability in connection with your current dorsal lumbar condition."

Claimant timely requested hearings on each of the denials.

The case was submitted for decision on the record.

## FINDINGS OF ULTIMATE FACT

Liberty Northwest's denial was not a denial of future disability or medical services.

At the time SAIF's October 31, 1988 denial issued, claimant had submitted no claim for additional disability or medical services for his back condition.

## CONCLUSIONS OF LAW AND OPINION

In claimant's written argument to the Referee, claimant contended that the Referee should decide whether Liberty Northwest or SAIF should have ongoing responsibility for claimant's back difficulties. Claimant urged that his 1988 injury had resolved and therefore that Liberty Northwest "should be held responsible for processing any subsequent billings or other claim by claimant the same as if neither denial had ever been entered." Although counsel for Liberty Northwest objected to this characterization of the issue, the Referee treated the case as a dispute concerning future responsibility and set aside Liberty Northwest's aggravation denial; he remanded the claim "for continued acceptance by that carrier."

On review, Liberty Northwest renews its objection to the characterization of this dispute by claimant and the Referee. We are persuaded that Liberty Northwest is correct and that the two denials must be addressed separately.

### Liberty Northwest's Denial

Liberty Northwest's denial addressed Dr. Bert's August 3 time loss authorization and claimant's attorney's request for reopening of the 1986 claim. That period of time loss has been paid in the 1988 claim by SAIF. Claimant does not contend that Liberty Northwest rather than SAIF was responsible for that period of time loss. Instead, claimant contends that Liberty Northwest's denial repudiated responsibility for future benefits. It plainly does not. Therefore, we reinstate Liberty Northwest's denial.

### SAIF's Denial

SAIF's denial, on the other hand, is apparently intended to establish that SAIF will no longer have any responsibility for claimant's back problems: we so construe it because claimant had made no claim for benefits of any kind when SAIF issued its denial of responsibility within six days following closure of the 1988 claim. See Mark E. Fuller, 42 Van Natta 1731 (1990). ORS 656.307 and the Director's rules promulgated thereunder contemplate that responsibility will be adjudicated only when there is a dispute over the duty to pay pursuant to a claim for benefits. Thus, the rule requires the insurer that denies responsibility to send information concerning the claim to any other insurer it deems responsible, requires the second insurer to process the information as a claim on behalf of the worker and provides for a hearing to determine responsibility. Former OAR 436-60-180. The rules do not contemplate that we should conduct hearings concerning responsibility for a condition that has occasioned no claim. Inasmuch as there was no claim when SAIF's denial issued, we shall set it aside. Evanite Fiber Corporation v. Striplin, 99 Or App 353 (1989). See Bernice Erwin, 41 Van Natta 154 (1989), aff'd mem., 100 Or App 551 (1990).

If at any time in the future claimant makes a claim for disability or medical services, the insurers may determine whether to accept or deny that claim and the parties will be free to litigate the question of responsibility for that particular disability or need for medical services.

## ORDER

The Referee's order dated March 30, 1989, and republished on June 9, 1989, is reversed. The SAIF Corporation's denial of October 31, 1988 is set aside. For services at hearing and on review concerning this issue, claimant's attorney is awarded a $750 attorney fee, to be paid by SAIF. Liberty Northwest Insurance Corporation's denial of September 27, 1988 is reinstated and upheld. The Referee's $750 attorney fee award is reversed.

In the Matter of the Compensation of
**JANNETTE I. SHUE, Claimant**
WCB Case No. 88-22594
ORDER ON REVIEW
Dennis O'Malley, Claimant Attorney
Saif Legal Department, Defense Attorney

Reviewed by Board Members Nichols and Brittingham.

Claimant requests review of Referee Hoguet's order which: (1) declined to address the compensability of claimant's alleged bilateral tendinitis condition; (2) upheld the SAIF Corporation's denial of claimant's bilateral carpal tunnel syndrome; (3) declined to assess penalties and attorney fees for SAIF's alleged back-up denial of that condition; and (4) declined to assess penalties and attorney fees for SAIF's alleged untimely denial. On review, the issues are scope of review, compensability, and penalties and attorney fees. We affirm.

## FINDINGS OF FACT

We adopt the Referee's "Findings of Fact."

## FINDINGS OF ULTIMATE FACT

The issue of compensability of claimant's alleged bilateral tendinitis condition was not raised by claimant at hearing.

Claimant does not have a work-related bilateral carpal tunnel syndrome.

SAIF's denial of claimant's bilateral carpal tunnel condition was not a back-up denial of a previously accepted condition.

SAIF's failure to process claimant's left arm claim within 60 days was unreasonable, but was not a resistance to payment of compensation.

## CONCLUSIONS OF LAW AND OPINION

### Scope of Review/Compensability of Bilateral Carpal Tunnel Syndrome

We adopt the Referee's conclusions and opinion as they relate to the scope of review and compensability issues.

### Penalties and Attorney Fees for Alleged Back-Up Denial

We affirm the Referee's conclusion that no penalties and attorney fees can be awarded on this issue. However, we do so for different reasons.

In the absence of fraud, misrepresentation, or other illegal activity, an insurer who accepts a claim for a condition under ORS 656.262(6) may not subsequently deny the compensability of the underlying claim. Bauman v. SAIF, 295 Or 788, 794 (1983). The Bauman rule applies only to a denial of a condition specifically or officially accepted by the insurer. Johnson v. Spectra Physics, 303 Or 49, 52 (1987).

The Referee concluded that SAIF never accepted claimant's bilateral carpal tunnel claim as required by ORS 656.262(6). For this reason, he declined to assess penalties and attorney fees. The Referee specifically found no authority to support claimant's contention that SAIF's checking the acceptance box in the "insurer use only" portion of the 801 Form constituted a valid acceptance of claimant's claim.

Subsequent to the Referee's order, we considered this same issue in Nancy V. Storey, 41 Van Natta 1951 (1989). We noted that "acceptance" is an act through which the insurer acknowledges responsibility for the injury or condition contained in a claim and obligates itself to provide the benefits due under the law. Id. at 1952-53. Therefore, we concluded that checking the appropriate options on an 801 claim form is one manner in which a claim may be accepted.

Notwithstanding the Storey holding, we are not persuaded that SAIF accepted claimant's bilateral carpal tunnel syndrome when it completed the 801 form in July 1988. That form identified "arms and hands" as the body parts affected, but did not explain the nature of the injury or disease other than a comment from the employer representative that claimant's hands sometimes swelled. Three days after the employer signed the form, it issued a formal acceptance of only claimant's right lateral epicondylitis. In its November 1988 partial denial of claimant's bilateral carpal tunnel syndrome, SAIF confirmed that it had accepted claimant's right elbow condition. Under the circumstances, we find that SAIF's specific acceptance was limited to claimant's right lateral epicondylitis. Therefore, we conclude that SAIF's denial of claimant's bilateral carpal tunnel syndrome was not a back-up denial under Bauman. Accordingly, no penalties and attorney fees should be assessed.

Penalties and Attorney Fees for Late Denial

We also affirm the Referee's conclusion that no penalties and attorney fees are due for SAIF's denial. However, we again do so for different reasons.

A claim is defined as "a written request for compensation from a subject worker or someone on the worker's behalf . . . of which a subject employer has notice or knowledge . . ," and which is causally related to the claimant's employment [emphasis supplied]. ORS 656.005(6); 656.005(7)(a); Michael L. Orr, 41 Van Natta 192 (1989).

The Referee concluded that claimant had not established when she filed a claim for bilateral carpal tunnel syndrome, so that claimant had not proven that the November 1988 denial of that condition was untimely. We disagree with the Referee's analysis.

SAIF knew of claimant's claim for injury affecting both the right and left upper extremities at least as of June 24, 1988, when it received Dr. Button's report of June 6, 1988 which diagnosed claimant's condition as cumulative trauma disorder with lateral epicondylitis, right elbow greater than left. Furthermore, SAIF had additional notice that claimant's condition involved both the right and left arms and hands no later than July 12, 1988, when it completed the 801 Form. We find that Dr. Button's report, along with the 801 Form constitute a claim for bilateral epicondylitis, if nothing else.

SAIF should have accepted or denied this bilateral claim within 60 days. SAIF issued a timely acceptance of right epicondylitis but did nothing regarding the left arm until November 1988, when it denied bilateral carpal tunnel syndrome. Moreover, it has never denied or accepted the left epicondylitis condition. Accordingly, we conclude that SAIF unreasonably failed to timely process claimant's left arm claim.

Nevertheless, a penalty may not be assessed for this failure. ORS 656.262(10) provides for a penalty based upon a percentage of "amounts then due." Here, because we have found that claimant's carpal tunnel condition is not compensable, there was no compensation "then due." Therefore, a penalty is not authorized by law. Ellis v. McCall Insulation, 308 Or 74 (1989).

Unlike a penalty, an attorney fee can be awarded even though there are no "amounts then due," if the carrier's behavior constitutes unreasonable resistance to the payment of compensation. ORS 656.262(10); ORS 656.382(1); Ellis, supra; Cindi A. Cadieux, 41 Van Natta 2259 (1989). Because claimant has not established a compensable left epicondylitis or bilateral carpal tunnel condition, we do not find any unreasonable resistance to the payment of compensation under ORS 656.382. As a result, we do not assess an attorney fee on the untimely denial issue. Lloyd L. Cripe, 41 Van Natta 1774 (1989).

ORDER

The Referee's order dated April 12, 1989 is affirmed.

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In the Matter of the Compensation of
**HATTIE L. GOODRICH, Claimant**
WCB Case No. 88-14463
ORDER ON REVIEW (REMANDING)
Stebbins & Coffey, Claimant Attorneys
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Myers and Gerner.

Claimant requests review of that portion of Referee Quillinan's order that awarded 20 percent (64 degrees) unscheduled permanent disability for a psychological condition, whereas a Determination Order awarded no permanent disability. On review, the issue is extent of unscheduled permanent disability. We remand.

FINDINGS OF FACT

Claimant, 64 years of age at hearing, has a 10th grade education and no GED. At the time of her claim, claimant was working as a checkout clerk supervisor.

In September 1986, claimant filed a claim for acute situational stress, later diagnosed as an adjustment disorder with anxiety and depression. She was treated, and continues to be treated, by Dr. Martin, psychiatrist. Her claim arose out of an incident surrounding her termination with the employer. By Opinion and Order dated February 5, 1988, her stress claim was found compensable.

Claimant's condition became medically stationary in mid-July 1988 and Martin released her to return to work. Her claim was closed by Determination Order on August 5, 1988, awarding temporary disability only. Claimant requested a hearing.

In October 1988, claimant was evaluated by Dr. Turco, psychiatrist and independent medical examiner. Turco diagnosed a "mixed neurosis with depression," noting that the "adjustment disorder" diagnosis, made by Dr. Martin, was no longer appropriate. Claimant is treated conservatively with medicine which controls her insomnia and depression.

Claimant suffers permanent impairment resulting from her compensable 1986 stress claim.

She has not returned to work since her claim was filed. She is capable of returning to work. Her highest demonstrated "SVP" value is 2 for her check-out clerk position, and she has no documented training.

CONCLUSIONS OF LAW AND OPINION

The Referee awarded claimant 20 percent unscheduled permanent disability under the standards. The Referee found claimant to be within Class 2 for the rating of permanent impairment under former OAR 436-35-400(4)(b)(B), and awarded 20 percent disability for a depressive reaction. Claimant seeks an increase in the extent of her permanent disability.

We agree that claimant suffers some unscheduled permanent disability under the standards resulting from her compensable stress claim. See former OAR 436-35-270 through 436-35-440. However, in order to rate the extent of a claimant's unscheduled permanent disability under the standards, specific requisite information must be present in the record, i.e., evidence sufficient for us to determine appropriate values for age, education, adaptability, and impairment. See former OAR 436-35-001 et seq.

We may remand should we find that the record has been "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(5). We so find.

We note that former OAR 436-35-280(1) provides that there shall be no unscheduled disability award if the compensable injury does not result in impairment. Therefore, were we to find that claimant did not suffer permanent impairment resulting from her compensable injury, we would not remand.

Here, there is sufficient information with which to determine values for claimant's age, education and impairment. However, there is no evidence from which claimant's adaptability can be determined.

Former OAR 436-35-310(1) provides that the range of impact for the adaptability factor is from zero to +8. Subsections (2) through (4) are to be used to determine a claimant's adaptability value, depending upon the specific circumstances of the case.

Under subsection (2)(b), if claimant has returned to her usual and customary work, or been offered such work, her adaptability value would be zero.

Under subsection (2)(c), if the employer has offered claimant her usual and customary work in writing within five working days after her release to return to such work, and claimant refuses or does not respond, her adaptability value would be zero.

Under subsection (3)(a), if claimant is unable to return to her usual and customary work, but has returned to modified work, her adaptability value shall be based on the table found under subsection (3)(a). Under (3)(b), if claimant is unable to return to her usual and customary work and the employer offered her a job that the attending physician agrees is within her physical capacity, her adaptability value shall be based on the table in subsection (3)(a).

Under subsection (4), if claimant, as a result of her compensable stress claim, is not working and no employment has been offered, her adaptability value shall be based on her physical capacity according to subsections (4)(a) through (d), ranging from +1 to +8.

The only medical evidence with which to assess claimant's adaptability consists of two psychiatric reports which state that claimant "could return to work if employment was available to her," and claimant "could handle some kind of a job." (Ex. 12, 13). We do not find that this evidence, alone, is sufficient evidence with which to assess an adaptability value under the standards.

The record does establish that claimant has not returned to regular or modified work at the time of hearing (Tr. 6). The record is not clear, however, as to whether claimant was offered any work. If she was not, her adaptability value must be determined by her physical capacity under former OAR 436-35-310(4). There is no evidence in this record to determine claimant's physical capacity.

Consequently, we find that there is insufficient evidence with which to determine claimant's adaptability value. Furthermore, because there is insufficient evidence with which to rate claimant's disability under the standards, we remand for the taking of further evidence solely on claimant's adaptability.

Specifically, the Referee shall make additional findings sufficient to determine the appropriate adaptability value under former OAR 436-35-310. Those findings shall include, but are not limited to, the following: (1) whether or not an offer was made; (2) the physical capacity required of claimant to perform her usual and customary work (at-injury work); and (3) the physical capacity required of claimant to perform her modified work resulting from her compensable injury. The Referee shall then issue an order rating claimant's disability using the standards.

ORDER

The Referee's order dated December 6, 1988, which awarded claimant 20 percent (64 degrees) unscheduled permanent disability, is vacated and the matter is remanded to Referee Quillinan for further proceedings consistent with this order.

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In the Matter of the Compensation of
**DEBORAH L. PEARSON, Claimant**
WCB Case No. 88-21361
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Acker, et al., Defense Attorneys

Reviewed by Board Members Myers and Cushing.

The self-insured employer requests review of Referee Higashi's order that: (1) set aside its "de facto" denial of a claim for medical services; and (2) assessed penalties and related attorney fees for an untimely acceptance or denial of a claim for medical services. On review, the issues are medical services and penalties and related attorney fees. We affirm in part, and reverse in part.

FINDINGS OF FACT

Claimant injured her neck, right shoulder, and back on March 21, 1983. The claim was accepted.

On October 23, 1983, claimant was involved in a motor vehicle accident while driving to a doctor's office for treatment of the compensable condition. As a result of the accident, claimant reinjured her neck, right shoulder, and back.

A Determination order issued August 7, 1984, awarding no permanent disability. By stipulated order dated January 4, 1985, claimant was granted 10 percent unscheduled permanent partial disability.

By letter from claimant's counsel, dated October 29, 1985, claimant brought a claim for medical services, in the form of unpaid medical bills resulting from the motor vehicle accident of October 1983. These bills concerned medical services provided by claimant's treating physician, Dr. Hebert, University Radiologists, University Medical Associates, Inc., Oregon Health Science

University, Barbur Psychological Clinic, and Molalla Chiropractic Clinic. The employer denied the medical services claim on February 20, 1986. By Stipulation dated July 16, 1986, the parties agreed the employer's denial would be upheld.

Claimant filed a second claim for medical services due to unpaid medical bills from Dr. Hebert relating to claimant's neck, right shoulder, and back condition. On June 18, 1987, the employer denied the claim, on the basis that claimant's then current cervical condition was due to the 1983 motor vehicle accident and not the 1983 accepted injury. Claimant requested a hearing. A hearing was held on October 15, 1987.

By Opinion and Order dated November 27, 1987, the employer's 1987 denial was upheld. On May 4, 1990 the Board eventually reversed the order of the Referee. See Deborah L. Pearson, 41 Van Natta 2366 (1989), on recon 42 Van Natta 1023 (1990).The Board held that: (1) res judicata did not bar claimant from bringing a claim for medical services; and (2) claimant had proven that her then current cervical condition was compensable, relying on Fenton v. SAIF, 87 Or App 78, 83 (1987).

Claimant submitted a third claim for medical services, seeking payment for unpaid bills for medical services received from January through June of 1988. The employer has neither accepted nor denied the claim for medical services.

Hearing was held on February 8, 1989, and the record closed on March 15, 1989. By Opinion and Order dated March 21, 1989, as reconsidered June 26, 1989, Referee Higashi found claimant's current claim for medical services compensable and assessed a penalty and attorney fee for an untimely acceptance or denial of claimant's claims for medical services.

## ULTIMATE FINDINGS OF FACT

The March 21, 1983 compensable injury was a material contributing cause of claimant's current cervical condition.

## CONCLUSIONS OF LAW AND OPINION

The Referee found the July 1986 stipulated order barred claimant from bringing a claim for medical services resulting from the October 1983 motor vehicle accident. He also found claimant's current cervical condition was materially related to the March 1983 compensable injury. Thus, the Referee concluded that claimant's current condition was compensable and ordered payment of the outstanding medical bills. We affirm with comment.

### Preclusion by former adjudication

The employer argues that res judicata bars claimant's present medical services claim due to the preclusive effect of the 1986 stipulation. We disagree.

This case raises the question of whether the doctrine of "preclusion by former adjudication"[1] gives the 1986 stipulated order or 1987 Opinion and Order preclusive effect.

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1. In our recent decisions we have used the nomenclature "res judicata" to refer to this doctrine, but have adopted the nomenclature "claim preclusion" and "issue preclusion" to refer to the two branches of this doctrine. E.g. Jimmy M. Campoz, 42 Van Natta 903 (1990) and Tana Wilson, 40 Van Natta 476 (1988). The Supreme Court has just adopted the nomenclature "preclusion by former adjudication" to refer to the doctrine; however, it approves of the use of "claim preclusion" and "issue preclusion" to refer to the two branches of the doctrine. Drews v. EBI Companies, 310 Or 134 (July 11, 1990).

The Court in Drews, summarized issue preclusion:

> "[I]ssue preclusion...precludes future litigation on a subject issue only if the issue was 'actually litigated and determined' in a setting where 'its determination was essential to' the final decision reached....Issue preclusion applies to an issue of either fact or law." Drews, supra, slip op. at 7.

The Court summarized claim preclusion with a quote from its earlier decision in Rennie v. Freeway Transport, 294 Or 319, (1982):

> "'[A] plaintiff who has prosecuted one action against a defendant through to a final judgment * * * is barred [i.e.,precluded] * * * from prosecuting another action against the same defendant where the claim in the second action is one which is based on the same factual transaction that was at issue in the first, seeks a remedy additional or alternative to the one sought earlier, and is of such a nature as could have been joined in the first action.' Rennie v. Freeway Transport, 294 Or 319, 323, 656 P2d 919 (1982)." Drews, supra slip op. at 7.

The Drews Court emphasized that claim preclusion does not require actual litigation of an issue of fact or law, nor does it require that the issue be essential to the result reached in the former adjudication; it does, however, require the opportunity to litigate that issue and a final determination. Drews, supra, slip op. at 7.

We conclude that neither issue preclusion nor claim preclusion bars claimant's present claim for medical services. Claimant has twice before brought a medical services claim against the same employer for unpaid medical bills resulting from treatment for claimant's cervical condition.

The first occasion concerned unpaid medical billings from Dr. Hebert, and several other medical providers, for claimant's cervical condition, as well as psychological counseling sessions, as identified in an October 1985 letter from claimant's counsel. By a July 1986 stipulated order, the parties agreed that the claim for medical services, as represented by these unpaid medical billings resulting from the 1983 motor vehicle accident, was not compensable.

On the second occasion, the unpaid medical billings at issue concerned chiropractic treatments from Dr. Hebert from the date of the July 1986 stipulated order until the date of the denial on June 18, 1987. These billings were denied by the employer in June 1987. By a November 1987 Opinion and Order, the Referee found the bills noncompensable as they were related to the 1983 motor vehicle accident. After noting the claim was not barred by res judicata, the Board reversed and found that the October 1983 motor vehicle accident was a compensable consequence of the March 21, 1983 injury.See Deborah L. Pearson, supra.

Therefore, we find that the previous legal action of the 1986 stipulated order and 1987 Opinion and Order, has resolved the following issues: (1) the effect of the 1986 stipulated order is to bar only those medical services rendered at the time of the stipulated order; and (2) the October 1983 motor vehicle accident is a compensable consequence of the March 21, 1983 injury. Deborah L. Pearson, supra. Thus, we do not find issue preclusion bars claimant from bringing the present claim for medical services.

We turn next to claim preclusion. Here, claimant has brought a medical services claim resulting from unpaid bills related to claimant's current cervical condition from a different chiropractor, Dr. Damon, for treatments which occurred during the January through June 1988 time frame. Thus, this claim involves different medical services, rendered on different dates, by a different medical provider, than those services which were dealt with by the 1986 stipulated order or the 1987 Opinion and Order.

Accordingly, we do not find that the present claim arises out of the same factual transaction as existed at the time of the 1986 stipulation or the 1987 Opinion and Order. The operative set of facts relevant to each one of these three claims for medical services are different. Inasmuch as we find there is a different set of operative facts, we find no claim preclusion. As claimant has not yet had an opportunity to litigate the present issue before any forum, she is not precluded from bringing an action on her present medical services claim.

Compensability

Turning to the merits, we find the 1983 compensable injury a material contribution to the need for medical care and treatment for claimant's current cervical condition. By correspondence dated September, November, and December 1988, claimant's present treating physician, Dr. Damon, persuasively explained that the compensable 1983 injury is the cause of claimant's current cervical condition. Accordingly, we find the claim for medical services to be compensable.

Penalties and Attorney Fees for untimely acceptance or denial

The Referee assessed a penalty and related attorney fee for the employer's failure to accept or deny the claim for medical services within 30 days. We disagree.

At the outset, we note that contrary to the Referee's statement, the employer had 60 days, not 30 days, in which to accept or deny the claim for medical services. ORS 656.262(6). Here, the employer neither accepted nor denied claimant's claim for medical services, which consisted of unpaid medical billings from January to June of 1988. Thus, we treat this as a "de facto" denial.

As long as an employer has a legitimate doubt, from a legal standpoint, of its liability, its conduct was not unreasonable. Norgard v. Rawlinsons, 30 Or App 999, 1003 (1977). At the time of receipt of the unpaid billings by the employer, the legal posture of the employer was that its June 18, 1987 denial of claimant's claim for medical services had been upheld by Opinion and Order of a Referee dated November 27, 1987. This denial was not set aside until the Order on Review dated December 18, 1989, as reconsidered May 4, 1990. Thus, at the time the hearing in this case was held, the employer still believed its 1987 denial was valid because of the "claim preclusive" effect of the 1986 stipulation. Under these circumstances, we decline to find the action of the employer unreasonable.

ORDER

The Referee's order dated March 21, 1989, as republished June 26, 1989, is affirmed in part, and reversed in part. The assessed penalty and $500 related attorney fee are reversed. The remainder of the Referee's order is affirmed. For services on Board review regarding the compensability of medical services issue, claimant's attorney is awarded an assessed fee of $725, to be paid by the employer.

In the Matter of the Compensation of
**WILLIAM T. SHIELDS, Claimant**
WCB Case Nos. 89-02938 & 89-02937
ORDER ON REVIEW
Galton, et al., Claimant Attorneys
Terrall & Miller, Defense Attorneys

Reviewed by Board Members Gerner and Myers.

Claimant requests review of Referee Tenenbaum's order which: (1) declined to direct the self-insured employer to pay an attorney fee directly to claimant's attorney; and (2) declined to assess a penalty and associated attorney fee for the employer's allegedly unreasonable failure to pay that attorney fee. On review, the issues are penalties and attorney fees. We reverse in part and affirm in part.

## FINDINGS OF FACT

Claimant has two accepted claims with the employer for right knee injuries. At close to the same time, Determination Orders were issued on both claims. A Determination Order awarded 15 percent (22.50 degrees) scheduled disability to the right knee on the earlier claim (the 1984 claim). Another Determination Order awarded no permanent disability on the later claim (the 1986 claim).

Both Determination Orders were appealed and a consolidated hearing convened before Referee Tenenbaum on September 4, 1987. By Opinion and Order dated September 8, 1987, the referee reduced the award on the 1984 claim to zero and increased the award on the 1986 claim to 15 percent scheduled disability to the right knee. In effect, she flipped the awards. She also allowed the employer to credit the payment made on the 1984 claim as an advance on the disability awarded on the 1986 claim. Finally, she refused to authorize an attorney fee to claimant's attorney because "claimant's net disability award has neither increased nor decreased. . ."

Claimant requested Board review. The Board, by Order on Review dated January 5, 1989, affirmed the referee except on the attorney fee to claimant's attorney.[1] We ordered:

> "That portion of the order that declined to award an attorney fee out of compensation with regard to the August 1, 1986 Determination Order is reversed. Claimant's attorney is allowed an attorney fee equal to to 25 percent of the additional compensation awarded by the Referee, not to exceed $2,800. The remainder of the Referee's order is affirmed."

No party requested review of the Board's order. The employer did not pay an attorney fee to claimant's attorney after the Board's order. Claimant then requested a hearing. Referee Tenenbaum again heard the case. She declined to order the employer to pay a fee.

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[1] The Referee and the Board probably erred in allowing the employer to credit payment made on one claim against another claim. Stephen M. Ginther, 42 Van Natta 526 (1990). Nonetheless, that is the law of the case, which we may not now disturb.

## CONCLUSIONS OF LAW AND OPINION

There is no question that claimant's attorney is entitled to an attorney fee. That entitlement was established by the Board's Order on Review. The issue is whether the employer must pay the fee or whether claimant's attorney must look to claimant to recover the fee. We conclude that the employer is obligated to pay the fee to claimant's attorney.

This case is governed by our recent holding in Anthony E.Cochrane, 42 Van Natta 1619 (1990). In Cochrane, we held that the claimant's attorney was entitled to an approved fee as awarded by an earlier Referee where that Referee had awarded "additional" temporary total disability (TTD) for a period in which claimant had already procedurally received such benefits pending the issuance of a Determination Order. In reaching our conclusion, we reasoned that the claimant was not substantively entitled to the TTD awarded by the earlier Referee beyond the date fixed by the Determination Order until the earlier Referee had granted such an award. Since, in refusing to pay an attorney fee, the employer had essentially offset the procedurally paid TTD against the approved attorney fee awarded by the earlier Referee, we held that the employer had effectively violated OAR 438-15-085(2). Consequently, we found that the claimant's attorney was entitled to an attorney fee payable from the substantive TTD granted by the earlier Referee's order.

Here, as a result of the earlier Referee and Board order, claimant was awarded permanent disability concerning the 1986 injury claim. Furthermore, claimant's attorney was granted a fee payable out of the additional compensation awarded under the Referee's order. As a procedural matter, claimant's permanent disability award was offset against the permanent disability awarded under the 1984 injury claim. Yet, as in Cochrane, notwithstanding this offset, claimant's attorney remains entitled to a fee payable from the additional compensation awarded under the earlier Referee's order. OAR 438-15-085(2).

Considering the earlier Referee's "offset" authorization and the procedural context in which this attorney fee issue arose, we do not find the employer's failure to pay an attorney fee under these particular circumstances to have been unreasonable. Accordingly, no penalty or attorney fee is assessable. ORS 656.262(10); 656.382(1).

## ORDER

The Referee's order dated May 22, 1989 is reversed in part and affirmed in part. As previously directed by the Board's January 5, 1989 order, the self-insured employer shall pay claimant's attorney an approved fee equal to 25 percent of the 15 percent (22.5 degrees) scheduled permanent disability award for the 1986 right knee injury claim as awarded by the September 8, 1987 Referee's order, not to exceed $2,800. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
**JAN K. WILLIAMSON, Claimant**
WCB Case No. 88-18040
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Gerner and Myers.

Claimant requests review of Referee Leahy's order which upheld the insurer's denial of her occupational disease claim for a psychological condition. In its brief, the insurer contends that the Referee erred in admitting certain evidence into the record. On review, the issues are admission of evidence and compensability. We affirm.

## FINDINGS OF FACT

In 1980, claimant began working for the employer as a respiratory therapist. In 1984, her performance appraisal indicated that she needed to improve the productivity of her work as well as her work attendance. In 1985, her performance appraisal was satisfactory, but again indicated a need for improvement in the area of work attendance and punctuality. In 1986, claimant received a written warning for absenteeism. In 1986, claimant's performance appraisal again indicated satisfactory work, but noted the need for improvement in the areas of organization, attendance and ability to work with fellow employees. Claimant refused to sign this evaluation.

In September 1987, there was a management change in claimant's department and William Bathurst became the director. Bathurst declined to do employee evaluations until he had time to evaluate the workers in the department. In December 1987, Cyndy O'Brien became the supervisor of claimant's shift. In early 1988, claimant was verbally counseled by O'Brien at various times for leaving her shift without notifying the supervisor as well as forgetting her pager.

In August 1988, Bathurst completed claimant's performance appraisal which indicated that her work performance was unsatisfactory. The appraisal indicated that claimant was deficient in the areas of attendance, productivity and peer relationships. Claimant refused to sign this evaluation and filed a grievance with the NLRB which was ultimately denied. Shortly thereafter, claimant was given a job assignment to perform a procedure on a patient. Claimant refused to perform the assignment on the basis that she felt it was not appropriate. The procedure was deemed appropriate by the treating physician. As a result of this incident claimant was given a "final" warning for gross misconduct and suspended for five days. Claimant again filed a grievance with the NLRB which was also denied.

In October 1988, claimant sought treatment from Dr. Beavers, psychiatrist, for complaints of nausea, chest pain and high blood pressure. Dr. Beavers released claimant from work and thereafter she filed a claim for this condition with the insurer alleging that it was caused by harassment on the job. In November 1988, the insurer denied the claim.

## FINDINGS OF ULTIMATE FACT

The employer's disciplinary and job evaluation actions were reasonable.

## CONCLUSIONS OF LAW AND OPINION

### Admission of Evidence

The insurer contends that the Referee erred in admitting documentary evidence which pertained to a fellow employee of claimant's. We disagree.

The evidence in question was either authored by or concerned claimant's fellow employee. In particular, the documents were in regard to the employer's disciplinary practices. The fellow employee was called as a witness by claimant and was cross-examined by the insurer's counsel. Under these circumstances, we conclude that the Referee was within his discretion in admitting the documentary evidence into the record. We have therefore considered exhibits 9A1-12, 9B1-3a, 10A, and 14 on review.

### Compensability

The Referee concluded that claimant had not established that her mental stress claim was compensable. We agree.

In order to establish that her psychological condition is compensable, claimant must prove, by clear and convincing evidence, that her work exposure was a material contributing cause of her condition. Former 656.802(1)(b); ORS 656.802(2)(d); Ellen L. Crawford, 41 Van Natta 1257 (1989). However, if claimant's condition results from reasonable disciplinary, corrective or job performance evaluation actions by the employer, it is not compensable. Former ORS 656.802(2)(b).

Claimant contends that her condition was caused by on-the-job harassment in the form of unreasonable performance evaluations and disciplinary measures which were undertaken after September 1987. We disagree.

Dr. Beavers, claimant's treating psychiatrist, reported that claimant's psychological condition was attributable to on-the-job stressors. In particular, he related her condition to disciplinary matters between claimant and management. There is no contrary medical evidence. Accordingly, we conclude that the disciplinary actions caused claimant to seek medical treatment. Therefore, the issue becomes whether the disciplinary actions taken by the employer were reasonable.

Prior to the change of management in September 1987, claimant's evaluations, although satisfactory, indicated that she needed to improve in the areas of work attendance, quantity of work, and ability to work with fellow employees. In 1986, claimant received a written warning concerning her work attendance.

In 1987, claimant was verbally counseled by O'Brien on numerous occasions concerning leaving her area without informing the supervisor and forgetting to carry her pager while on duty. These incidents, in conjunction with claimant's poor attendance, lack of productivity and negative peer relationships led to an unsatisfactory performance appraisal in August 1988. Also in August 1988, claimant received a written warning and suspension for gross misconduct when she refused to perform an assigned task.

We conclude that the employer's disciplinary and job evaluation actions were reasonable. Prior to the change of management in 1987, claimant's job evaluations, although satisfactory, consistently indicated that claimant needed improvement in the area of work attendance and peer relationship. Her evaluation in 1988 again indicated deficiencies in these areas. Further, she was verbally counseled on numerous occasions for leaving her work area without notifying her supervisor and failing to carry her pager. In light of these facts, we

do not find that an unsatisfactory job appraisal was unreasonable. Finally, we do not find that the written warning and suspension was unreasonable. Claimant refused a job assignment which was authorized by the attending physician.

Finally, there is no persuasive evidence that the employer "singled out" claimant for discipline. All of the above incidents were consistent with the employer's work policy and claimant was aware of the work policy. Accordingly, claimant's psychological condition is not compensable. Former ORS 656.802(2)(b).

ORDER

The Referee's order dated May 2, 1989, is affirmed.

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August 14, 1990 Cite as 42 Van Natta 1762 (1990)

In the Matter of the Compensation of
**TED G. DOLLARHIDE, Claimant**
WCB Case No. 88-20698
ORDER ON REVIEW
Bernt A. Hansen, Claimant Attorney
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Gerner and Myers.

The insurer requests review of that portion of Referee Higashi's order that granted claimant permanent total disability, whereas a Determination Order did not award additional permanent disability beyond his previous awards of 20 percent (38.4 degrees) scheduled permanent disability for a left arm injury and 55 percent (176 degrees) unscheduled permanent disability for a left shoulder injury. Claimant has also moved for a lump sum payment of his approved attorney fee as awarded by the Referee's order. On review, the issues are extent of permanent disability, including permanent total disability, and attorney fees.

The Board affirms and adopts the order of the Referee with the following comment concerning the request for a lump sum payment of attorney fees.

We have previously held that, as a matter of policy, requests for lump sum payments of attorney fees must be made while the Referee who granted the increased compensation award retained jurisdiction over the merits of the case. Linda K. Jones, 41 Van Natta 780 (1989). Here, the request for lump sum payment of claimant's attorney fee was not addressed by the Referee before the insurer had requested review of the Referee's order. Consequently, the request for lump sum payment is denied. See Linda K. Jones, supra.

ORDER

The Referee's order dated April 28, 1989 is affirmed. For services on review concerning the permanent disability issue, claimant's attorney is awarded an assessed fee of $950, to be paid by the insurer.

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In the Matter of the Compensation of
**KATHERINE A. BECKWITH, Claimant**
WCB Case No. 88-18318
ORDER ON REVIEW
Patrick K. Mackin, Claimant Attorney
Saif Legal Department, Defense Attorney

Reviewed by Board Members Crider and Brittingham.

The SAIF Corporation requests review of that portion of Referee Mulder's order that assessed penalties and related attorney fees for an alleged unreasonable denial. Claimant cross-requests review of that portion of the order which declined to assess penalties and attorney fees for an alleged late denial and for a discovery violation. 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" with the following supplementation.

Claimant compensably injured her right shoulder on July 22, 1988. An emergency room chart note and radiology report, dated July 23, 1988 and diagnosing calcific bursitis versus acromial exostosis, was received by SAIF on August 11, 1988. The emergency room chart note referenced a shoulder injury at work. SAIF also received a Form 827 on August 11, 1988, which described the July 22, 1988 shoulder injury. On August 19, 1988, SAIF accepted claimant's claim as a right shoulder strain.

On October 10, 1988, SAIF sent a letter to claimant, referencing the claim number of claimant's April 14, 1988 "toe/foot" claim, in which it denied her right shoulder bursitis as unrelated to her toe/foot injury.

## FINDINGS OF ULTIMATE FACT

SAIF issued its denial of claimant's bursitis condition within 60 days of receipt of the August 11, 1988, radiology report.

SAIF's processing of the bursitis condition under the toe injury claim, rather than the shoulder claim, was unreasonable. SAIF's improper processing was an unreasonable resistance to the payment of compensation.

SAIF's response to claimant's discovery request was not unreasonable.

There were no amounts due under the shoulder claim at the time of the discovery violation or at the time of hearing.

## CONCLUSIONS OF LAW AND OPINION

### Untimely Denial

Claimant argues that SAIF's denial of October 10, 1988 was untimely. We disagree. There is no evidence that SAIF had notice of claimant's bursitis condition prior to its receipt of the radiology report on August 11, 1988, and it issued the denial within 60 days of receipt of the radiology report. Therefore, we find that the denial of the bursitis claim was not late.

Unreasonable Denial

The Referee found the denial of the bursitis condition to be unreasonable. We agree under the following reasoning. Claimant filed a claim for a July 22, 1988 shoulder injury which was accepted by SAIF on August 19, 1988. At the time the emergency room and radiology report was sent to SAIF, there is no indication that SAIF had assigned a claim number to the shoulder claim. At the same time that SAIF received the emergency room chart note and x-ray report, on August 11, 1988, it also received an 827 form ("First Medical Report") describing the accident involving the shoulder and showing a date of injury of July 22, 1988, the date that appeared on the shoulder claim and not the date of injury (April 14, 1988) given on the toe injury claim. Given the fact that SAIF had this information which connected the bursitis to the shoulder injury, we find its processing of the bursitis condition under the toe claim, rather than the shoulder claim, to have been unreasonable.

Penalties and attorney fees may be assessed when a carrier "unreasonably delays or unreasonably refuses to pay compensation." ORS 656.262(10); 656.382(1). Although the Referee found that claimant was entitled to penalty and attorney fees for the unreasonable denial, we find that claimant is not entitled to a penalty because there were no amounts "then due". Thus, that portion of the Referee's order that assessed a penalty is reversed.

However, we affirm the Referee's assessment of an attorney fee. SAIF issued a denial under the toe claim, and failed to process the pertinent reports under the compensable shoulder injury claim, even though it had received medical evidence linking the bursitis to the shoulder injury. We consider such conduct to be "unreasonable resistance to the payment of compensation" under ORS 656.382. See Ellis v. McCall Insulation, 308 Or 74 (1989); Lloyd L. Cripe, 41 Van Natta 1774 (1989).

Discovery Violation

The Referee found that claimant was not entitled to penalties and attorney fees for failure to provide complete discovery. Even assuming that SAIF's conduct was unreasonable, claimant is not entitled to a penalty inasmuch as there were no amounts "then due". ORS 656.262(10); former OAR 438-07-015.

Furthermore, the hearing requests did not specify the claim numbers, although the denial date was indicated. Considering this confusion concerning the claim numbers, we do not find unreasonable SAIF's failure to provide all of the documents related to both claims. Accordingly, we do not assess an attorney fee. In reaching this conclusion, we wish to emphasize that the recitation of claim numbers is not a prerequisite to obtaining discovery from an opposing party under the Board rules. Rather, we are merely finding that, under these circumstances, SAIF's failure to provide entire discovery was not unreasonable.

Claimant has successfully defended the Referee's award of a penalty-related attorney fee for an unreasonable denial. However, inasmuch as attorney fees are not compensation for purposes of ORS 656.382(2), claimant is not entitled to an attorney fee for services on review. Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The Referee's order dated February 24, 1989 is affirmed in part and reversed in part. The Referee's assessment of a penalty for an unreasonable denial is reversed. The remainder of the order is affirmed.

In the Matter of the Compensation of
**PAMELA A. GORDON, Claimant**
WCB Case No. 89-00012
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Nichols and Crider.

The insurer requests review of that portion of Referee Schultz's that: (1) set aside its denial of claimant's aggravation claim; and (2) assessed a penalty and related attorney fee for untimely denial. On review, the issues are aggravation, penalties and attorney fees.

The Board affirms and adopts the order of the Referee with the following discussion.

We note that since issuance of the Referee's order, the court has reconsidered its opinion in Ybarra v. Castle & Cooke, Inc., 94 Or App 746 (1989). On reconsideration, the court held that the aggravation analysis articulated in Gwynn v. SAIF, 304 Or 345 (1987), does apply to cases in which a claimant has not returned to work prior to the filing of an aggravation claim. Ybarra v. Castle & Cooke, Inc., 96 Or App 665 (1989). Under both Gwynn and Smith v. SAIF, 302 Or 396 (1986), claimant established an aggravation when she established that due to a symptomatic exacerbation of her physical condition, she was less able to work than at the time of the last arrangement of compensation.

ORDER

The Referee's order dated April 20, 1989, as reconsidered May 11, 1989, is affirmed. For services on review concerning the aggravation issue, claimant's attorney is awarded an assessed fee of $1,000, to be paid by the insurer.

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In the Matter of the Compensation of
**LOUIS J. GREEN, Claimant**
WCB Case No. 90-00505
ORDER OF DISMISSAL
Rex Q. Smith, Claimant Attorney
Cooney, et al., Defense Attorneys

The self-insured employer has moved the Board for an order dismissing claimant's request for review on the ground that the request was untimely. The motion is granted.

FINDINGS OF FACT

The Referee's Opinion and Order issued May 23, 1990. The order indicated that copies of the order had been mailed to all parties and their attorneys on May 23, 1990.

On July 19, 1990, the Board received claimant's request for review of the Referee's order. On July 23, 1990, the Board mailed a computer-generated letter to the parties, acknowledging claimant's request for Board review.

Claimant's counsel did not receive a copy of the Referee's May 23, 1990 order until shortly after July 12, 1990. At that time, at the request of

claimant's counsel's secretary, the Referee's secretary mailed claimant's counsel a copy of the order.

ULTIMATE FINDINGS

Claimant's request for Board review was received by the Board more than 30 days after the Referee's order was mailed to the parties.

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). "Party" means a claimant for compensation, the employer of the injured worker at the time of injury and the insurer, if any, of such employer. ORS 656.005(19). Attorneys are not "parties." Berliner v. Weyerhaeuser Company, 92 Or App 264, 266-67 n.1 (1988); Frank F. Pucher, Jr., 41 Van Natta 794, 795 (1989); Robert Casperson, 38 Van Natta 420, 421 (1986).

Here, claimant's counsel asserts that he did not receive a copy of the Referee's order. Yet, an attorney's failure to receive a copy of an order does not invalidate an order. See Berliner v. Weyerhaeuser, supra; Pucher, supra. Moreover, the determinative factor is whether the order was mailed to the parties to the hearing, not whether it was received by them. See Berliner v. Weyerhaeuser, supra.

There is no contention rebutting the statement in the Referee's order that claimant and the other parties to the hearing had been mailed a copy of the Referee's order. Under such circumstances, we find that copies of the Referee's order were mailed to the parties on May 23, 1990.

Inasmuch as claimant's request for review was received by the Board on July 19, 1990, which is more than 30 days after the Referee's May 23, 1990 order, it is untimely. See ORS 656.289(3). Consequently, we lack jurisdiction to review the Referee's order.

Accordingly, the request for Board review is dismissed.

IT IS SO ORDERED.

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In the Matter of the Compensation of
**CECILIA H. HERRINGTON, Claimant**
WCB Case No. 89-02259
ORDER ON REVIEW
Peter O. Hansen, Claimant Attorney
Davis & Bostwick, Defense Attorneys

Reviewed by Board Members Nichols and Brittingham.

The insurer requests review of Referee Lipton's order which: (1) held that claimant's temporary total disability compensation rate was improperly calculated without the inclusion of overtime pay; and (2) assessed penalties and an associated attorney fee for the insurer's alleged unreasonable failure to include overtime pay in the temporary total disability calculation. In her brief,

claimant contends that: (1) her temporary total disability rate should be calculated based on her availability for work 70 hours per week; and (2) the calculation of her temporary total disability rate should include her Christmas bonus. On review, the issues are rate of temporary total disability compensation, penalties and attorney fees. We reverse.

## FINDINGS OF FACT

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

Claimant began working for the insured as an assembler in January 1988. She was scheduled to work from 7 a.m. to 3:30 p.m., Monday through Friday, and was paid an hourly wage.

Claimant worked overtime during peak production periods and emergencies, with only one hour to one day's advance notice.

In December 1988, claimant received a $105 Christmas bonus. Employees were not promised a Christmas bonus.

## FINDINGS OF ULTIMATE FACT

Claimant was scheduled to work 40 hours a week, and was regularly employed for 40 hours a week. Her remuneration was based solely on daily wages.

Claimant did not regularly work overtime.

Claimant's Christmas bonus pay was not incentive pay or a regular part of her wages.

## CONCLUSIONS OF LAW AND OPINION

### Calculation of Temporary Total Disability

The Referee found that claimant worked some overtime every month on a regular basis. Therefore, pursuant to former OAR 436-60-020(7)(i), he concluded that claimant's rate of temporary total disability [TTD] compensation should be calculated to include the average amount of overtime she worked. The insurer asserts that claimant was a regularly employed worker, so that the calculation of her rate of TTD should be computed as outlined in ORS 656.210, and thus should not include any overtime she worked. We agree that claimant's rate of TTD should be calculated under the statute.

ORS 656.210(1) provides that when a claimant's disability is temporary, she shall receive compensation equal to 66-2/3 percent of wages. Consequently, the TTD calculation begins with a determination of the weekly wage of the injured worker. Nelson v. SAIF, 302 Or App 463 (1986). Generally, the weekly wage of a "regularly employed worker" is the number of days a week the injured worker was regularly employed times the daily wage at the time of the injury. ORS 656.210(2)(a) and (b). "Regularly employed" means actual employment or availability for such employment. ORS 656.210(2)(c).

For workers not regularly employed, and for regularly employed workers with no remuneration or remuneration not based solely upon daily or weekly wages, the statute authorizes the Director of the Department of Insurance and Finance to promulgate rules establishing such workers' weekly wages to be used in determining the TTD rate. Id. The Director has done so in former OAR 436-60-020(7). Included in this rule are calculations for workers with regular

overtime (former OAR 436-60-020(7)(i)) and incentive pay (former OAR 436-60-020(7)(j)).

In this case, then, the initial question is whether claimant was a regularly employed worker as contemplated by the statute. The 801 Form indicates that claimant was scheduled to work from 7 a.m. to 3:30 p.m., at $5.32 an hour, Monday through Friday. Furthermore, at the hearing claimant confirmed that she did in fact work a full-time, regular 40 hour week. Unlike an "irregularly" employed worker, claimant did not report to work each day not knowing in what job, for what pay, or for how many hours she would be employed. See Robert T. Moon, 39 Van Natta 370, reconsidered on other grounds, 39 Van Natta 503 (1987). After reviewing the circumstances of claimant's employment, we find that claimant was "regularly employed" at the time of her injury within the meaning of ORS 656.210(2)(c). See Charles M. Poole, 40 Van Natta 41 (1988).

Even though claimant was regularly employed, the insurer incorrectly calculated claimant's TTD under ORS 656.210(2)(a) and (b) if her remuneration was not based solely upon daily or weekly wages. See ORS 656.210(2)(c).

It is undisputed that claimant's earnings were based on the number of hours she worked. Nevertheless, the fact that a claimant is an hourly worker does not necessarily mean that her time loss rate should not be calculated under ORS 656.210(2)(a) and (b). An hourly worker who works a regular work shift with a consistent length--as does claimant--is, in effect, paid by the day. Donald E. Lowry, 40 Van Natta 1957 (1988); Charles M. Poole, supra.

Further, we are not persuaded by claimant's argument that she worked regular overtime so that her TTD should be calculated under former OAR 436-60-020(7)(i). Claimant established only that she worked sixteen hours of overtime during a five-month period in 1988: 1 hour in June, four hours in July, seven hours in August, one hour in September, and three hours in October. In contrast to the conclusion of the Referee, we do not find any evidence that claimant worked overtime in "every" month that she worked for the insured. Furthermore, claimant and the insured's personnel representative established that overtime was on an as-needed basis depending on production peaks and emergencies, and employees could be asked to work overtime with only one hour to one day's notice. On these facts, we find that claimant's overtime was sporadic and unscheduled, and, therefore, not regular. See Craig E. Hobbs, 39 Van Natta 690 (1987).

Nor are we persuaded by claimant's argument that her $105 Christmas bonus should be included in calculating her TTD rate, as provided in former OAR 436-60-020(7)(j). That rule states that "[i]ncentive pay provided by contract of employment shall be considered only when regularly earned . . . ." [Emphasis supplied]. Claimant began working for the insured in January 1988. In December 1988, she received a $105 Christmas bonus. She received it only one time--not every pay period. Employees with the company for all three years of its existence were never promised a Christmas bonus. Claimant does not assert nor has she established proof that this bonus was contemplated by her contract of employment. Therefore, we find that this money was not a regular part of claimant's wages. See Paula M. Paterson, 42 Van Natta 1302 (1990).

Furthermore, claimant has presented no evidence as to the insured's motivation in giving her this bonus. The record does not establish that the insured paid this bonus to reward her production effort or as incentive to encourage any particular behavior at work. Therefore, on these facts, we do not find that the Christmas bonus was incentive pay under former OAR 436-60-020(7)(j). See Donna J. Russell, 40 Van Natta 568 (1988).

Finally, claimant asserts the alternative theory that her TTD rate should be calculated based on her availability for work 70 hours a week. Claimant correctly notes that ORS 656.210(2)(c) defines "regularly employed" as "actual employment or availability for such employment." [Emphasis supplied]. In support of her contention, claimant cites cases where the Board found that workers who are required to be available for "regular employment" are "regularly employed" under ORS 656.210(2). See Richard R. D'Ostroph, 41 Van Natta 1050 (1989); Joyce Yates, 37 Van Natta 256 (1985).

Claimant's circumstances are clearly distinguishable. In the cited cases, employees had to be available to work a regular week but actually were called to work less than their scheduled hours, and were paid for less than a full week. Claimant, on the other hand, was scheduled to work 40 hours a week, worked a full, regular 40-hour week, and was paid based on 40 hours work.

Moreover, claimant has not proven that the insured required that she be available 70 hours a week as she contends. Claimant bases her argument on a section in the Employee Handbook regarding outside employment. The Handbook states that full-time regular employees should not accept other jobs which might have an adverse effect on their primary employment with the insured. Claimant testified that she could not work a second job if she wanted, then later conceded that she only had to give her job with the insured first priority. She further testified that she believed that she had to accept overtime if requested to work.

The insured's personnel representative testified that employees are permitted to work second jobs, and many do. She further refuted claimant's testimony that she was "on call" to work overtime, or that an employee would be disciplined or fired if she refused to work overtime. On this record, claimant has not proven that she was required to be available to work 70 hours a week. Based on the above discussion, we conclude that claimant was "regularly employed" with remuneration based solely on a daily wage. Accordingly, the insurer properly calculated claimant's rate of TTD by using $5.32 an hour, times 8 hours a day, times 5 days a week, without regard to claimant's overtime and Christmas bonus. See ORS 656.210(2)(a)(C).

Penalties and Attorney Fees

Because we have found that the insurer's initial method of calculation was in fact correct, the assessment of penalties and associated attorney's fee will be reversed.

ORDER

The Referee's order dated May 24, 1989 is reversed. The Referee's $500 penalty-related attorney fee award is reversed.

In the Matter of the Compensation of
**DONNA M. HOOPER, Claimant**
WCB Case Nos. 87-13181, 87-02763 & 87-09367
ORDER ON REVIEW
Stunz, et al., Claimant Attorneys
Sullivan & Powell, Attorneys
Saif Legal Department, Defense Attorney
Davis & Bostwick, Defense Attorneys

Reviewed by Board Members Brittingham and Crider.

The alleged noncomplying employer requests review of those portions of Referee Wasley's order that: (1) affirmed a Proposed and Final Order of noncompliance; (2) found that claimant had sustained a compensable right groin injury; and (3) in the alternative, upheld the SAIF Corporation's acceptance of that injury as processing agent for the employer because the employer did not issue a timely denial. On review, the issues are compliance, timeliness of the employer's hearing request and compensability. We affirm.

## FINDINGS OF FACT

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

The oral insurance quote the employer received from Mr. Romriell, Farmers' agent, did not include workers' compensation insurance. Mr. Romriell did not discuss workers' compensation coverage with the employer at the time he presented the oral quote. The written policy obtained by the employer was a "Special Sentinel Policy," which did not provide workers' compensation coverage. The employer obtained the same policy for two other stores. Mr. Romriell mailed a copy of the policy to the employer's business address and to her bank and the policies were not returned as nondeliverable.

Mr. Romriell gave the employer a brochure which described the policy coverage. Two brochures describing the policy coverage were admitted at hearing. There was no indication from the brochures that workers' compensation was included in the coverage. These were the only brochures that Mr. Romriell had ever used. The employer took the brochure given to her by Mr. Romriell to the bank.

The employer did not post a notice of compliance in any of her stores, did not deduct any employee contribution from her payroll and did not pay any specifically identified workers' compensation premium.

The employer has prior experience as an employer, at which time she submitted payroll information for workers' compensation purposes.

Two or three days after claimant's injury, the employer told claimant that she did not have any workers' compensation insurance and that she would pay claimant's bills herself. The employer paid the first bill. The employer again stated in November 1986 that she did not have workers' compensation insurance.

On January 15, 1987, Farmers Insurance Company mailed a letter to the employer denying that the employer had workers' compensation coverage and stating that the employer could request a hearing within 60 days. The letter was in the form required for denials issued to claimants.

On February 17, 1987, the employer requested a hearing in order to challenge Farmers' denial of coverage. This request was acknowledged on March 20, 1987.

On April 8, 1987, the Compliance Division issued a Proposed and Final Order of noncompliance. On this date the Compliance Division referred the claim to the SAIF Corporation for processing. The employer received notice of the Proposed and Final Order on May 28, 1987. The following day, May 29, 1987, the employer requested a hearing in order to challenge the April 8, 1987 order.

On June 31, 1987, SAIF accepted claimant's hernia claim as disabling.

On July 6, 1987, an Order of Joinder issued, joining Farmers as a necessary party.

On August 20, 1987, the employer requested a hearing regarding the compensability of claimant's claim.

## FINDINGS OF ULTIMATE FACT

Claimant's work-related injury materially contributed to her right inguinal hernia condition.

Farmers did not make a false representation to the employer that her coverage included workers' compensation coverage.

The employer had knowledge that she was not covered by workers' compensation insurance.

The employer requested a hearing regarding the compensability of claimant's claim more than 60 days after the claim was referred to SAIF for processing.

## CONCLUSIONS OF LAW AND OPINION

### Compliance

The employer argued at hearing that Farmers should be equitably estopped from denying workers' compensation coverage because Farmers' agent represented that the proposed policy included workers' compensation insurance. The Referee concluded that the doctrine of estoppel is not available to an employer in a workers' compensation case. The employer argues on review that estoppel should apply in this case, and that she has established the elements of estoppel. We find that the employer has not proven the elements of common law estoppel. Accordingly, we need not address whether the doctrine applies generally in workers' compensation matters.

In order for the employer to establish an estoppel, there must be evidence from which the trier of fact could find: (1) that a false representation was made; (2) by someone having knowledge of the facts; (3) to one who was ignorant of the truth; (4) that the statement was made with the intention that it be acted upon by the plaintiff; and (5) that plaintiff acted on it. Donahoe v. Eugene Planing Mill, 252 Or 543 (1969).

The employer relies on her testimony that she believed her policy with Farmers included workers' compensation coverage, based on representations made by the Farmers' agent. The Referee concluded that claimant's testimony was credible in this regard. There is no indication that the Referee's conclusion

was based on his observation at hearing as opposed to the content of the testimony and the documentary evidence in the record. Here, based on the substance of the employer's testimony, we find her not credible. See International Paper Co. v. McElroy, 121 Or App 61 (1990); Coastal Farm Supply v. Hultberg, 84 Or App 282 (1987).

The policy obtained by the employer was a "Special Sentinel Policy," which did not provide workers' compensation insurance. The same policy was obtained by the employer for two other stores. The employer admitted taking a brochure to the bank which described her policy coverage. Two brochures describing the policy purchased by the employer were admitted at hearing. Farmers' agent testified that these were the only such brochures that he had ever used. Workers' compensation was not included in the coverage described in the brochures. The employer further testified that she did not post a notice of compliance in any of her three stores, did not deduct any employee contribution from payroll, and did not pay any separately identified workers' compensation premium. The employer has prior experience as an employer, at which time she submitted payroll information for workers' compensation purposes. These facts suggest that the employer knew that she did not have workers' compensation insurance.

We also base our credibility finding on claimant's testimony. Claimant told the investigator from the Compliance Section that she notified the employer that she had been injured two or three days after her injury, and at that time, the employer related that she did not have workers' compensation insurance and would pay claimant's medical bills herself. The employer did pay the first bill. Claimant testified that when she notified the employer in November 1986 that she was scheduled for surgery, the employer stated that she did not have workers' compensation insurance.

Finally, Farmers' agent credibly testified that the oral proposal which he gave to the employer gave no indication that workers' compensation coverage would be included in the policy, and workers' compensation was not discussed at that time. He stated that he mailed a copy of the policy to the employer's business address and to her bank and that the policies were not returned as nondeliverable.

In light of these facts, we find that the employer has not established that Farmers' agent falsely represented that the employer was covered by workers' compensation insurance; or that she did not know she had no such coverage. Therefore, the employer has not proven all the necessary elements of estoppel. Accordingly, the Referee's noncompliance ruling is affirmed.

Timeliness of Hearing Request/Compensability

The Referee found that the employer failed to properly deny claimant's claim so that it remains in accepted status. The Referee further concluded that the claim is compensable on the merits. For these reasons, he upheld SAIF's acceptance of the claim. We agree with the Referee that the medical record combined with claimant's testimony establishes the compensability of claimant's claim on the merits. We also agree with the Referee's ultimate procedural ruling that the claim remains in accepted status; however, we do so for different reasons than those stated by the Referee.

The Referee's holding that the claim remained in accepted status because the employer failed to issue a denial was based upon the court's opinion in Derryberry v. Dokey, 91 Or App 533 (1988). There, the court concluded that because SAIF properly accepted a claim as processing agent for a noncomplying employer, and no party had ever denied the claim, claimant was entitled to compensation.

However, in its subsequent decision in Clark v. Linn, 98 Or App 393 (1989), the court disavowed that portion of Derryberry which suggests that it is a noncomplying employer's responsibility to accept or deny a claim. The court held that a noncomplying employer may request a hearing on SAIF's acceptance of a claim if it contests compensability whether or not the employer denied the claim pursuant to ORS 656.262. Accordingly, the employer did not waive its right to a hearing on the compensability issue when it failed to issue a denial of the claim.

Nevertheless, we conclude the employer is not entitled to a hearing on the compensability issue for a different reason. Once SAIF has accepted a claim and more than 60 days have passed since the claim was referred to SAIF, the noncomplying employer may not challenge compensability of the claim without proving fraud, misrepresentation or other illegal activities capable of affecting acceptance. Kristi L. Chase, 42 Van Natta 1247 (1990).

Here, the Compliance Division referred the claim to SAIF for processing on April 8, 1987. The employer requested a hearing regarding the compensability of claimant's injury on August 20, 1987. As this request came after the expiration of the 60-day period, the claim remains compensable absent a showing of fraud, misrepresentation or other illegal activity. No such showing has been made on this record. Accordingly, the claim remains in accepted status.

Alternatively, we conclude that the claim is compensable on the merits. Claimant credibly testified that she experienced right groin pain immediately after her accident and informed the employer that she had injured herself. The pain steadily worsened in the months after the accident. Claimant was eventually referred to Dr. Cushman, surgeon, who performed surgical repair of the hernia on November 18, 1986. On July 20, 1987, Dr. Cushman opined that claimant's hernia was caused by her accident of August 1, 1985.

Claimant's testimony and Dr. Cushman's opinion that claimant's fall was the cause of her right inguinal hernia are unrefuted on the record. Therefore, we are persuaded that the fall was the cause of claimant's hernia condition.

ORDER

The Referee's order dated October 31, 1988 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,337, payable by the SAIF Corporation on behalf of the noncomplying employer.

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August 15, 1990 Cite as 42 Van Natta 1773 (1990)

In the Matter of the Compensation of
**THOMAS E. JOHNSTON, Claimant**
WCB Case Nos. 88-04637, 88-02719, 87-12248, 87-12247 & 87-11129
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Brian L. Pocock, Defense Attorney
Acker, et al., Defense Attorneys
E. Jay Perry, Defense Attorney
Saif Legal Department, Defense Attorney

Reviewed by Board Members Howell and Speer.

Liberty Northwest Insurance Corporation (Falcon Manufacturing) requests review of those portions of Referee Nichols' order that: (1) assessed penalties and attorney fees for an untimely denial; (2) awarded claimant interim

compensation; and (3) awarded an assessed fee to claimant's counsel. Liberty Northwest (Emerald Forest Products) cross-requests review of that portion of the Referee's order that: (1) set aside its denial of claimant's occupational disease claim for his bilateral shoulder condition; (2) upheld Liberty Northwest's (Bohemia) denial of the same condition; (3) upheld the SAIF Corporation's denial of the same condition; and (4) upheld Liberty Northwest's (Falcon) denial of the same condition. On review, the issues are penalties and attorney fees, interim compensation and responsibility. We reverse in part and affirm in part.

## FINDINGS OF FACT

The Board adopts the Referee's Findings of Fact.

## CONCLUSIONS OF LAW AND OPINION

The Board adopts the Referee's conclusions except with respect to the following issues.

### Interim compensation/Penalties and attorney fees for untimely denial

The Referee found that a Motion for Joinder, filed by SAIF on January 18, 1988, constituted notice of a claim. The Referee found that Falcon's denial, issued February 12, 1988, and Bohemia's denial, issued March 23, 1988, were untimely. She therefore assessed penalties and attorney fees for the untimely denials.

ORS 656.262(4) provides that interim compensation shall be paid no later than the fourteenth day after the employer has notice or knowledge of the claim. On review, Falcon argues that, although counsel for Bohemia indicated that the Motion for Joinder was received January 19, 1988, Falcon has not conceded if or when the Motion was received by Falcon.

We agree that claimant has not shown if or when Falcon received the Motion for Joinder. Therefore, we are unable to find that Falcon had notice of a claim sufficient to trigger a duty to pay interim compensation. Accordingly, we conclude that Falcon has not been shown responsible for payment of interim compensation or for a penalty and attorney fee for an untimely denial.

## ORDER

The Referee's order dated December 13, 1988 is affirmed in part and reversed in part. Those portions of the Referee's order which directed Liberty Northwest (Falcon) to pay interim compensation and assessed penalties and attorney fees against Liberty Northwest (Falcon) for an untimely denial, are reversed. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
**PAMELA A. PERRY, Claimant**
WCB Case No. 88-20836
ORDER ON RECONSIDERATION
Cynthia Cumfer, Claimant Attorney
Chelsea Mohnike (Saif), Defense Attorney

On its own motion, the Board has decided to reconsider its Order on Review in the above-captioned case, issued July 26, 1990.

In that order, we determined the extent of claimant's unscheduled permanent partial disability under the "standards" for evaluation of disability adopted effective July 1, 1988, (former OAR 436-35-001 et seq.), as amended by temporary rules effective August 19, 1988. In respect to the standards regarding age, education and adaptability, claimant argued that former OAR 436-35-290(2)(b), former OAR 436-35-300(2)(b) and former OAR 436-35-310(2)(b) are contrary to ORS 656.214(5) and, therefore, invalid.

In our initial order, we concluded our discussion on this issue with the following language: "We conclude, therefore, that the age, education and adaptability standards cited above are valid, and we apply them in this case. Accordingly, the appropriate value for claimant's age, education, and adaptability is 0." On reconsideration, we withdraw that language and substitute the following: "We conclude, therefore, that the age, education and adaptability standards cited above are not in conflict with ORS 656.214(5) for the reasons argued by claimant, and we apply them in this case. Accordingly, the appropriate value for claimant's age, education, and adaptability is 0."

Accordingly, our July 26, 1990 order is abated and withdrawn. As amended herein, we adhere to and republish our July 26, 1990 order in its entirety. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

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In the Matter of the Compensation of
**PAUL E. VOELLER, Claimant**
WCB Case No. 88-18620
ORDER ON REVIEW
Peter O. Hansen, Claimant Attorney
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Crider and Nichols.

The self-insured employer requests review of those portions of Referee Shebley's order that: (1) set aside a July 13, 1988 Determination Order as premature; and (2) in the alternative, set aside the employer's denial of claimant's aggravation claim for his mental condition. On review, the issues are premature closure, and, alternatively, aggravation. We affirm.

## FINDINGS OF FACT

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

Referee Neal's April 15, 1988 Opinion and Order, which set aside the self-insured employer's denial of claimant's occupational disease claim for depression or major affective disorder, was affirmed by the Board in Paul E. Voeller, 41 Van Natta 2349 (1989).

On April 21, 1986, Dr. Parvaresh, claimant's treating psychiatrist, indicated that claimant could resume limited duties as a physical education teacher, but was restricted from classroom teaching. That same day, claimant worked a half day, became agitated, and went home. Dr. Parvaresh readmitted claimant to the hospital on April 29, 1986 for continued treatment of his major affective disorder.

Following discharge from the hospital in May 1986, claimant's condition deteriorated further and he continued to have problems with concentration. Claimant was again admitted to the hospital in August 1986 for major affective disorder. During October 1986, Dr. Parvaresh continued to treat claimant for severe major affective disorder.

In February 1987, Dr. Altfas saw claimant in psychiatric consultation. He noted continuing symptoms of depression which had been present since February 1986. An MRI scan performed in March 1987 was normal, ruling out organic brain syndrome which had been suggested by an earlier CT scan. Dr. Altfas became claimant's treating psychiatrist in mid-1987. A new treatment plan was developed on July 13, 1988. On that same date, a Determination Order issued closing the claim. The employer did not request any information from claimant's treating psychiatric physician regarding his medically stationary status prior to submitting the claim for closure.

In the fall of 1988, claimant became increasingly depressed with suicidal thoughts. While claimant was hospitalized in September 1988 for depression, Dr. Gelzlaf retested claimant for organic brain syndrome, as prior testing was equivocal. Extensive neuropsychological examination ruled out an organic mental disorder and, instead, confirmed a depressive etiology for claimant's memory and concentration problems.

During 1988, claimant worked as a volunteer driver for the Red Cross and the State of Oregon Adult and Family Services Division, and in sheltered work through the Vocational Rehabilitation Division at St. Vincent de Paul's and Products Recovery. In February 1989, claimant, on his own, obtained a trial part-time job as a drivers' education instructor. As of the date of the hearing, claimant continued having problems with concentration and memory.

## FINDINGS OF ULTIMATE FACT

Claimant was not medically stationary when his claim was closed by the July 13, 1988 Determination Order.

## CONCLUSIONS OF LAW AND OPINION

### Premature Closure

The Referee found that claimant's claim was prematurely closed based entirely on lay testimony and the Referee's finding that claimant was not medically stationary at the time of hearing. While we agree with the Referee's conclusion, our decision is based on medical evidence.

Claims shall not be closed if the worker's compensable condition has not become medically stationary. ORS 656.268(1). In order to establish that the July 13, 1988 Determination Order prematurely closed his claim, claimant must

demonstrate that he was not medically stationary on the date of closure. Scheuning v. J. R. Simplot & Company, 84 Or App 622, 625, rev den 303 Or 590 (1987); Berliner v. Weyerhaeuser Corp., 54 Or App 624 (1981); Dale R. Bennett, 40 Van Natta 843 (1988). "Medically stationary" means that "no further medical improvement would reasonably be expected from medical treatment or the passage of time." ORS 656.005(17).

Here, the Determination Order found that claimant's condition was medically stationary on April 21, 1986, apparently relying upon Dr. Turco's April 1988 report. After reviewing claimant's medical record, Dr. Turco opined that claimant was medically stationary on April 21, 1986, based on his return to regular work on that date. On review, the employer asserts that the Referee improperly rejected Dr. Turco's medical opinion, the only medical evidence concerning claimant's medically stationary date. The employer seems to imply that claimant can prove that his condition was not medically stationary only by offering a physician's report which states that he was not medically stationary. We disagree.

It is well settled that 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). Therefore, lay testimony alone is not sufficient for this purpose. Nevertheless, as the court noted in Austin, supra, competent medical evidence is not limited to a physician's statement concerning the medically stationary date, but includes circumstantial as well as direct evidence. The circumstantial medical evidence in this case supports a finding that claimant's condition was not medically stationary at the time of closure.

The only evidence supporting claim closure is Dr. Turco's April 1988 report (later clarified and reaffirmed in June 1988) in which he concluded that claimant was medically stationary as of April 21, 1986. In a subsequent report in November 1988, Dr. Turco further concluded that claimant's continuing depression was due to underlying organic brain changes. We find that Dr. Turco's opinion is contrary to the medical evidence in this record and, therefore, is entitled to little weight. See Somers v. SAIF, 77 Or App 259 (1986).

Claimant was undergoing very significant psychiatric treatment by Dr. Parvaresh on April 21, 1986, the very time Dr. Turco said claimant was stationary. Further, claimant was rehospitalized on April 29, 1986, because he was unable to perform even restricted teaching duties. Dr. Turco's finding that claimant was ready to return to regular work on April 21, 1986 is not consistent with this history. Moreover, the ability to return to regular work does not, necessarily, establish that a claimant is medically stationary. Finally, extensive neuropsychological testing in September 1988 clarified that claimant's memory and concentration difficulties are a consequence of his compensable depression, and are not due to an organic brain disorder as Dr. Turco opined.

Under these circumstances, we accord greater weight to the records of claimant's hospitalizations and the chart notes of treating physicians Parvaresh and Altfas and mental health therapist Schradle. The opinions of Parvaresh, Altfas and Schradle are based on a complete and accurate history compiled during their treatment of claimant over the long course of his mental condition. See Weiland v. SAIF, 64 Or App 810, 814 (1983); Somers, supra.

After claimant's unsuccessful April 21, 1986 attempt to return to work, Dr. Parvaresh explained to claimant that he had gone back to school too soon, that he was not recovered from his depression, that he should stay off work until the end of the year, and that he required ongoing medication and treatment. In October 1986, Dr. Parvaresh reported that for ten months he had

treated claimant extensively, including hospitalization, anti-depressant medication and ongoing psychiatric visits at the office, all without significant improvement. Claimant continued to receive medication and psychiatric treatment for his work-induced depression from Dr. Parvaresh until mid-1987.

Dr. Altfas assumed claimant's psychiatric treatment in mid-1987. A new treatment plan was begun on July 13, 1988, the very day the Determination Order issued. Dr. Altfas opined in September 1988, when admitting claimant to the hospital for the fourth time, that for more than one year claimant had required continuing treatment with anti-depressant and anti-anxiety agents and hypnotics for his ongoing depression. This suggests that claimant's condition was ongoing and had not become stationary.

Consequently, the medical evidence confirms the lay testimony and establishes that claimant's psychiatric condition was not yet medically stationary as of the July 13, 1988 claim closure. Accordingly, we affirm the Referee's ruling that the claim was prematurely closed.

Aggravation

In light of our decision on the premature closure issue, we need not address the Referee's alternative aggravation ruling.

ORDER

The Referee's order dated March 3, 1989, as reconsidered March 23, 1989, is affirmed. For services on review regarding the premature closure issue, claimant's attorney is awarded an assessed fee of $1,250, payable by the self-insured employer.

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August 16, 1990 Cite as 42 Van Natta 1778 (1990)

In the Matter of the Compensation of
**DAVID M. MARVIN, Claimant**
WCB Case No. 89-15789
ORDER ON REVIEW
Larry Schucht (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

Claimant, pro se, requests review of Referee Knapp's order that dismissed his request for hearing which concerned the SAIF Corporation's denial of his current left shoulder complaints and other issues regarding the processing of his 1968 left shoulder and left clavicle injury claim, including aggravation rights, vocational rehabilitation and extent of disability. On review, the issues are the propriety of the dismissal, and alternatively, aggravation, medical services, temporary total disability, vocational assistance and compensability. We reverse in part and affirm in part.

FINDINGS OF FACT

The Board adopts the Referee's Findings of Fact.

## CONCLUSIONS OF LAW AND OPINION

### Dismissal

The Referee dismissed claimant's request for hearing on the grounds that his aggravation rights had expired prior to his 1989 aggravation claim and that claimant had waived the issues of compensability of a 1971 aggravation claim and entitlement to vocational rehabilitation services by entering into a disputed claim settlement. We do not agree that the request for hearing should have been dismissed in its entirety. Even if claimant's aggravation rights had expired, the processing of an aggravation claim may be limited to the payment of appropriate medical services. See Joyce E. Mitts, 42 Van Natta 333 (1990).

Here, SAIF's partial denial of claimant's then current condition had the effect of denying both his claim for aggravation and for the medical services he was receiving. Thus, the issue of compensability of medical services was properly before the Referee and the request for hearing with regard to that issue should not have been dismissed. See Weyerhaeuser Co. v. Bryant, 102 Or App 432 (1990).

### 1971 Aggravation Claim

The Referee concluded that the 1986 disputed claim settlement settled all issues raised or raisable at that time. The Referee found that claimant was represented by counsel who knew the background of his claim, and he therefore waived his 1971 aggravation claim by entering into the settlement. We disagree.

In March 1985, claimant requested reopening of his 1968 shoulder and clavicle claim. On August 26, 1985, SAIF denied that claimant's shoulder condition had worsened. SAIF also denied responsibility for claimant's current degenerative cervical spine disease and carpal tunnel syndrome. In September 1985, claimant requested a hearing on SAIF's denial.

In May 1986, claimant entered into a disputed claim settlement. In the document, the parties agreed to settle compensability of claimant's current condition and need for medical treatment. The parties also stipulated that the amount accepted by claimant was in full settlement of all issues raised or raisable.

We do not agree with the Referee's conclusion that claimant waived the issues of his 1971 aggravation claim or his claim for vocational rehabilitation services. For a waiver to have occurred, claimant must have intentionally relinquished a known right. See Drews v. EBI Companies, 310 Or 134 (1990). Waiver will not be presumed or implied contrary to the intention of the party whose rights would be injuriously affected. Waterway Terminals v. P.S. Lord, 242 Or 1, 26-27 (1965). To establish waiver, there must be a clear, unequivocal and decisive act of the party showing such a purpose. Waterway, supra.

In the present case, we are unable to find that claimant intentionally relinquished his 1971 aggravation claim. The 1971 claim was not mentioned in the disputed claim settlement and the terms of the document settled only the 1985 aggravation and medical services claims. The record does not provide evidence of a clear and unequivocal act by claimant demonstrating his intent to waive his 1971 aggravation claim.

Because we have found that claimant did not waive his 1971 aggravation claim by entering into the disputed claim settlement, we address the claim on the merits. To establish an aggravation, claimant must show a worsening of his

compensable condition since the last arrangement of compensation. Smith v. SAIF, 302 Or 396 (1986).

A May 7, 1969 Determination Order awarded claimant temporary total disability. In January 1971, Dr. Blauer, M.D., examined claimant and reported that he had moderate tenderness over the left clavicle and a full range of motion of the left arm at the shoulder. Dr. Blauer reported that claimant's muscle strength was good and he opined that claimant had experienced a worsening of his symptoms.

In an October 20, 1971 letter to SAIF, Dr. Holm, M.D., reported that claimant returned complaining of an aggravation of his left shoulder. Dr. Holm examined claimant and opined that there was no appreciable instability of the distal clavicle and no evidence of atrophy or changes in the hand. He also reported that claimant's circulation was good and that x-rays of the shoulder revealed no change other than the resection of the outer portion of the clavicle. Dr. Holm advised claimant that he could continue working without losing time from work.

We are not persuaded that claimant has shown that his underlying condition had worsened since the May 7, 1969 Determination Order. Even if claimant's condition had worsened, Dr. Holm reported that his symptoms were not incapacitating. See Smith, supra. (To demonstrate a worsening of a compensable condition, claimant must show that he is more disabled, i.e., less able to work.) We conclude that claimant has not established an aggravation of his left shoulder condition.

Temporary total disability/Vocational assistance

Claimant contends that he is entitled to additional temporary disability from December 30, 1968, to April 30, 1969. Claimant also argues that he was qualified for vocational assistance as a result of his 1968 injury.

We do not agree that claimant may now raise the issue of entitlement to additional temporary total disability. Claimant does not dispute the rate of temporary disability, rather, he contends that the time period over which he was paid was incorrect. The May 1969 Determination Order specified that claimant was entitled to temporary disability until December 30, 1968.

We conclude that claimant may not raise the issue of temporary disability at this time. The period for payment of temporary total disability prior to May 1969 was fixed by Determination Order which became final by operation of law when claimant failed to appeal within the statutory limitation. That determination is final and a hearing on claimant's objection may not be granted. ORS 656.319(4).

Neither the Referee nor the Board has jurisdiction to address claimant's claim for vocational assistance. ORS 656.283(2) provides that:

> "If a worker is dissatisfied with an action of the insurer or self-insured employer regarding vocational assistance, the worker must first apply to the director for administrative review of the matter before requesting a hearing on that matter."

Because claimant did not first apply to the Director for review of this issue, the Referee did not have jurisdiction to address the matter.

Compensability

On July 17, 1989, SAIF denied that claimant's current left shoulder condition or its symptoms were causally related to his 1968 compensable injury. Claimant bears the burden of proving by a preponderance of the evidence that his 1968 compensable injury materially contributes to his current need for medical treatment. Milburn v. Weyerhaeuser Co., 88 Or App 375, 378 (1978).

Although claimant testified that he had left shoulder symptoms that continued from after his compensable 1968 injury until the present, he sustained two intervening left shoulder injuries during that time. For that reason, although we find claimant's testimony to be probative, we conclude that the causal relationship of his current condition to his compensable injury is a complex medical question. The resolution of the issue of causation, therefore, 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).

In July 1978, claimant injured his left shoulder and arm while lifting a patient during his work as a nurse's aide for a subsequent employer. His claim was accepted. In March 1989, claimant was treated by Dr. Simpson, M.D., for a "recent" left shoulder injury which occurred during a lifting incident. Dr. Simpson reported that the principal source of claimant's current symptoms were due to the "recent injury of the shoulder."

On this record, we conclude that claimant has failed to prove that his compensable 1968 injury materially contributed to his current condition. SAIF properly denied claimant's 1989 claim for his current left shoulder condition.

ORDER

The Referee's order dated December 29, 1989 is reversed in part and affirmed in part. That portion of the Referee's order that dismissed claimant's request for hearing as to his 1971 aggravation claim and as to the compensability of his 1989 condition is reversed and claimant's request for hearing is reinstated. The SAIF Corporation's "de facto" denial of claimant's 1971 aggravation claim is upheld. SAIF's July 17, 1989 partial denial is upheld. The remainder of the Referee's order is affirmed.

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August 16, 1990 Cite as 42 Van Natta 1781 (1990)

In the Matter of the Compensation of
**LAVERNE K. McCORMICK, Claimant**
WCB Case No. 88-18335
ORDER ON REVIEW
Rasmussen & Henry, Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Speer and Howell.

The slef-insured employer requests review of Referee Young's order which set aside its denial of claimant's occupational disease claim for migraine headaches. The issue on review is compensability. We affirm.

FINDINGS OF FACT

At the time of hearing, claimant was 42 years of age. She had been off work since 1984 due to a compensable elbow injury. In March 1988 she re

turned to work as a communications operator with the insured. Very soon after beginning work, claimant experienced job stress which was attributed in part to her long absence from the work force. Claimant also had a history of occasional headaches before starting her new job and these were allegedly related to an unresolved stress associated with an earlier mitral valve implant. She began counselling with Dr. Acker in April 1988 to help cope with the new job and the mitral valve concerns.

Claimant began having "Tylenol" type headaches shortly after starting work as a communications operator. These headaches increased in frequency and intensity and were triggered by long hours of viewing the computer screen. (Exs. 1A-2, 2, 4A; Tr. 8-9, 23).

As a communications operator, claimant wears an ear piece and microphone. The telephone calls come in and claimant views them on a computer screen that sits directly in front of her. As the phone rings, the operator must switch from call to call and line to line by the use of a keyboard. All of this is displayed on the computer screen and claimant then distributes calls, takes messages, and relays messages using the keyboard and screen. (Tr. 5-7).

Claimant works an eight-hour day in two-hour shifts with ten minute breaks and a half hour lunch period. Only 50 minutes a day is not spent looking at the computer screen. (Tr. 7). Claimant is looking at the screen constantly because there is very little time when calls are not coming in. (Tr. 34).

Claimant consistently described the onset of her migraines as seeing a shimmer and heat waves in the peripheral fields of vision while viewing the screen. Eventually this progressed closer to her central field of vision and she would have to turn her head in order to clear her vision for reading the computer screen. The visual disturbances increased to the point that when claimant looked at the screen, she would get dry heaves and was sent home from work due to vomiting. (Exs. 2, 4A; Tr. 9-12).

While claimant was off work her headaches were finally brought under control by a combination of medications prescribed by Dr. Tearse. (Tr. 13-14). Claimant has even been able to return to work full time. If she catches the shimmering in time and takes an Inderal 80, she can completely prevent the headaches. (Tr. 14-15).

Claimant was examined and treated by Dr. Helfing at least three times during September 1988. Dr. Helfing reported a definite visual component to the onset of claimant's migraine headaches. After about two hours in front of a computer screen claimant would experience a change in visual fields, see a crescent shaped white image in the periphery and be unable to tolerate movement in the peripheral fields. These visual disturbances were followed by nausea, vomiting, photophobia (abnormal intolerance to light) and intense pounding headaches. (Ex. 1A-1, 2 and 3). Claimant was found to have migraine headaches almost daily when in front of a computer terminal.
(Ex. 6).

The treating neurologist, Dr. Tearse, similarly noted that claimant's headaches increased when in front of a computer terminal. He described the visual component of claimant's migraines to include horizontal heat waves shimmering in her field of vision, visual scintillations in both eyes, and photophobia. (Exs. 3-1, 4A, 4B-2). Although the stressful pace of claimant's job duties (Ex. 4B-3) did not cause the migraines, the stress did exacerbate them. (Ex. 5).

ULTIMATE FINDINGS OF FACT

Claimant's job as a communications operator requires continuous viewing of a computer screen and repetitive use of the eyes. This repetitive overuse of the eyes is a series of traumatic events or occurrences which is evidenced by visual field disturbances and increased symptoms of an underlying migraine condition.

Claimant's work activities as a communications operator are a material contributing cause of an increase in the symptoms of a preexisting migraine condition.

Claimant's migraine headaches were of such severity and frequency that they required medical services and caused her to miss work for periods in excess of two weeks.

CONCLUSIONS OF LAW AND OPINION

The Referee determined that stress at work increased the frequency and severity of claimant's migraine headaches resulting in disability and the need for medical services. We agree that claimant has established a compensable occupational disease, for the following reasons.

For an occupational disease claim, the date of "injury" is the date upon which the claimant was last exposed to the employment conditions which caused the disease. Johnson v. SAIF, 78 Or App 143, rev den 301 Or 240 (1986). Here, claimant's last work exposure occurred in August 1988. Accordingly, the occupational disease law which became effective January 1, 1988, is applicable.

In order to qualify as a compensable occupational disease, the claim must be for a condition which meets one of the three definitions set forth in former ORS 656.802(1). The Referee concluded that claimant's case is not covered under former ORS 656.802(1)(c), but rather, is compensable under subsection (1)(a) of the statute. We disagree. A claim is properly analyzed under subsection (1)(a) when it involves "ingestion of, absorption of, inhalation of or contact with dust, fumes, vapors, gases, radiation or other conditions or substances." There is no indication in the record that claimant was exposed to such conditions.

By contrast, we recently relied on legislative intent regarding the fact that a "series of traumatic events," as that phrase is used in former ORS 656.802(1)(c), was intended to include "overuse of a body part." Ronald V. Dickson, 42 Van Natta 1102 (1990). Disabling headaches caused by a series of physical traumatic events, as opposed to mentally induced stress-related headaches, are compensable as an occupational disease under former ORS 656.802(1)(c). Dickson, supra, at 1106.

To establish that claimant's migraine headaches are compensable as an occupational disease under former ORS 656.802(1)(c), she would have to prove by a preponderance of the evidence that she had endured a series of physical traumatic events or occurrences arising out of and in the course of employment which required medical services or resulted in physical disability or death. Dickson, supra, at 1107. In this regard, claimant must prove that her work exposure was a material cause of either increased symptoms or a worsening of her underlying condition. Donna E. Aschbacher, 41 Van Natta 1242 (1989). Claimant has met her burden.

Here, claimant worked for the employer as a full time communications operator which involved repetitive and physically demanding use of her eyes.

Claimant's sole job duties involve constant and prolonged viewing of a communications computer terminal as she answers the telephone, distributes calls, takes and relays messages -- all involving the use of a computer keyboard and terminal. The only periods throughout the day not spent viewing the terminal are the approximate 50 minutes of scheduled breaks. After about two hours of this repetitive eye use, claimant begins experiencing progressively worsening alterations of her visual fields which result in vomiting, photophobia, and disabling migraine headaches. Although the migraines are now under control with medication, claimant continues to have symptoms effecting her vision after prolonged viewing of the computer screen. When this occurs, she must immediately take medication to prevent the severe headaches.

Based on demeanor, the Referee found claimant entirely credible. We defer to this finding. Coastal Farm and Supply v. Hultberg, 84 Or App 282 (1987).

The causation of claimant's visual field disturbances and resulting migraines is a complex medical question. Thus, while her testimony is probative, the resolution of this matter turns on the medical evidence. Kassahn v. Publishers Paper Co., 76 Or App 259, 263 (1986). Claimant's testimony is fully supported by the medical evidence.

Treating physician, Dr. Helfing, opined that the prolonged viewing of the computer terminal exacerbated claimant's headaches. (Ex. 6). Although unable to say with certainty that the computer screen played a significant role in claimant's headaches, the treating neurologist, Dr. Tearse, reported that "[p]rolonged use of the computer terminal can exacerbate ... migraine." (Ex. 5). Dr. Tearse also opined that the stressful pace of claimant's job duties exacerbated her migraines and ruled out completely a number of other possible causes for claimant's migraines. (Ex. 5). There were no contradictory medical findings and, in fact, the insurer acknowledges the link between claimant's viewing of the computer terminal, the resulting changes in her visual fields, and the exacerbation of migraine headaches. (Appellant Brief, 11; Closing Argument, 5).

We are persuaded that prolonged exposure to a computer screen, as described in claimant's credible testimony, and as supported by medical opinion, was a repetitive traumatic event which overused claimant's eyes. See Terry L. Babcock, 42 Van Natta 1318 (1990); Dickson, supra,. In addition, claimant has proven that this repetitive trauma materially increased the symptoms of a preexisting migraine condition. Aschbacher, supra. Accordingly, claimant's migraine headaches are a compensable occupational disease under former ORS 656.802(1)(c).

## ORDER

The Referee's order, dated February 13, 1989, is affirmed. For services on review, claimant's attorney is awarded an assessed attorney fee of $500, to be paid by the employer.

In the Matter of the Compensation of
**MARVIN L. MCGUIRE, Claimant**
WCB Case No. 88-22125
ORDER ON REVIEW
Patrick Lavis, Claimant Attorney
Stafford J. Hazelett, Defense Attorney

Reviewed by Board Members Gerner and Cushing.

Claimant requests review of Referee Knapp's order which upheld the insurer's denial of his claim for a lumbar and cervical back condition. In his brief, claimant also contends that the Referee erred in admitting a videotape into evidence. On review, the issues are admission of evidence and compensability. We affirm.

## FINDINGS OF FACT

We adopt the "Findings of Fact" as set forth in the Referee's order.

## CONCLUSIONS OF LAW AND OPINION

### Admission of Evidence

Claimant contends that the Referee erred in admitting Exhibit 60, a videotape of claimant's job activities, on the basis that it was not disclosed prior to the hearing. We disagree.

Former OAR 438-07-017 provides that evidence offered solely for impeachment purposes need not be disclosed in advance of the hearing. In the instant case, the insurer offered the videotape solely for impeaching claimant's testimony regarding the operation of a yarder. The Referee allowed the videotape into the record solely as impeachment evidence and not as substantive evidence. Inasmuch as Exhibit 60 was solely impeachment evidence, the Referee correctly admitted it for that purpose and we have so considered it on review.

Claimant also requests that we remand this matter for consideration of affidavits concerning the videotape that are not otherwise in the record. Claimant, however, has not established that these affidavits concerning his job activities were unobtainable with due diligence prior to the hearing. Accordingly, claimant's motion to remand is denied. See Kienow's Food Stores v. Lyster, 79 Or App 416 (1986); Delfina P. Lopez, 37 Van Natta 164, 170 (1985).

### Compensability

We adopt the "Conclusions of Law and Opinion" as set forth in the Referee's order.

## ORDER

The Referee's order dated April 6, 1989, is affirmed.

In the Matter of the Compensation of
**WILLIS MEREDITH, Claimant**
WCB Case No. 87-12786
ORDER ON REVIEW
Coons & Cole, Claimant Attorneys
Kevin L. Mannix, Defense Attorney

Reviewed by Board Members Brittingham and Nichols.

Claimant requests review of those portions of Referee Miller's order that: (1) declined to grant permanent total disability; and (2) increased claimant's unscheduled permanent partial disability award for an inguinal hernia injury from 25 percent (80 degrees), as awarded by Determination Order, to 40 percent (128 degrees). The self-insured employer cross-requests review of: (1) the Referee's permanent disability award; and (2) the Referee's affirmation of the Evaluation Division's finding that October 29, 1987 was claimant's medically stationary date. On review, the issues are extent of permanent disability, including permanent total disability, and the date on which claimant became medically stationary. We affirm in part and reverse in part.

## FINDINGS OF FACT

We adopt the Referee's "Findings."

## FINDINGS OF ULTIMATE FACT

Claimant was released to modified work in August 1987.

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

Claimant has sustained a permanent 40 percent loss of earning capacity due to his compensable bilateral inguinal hernia.

Claimant became medically stationary on July 23, 1987.

## CONCLUSIONS OF LAW AND OPINION

### Permanent Total Disability

The Referee did not address this issue in her opinion. Claimant worked on the dryer feeder from August 4, 1987, until the time of hearing. He had increased his work hours from two each day in August 1987 to four each day in October. Claimant retired four days after hearing, but before the record closed. Claimant contends that he retired because he cannot work. However, claimant testified that he just didn't want to deal with the pain. (Tr. 23, 30). He also said he couldn't do the job well. (Tr. 23, 32). Furthermore, the foreman testified that claimant performed his job acceptably, although he was slow. On this record, we conclude that claimant has not shown that he is permanently incapacitated from regularly performing work at a gainful and suitable occupation. Accordingly, we find that claimant is not permanently totally disabled as a result of his compensable injury.

### Extent of Unscheduled Permanent Disability

We affirm and adopt the Referee's opinion and order on this issue.

Medically Stationary Date

The employer maintains that claimant was medically stationary on July 23, 1987, earlier than the October 29, 1987 date of the Determination Order. The employer has the burden to establish that a date earlier than the one used by Evaluation is the correct medically stationary date. Harris v. SAIF, 292 Or 683 (1982); Kurt C. Miller, 41 Van Natta 1899 (1989).

The Referee concluded that claimant was medically stationary on October 29, 1987 because he slowly increased his work hours according to a work program between July and October and not after that. However, Dr. Soder provided for claimant's gradual return to work because he had been away from work for a lengthy period. (Ex. 28). The Referee also based her conclusion on other material that indicated that Soder "expected claimant to get better." We disagree. Instead, the evidence indicates that Soder continually recommended that claimant retire. (Ex. 29, 31).

Furthermore, although Soder's October 29, 1987 "check the box" opinion that claimant "is medically stationary" is ambiguous standing alone, the July 23, 1987 medically stationary date is supported by additional evidence. Dr. Bascom found claimant to be medically stationary on July 23, 1987. On July 30, 1987, Soder agreed with Bascom that claimant was medically stationary. (Ex. 12). On October 29, 1987, and again on November 6, 1987, Soder concurred with Bascom's findings and narrative report. In February 1988, Soder's concurrence was clarified when he was expressly asked whether he concurred with the July 23, 1987 medically stationary date, which he did. (Ex. 38). Based on this record, the employer has established that a date earlier than the one used by Evaluation is the correct medically stationary date. Accordingly, we find that July 23, 1987 is the date when claimant became medically stationary.

ORDER

The Referee's order dated June 21, 1988 is affirmed in part and reversed in part. That portion of the order that affirmed the Determination Order medically stationary date of October 29, 1987 is reversed. Claimant is entitled to temporary disability through a medically stationary date of July 23, 1987, rather than the October 29, 1987 date found by the Determination Order. The employer is authorized to recover the overpaid temporary disability created by this order against claimant's future permanent disability awards in this claim, if any. For services on review regarding claimant's award of unscheduled permanent partial disability, we award claimant's attorney a $200 assessed fee, payable by the employer. The remainder of the Referee's order is affirmed.

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August 17, 1990 Cite as 42 Van Natta 1787 (1990)

In the Matter of the Compensation of
**RICHARD A. GONSALVES, Claimant**
WCB Case No. 87-12745
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
Saif Legal Department, Defense Attorney

Reviewed by Board Members Speer and Howell.

Claimant requests review of Referee Harri's order that increased his unscheduled permanent disability award for his low back injury from 28 percent (89.6 degrees), as awarded by Determination Order, to 39 percent (124.8 degrees). On review, the issue is extent of unscheduled permanent disability. We affirm.

## FINDINGS OF FACT

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

As a result of his compensable injury, claimant consistently experiences pain when he bends forward. His ability to repeatedly bend forward has been limited. As a result of his injury, claimant has loss of range of motion in his spine. Claimant's thoracolumbar extension is limited to 6 degrees. Right thoracolumbar flexion is limited to 24 degrees. Thoracolumbar rotation to the left has been reduced to 15 degrees. Thoracolumbar rotation to the right has been reduced to 20 degrees.

## CONCLUSIONS OF LAW AND OPINION

The Board adopts the Referee's "Conclusions and Opinion" with the exception of the section pertaining to impairment.

### Impairment

Claimant continuously has pain when he bends forward. For his chronic lumbosacral strain which limits repetitive use of his back, claimant is entitled to an impairment value of 5 percent. OAR 436-35-320(4). For reduced thoracolumbar extension (from 30 degrees to 6 degrees), claimant is entitled to an impairment value of 2.4 percent. OAR 436-35-360(7). For reduced right thoracolumbar flexion (from 30 degrees to 24 degrees), claimant is entitled to an impairment value of 1.2. OAR 436-35-360(8). For reduced thoracolumbar rotation to the left (from 30 degrees to 15 degrees), claimant is entitled to an impairment value of 3. OAR 436-35-360(9). For reduced thoracolumbar rotation to the right (from 30 degrees to 20 degrees), claimant is entitled to a value of 2. OAR 436-35-360(9). The values for lost range of motion in claimant's spine are added to obtain a single value. OAR 436-35-360(10). In this case, the sum of the impairment values for lost spinal motion is 8.6. That value is combined with (not added to) the value for limited repetitive use. The result is 13.2.

Having determined the impairment value necessary to compute claimant's permanent disability under the standards and utilizing the remaining values as determined by the Referee, we proceed to that calculation. When claimant's age value (1) is added to his education value (2), the sum is 3. When that value is multiplied by claimant's adaptability value (3) the product is 9. When that value is added to claimant's impairment value (13.2), the result is 22.2 percent unscheduled permanent partial disability. That disability figure is rounded to the next higher percentage. OAR 436-35-280(7). Claimant's permanent disability under the standards is, therefore, 23 percent.

### Clear and convincing evidence

Claimant contends that there is clear and convincing evidence that he is entitled to an award greater than that provided under the standards. He argues that his vocational expert has reported that claimant has lost approximately 50 percent of the labor market available to him before his injury. Claimant also argues that he is no longer able to do any of the heavy work associated with his trade as a truck driver. Claimant testified that, due to his injury, he is unable to perform household and gardening tasks and can now only bend over with difficulty to tie his shoes. Claimant also testified that his stamina and endurance have decreased and he cannot walk as far as he could before his injury.

We are not persuaded by the testimony of claimant's vocational expert that claimant's earning capacity has been reduced by 50 percent because he has lost 50 percent of the labor market previously available to him. See Goldie M. Ames 42 Van Natta 1657 (1990) (Earning capacity is based upon not only the number of types of jobs a worker can perform, but also upon factors such as wages, hours and days worked and availability and number of jobs in a worker's hypothetically normal labor market).

We conclude, however, that claimant is entitled to a greater award than the 23 percent permanent disability provided by the standards. The Western Medical Consultants and claimant's treating doctor rated claimant's lumbosacral impairment in the "moderately severe" range overall and in the "mildly moderate" range as it relates to his 1986 injury. Claimant credibly testified that, due to his injury, his overall endurance and his capacity to walk are both limited. He is unable to perform simple household tasks without difficulty and he cannot sit for prolonged periods of time. We conclude that 35 percent unscheduled permanent disability has been established by clear and convincing evidence to represent claimant's loss of earning capacity due to the compensable injury.

Although we have found that claimant is entitled to a total award of 35 percent unscheduled permanent disability, SAIF has not requested a reduction of the Referee's award. We therefore affirm the Referee's award of 39 percent unscheduled permanent disability for claimant's low back injury. We note that the Referee's order contains a clerical error listing 39 percent unscheduled permanent disability as equal to 125 degrees, rather than 124.8 degrees.

ORDER

The Referee's order dated April 5, 1989 is affirmed.

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August 17, 1990 Cite as 42 Van Natta 1789 (1990)

In the Matter of the Compensation of
**JEFFREY L. JONES, Claimant**
WCB Case No. TP-90034
THIRD PARTY DISTRIBUTION ORDER
Dennis W. Skarstad, Claimant Attorney
Michael O. Whitty (Saif), Defense Attorney

Claimant has petitioned the Board to resolve a dispute concerning the just and proper distribution of proceeds from a third party settlement. See ORS 656.593(3). Specifically, claimant contends that: (1) the SAIF Corporation, as processing agent for a noncomplying employer claim through the Department of Insurance & Finance, is not entitled to a share of the settlement proceeds; or (2) SAIF's recovery of a share of the settlement proceeds would not be "just and proper." We conclude that the settlement proceeds are subject to SAIF's lien as a paying agency and that its share of the proceeds under the statutory distribution scheme is "just and proper."

FINDINGS OF FACT

In December 1987, while performing his employment activities, claimant suffered injuries in a motor vehicle accident with another vehicle operated by a third party. In February 1988, following an investigation by the Director, it was determined that claimant's employer lacked workers' compensation coverage. Consequently, claimant's low back and neck injury claim was forwarded to SAIF for processing.

In April 1988 SAIF denied the claim, contending that a prior employer under an accepted 1985 claim was responsible for claimant's current disability and need for medical treatment. When the prior carrier also denied responsibility, claimant requested a hearing concerning the denials.

In April 1989, prior to the hearing concerning the denials, SAIF rescinded its denial and accepted the claim. In consideration of SAIF's acceptance, the prior carrier paid SAIF $9,000. Thereafter, SAIF began processing the claim.

To date, SAIF has incurred claim costs totalling $5,659.50. These costs are comprised of $2,253 in medical expenses and $3,406.50 in temporary disability benefits.

With the assistance of legal counsel, claimant attempted to recover damages from the third party. Eventually, claimant and the third party agreed to settle the matter for $3,500.

SAIF has approved the settlement. If entitled to a share of the proceeds as it asserts, SAIF's share as a paying agency would equal $1,427.29. Contending that all of SAIF's claim costs will eventually be reimbursed by the Department of Insurance and Finance, claimant asserts that any recovery from the settlement proceeds by SAIF would amount to "a double recovery at [his] expense." Consequently, claimant argues that SAIF is not entitled to a portion of the proceeds.

CONCLUSIONS OF LAW

If a worker of a noncomplying employer receives a compensable injury in the course of employment, or if a worker receives a compensable injury due to the negligence or wrong of a third person not in the same employ, the worker shall elect whether to recover damages from such employer or third person. ORS 656.578. The proceeds of any damages recovered from a third person by the worker shall be subject to a lien of the paying agency for its share of the proceeds. ORS 656.593(1).

"Paying agency" means the self-insured employer or insurer paying benefits to the worker or beneficiaries. ORS 656.576. "Insurer" means SAIF or an insurer authorized under ORS Chapter 731 to transact workers' compensation insurance in this state. ORS 656.005(14).

A claim for compensation made by a worker of a noncomplying employer shall be processed by SAIF in the same manner as a claim made by a worker employed by a carrier-insured employer. ORS 656.054(1). Where a claimant suffers a compensable injury while working for a noncomplying employer and SAIF provides benefits to the injured worker as a result of that injury, SAIF is considered to be a paying agency and is entitled to a share of the proceeds from a third party recovery. Jeffrey J. Henry, 40 Van Natta 1652 (1988).

Here, claimant argues that Henry was "improperly decided" in that the third party statute does not allow for a recovery to the Department when the amounts paid are on a noncomplying employer claim. In support of this contention, claimant notes that 1985 amendments to ORS 656.593 extended the definition of "paying agency" to include the Department with respect to costs paid out to other paying agencies for vocational assistance. See ORS 656.593(4); Raymond D. Taylor, 37 Van Natta 1082 (1985).

We disagree with claimant's assertion. The statute in question was expressly amended to permit the Department to recover vocational assistance expenses previously extended to a paying agency. Such a provision was necessary

to insure reimbursement to the Department for its vocational assistance costs. In this respect, the statute was specifically supplemented to include the Department within the definition of "paying agency," but solely for the purposes of recovering reimbursement for vocational assistance expenses. In other words, except for the express purpose discussed above, the Department is not considered to be a paying agency.

The inclusion of the Department within the statutory definition of "paying agency" for purposes of vocational assistance expense reimbursement does not lead to the conclusion that SAIF, as processing agent for the noncomplying employer claim, is excluded from "paying agency" status. In fact, we find no suggestion in the remaining provisions of ORS 656.593 or the entire third party statutory scheme which would support claimant's contention that SAIF, as processing agent for a noncomplying employer, is prohibited from sharing in the proceeds of claimant's third party settlement. See Robertson v. Davcol, Inc., 99 Or App 542 (1989) (Where SAIF, as processing agent for a noncomplying employer, was considered to be paying agency, although not entitled to a share of the settlement proceeds because the settlement clearly allocated no portion of its proceeds to claimant's third party claim).

Claimant further argues that SAIF is not acting as an insurer in that it will eventually be fully reimbursed from the Department. Again, we disagree.

SAIF's reimbursement from the Department for its claim costs does not alter the fact that SAIF has accepted claimant's injury claim and provided compensation in the same manner as any employer/insurer. Under these circumstances, we conclude that SAIF is a paying agency and, as such, entitled to its statutory share of any third party recovery. See ORS 656.005(14); 656.054(1); 656.576; Robertson v. Davcol, Inc., supra; Jeffrey J. Henry, supra. Moreover, we note that SAIF must offset any amounts received from a third party recovery against its expenditure reimbursement from the Department. See OAR 436-80-070(1), (3), & (4). Thus, any potential for a "double recovery" will have been eliminated.

Finally, claimant contends that SAIF's recovery of a share of the settlement proceeds in accordance with the statutory distribution scheme would not be "just and proper" in light of its previous recovery from the prior carrier. We do not agree.

To begin, 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).

We find no persuasive reason to depart from the aforementioned approach. The statutory scheme does not provide for an exemption from the recovery process which would prohibit a paying agency, who has previously received moneys from other sources, from receiving a portion of a third party recovery. Instead, the statute expressly limits the paying agency's recovery to the extent that its lien for actual and reasonably anticipated future claim costs can be satisfied. ORS 656.593(1)(d); 656.593(3).

Here, claimant does not contest the fact that SAIF has actually incurred claim costs totalling $5,659.50, which roughly quadruples its asserted $1,427.29 share of the settlement proceeds. Since these costs have been actually realized, we do not consider it a "just and proper" distribution of the third party settlement to preclude SAIF from receiving its statutory recovery.

Moreover, rather than constituting a potential "double recovery", it is equally plausible that SAIF's receipt of the payment from the prior carrier represents reimbursement for projected claim costs for future aggravations and medical services. Such costs are either not lienable (no reimbursement for anticipated aggravations - ORS 656.593(1)(c)) or not recoverable in this instance (because SAIF's actual claim costs exceed its potential share of the proceeds). Therefore, SAIF's receipt of such a payment from the prior carrier does not foreclose it from recovering partial reimbursement of its actual claim expenditures from the third party settlement to the extent to which it is statutorily entitled.

Accordingly, claimant's attorney is directed to distribute $1,427.29 from the remaining balance of the third party settlement proceeds to the SAIF Corporation, which we conclude represents a "just and proper" distribution. See ORS 656.593(3).

IT IS SO ORDERED.

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August 17, 1990 Cite as 42 Van Natta 1792 (1990)

In the Matter of the Compensation of
**DEREK OLIVER, Claimant**
Own Motion No. 89-0464M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
EBI Companies, Insurance Carrier

Claimant requests review of the insurer's January 12, 1990, Notice of Closure which declared him medically stationary as of December 22, 1989. The insurer terminated the payment of temporary disability benefits as of January 5, 1990. Claimant contends that his claim is not subject to the Board's own motion jurisdiction under ORS 656.278. Alternatively, he contends that claim closure is premature because he is not medically stationary.

The Board's own motion jurisdiction under ORS 656.278 extends to claims on which the aggravation rights have expired. Miltenberger v. Howard's Plumbing, 93 Or App 475 (1988). The duration of aggravation rights on a claim is defined under ORS 656.273(4). Effective July 1, 1990, Senate Bill 1197 amended ORS 656.273(4)(b) to provide that, if a compensable injury has been in a nondisabling status for one year or more after the date of injury, an aggravation claim must be filed within five years after the date of injury. That amendment applies to "all claims existing or arising on and after July 1, 1990, regardless of date of injury." See SB 1197, 54(1). Here, inasmuch as claimant's claim was in existence on July 1, 1990, his claim is subject to the new amendment. Claimant's compensable 1981 injury was classified as nondisabling until 1984; therefore, he had five years from the date of injury in which to file an aggravation claim. Claimant contends that he filed his most recent claim for a worsening in 1989. Because he filed his claim after his aggravation rights expired on October 16, 1986, the claim is properly subject to the Board's own motion jurisdiction under ORS 656.278. Miltenberger v. Howard's Plumbing, supra.

By chart note dated December 22, 1989, Dr. Moritz, the treating physician, declared claimant "permanent and stationary." There is no persuasive medical evidence to the contrary. Therefore, we find that claimant became medically stationary on December 22, 1989, and affirm the insurer's Notice of Closure in its entirety.

IT IS SO ORDERED.

In the Matter of the Compensation of
**MARK A. YOUNG, Claimant**
WCB Case N. 88-13983
ORDER ON REVIEW
Robert L. Philmon, Claimant Attorney
Sharon Schooley (Saif), Defense Attorney

Reviewed by Board Members Speer and Howell.

Claimant requests review of that portion of Referee Mulder's order which upheld the SAIF Corporation's denial of chiropractic treatments in excess of two times per month. On review, the issue is medical services. We affirm in part and reverse in part.

FINDINGS OF FACT

Claimant suffered a compensable low back injury on August 7, 1987, while employed by SAIF's insured. He underwent a laminectomy and discectomy on October 19, 1987, performed by Dr. Hill, neurosurgeon.

Claimant subsequently returned to his regular work for one to two months before continuing symptoms forced him off work again.

Claimant began receiving chiropractic treatments in February or March 1988. Initially, he treated five times per week. After several months, this was reduced to three times per week. Following receipt of SAIF's July 27, 1988 denial, claimant's treatments were reduced to twice per week.

Claimant receives these treatments on a scheduled basis. The treatments provide claimant with increased range of motion in his lower back allowing him greater flexibility. The duration of the benefits claimant experiences from the treatments is undetermined.

Claimant was not working between the date of the denial and the date of hearing.

CONCLUSIONS OF LAW AND OPINION

The Referee upheld SAIF's denial of treatment in excess of the Director's guidelines of two treatments per month. We agree in part, but set aside the portion of the denial which is prospective.

A claim for medical services is generally made in the form of a medical billing or a request for authorization of treatment addressed to the carrier. Billie J. Eubanks, 35 Van Natta 131 (1983). In the present case, the employer denied chiropractic treatment in excess of twice per month as unreasonable and unnecessary. There is no evidence of any claims (unpaid bills) at the time of the denial. Such a denial is prospective.

Prospective denials are impermissible. A carrier may not deny its future responsibility for payment of medical services for a previously accepted claim. ORS 656.245(1); Evanite Fiber Corp. v. Striplin, 99 Or App 353 (1989). However, because the record indicates that claimant continued to receive chiropractic treatments in excess of twice per month until hearing, and because the parties treated those services as claimed and denied, the reasonableness and necessity of these post-denial services are also at issue. (Ex. 43); Hollie J. Rahim, 42 Van Natta 415 (1990). We proceed to address the compensability of these medical services.

For his compensable injury, claimant is entitled to medical services "for such period as the nature of the injury or the process of recovery requires." ORS 656.245(1). Medical services are compensable provided they are reasonably and necessarily incurred in the treatment of the compensable injury. West v. SAIF, 74 Or App 317 (1985). Additionally, medical expenses for purely palliative purposes are recoverable where they are necessarily and reasonably incurred in treatment that enables claimant to work. West, supra.

In determining what is reasonable and necessary, the Board may consider the frequency of treatment. James v. Kemper Ins. Co., 81 Or App 80 (1986); Stephen C. Marr, 38 Van Natta 1304 (1986). Guidelines issued by the Workers' Compensation Division identify two visits per month, after the initial 60 days, as the usual frequency of medical services. OAR 436-10-040(2)(a). However, a claimant is entitled to treatment in excess of the administrative guidelines if he or she proves that the treatment is necessary due to the nature of the injury or to the process of recovery. James v. Kemper, supra at 82-84; West v. SAIF, supra at 320; Kemp v. Workers' Comp. Dept., 65 Or App 659, 669 (1983), modified 67 Or App 270, rev den 297 Or 227 (1984).

Since the date of SAIF's denial, the only doctor who opines that claimant requires treatments in excess of twice per month is Dr. Mulrooney, his treating chiropractor. Even Dr. Mulrooney's opinion is not unequivocal. In a report written on the date of hearing, Dr. Mulrooney opined that claimant would be "better off to maintain a treatment schedule of no less than two treatments per month." Therefore, as of the date of hearing, Dr. Mulrooney agreed that a twice-per-month treatment regime was appropriate. Moreover, Dr. Mulrooney further opined that claimant could "immediately" commence this treatment schedule, subject to increased treatment during periods of exacerbation. While Dr. Mulrooney also opined that claimant had experienced exacerbations "on at least three occasions in the past four months," the record indicates that claimant continuously treated twice per week during this period without any reduction during corresponding periods of nonexacerbation. Therefore, we agree with the Referee that Dr. Mulrooney's opinion lacks persuasiveness. Moreover, we concur with the Referee's reliance upon the opinions of Dr. Takacs and the Western Medical Consultants.

Given the fact that the persuasive medical reports support SAIF's denial, as well as the fact that claimant has failed to establish the duration of the benefits he experiences from the scheduled treatment, we conclude that claimant has failed to prove that treatment he received in excess of the guidelines is necessary due to the nature of his injury or to the process of recovery.

## ORDER

The Referee's order dated February 22, 1989 is affirmed in part and reversed in part. The SAIF Corporation's medical services denial is set aside, in part, as prospective. The remainder of the order is affirmed. The unpaid treatments in excess of two per month rendered between the date of the denial and the hearing are not compensable. Claimant's attorney is awarded an assessed fee of $500 for services at hearing and on Board review regarding the prospective denial issue, to be paid by SAIF.

In the Matter of the Compensation of
**ANTHONY S. AMADO, JR., Applicant**
WCB Case No. CV-90002
FINDINGS OF FACT, CONCLUSIONS AND FINAL ORDER (CRIME VICTIM ACT)
Thomas E. Ewing, Assistant Attorney General

Pursuant to notice, a hearing was conducted and concluded by James W. Moller, special hearings officer, on June 26, 1990 at Salem, Oregon. Applicant was present and not represented by counsel. The Department of Justice Crime Victim Compensation Fund ("Department") was represented by Thomas E. Ewing, Assistant Attorney General. The court recorder was Marlene Cromwell. The record was closed June 26, 1990.

Applicant has requested review by the Workers' Compensation Board of the Department's Findings of Fact, Conclusions and Order on Reconsideration dated April 9, 1990. By its order, the Department denied applicant's claim for compensation as a victim of a crime under ORS 147.005 to 147.365. The Department based its denial on: (1) applicant's failure to file a claim for benefits within one year from the date of the criminal injury; and (2) a lack of evidence that applicant was mentally or physically incapable of filing the claim within one year of the injury, as a direct result of the criminal injury.

I conclude that applicant did file a claim for benefits within one year from the date of the criminal injury. However, I further find that applicant has failed to establish "good cause" for his failure to file his claim within six months of the criminal injury. Accordingly, I conclude that he is not entitled to benefits.

## FINDINGS OF FACT

Applicant was physically assaulted in an altercation outside a bar shortly after midnight on November 26, 1987. As a result of this assault, he sustained a stab wound to his mid back. Applicant's injury required emergency room treatment. While at the emergency room, applicant was interviewed by a Portland police officer. The investigating officer informed applicant of the existence of the Crime Victim Compensation Program. Applicant was told that, if he pressed charges against his assailant, the Fund would pay his medical expenses. Applicant seeks payment of his medical expenses by the Fund.

Applicant's claim form, which was signed and notarized on November 5, 1988, was received by the Department on Monday, November 28, 1988.

Between the date of the incident and the date applicant submitted his claim, applicant resided in his Oregon residence intermittently for approximately two-and-one-half months. During the remainder of this period, he was out-of-state training for and competing in amateur wrestling competitions on both national and international levels. Upon returning from one such period out-of-state, applicant learned that his medical bills had not been paid by the Fund. Shortly thereafter, applicant completed and submitted his November 1988 application.

Based upon his demeanor at hearing, I find that applicant was a truthful witness. However, due to vagueness and confusion in his testimony, applicant was not an entirely reliable witness. I find the testimony of Investigator May, who testified on behalf of the Department, to be credible and reliable.

## CONCLUSIONS OF LAW AND OPINION

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

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

Lack of knowledge of the Fund or failure of an investigating officer to provide information as provided for in ORS 147.365 shall be deemed to be "good cause" for extension of the time in which a claim must be filed. OAR 137-76-030(1). The extension consists of an additional six months from the date of the injury. Id. In the interest of orderly and consistent administration, no extension of time within which a claim must be filed will be granted beyond one year from the date of the criminal injury for any cause except for mental or physical incapacity directly resulting from the criminal injury sustained. OAR 137-76-030(2).

Applicant's claim form indicates that his injury occurred on November 27, 1987. However, the police report and medical reports completed shortly after the incident indicate that the crime occurred during the early morning hours of November 26, 1987. I find the contemporaneous reports more reliable on this point than claimant's after-the-fact recollection. I, therefore, conclude that claimant was injured on November 26, 1987. Accordingly, Saturday, November 26, 1988 is the date which is one year from the date of injury. The issue is thus raised as to the effect, if any, of the fact that the "good cause" six-month extension for filing a claim as provided by OAR 137-76-030(1) expired on a Saturday rather than on a working day.

The administrative rules, chapter 137, do not define the term "filed" as used therein. I find guidance in the Oregon Rules of Civil Procedure. In this regard, ORCP 10 provides, in part:

> "A. Computation. In computing any period of time prescribed or allowed * * * by any applicable statute, [t]he last day of the period so computed shall be included, unless it is a Saturday or a legal holiday, including Sunday, in which event the period runs until the end of the next day which is not a Saturday or a legal holiday."

In the absence of an indication in the Department's rules to the contrary, I conclude that it is appropriate to apply the rule set forth in ORCP 10A to the computation to be made under OAR 137-76-030. Applying that rule, I find that applicant had until the end of the day on Monday, November 28, 1988 within which to file his claim. The record establishes that he has done so.

Because the Department found that applicant did not file his claim within one year of the date of the criminal injury, the Department did not address the question whether applicant had established "good cause" for an untimely filing. I have concluded that applicant's claim was filed more than six months, but within one year, of the date of his injury. Therefore, applicant can succeed on his claim only if he can establish "good cause" for his failure to file his application within six months of his injury.

Because review of the Department's decision is de novo, and because the record is fully developed concerning the cause(s) of applicant's untimely filing, I proceed to address that issue.

Applicant argues that his extended absences from the state while training and competing in wrestling competitions constitute "good cause" for his failure to file within six months of the criminal injury. I disagree.

Applicant was informed of the existence of the Fund by the investigating officer who interviewed him at the hospital on the day of the criminal incident. In addition, although applicant was absent from the state on numerous occasions during the period in question, he testified that he resided in Oregon for a total of approximately two-and-one-half months during this period. Under these circumstances, I conclude that claimant's absences from the state do not amount to "good cause" for untimely filing as set forth in OAR 137-76-030(1).

At hearing, applicant raised an additional argument for finding that he had timely complied with the filing requirements. Applicant testified in this regard that he completed an application prior to the application which was received by the Department on November 28, 1988. He believed that it was the same type of form which he subsequently filed with the Department. He testified that he mailed the form sometime prior to January 1988. He offered no independent evidence, such as a return receipt, as proof of such mailing.

Diane L. May, an investigator with the Department, testified to the Department's procedures for the handling of all claims received by the Fund. According to investigator May, Crime Victim claim forms receive priority handling by the Department. In this regard, claim applications are immediately separated from other Departmental mail and are assigned claim numbers. She credibly testified that the Department's records contained no reference to any claim from applicant other than the claim received on November 28, 1988.

During his testimony, applicant understandably demonstrated some confusion as to the various agencies with which had had dealt on his claim, i.e., the police, the Department, and the Board. It is possible that applicant mailed his prior application to the wrong party and that it was not forwarded to the Department. However, inasmuch as such circumstances would be mere speculation, I am unable to find that applicant did, in fact, mail a completed claim form properly addressed to the Department prior to the application received by the Department on November 28, 1988. Moreover, I am also unable to find that "good cause" exists on this basis for applicant's untimely claim filing.

In sum, applicant has established that he in fact filed his claim within one year of the date of the criminal injury. However, he has failed to establish "good cause" for not filing his claim within six months of the injury. Therefore, applicant is not entitled to reimbursement from the Fund for his medical expenses related to the criminal injury.

ORDER

I recommend that the Findings of Fact, Conclusions and Order on Reconsideration of the Department of Justice Crime Victims' Compensation Fund dated April 6, 1990 be reversed insofar as it found that applicant did not file his claim within one year of the injury. I further recommend that that Department's order be affirmed insofar as it concluded that applicant is entitled to no recovery of benefits.

In the Matter of the Compensation of
**DAVID C. ARABIA, Claimant**
WCB Case No. 88-14034
ORDER ON REVIEW
Robert G. Dolton, Claimant Attorney
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Gerner and Cushing.

The insurer requests review of that portion of Referee Hoguet's order that increased claimant's unscheduled permanent disability award for a low back and neck injury from 35 percent (112 degrees), as awarded by Determination Order, to 50 percent (160 degrees). Claimant cross-requests review of those portions of the Referee's order that: (1) reduced claimant's scheduled permanent disability award for the loss of use or function of his right arm from 20 percent (38.4 degrees), as awarded by Determination Order, to no scheduled permanent disability; and (2) allowed the insurer an offset for overpaid permanent disability. On review, the issues are extent of permanent disability, scheduled and unscheduled, and offset. We affirm in part and reverse in part.

FINDINGS OF FACT

Claimant, 57 years of age at hearing, compensably injured his back and right shoulder in August 1987 while working as a tote closer. (Tr. 10, Ex. 10). His treating physician for that condition was Dr. Wilson, M.D.

In October 1987, Dr. Snodgrass, neurologist, performed an independent medical examination.

On December 2, 1987, Wilson released claimant to return to modified light duty work with restrictions. (Ex. 5B).

Claimant's condition was medically stationary in January 1988. He continued to complain of cervical pain up until the time of hearing.

Claimant has preexisting osteoarthritis and degenerative conditions. Those conditions were symptomatically worsened by his compensable injury, but were not worsened permanently.

Wilson released claimant to return to his job-at-injury, tote closer, on February 19, 1988. That same day, a Determination Order closed claimant's claim, awarding 35 percent unscheduled permanent partial disability and 20 percent scheduled permanent disability for the loss of use or function of claimant's right arm. Claimant requested a hearing, seeking increased awards. The insurer did not seek a reduction in claimant's awards.

Claimant returned to work as a tote closer. He was subsequently laid off and has not worked since that time. He has a GED and has transferable skills. (Tr. 30).

Claimant suffers permanent loss of earning capacity resulting from his compensable 1987 back and right shoulder injury. He does not suffer permanent loss of use or function of his right arm resulting from his compensable injury.

Subsequent to the issuance of the Referee's January 12, 1989 order, the insurer requested reconsideration, seeking, for the first time, an offset against permanent disability benefits of the sums that the Referee had reduced in his order. The Referee abated his order and requested further information.

In his March 7, 1989 Order on Reconsideration, the Referee granted the insurer's request for an offset.

The insurer did not raise the offset issue prior to the closing of the hearing record. The offset issue did not come into existence until the issuance of the Referee's order, because it was the Referee's order that caused the overpayment that led to the offset issue.

## CONCLUSIONS OF LAW AND OPINION

### Scheduled Permanent Disability

The Referee found no evidence of permanent loss of use or function of claimant's right arm resulting from his compensable injury. Consequently, the Referee set aside that portion of the February 19, 1988 Determination Order that awarded claimant 20 percent scheduled permanent disability. We agree.

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 former 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 (1986).

Both claimant and his treating physician, Dr. Wilson, agree that claimant's compensable injury did not result in any loss of use or function of his right arm. Therefore, we conclude that claimant is not entitled to a scheduled permanent disability award.

### Extent of Unscheduled Permanent Disability

The Referee increased claimant's unscheduled disability award from 35 percent to 50 percent. We disagree.

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 App 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 applied as guidelines in the evaluation of the extent of permanent partial disability. They are not mechanically applied. Harwell v. Argonaut Insurance Co., 296 Or 505 (1984).

It is claimant's burden to prove by a preponderance of the evidence that he has sustained a permanent loss of earning capacity due to his compensable injury greater than that reflected in the February 19, 1988 Determination Order. Claimant has failed to meet that burden.

After our de novo review of record and evaluation of claimant's relevant social and vocational factors, we do not find that claimant is entitled to additional unscheduled permanent disability beyond that already awarded by Determination Order.

First, we find that claimant returned successfully to his job-at-injury. Claimant credibly testified that his job-at-injury was a tote closer. (Tr. 10). In February 1988, claimant's treating physician, Dr. Wilson, released claimant to return to that very job. (Exs. 10, 11). In fact, claimant returned to the tote closer position. He left that work for reasons unrelated to his compensable injury. We conclude, therefore, that claimant did, in fact, return to his at-injury employment.

Furthermore, we note that claimant has many transferable skills which would allow him to find suitable employment. Claimant has at least 20 years experience working as a farmer, and has worked as a sand and rock quarry laborer, game farmer and as a cannery worker.

The record establishes, however, that claimant does suffer some permanent impairment due to the compensable injury. The insurer argues that the Referee incorrectly considered claimant's total condition, including the effects the compensable injury had on claimant's preexisting osteoarthritis and degenerative conditions. We disagree.

Wilson reported that claimant's condition "due to his injury" was in the "mild" range, and reported that his total condition was in the moderately severe range. However, we find that there is no persuasive evidence, medical or otherwise, in the record to establish that claimant's preexisting condition worsened permanently due to the compensable injury. In fact, in response to the specific question of whether claimant's compensable injury caused a worsening of his preexisting osteoarthritis and degenerative conditions, Wilson reported that it probably had not caused the worsening. Wilson went on to state that claimant "aggravated a pre-existing condition and made it symptomatic. Usually, these aggravations are temporary in nature . . ." (Ex. 14). Wilson concluded by opining that claimant's condition due solely to the injury, was in the mild range. Id.

Therefore, based on Wilson's report, we find that claimant has failed to establish that his preexisting conditions were permanently worsened by the compensable injury. Consequently, claimant's "total" condition is not considered in determining extent of unscheduled permanent disability.

After considering claimant's mild permanent impairment attributable to his 1987 compensable injury, and in light of the relevant social and vocational factors described above, we conclude that an unscheduled permanent disability award of 35 percent provides appropriate and adequate compensation for the permanent loss of earning capacity resulting from claimant's compensable injury.

Offset

Claimant asserts that the Referee erred in granting the insurer an offset, contending that the issue of an offset was not raised prior to or at the hearing, but was first raised by motion for reconsideration after the Referee's order issued. We disagree.

Generally, where a carrier seeks to recover an offset and overpayment which is in existence and ripe for adjudication at the beginning of hearing, the carrier is required to raise the overpayment and offset issues before the hearing record closes. ORS 656.726(4); OAR 438-06-031, 438-07-025; Reine R. Webb, 42 Van Natta 477 (1990); see also William G. Page, 39 Van Natta 693 (1987); Randy D. Johnson, 39 Van Natta 463 (1987). Therefore, if the offset and overpayment issues are not raised before the record closes, those issues are deemed waived. See Reine R. Webb, supra; Randy D. Johnson, supra; Mavis v. SAIF, 45 Or App 1059 (1980); Darrell R. Zwicker, 42 Van Natta 136 (1990), Gunther H. Jacobi, 41 Van Natta 1031 (1989).

Here, the insurer did not seek reduction of claimant's permanent disability awards at hearing. Thus the offset issue, which would naturally flow from a "reduction" request, was not in existence or ripe for adjudication at the beginning of the hearing. Rather, it was the Referee's order that created the existence of the overpayment and offset issues by unilaterally reducing claimant's scheduled award. Consequently, the Reine R. Webb analysis is inapplicable to the facts in this case.

The facts in this case are substantially similar to those in Hicks v. Fred Meyer, Inc., 57 Or App 68, 71 (1982). In Hicks, after the referee issued his order, the employer requested reconsideration, requesting authority to offset overpaid compensation against the permanent disability award granted by the referee's order. The referee allowed reconsideration and authorized the requested offset.

Here, the Referee issued his order. Subsequently, the carrier requested reconsideration, citing misstatements of fact and errors of law, including error on the part of the Referee by not automatically ordering an offset. The insurer requested the authority to offset overpaid compensation against the permanent disability award granted by the Referee's award.

The Hicks court stated:

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

Consequently, because Hicks is still applicable law, and because the offset issue did not come into existence until the Referee issued his order and unilaterally reduced claimant's scheduled permanent disability award, thereby creating the overpayment, we conclude that the Referee in the instant case did not err in granting the insurer's request for an offset. Accordingly, the insurer is authorized to recover its overpayment against claimant's current and future permanent disability awards.

## ORDER

The Referee's order dated January 12, 1989, as reconsidered March 7, 1989, is affirmed in part and reversed in part. That portion of the order which increased claimant's unscheduled permanent disability award from 35 percent (112 degrees) to 50 percent (160 degrees) is reversed. The February 19, 1988 Determination Order award of 35 percent (112 degrees) unscheduled permanent disability is reinstated. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
**JACLENE I. JOHNSON, Claimant**
WCB Case No. 88-19221
ORDER ON RECONSIDERATION
Robert E. Nelson, Claimant Attorney
Roberts, et al., Defense Attorneys

Claimant has requested reconsideration of the Board's Order on Review issued July 25, 1990. In that order, we affirmed Referee Bennett's order that: (1) declined to award additional temporary total disability compensation; and (2) declined to assess a penalty and related attorney fee for the insurer's failure to pay that compensation. On reconsideration, claimant contends that our ruling is inconsistent with our decision in Diane R. Douglas, 42 Van Natta 1541 (1990). We disagree.

The issue in both Douglas and the present case was whether the insurer properly stopped paying temporary total disability and began paying temporary partial disability following a refusal of an offer of modified work. In the present case, we concluded that the insurer had properly terminated temporary total disability. We reached the opposite ultimate conclusion in Douglas.

Factually, the cases are similar. Both claimants were injured while working full daytime shifts as nurses for the same employer, and both refused written offers of modified employment on a four-hour night shift. However, in Douglas the offer did not include the start-up date, whereas in the present case claimant received a written offer stating the beginning time, date and place of modified employment.

This factual distinction is the basis for our different rulings. In the present case, the insurer complied with the procedural requirement that the written job offer include the start-up date of the modified job. See OAR 436-60-030(5)(c). Accordingly, it was necessary to address whether the four-hour night shift was a bona fide offer of employment within the meaning of the rule. Like the Referee, we rejected claimant's contention that the job was not covered by the rule because it was a make-work job with inappropriate hours.

In Douglas, on the other hand, the insurer had not complied with the requirement that the offer include the start-up date of the job. On that basis, alone, we concluded that the insurer had improperly terminated benefits. We did not address whether the four-hour night shift was a bona fide offer of employment.

On reconsideration, we continue to hold that the factual difference between these two cases mandate opposite ultimate conclusions.

Accordingly, our prior order is abated and withdrawn. On reconsideration, the Board adheres to and republishes its former order, effective this date.

IT IS SO ORDERED.

**Board Member Crider, dissenting.**

As a preliminary matter, I note that the panel's initial order on review inadvertently issued without my dissenting opinion. Therefore, I publish this dissenting opinion on claimant's motion for reconsideration.

Claimant was employed as a nurse's aide at the employer's nursing home when she was compensably injured. She worked the day shift, commencing at 6:30

a.m. and concluding at 3:00 p.m. At the time of injury, she was paid $5 per hour or $200 every two weeks.

Her employer called her back to work on a light duty basis doing work similar to her own. She returned. However, after working one day, she was told not to return. Thereafter, the employer prepared a job description calling for her to work four hours a day doing light clerical work. The job was to last three weeks. Claimant's physician indicated that the job was within her physical capacities. By letter dated September 28, 1988, the employer offered claimant a job doing this approved light clerical work commencing October 3, 1988. Claimant was directed to report each day, Monday through Friday, at 10:00 p.m. She was to work until 2:00 a.m. She would be paid $3.35 per hour.

Claimant declined to work because she was unable to find anyone who could care for her children at the specified time.

The insurer then reduced claimant's temporary disability compensation under the authority of OAR 436-60-030(5).

ORS 656.325(5) provides for reduction of a worker's temporary disability benefits when a worker refuses employment:

> "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."

The Director of the Department of Insurance and Finance has adopted rules implementing this statute. The rules require that the physician have approved the job as within the worker's capacities and that the worker be given a clear written job offer. The rules do not expressly require that the offer be bona fide or reasonable. However, I submit that the rule does not serve the statutory purpose unless it is read to include an implicit requirement that the offer be bona fide and reasonable. Indeed, the insurer concedes, in his brief, that a good faith requirement is properly read into the rule.

The purpose of ORS 656.325(5) is to encourage employers to provide work for injured workers who are not yet able to perform their customary work and to preclude workers, who are physically able to do modified work, from continuing to draw full benefits when remunerative work is available to them. I submit, however, that it was not intended to authorize an insurer to avoid paying benefits to workers who are offered work which, while within the worker's capacities, it would be unreasonable to expect the worker to accept. Thus, I would read the rule to permit reduction of temporary disability benefits only if a worker refuses a bona fide offer of reasonable employment.

The offer in this case was not reasonable. It called for claimant to work a part time, minimum wage job, on a schedule which not only was not her own pre-injury schedule and was not a schedule worked by regular clerical employees but also was in the middle of the night.

The panel correctly observes that the employer satisfied the express requirements of the rule. However, inasmuch as the job appears to have been designed so that is was certain to be rejected, and inasmuch as the offer was not reasonable I would hold that the worker has not refused a bona fide offer of wage earning employment, and that the worker is entitled to temporary disability compensation without reduction.

In the Matter of the Compensation of
**MIKE J. MOODY, Claimant**
WCB Case No. 88-18100
ORDER ON REVIEW
Dean Heiling, Claimant Attorney
Employers' Defense Counsel, Defense Attorneys

Reviewed by Board Members Gerner and Cushing.

The insurer requests review of those portions of Referee Davis' order which: (1) set aside its denial of claimant's temporomandibular joint dysfunction (TMJ) condition; and (2) set aside its denial of claimant's cervical condition, but only to the extent that the denial includes muscular pain in the cervical area. Because the Referee found the TMJ and cervical conditions to be compensable and not medically stationary, he set aside a Determination Order as premature. Consequently, the Referee did not determine the issues of the insurer's denial of claimant's aggravation claim, and the extent of permanent disability, scheduled and unscheduled. On review, the issues are compensability, premature closure and, alternatively, aggravation and extent of permanent disability, scheduled and unscheduled.

## FINDINGS OF FACT

The Board adopts the Referee's Findings of Fact as our own, with the following supplementation.

Claimant's temporomandibular joint dysfunction (TMJ) and cervical conditions are not materially related to his compensable 1985 left knee and foot injury.

Claimant's psychological condition has symptomatically exacerbated since the last arrangement of compensation.

Claimant's exacerbated psychological condition has not resulted in a diminished earning capacity beyond that established at the time of the last arrangement of compensation. His symptomatic exacerbation did not result in 14 or more days of total disability.

Claimant, 35 years of age at hearing, has a GED. He has completed six terms of college education, but has no documentation demonstrating competence in any specific vocational pursuit. Claimant's past occupations include laborer, welder, apartment maintenance worker, dish washer and telephone repairer. His highest specific vocational preparation (SVP) during the ten years preceding the date of injury is a 5, for welding.

Claimant has not returned to work since the 1985 compensable injury. No offer of employment has been made. He is capable of lifting 11 to 20 pounds occasionally and performing light work. Claimant suffers disabling pain resulting from his compensable injury, and he suffers some permanent loss of earning capacity and some permanent loss of use or function of his left leg (knee) and foot resulting from his compensable injury.

## CONCLUSIONS OF LAW AND OPINION

### Compensability

The Referee found that claimant met his burden of proving that his compensable 1985 injury was a material cause of his TMJ and cervical conditions. We disagree.

It is well settled that a carrier is liable for the natural consequences flowing from a compensable injury. Williams v. Gates McDonald & Co., 300 Or 278, 281 (1985); Pattitucci v. Boise Cascade Corp., 8 Or App 503, 507-8 (1972). Therefore, to establish the compensability of claimant's current TMJ and cervical conditions, claimant has the burden of proving that his 1985 compensable injury is a material cause of those conditions. See Harris v. Albertson's, Inc., 65 Or App 254, 256-57 (1983). "Material contributing cause" means a substantial cause, but not necessarily the sole cause or even the most significant cause. See Van Blokland v. Oregon Health Sciences University, 87 Or App 694, 698 (1987); Lobato v. SAIF, 75 Or App 488, 492 (1985). Claimant has failed to meet this burden with respect to both conditions.

Compensability of Cervical Condition

Claimant's low back condition is causally related to his 1985 compensable injury. The Referee separated claimant's cervical condition into two parts: degenerative changes and muscular pain. Based on Dr. Grossenbacher's independent medical report, the Referee found that the degenerative changes in claimant's cervical area were not causally related to his compensable injury, but the muscular pain in the cervical area was materially caused by his compensable injury. We disagree in part with the Referee and find that claimant's 1985 compensable injury is not a material cause of either the degenerative changes or the cervical muscular pain.

The medical record establishes that three physicians rendered opinions regarding the causation of claimant's combined cervical condition: Dr. Black, claimant's treating physician; Dr. Grossenbacher, M.D.; and Dr. Kuller, M.D. Each of these physicians rendered somewhat conflicting opinions regarding the causation of claimant's current cervical condition. Neither of the three physicians made a significant distinction between claimant's degenerative changes and the muscular pain in claimant's cervical area.

In conflicts of medical opinion, the opinion of the treating physician is generally given greater weight, unless there are persuasive reasons to do otherwise. Weiland v. SAIF, 64 Or App 810, 814 (1983); Nancy E. Cudaback, 37 Van Natta 1580, withdrawn on other grounds, 37 Van Natta 1596 (1985), republished 38 Van Natta 423 (1986). We find no persuasive reason not to give deference to claimant's treating physician, Dr. Black.

Black treated claimant from the date of the initial 1985 compensable injury through January 1989 and reported that claimant did not complain of cervical pain until 1987, some two years after the initial compensable injury. After considering the delay in reporting the cervical complaints and claimant's medical history, Black opined that claimant's cervical condition was not related to his compensable injury. (Ex. 9).

In October 1988, Dr. Kuller performed a thorough independent medical examination. Kuller noted a history, as reported by claimant, of cervical pain stemming from 1983, two years before his compensable injury. (Ex. 26). Kuller also noted that cervical x-rays taken in both 1983 and 1987 were normal. As a result of these observations, Kuller opined that claimant's current cervical condition predated his occupational injury, and was therefore not causally related to his compensable injury.

We note that Dr. Black's medical reports did not indicate that claimant's cervical condition predated his compensable injury. However, Black still concluded that claimant's current cervical condition was not related to his compensable injury.

Dr. Grossenbacher saw claimant only once, when he performed his independent medical examination in August 1988. After noting that claimant exhibited a full range of motion of the cervical spine, and stating that claimant had persistent subjective complaints, Grossenbacher opined that claimant suffered minimal permanent disability. He went on to report that claimant's cervical spine complaints "are probably indirectly related to his lower back area. That is, the vertebral column usually works in a symphonic cascade." Grossenbacher continued by stating that claimant was "probably demonstrating a mild amount of thoracic outlet syndrome . . ," and then concluded that claimant's cervical complaints would not contribute to his permanent disability. Finally, Grossenbacher opined that claimant's "permanent partial disability of mild is directly related to his lower back." (Ex. 11-3).

Grossenbacher did not specifically say whether or not claimant's current cervical condition was causally related to his compensable injury. Therefore, we do not read Grossenbacher's report as supportive of the proposition that claimant's cervical condition is causally related to his compensable injury. The theory that the vertebrae usually works in a "symphonic cascade," upon which the Referee relied, does not itself establish a causal relationship between claimant's compensable injury, which consequentially resulted in a compensable low back condition, and claimant's current cervical condition. Because we find Grossenbacher's opinion to be incomplete, we do not find his opinion to be persuasive. Somers v. SAIF, 77 Or App 259, 262 (1986); See Hammons v. Perini Corp., 43 Or App 299, 302 (1979).

After our review of these three medical reports, we find the more well-reasoned, complete reports of Dr. Black and Dr. Kuller to be persuasive. Thus, the preponderance of the medical evidence establishes that claimant's cervical condition is not causally related to his compensable injury.

Therefore, we find that claimant has failed to meet his burden of proving that his compensable injury was a material cause of his current cervical condition.

Compensability of TMJ Dysfunction Condition

The Referee found that claimant's TMJ dysfunction condition was materially caused by his compensable injury. We disagree.

Claimant's compensable February 1985 injury involved his left knee and foot. As a result of that injury, claimant also suffered a compensable low back condition and an exacerbated psychological condition. Claimant now contends that his current TMJ dysfunction condition is a compensable consequence of his 1985 compensable injury. We disagree.

After our de novo review of the record, we find that claimant's first complaints of TMJ dysfunction did not appear in the medical records until sometime in mid-1988, approximately three years after his compensable injury.

Therefore, given the length of time between claimant's compensable injury and the onset of his current TMJ condition, we find that the causation of claimant's TMJ condition is of sufficient medical complexity that we cannot decide it without expert opinion. Uris v. Compensation Department, 247 Or 420, 424-26 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985).

Two dentists address the issue of claimant's TMJ dysfunction: Dr. Garey, D.M.D., and Dr. Shirtcliff, D.M.D., neither of which are claimant's treating physician.

Dr. Garey performed an independent medical examination in August 1988. As part of that exam, Garey evaluated claimant's previous medical records. After finding that claimant did have a right TMJ internal derangement, noting the possible causes of TMJ dysfunction, and considering the type of compensable injury claimant originally suffered, Garey concluded that the TMJ dysfunction condition was not related to or caused by claimant's 1985 compensable injury. (Ex. 12). We find Garey's well-reasoned and thorough opinion to be persuasive. Somers v. SAIF, supra.

Dr. Shirtcliff, on the other hand, concluded that claimant's TMJ dysfunction condition was related to his compensable injury. (Ex. 1-1). In making his determination, Shirtcliff relied heavily upon the opinion of Dr. Grossenbacher. After agreeing with Grossenbacher's "symphonic cascade" theory, Shirtcliff stated that "[that theory] is precisely why [he] attributes [claimant's] neck and TMJ problems to [claimant's] original injury." (Ex. 1-1). Further, after noting that clenching of the teeth can cause TMJ dysfunction, Shirtcliff concluded that teeth clenching was most likely what caused claimant's TMJ condition.

We have noted, in our discussion on the compensability of claimant's current cervical condition, that we do not find the opinion of Dr. Grossenbacher to be persuasive. For those same reasons, we do not find Grossenbacher's opinion, nor Shirtcliff's opinion, to be persuasive regarding claimant's TMJ dysfunction condition. See Somers v. SAIF, supra.

Based on the well-reasoned opinion of Dr. Garey, we conclude that claimant's current TMJ dysfunction condition was not a compensable consequence of claimant's compensable 1985 injury.

Premature Closure

After finding both claimant's TMJ and cervical conditions compensable and the conditions not medically stationary, the Referee set aside the October 19, 1988 Determination Order as premature. However, because we have upheld the insurer's denials, we conclude that the Determination Order was not prematurely issued because the record establishes that claimant's compensable conditions were medically stationary at the time of the Determination Order. Therefore, the October 19, 1988 Determination Order shall be reinstated.

Aggravation

Because of the premature closure finding, the Referee determined that the aggravation issue was moot. Since we have found otherwise, we now analyze claimant's aggravation claim.

To establish an aggravation, claimant must show a worsening of his compensable condition since the last arrangement of compensation. Smith v. SAIF, 302 Or 396 (1986). "Worsening" within this context means increased symptoms, or a worsened underlying condition, resulting in a diminishment of earning capacity. Id. If the last arrangement of compensation anticipated future exacerbations accompanied by a diminished earning capacity, claimant must also prove: (1) that his earning capacity was diminished longer or in greater degree than was anticipated; or (2) that his exacerbation resulted in 14 consecutive days of total disability or in-patient hospitalization. Gwynn v. SAIF, 304 Or 345, 352-53 (1987), on rem 91 Or App 84 (1988); Edward D. Lucas, 41 Van Natta 2272 (1989).

The last award of compensation was the October 19, 1988 Determination Order, which awarded claimant an additional 8 percent unscheduled permanent

disability, for a total of 13 percent unscheduled permanent disability and 5 percent scheduled permanent disability for the loss of use or function of his left leg (knee).

The focus of this aggravation claim is a worsening of claimant's compensable psychological condition. The first issue, then, is whether claimant has established that he has suffered either a pathological or symptomatic worsening of his psychological condition since the last award of compensation.

After our review of the record, we find that claimant complained continuously of psychological symptoms such as depression, anxiety, suicidal tendencies and paranoia, and the treating and evaluating psychologists and psychiatrists consistently diagnosed depression, mild suicidal ideation, paranoia, anxiousness and passive-dependent psychosis. Both the symptoms and diagnoses were made prior to the compensable injury and the last arrangement of compensation, and at the time of the aggravation claim. Therefore, based on symptoms and diagnoses, both before and after the alleged aggravation, it does not appear that claimant's psychological condition has pathologically worsened.

We proceed to the issue of whether claimant's psychological condition has worsened symptomatically. A symptomatic exacerbation is sufficient if it results in diminished earning capacity and is not anticipated by the last award of compensation. See Margaret Boateng, 42 Van Natta 1552 (1990).

The Board generally defers to the opinion of the treating physician absent persuasive reasons to do otherwise. Weiland v. SAIF, supra; Nancy E. Cudaback, supra. We find no reason not to defer to claimant's treating psychologist, Dr. Eckstein.

Eckstein's November 22, 1988 report indicates that claimant's psychological condition is no longer medically stationary and his depression and paranoia have "markedly increased." (Ex. 29C-1). Eckstein opined that there was no way claimant could work due to his "worsening of symptomology." Id.

Therefore, based on Eckstein's opinion, we conclude that claimant has established that his psychological symptoms have exacerbated since the last arrangement of compensation.

The next issue is whether claimant's symptomatic exacerbation resulted in diminished earning capacity below the level fixed at the time of the last award of compensation and whether that prior award anticipated waxing and waning symptoms. Edward Lucas, supra.

We find that the last arrangement of compensation anticipated future waxing and waning of symptoms. Evidence supporting a finding that waxing and waning symptoms were anticipated by the last arrangement of compensation includes documented history of repeated exacerbations of both claimant's back problems and his psychological condition. See Lance O. Glover, 42 Van Natta 256 (1990).

Since the October 1985 Determination Order, claimant has experienced many episodes of increased back pain, which, in turn, caused increased psychological problems. These episodes include return visits to physicians in July, September and December 1986; January, June, September and October 1987; and, January and March 1988. Further, we note that on several occasions between November 1985 and October 1988, claimant was released to return to some kind of work. See Exhibits O-A, O-B, O-C, 1, 10, 11 and 17A.

In late August 1988, claimant's treating psychiatrist, Dr. Eckstein, opined that claimant's psychiatric condition was medically stationary, but reported that she wished to continue psychotherapy with claimant "as I anticipate

this will be a strenuous time for him. I would imagine terminating treatment before the new year with a gradual tapering off of sessions." (Ex. 17A-1). We read Eckstein's opinion to mean that she anticipated continued psychiatric problems. All other treating physicians concurred with Eckstein's opinion that claimant was medically stationary. Consequently, based on all this information, claimant's claim was closed and the October 1988 Determination Order issued.

This medical history was available to the evaluator at the time of the last arrangement of compensation. Therefore, we find that the last arrangement of compensation anticipated future periods of waxing and waning of symptoms. Finally, we conclude that claimant's current exacerbation, the November 1988 flare-up, is of the type and duration anticipated by the last arrangement of compensation. Consequently, we find that claimant has failed to show that his periods of flare-up are in excess of that anticipated by the prior award.

Whether the Exacerbation Resulted in 14 Days of Total Disability/Inpatient Hospitalization

Alternatively, claimant may prove an aggravation by establishing that the exacerbation resulted in inpatient hospitalization or 14 days of total disability. See Gwynn v. SAIF, supra; Kurt K. Kral, 42 Van Natta 129 (1990). Claimant has had no inpatient hospitalization and he has failed to establish that his exacerbation resulted in 14 days of total disability.

The only evidence in the record which addresses claimant's condition during the exacerbation is that of Dr. Eckstein's November 22, 1988 report. (Ex. 29C-1).

While the Board generally gives greater weight to the conclusions of a treating physician, it does not so defer if there are persuasive reasons to do otherwise. Weiland, supra. We find persuasive reasons not to defer to Eckstein's opinion concerning the issue of whether claimant was totally disabled as a result of his compensable injury for 14 days or more.

On November 22, 1988, in a letter to the insurer, Eckstein opined that claimant was "psychologically nonstationary due to this worsening from the time he was made medically stationary." Further, Eckstein requested permission to reopen claimant's case "to provide more stabilization" of his condition. (Ex. 29C-1).

The issue here is whether claimant, because of the exacerbation, is totally disabled for 14 or more days. We do not find that Eckstein's opinion answers this question.

Eckstein states that claimant's condition is nonstationary since the time his condition was found medically stationary. This statement does not support a conclusion that claimant was totally disabled. Moreover, we note that Eckstein sought the reopening to provide "more stabilization." Such a statement is suggestive of partial, as opposed to total, disability.

In conclusion, Eckstein's opinion does not establish that claimant was totally disabled because of the anticipated exacerbation. Furthermore, we are unpersuaded that claimant was totally disabled for a period of 14 days or more.

Under these circumstances, we conclude that claimant has failed to establish that his anticipated exacerbation resulted in 14 or more days of total disability. Accordingly, we conclude that claimant has not established a compensable worsening since the last arrangement of compensation. See Margaret Boateng, supra.

Because we have concluded that claimant has failed to establish a compensable aggravation, and because we have found that his claim was properly closed by the October 19, 1988 Determination Order, we find it within our jurisdiction to rate the extent of claimant's permanent disability, both scheduled and unscheduled. We do so now.

Extent of Permanent Disability

Because claimant's condition was medically stationary on August 30, 1988, and because his claim for that condition was closed by Determination Order on October 19, 1988, the "standards" adopted effective July 1, 1988, (former OAR 436-35-001 et seq), as amended by temporary rules effective August 19, 1988, apply to the rating of claimant's permanent partial disability. Former OAR 436-35-010 through 436-35-260 apply to the rating of scheduled permanent partial disabilities. Former OAR 435-35-270 through 436-35-440 apply to the rating of unscheduled permanent partial disabilities.

Extent of Scheduled Permanent Disability

An October 28, 1985 Determination Order awarded claimant 5 percent scheduled disability for the loss of use or function of his left leg (knee). The October 19, 1988 Determination Order did not increase that award.

After our de novo review of the record, we find no evidence to establish that claimant suffers scheduled permanent disability in excess of his prior award of 5 percent. Therefore, we affirm the October 25, 1988 Determination Order that did not award additional scheduled permanent disability for a loss of use or function of his left leg (knee).

Extent of Unscheduled Permanent Disability

Claimant's compensable claim includes, as a compensable consequence, both a low back condition and a psychological component. We proceed with our determination.

Age and Education

The appropriate value for claimant's age of 35 is 0. Former OAR 436-35-290(3). He holds a GED. Therefore, the appropriate value for his formal education is 0. Former OAR 436-35-300(3). His highest SVP during the ten years preceding the date of injury is 5 (DOT # 810.384-014), for an appropriate skills value of 2. Former OAR 436-35-300(4). There is no documentation in the record demonstrating competence in some specific vocational pursuit. Therefore, the appropriate value for training is 1. Former OAR 436-35-300(5).

The total value for claimant's age and education, therefore, is 3.

Adaptability

Claimant has not worked since the date of his compensable injury. Further, because there is no evidence in the record to determine whether an offer of employment has been made, we conclude that no offer was made. Consequently, the appropriate adaptability value is determined by use of former OAR 436-35-410(4).

Claimant can occasionally lift 11 to 20 pounds, carry up to 20 pounds, and can occasionally bend, squat, crawl, twist, walk on rough ground and reach above his shoulders, but cannot climb or work at heights. (Ex. 2-7). Based on claimant's abilities, we find that he is capable of performing light work. Therefore, the appropriate value for claimant's adaptability is 4. Former OAR 436-35-310(4).

Impairment

It is claimant's burden to prove that permanent impairment results from his compensable injury. ORS 656.214(2). Here, claimant's compensable injury includes a compensable psychological component. Claimant contends that he suffers permanent impairment resulting from that component of his claim. We disagree.

After our review of the medical and lay evidence, we find that claimant has failed to establish that he suffers permanent impairment resulting from the psychological component of his compensable injury. The record establishes that claimant suffers from ongoing depression, suicidal ideation, borderline personality disorder, among other psychological problems. However, the record does not establish which, if any, of those conditions are the permanent result of claimant's compensable injury.

In other words, we find that the record fails to delineate which, if any, of claimant's psychological conditions are materially caused or worsened by his compensable injury, and whether those conditions are, in fact, permanent. Consequently, no value is given to the psychological component of claimant's compensable injury.

With respect to the physical aspect of his claim, we have already found that claimant's cervical condition is not related to his compensable injury. Therefore, medical findings relative to the cervical condition are not considered when determining the extent of unscheduled permanent disability.

Lessened range of motion findings can equate to permanent disability. Former OAR 436-35-360. Here, however, two physicians have found that claimant exhibited a full range of motion in his lumbar spine.

Dr. Grossenbacher, claimant's treating physician, reported that claimant had a "full range of motion of the lumbar spine." (Ex. 11). And, in October 1988, Dr. Kuller, independent medical examiner, reported a full range of motion in claimant's lumbar spine. (Ex. 26).

Therefore, based on the opinions of Dr. Grossenbacher and Dr. Kuller, we find that claimant's range of motion findings preclude an award for permanent impairment for loss of range of motion.

Pursuant to former OAR 436-35-350, an impairment value may be given for an unoperated disc derangement with any clinically-related residual symptoms. Claimant contends that he is entitled to 4 percent under that rule. We disagree.

Claimant has an L5-S1 disc protrusion, for which the Evaluation Division awarded claimant 4 percent under former OAR 436-35-350(2). However, we find that there is no medical evidence to establish that the disc protrusion has any clinical significance. In fact, in a July 1988 independent medical report, Dr. Schroeder, D.C., reported specifically that the L5-S1 disc bulge was "without nerve root displacement or thecal sac indentation." (Ex. 8). See Ex. O-B, O-C. Further, Grossenbacher, in his August 1988 report, mentioned the L5-S1 disc protrusion, but only in the context of past history, indicating that an April 1987 MRI revealed "slight abnormalities" at L5-S1. (Ex. 11). Finally, we note that Dr. Kuller's October 1988 report indicated that a "bulging disc not indenting the thecal sac, is likewise common due to the normal degenerative processes in the spine. . ." (Ex. 26).

Based on the findings of Drs. Schroeder, Grossenbacher and Kuller, we find that the L5-S1 disc protrusion has no clinical significance to claimant's compensable injury. Consequently, we do not award claimant an impairment value based on the disc protrusion.

We do find, however, that claimant does suffer some disabling pain resulting from his compensable injury, mainly affecting his ability to lift, bend and carry.

Disabling pain may be evaluated and given an impairment value under former OAR 436-35-320(1)(a) when it results in the loss of use or function. Daniel M. Alire, 41 Van Natta 752 (1989). We conclude, therefore, based on claimant's limited ability to lift, bend and carry, that he suffers 5 percent disabling pain resulting from his compensable injury.

After considering all the evidence, medical and lay, we conclude that claimant's total impairment value is 5.

Computation of Unscheduled Disability

Having determined each value necessary to compute claimant's permanent disability under the "standards," we proceed to that calculation. When claimant's age value 0 is added to his education value 3, the sum is 3. When that value is multiplied by claimant's adaptability value 4, the product is 12. When that value is added to claimant's impairment value 5, the result is 17 percent unscheduled permanent partial disability. Former OAR 436-35-280(7). Claimant's unscheduled permanent disability under the "standards" is, therefore, 17 percent.

ORDER

The Referee's order dated May 18, 1989 is reversed in part and modified in part. The insurer's denial of claimant's TMJ and cervical problems is reinstated and upheld in its entirety. The Referee's attorney fee award of $2,000 is reversed. The insurer's aggravation denial is reinstated and upheld. The October 19, 1988 Determination Order is reinstated. In addition to the October 19, 1988 Determination Order award of 13 percent (41.6 degrees) unscheduled permanent disability, claimant is awarded 4 percent (12.8 degrees) unscheduled permanent disability, for a total of 17 percent (54.4 degrees) unscheduled permanent disability. Claimant's attorney is awarded 25 percent of the increase in compensation created by this order, not to exceed $3,800.

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August 20, 1990 Cite as 42 Van Natta 1812 (1990)

In the Matter of the Compensation of
**ROBERT SEXTON, Claimant**
WCB Case Nos. 88-09708 & 88-03876
ORDER ON REVIEW
Olson, et al., Claimant Attorneys
Meyers & Radler, Defense Attorneys
Snarskis, Yager, et al., Defense Attorneys

Reviewed by Board Members Cushing and Gerner.

Claimant requests review of those portions of Referee Mills' order which: (1) upheld Liberty Northwest's denial of a "new injury" claim for a back injury; and (2) declined to address the issue of aggravation because he found that claimant had not timely requested a hearing concerning Industrial Indemnity's aggravation denial. On review, the issues are compensability and responsibility.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

We adopt the Referee's conclusions and rationale as our own with the following supplementation. The Referee stated that Donald D. Davis, 40 Van Natta 2000 (1988), was the controlling authority regarding the burden of proof in all aggravation versus new injury cases. We have since overruled that position in Linda L. Wise, 42 Van Natta 115 (1990). The Referee did state accurately, and we agree, that the burden of proof only makes a difference to the outcome when the evidence is in equipoise. This was true under both Davis and Wise. In this case, the evidence was not in equipoise.

ORDER

The Referee's order dated May 26, 1989 is affirmed.

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In the Matter of the Compensation of
**MARY J. GATES, Claimant**
WCB Case Nos. 86-16302, 86-17922 & 87-00191
ORDER REPUBLISHING ORDER ON REVIEW
Cooney, et al., Attorneys
Williams, Zografos, et al., Attorneys

Reviewed by Board Members Nichols and Crider.

Claimant has requested republishing of our March 8, 1989 Order on Review. Contending that she never received a copy of the Board's order, claimant asks that her rights of appeal be "reinstated." Inasmuch as we find that our prior order has not become final, we conclude that we have authority to republish our order.

A Board order is final unless within 30 days after the date of mailing of copies of such order, one of the parties appeals to the Court of Appeals for judicial review. ORS 656.295(8). The time within which to appeal an order continues to run, unless the order has been "stayed," withdrawn, or modified. International Paper Co. v. Wright, 80 Or App 444 (1986); Fischer v. SAIF, 76 Or App 656, 659 (1986).

The Board may republish an order if it finds that it failed to mail a copy of its prior order to a party. Berliner v. Weyerhaeuser Company, 92 Or App 264, 266-67 (1988). When an order has been mailed to a party at an address other than that previously provided to the forum, the order has not been mailed to a party and is not final. Ernest L. Vaughn, 40 Van Natta 1574 (1988); Douglas Meuler, 40 Van Natta 989 (1988); compare Joyce E. Mitts, 42 Van Natta 972 (1990) (Where current address of a party provided to the Hearings Division in another case, but not to the Board in the case in question, and a copy of the Board's order, which was mailed to that party at address provided to the Board, was not returned as undeliverable, the order had been mailed to all parties and was final).

Here, claimant did not receive a copy of the Board's March 8, 1989 order. She accurately assumes that the order was mailed to the address she had previously provided to the Hearings Division and Board. Contending that she was

"effectively denied the right to appeal the Board's decision" by her failure to receive notice of the order, claimant seeks reissuance of the order.

A review of the file confirms that a copy of the Board's order was mailed to claimant's former address. However, this was the same address that had been provided to the Hearings Division at the time of her hearing request, as well as by her former counsel at the time of Board review. The envelope containing the copy of the order which was addressed to claimant was returned to the Board on March 14, 1989 as undeliverable and marked "unable to forward."

When the Board was unable to determine an alternative address for claimant, no further action was taken. Yet, further inspection of the file does reveal that a December 30, 1988 letter to the Board from claimant contains a return address at which claimant apparently currently resides.

In response to claimant's request, the insurers note that she failed to alert the Board to the fact that the "December 30, 1988" address was different from the address she had previously provided. In addition, the insurers assert that she apparently neglected to leave a forwarding address with the Post Office. Considering such circumstances, the insurers argue that the order was mailed to claimant, has become final, and cannot be republished. We disagree.

We acknowledge that claimant could have been more vigilant in keeping the Board apprised of her current address. However, the fact remains that, at the time the March 8, 1989 order was issued as well as when claimant's copy of the order was returned to the Board as undeliverable, the Board did have a document indicating claimant's current address in its file. Because of this inattentiveness, claimant was effectively prevented from learning of the Board's decision.

Under such circumstances, we conclude that our March 8, 1989 order was not mailed to a party in interest to the proceeding. Therefore, the order is not final and we retain jurisdiction. ORS 656.295(8); Berliner, supra.

Turning to the merits of claimant's request for review of the Referee's order, we adhere to and republish our March 8, 1989 order in its entirety. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

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In the Matter of the Compensation of
**LORI S. PRATT, Claimant**
WCB Case No. 88-20302
ORDER ON REVIEW
Rasmussen & Henry, Claimant Attorneys
Beers, et al., Defense Attorneys

Reviewed by Board Members Speer and Howell.

The insurer requests review of those portions of Referee Mirassou's order which: (1) increased claimant's scheduled permanent disability award for loss of use or function of the left thumb from 30 percent (14.4 degrees), as awarded by Determination Order, to 34 percent (16.32 degrees); and (2) awarded 3 percent (.18 degrees) scheduled permanent disability for loss of use or function of the left little finger whereas a Determination Order had awarded no permanent disability. On review, the issue is extent of scheduled permanent disability. We affirm.

## FINDINGS OF FACT

The Board adopts the Referee's "Findings of Fact" through the second full paragraph of page two of the Opinion and Order with the following supplementation.

Claimant suffers disabling pain which results in a loss of use or function of her left thumb.

## CONCLUSIONS OF LAW AND OPINION

We adopt the Referee's opinion subject to the following exception and supplementation.

The Referee awarded a value of 2.5 for loss of opposition of the little finger to the thumb. The insurer argues that, because the standards adjust the rating in steps of 5 percent, and because the rating should be decreased as it gets closer to the end of the thumb, claimant should not be entitled to any rating for loss of opposition of the little finger to the thumb due to the close proximity of the amputation to the tip of the thumb. We disagree. Former OAR 436-35-040(2) requires that, for amputations which are not exactly at the joints, adjustments to the maximum value for loss of opposition must be made in 5 percent steps. The maximum value for loss of opposition of the little finger is 5 percent. Although claimant's amputation was not exactly at the interphalangeal joint of the thumb, she lost one-half or more of the opposition function of the distal phalange of her left thumb to her little finger. Thus, the nearest 5 percent interval for loss of opposition with the little finger is 5 percent rather than 0.

The Referee awarded claimant an additional 5 percent impairment value for "increased fatigability and consequent cramping and swelling associated with repetitive or continued use of the thumb." The insurer argues that the applicable "standards" do not support an award for limitations on repetitive use. We agree. Former OAR 436-35-001 et seq did not allow an award for loss of repetitive use, as do the current rules. Nevertheless, claimant experiences constant cramping and swelling of the thumb due to ordinary use. We conclude that a 5 percent award for disabling pain and the resultant loss of use or function of the thumb due to cramping and swelling is appropriate. See Daniel M. Alire, 41 Van Natta 752 (1989). We agree with the Referee that any additional award for disabling pain is unwarranted.

### Computation of Scheduled Disability

Having determined the values necessary to compute claimant's left thumb permanent disability under the standards, we proceed to that calculation. For multiple losses in the thumb, each loss is rated separately, then the ratings are combined to find total impairment of the thumb. Former OAR 436-35-050(6).

The following values are given for loss of opposition of the fingers to the thumb:

| | |
|---|---|
| Index finger | 10% |
| Middle finger | 10% |
| Ring finger | 5% |
| Little finger | 5% |

When these values are combined we arrive at 26.9 (rounded to the nearest one-tenth).

For amputation of 1/2 the distal phalanx of the thumb, a value of 30 is given. Former OAR 436-35-030(5). Combining that with the opposition figure the total is 48.8.

An additional 5 percent was awarded for loss of use or function of the thumb due to disabling pain. Combining that with the previous figure we arrive at 51.4. That figure is rounded up to the next whole number, 52. Claimant's scheduled permanent disability under the standards is 52 percent of the left thumb. Because claimant did not request an increase in her permanent disability award, we affirm the Referee.

ORDER

The Referee's order dated March 3, 1989 is affirmed. For services on review, claimant's attorney is awarded a reasonable assessed fee, payable by the insurer, of $675.

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In the Matter of the Compensation of
**WILLIAM R. WRIGHT, Claimant**
WCB Case No. 88-13372
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Roy Miller (Saif), Defense Attorney

Reviewed by Board Members Nichols and Crider.

Claimant requests review of Referee Peterson's order which: (1) declined to grant claimant an award of permanent and total disability; and (2) reduced claimant's unscheduled permanent disability for injury to the right shoulder, ribs and low back from 36 percent (115.2 degrees), as awarded by a Determination Order, to 26 percent (83.2 degrees). On review, the issues are extent of permanent disability, including permanent total disability. We reverse in part and modify in part.

FINDINGS OF FACT

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

Claimant received his diploma from a four-year vocational high school.

Claimant has documented training as an automotive mechanic from Ford Motor Company and Chrysler Corporation.

Claimant was medically stationary March 21, 1988. He can lift up to 10 pounds frequently and up to 50 pounds occasionally.

Claimant is unable to return to his usual and customary work as an automotive mechanic. As of the date of the hearing, claimant had not returned to or been offered regular or modified work.

Claimant sustained a lumbar transverse process fracture and grade III shoulder separation when he was compensably injured.

Claimant suffers from disabling pain which restricts his ability to use his right shoulder and to stand and walk. Claimant is unable to use his dominant right arm to perform overhead work or repetitive pushing and pulling. He cannot stand or walk over 15 minutes without sitting to alleviate the pain.

Claimant is capable of performing entry-level jobs within his residual physical capacity without retraining.

FINDINGS OF ULTIMATE FACT

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

Claimant has sustained a 30 percent permanent loss of earning capacity as a result of his compensable right shoulder and low back injuries.

CONCLUSIONS OF LAW AND OPINION

Propriety of Dismissal

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

Permanent Total Disability

We affirm and adopt the Referee's "Conclusions of Law and Opinion" regarding claimant's entitlement to Permanent Total Disability.

Permanent Partial Disability

The Referee reduced the Determination Order award of 36 percent unscheduled permanent partial disability. On review, claimant asserts that he is entitled to an award in excess of that allowed by Determination Order. We agree with the Referee that the Determination Order award should be reduced. However, we calculate a higher award than did the Referee.

To establish the extent of claimant's permanent partial disability, the Referee properly applied the standards for the evaluation of disabilities adopted by the Director pursuant to ORS 656.726(3)(f)(A). Those are the standards we apply as well. Specifically, former OAR 436-35-270 through 436-35-440, the "standards" in effect at the time of the July 13, 1988 Determination Order, apply to the rating of unscheduled permanent partial disabilities. Former OAR 436-35-270(1).

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

Age

The parties do not dispute that the appropriate value for claimant's age of 42 years is 1. Former OAR 436-35-290(4).

Formal Education

Claimant graduated and received a diploma from a vocational high school at which he took a 4 year cooperative work/study industrial course in automotive mechanics. In addition to his mechanical training, claimant also attended regular courses such as Mathematics and English. Claimant asserts that because he

attended a vocational high school, he is not a high school graduate for the purposes of former OAR 436-35-300(3). We reject claimant's argument that his vocational high school diploma is not a high school education for purposes of the standards. Therefore, the appropriate value for claimant's 12 years of formal education is 0. Id.

Skills

Former OAR 436-35-300(4) adopts by reference the "SVP" (specific vocational preparation time) values assigned to various occupations by the Dictionary of Occupational Titles (DOT), published by the U.S. Department of Labor. The highest SVP level demonstrated by a claimant during the ten years prior to the date of injury is used to determine a value for skills. Former OAR 436-35-300(4). Claimant's highest SVP during the ten years prior to the date of injury was 7 as an automotive mechanic (DOT # 620.261-010). Therefore, the appropriate value for skills is 1. Id.

Training

Claimant worked for one year after completing his high school automotive training program to become a certified mechanic. Additionally, claimant has documented training as an automotive mechanic with Ford Motor Company and Chrysler Corporation for which he has received certificates of training. Therefore, the SAIF Corporation contends, claimant is entitled to no value for this disability factor. We agree. The appropriate value for claimant's documented training is 0. Former OAR 436-35-300(5).

Claimant's total education value is 1, the formal education value plus the skills value plus the value for training. Former OAR 436-35-300(5)(sic).

Adaptability

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

Claimant is unable to return to his usual and customary work as an automotive mechanic and has not returned to, or been offered, regular or modified work since he became medically stationary March 21, 1988. Claimant alleges that he now is limited to performing work that only requires him to lift weights in the sedentary category.

A physical capacities evaluation by the Salem Hospital Industrial Medicine Department on March 21, 1988, indicates that claimant retains the ability to lift up to 10 pounds frequently and up to 50 pounds occasionally. An independent medical examination on August 5, 1988 by Drs. Kauffman and Gancher, orthopedic surgeon and neurologist respectively, indicates that claimant can perform light duty work. Dr. Blake, claimant's treating orthopedic physician, concurred.

On this record, we find that claimant's physical capacity falls within the light category. Apparently in reliance on the version of OAR 436-35-310 that became effective January 1, 1989, the Referee assigned an adaptability value of 6, reasoning that claimant is limited to light level exertion and is further limited in his ability to stand and walk for longer than 15 minutes. However, the standards effective July 1, 1988, which are applicable to this case, do not provide for averaging the values of categories under former

OAR 436-35-310(4) when a claimant retains a light lifting capacity but is otherwise limited in his ability to walk and stand. Such limitations, if attributable to disabling pain, may be considered under the impairment portion of the disability standards and not by an adjustment to the adaptability value. Thus, claimant is entitled to an adaptability value of 4. Former OAR 436-35-310(4)(c).

Impairment

Back

We adopt the Referee's reasoning and conclusions that claimant is entitled to 5 percent for lost range of back motion and 3 percent for fracture of a lumbar transverse process. These values are combined for a value of 7.85 percent. Former OAR 436-35-360(11).

Shoulder

We adopt the Referee's reasoning and conclusion that claimant retains full range of shoulder motion. Accordingly, other than disabling pain, claimant has no shoulder impairment for which a value may be assigned under the "standards." Former OAR 436-35-330(1) through 436-35-330(14) and OAR 436-35-010(2).

Disabling Pain

The Referee did not assign any value for disabling pain under the standards. On review, claimant asserts that he is entitled to an award for disabling pain based on his demonstrated loss of use of his right shoulder. We agree. Additionally, claimant is entitled to an award for disabling low back pain which restricts his ability to stand or walk for prolonged periods.

Former OAR 436-35-010(2)(a) provides that pain can result in loss of use or function. When it does, it is rated based on the loss of use or function which results and no additional value is allowed for pain alone. The Board in Daniel M. Alire, 41 Van Natta 752 (1989), held that, inasmuch as the standards do not provide for a value range for impairment attributable to disabling pain, the Board on de novo review can consider the evidence and award the claimant a value that adequately compensates him for his loss of use or function attributable to disabling pain.

Here, we find that the preponderance of the evidence demonstrates that claimant has a loss of use or function in his dominant right shoulder attributable to disabling pain. The March 21, 1988 Industrial Medicine evaluation reveals that pain from claimant's grade III acromioclavicular shoulder separation interferes with his ability to use his right shoulder to perform overhead work or for activities requiring repetitive pushing and pulling.

Furthermore, the record establishes that claimant sustained a fracture of a lumbar transverse process and now experiences back pain. Claimant credibly testified that he has low back pain that prevents him from walking or standing for more than 15 minutes without sitting for 45 minutes to relieve the pain. Claimant's perception of his disability is substantiated by the Industrial Medicine evaluation and by independent medical examiners Drs. Kauffman and Gancher. We are persuaded that claimant can no longer walk or stand in excess of 15 minutes at a time without significant pain. This further restricts claimant's ability to perform work-related activities.

We consider a value of 5 percent for loss of use or function of the right shoulder and 10 percent for inability to walk and stand for more than 15 minutes to be reasonable in this particular case, for a combined award of 14.5 percent

for disabling pain. When the total value for loss of low back range of motion and fracture of a transverse lumbar process (7.85 percent) and the value for disabling shoulder and low back pain (14.5 percent) are combined, the result is 21.21 total impairment value. Former OAR 436-35-360(11); and former OAR 436-35-320(2).

Computation of Unscheduled Disability

Having determined each value necessary to compute claimant's permanent disability under the "standards," we proceed to that calculation. When claimant's age value 1 is added to his education value 1, the sum is 2. Former OAR 436-35-280(4). When that value is multiplied by claimant's adaptability value 4, the product is 8. Former OAR 436-35-280(6). When that value is added to claimant's impairment value 21.21, the result is 29.21 percent. Former OAR 436-35-280(7). That disability figure is rounded to the next higher whole percentage. Id. Claimant's unscheduled permanent partial disability under the "standards" is, therefore, 30 percent.

ORDER

The Referee's order dated May 8, 1989 is affirmed in part, reversed in part and modified in part. Claimant's hearing request is reinstated. In lieu of the Determination Order award of 36 percent (115.2 degrees), and in addition to the Referee's award of 26 percent (83.2 degrees), claimant is awarded 4 percent (12.8 degrees), for a total award of 30 percent (96 degrees) unscheduled permanent disability for his right shoulder and low back injuries. The remainder of the order is affirmed.

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August 22, 1990 Cite as 42 Van Natta 1820 (1990)

In the Matter of the Compensation of
**MICHAEL W. DAVISON, Claimant**
WCB Case No. 88-15952
ORDER ON REVIEW
Ackerman, et al., Claimant Attorneys
Kenneth P. Russell (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

Claimant requests review of Referee Mirassou's order which awarded 20 percent (64 degrees) unscheduled permanent disability for a low back injury, whereas a Determination Order had awarded no permanent disability. On review, the issue is extent of unscheduled permanent disability. We modify.

FINDINGS OF FACT

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

The record contains no evidence of impairment resulting from loss of range of motion after claimant became medically stationary.

Claimant suffers from disabling pain which results in a loss of use or function of his low back.

Claimant did not remain at the job of autobody repairer for the length of time (over two years) necessary to meet the specific vocational preparation (SVP) time required for that job.

CONCLUSIONS OF LAW AND OPINION

In determining the extent of claimant's permanent disability, the Referee did not apply the standards for evaluating permanent disability as adopted by the Director, pursuant to ORS 656.726(3)(f). See ORS 656.283(7). The Referee did not apply the standards because she found the record lacked medical confirmation of identifiable reductions in range of motion after claimant became medically stationary. We agree with the Referee's reasoning in that respect. However, because we find impairment due to disabling pain, we proceed to rate claimant under the applicable standards. Specifically, we apply former OAR 436-35-001 et seq, as amended by temporary rules effective August 19, 1988, which were the rules in effect at the time of the August 23, 1988 Determination Order. OAR 438-10-010.

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

Age

The appropriate value for claimant's age of 36 years is 0. Former OAR 436-35-290(3).

Formal education

The appropriate value for claimant's 11-1/2 years of formal education is 1. Former OAR 436-35-300(3)(b).

Skills

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

The employer argues that claimant's highest SVP is 7 because claimant operated an automotive body shop. However, because we find that claimant did not remain at that job the length of time necessary to meet the specific vocational preparation time required for that job, he did not successfully perform that job. See former OAR 436-35-300(4). Accordingly, we do not use 7 as claimant's highest SVP.

Training

Claimant has no documented training. Therefore, the appropriate value for training is 1. Former OAR 436-35-300(5). Claimant's total education value is 5, the formal education value plus the skills value plus the value for training. Former OAR 436-35-300(6).

Adaptability

When, as a result of the compensable injury, claimant is not working and no employment has been offered, claimant's adaptability value is determined by his residual physical capacity, without regard to his physical capacity prior to the injury. See former OAR 436-35-310(4). We conclude that, because claimant can lift 10 pounds frequently and 20 pounds occasionally, he is able to perform jobs in the light category. Therefore, the appropriate adaptability value is 4.

Impairment

We are unable to rate claimant's loss of range of motion because, as the Referee also concluded, the record does not contain medical confirmation of loss of range of motion after claimant became medically stationary, and there is no evidence that claimant's condition did not change between the time of the medical reports that are in the record and the time he became medically stationary.

However, because claimant is precluded from engaging in work that involves repetitious and continued bending, twisting, stooping and heavy lifting, and because he suffers from constant back pain radiating to his legs, we conclude that he experiences 10 percent disabling pain which results in a loss of use or function of his low back.

Computation of unscheduled disability

Having determined each value necessary to compute claimant's permanent disability under the "standards," we proceed to that calculation. When claimant's age value, 0, is added to his education value, 5, the sum is 5. When that value is multiplied by claimant's adaptability value, 4, the product is 20. When that value is added to claimant's impairment value of 10, the result is 30 percent unscheduled permanent partial disability. Former OAR 436-35-280(7).

Claimant argues that, because he testified that none of his previous occupations required longer than 30 days for him to learn, he has proved by clear and convincing evidence that going outside the standards is appropriate in determining a value of 4 for "Skills." We disagree. We review the record as a whole for clear and convincing evidence that claimant's unscheduled permanent partial disability is greater or lesser than provided for by the "standards." Former ORS 656.283(7). We do not review for clear and convincing evidence of any particular finding necessary for application of the "standards." Leland M. Polock, 42 Van Natta 925 (1990). Thus, the issue of whether one element of the "standards" has been shown to inadequately value claimant's "skills" is only one consideration in our review of the entire record for clear and convincing evidence that claimant's loss of earning capacity is more or less than computed under the "standards." In this case, we do not find clear and convincing evidence that claimant's loss of earning capacity is greater or less than 30 percent.

We would also note that the rating standards have incorporated portions of the Dictionary of Occupational Titles (DOT). The DOT controls the SVP to be assigned, based upon jobs the worker has successfully performed. We are required by the "standards" [former OAR 436-35-300(4)] to utilize the SVP value assigned by the DOT. Arthur A. Harding, 42 Van Natta 933 (1990). Accordingly, in applying the "standards" we found that claimant is entitled to a value of 3 for "Skills", based on his employment as a log truck driver.

ORDER

The Referee's order dated January 9, 1989 is modified. In addition to the Referee's award of 20 percent (64 degrees) unscheduled permanent disability, claimant is awarded 10 percent (32 degrees), giving him a total award to date of 30 percent (96 degrees) unscheduled permanent disability. Claimant's attorney is awarded 20 percent of the increased compensation created by this order, payable directly to claimant's attorney by the SAIF Corporation. However, the total attorney fees awarded by the Referee and Board order shall not exceed $3,800.

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August 22, 1990 Cite as 42 Van Natta 1823 (1990)

In the Matter of the Compensation of
**LOUIS J. GREEN, Claimant**
WCB Case No. 90-00505
SECOND ORDER OF DISMISSAL
Rex Q. Smith, Claimant Attorney
Cooney, et al., Defense Attorneys

Claimant has requested reconsideration of our August 15, 1990 order which dismissed his request for Board review of a Referee's order as untimely. Specifically, he contends that we failed to address his argument that application of the points and authorities relied on in our order would be unconstitutional.

As a general proposition, we decline to address constitutional issues. Ray Lynn York, 35 Van Natta 558 (1983). However, under certain specific circumstances, we are authorized to determine the constitutional application of a statute. See Jane Goodman, 38 Van Natta 1374, 1376 (1986). (Where a prior Supreme Court holding invalidating a gender-based statute was "irrefutably" applicable to a similar gender-based statute in question, the Board applied the Supreme Court holding and found that the statute in question was "clearly unconstitutional.")

Here, the current circumstances do not warrant a departure from the aforementioned general proposition. To begin, there is no case precedent from a higher forum which either invalidated the authorities we relied upon in reaching our decision or pronounced as unconstitutional statutes similar to those applied in our prior order. Furthermore, the points and authorities upon which we based our decision are not "clearly unconstitutional." Consequently, we decline to further address the constitutionality argument posed by claimant's request.

Accordingly, our August 15, 1990 order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our August 15, 1990 order. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

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August 22, 1990 Cite as 42 Van Natta 1823 (1990)

In the Matter of the Compensation of
**CLARENCE HUNT, Claimant**
WCB Case Nos. 89-00440 & 88-18812
ORDER ON REVIEW (REMANDING)
Coughlin, et al., Claimant Attorneys
Cliff, Snarskis, et al., Defense Attorneys
Bonnie Laux (Saif), Defense Attorney

Reviewed by Board Members Nichols and Crider.

Industrial Indemnity requests review of Referee/Arbitrator Quillinan's order that: (1) set aside its denial of responsibility for

claimant's aggravation claim for a back condition; (2) upheld the SAIF Corporation's denial of responsibility for claimant's aggravation claim for the same condition; and (3) awarded claimant's attorney an assessed fee payable by Industrial Indemnity. In his respondent's brief, claimant concedes that he is not entitled to the attorney fee awarded by the Arbitrator's order. The issue is responsibility.

The sole dispute before the Arbitrator concerned the assignment of responsibility either to Industrial Indemnity or to SAIF. The order was issued subsequent to a .307 order that had issued on February 14, 1989 naming Industrial Idemnity as the paying agent. Therefore, ORS 656.307(2), which became effective January 1, 1988, applies in this case.

Under the applicable law, the Board is bound by the findings of the Arbitrator and can only review the record for errors of law. ORS 656.307(2); Timothy R. Schroeder, 41 Van Natta 568 (1989)

When there are two accepted injuries to the same part of the body, there is a rebuttable presumption that the insurer on the risk at the time of the last accepted injury remains responsible. Industrial Indemnity v. Kearns, 70 Or App 583 (1984). That insurer can shift responsibility to the earlier insurer by showing that the earlier accepted injury last contributed independently to the condition which presently gives rise to the claim for compensation; e.g., that its accepted injury caused only symptoms of the condition or involved a different condition affecting the same body part.

The Arbitrator concluded that there was no medical evidence indicating that either the 1975 or the 1982 condition had worsened as a result of the 1988 incident. This is not the rule of law that would be applicable in this case. Nor did the Referee make findings that would allow her to apply the rule for an aggravation of successive accepted claims. For these reasons we cannot review for errors of law.

Should we determine that a case has been improperly, incompletely, or otherwise insufficiently developed, we may remand for further evidence taking, correction or other necessary action. See ORS 656.295(5).

We conclude that this case has been insufficiently developed and that remand is appropriate.

ORDER

The Arbitrator's order dated May 4, 1989 is vacated. This matter is remanded to Arbitrator Quillinan for further action consistent with this order.

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In the Matter of the Compensation of
**DAVID J. LITTLETON, Claimant**
WCB Case No. 88-17631
ORDER ON REVIEW
Welch, Bruun & Green, Claimant Attorneys
Cooney, et al., Defense Attorneys

Reviewed by Board Members Cushing and Gerner.

The insurer requests review of Referee Mills' order that: (1) awarded claimant 10 percent (32 degrees) unscheduled permanent disability for a back injury, whereas a Determination Order awarded no permanent disability; and (2)

declined to allow the insurer an offset for a $735.70 overpayment. On review, the issues are extent of unscheduled permanent disability and offset. We affirm in part and reverse in part.

FINDINGS OF FACT

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

Claimant has no documented evidence demonstrating competence in any specific vocational pursuit.

Claimant suffers minimal disabling pain resulting from his compensable injury.

CONCLUSIONS OF LAW AND OPINION

The Referee awarded claimant 10 percent unscheduled permanent disability. In making this determination, the Referee found that claimant was entitled to 5 percent disability under an application of the standards, and 5 percent disability outside the standards, based on clear and convincing evidence. We modify.

Claimant's condition became medically stationary on April 21, 1988. His claim was closed by Determination Order on July 26, 1988. Therefore, the "standards" adopted effective July 1, 1988, (former OAR 436-35-001 et seq), apply to the rating of claimant's permanent partial disability. Former OAR 436-35-270 through 436-35-440 apply to the rating of unscheduled permanent partial disabilities. Former OAR 436-35-270.

The parties do not contest the values assigned for claimant's age (0), formal education (0), skills (3), or adaptability (1). See former OAR 436-35-290(3), 436-35-300(3), (4) and OAR 436-35-310(3)(a). Therefore, we do not disturb these findings.

The parties do, however, disagree with respect to the values for training and impairment. We turn to these issues.

Training

The insurer contends that claimant adequately testified to such training, and that such training is sufficiently reported in two physician's reports. Claimant, however, contends that he is entitled to a value of 1 for lack of documented training. We agree with claimant.

While claimant was trained as a carpenter, neither party provided "documentation" demonstrating competence in a specific vocational pursuit. "Documentation" as used in former OAR 436-35-300(5) means a certificate, diploma, degree, etc. No such documentation is in the record and none was offered or provided pursuant to the rule. Claimant's training value is, therefore, 1. OAR 436-35-300(5)(a).

Impairment

Loss of range of motion is ratable as impairment under the standards. Former OAR 436-35-360. The insurer contends that claimant is not entitled to an impairment value for loss of thoracolumbar range of motion, based primarily on the opinion of the Western Medical Consultants. Claimant, however, contends he is entitled to a value of 1 for loss of extension in the thoracolumbar region,

relying upon the opinion of the Orthopaedic Consultants. Former OAR 436-35-360(7). We agree with claimant.

Based on the most current medical report, that of the Orthopaedic Consultants (OC), we find that claimant has established that he is entitled to an impairment value of 1 for the loss of extension in the thoracolumbar region.

We also find that claimant suffers minimal disabling pain resulting from his compensable injury.

Pain, which results in loss of use or function, may be considered in determining permanent disability under OAR 436-35-010(2)(a). See Daniel M. Alire, 41 Van Natta 752 (1989). Here, after our de novo review of the lay and medical evidence, and based on claimant's credible testimony that his bending and lifting abilities are restricted because of resulting disabling pain, we find that claimant is entitled to an impairment value of 5 percent for disabling pain.

After combining claimant's disabling pain value (5) with his loss of range of motion value (1), we find that claimant's total impairment is 5.95. See former OAR 436-35-320(1)(a) and 436-35-360(11).

Computation of Unscheduled Disability

Having determined each value necessary to compute claimant's permanent disability under the "standards," we proceed to that calculation. When claimant's age value 0 is added to his education value 4 the sum is 4. When that value is multiplied by claimant's adaptability value 1 the product is 4. When that value is added to claimant's impairment value 5.95, the result is 9.95 percent unscheduled permanent disability. That disability figure is rounded to the next higher whole percentage. Former OAR 436-35-280(7). Claimant's permanent disability under the "standards" is, therefore, 10 percent.

Computation of Unscheduled Disability Outside the Standards

The Referee found by clear and convincing evidence, based on claimant's chronic conditions which limit repetitive bending and heavy lifting, that claimant suffers unscheduled permanent disability outside the standards. The insurer contends that the Referee erred. We agree with the insurer.

Claimant essentially argues, as the Referee found, that subsequent amendments to the disability standards establish by clear and convincing evidence that his award, as granted pursuant to the standards, was inadequate. Specifically, he argues that subsequent amendments to the disability standards provide an impairment value for loss of repetitive motion due to chronic conditions. OAR 436-35-320(4). Claimant contends that the amended statutes constitute clear and convincing evidence that he has not been adequately compensated under the prior standards. We disagree.

We have previously rejected arguments that the current standards are clear and convincing evidence per se that claimant was undercompensated by his award under the prior standards. See e.g. Joseph Anger, 41 Van Natta 827 (1989). Moreover, we find that in the application of the disability standards, former OAR 436-35-270 et seq, which were effective at the time of the April 21, 1988 Determination Order, claimant's physical limitations and specifically those caused by disabling pain, have been adequately considered.

Therefore, we conclude that there is no clear and convincing evidence that claimant suffers unscheduled permanent impairment greater than that awarded under the standards.

Offset

The Referee awarded an offset in the sum of $2,508.18, but declined to award an offset in the sum of $735.70, representing the insurer's previous overpayment.

The insurer contends that the Referee erred in not granting the total overpayment amount of $3,243.88. Claimant, however, contends that issue preclusion prevents the recovery of the $735.70. We agree with the insurer and grant an overpayment of the total amount.

A request for authorization need not be made within the time for seeking review of a Determination Order. See Travis v. Liberty Mutual Ins., 79 Or App 126 (1986).

Here, the first Determination Order, which issued May 23, 1985, did not award permanent partial disability. It awarded only temporary total disability. Claimant requested a hearing on the extent of permanent disability and the employer requested authorization to offset its $735.70 overpayment. By Opinion and Order dated October 9, 1986, the Determination Order was affirmed, but the overpayment issue was deemed moot, as no permanent partial disability against which to offset the overpayment was awarded.

The subsequent Determination Order, dated July 26, 1988, which is now in issue, likewise did not award any permanent disability. Claimant again requested a hearing on the issue of extent of permanent partial disability and the employer again requested authorization to offset its former overpayment of $735.70 and the more recent overpayment of $2,508.18, for a total overpayment of $3,243.88. The Referee refused to grant authority to offset the insurer's earlier $735.70 overpayment, stating that it was outside his jurisdiction because of the earlier Opinion and Order which found the offset issue moot.

We find that the overpayment issue is not precluded by the earlier Opinion and Order. That order did not authorize the overpayment as the issue was moot, i.e., there was no permanent disability award against which the overpayment could be offset.

Because we have found that claimant suffers unscheduled permanent disability resulting from his compensable injury, there is now a permanent disability award against which the insurer may offset its overpayment.

Consequently, we conclude that the Referee did err in not granting the authority to offset the entire amount of the insurer's overpayment. We so grant that authority.

ORDER

The Referee's order dated February 8, 1989 is affirmed in part and reversed in part. That part of the Referee's order that declined to authorize the insurer to offset its $735.70 overpayment is reversed. The insurer is hereby authorized to offset its total overpayment of $3,243.88 against the permanent partial disability awarded by this order and against any future awards of permanent disability. The remainder of the order is affirmed. For services on review concerning the permanent disability issue, claimant's attorney is awarded $400, to be paid by the insurer.

In the Matter of the Compensation of
**RONALD SASSE, Claimant**
WCB Case No. 89-01306
ORDER ON REVIEW
Peter O. Hansen, Claimant Attorney
Stafford J. Hazelett, Defense Attorney

Reviewed by Board Members Gerner and Cushing.

The insurer requests review of Referee Knapp's order that set aside the insurer's denial of claimant's low back and neck injury claim. Specifically, the insurer contends it did not provide the employer with workers' compensation coverage for claimant, a nonsubject worker, on September 4, 1986. On review, the issue is coverage. We reverse.

## FINDINGS OF FACT

With the exception of the Referee's "Ultimate Findings of Fact," the Board adopts the Referee's "Findings of Fact" as supplemented below.

## ULTIMATE FINDINGS OF FACT

Claimant's relationship with his employer was that of an independent contractor.

On the date of injury, September 4, 1986, claimant was a nonsubject worker.

The employer did not give written notice of election to provide workers' compensation coverage for claimant, an otherwise nonsubject worker, to its insurer in September 1986.

## CONCLUSIONS OF LAW AND OPINION

The Referee found that at the time of injury, claimant was an independent contractor, and thus, was a nonsubject worker. On appeal, the parties do not contest this finding. Accordingly, we will not address this issue on review. The Referee further found that the employer had given notice of an election to provide workers' compensation insurance coverage for claimant on the date of injury, September 4, 1986, to the insurer. Inasmuch as the Referee found there had been a proper election of coverage, he concluded claimant was a subject worker and the claim compensable. We disagree.

In order to establish a compensable claim, claimant, as the proponent of the proposition, must prove the existence of an employer-employee relationship. Specifically, claimant must show that the employer gave the insurer written notice of an election to provide workers' compensation coverage to claimant, a nonsubject worker not otherwise entitled. ORS 656.039(1); 656.419(3); Hutcheson v. Weyerhaeuser, 288 OR 51, 56 (1979).

The statute allowing election of coverage of nonsubject workers is ORS 656.039(1). This statute provides:

> "An employer of one or more persons defined as nonsubject workers or not defined as subject workers may elect to make them subject workers. If the employer is or becomes a carrier-insured employer, the election shall be made by filing written notice thereof with the insurer with a copy to the director. The effective date of coverage is governed by ORS 656.419(3)..."

ORS 656.419(3) further provides:

> "Workers' compensation coverage is effective when the application of the subject employer for coverage together with any required fees or premium are received and accepted by an authorized representative of an insurer."

Thus, in accordance with statute, in order to effectuate coverage of a nonsubject worker there are three essential elements which claimant must prove. These elements are as follows: (1) written notice to the insurer of the employer's election to provide coverage for nonsubject workers; (2) copy of this same written notice of election to the Director; and (3) payment and acceptance by the insurer of the required premium.

Written Notice of Election to the Insurer

The statute requires that written notice be provided to the insurer of the employer's election to provide coverage for nonsubject workers. ORS 656.039(1). We interpret the "written notice" to mean actual notice. Actual notice is defined as "such notice as is positively proved to have been given to a party directly and personally, or such as he is presumed to have received personally because the evidence within his knowledge was sufficient to put him upon inquiry." Actual notice can be either express or implied. Black's Law Dictionary, 957 (5th ed. 1979).

Where there is an existing contract of insurance, the employer need not file a separate application as required by ORS 656.039(1) in order to secure coverage of nonsubject workers. Moreover, where there is an existing contract of insurance, the election of coverage of nonsubject workers does not have to be "accepted" by the insurer. The unilateral act of the employer of giving written notice of election of coverage to the insurer is sufficient. Quadel Industries v. Luckman, 95 Or App 612 (1989).

Previously, the employer had contracted with the insurer to provide workers' compensation coverage. The record shows that a new policy year began September 1, 1986. It is during this period of coverage claimant's injury arose on September 4, 1986. Accordingly, we find the employer had an existing contract of coverage, and therefore did not need to file an application in order to effect coverage of nonsubject workers. ORS 656.039(1); Quadel, supra.

In Quadel the Court of Appeals found adequate notice of election in an 801 claim form filed by claimant. The case concerned a nonsubject worker, specifically a corporate officer, who had been fatally injured. The insurer alleged no election of coverage had been made and denied the claim. In affirming the Board's decision that the denial was to be set aside, the court indicated that an 801 signed and filed by the employer for a previous eye injury was adequate written notice of election of coverage. Quadel, supra.

The 801 in question identified claimant as a corporate officer seeking workers' compensation benefits. The 801 was acknowledged and signed by the employer, and was accepted as a compensable claim by the insurer. Subsequent to this action, claimant sustained fatal injuries in a work-related motor vehicle accident. The fatal injury was considered covered and found compensable, because the court found that the employer's signing and filing the 801 form, coupled with the employer's having paid premiums on behalf of the corporate officer, was notice of coverage of a nonsubject worker. Quadel, supra.

This case is distinguishable from Quadel. In Quadel the employer had identified to the insurer that claimant was a corporate officer. As a matter of law, corporate officers are not subject workers. ORS 656.027(9). Therefore, the 801 was prima facie evidence that claimant was a nonsubject worker. The 801 was sent to the insurer who accepted the claim and paid benefits. Furthermore, the insurer accepted premiums based upon coverage of nonsubject workers. Accordingly, in Quadel, the insurer had actual notice of an election of coverage by the employer prior to the claimant's fatal injuries. Quadel, supra.

This is not the case here. As an initial matter, there is no analogous prior 801. Although the record contains an 801 representing an accepted claim by a co-worker similarly situated as claimant, in that he is a nonsubject worker, we note that at the time the 801 was filed and accepted the co-worker was a dock hand, and hence a subject worker.

We therefore consider the employer's payroll reports provided to the insurer, to determine if these reports were sufficient to establish notice of election to the insurer. It appears that the function of the payroll reports was to provide premium estimates to the insurer. This task was accomplished by identifying and considering employee job classifications. The employer's office manager, Ms. Cleeton, testified that claimant was considered an "outside salesman." Apparently, outside salesmen were classified as "code 8742" workers.

There is no question that prior to September 1, 1986 no workers' compensation coverage was provided for nonsubject workers in claimant's job classification. However, in September 1986 the employer was audited by the insurer due to a new policy year taking effect as of September 1, 1986. The record shows that the question of coverage for code 8742 workers was considered, and apparently discussed.

Review of the payroll records suggests that nonsubject workers elected to be covered by the employer were listed by name. Nonetheless, the monthly payroll reports for the time periods of September, October, and November 1986 do not list workers designated as outside salesmen or code 8742 workers. Neither do these payroll reports list claimant by name.

On the other hand, on December 18, 1986, the employer submitted to the insurer a quarterly payroll report which indicated that the premium estimate was being computed using code 8742 workers, otherwise described as "sales contractors" for the time periods September, October, and November 1986. Although the names of individual sales contractors were listed on the payroll report, claimant's name was not.

Cleeton, by affidavit and further in testimony, stated that prior to December 1986 she never intended to include claimant in her premium computation. She further testified that when she finally decided to include claimant in the premium computation it was by way of afterthought. She included claimant's code classification because truck drivers/owners were covered. She testified that she consulted no other member of management in deciding to do so, nor did she notify the insurer. She gave no thought to the question of subjectivity, nor did she intend to alter in any way the employer-employee relationship.

We find, however, that these classifications alternatively described as "outside sales," "sales contractors," and "code 8742" workers were not identified on the payroll records as nonsubject workers. Nor can their subjectivity status be determined as matter of law. See former ORS 656.005(25); 656.027. Regardless of the intentions or actions of Cleeton, the fact remains that none

of these documents indicates and identifies that these categories and classifications represented nonsubject workers. Thus, the insurer was not put on actual notice that the employer was seeking to cover nonsubject workers.

We specifically decline to infer from the employer's December 18, 1986 payroll report, submitted for the purpose of estimating premiums, that the employer made an election of coverage of nonsubject workers in claimant's job classification. Thus, we conclude there has been no written notice of election of coverage as required by statute.

Copy of Written Notice of Election to the Director

In addition to providing the insurer with written notice of election of coverage, it is required that the Director be provided a copy of the written notice of election. ORS 656.039(1). There is no evidence of a copy being provided to the Director.

In Quadel, the court did not directly address this point. However, the court relied on the 801 as evidence of notice being given to the insurer. Quadel, supra. We note that the 801 would have been provided to the Director as a matter of law. ORS 656.262(12).

As previously pointed out, here, we have no analogous 801. Further, even should the payroll records be construed as a notice of election, which we do not, there is no evidence that any copy of the payroll reports were provided to the Director. Accordingly, we conclude the statutory requirement of providing the Director a copy of the notice of election was not complied with.

Acceptance of Premium

The third statutory requirement is the payment and acceptance of the appropriate fees and/or premiums. ORS 656.419(3). In Quadel, the correct amount of premiums were paid and accepted by the insurer. Here, likewise, the correct amount of premium was paid and accepted by the insurer. However, the distinction and crucial point between Quadel and the case here, is that in Quadel the insurer knew, i.e., was on notice per the 801, that the premium was based on nonsubject workers. Whereas here, the insurer was not put on notice that the premium included nonsubject workers.

Conclusion

Accordingly, we find that the employer did not give written notice of election to the insurer in order to effect workers' compensation coverage for claimant in September 1986. Because of our finding above, we do not reach or consider the appropriateness of retroactive application of coverage. Thus, claimant is not a subject worker, and his claim is not compensable.

ORDER

The Referee's order dated May 16, 1989, is reversed. The insurer's denial of claimant's low back and neck injury claim is reinstated and upheld. Claimant's assessed attorney fee of $1,400 is reversed.

In the Matter of the Compensation of
**ROBIN S. MASSE, Claimant**
WCB Case No. 87-00415
ORDER ON REVIEW
Emmons, et al., Claimant Attorneys
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Gerner and Cushing.

Claimant requests review of those portions of Referee Seifert's order which: (1) upheld the self-insured employer's denial of her aggravation claim for a low back injury; and (2) reduced her scheduled permanent disability for loss of use or function of the right leg from 10 percent (15 degrees), as awarded by a previous Determination Order, to zero. On review, the issues are aggravation and scheduled permanent disability. We vacate in part and affirm in part.

FINDINGS OF FACT

Claimant sustained a compensable low back injury in April, 1980. As a result of the compensable injury, she underwent a left L5-S1 laminotomy and discectomy in late 1980. Her claim was closed by a July 1981 Determination Order which awarded temporary disability benefits only. Claimant continued to experience low back, left hip and left leg pain. A second Determination Order issued in May 1982 which awarded her 5 percent unscheduled permanent disability for her low back injury.

Claimant continued with low back and left lower extremity pain and was ultimately hospitalized in February 1983. In April 1983, she underwent a repeat lumbar disc surgery and posterior lumbar interbody fusion. Thereafter, claimant returned to part-time work, however, her low back and left leg symptoms persisted. In October 1984, she underwent further surgery for an unstable fusion. Vocational assistance began in April 1985 with the goal of returning claimant to modified work with her at-injury employer. She also enrolled in computer classes at a community college.

In April 1986, claimant returned to part-time work with the employer. Her low back and leg symptoms persisted, however, relative to the amount of time spent on her feet at work. A December 1986 Determination Order closed claimant's claim with an award of 25 percent unscheduled permanent disability for a total award of 30 percent. The Determination Order also awarded her 10 percent scheduled permanent disability for loss of use or function of the right leg. Claimant appealed this Determination Order, however, the hearing was postponed when claimant entered a vocational training program in September 1987.

Claimant returned to light modified work on April 16, 1987. She continued this position until May 7, 1987 at which time she was released from work due to pain in her right lower extremity. In July 1987, the employer issued an aggravation denial on the basis that claimant's compensable condition had not worsened.

In September 1987, claimant entered into a vocational training program with the goal of being trained as a legal secretary. In June 1988, she completed her vocational training. Following completion of her vocational training, a July 1988 Determination Order closed her claim and increased her unscheduled permanent disability to 32 percent. The Determination Order also reduced her scheduled permanent disability award from 10 percent to zero.

## ULTIMATE FINDINGS OF FACT

The December 26, 1986 Determination Order did not become final by operation of law.

## CONCLUSIONS OF LAW AND OPINION

### Aggravation

The Referee found that claimant had not sustained a worsening of her compensable condition and upheld the self-insured employer's denial. We conclude, however, that the Referee was without jurisdiction to decide the merits of claimant's aggravation claim.

ORS 656.273(4)(c) provides that a claim for aggravation of a disabling injury must be made within five years of the first claim closure. ORS 656.278(1)(a) provides the Board with sole jurisdiction for "aggravation" claims filed after the five year period has expired.

In the instant case, claimant's claim was first closed by a Determination Order dated July 15, 1981. Claimant's aggravation rights therefore expired on July 15, 1986. The alleged aggravation at issue occurred in May 1987. Accordingly, the Referee did not have jurisdiction to consider the merits of claimant's aggravation claim. Rather, the Board has jurisdiction of this matter under its "Own Motion" authority. ORS 656.278(1)(a). We therefore vacate that portion of the Referee's order which upheld the self-insured employer's denial of claimant's aggravation claim.

We note parenthetically that we treat claimant's aggravation claim as a request for "Own Motion" relief and have issued an Own Motion Order this date.

### Reduction of Scheduled Permanent Disability

We adopt the conclusions and reasoning concerning the reduction of claimant's scheduled permanent disability award as set forth in the Referee's order with the following supplementation.

The December 1986 Determination Order which awarded claimant 10 percent scheduled permanent disability for loss of use or function of the right leg was appealed by claimant in January 1987. A hearing was set, but was postponed due to claimant's entrance into a vocational training program. Following claimant's completion of the program, the July 1988 Determination Order issued which reduced claimant's scheduled award to zero. Inasmuch as the December 1986 Determination Order was appealed, it did not become final by operation of law. Further, ORS 656.268(5) grants the Evaluation Division authority to redetermine claimant's permanent disability following completion of a vocational training program.

Accordingly, the Referee correctly found that the Evaluation Division had the authority to reduce claimant's scheduled permanent disability award.

## ORDER

The Referee's order dated February 16, 1989, as reconsidered May 4, 1989, is vacated in part and affirmed in part. That portion which upheld the self-insured employer's denial of claimant's aggravation claim is vacated. The remainder of the order is affirmed.

In the Matter of the Compensation of
**MARIA L. SOLIS, Claimant**
WCB Case No. 88-20344
ORDER ON REVIEW
Burt, et al., Claimant Attorneys
Rick Dawson (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

Claimant requests review of Referee Harri's order which increased her award of unscheduled permanent disability for a back injury from 20 percent (64 degrees), as awarded by Determination Order, to 32 percent (102.4 degrees). The SAIF Corporation cross-requests review of the Referee's order seeking a reduction in claimant's unscheduled permanent disability award. On review the issue is extent of unscheduled permanent disability. We affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

The Board adopts the Referee's "Conclusion and Opinion" with the following comments.

The Referee rated claimant's disability under the standards that were effective as of July 1, 1988. Claimant's condition was medically stationary as of October 5, 1988, and the claim was closed by Determination Order on November 1, 1988. Since claimant's compensable injury was medically stationary after January 1, 1988, and the claim was closed after August 19, 1988, the Board applies the "standards" adopted effective July 1, 1988, as amended by temporary rules effective August 19, 1988. The amendments, however, do not effect claimant's disability rating.

Claimant argues that she is entitled to additional impairment for a psychological condition. This condition, claimant contends, should be classified under former OAR 436-35-400(4)(b)(F), as a psychoneurosis, and be given a value of 10-45 percent. We disagree that claimant is entitled to additional impairment for her psychological condition.

A permanent state of psychoneurosis must be diagnosed by a psychiatrist or psychologist. Former OAR 436-35-400(4). Psychologist, Dr. Pitchford, diagnosed somatoform pain disorder and depression of long-standing duration. Some hysterical personality characteristics were also noted. (Ex. 9). No causal connection was made between this diagnosis and the back injury, other than the resulting financial worries associated with the loss of income due to disability. Claimant's symptoms are described as a situational distress resulting from the raising of children while being unemployed, having "empty nest" syndrome, and financial problems. We conclude that claimant has failed to prove that her current psychological condition was materially caused or worsened by her compensable injury.

Furthermore, even if claimant's psychological reactions were due to her compensable condition, they do not rise to the Class 1 level outlined in former OAR 436-35-400(4)(a), let alone the Class 2 level of subsection (4)(b). Accordingly, claimant is not entitled to additional impairment for a psychological condition.

The SAIF Corporation challenges the authority of the Board to find and rate disabling pain and requests that the Board reconsider its "pain rule," as set forth in Daniel M. Alire, 41 Van Natta 752 (1989). We decline to do so.

Claimant experiences disabling pain which had its onset at the time of injury. (Exs. 7 and 8). She has more than five typical and consistent pain trigger points and significant changes in the level of her pain depending on physical activity, tension, anxiety and stress. (Exs. 7 and 8). She is unable to sit for periods in excess of ten minutes due to severe pain and she has difficulty bending. (Tr. 14, 17). Pain also limits claimant's walking to 1-2 blocks and she is unable to do most household chores without frequent rest breaks. (Tr. 15-17). Because claimant has shown that pain causes loss of use and function in walking, sitting, bending, and lifting, the Referee's +10 impairment rating is appropriate.

Next, SAIF contends that claimant has competence in secretarial work and that the Referee's refusal to consider this training because it occurred over ten years ago is error. We agree with the Referee's +1 rating on the training factor; not because claimant's secretarial training occurred more than ten years ago, but because the training is not "documented" as required by former OAR 436-35-300(5)(a). Neither party has "provided" such documentation. See Jack E. Emerald, 42 Van Natta 1161 (1990).

On de novo review, after considering claimant's impairment as modified by age, education, and adaptability factors, we are persuaded that the Referee's analysis, computation, and increase of unscheduled permanent disability from 20 percent to 32 percent was appropriate.

ORDER

The Referee's order dated March 6, 1989 is affirmed. For services on review, claimant's attorney is awarded an assessed attorney fee of $400, to be paid by the SAIF Corporation.

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In the Matter of the Compensation of
**ADOLPH W. WENDE, Claimant**
WCB Case No. 86-16961
ORDER ON REMAND
Brothers, et al., Claimant Attorneys
Schwabe, et al., Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Schwabe, Williamson & Wyatt v. Workers' Compensation Board, 101 Or App 645 (1990). Relying on Amfac, Inc. v. Garcia-Maciel, 98 Or App 88 (1989), the court reversed our order which retroactively applied then-existing OAR 438-15-027(1)(d) and denied the insurer's counsel's request for authorization of a client-paid fee as untimely. The court further reasoned that it was unclear what impact the Amfac ruling would have had on our additional conclusion that the insurer's counsel's request was also not approvable because it was not accompanied by an executed retainer agreement as required by former OAR 438-15-010(1). Consequently, the court has remanded for reconsideration.

In Amfac, Inc. v. Garcia-Maciel, supra, the court held that the Board's retroactive application of its "statement of services" rule was unreasonable in that it required the insurer's counsel to comply with a rule which did not exist at the time compliance was putatively required. Consistent with the reasoning

expressed in the Amfac holding, we conclude that the retroactive application of former OAR 438-15-010(1) to requests for client-paid fee authorizations would likewise be improper. Accordingly, we hold that the aforementioned rule has no application to these circumstances.

Following our review of the insurer's counsel's statement of services and after considering the factors set forth in former OAR 438-15-010(6) (renumbered 438-15-010(4), July 1, 1990, WCB Admin. Order 7-1990), we approve a client-paid fee, not to exceed $2,064. In reaching this conclusion, we note that, effective July 1, 1990, Referee, Board, or court authorization of attorney fees payable from carriers to their legal counsel is no longer required. Senate Bill 1197, 30, 54(2). Yet, because this issue arose prior to the effective date of the statutory amendments and since this matter has been remanded to us for consideration of a client-paid fee, we have expressly authorized a fee.

IT IS SO ORDERED.

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August 24, 1990 Cite as 42 Van Natta 1836 (1990)

In the Matter of the Compensation of
**RILEY F. BEAN, Claimant**
WCB Case No. 88-17098
ORDER OF ABATEMENT
Malagon & Moore, Claimant Attorneys
Snarskis, Yager, et al., Defense Attorneys

The Board issued an Order on Review in the above-captioned matter on August 10, 1990. In that order, we concluded that clamant had not sustained a compensable aggravation of his low back condition. Claimant now requests that the Board abate its order and remand the matter to the Referee for further development of the record pursuant to ORS 656.295(5).

In order to allow sufficient time to consider the motion, the above noted Board order is abated and withdrawn. The insurer is requested to file a response to the motion within ten days. Thereafter, this matter will be taken under advisement.

IT IS SO ORDERED.

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August 24, 1990 Cite as 42 Van Natta 1836 (1990)

In the Matter of the Compensation of
**CHARLES M. KEPFORD, Claimant**
WCB Case No. 87-02846
ORDER ON REMAND
Malagon, et al., Claimant Attorneys
Acker, et al., Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Weyerhaeuser Company v. Kepford, 100 Or App 410 (1990). The court has held that the employer did not act unreasonably in failing to pay temporary total disability benefits to a retired worker. Consequently, the court has reversed that portion of our order that affirmed a Referee's order which assessed a penalty for the self-insured employer's failure to pay temporary disability benefits. See Charles M. Kepford, 41 Van Natta 573 (1989).

Reasoning that we also assessed a penalty for the employer's failure to characterize claimant's occupational disease claim as disabling and its failure to timely submit the claim to the Evaluation Division for closure, the court has remanded for reconsideration in light of its decision. We proceed with our reconsideration.

## FINDINGS OF FACT

We adopt the findings of fact as recited in our prior order. Charles M. Kepford, supra. We make the following supplementation.

On May 27, 1986, the employer submitted a form 1503 to the Evaluation Division seeking a Determination Order. Rather than referring to claimant's 1981 occupational disease claim, the request for claim closure carried claimant's 1974 claim number. The form also included a letter from the employer's claim representative asserting that claimant was not entitled to temporary total disability because he had retired.

On June 10, 1986, the Board issued its Order on Remand. As instructed by the court, the Board set aside the employer's denial of claimant's occupational disease claim and remanded the claim to the employer "for acceptance, payment of compensation according to law and processing to closure under the provisions of ORS 656.268."

On June 13, 1986, the Evaluation Division issued a form 873. Indicating that further information was required, the employer was directed to: (1) schedule an orthopedic exam; (2) provide a medical report describing claimant's objective findings; and (3) verify claimant's education level.

On July 17, 1986, claimant's counsel requested that the employer comply with the Board's June 10, 1986 order and process claimant's occupational disease claim.

On July 30, 1986, the employer asked Dr. Whitney, orthopedist, to provide the information sought by the Evaluation Division. The employer did not schedule an examination. Rather, it requested that Whitney make such arrangements if he needed to do so.

On August 4, 1986, the employer's attorney responded to claimant's counsel's July 17, 1986 request that the employer process the claim. The employer's attorney provided copies of the employer's form 1503 and its submissions, as well as a copy of the Evaluation Division's form 873.

On August 19, 1986, Dr. Whitney asked the employer for further directions concerning what information it was seeking.

On September 2, 1986, claimant's counsel requested an explanation from the employer's attorney as to why claimant had not been receiving temporary disability benefits. On September 4, 1986, the employer's attorney responded, stating that since claimant had retired and was receiving retirement benefits he was not entitled to temporary disability benefits.

On September 11, 1986, the employer's claim representative requested that Dr. Whitney perform an examination of claimant. Following this exam, Whitney was asked to provide a closure report describing claimant's range of motion findings, residual physical capacity, and other objective findings.

After conducting a September 26, 1986 exam, Dr. Whitney provided a closing report on September 30, 1986. Noting claimant's previous back surgeries, Whitney reported "marked degeneration" in the lumbar spine and "some severe spurring in the thoracic spine with what appears to be some fusion."

On February 20, 1987, claimant's counsel requested a hearing. Contending that the employer had failed to pay temporary total disability and process his claim to closure, claimant sought penalties and attorney fees.

On March 16, 1987, the Evaluation Division advised the employer that its request for claim closure had inaccurately referred to the 1974 injury claim. Noting that the court and Board orders had directed processing of claimant's occupational disease claim, the employer was requested to submit the closure forms under the appropriate claim.

On April 27, 1987, the employer's attorney advised claimant's counsel that the employer had attempted to close claimant's claim as directed by the Board's June 10, 1986 order. Stating that the Evaluation Division would not process the claimant under the 1974 claim number, the employer's attorney stated that steps were being taken to process the claim under a new claim number.

On July 21, 1987, the employer submitted a form 1502 indicating that claimant's 1981 occupational disease claim had been accepted as nondisabling. The employer also enclosed a form 1503, seeking the issuance of a Determination Order. Included with these forms was a letter from the employer's claim representative, asserting that since claimant had retired and was receiving retirement benefits, he was not entitled to temporary disability.

On July 29, 1987, the Evaluation Division asked the employer to promptly submit claimant's "form 801." On August 10, 1987, the Evaluation Division issued another form 873. Noting that the claim had been classified as nondisabling and that claimant had not objected to that classification, the Evaluation Division stated that it would be unable to close the claim until the claim was reclassified and a new request for closure was received.

## CONCLUSIONS OF LAW

If a carrier unreasonably delays or unreasonably refuses to pay compensation, the carrier 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. Former ORS 656.262(10). Failure to promptly process a claim for closure can trigger the sanctions of penalties and attorney fees if the delay is unreasonable. Lester v. Weyerhaeuser Co., 70 Or App 307, 310-12 rev den 298 Or 427 (1984).

After reviewing the course of conduct followed in this claim, we find that the employer unreasonably delayed the payment of compensation by failing to timely process the claim to closure. Our conclusion is based on the following reasoning.

Although the employer attempted to close the claim in apparent anticipation of our June 10, 1986 Order on Remand, it failed to provide sufficient information to the Evaluation Division. When requested to obtain further information, the employer did not respond to its instructions for 6 weeks. Then, after finally seeking additional medical information from Dr. Whitney, claimant's orthopedist, the employer did not initially schedule an examination as it had been expressly directed.

In addition, after Whitney sought further clarification of his instructions, the employer did not respond for another 3 weeks. It was also at this point, September 11, 1986, that the employer finally complied with the Division's June 13, 1986 directive to schedule an examination.

Dr. Whitney eventually issued his closing evaluation on September 30, 1986. Noting claimant's previous back surgeries, Whitney reported "marked degeneration" in the lumbar spine and "some severe spurring in the thoracic spine with what appears to be some fusion."

It is unclear when the employer provided Dr. Whitney's closing report to the Evaluation Division. However, on March 16, 1987, the Division advised the employer that it was unable to process the request for closure because the employer was referring to a 1974 injury claim rather than the occupational disease claim. Consequently, the employer was requested to submit the appropriate claim processing forms under the occupational disease claim.

The Division's request was followed by another unexplained 3 month delay. Eventually, on July 21, 1987, the employer complied with the Division's request and submitted claim processing and closure forms coinciding with claimant's occupational disease claim. However, this information was still insufficient because the file lacked a form 801. Therefore, on July 29, 1987, the employer was requested to provide the missing 801 form.

Finally, on August 10, 1987, the Division reported that it was unable to issue a Determination Order because the employer had classified the claim as nondisabling and there was no request for reclassification. Thus, approximately 14 months after the Board's June 10, 1986 Order on Remand, claimant's occupational disease claim had still not been closed.

In defense of its conduct, the employer refers to the confusion caused by its use of claimant's 1974 injury claim numbers. It accurately notes that these numbers were used by all prior forums during the litigation of its denial of claimant's occupational disease claim.

We acknowledge that this apparent confusion was responsible for some of the delays in claim processing. However, an inaccurate claim number was not responsible for the employer's following delays: (1) 6 weeks to respond to the Evaluation Division's request to obtain further medical information; (2) 3 weeks to reply to Dr. Whitney's request for additional information; (3) 3 months to schedule an examination as instructed by the Division; (4) the apparent 6 month delay between Dr. Whitney's September 30, 1986 closing evaluation report and the Division's March 1987 reply; and (5) 4 months to resubmit the appropriate claim processing forms under the occupational disease claim number to the Evaluation Division.

In conclusion, we consider the aforementioned unexplained delays in processing the claim to closure to have been unreasonable. Consequently, we agree with the Referee's assessment of a penalty and related attorney fee for the employer's unreasonable conduct. See former ORS 656.262(10); Lester v. Weyerhaeuser Co., supra.

Inasmuch as the aforementioned unreasonable delay in closure is sufficient to support the assessment of a penalty and because any penalty for the employer's alleged unreasonable misclassification of the claim would apply to the same period, we do not address the issue of the employer's classification of the claim as nondisabling.

Accordingly, for its unreasonable conduct in failing to timely submit the claim for closure, the employer shall pay claimant 25 percent of the compensation awarded by the Referee's October 1, 1987 order. For services concerning this penalty issue, the Referee's $2,000 penalty-related attorney fee is reinstated, to be paid by the employer.

IT IS SO ORDERED.

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August 24, 1990 Cite as 42 Van Natta 1840 (1990)

In the Matter of the Compensation of
**KATHIE L. MCCORKLE, Claimant**
WCB Case No. 88-22096
ORDER ON REVIEW
Imperati, et al., Claimant Attorneys
Chelsea Mohnike (Saif), Defense Attorney

Reviewed by Board Members Nichols and Crider.

Claimant requests review of Referee Quillinan's order that increased claimant's unscheduled permanent disability award for a shoulder and neck injury from 20 percent (64 degrees) to 22 percent (70.4 degrees), whereas the Determination Order awarded no additional compensation. On review, the issue is extent of unscheduled permanent partial disability. We modify.

FINDINGS OF FACT

We adopt the Referee's findings of fact and make the following additional finding. Claimant is unable to regularly work more than 30 hours per week due to the compensable injury.

FINDINGS OF ULTIMATE FACT

Claimant has sustained a 30 percent loss of earning capacity as a result of her neck and shoulder injury.

CONCLUSIONS OF LAW AND OPINION

On review, claimant contends that she is limited by her injury to a 3-day work week of 7 hours per day, and thus that the standards, which do not consider endurance, inadequately compensate her for her injury. The SAIF Corporation replies that claimant voluntarily reduced her hours of work and that she has not proved by clear and convincing evidence that she cannot work a full work week.

The Referee increased claimant's unscheduled permanent disability award by 2 percent because the parties stipulated to a minimum of 22 percent. She did not consider the issue of claimant's reduced endurance. We do so now on de novo review.

Claimant worked as a medical office manager, bookkeeper and assistant. Occasionally she assisted with lifting patients. She sustained a compensable left shoulder and neck injury which ultimately required a laminectomy at C6-7. Prior to her surgery, claimant stipulated to an award of 20 percent unscheduled permanent disability. Her claim was reopened for a discectomy and fusion at C6-7. Claimant was declared medically stationary on June 28, 1988 and her claim was again closed by Determination Order on August 9, 1988, which awarded no additional permanent partial disability.

Extent of Permanent Partial Disability.

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

For purposes of determining injury-related permanent partial disability, ORS 656.283(7) and 656.295(5) require application of the standards for the evaluation of disabilities adopted by the director pursuant to ORS 656.726(3)(f)(A). Those "standards" in effect on the date of the Determination Order from which the hearing was requested control the evaluation of permanent partial disability. OAR 438-10-010.

In this case, the "standards" adopted effective July 1, 1988, former OAR 436-35-001 et seq, apply to the rating of claimant's permanent partial disability. Former OAR 436-35-270 through 436-35-440 apply to the rating of unscheduled permanent partial disabilities. Former OAR 436-35-270(1).

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

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

Age and Education.

The parties stipulated to a value of 4 for claimant's age and education factors.

Adaptability Where Claimant Has Returned to Modified Work.

An adaptability value for a claimant who is unable to return to his or her usual and customary work but who has returned to modified work is determined from a matrix of values at former OAR 436-35-310(3)(a). That matrix compares the physical capacity of the claimant's usual and customary work with the physical capacity required by the modified work. This is true even though claimant may have the physical capacity to do heavier work than is required by the modified employment. Physical capacities are not defined by the "standards" generally. We utilize those definitions contained in former OAR 436-35-310(4)(a)-(d).

Claimant testified that prior to the injury she lifted 50 pounds every day or every other day. Now she lifts nothing. In this case, claimant's usual and customary work required the physical capacity to do medium work. Claimant's modified work requires a sedentary physical capacity. Therefore, the appropriate adaptability value is 2.5. Former OAR 436-35-310(3)(a).

Impairment.

Claimant had full shoulder range of motion (ROM). Therefore no value is allowed. See former OAR 436-35-320. A laminectomy with a single discectomy is rated at 5 percent. Former OAR 436-35-350(2). A favorable spinal fusion of any two cervical discs is rated at 2 percent. Former OAR 436-35-350(3). Range of motion in the cervical region of the spine (flexion 25 degrees = .5; extension 25 degrees = .5; right rotation 70 degrees = 0; left rotation 40 degrees = 0 degrees; right lateral bending 20 degrees = 1; left lateral bending 15 degrees = 1.5) is added, not combined, for a rating of 3.5 percent. Former OAR 436-35-360(2), (3), (4), (5) and (10). The spinal ratings are combined, not added, to reach a final rating of 10.2. Former OAR 436-35-360(11).

Computation of Unscheduled Disability.

Having determined each value necessary to compute claimant's permanent disability under the "standards," we proceed to that calculation. Claimant's age value and her education value are 4. When that value is multiplied by claimant's adaptability value of 2.5, the product is 10. When that value is added to claimant's impairment value of 10.2 the result is 20.2 percent unscheduled permanent disability. Former OAR 436-35-280(7). That disability figure is rounded to the next higher whole percentage. Id. Claimant's permanent disability under the "standards" is, therefore, 21 percent.

Clear and Convincing Evidence.

Claimant has worked full time for the same employer for eleven years. She continues to work for him, but with modification of her job. Claimant testified without contradiction that she would like to work full time but is unable to do so because her endurance has been reduced as a result of her compensable injury. Claimant's employer has arranged for two hour lunch breaks, so that claimant can rest for the afternoon's work. She works only three days a week, Monday, Wednesday and Thursday, so that she can rest for the following week's work. She has been working from 6 to 10 hours a day, occasionally working longer by taking work home, for an average of about 27 hours a week. She should work no more than 30 hours a week, according to her treating neurosurgeon, Dr. Silver. Claimant has also hired a housekeeper to perform all her household chores, with the exception of cooking. Based on this record, we find that claimant has sustained a loss of endurance as a result of her compensable injury. Considering the residuals of claimant's neck injury, including this loss of endurance, we find by clear and convincing evidence that claimant has suffered a 30 percent loss of earning capacity.

ORDER

The Referee's order dated April 18, 1989, as reconsidered May 5, 1989, is modified. In addition to claimant's prior award of 20 percent (64 degrees) unscheduled permanent disability, as well as the Referee's award of 2 percent (6.4 degrees) unscheduled permanent disability, claimant is awarded 8 percent (25.6 degrees) unscheduled permanent disability, giving her a total award to date of 30 percent (96 degrees) unscheduled permanent disability for her neck and shoulder injury. Claimant's attorney is awarded 25 percent of the increased compensation created by this order, payable directly to claimant's attorney. However, the total attorney fees awarded by the Referee and Board orders shall not exceed $3,800.

In the Matter of the Compensation of
**LOUIS R. ANAYA, Claimant**
WCB Case No. C-00001
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Max Rae, Claimant Attorney

Reviewed by Board Members Howell, Perry and Crider.

On July 19, 1990, the Board acknowledged receipt of the parties' claim disposition agreement in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of $4,000 by Industrial Indemnity Company, claimant fully releases his rights to future workers' compensation benefits, except medical services, for his compensable injury.

Oregon Laws 1990, chapter 2, section 9 amended ORS 656.236 to provide that parties to workers' compensation claims may dispose of any matters regarding a claim, except medical services. Such agreements are subject to the terms and conditions prescribed by the director of the Department of Insurance and Finance. Effective July 1, 1990, the director adopted a temporary rule, OAR 436-60-145, setting forth the terms and conditions for dispositions of claims pursuant to ORS 656.236. Also effective July 1, 1990, the Board adopted temporary rules, OAR 438-09-020, 438-09-023 and 438-09-025, establishing the form and notice requirements for "claim disposition agreements" as well as the manner in which claim disposition agreements are to be processed.

Claim disposition agreements are filed with the Board for approval. ORS 656.236. ORS 656.236 permits the parties to file any disposition of an accepted claim which: 1) does not dispose of the right to medical services; 2) the parties consider reasonable; and 3) comports with the terms and conditions prescribed by the director.

When a claim disposition agreement is submitted to us, we will first determine if it meets our form, notice and filing requirements. We will also review all claim disposition agreements to determine if they satisfy the prerequisites established by ORS 656.236 and OAR 436-60-145 (Temp.). Filing will not be accepted, and acknowledgment will not be issued, if a claim disposition agreement fails to satisfy either our requirements or the requirements of the statute and the director's rule. See OAR 438-09-020(3).

ORS 656.236 provides that once a claim disposition agreement is properly filed with the Board:

"* * *

The disposition shall be approved in a final order unless:

(a) The board finds the proposed disposition is unreasonable as a matter of law;

(b) The board finds the proposed disposition is the result of an intentional misrepresentation of material fact; or

(c) Within 30 days of submitting the disposition for approval, the worker requests the board to disapprove the disposition."

We will apply OAR 438-09-025(2) to calculate time periods for purposes of determining if a worker requests us to disapprove a claim disposition agreement within 30 days of submission.

When determining if a claim disposition agreement resulted from intentional misrepresentation of material fact under ORS 656.236(1)(b), we will utilize the common legal meaning for the term "misrepresentation." Misrepresentation is, an intentional false statement of a substantive fact, or any conduct which leads to a belief of a substantive fact material to proper understanding of the matter in hand, made with intent to deceive or mislead.

ORS 656.236(1)(a) requires the Board to disapprove a claim disposition agreement which it finds to be "unreasonable as a matter of law." "Unreasonable as a matter of law" is not defined by Workers' Compensation Law and we have not found case law defining that term. We are persuaded by what legislative history there is on the subject that "unreasonable as a matter of law" was intended to mean more than that the claim disposition agreement exceeds the bounds of law, although "unreasonable as a matter of law" would encompass such an unlawful agreement. We believe that, just as in the case for a summary judgment or directed verdict in a civil proceeding, a question of fact may be determined "as a matter of law" when a reasonable fact-finder could only answer the question of fact in one way. See e.g. Celorie v. Roberts Brothers, Inc., 202 Or 671 (1954); McCoy v. Union Pacific Railroad Co., 102 Or App 620, 624 (1990). We will utilize such a standard in determining whether a claim disposition agreement must be rejected under ORS 656.236(1)(a). In other words, we will find a claim disposition agreement "unreasonable as a matter of law" if it exceeds the bounds of existing statutes, rules or applicable case law, or if a reasonable fact-finder could only conclude that the agreement was unreasonable as a matter of fact.

In this case the claim disposition agreement met each prerequisite for filing with us. The agreement was acknowledged as submitted on July 19, 1990. Thirty days have passed and the worker has not requested disapproval of the agreement. We do not find that the agreement is unreasonable as a matter of law or the result of an intentional misrepresentation of material fact. Therefore, the agreement is approved. In addition, the attorney fee provided for in the agreement is approved.

IT IS SO ORDERED.

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In the Matter of the Compensation of
**ANTHONY S. AMADO, JR., Claimant**
WCB Case No. CV-90002
ORDER DENYING REQUEST
Thomas E. Ewing, Assistant Attorney General

Applicant has objected to the special hearings officer's July 18, 1990 Findings of Fact, Conclusions and Proposed Order in this Crime Victim Compensation proceeding. We conclude that claimant's objections are untimely and that the proposed order has become a final order of the Board.

Pursuant to ORS 147.115, the decision by the Board in an appeal of a Department decision is final and not subject to further administrative or judicial review. The Board, under its rulemaking authority in ORS 656.726(4) and 147.155(5), has provided that the special hearings officer's proposed order shall be a final order of the Board 30 days after the filing of the proposed order with the Board and mailing to interested parties, unless the proposed order is sooner withdrawn or modified by the Board. OAR 438-82-045. Objections to a proposed order must be in writing and filed with the Board within 20 days from the date of the proposed order to be considered. OAR 438-82-045(6).

Here, the special hearings officer's proposed order was filed with the Board and mailed to the parties on July 18, 1990. That order contained a notice to the parties wherein applicant was advised of his right to object to the order within 20 days from the date of the order. Applicant filed a letter with the Board on August 17, 1990, stating that he objected to the findings contained in the proposed order. We find that applicant failed to file his objection to the proposed order within 20 days from the date of the proposed order. Moreover, the special hearings officer's proposed order was not withdrawn or modified prior to 30 days following filing and mailing of the proposed order. Accordingly, the proposed order has become a final order of the Board.

We note that, upon its own motion or the request of any interested party, within 30 days after a final decision of the Board, the Board may withdraw its decision for reconsideration. OAR 438-82-050. Applicant's letter gave no explanation for his objections to the findings contained in the proposed order. Our review of the proposed order discloses no basis upon which to reach conclusions other than those found in the proposed order. Therefore, even if we were to construe applicant's letter as a request for reconsideration, we would not alter the final order.

Accordingly, applicant's request is denied.

IT IS SO ORDERED.

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In the Matter of the Compensation of
**OLIVER F. COON, Claimant**
WCB Case No. 89-04061
ORDER ON REVIEW (REMANDING)
Peter O. Hansen, Claimant Attorney
Randolph Harris (Saif), Defense Attorney

Reviewed by Board Members Brittingham and Crider.

Claimant requests review of Referee Tenenbaum's order that: (1) excluded certain exhibits offered into evidence by claimant; and (2) upheld the SAIF Corporation's denial of his vestibular complaints. On review, the issues are evidence and compensability. We reverse on the evidence issue and remand.

## FINDINGS OF FACT

At the May 16, 1989 hearing, claimant submitted two exhibits in addition to those he submitted prior to hearing. The exhibits submitted at hearing were reports by Dr. Grimm and Dr. Hemenway, marked as Exhibits 47 and 49, respectively. Both reports were authored on May 15, 1989. They were received by claimant on May 16, 1989, and were not disclosed to SAIF prior to hearing.

The Referee rejected Exhibits 47 and 49 as untimely.

## FINDINGS OF ULTIMATE FACT

Claimant disclosed the reports of Drs. Grimm and Hemenway within seven days of receipt.

## CONCLUSIONS OF LAW AND OPINION

Claimant 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(2) requires claimant to submit his exhibits 10 days before the 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 7 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 or allow post-hearing cross-examination and/or rebuttal. The Referee may not simply exclude the report.

Drs. Grimm and Hemenway's reports were timely disclosed and should have been admitted. Therefore, this case has been improperly, incompletely or otherwise insufficiently developed. ORS 656.295(5). Accordingly, we remand to the Referee. On remand, Exhibits 47 and 49 shall be admitted. In addition, the Referee shall allow SAIF the opportunity to cross-examine or rebut the late-produced evidence.

ORDER

The Referee's order dated June 12, 1989 is vacated and the case is remanded to the Referee for further proceedings consistent with this order.

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In the Matter of the Compensation of
**KENNETH HOLLOWAY, Claimant**
Own Motion No. 90-0116M
OWN MOTION ORDER ON RECONSIDERATION
Malagon, et al., Claimant Attorneys
Saif Legal Department, Defense Attorney

Claimant requests reconsideration of the Board's Own Motion Order on Reconsideration issued April 23, 1990, that declined to assess the SAIF Corporation with a penalty and attorney fee for its processing of his request for own motion relief. Claimant again contends that SAIF failed to properly process his own motion claim.

In our April 23, 1990 order, we found that SAIF timely processed claimant's own motion request for temporary disability benefits. We adhere to that finding here. Claimant's attorney has submitted an attorney retainer agreement and, therefore, is entitled to an approved fee payable out of claimant's increased compensation. Claimant's attorney is awarded 25 percent of the additional compensation granted by our April 4, 1990 order, not to exceed $400, as a reasonable attorney's fee.

Our order dated April 4, 1990, as reconsidered April 23, 1990, is abated and withdrawn. On reconsideration, as supplemented herein, we adhere to and republish those prior orders in their entirety. The parties' rights of reconsideration and appeal shall run from the date of this order.

IT IS SO ORDERED.

**Board Member Crider, dissenting:**

The SAIF Corporation unreasonably resisted payment of compensation; therefore, claimant's attorney is entitled to an attorney fee, payable by SAIF, for efforts to get that compensation.

Board rules require insurers to submit own motion claims to the Board with a recommendation within 60 days of receipt. OAR 438-12-025(2). Claims subject to the rule include "any written request for additional compensation for worsened conditions resulting from the original injury, signed by or on behalf of a claimant . . ." OAR 438-12-020. In this regard, the rules parallel the statutory rules governing submission of a claim for aggravation under ORS 656.273. Thus, anything that would serve as an aggravation claim, if submitted within the five-year aggravation period, must be submitted to the Board pursuant to OAR 438-12-025(2) if it is filed with an insurer after the five-year aggravation period.

On October 12, 1989, SAIF had notice that claimant had been hospitalized for an L4-5 fusion. The reports submitted by Dr. Kendrick, M.D., indicated that the need for surgery was related to a prior L4-S1 fusion performed in 1974 due to the compensable injury. It was obvious from these reports that claimant was working for a logging company at the time of hospital admission and therefore would be entitled to temporary total disability compensation upon hospitalization for surgery. See report of Dr. Kendrick dated September 7, 1989.

Such a report would clearly require processing as an aggravation claim. See Haret v. SAIF, 72 Or App 668 (1985). It was in writing and it put SAIF on notice that claimant would be off work due to the compensable injury. Nevertheless, SAIF did not submit the claim to the Board until March 29, 1990, more than a month after claimant's attorney specifically requested payment of time loss.

Claimant's compensation was delayed by several months by SAIF's failure to process. A fee should be awarded under ORS 656.382(1). Because the Board fails to treat the doctor's report as a claim, I dissent.

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August 28, 1990 Cite as 42 Van Natta 1847 (1990)

In the Matter of the Compensation of
**HENRY L. SZWEBLIK, Claimant**
WCB Case No. 89-02552
ORDER ON REVIEW
Charles S. Robinowitz, Claimant Attorney
Norman Cole (Saif), Defense Attorney

Reviewed by Board Members Brittingham and Crider.

The SAIF Corporation requests review of those portions of Referee Thye's order that: (1) assessed a penalty based on the amount of compensation awarded by Determination Order; and (2) assessed an attorney fee for unreasonable resistance to compensation. Claimant cross-requests review of that portion of the order that increased claimant's scheduled permanent disability award for a binaural hearing loss from 20.53 percent (39.42 degrees), as awarded by Determination Order, to 20.91 percent (40.2 degrees). On review, the issues are extent of permanent disability, penalties and attorney fees. We affirm.

## FINDINGS OF FACT

We adopt the Referee's "Findings."

FINDINGS OF ULTIMATE FACT

We adopt the Referee's "Ultimate Findings" and make the following additional findings of ultimate fact.

SAIF's unreasonable failure to accept or deny the claim within 60 days of the employer's notice of claimant's work-related hearing loss delayed submission of the claim for disability rating and delayed claimant's receipt of permanent partial disability compensation.

SAIF unreasonably resisted payment of compensation.

CONCLUSIONS OF LAW AND OPINION

Permanent Disability

Claimant's compensable condition was medically stationary after January 1, 1988, and his claim was closed and his condition evaluated on October 17, 1988, after July 1, 1988. Therefore, the Referee and the Board must rate claimant's permanent partial disability pursuant to ORS 656.283(7) and 656.295(5), respectively. OAR 438-10-005 and Michelle Griffith, 40 Van Natta 2086 (1988).

For purposes of determining injury-related permanent partial disability, ORS 656.283(7) and 656.295(5) require application of the standards for the evaluation of disabilities adopted by the director pursuant to ORS 656.726(3)(f)(A). Those "standards" in effect on the date of the Determination Order from which the hearing was requested control the evaluation of permanent partial disability. OAR 438-10-010.

In this case, because the claim was closed on October 17, 1988, the "standards" adopted effective July 1, 1988, (former OAR 436-35-001 et seq), as amended by temporary rules effective August 19, 1988, apply to the rating of claimant's permanent partial disability. Former OAR 436-35-010 through 436-35-260 apply to the rating of scheduled permanent partial disabilities. Former OAR 436-35-010(1). Former OAR 436-35-250 governs the rating of permanent hearing loss.

The parties agree that the Referee correctly applied the rule for rating hearing loss; and we adopt that portion of his Conclusions and Opinion which discusses application of the rule (the first five paragraphs of the Conclusions and Opinion).

Nevertheless, claimant contends that the Referee erred in rating claimant's hearing loss because he applied OAR 436-35-250 which provides for reduction of the measured hearing loss by a factor, "presbycusis," representing the average hearing loss in specific frequencies that a person of his age would suffer due to age. He contends that there is no evidence that he suffered from hearing loss due to presbycusis and thus that application of the rule denies him full compensation for his compensable hearing loss. Claimant urges the Board to declare the rule illegal and to rate his disability without the presbycusis reduction. We decline to do so.

Although the Board is required to apply the administrative rule in its rating of permanent disability, either party may establish that the record, as a whole, constitutes clear and convincing evidence that the degree of permanent partial disability suffered by the claimant is more or less than the entitlement indicated by the "standards". ORS 656.283(7) and 656.295(5). If we were to conclude that it is highly probable that claimant's compensable hearing loss is

greater than that indicated by application of the rule, then, rather than "declaring the rule illegal," we would increase his award pursuant to our authority under ORS 656.295(5).

We are not persuaded on this record that claimant suffers greater disability than that calculated under the rule. First, although claimant correctly notes that no physician has opined that a portion of the claimant's high frequency hearing loss is due to age rather than to noise exposure, no physician or audiometric expert has opined that he has not suffered the hearing loss that is ordinarily suffered with age. Each of the physicians has reported calculations of hearing loss which take into account the presbycusis factor; neither has objected to application of the presbycusis reduction in this case. Therefore, claimant has failed to establish that the assumption made by the rule should not be applied to him.

Consequently, we decline to increase claimant's award beyond that awarded by the Referee.

The Penalty

The Referee found that the insurer had unreasonably failed to accept claimant's claim within 60 days of notice of the claim and assessed a penalty of 25 percent of the permanent disability award. SAIF does not challenge the finding that its conduct was unreasonable. However, SAIF contends that the Referee had no authority to assess a penalty because there were no amounts then due at the time of the infraction. We disagree.

The Board has recently reiterated its understanding that a penalty may be assessed against a permanent disability award when the insurer's conduct delays the rating of permanent disability. Virgil E. Moon, 42 Van Natta 1003 (1990). In Moon, the Board found that the insurer unreasonably delayed submission of a claim for closure thereby delaying payment of claimant's permanent disability award. The Board held that for purposes of ORS 656.262(10), the permanent disability award was due at the time that the claim was ready for closure but not submitted. In reliance on Brenda Hinkle, 40 Van Natta 1655 (1990), and Harold Lester, 37 Van Natta 745 (1985), the Board assessed a penalty based on the permanent disability that would be awarded upon claim closure.

Nevertheless, a delay in accepting or denying a claim, unlike delay in submission for closure, is not ordinarily tantamount to delay in payment of a permanent disability award. Thus, in Ozetta L. Domitrovich, 37 Van Natta 1553 (1987), we reversed a referee's order which assessed a penalty for delay in accepting a claim based on the amount of her permanent disability award. Ordinarily, as in Domitrovich, a delay in accepting or denying a claim would not justify a penalty so measured. However, in hearing loss cases, there is generally no period of medical instability. The claim is ready for submission for disability rating as soon as it is accepted. That was the case here as well. Therefore, the failure to timely process the claim also delayed submission for closure. Claimant's permanent disability was therefore "then due" at the time of the violation. The penalty award is affirmed.

Attorney Fees

The Referee also awarded a penalty-associated attorney fee for untimely processing of the claim. SAIF contends that inasmuch as there were no amounts then due against which a penalty could be assessed, no attorney fee may be awarded. We have affirmed the penalty; consequently, the underpinning of SAIF's argument is removed. In any event, the Supreme Court has clearly held that we may award an attorney fee for resistance to the payment of compensation,

under ORS 656.382(1), even when there are no amounts then due against which to assess a penalty. See Ellis v. McCall Insulation, 308 Or 74, 78 (1989). In this case, claimant's claim was compensable; SAIF's delay in processing it, therefore, amounted to a resistance to the payment of compensation. The Referee correctly awarded a fee.

ORDER

The Referee's order dated June 5, 1989 is affirmed.

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In the Matter of the Compensation of
**HELEN M. CHASE, Claimant**
WCB Case No. 87-03857
ORDER ON REVIEW
Merrill Schneider, Claimant Attorney
Mark Bronstein (Saif), Defense Attorney

Reviewed by Board Members Nichols and Crider.

Claimant requests review of those portions of Referee Smith's order that: (1) affirmed a Determination Order that awarded 15 percent (48 degrees) unscheduled permanent disability for a low back injury; (2) found that chiropractic treatments in excess of those allowed under the Oregon Administrative Rule Guidelines were not reasonable and necessary; and (3) declined to assess penalties and attorney fees against the SAIF Corporation for failing to timely deny or pay for these chiropractic treatments, for failing to timely pay certain other medical bills, and for failing to pay certain temporary disability payments timely. On review, we affirm in part and reverse in part.

ISSUES

1. Has claimant sustained a greater loss of earning capacity than the 15 percent granted in the Determination Order?

2. Has claimant established either a procedural or a substantive right to chiropractic treatment in excess of the Oregon Administrative Rule Guidelines?

3. Is claimant entitled to penalties and attorney fees for: SAIF's failure to either issue a proper denial of chiropractic treatments in excess of the guidelines or pay for the treatments timely; SAIF's failure to timely pay other medical billings, and SAIF's failure to pay time loss benefits timely?

FINDINGS OF FACT

The Board adopts the Referee's findings of fact with the following supplementation and correction.

At the time of hearing, claimant was treating with Dr. Bolera approximately two times per week. On July 8, 1987, SAIF sent a letter to Dr. Bolera requesting justification for treatment in excess of the two per month allowed under the guidelines. The Referee found there was no evidence that Dr. Bolera submitted a justification for treatment. We, instead, find that Dr. Bolera responded to SAIF by a letter dated August 4, 1987. SAIF issued no response to Dr. Bolera's letter.

SAIF received bills from Dr. Bolera for treatments within the guidelines on the dates listed on Exhibit 56. Payment for those bills was made more than 60 days after receipt.

Exhibit 53 is a printout of temporary total disability payments from SAIF to claimant for the period January 28, 1985 to February 10, 1985, and of dates those amounts were actually paid. The inclusive dates for payment did not include the last day listed for each period.

## FINDINGS OF ULTIMATE FACT

Claimant has suffered a 15 percent loss of earning capacity due to the compensable injury.

Chiropractic treatment in excess of two per month is not reasonable and necessary.

SAIF acted unreasonably in failing to process claimant's medical services claim, and by failing to pay certain medical bills timely.

SAIF acted unreasonably by failing to pay claimant's temporary total disability within the time required by ORS 656.262(4) and OAR 436-60-150(4).

## CONCLUSIONS OF LAW AND OPINION

### Extent of Permanent Partial Disability

The Board affirms and adopts the Referee's conclusions and opinion with regard to the extent of unscheduled permanent partial disability.

### Entitlement to Chiropractic Treatment in Excess of Two Treatments per Month

The Referee concluded that claimant had failed to establish a medical need for more than two treatments a month. Consequently, he upheld SAIF's denial of treatment in excess of the guidelines established by former OAR 436-10-040(2)(a). He rejected claimant's contention that SAIF is required to pay for all treatments because SAIF had failed to respond to Dr. Bolera's narrative report justifying treatment in excess of the guidelines. He rejected the procedural argument because he found that Dr. Bolera did not submit the report required by former OAR 436-10-040(2)(a). On review, claimant argues that SAIF did receive a letter justifying treatment from Dr. Bolera, so that she is procedurally entitled to chiropractic treatments in excess of the guidelines because SAIF did not issue a denial for the excess treatments following its receipt of the justification.

The Board affirms and adopts the Referee's conclusion and opinion that claimant has failed to show a medical need for chiropractic treatments in excess of those allowed under the guideline. We also agree with the Referee's ultimate conclusion that claimant has no procedural right to such treatments. However, we arrive at this conclusion for a different reason.

Former OAR 436-10-040(2)(a) provides:

> "Frequency and extent of treatment shall not be more than the nature of the injury and the process of recovery requires. Insurers have the right to require evidence of the efficacy of treatment. The usual range of the utilization of medical services does not exceed 15 office visits by any and all attending physicians in the first 60 days from first date of treatment, and two visits a month thereafter. This statement of fact does not constitute authority for an arbitrary limitation of

> services, but is a guideline to be used concerning requirements of accountability for the services being provided. Physicians requesting reimbursement for visits in excess of this amount must submit upon request a report documenting the need for such services. Insurer shall notify the physician within 30 days of receipt of the report whether or not the report justifies treatment in excess of the guidelines or justification will be assumed."

On July 8, 1987, SAIF sent a letter to Dr. Bolera in which it stated that, based on the assessment of Dr. Takacs, D.O., SAIF would not reimburse Dr. Bolera for treatments in excess of the guidelines. SAIF added that it would be in a better position to reconsider the bills if Dr. Bolera should provide a medical report justifying the frequency of treatment. A copy of the letter to Dr. Bolera was sent to claimant. The letter did not include the notification of hearing rights which must be included on any denial under former ORS 656.262(8) and OAR 438-05-055. Because of the absence of notice of hearing rights, we interpret the letter to be a request for a report documenting the need for such services rather than a denial. On August 4, 1987, Dr. Bolera responded by report to SAIF's July 8, 1987 letter in an attempt to justify the excess treatment. SAIF did not respond to Dr. Bolera's letter of justification within 30 days of receipt of the report.

Claimant contends that if an insurer does not respond to a letter justifying excess treatment within the 30 day period prescribed by the rule, the insurer must pay for all treatment rendered, whether or not it is reasonable and necessary. We disagree.

We do not construe the language of former OAR 436-10-040(2)(a) to authorize us to require SAIF to pay for services not compensable on the merits. Rather, where the carrier fails to issue a denial within 30 days, as required by the OAR, it may be liable for a penalty and associated attorney fee. We find that to read the Director's rule in any other manner would be inconsistent with the court's holding in Kemp v. Workers' Compensation Department, 65 Or App 659 (1983), modified, 67 Or App 270 (1983), rev den, 297 Or App 227 (1984). In Kemp, the court was required to construe the language of former OAR 436-69-801(4) which purported to require an insurer to pay for treatment not compensable on the merits if the insurer failed to deny the claim within 60 days. The court, in Kemp, held that by requiring payment of untimely denied bills regardless of compensability, the rule required an additional penalty. As the legislature had already created a penalty for insurers for unreasonable delay in denying a claim, the court concluded that the director exceeded his authority in promulgating the rule. We find that to require SAIF, in this case, to pay for treatment that is not reasonable and necessary because it did not respond to Dr. Bolera within 30 days would be contrary to the court's holding in Kemp. Consequently, we do not construe the rule to have this effect.

Moreover, we find this rationale is consistent with the court's rule in Freres Lumber Company v. Murphy, 101 Or App 92 (1990). The court held that an employer's general denial of a claimant's claim for medical services, "eliminated any 'assumption' about justification of medical treatment to which former OAR 436-10-040(2)(a) may have given rise." Freres, supra at 96. Although SAIF did not formally deny treatment in excess of the guidelines, it failed to pay bills for this treatment. Claimant requested a hearing on refusal to pay the bills. At hearing, claimant contended the services were compensable. SAIF contended they were not. Therefore, we conclude that at the time of the hearing any assumption that may have arisen from SAIF's failure to respond within thirty

days of the receipt of Dr. Bolera's justification report was eliminated. Accordingly, we find that claimant is not procedurally entitled to treatments in excess of the guidelines.

Penalties and Fees for Failure to Deny or Pay for Chiropractic Treatments.

Medical services fall within the definition of compensation in ORS 656.005(8). Claims for medical services are often made in the form of billings. Where they are so made, the billings are to be paid or the treatment denied within 60 days. Former ORS 656.262(6). See Billy J. Eubanks, 35 Van Natta 131 (1983); former OAR 436-10-090(10). Here, billings for chiropractic treatments in excess of the guidelines were neither formally denied nor paid. We conclude that SAIF acted unreasonably in failing to timely deny the claim. See ORS 656.262(10). However, because the excess treatment is not compensable, there are no amounts "then due" upon which to base a penalty for SAIF's unreasonable claims processing. Further, because the excess treatments are not compensable, there has been no resistance to the payment of compensation justifying the assessment of attorney fees. Ellis v. McCall Insulation, 308 Or App 74 (1989). Accordingly, the Referee correctly declined to assess a penalty and attorney fee in this matter.

Late Payment of Chiropractic Bills

At hearing, the parties stipulated to dates of receipt of certain medical bills and dates the amounts were paid by SAIF. (Ex. 56, Tr. 2, 6). The medical bills paid by SAIF were for treatments within the guidelines. No denial with respect to these treatments was issued. The amounts listed on Exhibit 56 were paid more than 60 days after receipt. SAIF offered no justification for its tardiness in payment. We conclude that such action was unreasonable and justifies penalties and attorney fees under ORS 656.262(10). See Donald J. Mara, 41 Van Natta 2390 (1989). Accordingly, we reverse the Referee on this issue.

Penalties and Fees for Late Payment of TTD Benefits

Claimant contends certain TTD payments listed in Exhibit 53 were paid one day late, and requests penalties and attorney fees under ORS 656.262(10).

ORS 656.262(4) requires the first installment of compensation to be paid no later than the 14th day after the employer has notice or knowledge of the claim, and that, thereafter, compensation shall be paid at least once each two weeks, unless the director determines that payment should be made at some other interval. The rule further provides that the subsequent payments must be paid to "within 7 days" of the payment. See OAR 436-60-150(4).

Considering the explanation of the SAIF claims examiner at hearing, together with the dates specified on Exhibit 53, we agree with claimant. Because the ending date listed for certain benefit periods was not included in the payment for those periods, the checks were issued to claimant within eight days of the date of payment rather than the maximum of seven allowed under the rule. SAIF offered no justification for its tardiness, and we conclude that the payments were unreasonably delayed, justifying a penalty and attorney fee. See Ronald L. Matthews, 41 Van Natta 1062 (1989).

In determining the "amounts then due" under ORS 656.262(10) upon which to base the penalty, we find that the entire amount of each late temporary disability payment was due on the seventh day. Thus, the penalty shall be based on those amounts. Catherine A. Medina, 38 Van Natta 384 (1987).

ORDER

The Referee's order, dated January 14, 1988, is affirmed in part and reversed in part. We reverse that portion of the Referee's order that declined to assess penalties and related attorney fees for the SAIF Corporation's failure to timely pay certain billings for chiropractic treatment and temporary disability benefits. SAIF shall pay to claimant a penalty equal to 25 percent of the untimely paid chiropractic bills. SAIF shall pay to claimant's attorney a $500 fee for his efforts on the issue of untimely paid chiropractic treatments. In addition, SAIF shall pay to claimant a penalty equal to 10 percent of all temporary total disability payments listed in Exhibit 53 which were not paid timely. SAIF shall pay to claimant's attorney a $400 fee for his efforts in obtaining this penalty. The remainder of the Referee's order is affirmed.

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In the Matter of the Compensation of
**RITA M. DUNCAN, Claimant**
WCB Case No. 88-20630
ORDER ON RECONSIDERATION
Burt, et al., Claimant Attorneys
Merrily McCabe (Saif), Defense Attorney

On June 28, 1990, we issued an Order of Abatement stating that we had decided to reconsider our Order on Review in the above-captioned case, issued May 31, 1990. In our initial order, we reversed a Referee's order affirming a July 29, 1988 Determination Order that awarded no permanent partial disability for claimant's right forearm condition. In our order, we applied the "standards" for the evaluation of disabilities, effective July 1, 1988. Former OAR 436-35-001 et seq. We concluded that claimant had sustained a 5 percent loss of use or function of her right forearm under the standards. Consequently, we awarded claimant 5 percent (7.5 degrees) scheduled permanent disability for loss of use or function of the right forearm. In addition, we awarded claimant's attorney a fee equal to 25 percent of this increased compensation.

We issued our initial order in the belief that claimant had not received any prior permanent disability award for her right forearm condition. On reconsideration, the SAIF Corporation moves the Board to: (1) take administrative notice of a stipulation between the parties, approved August 21, 1987, awarding claimant 10 percent (15 degrees) scheduled permanent disability for her right wrist condition; and (2) clarify that our award of 5 percent permanent disability is in lieu of the stipulated award. Claimant has not filed a timely response to SAIF's motion.

We grant SAIF's request to take administrative notice of the August 21, 1987 stipulation. See Susan K. Teeters, 42 Van Natta 1115 (1988) (Board can take administrative notice of request for hearing notwithstanding fact request was obtainable with due diligence at the time of hearing).

We deny SAIF's request to award 5 percent permanent disability in lieu of the 10 percent stipulated award. The August 21, 1987 stipulation has become final as a matter of law, notwithstanding the fact that claimant would be entitled to a lesser award under the standards.

However, claimant is not entitled to any additional award of compensation above the 10 percent she has already received by stipulation. Accordingly, our initial award of 5 percent scheduled permanent disability was in error, as was our award of an out-of-compensation attorney fee. Although we disagree with the Referee's rationale, he correctly affirmed the July 29, 1988 Determination Order awarding no additional permanent disability. Consequently, the Referee's order dated February 17, 1989 is affirmed.

Subject to this correction, we republish our May 31, 1990 order in its entirety. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

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August 29, 1990 Cite as 42 Van Natta 1855 (1990)

In the Matter of the Compensation of
**T. S. NACOSTE, Claimant**
WCB Case No. 88-22168
ORDER ON REVIEW
Paul J. Rask, Claimant Attorney
Roberts, et al., Defense Attorneys

Reviewed by Board Members Gerner and Cushing.

Claimant requests review of Referee Menashe's order which: (1) upheld the insurer's denial of claimant's medical services claim for a right elbow condition; and (2) declined to assess penalties and attorney fees for an alleged unreasonable denial. Claimant also objects to several evidentiary rulings by the Referee: (1) the admittance of a report by Dr. Kemple that had been offered on the day of hearing by the insurer; (2) the rejection of a report by Dr. Manley that had been offered by claimant after the hearing; and (3) the refusal to allow claimant's undisclosed expert witness to testify at the hearing. On review, the issues are admission of evidence, compensability, and penalties and attorney fees. We affirm.

## FINDINGS OF FACT

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

## CONCLUSIONS OF LAW AND OPINION

### Admission of Evidence

First, claimant objects to the Referee's admission of Dr. Kemple's March 20, 1989 report on the day of the hearing because it was not submitted 20 days prior to the hearing as required by OAR 438-07-018(1). We agree with the Referee's action.

OAR 438-07-018(4) allows the Referee the discretion to admit evidence that did not meet the requirements of OAR 438-07-015. In this case the insurer met the requirements of OAR 438-07-015(4) and therefore the Referee had no discretion but to admit the report. Cherry Walker, 40 Van Natta 1973 (1988). OAR 438-07-015(4) states that:

> "Documents acquired after the initial exchanges shall be provided to the other parties within seven (7) days after the disclosing parties' receipt of the documents."

This rule created the "seven day rule" which allows for evidence to be submitted within the 20/10 day time limit if it is disclosed to the other party within seven days of the disclosing parties receipt of the evidence. Here, the insurer received the report on March 20, 1989 and disclosed it when offered into evidence on the day of hearing, March 21, 1989. The Referee did not violate any rule by admitting the report or by permitting an opportunity to also solicit a response from Dr. Kemple.

Second, claimant objects to the Referee's refusal to admit Dr. Manley's report. This report was offered by claimant after the hearing had ended and the record had been closed to all evidence, except for a report from Dr. Kemple which claimant had been allowed to solicit. We again agree with the Referee's action.

After the Referee admitted Dr. Kemple's March 20, 1989 report into evidence, over claimant's objection, he allowed the record to remain open for claimant to cross-examine Dr. Kemple. This was the only rebuttal requested and allowed. On April 14, 1989, claimant indicated that he would not be deposing Dr. Kemple, but would be asking him only to submit a report in response to certain questions. At the same time, claimant also submitted another report from Dr. Manley, dated March 20, 1989, for the purpose of rebuttal. This report was addressed to claimant's attorney and was responding to questions asked by him. At the end of the hearing, when the request for cross-examination and presentation of rebuttal evidence were entertained, claimant did not mention this report, nor did he request that the record be held open for any thing other than the cross-examination of Dr. Kemple. Based on these facts, the Referee refused to admit into evidence the report of Dr. Manley. The Referee's ruling was within his discretion.

The Referee may, in his or her discretion, allow admission of additional documentary evidence into the record that had not been disclosed pursuant to OAR 438-07-015. Dr. Manley's report falls into this category because it was procured by the direct efforts of claimant's attorney and was not disclosed until after the hearing. Therefore, the admission of this document was within the discretion of the Referee. There being no evidence that the Referee abused his discretion in this action, we refuse to disturb his ruling.

Third, claimant objects to the Referee's refusal to allow his expert witness to testify. Claimant failed to give the notice of intent to call an expert witness as required by OAR 438-07-016 and did not offer any reason for failing to do so. We agree with the Referee's action.

OAR 438-07-016 provides for the exclusion of expert testimony if the party offering the expert testimony fails to give adequate notice of its intent to call the expert witness at hearing. The purpose of this rule is to allow the opposing party to prepare their case accordingly and be prepared to examine the expert witness effectively. Under this rule, the Referee is given the discretion to allow the undisclosed expert testimony under certain circumstances.

In this case, the witness would have been testifying about key elements of the medical causation issue (i.e., the properties and potential consequences of claimant's use of prescribed medications). The insurer, since it was without advance notice of this testimony, would not have been able to effectively cross-examine the witness or rebut his testimony on this key issue of compensability. Further, claimant offered no reason for failing to comply with the rule. Under such circumstances, the Referee did not abuse his discretion in not allowing claimant's undeclared expert to testify.

Compensability and Penalties and Attorney Fees

We adopt the Referee's "Opinion and Conclusion" as our own.

ORDER

The Referee's order dated June 13, 1989, is affirmed.

In the Matter of the Compensation of
**RONALD PETTIT, Claimant**
Own Motion No. 90-0052M
SECOND OWN MOTION ORDER ON RECONSIDERATION
Pozzi et al., Claimant Attorneys
Saif Legal Department, Defense Attorney

Claimant's attorney requests Board authorization to bill claimant an attorney fee for services culminating in the Board's July 18, 1990, Own Motion Order which reopened the above-captioned claim for additional medical benefits only. We decline to do so.

Claimant's attorney expended a "couple of hours' in legal services which were instrumental in obtaining payment of medical service claims for claimant. Claimant's attorney requests authorization to bill claimant a reasonable fee of $150 for those services. We conclude that we lack the authority to approve such action.

OAR 438-015-010(2) provides: "Attorney fees for an attorney representing a claimant shall be paid out of the claimant's compensation award except as provided by ORS 656.307, 656.382 and 656.386."

A fee out of claimant's compensation is not requested. This case does not involve responsibility under ORS 656.307. Neither does this case involve a claimant finally prevailing at a hearing or on review from an insurer's or self-insured employers' denial. An assessed fee is not authorized under ORS 656.386. Finally, a fee is not authorized under ORS 656.382. Subsection (1) of that statute provides for an assessed fee for unreasonable refusal to comply with an order or unreasonable resistance to the payment of compensation. Again, an assessed fee is not requested and unreasonable conduct has not been found. ORS 656.382(1) does not apply. ORS 656.382(2) and (3) involve situations in which an insurer or self-insured employer requests a hearing or review. That is not the case here. ORS 656.382(2) and (3) do not apply. Finally, ORS 656.382(4) deals with awards of permanent disability compensation. It does not apply.

We conclude that we lack authority to grant claimant's attorney's request. It is, therefore, denied.

IT IS SO ORDERED.

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In the Matter of the Compensation of
**JOHN C. STAMP, Claimant**
WCB Case No. 88-05017
ORDER ON REVIEW
Malagon & Moore, Claimant Attorneys
Nancy Marque (Saif), Defense Attorney

Reviewed by Board Members Crider and Nichols.

Claimant requests review of those portions of Referee Gruber's order that: (1) awarded temporary disability compensation through March 17, 1988 but not through April 5, 1988; and (2) assessed a penalty based on compensation due through March 17, 1988 but not through April 5, 1988. The SAIF Corporation contends that the Referee did not have jurisdiction to enforce any duty to pay temporary disability benefits pursuant to another Referee's order. On review, the issues are jurisdiction, temporary disability compensation, penalties and attorney fees. We modify.

## FINDINGS OF FACT

Claimant filed a claim for a June 5, 1987 injury. SAIF denied the claim.

On March 10, 1988, Referee Duncan, after hearing, issued an order in WCB Case No. 87-15062, setting aside the denial and remanding the claim to SAIF for processing.

On March 18, 1988, SAIF filed a motion for reconsideration.

On March 30, 1988, claimant, having received no temporary disability compensation payment, filed a request for hearing in the case presently before the Board.

On April 5, 1988, Referee Duncan abated his order and allowed the parties to make written argument on the motion for reconsideration. Referee Duncan issued an Amended Opinion and Order on August 5, 1988. In its unpublished Order on Review, issued February 12, 1990, the Board affirmed and adopted Referee Duncan's order.

On April 20, 1988, hearing was convened in this case before Referee Gruber; on April 26, 1988, Referee Gruber issued his order; thereafter, Referee Gruber abated his order and reissued it on August 1, 1988.

## FINDINGS OF ULTIMATE FACT

SAIF failed to pay temporary disability compensation within 14 days of issuance of Referee Duncan's March 18, 1988 order.

SAIF's conduct was unreasonable.

## CONCLUSIONS OF LAW AND OPINION

Referee Gruber concluded that SAIF was required, under the applicable administrative rules, to commence payment of temporary disability compensation on March 24, 1988, 14 days after issuance of Referee Duncan's March 18, 1988 order setting aside the denial. He ordered SAIF to pay temporary disability compensation pursuant to the order through March 17, 1988, reasoning that, under the rules, on March 24, 1988, SAIF was required to pay compensation only through a date seven days before the payment is due. He noted that the rules require insurers to make payments every 14 days; he reasoned that inasmuch as Referee Duncan had abated his order before April 7, 1988, when the next payment was required to be made, SAIF had no duty to pay compensation for the remainder of the period before the order of abatement issued. Consequently, he concluded that the amount then due for purposes of calculating the penalty was only the temporary disability compensation payable for the period through March 17, 1988.

On review, claimant contends that SAIF was required to pay compensation through the date of the abatement order. He analogizes to the Board's holding in Harold B. Bates, 39 Van Natta 1143 (1987), that once 14 days have elapsed from notice of a claim and the duty to pay has arisen under ORS 656.262(4), an insurer must pay temporary disability compensation through the date of a denial even if the check for a portion of the compensation need not have issued until after the date of the denial.

SAIF, on the other hand, contends that the Referee had no jurisdiction to entertain claimant's request for enforcement of the duty to pay under Referee Duncan's order because, at the time of hearing, the order had been abated.

We conclude that the Referee had jurisdiction to entertain claimant's request for hearing; that the Referee was required to enforce the duty to pay that arose on March 24, 1988, even though the order was subsequently abated; that SAIF should have been required to pay through the date of the order of abatement; and that the penalty should be based on the total compensation which we have concluded SAIF was required to pay under Referee Duncan's order.

Jurisdiction

SAIF argues that once Referee Duncan abated his order, the Referee was without jurisdiction to entertain this enforcement proceeding. We disagree.

Claimant requested a hearing concerning the amount of temporary disability compensation to which he was entitled. The issue posed was a matter concerning a claim. Consequently, the Referee had jurisdiction of the subject matter.

If, rather than jurisdiction of the subject matter, SAIF means to suggest that a Referee may not enforce a duty to pay which arose under an order that has been abated, SAIF is wrong.

ORS 656.262(2) requires an insurer to pay compensation "periodically, promptly and directly" to the worker except when the right to compensation has been denied. The Director adopted a rule, pursuant to subsection (2), which requires an insurer whose denial has been set aside by order to commence payments of compensation within 14 days of the order. Former OAR 436-60-150(3)(e). Former OAR 436-60-150(4) requires additional payments to be made each 14 days thereafter.

The Supreme Court has held that the duty to pay pursuant to a referee's order is enforceable even though the referee's order was substantively wrong; thus, while reversing the referee's order on the merits, the Court simultaneously enforced a second order requiring the insurer to pay pursuant to the first, but erroneous, order. Georgia-Pacific v. Hughes, 305 Or 286 (1988). An abated order is no different from an order later reversed--after the order is abated or reversed, it does not continue to create a duty to pay benefits for future periods of temporary disability. However, until it is abated or reversed, it creates a liquidated duty to pay. That is, the duty to pay arises 14 days following issuance of the order, the duty to pay continues until the order is abated or reversed, and it cannot be eliminated by any subsequent event.

We hold, therefore, that the duty to pay under Referee Duncan's order was enforceable even though it had been abated when Referee Gruber issued his enforcement order.

Temporary Disability Compensation

The Referee erred, however, when he required SAIF to pay only through March 17, 1988.

In Harold B. Bates, supra, the Board held that an insurer must pay temporary disability compensation for each day a claimant is disabled from work to the date it issues a denial. We rejected an argument that the claimant was not entitled to compensation for the entire period prior to the denial simply because the check was not required to issue until after the denial. We see no reason to treat the duty to pay through the date of abatement differently than the duty to pay through the date of denial.

Therefore, in addition to the compensation due under Referee Gruber's order, we will require that compensation be paid for the period between March 17 and April 5, 1988.

Penalties and Attorney Fees

Inasmuch as we hold that temporary disability compensation was due under Referee Duncan's order for the entire period prior to April 5, 1988, we will modify Referee Gruber's order, which assessed a 15 percent penalty, accordingly.

ORDER

The Referee's order dated April 26, 1988, as republished August 1, 1988, is modified. In addition to the temporary disability compensation awarded by the Referee, claimant is awarded temporary total disability compensation for the period between March 17 and April 5, 1988. However, the SAIF Corporation shall not duplicate temporary disability benefits paid in WCB Case No. 87-15062. Claimant's attorney is awarded 25 percent of the increased compensation, if any, due under this order that is not paid in WCB Case No. 87-15062, not to exceed $750. In addition to the penalty assessed by the Referee, for SAIF's failure to pay compensation pursuant to an order, SAIF is directed to pay 15 percent of the compensation due between March 17 and April 5, 1988. The remainder of the order is affirmed.

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August 30, 1990 Cite as 42 Van Natta 1860 (1990)

In the Matter of the Compensation of
**PATRICIA A. BROOKS, Claimant**
and, In the Matter of the Complying Status of Mitzi Dodson, dba,
**COTTAGE GROVE PROFESSIONAL GROOMING, Noncomplying Employer**
WCB Case Nos. 88-20715, 88-15205 & 88-15204
ORDER ON REVIEW
Coons & Cole, Claimant Attorneys
Karen M. Werner, Attorney
David Ray Fowler (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

The alleged noncomplying employer requests review of those portions of Referee Myzak's order that: (1) found that the employer was a subject employer and claimant was a subject employee; (2) affirmed the July 19, 1988 Order of Noncompliance; (3) found that the employer had improperly issued a "back-up" denial; and (4) awarded an assessed fee for an unreasonable denial. On review, the issues are compensability, subjectivity 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.

The employer's request for hearing from the Proposed and Final Order was received by the Department of Insurance and Finance on August 9, 1988.

CONCLUSIONS OF LAW AND OPINION

Jurisdiction

The Referee concluded that claimant had failed to prove that the employer's request for hearing from the Proposed and Final Order was untimely. We agree that the Referee had jurisdiction in this matter but we base our conclusion upon the following reasoning.

The employer received the Order of Noncompliance on July 23, 1988. The employer's request for hearing was date stamped by the Department of Insurance and Finance on August 9, 1988. We conclude that the Department received

the request for hearing within 20 days of the employer's receipt of the Order. The request for hearing was timely and the Referee had jurisdiction to hear the case.

Compliance

The Board adopts the Referee's Opinion and Conclusions of Law on the issue of compliance.

"Back-up" denial

Relying on Derryberry v. Dokey, 91 Or App 533 (1988), the Referee concluded that the noncomplying employer's denial was an improper back-up denial. Since the Referee issued her order, the court has disavowed its holding in Derryberry.

When a claim is filed by an employee, the employer is found to be noncomplying and the claim is referred to SAIF for processing, only SAIF has the legal power to accept or deny the claim. ORS 656.054(1); Clark v. Linn, 98 Or App 393, 396 (1989). Here, SAIF accepted the claim on August 21, 1988. We conclude that, under ORS 656.054(1) and the Clark holding, the employer's denials had no legal effect.

Compensability

On November 22, 1988, the employer filed a request for hearing from SAIF's September 22, 1988 acceptance of claimant's injury claim. Therefore, even though we have found that the employer's denials had no legal effect, we retain jurisdiction over the issue of the compensability of claimant's back injury.

The Referee found claimant to be a credible witness. Claimant testified that she injured her back at work while she was washing a dog at the employer's grooming business. Claimant sought treatment for her back the day after her injury. Dr. Brooks, M.D., diagnosed work-related low back strain. We conclude that claimant's work activity was a material contributing cause of her disability or need for medical treatment. Furthermore, because the employer's request for hearing from SAIF's acceptance was filed more than 60 days after July 19, 1988, when the claim was referred to SAIF (See Ex. 10), the employer must prove fraud, misrepresentation or other illegal activity. Kristi L. Chase, 42 Van Natta 1247 (1990). The employer has not done so. Claimant's claim is compensable.

Attorney fee for alleged unreasonable denials

On reconsideration, the Referee awarded claimant a $500 assessed attorney fee for prevailing on the issue of unreasonable denials. We have found that the employer's denials had no legal effect. Therefore, the denials could not have represented an unreasonable resistance to the payment of compensation, a function SAIF was properly performing. No attorney fee is authorized under ORS 656.382(1). We reverse the Referee's award of an attorney fee for unreasonable denials.

ORDER

The Referee's order dated April 28, 1989, as reconsidered May 9, 1989, is reversed in part and affirmed in part. That portion of the Referee's order that found the employer's denials unreasonable and awarded a $500 assessed attorney fee for prevailing on the issue, is reversed. The remainder of the Referee's order is affirmed. For services on review, concerning the compensability-related issues claimant's counsel is awarded an assessed fee of $900, payable by the SAIF Corporation on behalf of the noncomplying employer.

In the Matter of the Compensation of
**JEREMY LEWIS, Claimant**
WCB Case No. 89-04718
ORDER ON REVIEW
Philip H. Garrow, Claimant Attorney
Roberts, et al., Defense Attorneys

Reviewed by Board Member Brittingham, Nichols and Crider.

Claimant requests review of that portion of Referee Howell's order which declined to award claimant's counsel an insurer-paid attorney fee for services rendered in obtaining the insurer's rescission of its denial of acupuncture treatment. In its brief, the insurer moves to strike that portion of claimant's brief which recites telephone conversations between counsel. On review, the issues are evidence and attorney fees. We affirm.

FINDINGS OF FACT

The Board adopts the Referee's "Findings of Facts" with the following supplementation. No hearing on the merits regarding the denial of medical services was held before a referee.

FINDINGS OF ULTIMATE FACT

Claimant did not prevail against the insurer's denial in a hearing before a referee.

CONCLUSIONS OF LAW AND OPINION

The Referee found that no basis exists for the assessment of an insurer-paid attorney fee. We agree that claimant is not entitled to attorney fees, and we base our conclusion upon the following reasoning.

Claimant asserts entitlement to an assessed attorney fee under ORS 656.386(1) and OAR 438-15-030. Although claimant's counsel may have been instrumental in obtaining a rescission of the medical services denial, he is not entitled to a fee under ORS 656.386(1). That statute provides for an assessed attorney fee only where claimant finally prevails in a hearing before a referee. See ORS 656.386(1); Duane L. Jones, 42 Van Natta 875 (1990). Here, the insurer rescinded the denial and the matter was resolved prior to the hearing. Accordingly, claimant is not entitled to an assessed fee pursuant to ORS 656.386(1). See Duane L. Jones, supra.

Moreover, claimant is not entitled to an assessed attorney fee under OAR 438-15-030. We have previously held that that portion of section (1) of the rule which provides for an assessed carrier-paid attorney fee without a hearing and without the necessity of claimant prevailing finally before a referee is invalid as it exceeds the scope of the governing statute, ORS 656.386(1). Id.

Consequently, claimant is not entitled to an assessed attorney fee under either ORS 656.386(1) or OAR 438-15-030.

Evidence

We do not address the insurer's evidence issue as we have ruled for the moving party without considering the conversations between counsel.

ORDER

The Referee's order dated June 15, 1989 is affirmed.

**Board Member Crider, dissenting.**

The majority concludes that, assuming claimant's attorney was instrumental in achieving rescission of the insurer's denial and acceptance of the claim, he is not entitled to a fee for overcoming the denial under our holding in Duane L. Jones, 42 Van Natta 875 (1990). I believe it is clear that claimant's attorney was instrumental. Although the insurer was apparently moved to withdraw its denial by issuance of a Board decision, it is quite apparent that the denial would not have been rescinded but for counsel's filing of a request for hearing. The Board decision had issued before the request for hearing. Indeed, it appears from the documentary record that the rescission was, in part, an outgrowth of discussion at a dispute resolution conference conducted by this agency and involving attorneys for both parties.

The claim was rejected, a request for hearing was filed, the claim was thereafter accepted, and claimant's attorney was instrumental in achieving this benefit for his client. Consequently, the attorney is entitled to a fee. See Duane L. Jones, supra (dissenting opinion of Board Member Crider).

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August 30, 1990 Cite as 42 Van Natta 1863 (1990)

In the Matter of the Compensation of
**E. EARLENE J. LITTLE, Claimant**
WCB Case No. 87-19635
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Meyers & Radler, Defense Attorneys

Reviewed by Board Members Brittingham and Nichols.

Claimant requests review of those portions of Referee Garaventa's order that: (1) excluded evidence offered by claimant regarding the identity of her treating physician; (2) found that the self-insured employer had complied with OAR 436-60-030(5) and could terminate claimant's temporary disability on December 11, 1987; and (3) declined to assess penalties and attorney fees for alleged unreasonable claims processing. The employer cross-requests review of that portion of the Referee's order that declined to dismiss claimant's hearing request for claimant's failure to personally appear. On review, the issues are dismissal, evidence, remand, unilateral termination of temporary total disability compensation, penalties and attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

Claimant, 51 at hearing, sustained a compensable low back injury in May 1987. Dr. Womack, chiropractor, of Pendleton, Oregon was indicated as her attending physician on a Form 801. He ordered a June 1987 CT scan of her lumbar spine. Claimant has never submitted a form changing her treating physician.

Womack referred claimant to Dr. Hendricks, M.D., a Walla Walla, Washington rehabilitation and electrodiagnosis specialist, with whom claimant began treating in July 1987. Hendricks sent a medical report to Womack, with a copy to the claims administrator, in which he noted that claimant's regular physician was Dr. Marier, M.D., of Pendleton. X-rays taken July 1, 1987 showed degenerative disc disease. Hendricks was listed as the physician. He was also identified as the physician on a July 17, 1987 CT scan, which showed a moderate disc at L5-S1. During July 1987 Hendricks reported the substance of phone calls to, and tests and examinations of, claimant to the claims administrator. Hendricks recommended that claimant remain off work.

A growth unrelated to claimant's industrial injury was discovered on claimant's kidney during the latter part of July 1987. Hendricks notified the claims administrator that he would be sending Dr. Marier the sonogram of claimant's kidney and, in regard to claimant's back, would give Marier information regarding claimant's anti-inflammatory medication and physical therapy for her back in the Pendleton area.

In August 1987 Hendricks told claimant, claimant's supervisor, and the claims administrator that claimant would have to give up her present job and be trained to do a job that did not require frequent stooping, bending, lifting, or twisting.

Claimant consulted Dr. Marier on July 28 and again on October 14, 1987 for, inter alia, follow-up on her back pain. Marier made note that claimant was under Dr. Hendricks' care for her back.

The claims administrator scheduled claimant for an independent medical examination with Dr. Baker, orthopedist, in Eugene, Oregon on November 17, 1987. Baker recommended exercise therapy and a weight reduction program. He found claimant was not medically stationary and that she was presently precluded from her usual work.

In a November 30, 1987 letter replying to a query from the employer, Dr. Marier stated that he had been treating claimant for a number of medical problems unrelated to her compensable injury. He indicated that claimant's back injury had been under the care of Drs. Hendricks and Womack. In regard to authorizing medical leave for claimant's back injury, Marier noted that he was not a back pain specialist and recommended getting an opinion by an independent orthopedist or occupational therapy specialist.

In a December 2, 1987 letter, Dr. Marier notified claimant that the employer would offer her any sort of limited duty employment she could tolerate and that he released her to return to limited duty work. As of the same date, the employer terminated claimant's temporary total disability benefits.

In a December 11, 1987 letter the the claims administrator, Dr. Baker stated that claimant could return to light work in a sedentary, sitting down position, answering the phone and talking with customers for a full 8-hour day. On the same date, the employer wrote claimant a letter advising her that Dr. Baker released her for full time light/sedentary work, 8 hours a day, 5 days a week; that a position within her limits was available at her regular rate of pay; that the starting date was December 20, 1987; and that she should contact the store manager before that date for her weekly work schedule; and that failure to report to work might terminate her temporary total disability benefits.

On December 17, 1987, the claims administrator wrote to Dr. Marier, enclosing a copy of the December 11, 1987 letter, asking if he agreed that claimant was capable of performing the work described and stating she assumed he was not claimant's treating doctor for her back, even though he did look at her back. Marier replied on December 21, 1987, agreeing that claimant was capable of performing the work described, and stating that claimant was seeing a chiropractor and Dr. Hendricks for her back at the same time she asked him (Marier) to look at her back. He said it was "a good question" who the treating doctor was for her back.

On December 18, 1987, claimant wrote to the employer, saying: "Dr. Baker told me I could not return to work until I had some therapy on my back. I start this Monday December 21. As soon as the doctor releases me, I will return to work."

On December 22, 1987, the claims administrator wrote to Dr. Hendricks, enclosing a copy of the December 11, 1987 offer letter, and asking him if he agreed that claimant was capable of doing the described work.

On January 4, 1988, the claims administrator received a December 15, 1987 letter from Dr. Rosen in Phoenix, Arizona, stating that claimant "has been treated in Beaverton, Oregon by Dr. Baker."

On January 6, 1988, Dr. Hendricks concurred with Baker's December 11 opinion that claimant was able to do the offered work.

## FINDINGS OF ULTIMATE FACT

The employer prematurely terminated claimant's temporary total disability payments.

The employer's unilateral termination of temporary total disability benefits was unreasonable.

## CONCLUSIONS OF LAW AND OPINION

### Dismissal for Failure to Appear

The employer contends that the Referee erred in not dismissing claimant's hearing request when she failed to personally appear at hearing. We disagree. The Referee was correct in her construction of OAR 438-06-071. A request for hearing may be dismissed with prejudice if neither claimant nor claimant's attorney appear for hearing. Nothing in the rule authorizes a Referee to dismiss a request for hearing simply because claimant does not appear. Williams v. SAIF, 99 Or App 367 (1989).

### Evidence/Remand/Unilateral Termination of Temporary Total Disability

In order to terminate temporary total disability, an employer must first notify the attending physician of the specific duties to be performed by the injured worker and the physical requirements thereof; the physician must agree that the offered employment is within the worker's capabilities; and the employer must provide the worker with a written offer of the employment which states, inter alia, an accurate description of the job duties and that the attending physician has said the offered employment appears to be within the worker's capabilities. OAR 436-60-030(5). The rule is clear, unambiguous and specific in what is required before an employer may unilaterally terminate temporary total disability payments. See Eastman v. Georgia Pacific Corp., 79 Or App 610 (1986).

Claimant contends that the Referee improperly excluded 11 of 31 exhibits relevant to establishing the identity of the treating physician. The Referee excluded the exhibits because they were "based on claimant's statements" and the employer had no opportunity to cross-examine claimant because she did not appear at hearing.

We disagree with the Referee's reasoning. In this case, the reports in issue did not contain statements from claimant to doctors which pertained to the identity of her attending physician. Rather, the reports merely document claimant's course of treatment by a variety of physicians. Under such circumstances, we do not consider the unavailability of claimant for cross-examination at hearing to be prejudicial to the employer. Accordingly, we conclude that the reports should have been admitted. In this case, we need not determine whether

the reports would have been admissible if offered to establish the truth of claimant's statements to the physicians.

The Board may remand a case if it determines that the record has been improperly, incompletely or otherwise insufficiently developed. ORS 656.295(5). However, the reports at issue here were offered for admission while the hearing record remained open and are included in the hearing record. Thus, we admit the documents and review the matter de novo on the hearing record.

We now consider the document excluded by the Referee and turn to the issue of unilateral termination of temporary total disability. Claimant originally treated with Dr. Womack, who referred her to Dr. Hendricks in June 1987. In July 1987 he referred claimant back to her family physician, Dr. Marier, for monitoring of drugs for her back which was the only treatment being provided for that condition at that time and to keep track of the unrelated kidney mass. Claimant saw Dr. Marier for follow-up on her back on two occasions, July 28 and October 14, 1987. Claimant was last under the care of Hendricks on August 21, 1987, when he recommended a change in her work activity to the employer.

Claimant was then scheduled for an independent medical examination with Dr. Baker in Eugene. He did not find claimant medically stationary or able to return to work at the time of the examination, but nothing in his report indicated that he would treat claimant or that claimant would return to him. Claimant's December 18, 1987 note to the employer does not say Baker is the treating physician; nor does the December 15, 1987 letter from Dr. Rosen. As a result, contrary to the employer's position, we find that Dr. Baker is not claimant's attending physician.

In this case, it is extremely difficult to determine whether Dr. Hendricks, Dr. Marier or Dr. Womack is the attending physician. However, resolution of this factual issue is not necessary to determine whether claimant's temporary total disability compensation was improperly unilaterally terminated. The employer had the responsibility under the rule to resubmit the job offer to claimant after the treating doctor approved the job offer, especially in light of her response to the earlier offer. Accordingly, whether the treating physician was Dr. Hendricks, Dr. Marier or Dr. Womack, the employer failed to comply with the procedural requirements of OAR 436-60-030(5).

Since the triggering event is the worker's refusal of a job offer, and the employer terminated claimant's benefits prior to her refusal of the job offer based on Baker's authorization, we conclude that the employer unilaterally ceased payment in violation of the rule. Furthermore, because in this case it was incumbent on the employer to resubmit the job offer to claimant after the treating doctor's agreement not to the duties, the termination was not permissible even after claimant's refusal. Accordingly, we reverse the Referee's ruling on this issue.

Penalty and Attorney Fees

Claimant contends that the Referee erred in not assessing a penalty and attorney fee regarding the employer's unilateral termination of benefits. The Referee reasoned the termination was not unreasonable because there was confusion as to the identity of claimant's treating physician. We disagree. The employer must continue to pay temporary total disability benefits until the statutory triggering event permitting termination occurs or risk the imposition of penalties, based on "amounts then due," and attorney fees. ORS 656.262(6) and (10). Here, the employer unreasonably stopped benefits prior to claimant's refusal of the job. Accordingly, claimant is entitled to a penalty and an associated attorney fee.

Assessed Fee on Review

Claimant requests an assessed fee for prevailing against the employer's request for review of the Referee's dismissal ruling. We find that the employer's cross-appeal was not an effort to reduce compensation within the meaning of ORS 656.382(2) because claimant had received nothing at hearing that the employer was trying to take away on review. Instead, the employer's request to dismiss was merely a defensive argument to avoid the duty to pay additional compensation. See Saiville v. EBI Companies, 81 Or App 469 (1986). Consequently, claimant is not entitled to a fee under ORS 656.382(2).

ORDER

The Referee's order dated May 31, 1988 is affirmed in part and reversed in part. That portion of the Referee's order that declined to dismiss claimant's hearing request is affirmed. The remainder of the order is reversed. The claim is remanded to the self-insured employer for payment of additional temporary total disability compensation commencing December 2, 1987. 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 out of and not in addition to the increased compensation. The employer shall pay to claimant a penalty equal to 25 percent of the temporary disability compensation due under this order. For services regarding the penalty issue, claimant's attorney is awarded a fee of $500, payable by the employer.

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August 30, 1990 Cite as 42 Van Natta 1867 (1990)

In the Matter of the Compensation of
**E. EARLENE J. LITTLE, Claimant**
WCB Case No. 88-18059
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Meyers & Radler, Defense Attorneys

Reviewed by Board Members Crider and Nichols.

Claimant requests review of Referee Seymour's order that: (1) declined to reinstate temporary total disability compensation for her low back condition; and (2) declined to assess penalties and related attorney fees for an alleged unreasonable failure to timely pay temporary total disability compensation. On review, the issues are payment of temporary total disability compensation, penalties and attorney fees. We reverse.

FINDINGS OF FACT

Claimant sustained a compensable low back injury in May 1987. She was unable to return to work and received temporary total disability payments.

The self-insured employer unilaterally terminated temporary total disability benefits on December 2, 1987, prior to the employer's proffer and claimant's refusal of a modified job offer. The employer made the job offer on December 11, 1987, and claimant refused the offer on December 18, 1987.

A referee, by order dated June 14, 1988, held that the employer's termination of benefits on December 11, 1988 was permissible. Claimant requested review and the Board today reverses, reinstating temporary total disability payments beginning December 2, 1987. See E. Earlene J. Little, 42 Van Natta 1863 (1990).

Claimant, who had been staying in Arizona, moved back to Oregon, where she presented herself to her treating physician, Dr. Lumsden, M.D., on May 2, 1988. On June 16, 1988, he wrote a letter stating that claimant had been unemployable since May 2, 1988 due to a back injury and would probably continue to be unemployable for six more months. On June 22, 1988, claimant's attorney forwarded a copy of this letter to the employer's attorneys and to Scott Wetzel Services, the employer's then processing agent, along with a request that temporary total disability benefits be reinstated.

Claimant has received no temporary total disability payments based on Dr. Lumsden's notice from either the employer or Scott Wetzel Services.

Claimant has not received a denial letter concerning her entitlement to temporary disability benefits.

Claimant has not been declared medically stationary. Her claim was still open at the time of hearing.

## FINDINGS OF ULTIMATE FACT

At the time the employer received notice that claimant could no longer work due to her compensable low back injury, claimant's claim was open.

## CONCLUSIONS OF LAW AND OPINION

This is the second claim to be reviewed by the Board regarding claimant's entitlement to temporary total disability payments as a result of a compensable low back injury sustained by claimant in May 1987. The Referee in the first claim (WCB Case No. 87-19635) approved the self-insured employer's termination of temporary disability payments on December 11, 1987. We reversed on Board review, in a companion case issued this date, finding that the employer prematurely terminated claimant's benefits in violation of OAR 436-60-030(5). Id. The matter currently before us arose when claimant sought temporary total disability payments effective May 2, 1988, the date claimant was again declared by her doctor to be unable to work.

The Referee concluded that claimant was not entitled to temporary total disability payments beginning May 2, 1988, because she could have been performing the light duty work originally offered to her in December 1987. We disagree with the Referee's analysis.

Both claimant and the employer raise arguments addressing the December 2, 1987 termination of benefits. As this issue was dealt with in the prior case, we do not address it again.

Claimant contends that, assuming that the employer was entitled to suspend claimant's temporary total disability compensation because she refused offered employment, compensation should have been reinstated under OAR 436-60-030(6)(a), which provides that temporary partial disability payments under section (5) must be paid until the attending physician verifies that the worker's condition prevents performance of modified work and is again temporarily totally disabled. Because Dr. Lumsden's notice stated that claimant was unable to work, claimant maintains that the employer should have reinstated her temporary total disability payments, effective May 2, 1988, within 14 days of receipt of notice. See ORS 656.262 and OAR 436-60-150(3).

The employer contends that Lumsden's reference to a back injury did not identify it as the industrial injury, and even if it was the industrial injury, the employer further contends it was under no duty to resume temporary disability payments for the following reasons: (1) Lumsden's notes did not establish any change in claimant's back condition; (2) claimant did not establish that she had lost any wages because she refused the employer's job offer and left the job

market; and (3) Dr. Lumsden lacked the relevant facts regarding claimant's ability to be doing the light duty work she had previously been offered.

We find the employer's arguments to be without merit. Claimant had an open and accepted claim for a low back injury. Dr. Lumsden declared that claimant was unable to work due to her back injury. Claimant's attorney's cover letter that accompanied Dr. Lumsden's notice sufficiently identified the claim. (Ex. 35A). Under the rule, as a claims processing matter, the employer was obligated to pay temporary total disability benefits within 14 days of Dr. Lumsden's notice that claimant's condition was such that she could no longer perform her regular work. Rodgers v. Weyerhaeuser Company, 88 Or App 458 (1987); Michael J. Harvey, 41 Van Natta 980, 981 (1989).

Furthermore, the rules do not require a claimant to establish a change in his or her condition unless he or she is filing a claim for aggravation, which is not the case here. See OAR 436-60-030(6). In addition, the employer's contention that a retired worker is not entitled to temporary disability compensation does not apply when, as here, claimant's claim has not been closed. The employer's reliance on Cutright v. Weyerhaeuser, 299 Or 290 (1985), in support of that proposition is misplaced. Claimant has never been declared medically stationary. Her claim is still open. Cutright does not apply to an open claim. See Weyerhaeuser v. Kepford, 100 Or App 410 (1990). Under these circumstances, there was no authority for the employer to terminate temporary disability benefits on the theory that claimant withdrew from the labor market.

The employer's last argument, that Dr. Lumsden lacked the relevant facts to properly assess claimant's ability to perform work, goes to claimant's substantive entitlement to compensation, as contrasted with the statutory procedural requirements we address here.

Accordingly, even if claimant's temporary total disability compensation should not have continued after December 2, 1987 (i.e., assuming the outcome of the previous case had been different on Board review), once the employer received evidence that claimant, who had an open and accepted claim, could not work, it should have begun paying temporary total disability payments. Here, the employer ignored claimant's notice. We conclude that the employer's failure to pay temporary total disability benefits was unreasonable given the plain language of the rule. Accordingly, we assess a 25 percent penalty and a reasonable attorney fee.

## ORDER

The Referee's order dated February 13, 1989 is reversed. The self-insured employer is directed to pay claimant temporary total disability benefits and to continue to pay those benefits until they may be properly terminated according to law, but not to duplicate benefits it may pay under our order in WCB Case No. 87-19635, issued this date. The employer shall pay to claimant a penalty for its unreasonable claim processing equal to 25 percent of the temporary total disability benefits due from May 2, 1988 to February 13, 1989, the date of hearing. For services at hearing and on review regarding the penalty issue, claimant's attorney is awarded a fee of $500, payable by the employer. Claimant's attorney is awarded an approved fee in the amount of 25 percent of the increased compensation, if any, gained by this order that is not paid under our order in WCB Case No. 87-19635, not to exceed $3,800, payable by the employer directly to claimant's attorney.

In the Matter of the Compensation of
**TANYA L. BAKER, Claimant**
WCB Case Nos. 88-18028 & 88-19615
ORDER ON REVIEW
Black, Chapman & Webber, Claimant Attorneys
Cowling & Heysell, Defense Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Speer and Howell.

Royal Insurance of America requests review of Referee Brown's order that: (1) set aside its denial of claimant's "new injury" claim for a low back 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 injured her low back and left hip in a non-work-related accident in 1978. In 1982 she had a sciatic nerve neurolysis and two diskectomies (L5-S1). In December 1986, while employed by Liberty Northwest's insured, claimant sustained a compensable lumbar strain. The claim was closed by a February 1988 Determination Order which awarded claimant 15 percent unscheduled permanent disability. A later Stipulation on August 15, 1988, gave claimant an additional 5 percent unscheduled permanent disability.

On August 26, 1988, claimant worked a six-hour shift for Royal Insurance's insured, a motel. She performed laundry work at the motel which consisted of bending and lifting as she loaded and unloaded washing machines and dryers. At the end of her one shift, the employer sent her home because she was working too slowly. (Tr. 15). Claimant began to have low back pain while working her shift. (Tr. 24). She did not return to work and did not notify the motel that she was injured. (Ex. 59). Claimant did not seek treatment until September 12, 1988, when she returned to her former neurosurgeon, Dr. Sutherland, for medical care. (Ex. 58A).

Since shortly after her 1986 injury Dr. Sutherland had followed claimant's back and hip condition. (Ex. 15-1). Dr. Sutherland diagnosed claimant's original injury condition as lumbar strain with no recurrence of disc problems. (Ex. 15). Throughout her conservative management, no real changes were noted in her symptoms of leg and low back pain. (Exs. 17, 18). Dr. Sutherland would not return claimant to her nursing home job with Liberty Northwest's insured and recommended she seek suitable light work. (Ex. 19-1). In March 1987 she was still experiencing pain as severe as it had been when the injury first occurred. (Ex. 21-3).

In April 1987, claimant underwent an independent medical evaluation (IME) by the Orthopaedic Consultants. Dr. Reilly, neurologist, and Dr. Farris, orthopedic surgeon, reported that claimant was approaching a stationary medical condition with intermittent pain and aggravation if she lifted the wrong way. She was restricted to light work. (Ex. 23, pp 4-6). Dr. Sutherland concurred with these findings on May 12, 1987. (Ex. 25).

During the eight-month period of May through December 1987, claimant continued to have complaints of moderate to severe back and leg pain. (Exs. 26, 36, 38, 39, 40, 41). Claimant received another IME in January 1988 and was found to be medically stationary and restricted to light work. (Ex. 42-4). Dr. Sutherland concurred with this opinion. (Exs. 43, 47). After claim closure in January 1988, Dr. Sutherland continued to prescribe anti-inflamatory medications and claimant began chiropractic treatments with Dr. Litwiller. (Exs. 48-1, 54-3).

Throughout Dr. Litwiller's treatment of claimant he reported that she was in acute discomfort, and doing very poorly with continuing severe pain and persistent soreness. (Exs. 54, 57). On her last visit in July 1988, Dr. Litwiller recommended further treatment. (Ex. 57).

Claimant's next medical examination was on September 12, 1988, eighteen days following her work exposure at Royal's insured. At that time, Dr. Sutherland diagnosed a lumbar strain and noted objective findings of muscle spasm and a 50 percent reduction in range of motion. (Ex. 58A). Claimant's complaints of back pain were not materially different from her medical history following the compensable injury in December 1986 and there was no evidence of pathological worsening of claimant's underlying condition. (Ex. 67, pp. 14-16). Due to the increase in claimant's symptoms, she was at least temporarily totally disabled in September 1988. (Ex. 67, pp. 24-25).

## ULTIMATE FINDINGS OF FACT

Claimant's work exposure in August 1988, with Royal Insurance's insured, did not independently contribute to a pathological worsening of her underlying condition. Instead, claimant experienced worsened symptoms only of her December 1986 compensable injury.

## CONCLUSIONS OF LAW AND OPINION

The Referee concluded that he was unable to determine whether claimant's new period of disability was the result of a new injury, or a continuation of a prior compensable back strain. Accordingly, he applied the last injurious exposure rule and placed liability on the last employer. Champion International v. Castilleja, 91 Or App 556 (1988). We do not agree that the evidence is in equipoise. Therefore, we do not rely on the last injurious exposure rule for assignment of liability.

When, as here, the evidence shows that disability is caused solely by an injury occurring during an earlier employment there is no reason to apply the last injurious exposure rule. Boise Cascade Corp. v. Starbuck, 296 Or 238, 243 (1984). We find that claimant's employment at Royal's insured resulted in merely a recurrence of symptoms from the first compensable condition. Furthermore, the second work exposure did not contribute even slightly to the causation of the disabling condition. Therefore, Liberty Northwest remains responsible for claimant's ongoing back condition.

Here, other than claimant's subjective complaints of increased pain after her August 1988 work activities at Royal's insured, there is no objective evidence of an independent contribution to a worsening of her underlying condition. Rather, the preponderance of the well-reasoned evidence demonstrates that claimant had a continuation of a lumbar strain. The causation of claimant's current lumbar strain is a complex medical question. Thus, while her testimony is probative, the resolution of this matter turns on the medical evidence. Kassahn v. Publishers Paper Co., 76 Or App 259, 263 (1986).

Shortly before claimant began work with Royal's insured, claimant was in intermittent severe pain, taking anti-inflammatory medications, and receiving chiropractic treatments for her compensable injury with Liberty Northwest's insured. Furthermore, claimant only worked six hours for Royal's insured, did not inform this employer of any injury, and did not seek treatment for nearly three weeks. Also, the treating neurologist, Dr. Sutherland, reported no real changes, except intensity of symptoms, since the December 1986 injury. Even

though a disc bulge was observed on x-ray, this was judged clinically insignificant by Dr. Sutherland. While it was "possible" that the August 1988 work exposure caused the bulge, Dr. Sutherland would not say it was "probable." (Ex. 67, pp. 23, 26). Dr. Sutherland additionally stated that regardless of the cause of claimant's increased symptoms, she was at least temporarily totally disabled in September 1988. (Ex. 67, pp. 24-25).

On the other hand, the medical evidence supports the conclusion that claimant's symptoms following her August 1988 work exposure are an aggravation of her earlier compensable injury. For example, all of the medical evidence from December 1986 to July 1988 describes claimant as having intermittent moderate to severe radiating back and left leg pain due to back strain. The severity of the pain varies with her activity level and she receives periodic relief with conservative management and inflammatories. These medical findings are consistently reported by the treating neurologist and chiropractor, as well as independent orthopedic evaluation teams.

At one point Dr. Sutherland checked a box, without explanation or supporting findings, that the August 1988 employment activities independently causes claimant's current condition. (Ex. 66). He inconsistently checked off other boxes that assigned responsibility to the compensable injury of December 1986. We are not persuaded by the inconsistent and unexplained conclusory nature of this medical report. See Marshall v. Boise Cascade, 82 Or App 130 (1986); Melody M. Schneider, 40 Van Natta 1297 (1988).

In a later deposition, Dr. Sutherland changed his opinion and concluded that claimant had experienced a gradually increasing strain or aggravation of a previous condition. (Ex. 67). This subsequent opinion was based on Sutherland's finding that there was no objective evidence of a pathological worsening and no material difference in claimant's subjective complaints. Thus, he reasoned that claimant was experiencing a symptomatic worsening only. (Ex. 67, pp. 14-16). Greater weight is given this second opinion which was both better reasoned and based on more complete information than his earlier "check-the-boxes" opinion. Somers v. SAIF, 77 Or App 259 (1986).

Where a claimant initially suffers an injury while working for the first employer, and the work exposure with the second employer merely contributes to a worsening of symptoms, then the condition is an aggravation with responsibility remaining with the first employer. Hensel Phelps Const. v. Mirich, 81 Or App 290, 294 (1986), citing 4 Larson, Workmen's Comp. Law sec. 95.12 (1976). The facts of this claim fit squarely within Larson's back injury example quoted in Hensel Phelps Const., supra. The weight of the medical evidence shows that claimant continued to have significant back pain after settlement of her first claim on August 11, 1988. The period of continuing symptoms ran right into her one-day work exposure with Royal's insured on August 26, 1988. While claimant's symptoms worsened, there was no evidence of a worsening of the underlying condition which was necessary to shift responsibility to Royal Insurance. Hensel Phelps Const., supra. Accordingly, we hold that claimant suffered an aggravation of a compensable condition and responsibility remains with Liberty Northwest's insured.

## ORDER

The Referee's order, dated April 14, 1989, is reversed. Royal Insurance of America's denial is reinstated and upheld. Liberty Northwest's denial is set aside and the claim is remanded to Liberty Northwest for processing according to law.

In the Matter of the Compensation of
**CHARLES H. CLINGINGS, Claimant**
WCB Case No. 89-02773
ORDER ON REVIEW
Stebbins, et al., Claimant Attorneys
Thomas Andersen (Saif), Defense Attorney

Reviewed by Board Members Nichols and Crider.

Claimant requests review of Referee Gruber's order that affirmed claimant's unscheduled permanent disability award for a low back injury of 14 percent (44.8 degrees), as awarded by a Determination Order. On review, the issue is extent of unscheduled permanent partial disability. We reverse.

FINDINGS OF FACT

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

Claimant returned to modified work.

FINDINGS OF ULTIMATE FACT

Claimant has sustained a 22 percent loss of earning capacity as a result of his low back injury.

CONCLUSIONS OF LAW AND OPINION

Claimant became medically stationary after January 1, 1988 and his claim was closed after July 1, 1988. Therefore, our determination of claimant's permanent partial disability is made pursuant to ORS 656.283(7) and 656.295(5), respectively. OAR 438-10-005 and Michelle Griffith, 40 Van Natta 2086 (1988). In order to determine the extent of injury-related permanent partial disability, these statutes require application of the standards in effect on the date of the Determination Order from which the hearing was requested. OAR 438-10-010. In this case, former OAR 436-35-270 through 436-35-440, the standards adopted effective July 1, 1988, as amended by temporary rules effective August 19, 1988, apply to the rating of claimant's unscheduled permanent partial disability. Former OAR 436-35-270(1).

The Referee found that claimant had returned to regular work and thus did not consider the factors of age, education and adaptability when rating the extent of claimant's unscheduled permanent disability. Claimant contends that these factors should have been considered, because he neither returned to regular work nor was offered regular work. He argues that he was released by Dr. Jones to modified rather than regular work, that he was never offered a job by his employer, and that he was unable to successfully return to regular work. Claimant further argues that the Referee failed to consider claimant's limited extension. The SAIF Corporation argues that the Referee's assessment was correct.

Dr. Jones released claimant to return to work as an employee of an investigative firm, where he had performed surveillance and served legal process. The job required a great deal of driving. Dr. Jones recommended modification of the job by providing a special lumbar support seat in claimant's vehicle and a grab bar to assist him in getting in and out of it. Claimant did not return to his old job because he resigned after an acrimonious exchange with the owner. There is no evidence he was ever offered his old job back. Instead, he started his own business, primarily doing process-serving. He ran the business from

October 1987 until March 1988, when his wife took it over. We are not persuaded that claimant quit because he was unable to physically perform the work. On this record, we find that claimant returned to modified work.

Claimant argues that at hearing he demonstrated that he was unable to engage in extension. He also argues that the Referee erred in finding that because claimant's limited extension was not enumerated in the medical reports, it did not exist. The Referee was correct in his assessment. Dr. Jones opined in February 1988 that claimant's extension was normal. He recorded no limitation of extension in his August 1988 closing examination. The record does not indicate that claimant's condition worsened after Dr. Jones' last reported examination. The only medical opinion is inconsistent with claimant's demonstration at hearing that he has a loss of extension. Under these circumstances, we give greater weight to the expert opinion of Dr. Meyers than to claimant's demonstration at hearing. Therefore, we find no loss of extension.

We proceed to a determination of claimant's permanent disability under the standards. Because claimant returned to modified work, we determine his permanent partial disability under the standards by applying the appropriate values assigned to the claimant's age, education, adaptability and impairment. Once established, the values for age and education are added and the sum is multiplied by the appropriate value for adaptability. The product of those two figures is then added to the appropriate value for impairment to yield the percentage of unscheduled permanent partial disability. Former OAR 436-35-280.

Age.

The appropriate value for claimant's age of 50 years is 1. Former OAR 436-35-290.

Formal education.

The appropriate value for claimant's 9 years of formal education is 1. Former OAR 436-35-300(3).

Skills.

Former OAR 436-35-300(4) adopts by reference the "SVP" (specific vocational preparation time) values assigned to various occupations by the Dictionary of Occupational Titles (DOT), published by the U.S. Department of Labor. The highest SVP level demonstrated by a claimant during the ten years prior to the date of injury is used to determine a value for skills. Former OAR 436-35-300(4). Claimant's highest SVP during the ten years prior to the date of injury was 6 as a sheetrock installer (DOT # 842.681-010). Therefore, the appropriate value for skills is 2. Former OAR 436-35-300(4).

Training.

Claimant has no documented training. Therefore, the appropriate value for training is 1. Former OAR 436-35-300(5). Claimant's total education value is 4, the formal education value plus the skills value plus the value for training. Former OAR 436-35-300(5) (sic).

Adaptability where claimant has returned to modified work.

An adaptability value for a claimant who is unable to return to his or her usual and customary work but who has returned to modified work is determined from a matrix of values at former OAR 436-35-310(3)(a). That matrix compares

the physical capacity of the claimant's usual and customary work with the physical capacity required by the modified work. This is true even though claimant may have the physical capacity to do heavier work than is required by the modified employment. Physical capacities are not defined by the "standards" generally. We utilize those definitions contained in former OAR 436-35-310(4)(a)-(d).

In this case, claimant's usual and customary work required the physical capacity to do light work. Claimant's modified work required a light/sedentary physical capacity. Therefore, the appropriate adaptability value is 1.5. Former OAR 436-35-310(3)(a).

Impairment.

Aside from extension, for which we gave no value, the extent of claimant's impairment was not at issue on review. Therefore, we adopt the Referee's assessment of 14 percent.

Computation of unscheduled disability.

Having determined each value necessary to compute claimant's permanent disability under the standards, we proceed to that calculation. When claimant's age value 1 is added to his education value 4 the sum is 5. When that value is multiplied by claimant's adaptability value 1.5 the product is 7.5. When that value is added to claimant's impairment value 14 the result is 21.5 percent unscheduled permanent partial disability. Former OAR 436-35-280(7). That disability figure is rounded to the next higher whole percentage. Id. Claimant's permanent disability under the standards is, therefore, 22 percent.

ORDER

The Referee's order dated June 9, 1989 is reversed. In addition to the 14 percent (44.8 degrees) unscheduled permanent disability awarded by Determination Order, claimant is awarded 8 percent (25.6 degrees) unscheduled permanent disability, giving him a total award to date of 22 percent (70.4 degrees) unscheduled permanent disability for his low back injury. Claimant's attorney is awarded 25 percent of the increased compensation created by this order, not to exceed $3,800.

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August 31, 1990 Cite as 42 Van Natta 1875 (1990)

In the Matter of the Compensation of
**TONYA (STODDARD) DELANO, Claimant**
WCB Case No. 89-08714
ORDER ON REVIEW
Robert J. Guarrasi, Claimant Attorney
David Ray Fowler (Saif), Defense Attorney

Reviewed by Board Members Speer and Howell.

The SAIF Corporation requests review of Referee Brazeau's order which assessed a penalty-related attorney fee for late payment of an assessed attorney fee. On review the issue is attorney fees. We reverse.

FINDINGS OF FACT

At hearing the parties stipulated that SAIF paid an additional attorney fee of $400, pursuant to an Order on Reconsideration, more than 30 days after the Order on Reconsideration issued. SAIF inadvertently overlooked the additional assessed attorney fee.

CONCLUSIONS OF LAW

Entitlement to attorney fees in workers' compensation cases is governed by statute. Unless specifically authorized by statute, attorney fees cannot be awarded. Forney v. Western States Plywood, 297 or 628 (1984).

There are no provisions in Workers' Compensation Law for awarding an attorney fee for late payment of an assessed attorney fee. Penalties and related attorney fees are controlled by ORS 656.262(10) and 656.382(1). Both provisions are invoked where there is unreasonable behavior by a carrier in delaying or refusing to pay compensation. Assessed attorney fees (and penalties) are not compensation within the meaning of these two provisions. Saxton v. SAIF, 80 Or App 631, rev den 302 Or 159 (1987); Dotson v. Bohemia, Inc., 80 Or App 233 (1986); Lloyd v. EBI Cos., 96 Or App 591 (1989). James C. Ingram, 41 Van Natta 2417 (1989).

Accordingly, an attorney fee may not be awarded under these circumstances pursuant to Workers' Compensation statutes.

ORDER

The Referee's order dated June 7, 1989 is reversed. The Referee's $200 attorney fee award is reversed.

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In the Matter of the Compensation of
**ARLETA M. GIBBS, Claimant**
WCB Case Nos. 89-05213 & 89-05214
ORDER ON REVIEW
Charles D. Maier, Claimant Attorney
Alan Ludwick (Saif), Defense Attorney

Reviewed by Board Members Nichols and Crider.

Claimant requests review of that portion of Referee Myers' order that affirmed a Determination Order awarding 18 percent (57.6 degrees) unscheduled permanent disability for injuries to claimant's low back and right hip. On review, the issue is extent of unscheduled permanent partial disability. We reverse.

FINDINGS OF FACT

Claimant compensably injured her back and right hip on March 15, 1987. The SAIF Corporation accepted the claim. Claimant missed two days of work and then returned to her regular work as a food service worker for SAIF's insured.

Claimant injured her right hip again on May 10, 1987. The initial diagnosis was right trochanteric bursitis. SAIF accepted the injury. In approximately June 1987, claimant began reporting low back problems.

Claimant was medically stationary by December 27, 1988.

Claimant's March 15, 1987 low back and right hip injury claim was closed by a Determination Order dated February 21, 1989. Claimant was awarded temporary disability only. Claimant's May 10, 1987 hip injury was closed by a Determination Order dated February 17, 1989. Claimant was awarded 18 percent unscheduled permanent disability.

Claimant is 53 years old. She has completed 11 years of formal education and has taken classes in dietetics. At the time of her May 1987 injury, claimant had worked for her employer as a prison steward for two and one half years. Prior to that, claimant worked for eight and one half years as a food service supervisor.

CONCLUSIONS OF LAW AND OPINION

The Referee affirmed the Determination Order award of 18 percent (57.6 degrees) unscheduled permanent disability. In so doing, the Referee failed to apply the standards adopted by the director for the rating of permanent partial disability. The Referee concluded that he was unable to apply the standards because he believed there was no persuasive evidence of impairment, other than the 5 percent given by the Western Medical Consultants. Therefore, because SAIF did not challenge the Determination Order award of unscheduled permanent partial disability, the Referee affirmed the Determination Order award. We disagree.

In determining the extent of claimant's permanent disability, we apply the standards for evaluating permanent disability as adopted by the Director, pursuant to ORS 656.726(3)(f). See ORS 656.283(7). Specifically, we apply the current version of OAR 436-35-001 et seq, the rules in effect at the time of the February 17, 1989 and February 21, 1989 Determination Orders.

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

Age.

The appropriate value for claimant's age of 53 years is 1. OAR 436-35-290(4).

Formal Education.

The appropriate value for claimant's 11 years of formal education is 1. OAR 436-35-300(3)(b).

Skills.

OAR 436-35-300(4) adopts by reference the "SVP" (specific vocational preparation time) values assigned to various occupations by the Dictionary of Occupational Titles (DOT), published by the U.S. Department of Labor. The highest SVP level demonstrated by a claimant during the ten years prior to the date of hearing is used to determine a value for skills. OAR 436-35-300(4). Claimant's highest SVP during the ten years prior to the date of hearing was 6 for her food supervisor position. (DOT # 319.137-010). Therefore, the appropriate value for skills is 2. OAR 436-35-300(4).

Training.

OAR 436-35-300(5) states:

> "Training: (a) For workers who do not have competence in some specific vocational pursuit, a value of plus one shall be allowed.
>
> (b) For workers who do have competence in some specific vocational pursuit, no value shall be allowed."

The "standards" do not define the term "specific vocational pursuit." Because we conclude that OAR 436-35-300(5) was intended to differentiate between those who have and those who have not acquired formal or on-the-job training sufficient to perform something other than entry level employment, we interpret "specific vocational pursuit" to mean employment other than an entry level position. See Larry L. McDougal, 42 Van Natta 1544 (1990).

In this case, claimant has obtained training which would provide her with competence as a supervisor in a dietary department, a position that claimant has successfully performed in the past. Claimant is, therefore, entitled to no value for training.

Adaptability.

When, as a result of the compensable injury, claimant is not working and no employment has been offered, her adaptability value is determined by his residual physical capacity, without regard to his physical capacity prior to the injury. See OAR 436-35-310(4).

Claimant contends that Dr. Warner has released her to return to sedentary work only and therefore her adaptability value should be a +8. See OAR 436-35-310(4)(d). We disagree. Claimant's treating chiropractor, Dr. Leary, filled out a physical capacities evaluation that placed claimant in the light work category. In addition, the Western Medical Consultants found that claimant was capable of performing light work. Therefore, we find that claimant is capable of performing work in the light category. Accordingly, we find that claimant's adaptability value is +4. OAR 436-35-310(4)(c).

Impairment.

The Referee did not award claimant a value for lost range of motion in claimant's low back or right hip. We find however, that the physicians that examined claimant consistently found lost range of motion in both her low back and right hip areas. Accordingly, we assign claimant the following values for lost range of motion.

Claimant is entitled to these values for lost range of motion in the thoracolumbar region. For 80 degrees of flexion claimant is assigned a value of 1 percent. OAR 436-35-360(6). For 10 degrees of extension claimant is assigned a value of 2 percent. OAR 436-35-360(7). For 20 degrees of right flexion and 20 degrees of left flexion claimant is assigned a value of 2 percent for each direction. OAR 436-35-360(8). To arrive at a total value for lost range of motion the values are added (not combined) for a total value of 7 percent. OAR 436-35-360(10).

For lost range of motion in the right hip, claimant is assigned a value of 1 percent for 35 degrees of abduction. OAR 436-35-340(5).

To arrive at a total impairment value, the values of different residuals are combined (not added). Therefore, we combine the value for lost range of motion in the thoracolumbar spine (7) with the value for lost range of motion in the right hip (1) to arrive at a total impairment value of 7.93 percent.

Impairment Value for Chronic Conditions Limiting Repetitive Use of a Body Part.

Claimant contends that she is entitled to a value of 10 percent for loss of repetitive use in her low back and right hip. We disagree.

In accordance with OAR 436-35-320(4), an injured worker is entitled to a 5 percent impairment value for loss of repetitive use of a body part. However, in this case we find that claimant is entitled to no value for loss of repetitive use. We do not rely on claimant's testimony or on those portions of the medical reports that are based on claimant's subjective complaints of pain and loss of repetitive use. The Referee found that claimant exaggerated her symptoms and was not credible. We agree. Accordingly, we find that claimant is entitled to no value for loss of repetitive use of either her low back or right hip.

Computation of Unscheduled Disability.

Having determined each value necessary to compute claimant's permanent disability under the "standards," we proceed to that calculation. When claimant's age value, 1, is added to his education value, 3, the sum is 4. When that value is multiplied by claimant's adaptability value, 4, the product is 16. When that value is added to claimant's impairment value of 7.93, the result is 23.93 percent unscheduled permanent partial disability. OAR 436-35-280(7). That disability figure is rounded to the next higher whole percentage. Id. Claimant's permanent disability under the "standards" is, therefore, 24 percent.

ORDER

The Referee's order dated June 19, 1989 is reversed in part and affirmed in part. In addition to the 18 percent (57.6 degrees) unscheduled permanent disability awarded by the Determination Order, claimant is awarded 6 percent (19.2 degrees) unscheduled permanent disability, giving her a total award to date of 24 percent (76.8 degrees) unscheduled permanent disability for a low back and right hip injury. The remainder of the order is affirmed. Claimant's attorney is awarded 25 percent of the increased compensation created by this order, payable directly to claimant's attorney, not to exceed $3,800.

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In the Matter of the Compensation of
**BARBARA J. GLENZER, Claimant**
WCB Case No. 88-21675
ORDER ON REVIEW
Robert J. Guarrasi, Claimant Attorney
Nancy C. Marque (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

Claimant requests review of Referee Brazeau's order which: (1) found claimant medically stationary as of February 21, 1988; (2) declined to award additional temporary disability; and (3) affirmed a Determination Order that awarded 67 percent (100.5 degrees) for loss of use of her left hand. On review, the issues are temporary total disability and extent of scheduled permanent disability. We reverse and modify.

FINDINGS OF FACT

Excluding the last two paragraphs, we adopt the Referee's "Findings of Fact" with the following supplementation.

On January 27, 1988, claimant's left long finger was surgically amputated by Dr. Dreyer, M.D., the treating physician. (Exs. 12 & 13). Following the January 1988 surgery, claimant underwent weekly physical therapy through March 14, 1988 and her hand remained in splints. (Exs. 14, 15, 15A). Dr. Dreyer released claimant for work on February 21, 1988. (Ex. 16).

ULTIMATE FINDINGS OF FACT

Claimant was medically stationary on May 8, 1988. (Ex. 16).

CONCLUSIONS OF LAW AND OPINION

Medically Stationary Date

"Medically stationary means that no further material improvement would reasonably be expected from medical treatment, or the passage of time." ORS 656.005(17). Whether claimant is medically stationary is a question determined by medical evidence. Dimitrofff v. State Acc. Ins. Comm., 209 Or 316, 334 (1957). Such medical evidence includes circumstantial evidence as well as direct evidence. Austin v. SAIF, 48 Or App 125 (1981).

In finding that claimant's condition was medically stationary as of February 21, 1988, the Referee relied in part on his interpretation of Dr. Dreyer's December 23, 1987 letter. (Ex. 11). We disagree with the Referee's interpretation.

Dr. Dreyer wrote, "I last saw (claimant) on September 14th...I did not think then her condition was medically stationary although it may be now...You might contact (claimant) and urge her to return in January for consideration of a final disability rating or a further procedure as she wishes." (Ex. 11). Because Dr. Dreyer had not seen claimant in over two months at the time he wrote the December 23rd letter, his statement regarding claimant's medical status is conjecture. Further, it appears that on December 23rd, Dr. Dreyer anticipated the possibility of further medical treatment to improve claimant's condition. On May 8, 1988, following the February 1988 amputation surgery, Dr. Dreyer wrote, "...(claimant) was given a full work release on 2/21/88. I would consider her medically stable at this point and feel that she can participate in any activities she wishes." (Ex. 16). We conclude that Dr. Dreyer considered that claimant was medically stationary as of May 8, 1988, and that claimant was, in fact, medically stationary at that time.

Termination of Temporary Total Disability

Temporary total disability benefits are to be paid every 14 days until a worker is medically stationary and has returned to work or has been released by attending physician to return to regular employment. ORS 656.262(4); 656.268(2). See Fazzolari v. United Beer Distributors, 91 Or App 592, on recon, 93 Or App 103 (1988), rev den 307 Or 236 (1988). Penalties and attorney fees are assessable when a carrier unreasonably refuses to pay compensation or to deny a claim. ORS 656.262(10).

Dr. Dreyer released claimant for regular work on February 21, 1988 and found claimant medically stationary on May 8, 1988. (Ex. 16). The SAIF Corporation paid claimant temporary total disability from February 21, 1987 until September 14, 1987, and from January 27, 1988 (the date of the surgical amputation of claimant's long finger) until March 20, 1988. (Ex. 16A). Because SAIF had no information indicating that claimant was either medically stationary or released to work, it was unreasonable for SAIF to have terminated claimant's temporary total disability as of March 20, 1988. Accordingly, we assess a penalty and associated attorney fee.

Extent of Disability

In calculating the extent of claimant's disability we refer to the range-of-motion and loss-of-use measurements reported by the physical therapist and which Dr. Dreyer specifically adopted. (Exs. 16 & 19).

Because claimant was found to be medically stationary on May 8, 1988, and the claim was closed by Determination Order on October 19, 1988, the "standards" adopted effective July 1, 1988, former OAR 436-35-001 et seq, apply to the rating of claimant's permanent partial disability. Former OAR 436-35-010 through 436-35-260 apply to the rating of scheduled permanent partial disabilities. Former OAR 436-35-010(1).

Amputation

Ratings for amputation of the thumb and fingers are governed by former OAR 436-35-030. No additional value is permitted for reduced grip strength because it is already figured in the amputation charts. Former OAR 436-35-110(3)(b).

The parties agreed and the record indicates that claimant's left thumb was amputated on the proximal side of the interphalangeal joint for a rating of 50 percent. Former OAR 436-35-030(5). (Ex. 19).

Claimant's left index and left middle (long) finger were amputated at the distal one-third of the proximal phalanx for a rating of 75 percent each. Former OAR 436-35-030(6). (Ex. 19).

Loss of Opposition

Loss of a thumb or finger creates a loss of opposition which is the loss of function of the digits which can no longer be opposed. Former OAR 436-35-040.

For amputation of the thumb at the interphalangeal level, claimant has 20 percent loss of opposition to her index finger; loss of opposition to her middle finger -- 20 percent; loss of opposition to her ring finger -- 10 percent; and loss of opposition to her little finger -- 5 percent. These ratings are combined, not added, for a total loss of opposition of the thumb of 45.3 percent. Former OAR 436-35-040(2)(a).

For loss of opposition of claimant's index and middle finger, the opposing digit is the thumb, and a rating of 25 percent is assigned to each finger, the index and middle, for loss of opposition. Former OAR 436-35-040(3).

Loss of Motion

Claimant is able to flex her thumb at the metacarpophalangeal joint 54 degrees for a 5.4 percent loss of motion. Former OAR 436-35-050(3).

She is able to flex her index and middle fingers 65 degrees at the metacarpophalangeal joint for 15 percent loss of flexion of both fingers. Former 436-35-060(5).

She is able to flex her ring finger 86 degrees at the metacarpophalangeal joint for a 2.4 percent loss of flexion. Former 436-35-060(5). She has sustained no loss of flexion of the ring finger at the proximal interphalangeal joint. Former OAR 436-35-060(3). She is able to flex her ring finger 61 degrees at the distal interphalangeal joint for a 5.4 percent loss of flexion.

Former OAR 436-35-060(1). When two or more losses of range of motion have been rated in a single joint, the losses are added (not combined). Former OAR 436-35-120(1). Claimant has sustained a total loss of flexion of the ring finger of 7.8 percent.

She is able to flex her little finger 84 degrees at the metacarpophalangeal joint for a 3.6 percent loss of flexion. Former 436-35-060(5). She has sustained no loss of flexion of the little finger at the proximal interphalangeal joint or the distal interphalangeal joint. Former OAR 436-35-060(1) & (3).

Loss of Sensation

Claimant argues that the Referee failed to take into consideration and to rate, the loss of sensation she sustained. Loss of palmar sensation in the fingers is rated according to the location and quality of the loss. Former OAR 436-35-110(1). Claimant has enough sensitivity in her thumb to distinguish two pin pricks, 5 millimeters apart, so that there is no rating assigned to her thumb for loss of sensation. (Ex. 17). Former OAR 436-35-110(1)(b).

Claimant has 10 millimeters 2 point discrimination on the radial and ulnar sides of the proximal phalanx of her index finger for a loss of sensation rating of 18. (Ex 17). Former OAR 436-35-110(1)(a). She has 7 millimeters 2 point discrimination on the radial and ulnar sides of the proximal phalanx of her middle finger for a rating of 20. Former OAR 436-35-110(1)(a).

Total Permanent Partial Disability:

There are two methods for rating the amount of total impairment claimant has sustained due to her injury. Claimant may be awarded a total disability due to the injury by rating the multiple losses of each finger separately (combining not adding) and then making a separate award for each finger.ORS 656.214; Former OAR 436-35-060(7). Alternatively, the loss of or loss of use of two or more digits of claimant's hand may be converted to a value for loss of use of the hand if claimant will receive more money by the conversion method. Former OAR 436-35-070(1).

Rating Each Finger Separately

Thumb: The amputation rating of 50 percent, loss of opposition 45.3 percent, MP flexion of 5.4 percent and loss of sensation of 0 is combined for a total of 74.1 percent (35.6 degrees).

Index Finger: The amputation rating of 75 percent, loss of opposition of 25 percent, MP flexion of 15 percent, and loss of sensation of 18 is combined for a total of 86.9 percent (20.9 degrees).

Middle (Long) Finger: The amputation rating of 75 percent, loss of opposition of 25 percent, MP flexion of 15 percent, and loss of sensation 20 is combined for a total of 87.3 percent (19.2 degrees).

Ring Finger: The total rating for the ring finger is the sum of the loss of flexion ratings for a total of 7.8 percent (.78 degrees).

Little Finger: The total rating for the little finger is the sum of the loss of flexion ratings for a total of 3.6 percent (.2 degrees).

Total of individual finger impairment is 76.68 degrees.

Conversion Method to Loss of Use of Hand

The total value of loss use of claimant's hand is found by rating each digit, converting to values for loss in the hand, and adding (not combining) the converted values. Former OAR 436-35-070(2).

No additional rating is allowed for opposition because that is already figured into the chart. Former OAR 436-35-070(3).

Thumb: The amputation rating of 50 percent, loss of MP flexion 5.4 percent and loss of sensation of 0 are combined for a total of 52.7 percent which converts to a 21 percent loss of use of the hand. Former OAR 436-35-070(4).

Index finger: The amputation rating of 75 percent, loss of MP flexion of 15 percent, and loss of sensation of 18 are combined for a total of 82.575 percent which converts to a 21 percent loss of use of the hand. Former OAR 436-35-070(5).

Middle (long) finger: The amputation rating of 75 percent, loss of MP flexion of 15 percent are combined for a total of 78.75 percent which converts to a 16 percent loss of use of the hand. Former OAR 436-35-070(6).

Ring Finger: Loss of MP flexion 2.4 percent and loss of DIP flexion of 5.4 percent are added for a total of 7.8 percent which converts to a 1 percent loss of use of the hand. Former OAR 436-35-070(7).

Little finger: Loss of MP flexion of 3.6 percent converts to a 0 percent loss of use of the hand. Former OAR 436-35-070(8).

The converted values are added. Claimant has sustained a 59 percent (88.5 degrees) loss of use of her hand.

Therefore, the most beneficial method of calculating claimant's impairment is through OAR 436-35-070--converting finger losses to values for loss of use of the hand.

Disabling Effect of Pain

Claimant argues that her pain interferes with her use and function of her left hand. The Referee held that claimant had not shown by clear and convincing evidence that claimant sustained a loss more than that awarded by the Determination Order.

Disabling pain can result in loss of use or function beyond that to be expected from an amputation. When it does, it may be taken into consideration and assessed based on the loss of use or function which results. Former OAR 436-35-010(2). Daniel Alire, 41 Van Natta 752, 757 (1989).

Here, claimant credibly testified that she experiences pain (running up through her wrist) and problems while typing, operating a computer keyboard, lifting, arranging flowers, handling utensils, buttoning clothes, tying shoes, working with tools, golfing. (Tr. 20, 21, 22, 23). Sometimes the pain lasts all day long, sometimes just a few minutes. (Tr. 23). When she experiences this pain, she generally will refrain from using her left hand until the pain goes away. (Tr. 23).

We conclude that claimant has sustained 20 percent loss of use or function due to disabling pain beyond that expected from the amputation of her

thumb and fingers. When combined with 59 percent the result is 67.2, rounded up to 68 percent, loss of use or function of her left hand.

ORDER

The Referee's order dated March 16, 1989 is reversed in part and modified in part. That portion which found the medically stationary date of February 21, 1988, is reversed. That portion which declined to assess a penalty and associated attorney fee for unreasonable failure to pay temporary total disability compensation is reversed. Claimant is awarded temporary disability from March 21, 1988 to May 8, 1988, her medically stationary date. SAIF is ordered to pay a penalty, to claimant pursuant to ORS 656.262(10), equal to 25 percent of the temporary disability awarded herein. Additionally, SAIF is ordered to pay a reasonable penalty-related attorney fee, pursuant to ORS 656.382(1), in the amount of $250. Claimant is awarded 1 percent (1.5 degrees) scheduled permanent disability compensation for the loss of use or function of the left hand in addition to the 67 percent (100.5) degrees) awarded by Determination Order for a total award of 68 percent (102 degrees). Claimant's attorney is awarded 25 percent of the increased compensation awarded herein, not to exceed $3,800.

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In the Matter of the Compensation of
**TRAVIS H. HOLLAND, Claimant**
WCB Case Nos. 88-20401 & 88-21598
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
Snarskis, et al., Defense Attorneys
Pamela Schultz, Defense Attorney
Darrell Bewley, Defense Attorney

Reviewed by Board Members Gerner and Cushing.

Liberty Northwest requests review of those portions of Referee Mulder's order which: (1) set aside its denial of responsibility for claimant's current low back condition; and (2) upheld Industrial Indemnity's denial of responsibility for claimant's current condition. Industrial Indemnity cross-requests review of that portion of the Referee's order which found it responsible for the payment of the costs of Drs. Rosenbaum's and Larson's depositions. On review, the issues are responsibility and deposition costs. We affirm in part and reverse in part.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Responsibility

On the issue of responsibility, we adopt the Referee's opinion with the following supplementation.

When there are two compensable injuries to the same body part, there is a rebuttable presumption that the last insurer is responsible. Industrial Indemnity v. Kearns, 70 Or App 583 (1984). The last insurer has the burden of proving that it is not responsible by showing that it no longer materially contributes to the current disability or need for treatment. Absent a showing of this type, it will be presumed to continue to materially contribute to the current disability. Industrial Indemnity v. Kearns, supra., Hallmark Furniture v.

SAIF, 81 Or App 316 (1986), see also Golden West Homes v. Hammett, 82 Or App 63 (1986), see also Clark W. Buchanan, 41 Van Natta 366 (1989).

In this case, as noted by the Referee, there is sufficient medical evidence to find that claimant's 1988 injury with Liberty Northwest was a material contributing cause to the current disability. But even if the medical evidence is viewed as Liberty Northwest contends, that the doctors attribute the causation of the current condition to the 1984 injury with Industrial Indemnity, Liberty Northwest would still be found responsible. We reach such a conclusion because the doctors in this case do not address the other important inquiry of whether Liberty Northwest's injury continues to be a material contributing cause, in conjunction with the original 1984 injury, to claimant's current disability. In the absence of such proof, Liberty Northwest has failed to overcome the Kearns presumption and would remain responsible. Hallmark Furniture v. SAIF, supra., Golden West Homes v. Hammett, supra.

Payment of the Depositions

The Referee held that Industrial Indemnity was responsible for the payment of the costs of deposing Drs. Rosenbaum and Larson. We disagree.

As a general rule, deposition costs are the responsibility of the party whose witness is the subject of the deposition. Gregg C. Sorbets, 38 Van Natta 39, 40 (1986), citing Michael M. McGarry, 34 Van Natta 1520 (1980); see Hanna v. McGrew Bros. Sawmill, 44 Or App 189, 194-95, modified on other grounds, 45 Or App 757 (1980). A witness who appears by means of written reports, see e.g., ORS 656.210(2), is the witness of the party that offers the report which gives rise to the deposition request. See Hanna v. McGrew Bros. Sawmill, supra., 44 Or App at 194-95; Michael M. McGarry, supra., 34 Van Natta at 1520.

In this case, Industrial Indemnity produced written reports from Drs. Rosenbaum, Larson, and Vessely. It then offered those reports as evidence at the hearing. When the reports were offered, Liberty Northwest requested cross-examination of the doctors. Industrial Indemnity then withdrew its offer of Drs. Rosenbaum's and Larson's reports. At that point, Industrial Indemnity was no longer the sponsoring party for those reports. Furthermore, the reports would not have been admitted into the record unless one of the other parties decided that it wanted to sponsor the reports.

Here, claimant decided that he wanted to sponsor the reports that Industrial Indemnity was no longer willing to offer. Liberty Northwest's request for cross-examination then became a request to depose claimant's medical witness. Under such circumstances, it is the insurer who seeks the deposition that has the responsibility to pay for the costs. OAR 438-07-005(3). Therefore, in this case, Liberty Northwest is the party responsible for paying for the costs of deposing Drs. Rosenbaum and Larson.

ORDER

The Referee's order dated June 26, 1989 is affirmed in part and reversed in part. That portion of the order requiring Industrial Indemnity to pay for the depositions of Drs. Rosenbaum and Larson is reversed. Liberty Northwest is responsible for the payment of the depositions. The remainder of the order is affirmed. For services on review concerning the denial issue, claimant's attorney is awarded an assessed fee of $500, to be paid by Liberty Northwest.

In the Matter of the Compensation of
**JOHN W. KUYKENDALL, Claimant**
WCB Case No. 89-03129
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
James E. Dodge (Saif), Defense Attorney

Reviewed by Board Members Perry and Speer.

Claimant requests review of Referee Higashi's order which declined to recalculate claimant's rate of pay and award additional temporary disability benefits. On review, the issue is rate of temporary disability. We reverse.

## FINDINGS OF FACT

The Board adopts the Referee's "Findings."

## CONCLUSIONS OF LAW AND OPINION

The Referee concluded that, because claimant was paid time loss benefits based on the pay he was actually receiving at the time of injury, that was the proper amount upon which to base the payment. We disagree.

Temporary disability is based on the wage of the worker at the time of injury. ORS 656.210(2)(b)(A). As defined in ORS 656.005(26), "'wages' means the money rate at which the service rendered is recompensed under the contract of hiring in force at the time of the accident . . . ." (Emphasis added).

Claimant argues that, even though he was not being paid at the rate of his contract, his wages upon which temporary disability is based should be the amount under the contract. We agree.

The employer had negotiated and agreed on a contract for its union workers in 1983. In 1984 the employer withdrew recognition of the union and in 1985 it unilaterally reduced the wages paid to workers, to below the contract amount. That reduction was subsequently found by the National Labor Relations Board (NLRB) to be illegal.

The NLRB ordered the employer to pay back wages to its employees. Pursuant to the terms of the agreement, claimant retroactively received wages commensurate with those required by the contract under which he was working.

Based on the plain language of former ORS 656.005(26), we conclude that the rate of claimant's temporary disability benefits should have been based on what his wages would have been if the employer had not unilaterally and illegally reduced its employee's pay from the amount stated by the contract.

## ORDER

The Referee's order dated May 15, 1989 is reversed. The SAIF Corporation is directed to recalculate claimant's temporary disability benefits based upon claimant's weekly wage under the contract in force at the time of hiring. Claimant's attorney is awarded 25 percent of the increased compensation created by this order, payable directly to the attorney, in an amount not to exceed $3,800.

In the Matter of the Compensation of
**BETTY J. LINCOLN, Claimant**
WCB Case Nos. 88-16094, 88-07852 & 88-12172
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
Constance L. Wold, Defense Attorney
Schuyler T. Wallace, Jr., Defense Attorney
Roberts, et al., Defense Attorneys

Reviewed by Board Members Crider and Nichols.

Wausau Insurance Companies requests review of those portions of Referee Schultz's order that: (1) set aside its denial of claimant's osteoarthritis of the back, shoulders and arms; (2) upheld American International Adjustment Company's (AIAC's) denials of the same condition; (3) set aside Wausau's denial of claimant's right knee condition; and (4) upheld AIAC's denials of the same condition. In her brief, claimant requests that we increase the assessed attorney fee awarded by the Referee. On review, the issues are compensability, responsibility and attorney fees. We affirm in part, reverse in part, and modify in part.

FINDINGS OF FACT

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

On September 1 and November 22, 1988, AIAC denied compensability of and responsibility for claimant's arthritic condition which affected her back, shoulders and arms.

On September 26 and November 10, 1988, Wausau denied compensability of and responsibility for claimant's "various medical conditions."

On September 29, 1988, AIAC denied the compensability of a May 27, 1988 knee injury.

On November 22, 1988, AIAC denied compensability of claimant's right knee arthritis.

Claimant timely requested hearing with respect to each of the denials.

Claimant first sought treatment for right knee pain after she twisted her knee at work in May 1988. Her knee pain and need for treatment from the date of injury through August 30, 1988 was caused by a combination of the strain injury, her osteoarthritis and her continued repetitive use of the knee at work. The injury had resolved by August 30, 1988; thereafter, claimant's need for treatment was caused by a combination of osteoarthritis and work activity.

FINDINGS OF ULTIMATE FACT

Claimant's work for Code-A-Phone (insured successively by Fireman's Fund, AIAC and Wausau) was a material contributing cause of a symptomatic worsening of claimant's osteoarthritic condition. Her work activities throughout her employment increased her disability and her need for treatment.

The twisting incident of May 27, 1988, which occurred while AIAC was on the risk, was a material contributing cause of claimant's right knee sprain. The sprain caused a temporary worsening of the symptoms of claimant's preexisting osteoarthritis of the knee and was a material contributing cause of her need for treatment.

Continued work for Code-A-Phone following the knee injury, while AIAC and Wausau were on the risk, was a material contributing cause of a continued worsening of the symptoms of claimant's preexisting osteoarthritis of the knee and of her need for treatment.

Claimant first experienced right knee disability due to the osteoarthritis on July 25, 1988.

## CONCLUSIONS OF LAW AND OPINION

### Compensability of Claimant's Osteoarthritis of the Back, Shoulders and Arms

Wausau challenges the Referee's holding that claimant's osteoarthritic condition is compensable as it affects her back, shoulders and arms. Assuming, however, that we concur in the Referee's compensability decision, Wausau does not challenge the Referee's assignment of responsibility.

We affirm and adopt the Referee's opinion on the compensability issue as articulated in that portion of the March 13, 1989 order titled "Compensability of the occupational disease claim" as modified in his Order on Reconsideration dated May 4, 1989. See Donna E. Aschbacher, 41 Van Natta 1242 (1989).

### Compensability of and Responsibility for Claimant's Knee Condition

The Referee initially set aside AIAC's denial of claimant's claim for a May 1988 knee injury and her claim for occupational disease affecting the knee. He also set aside Wausau's denial of her occupational disease claim for the period beginning July 1, 1988, when Wausau came on the risk.

AIAC then sought reconsideration. AIAC contended that the Referee's order split responsibility for the knee between two carriers and thus was erroneous; AIAC suggested that responsibility be assigned to Wausau as the insurer on the risk when claimant was last subjected to potentially causal conditions. The Referee agreed and modified his order.

We conclude that the knee injury and disease claims must be addressed separately; and responsibility to pay must be clarified.

#### Knee Injury Claim

Like the Referee, we conclude that claimant's testimony that she injured her right knee on or about May 27, 1988 is credible. When claimant first reported right knee pain to Dr. Rabie on June 28, 1988, she reported that the knee had not been injured. On July 14, 1988, however, she recalled that the knee had been twisted at work. Other than this delay in reporting, there is nothing in this record that would shed any doubt on claimant's recollection. Therefore, we have found that the injury did occur.

Dr. Rabie, M.D., claimant's treating physician, has opined that claimant's knee pain, for which she was treated in June and July 1988, was caused by a sprain injury coupled with her preexisting osteoarthritis. Consequently, we find that the injury was a material cause of her need for treatment and, therefore, is compensable. AIAC's denial of September 29, 1988 will be set aside.

#### Occupational Disease Claim

Claimant has also established a compensable occupational disease affecting the right knee. Claimant's last potentially injurious exposure occurred in early 1989. Consequently, the 1987 amendments to the occupational disease law

apply. Donna E. Aschbacher, supra. See Johnson v. SAIF, 78 Or App 143, rev den 301 Or 240 (1986). In order to establish the compensability of her condition as an occupational disease pursuant to former ORS 656.802(1)(c), claimant has the burden of proving that her work activity involved a series of traumatic events which were a material contributing cause of either increased symptoms or a worsening of her underlying condition requiring medical services or resulting in disability. See Donna E. Aschbacher, supra.

Claimant's repetitive bending and continuous weight-bearing activities bring her within subsection (1)(c). Both Dr. Rabie and Dr. Kappes, M.D., who reviewed claimant's medical records, have opined that claimant's ongoing work activity for the employer has contributed to a worsening of claimant's osteoarthritic symptoms and to her difficulty working. Specifically, Dr. Kappes related claimant's knee difficulties to weight-bearing, walking and repetitive bending at work. Dr. Rabie has treated claimant for the symptoms caused in material part by these activities. Moreover, he had recommended for some time prior to claimant's retirement that she quit work due to the symptomatic worsening of her osteoarthritic back and knee conditions; consequently, she has established that her work exposure resulted in right knee disability and need for treatment. She has satisfied her burden.

Responsibility for Occupational Disease Claim

The last injurious exposure rule provides that, if a worker proves that an occupational disease was caused by work conditions that existed where more than one carrier is on the risk, the last employment providing potentially causal conditions is deemed responsible for the disease. Boise Cascade Corp. v. Starbuck, 296 Or 238 (1984); Meyer v. SAIF, 71 Or App 371, 373 (1984). The "onset of disability" is the triggering date for determination of which employment is the last potentially causal employment. Bracke v. Baza'r, 293 Or 239, 248 (1982). The onset of disability is the date upon which the claimant first becomes disabled as a result of the compensable condition or, if the claimant does not become disabled, the date she first seeks medical treatment for the condition. Progress Quarries v. Vaandering, 80 Or App 160 (1986); SAIF v. Carey, 63 Or App 68 (1983).

In order to shift responsibility to an earlier carrier, the carrier on the risk when claimant became disabled or sought medical treatment must establish that the work conditions while the prior carrier was on the risk were the sole cause or that it was impossible for work conditions during the period when the last carrier was on risk to have caused the disease. FMC Corp. v. Liberty Mutual Ins. Co., 70 Or App 370 (1984), clarified 73 Or App 223 (1985). In order to shift responsibility to a later carrier, the initially responsible carrier must show that a later employment independently contributed to a pathological worsening of the condition.

Here, claimant first sought medical treatment for her right knee complaints on June 28, 1988. However, claimant did not suffer disability until July 25, 1988, at which time Dr. Rabie restricted her to modified duty for a period of one month. Under such circumstances, we conclude that the onset of disability for claimant's right knee occupational disease claim was July 25, 1988.

Consequently, responsibility for the occupational disease claim rests, in the first instance, with the carrier on the risk during the last "potentially causal" employment exposure prior to the July 25, 1988 onset of disability. Boise Cascade Corp. v. Starbuck, supra; Meyer v. SAIF, supra. Inasmuch as Wausau came on the risk effective July 1, 1988, it is the last "potentially causal" carrier.

Wausau can transfer responsibility to a prior insurer by showing that a prior employment exposure was the sole cause of claimant's disability or that it was impossible for claimant's employment exposure while Wausau was on the risk to have caused claimant's disability. FMC Corporation v. Mutual Ins. Co., supra. Here, Drs. Rabie and Kappes each support the conclusion that claimant's work activities after July 1, 1988 were a contributing factor in her right knee disability.

Accordingly, we hold that Wausau has neither established that claimant's work activities while AIAC was on the risk were the sole cause of her right knee disability nor that claimant's work activities while Wausau was on the risk did not contribute to her disability. Since there is no later carrier, responsibility for claimant's right knee occupational disease claim remains with Wausau.

Claims Processing

As previously noted, the compensable knee injury and occupational disease are separate conditions. Thus, it is appropriate that a different carrier have responsibility for each condition.

Turning to the record, we find that claimant's May 1988 right knee strain injury ceased being a material contributing cause of claimant's right knee disability and need for medical treatment after August 30, 1988. In making this finding, we rely upon the August 30, 1988 opinion of Dr. Rabie, who concluded that claimant's osteoarthritis was the primary reason for her current need for medical care and treatment.

Consequently, we conclude that AIAC shall be responsible for claimant's right knee disability and need for medical treatment until August 30, 1988, and Wausau shall be responsible for such disability and medical treatment thereafter.

Attorney Fees

The Referee awarded claimant's attorney $1,500 for prevailing against Wausau's denials. Claimant's attorney contends that the award is insufficient. We agree.

Claimant's attorney submitted a statement of services after hearing but before the Referee's first opinion issued. Counsel reported 22 attorney hours and four paralegal hours. Thereafter, claimant's attorney submitted a motion for reconsideration with accompanying authority which persuaded the Referee to rule for claimant against Wausau's denials. Given the novelty of the legal issues, the quality of counsel's work and the other factors enumerated in former OAR 438-15-010(6), we conclude that a reasonable fee for prevailing against Wausau's denials should be in excess of that awarded. Consequently, we increase the fee for services at hearing on those issues.

ORDER

The Referee's order dated March 13, 1989, as reconsidered May 4, 1989, is affirmed in part, reversed in part and modified in part. That portion of the order that upheld American International Adjustment Company's September 29, 1988 denial of claimant's right knee injury claim is reversed. The denial is set aside and the claim is remanded to AIAC for processing according to law. For services at hearing and on review regarding the compensability of the knee injury, claimant's attorney is awarded an assessed fee of $1,500, payable by AIAC. In lieu of the attorney fee assessed by the Referee for services at hearing concerning Wausau Insurance Companies' denials and for services on review on the same issues, claimant's attorney is awarded an assessed fee of $3,200, payable by Wausau. The remainder of the order is affirmed.

In the Matter of the Compensation of
**BETTY J. LOWE, Claimant**
WCB Case No. 88-02319
ORDER ON REVIEW
Vick, et al., Claimant Attorneys
Thomas Ewing (Saif), Defense Attorney

Reviewed by Board Members Brittingham, Nichols and Crider.

The SAIF Corporation requests review of Referee Bennett's order that set aside SAIF's denial of claimant's mental stress claim. On review, the issue is compensability. We reverse.

## FINDINGS OF FACT

Claimant began working for the employer in 1986. She began as a parts sorter and was paid $5.00 per hour. Claimant testified that she began to feel stress in February 1987. Claimant contends that this was caused by various alleged events which occurred at the work place, including harassment by co-workers, being shifted from job-to-job around the company, being told to quit, not being allowed to work overtime, and receiving smaller raises than temporary employees.

Claimant did not always get along with her co-workers and her supervisor in the glue department, Mrs. Chavers. In particular, claimant was bothered by the fact that Chavers messed up the bathroom and watched her work. Claimant also felt Chavers gave her incorrect models to make parts from.

Claimant was not allowed to work the overtime schedule she desired. The employer's policy was that overtime for all employees was to be put in before work from 5:30 to 6:30 a.m. Claimant's regular work day started at 6:30 a.m. Claimant was unable to arrive at the work site until 6:00 a.m. but wanted to work overtime from 4 p.m. until 4:30 p.m. to compensate for her late arrival. Mr. Brogan, the manager, allowed this until he discovered that claimant was the only one working in the plant after 4 p.m.; Brogan felt this was an unsafe practice and did not allow claimant to continue it.

Claimant was transferred among the employer's various departments, spending two to three months in each one. At one point claimant, a permanent employee, received a 25 cent per hour raise, whereas temporary employees received a $1.00 per hour raise. The employer's policy is that the temporary employees are paid $4.00 per hour when they are first hired. After a sixty-day period, they become permanent employees and their wage is raised a full dollar to $5.00 per hour. Claimant started as a permanent employee and was given three raises of 25 cents per hour, which is a standard practice for the employer; her final wage was $5.75 per hour. Claimant was never paid less per hour than the temporary employees. Finally, Mr. Brogan told claimant that if he were being treated as badly as she said she was, he would quit. This statement was not meant as an invitation to terminate her employment. However, claimant interpreted this as a request to quit.

In January 1988, claimant began to treat with Dr. de Bardelaben, psychologist.

In February 1988, Dr. Parvaresh, psychiatrist, performed an independent psychological examination of claimant.

FINDING OF ULTIMATE FACT

Claimant's complaints of not being allowed to work overtime and harassment by co-workers were not real events. The other events of which claimant complained, while real, were misperceived and not objectively capable of causing mental stress.

CONCLUSIONS OF LAW AND OPINION

In order for her stress claim to be compensable, claimant must prove that her employment involved real events capable of producing stress when viewed objectively, even though an average worker might not have responded adversely to them; that she suffered a mental disorder; and that the real stressful events were the major contributing cause of such mental disorder. McGarrah v. SAIF, 296 Or 145, 164-65 (1983). The Referee concluded that claimant's mental stress claim was compensable because he found that claimant's testimony and the reports of claimant's treating psychiatrist described real events which were objectively capable of causing stress and which were the major cause of claimant's stress disorder. We disagree.

In McGarrah v. SAIF, supra, the Court stated that in order for a stress-related mental disorder to be compensable, the events or conditions producing the stress must be "real" and not merely imagined or perceived by the worker. The Court explained the distinction between real and imaginary perceptions as follows:

> ""A worker may honestly believe that the employer plans to kill him and as a result of that fear cannot work, but if that belief emanates only from the worker's own paranoia and "there was no evidence the employer had any such plan, no stress condition factually existed on the job and the resulting impairment would not be compensable. On the other hand, a worker with a nondisabling paranoid personality may lapse into a totally disabling psychotic paranoia if managers pile too heavy a workload on such a susceptible employee. Honest perception exists in both cases, but workers' compensation would be properly denied in the first case and properly allowed in the second." 296 Or at 164. (emphasis supplied).

Considering the complexity of claimant's alleged condition and its contested relationship to her work activities, we conclude that a resolution of this issue can best be achieved through an appraisal of the medical opinions. Thus, although claimant's credible testimony is probative, the resolution of this issue largely turns on an analysis of the medical evidence. Uris v. Compensation Department, 247 Or 420, 426 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985).

Here, claimant asserted that she was harassed by her co-workers who complained that she was hard to get along with. Yet, she also stated that she got along well with her co-workers. She explained that if there was a problem with a particular worker, she would go and talk with someone and get it resolved. Mr. Brogan testified that he spoke with claimant on a weekly basis and she had no complaints. When claimant did complain to him that she was being treated unfairly, he was unable to ascertain a problem. Claimant's supervisors in both the premold and the glue departments testified that claimant never complained about any dissatisfaction with her co-workers. In light of this contrary testimony and the contradictions in claimant's own testimony, we are not persuaded that the alleged harassment by her co-workers occurred. Accordingly, such "events" were not real or stressful.

Claimant also contends that a source of stress was that she was not allowed to work overtime. Specifically, claimant wished to work overtime from 4 p.m. to 4:30 p.m., whereas the employer's policy was to allow overtime only from 5:30 a.m. to 6:30 a.m. The employer did not allow claimant to work overtime after 4 p.m. for safety reasons. On this record, we conclude that claimant was not denied overtime. Rather, she simply could not keep the schedule required to perform it. Moreover, when these events are viewed objectively, we conclude that claimant misperceived the employer's motive, which was intended as a safety precaution, not as harassment.

Other events which were real were misperceived by claimant and would not objectively cause stress. For example, claimant contends that, in so many words, she was told to quit. Mr. Brogan testified that he may have told claimant that if he were being treated as badly as she said she was, he would quit. Brogan testified further, however, that "I never believed that [circumstances] were as bad as she made it to believe, because every time I went to investigate this. . . it seemed to me that it was always blown out of--way out of proportion." (Tr. 99). We conclude that, in this context, Brogan's statement was not intended as an invitation to quit, but was instead meant to convey to claimant that he did not believe she was being treated as badly as she claimed. Thus, when viewed objectively, we find that claimant misperceived Brogan's comment.

Claimant further contends that she experienced stress because she was shifted from department to department to make room for other employees who wanted jobs for which she had been trained. However, Mr. Brogan testified that by moving her to two or three different areas, he was able to cross-train claimant and find out where she performed the best. Claimant testified that she worked from two to three months in the different departments. Brogan's and claimant's testimony demonstrate that these actions were part of the employer's normal training procedure. Thus, when once again viewed objectively, claimant misperceived this action as harassment.

Claimant further complained that temporary employees received a higher hourly raise than she did. The disparity in the amount of the individual raises was real. However, claimant's manager, Mr. Brogan, explained that it was in keeping with the employer's standard wage schedule. Moreover, claimant's total hourly wage still exceeded that of the temporary employees. Considering such circumstances, we are persuaded that, when viewed objectively, the lower raise was misperceived as harassment by claimant.

Finally, claimant testified that she had problems with her supervisor, Mrs. Chavers, who runs the glue department. Claimant asserted that she was forced to recount her parts, and this caused her stress. Claimant testified that her job in the glue department involved copying models made by Chavers and that when Chavers made an incorrect model, this caused claimant stress. However, on cross-examination claimant stated that this only happened twice, and when it did she would bring the error to Chavers' attention, who would then correct the problem. Claimant was also bothered by Chavers' practice of watching claimant work. She also complained that Chavers messed up the bathroom, which was denied by Chavers. While these events may have been real, we are persuaded that, when viewed objectively, they were misperceived as harassment. Furthermore, even if these two events were real and objectively capable of producing stress, we are not persuaded that they, or any other combination of the events described herein, were the major contributing cause of any alleged mental disorder.

In summary, we find that the work events described by claimant were either not real events, or were misperceived and not objectively capable of causing stress. In reaching this conclusion, we draw support from the opinion authored by Dr. Parvaresh, consulting psychiatrist. Parvaresh concluded that, because

claimant could not give him any specific history of actual harassment, her complaints were not psychiatric in nature. Inasmuch as we too have found no harassment, it follows that claimant did not suffer from any mental disorder.

Furthermore, we give little weight to the opinion of claimant's psychologist, Dr. de Bardelaben. He concluded that claimant had an adjustment disorder attributable to the cumulative effect of the events which took place at her employment. Inasmuch as this opinion was based on claimant's description of her work environment and since we have found that claimant misperceived the work events, we are unpersuaded by Dr. de Bardelaben's conclusion. See Blakely v. SAIF, 89 Or App 653, 656, rev den 305 Or 672 (1988).

Accordingly, on this record we conclude that, from an objective viewpoint, claimant's alleged mental disorder is not attributable to real work events objectively capable of producing stress. Therefore, she has not established a compensable stress claim.

In reaching this conclusion, we wish to emphasize that we are not disturbing the Referee's finding that claimant was a credible witness. Rather, we defer to the Referee's demeanor-based credibility finding. Yet, such a finding does not end our inquiry as to whether claimant's perceptions of events at the work place, albeit genuine, were accurate reflections. Consequently, based on the Referee's observations at hearing, we are persuaded that claimant honestly and forthrightly believed that she was harassed at work. However, for the reasons discussed above, we are not persuaded that these events of alleged harassment were real or, if real, objectively stressful.

ORDER

The Referee's order dated June 6, 1988 is reversed. The SAIF Corporation's denial is reinstated and upheld. The Referee's award of a $1,400 assessed fee is reversed.

**Board Member Crider, dissenting.**

The Referee found that claimant suffers from a mental disorder the major contributing cause of which is work-place stress caused by real events which were objectively capable of causing stress. He, therefore, properly found the claim compensable even though similar events may not have produced disability in the average person. The majority nevertheless reverses. On its way to reversal, the majority ignores the Referee's finding, based on demeanor, that claimant was credible and that, when her testimony conflicts with that of other witnesses, hers should be credited. As for those events whose reality cannot be denied by reliance on testimony which the Referee did not credit, they are dismissed as incapable of causing stress. I submit that the majority errs seriously in disregarding credibility findings based on demeanor and in declaring incapable of causing stress a host of events that concededly occurred. Therefore, I dissent.

The Referee found that claimant was subjected to the following conditions while working for SAIF's insured: Temporary employees received a $1.00 per hour raise whereas she, a permanent employee, received only a 25-cent per hour raise. Claimant asked for overtime but worked very little although other employees worked overtime. She was told by a supervisor, in response to her complaints, that if things were as bad as she reported then she should quit. Another employee was promoted ahead of her for a job for which she had trained. She was harassed by her co-workers; specifically, co-workers took parts out of her boxes, hid her tools and damaged her work.

The majority rejects, without discussion of the specific incidents discussed by the Referee, the finding that claimant was harassed by her co-workers. The majority rejects the Referee's findings with respect to overtime, preferring to believe the manager's testimony over that of claimant.

A referee's demeanor credibility findings are entitled to great weight because the referee, unlike the Board, has the opportunity to see and hear the witnesses. See International Paper Co. v. McElroy, 101 Or App 61 (1990); Anfilofieff v. SAIF, 52 Or App 127 (1981); Miller v. Granite Construction Co., 28 Or App 473 (1977). The majority not only fails to defer to the Referee's findings; they ignore them entirely. We owe more to the parties. See Benson v. Multnomah Co. School Dist. #1, 101 Or App 122 (1990).

An equally serious error, I believe, is the majority's assertion that a host of events are not objectively capable of causing stress--because they were not intended to wrong claimant. Thus, for example, the majority holds that the manager's statement that claimant should quit if things were as bad as she reported them to be was not objectively capable of causing stress because "it was not intended as an invitation to quit." The majority also holds that it was not stressful for claimant to be moved from department to department to learn new jobs because "these actions were part of the employer's normal training procedure" and "claimant misperceived harassment as the motive." Similarly, the majority holds that incidents involving claimant and her supervisor were not stressful to her because "they were misperceived as harassment." Employer motivation is irrelevant to the question of compensability in mental stress cases as in all other workers' compensation matters.

It may be that my colleagues do not find frequent changes in responsibility stressful; that they would not be bothered if the manager at their work place indicated that he did not believe their reports of work place problems in words that on their face invited them to quit; and that they would not be at least frustrated by watching other employees promoted to jobs they had anticipated receiving. Many of us, however, would find these things stressful. What is more, Dr. de Bardelaben, claimant's treating physician, was persuaded that the manager's reaction to claimant's difficulties and claimant's treatment by her co-workers was sufficient to explain claimant's adjustment disorder. That being the case, I would have difficulty concluding, as does the majority, that these events were not objectively capable of causing stress.

Even if we assume that claimant's perception of real events may have been a bit askew, the events were real and objectively capable of causing stress. Therefore, the fact that claimant's personal lens on the world may have contributed to the intensity of her emotional reaction to these events does not render her claim noncompensable. Duran v. SAIF 87 Or App 509 (1987); Shirley A. McCoy, 40 Van Natta 1596 (1988), aff'd mem 97 Or App 431 (1989).

The panel errs in allowing notions of fault to creep into its analysis of what is and is not objectively capable of causing stress, and in reinstating the denial simply because this woman's perception of real events may have played a part in the development of her disability.

In the Matter of the Compensation of
**JOHN B. NEWMAN, Claimant**
WCB Case Nos. 87-11219 & 85-03525
ORDER ON REVIEW
Haugh, Dean & Powell, Claimant Attorneys
Barbara Brainard (Saif), Defense Attorney
Roberts, et al., Defense Attorneys

Reviewed by Board Members Crider and Brittingham.

Farmers Insurance Company requests review of Referee Tuhy's order that: (1) set aside Farmers' denial of claimant's psychological condition; (2) upheld the SAIF Corporation's denial of the same condition; (3) awarded temporary total disability compensation for an unspecified period; (4) rejected claimant's contention that his claim was prematurely closed; (5) affirmed a Determination Order that awarded no additional scheduled or unscheduled permanent disability; and (6) awarded an attorney fee for services at hearing payable by Farmers. On review, the issues are responsibility, premature closure, temporary total disability compensation, and attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

Claimant compensably injured his left knee on September 22, 1977 while working for SAIF's insured. He treated with Dr. Thompson, orthopedist. As a result of the injury, claimant has undergone left knee surgery on eleven occasions. His knee is fused such that he has almost total loss of flexion in the knee and is therefore unable to bend, stoop, crawl and the like. As a consequence of the knee injury, he also experiences significant low back pain and disability. By the end of March 1984, he had been awarded 90 percent scheduled permanent disability for the left knee and 40 percent unscheduled permanent disability for the back.

On August 16, 1984, while working for Farmers' insured, claimant was injured while trying to load a photocopy machine into a truck. His claim for a twisted right knee and back strain was accepted by Farmers. The back strain was apparently insignificant as claimant never treated for it. As a consequence of this injury claimant underwent a right knee arthroscopy. His claim was closed by Determination Order on January 21, 1985, with an award of 15 percent scheduled permanent disability for the right knee and no additional disability for the back.

By February 15, 1985, claimant's right knee condition had worsened. He began using crutches to ambulate. Claimant was referred to the Callahan Center where he underwent a psychological as well as physical examination. At that time, no depression was noted.

Later that year claimant underwent surgery on the right knee. His right knee claim was reclosed September 25, 1986 with a total award of 40 percent scheduled permanent disability.

In February 1986, on evaluation for admission to a pain center program, claimant had been eager to return to work, felt he was doing satisfactorily emotionally and denied depression.

By April 1986, however, it was determined that claimant could not return to his former work because sitting aggravated his back and right knee. After the September 1986 claim closure, the right knee claim was reopened for an authorized training program. In June 1987, after six months in the program, he began a new phase of the program. He suffered a flareup of back pain associated

with the activities required by the training program including sitting and getting in and out of an automobile. He remained in the program for a few months, relying on medication for relief of pain. He progressed very well, but was unable to work an eight hour day. He began to feel depressed.

In September 1987, Dr. Dine, a neurologist to whom claimant had been referred for back pain, indicated that claimant needed a psychological evaluation.

In October 1987, the training program was discontinued because claimant rejected an offer of a job working for the Adult and Family Services Division. He rejected the position because he felt he was physically unable to do it.

On November 4, 1987, Dr. Thompson, claimant's longtime treating physician, indicated that he could no longer work and recommended that he pursue social security disability benefits. Claimant saw Dr. Rosenzweig, Ph.D., a clinical social worker, who diagnosed a major depressive episode. She recommended that claimant not attempt to work until his problems coping with his physical disability had resolved.

A Determination Order reclosed the right knee claim on December 7, 1987, with an award of temporary total disability compensation for the period claimant was in the training program. No further permanent disability was awarded.

On January 21, 1988, Farmers denied responsibility for claimant's psychological condition. The insurer suggested that claimant file a claim with SAIF.

On April 4, 1988, SAIF also denied responsibility for the psychological condition contending that work for Farmers' insured had independently contributed to his psychological condition.

No .307 order issued.

## FINDINGS OF ULTIMATE FACT

Claimant's psychological condition was caused in material part by both the 1977 and the 1984 injuries.

The psychological condition had its onset in June 1987 and became disabling in November 1987.

Claimant's psychological condition was not medically stationary at the time his claim was closed on December 7, 1987.

At the time claimant's training program was discontinued, claimant was unable to work due to a combination of his left knee, back and psychological conditions.

## CONCLUSIONS OF LAW AND OPINION

### Responsibility for the Psychological Condition

The insurers concede that claimant's psychological condition, depression, is compensable. The Referee assigned responsibility to Farmers. In so doing, he said that he was relying on Industrial Indemnity v. Kearns, 70 Or App 583 (1984). He reasoned that claimant had suffered multiple injuries, both of which led to claimant's depression. He concluded that Farmers, as insurer of the most recent injury, in order to escape responsibility, had the burden to prove that the most recent injury (the right knee injury) did not independently contribute to claimant's psychological condition. Relying on Dr. Rosenzweig's opinion that

the right knee injury did independently contribute to the psychological condition, he assigned responsibility to Farmers.

Farmers suggests a different analysis. The insurer suggests that to assign responsibility for a psychological condition caused by more than one compensable injury, we should apply the rule applied in EBI Companies v. Grover, 90 Or App 524 (1988). The Grover rule applies only when we rate disability in two separate claims simultaneously, the worker is permanently and totally disabled due to the combination of the two injuries, and we must assign responsibility for payment of that award. In such cases, responsibility for the award is assigned to the insurer whose injury (including aggravations thereof) last contributed to claimant's disability.

The Grover rule does not apply to assignment of responsibility for the sequelae of multiple compensable injuries. But see Ronald C. Earl, 41 Van Natta 530 (1989). Therefore, we decline to apply it here.

Nevertheless, we also reject the Referee's analysis. Kearns applies when a worker who has suffered multiple compensable injuries to the same body part, requires additional medical services or suffers additional disability for the same body part. The 1977 injury was to the left leg (and the back as a consequence of the leg injury) and the 1984 to the back and right leg. Moreover, the aggravation claim is for an entirely different condition--a psychological condition.

In this case, although the psychological condition is compensable as a consequence of an injury, rather than as an occupational disease, we conclude that responsibility should be assigned in accordance with the last injurious exposure rule.

Claimant had no psychological difficulty until several years after his 1984 injury. The onset of the psychological condition occurred while claimant was undergoing an authorized training program in the 1984 claim. The condition became disabling and is one of the reasons claimant was unable to work after the program was terminated. Therefore, under the last injurious exposure rule, Farmers is responsible as the insurer on the risk when claimant became disabled unless Farmers can establish that a prior injury was the sole cause of the psychological disability. Boise Cascade v. Starbuck, 296 Or 238 (1984). See also, Jerry Foster, 40 Van Natta 1687 (1988).

We have found that both the 1977 and the 1984 injuries contributed to claimant's psychological difficulties. In so finding, we rely on the opinions of Dr. Rosenzweig, who treated claimant for several months on referral from Dr. Thompson, and of Dr. Turco, who performed an independent medical examination for Farmers. Although the two did not agree as to the seriousness of claimant's condition, both felt that it was not really possible to isolate one or the other injury as cause of the condition. We are mindful that Dr. Thompson saw claimant's need for psychological treatment as a consequence only of the 1977 back injury. However, we note that claimant was able to work, without regard to the back condition, until he injured his right leg. His back became more painful when he worked under the conditions imposed by the training program commenced due to the right leg injury. Finally, Drs. Turco and Rosenzweig bring to this question special expertise in psychological disorders. Consequently, we defer to their opinions. Inasmuch as we are unable to find that the right knee injury did not contribute to the development of claimant's depression, we, like the Referee, assign responsibility to Farmers.

Premature Claim Closure

The Referee concluded that the claim was not prematurely closed. Although neither party has challenged the Referee's ruling on the premature closure issue, we may address it on de novo review. Destael v. Nicolai Co., 80 Or App 596 (1986).

The Referee's conclusion was apparently based on the want of evidence that claimant's right knee condition was likely to improve with treatment or the passage of time. Indeed, Dr. Thompson so stated in a report dated November 16, 1987. However, at the time of closure claimant was undergoing curative treatment for a compensable psychological condition. Consequently, the Determination Order must be set aside.

Temporary Total Disability

The Referee concluded that claimant was entitled to temporary total disability for her psychological condition and ordered payment of temporary disability compensation for an unspecified period.

Farmers contends that it should not be required to pay claimant's temporary disability compensation because claimant was not disabled by the psychological condition but in fact by the back condition. Drs. Rosenzweig and Thompson declared claimant unable to work for the two different reasons on the same date. Dr. Thompson, in a report of January 25, 1988, indicated that he felt claimant had been unable to work due to the back condition. Dr. Rosenzweig's November 4, 1987, report indicated that claimant had left work both due to inability to cope with work requiring him to deal with other people's problems in light of his own and to the physical demands of the job. Consequently, we find that claimant was unable to work when he left the ATP due to a combination of causes.

At the time claimant became unable to work, the 1984 claim was open. A claim open for an ATP may not be closed and temporary disability may not be discontinued until the worker becomes medically stationary from all conditions under the claim. ORS 656.268(5); OAR 436-120-230(2). Hence, temporary disability must be paid in the 1984 claim.

Attorney Fees

Finally, Farmers challenges the Referee's order assessing a carrier-paid fee, payable by Farmers, for claimant's attorney's services in overcoming the denial. Farmers contends that SAIF should be required to pay the fee because its denial jeopardized claimant's rights.

We note that neither carrier denied compensability. However, because claimant's aggravation rights in the 1977 (SAIF) claim had expired, a .307 order could not issue. Consequently, claimant's right to compensation was not secure and a fee is appropriate. Robert L. Montgomery, 39 Van Natta 469 (1987).

In Ronald L. Warner, 40 Van Natta 975 (1988), we concluded that when issuance of a .307 order is impossible because claimant's aggravation rights have expired in one of the claims, the carrier ultimately responsible in the claim should pay the fee. Assessment of the fee should not shift under Karen J. Bates, 39 Van Natta 42 (1987) in any event because SAIF, just as Farmers, denied only responsibility. The risk to claimant's compensation was no more created by SAIF than Farmers. Therefore, we affirm on this issue.

ORDER

The Referee's order dated September 22, 1988, is affirmed in part and reversed in part. That portion of the order that held that the claim was not prematurely closed is reversed. The Determination Order of December 7, 1987, is set aside and the claim remanded to Farmers Insurance Company for processing. The balance of the order is affirmed. For services on review regarding the denial of the psychological condition, claimant's attorney is awarded a $600 assessed fee, payable by Farmers.

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In the Matter of the Compensation of
**KATHLEEN M. PAYNE, Claimant**
WCB Case No. 88-14535
ORDER ON REVIEW
Victor Calzaretta, Claimant Attorney
David Jorling, Defense Attorney

Reviewed by Board Members Howell, Perry and Speer.

Claimant requests review of Referee Neal's order which: upheld the self-insured employer's denial of her occupational disease claim for a mental disorder; and (2) declined to assess a penalty and attorney fee for unreasonable denial. On review, the issues are compensability and penalty and attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

We find the following facts taken largely from the Referee's order.

Claimant, 23 years of age at the time of hearing, has worked for the Bureau of Emergency Communications or "BOEC" since November 1983. At first, she worked as an assistant to the coordinator at dispatch and then as a secretary. These were temporary jobs. In August 1984, after taking a civil service examination, claimant became an emergency communications officer or "ECO." Her job required her to receive emergency 911 calls and transfer them to another dispatcher, depending on whether the emergency involved a fire, medical problem or police problem. She also worked as a police dispatcher, emergency medical service dispatcher and on the service desk.

Claimant's job as an ECO was consistently stressful. She as well as other ECOs dealt with unhappy and anxious citizens as well as police officers who retaliated against dispatchers that they didn't like. When handling calls, several calls might be backed up at one time. If she missed some of the information, she had to have the call traced, as she could not play back calls. As a police dispatcher, she was required to keep track of police cars, provide information and determine when cover might be needed. Her performance and decisions as a police dispatcher often directly affected the safety of police officers in dangerous and life threatening situations.

The BOEC has always been understaffed. It has not been able to fill the staff positions allowed by the budget. In August 1988, of the 102 ECO positions budgeted, 74 had been filled. At the same time, the work load has been increasing. In 1984, BOEC received about 624,000 calls. In 1987 through 1988, it received 875,000 calls. Of the 875,000 calls, 319,000 involved dispatched emergency police calls, 37,054 were medical calls, and 49,290 were transferred fire calls.

There has always been a high turnover of employees at BOEC, especially during and just after training. In addition, the BOEC, which has only been under police control for the last three years, has had managerial problems in the past. Captain Davis who took over as director in May 1987, within the last year and a half, has instituted a new training program and has made other changes to improve the functioning of BOEC.

Claimant, as well as other BOEC employees, were often required to work through their lunch hour and had difficulty at times getting someone to cover for restroom breaks. BOEC had mandatory or forced overtime, if there were no volunteers to cover the time needed. Some of the BOEC employees had physicians' excuses from overtime work, which made a greater burden on the rest of the ECOs. At the time of hearing, 14 people out of 74 were unavailable for overtime work.

Claimant volunteered to work overtime so that she could control the times when she had to work. For the first seven months of 1988, claimant was paid for 243 hours of overtime, although some of these hours represented times when she was required to work through her lunch hour or deferred holidays.

Claimant was a good employee. She had only two citizen complaints about her work and only a few complaints from her supervisors about incidents at work. The file reflects that her supervisors talked to her about work problems, which included the citizen complaints, once in February 1987, once in April 1987, once in April 1988, once in June 1988, and two times in July 1988.

Claimant has had several medical problems while working at BOEC for which she sought treatment with her family physician, Dr. Sonneland. She had infections from 1984 through 1986. In February 1987, claimant reported to Dr. Sonneland that she was experiencing stress and was able to eat only one meal per day because of her work schedule. Also in February 1987, an ovarian cyst was diagnosed. She had surgery for this problem in February 1988. On July 29, 1988, claimant saw Dr. Sonneland for a physical problem, but also mentioned becoming more and more anxious about going out in public, a condition which claimant attributed to her stress at work with the mandatory overtime.

Claimant had an abortion in 1984, lived with a married man in late 1985 and then met her present husband, a police officer, in June 1986. She lived with her present husband in October 1986. In October 1987, claimant talked to the training coordinator about ways to deal with off-the-job stresses that might be affecting her sick time. She was informed of the counseling program.

Claimant first saw Dr. Hicks, Ph.D., on October 22, 1987. At that time, her main problem was her relationship with her present husband and her second problem was job stress. In November 1987, claimant decided to marry her present husband. Dr. Hicks saw both of them for premarital counseling in March 1988. It was about this time that claimant developed panic about going out in public. Claimant married her present husband in May 1988. By July 29, 1988, when claimant saw Dr. Sonneland and complained of job stress, her relationship with her present husband was stable and she had a good relationship with her parents.

On Friday, August 5, 1988, claimant talked to a co-worker about the problems the co-worker was having with stress from what the co-worker perceived as harassment from her supervisor. On August 6, 1988, claimant cried before leaving her home to begin work at 2:45 p.m. as she was having a bad day and did not want to go to work. She felt anxious and was bothered by what her co-worker had said. This was the first day claimant was to return to work from her week-end.

Claimant's husband visited claimant's place of employment that day because of his concern for her. After working several hours on August 6, 1988, claimant left work because she was "unable to take the job anymore." Before she left, she felt an anxiety attack, started crying and became hysterical. Claimant has not worked since August 6, 1988.

Claimant saw her attorney, who filed a workers' compensation claim for her on August 8, 1988.

Claimant, with her mother, saw her family physician, Dr. Sonneland on August 8, 1988, after seeing her attorney. She informed her physician that she wanted to file a stress claim. Dr. Sonneland filed a physician's report on August 24, 1988 that indicated that claimant's job stress was work-related.

On August 10, 1988, claimant saw her psychologist, Dr. Hicks. She had not seen him since April 1988. She told him about her problems with working overtime. She also reported that her family life was great.

On August 18, 1988, the employer denied claimant's claim. At the time the employer had Dr. Hicks' chart notes. The employer questioned whether claimant's condition arose out of and in the course of employment. It also questioned whether claimant's claim was compensable even if her condition was due to employment conditions, because the meaning of former ORS 656.802(2)(b) was unclear.

Psychiatrist, Dr. Turco, examined claimant for the employer on September 16, 1988. Dr. Turco concluded that claimant had experienced some anxiety and depression, personal in nature, but he found no significant problems to warrant a psychiatric diagnosis. Dr. Sonneland agreed with Dr. Turco's conclusions. Dr. Hicks did not agree with his report.

## ULTIMATE FINDINGS

Claimant suffered a mental disorder, an adjustment disorder with mixed emotional features, the cause or worsening of which arose out of and in the course of her employment as an ECO for the employer. That mental disorder required medical treatment and resulted in disability.

Employment conditions, which existed in a real and objective sense, including answering emergency calls, dealing with irate and anxious people, working extra hours, often without a lunch break, having difficulty getting restroom breaks and being responsible for the safety of others contributed in material part to claimant's worsened mental disorder.

The conditions which resulted in claimant's disabling mental disorder were not conditions generally inherent in every working situation; they were not disciplinary, corrective or job performance evaluation actions; and they were not associated with the cessation of employment.

Claimant's worsened condition was diagnosed as an adjustment disorder by Dr. Hicks. That condition is a mental disorder generally recognized in the psychological community.

The employer's denial was supported by a legitimate doubt as to its legal liability for claimant's claimed mental disorder.

## CONCLUSIONS OF LAW

### Compensability

This claim is for an occupational disease. Claimant's last exposure to potentially causal employment conditions occurred after January 1, 1988. Her claimed condition worsened in August 1988 and thereafter required medical services and resulted in disability. We therefore apply ORS 656.802 as amended effective January 1, 1988 (See Oregon Laws 1987, Chapter 713, Section 4) and before its amendment on July 1, 1990 (See Oregon Laws 1990, [Special Session] Chapter 2, [SB 1197 A - Engrossed], section 43). Ellen L. Crawford, 41 Van Natta 1362 (1989).

The applicable version of ORS 656.802 provides in pertinent part:

> "(1) As used in this chapter, 'occupational disease' means:
>
> " * * *
>
> "(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.
>
> " * * *
>
> "(2) Notwithstanding any other provision of this chapter, a mental disorder is not compensable under this chapter:
>
> "(a) Unless the employment conditions producing the mental disorder exist in a real and objective sense.
>
> "(b) Unless the employment conditions producing the mental disorder are conditions other than conditions generally inherent in every working situation or reasonable disciplinary, corrective or job performance evaluation actions by the employer, or cessation of employment.
>
> "(c) Unless there is a diagnosis of a mental or emotional disorder which is generally recognized in the medical or psychological community.
>
> "(d) Unless there is clear and convincing evidence that the mental disorder arose out of and in the course of employment."

One significant change made to ORS 656.802, effective January 1, 1988, was to delete the requirement that a mental disorder arise from employment conditions ". . . to which an employe is not ordinarily subjected or exposed other than during a period of regular actual employment therein." Thus, after January 1, 1988, a claimant was no longer required to prove that work was the major contributing cause of an occupational disease. See Dethlefs v. Hyster Co., 295 Or 298 (1983). It was sufficient to establish that employment materially contributed to the claimed mental disorder. Donna E. Aschbacher, 41 Van Natta 1242 (1989) and Ellen L. Crawford, supra.

Three experts have examined claimant for her mental condition and offered opinions as to its nature and cause. Dr. Sonneland, claimant's family physician, initially reported that claimant suffered a work-related mental disorder which prevented her from working and which required medical treatment.

Later, Dr. Sonneland concurred with a report of Dr. Turco which indicated that claimant suffered no psychiatric problems sufficient to warrant a psychiatric diagnosis and that the anxiety and depression she did experience were personal in nature. Dr. Sonneland did not explain either of her contradictory opinions. Because of the contradictions and lack of explanation, we find Dr. Sonneland's opinions of little or no persuasive value in determining the essential facts in this case.

Dr. Turco examined claimant for the employer on one occasion. He did not offer a psychiatric diagnosis for claimant's anxiety reaction and/or adjustment disorder because he did not want to "label" such a young lady with a psychiatric diagnosis that would follow her. He did not disagree, however, with the diagnosis of anxiety reaction made by Dr. Sonneland or adjustment disorder made by Dr. Hicks. (Tr. 486).

Dr. Turco also agreed that claimant was in need of medical treatment for her mental condition. (Tr. 533).

Dr. Turco offered his opinion that claimant's mental disorder was due in major part to personal problems (Tr. 489), but conceded that her personal and professional problems were interwoven. (Tr. 486). He reached those conclusions based in substantial part upon a few personnel records supplied by the employer and upon Dr. Hicks' chart notes. He admittedly misinterpreted those records as to a number of particulars. (See e.g. Tr. 523, 524, 542, 545 & 546). Most significant as regards Dr. Turco is that he was not asked, and did not offer, his opinion as to whether employment conditions "materially contributed" to claimant's worsened, disabling mental disorder. He did, though, point to evidence that claimant kept trying to do her stressful job, despite having difficulty, and eventually succumbed to the pressure and had a reaction to it. (Tr. 505 & 533). Dr. Turco's testimony suggests a material contribution by the work to claimant's mental disorder. However, there is no express, specific opinion from Dr. Turco in the record as to whether employment conditions materially contributed to claimant's mental disorder.

Dr. Hicks also offered an opinion as to the existence and cause of claimant's disabling mental disorder. He felt claimant's work was a very substantial cause of that disorder. (Tr. 168 & 171). Dr. Hicks treated claimant over an extended period which spanned earlier personal problems and more recent employment stress. He had a thorough history and was well acquainted with the stressors claimant experienced at work. For those reasons, we find his opinion persuasive as to the contribution of claimant's work to a mental disorder. Additionally, because his opinion is consistent with other evidence in the record and because there is no evidence that claimant's work did not materially contribute to her mental disorder, we conclude that the record as a whole constitutes clear and convincing evidence that claimant experienced a mental disorder which arose in material part out of and in the course of her work with the employer. Former ORS 656.802(2)(d).

It is not disputed that claimant's mental disorder required medical treatment and resulted in disability. The medical and lay evidence is unrebutted in that regard. Neither is it disputed that claimant's job involved real and substantial stressors. Again, the evidence is consistent in support of such a finding. Dr. Hicks diagnosed claimant's disabling condition as an adjustment disorder, a mental disorder generally recognized in the psychological community. (Tr. 158). Dr. Turco did not disagree. It is also clear from the record that claimant's mental disorder did not result from discipline, corrective or performance evaluation action or from cessation of employment.

The primary dispute in this matter, and the basis for the Referee's order upholding the employer's denial, is the interpretation of the phrase "generally inherent in every working situation." If the employment conditions which produced claimant's worsened mental disorder were "generally inherent in every working situation," her mental disorder is not compensable. Former ORS 656.802(2)(b).

The employer argues that "generally inherent in every working situation" means present in the claimant's particular job or occupation. Claimant argues that the disputed phrase means usually present in all jobs or occupations. We agree with claimant.

The clear and unambiguous language of the statute supports claimant's position. The statute does not, as the employer argues, hold mental disorders not to be compensable because they result from conditions usually present in the employment environment peculiar to the claimant. Such a reading of the statute would require us to ignore the usual meaning of the word "every", as "each one" or "all" and to assign it the nearly opposite meaning of "specific to a particular individual or occupation." Such a reading would also result in different and discriminatory tests of compensability for mental disorders suffered by claimants in various occupations.

Our conclusion as to the meaning of the phrase "generally inherent" in every working situation" is fortified by a review of legislative history.

The disputed language in former ORS 656.802(2)(b) was adopted by the 1987 legislature. Oregon Laws 1987, Chapter 713 section 4.

In HB 2271 A-Engrossed the House Labor Committee adopted the language:

> "(2) Notwithstanding any other provision of this chapter, a mental disorder is not compensable under this chapter:
>
> " * * *
>
> "(b) Unless the employment conditions producing the mental disorder are conditions other than conditions inherent in every working situation."

After passage by the House, the Senate Labor Committee added the word "generally" to the phrase "inherent in every working situation" because of concerns that the phrase was too "absolute" and would not allow a court or hearing officer leeway in determining whether something was commonly found or not commonly found in every work situation. (Senate Committee on Labor, Transcript of Proceedings, April 23, 1987, Pgs. 78-79).

On April 23, 1987, Representative Shiprack, Chair of the House Committee on Labor, testified before the Senate Committee on Labor regarding the intent of the House in its use of the language in former ORS 656.802(2)(b). (Senate Committee on Labor, Transcript of Proceedings, April 23, 1987, pgs. 2-8). He explained that the amendment to former ORS 656.802(2)(b);

> ". . . says they've got to be conditions other than those conditions inherent in any -- pardon me -- in every working situation. So that means they would have to be something everyone would -- everyone would agree are inherent to what you see everyday in the workplace."

He was then specifically asked whether conditions inherent in every working situation was a test which involved applying the same set of standards to an office worker as to a fire fighter. The response was:

> "REP. SHIPRACK: The intent there, Senator, is that in the workplace you're expected to show up on time, you're expected to cooperate, perhaps, with your fellow employees, you're expected to have certain things unrelated to the specific occupations involved. This may also address itself to the fact that perhaps in every -- in every experience you will have certain times of layoff. It does not -- the intent of this is not to say that a fire fighter has a more stressful job than someone digging ditches, perhaps, although occasionally maybe it wouldn't be that way, but we don't want to get into that. And that's not the intent of the House to say that this profession is something and this isn't. But you have certain duties in the workplace that are inherent to every job, and that's what we've tried to say there." (emphasis added). (Senate Committee on Labor, Transcript of Proceedings, April 23, 1987, pgs. 5 & 6.)

It is clear from the examples cited by Representative Shiprack and from his initial statement that the phrase in question was directed to certain conditions which were presumed present in all jobs and that these were ". . . things unrelated to the specific occupations involved." Representative Shiprack clearly states that it was not the intent of the House to create a distinct test for each profession but, instead, to say that ". . . you have certain duties in the workplace that are inherent in every job, . . ." and that mental disorders arising from such common conditions are not to be compensable.

The testimony in the record, including that of Drs. Hicks and Turco, indicates, and we find, that the stressful conditions to which claimant was exposed as an ECO are not generally inherent in every working situation.

Claimant has established that the mental disorder which caused her to leave work on August 6, 1988 and which required medical treatment is compensable as an occupational disease.

Penalty and Attorney Fee

Based upon the factual information available at the time and the uncertainty as to the meaning of former ORS 656.802(2)(b), we find that the employer had a legitimate doubt as to its legal liability for claimant's mental disorder. We, therefore, conclude that the employer did not unreasonably refuse to pay, or delay payment of, compensation by issuance of its August 18, 1988 denial. See ORS 656.262(10); Norgard v. Rawlings, 30 Or App 999 (1977).

ORDER

The Referee's order dated December 20, 1988 is reversed in part and affirmed in part. That portion of the order which upheld the employer's August 18, 1988 denial is reversed. The denial is set aside and the mental disorder claim is remanded to the employer for acceptance and processing according to law. The remainder of the Referee's order is affirmed. For services at hearing and on review, claimant's attorney is awarded an assessed fee of $7,500.

In the Matter of the Compensation of
**ROBERT L. REED, Claimant** (WCB Case No. 86-03723)
**JOHNIE F. HAYDEN, Claimant** (WCB Case No. 86-04618)
**ROBERT L. FOX, Claimant** (WCB Case No. 86-04619)
**WILLIAM WARNER, Claimant** (WCB Case No. 86-04621)
**JOHN GLEGOR, Claimant** (WCB Case No. 86-04622)
**MAYNARD ANDERSON, Claimant** (WCB Case No. 84-02795)
**OLIVE H. MORRIS, Claimant** (WCB Case No. 83-11186)
**DONALD L. SPICER, Claimant** (WCB Case No. 83-10945)
ORDER ON REVIEW
Pozzi, Wilson, et al., Claimants Attorneys
Mitchell, Lang & Smith, Defense Attorneys
Schwabe, et al., Defense Attorneys
Norman Cole (Saif), Defense Attorney
David O. Horne, Defense Attorney
Foss, Whitty, et al., Defense Attorneys
Jim G. Russell, Assistant Attorney General

Reviewed by Board Members Crider and Nichols.

The SAIF Corporation, Eldorado Insurance Company, Wausau Insurance Company, Weyerhaeuser Company, a self-insured employer, and the Workers' Compensation Division (formerly Workers' Compensation Department) have requested review of Referee St. Martin's order that set aside the Department's authorization allowing offset of federal social security disability benefits against permanent total disability benefits for each of the above-named claimants, after each claimant reached 62 years of age. Weyerhaeuser, the self-insured employer of claimant Johnie F. Hayden, has subsequently moved for its dismissal from the review proceedings. We grant Weyerhaeuser's request. On the merits of the authorization issue, we reverse.

## FINDINGS OF FACT

The pertinent facts as to each claimant are as follows:

### Robert L. Reed WCB #86-03723

Claimant Reed's date of birth is September 5, 1920. He was compensably injured on June 6, 1967 while employed by Eldorado's insured. He was awarded permanent total disability benefits effective August 7, 1980. The Department subsequently authorized Eldorado to offset federal social security disability benefits received by claimant against permanent total disability benefits otherwise owing to him, effective July 1981. This authorization was withdrawn in September 1982, when claimant turned 62 years of age. The authorization was reinstated in September 1983. The authorization was then again withdrawn in September 1985, when claimant turned 65 years of age.

### Robert L. Fox WCB #86-04619

Claimant Fox was born in January 1921. He was compensably injured on November 4, 1973, while employed by SAIF's insured. He was awarded permanent total disability benefits in March 1977. The Department subsequently authorized an offset of federal social security disability benefits received by claimant against permanent total disability benefits otherwise owing to him, effective July 1978. This authorization was withdrawn in January 1983, when claimant turned 62 years of age. The offset was reinstated in September 1983. The authorization was again withdrawn when claimant turned 65 years of age.

William Warner WCB #86-04621

Claimant Warner was born in 1919. He was compensably injured on November 6, 1970, while employed by SAIF's insured. He was awarded permanent total disability benefits in October 1973. The Department subsequently authorized an offset of federal social security disability benefits received by claimant against permanent total disability benefits otherwise owing to him, effective July 1978. This authorization was withdrawn when claimant turned 62 years of age. The offset was reinstated in September 1983. The authorization was again withdrawn when claimant turned 65 years of age.

John Glegor WCB #86-04622

Claimant Glegor was born on July 4, 1919. He was compensably injured on February 28, 1976, while employed by SAIF's insured. He was awarded permanent total disability benefits in June 1976. The Department subsequently authorized an offset of federal social security disability benefits received by claimant against permanent total disability benefits otherwise owing to him, effective July 1978. This authorization was withdrawn in July 1981, when claimant turned 62 years of age. The offset was reinstated in September 1983. The authorization was again withdrawn when claimant turned 65 years of age.

Maynard Anderson WCB #84-02795

Claimant Anderson was born on January 20, 1920. He was compensably injured on October 6, 1979, while employed by SAIF's insured. He was declared eligible for federal social security benefits in April 1980. He was awarded permanent total disability benefits, effective March 1982. The Department authorized a benefit offset effective January 1984. This authorization was withdrawn in January 1985, when claimant turned 65 years of age.

Olive H. Morris WCB #83-11186

Claimant Morris was born on January 10, 1921. She was compensably injured on March 4, 1973, while employed by Wausau's insured. She was declared eligible for federal social security benefits in March 1977. She was awarded permanent total disability benefits effective October 3, 1979. The Department subsequently authorized an offset of federal social security disability benefits received by claimant against permanent total disability benefits otherwise owing to him, effective January 1982. This authorization was withdrawn in January 1983, when claimant turned 62 years of age. The authorization was reinstated in September 1983. The authorization was again withdrawn when claimant turned 65 years of age.

Donald L. Spicer WCB #83-10945

Claimant Spicer was born on January 12, 1920. He was compensably injured on July 17, 1974, while employed by SAIF's insured. He was declared eligible for federal social security benefits in January 1975. He was awarded permanent total disability benefits, effective December 1975. The Department subsequently authorized an offset of federal social security disability benefits received by claimant against permanent total disability benefits otherwise owing to him, effective July 1978. This authorization was withdrawn in January 1982, when claimant turned 62 years of age. The authorization was reinstated in September 1983. The authorization was again withdrawn when claimant turned 65 years of age.

## FINDINGS OF ULTIMATE FACT

Each claimant received an award of permanent total disability as a result of a compensable injury or disease. Each claimant was also receiving federal social security disability benefits. Each claimant first became disabled before February 1981 and was entitled to federal social security disability benefits before September 1981. At various times, the Department authorized benefit offsets with regard to each claimant. These authorizations were withdrawn when each claimant reached the age of 62. However, the authorizations were reinstated in September 1983, at which time each claimant was between the age of 62 and 65. The authorizations were again withdrawn when each claimant reached the age of 65. None of the authorizations were applied to permanent total disability benefits for prior months or allowed recovery of any portion of the benefits paid for prior months.

## CONCLUSIONS OF LAW AND OPINION

These cases require us to determine whether the insurers and self-insured employer herein were entitled to offset social security disability benefits against permanent total disability benefits when claimants were between 62 and 65 years of age. Claimants requested hearings under ORS 656.283. They contended that the Workers' Compensation Department, now the Workers' Compensation Division of the Department of Insurance and Finance, unlawfully authorized such offsets with respect to individuals who were exempt from federal offsets while between the ages of 62 and 65 by the terms of the Omnibus Budget Reconciliation Act, P.L. 97-35. Consequently, they sought an order requiring the insurers and self-insured employer to pay the difference between their full permanent total disability awards and the amount actually paid under the offset authorizations when they were between the ages of 62 and 65. The Referee granted claimants' request, and the insurers and self-insured employer requested review.

In 1977, the Legislative Assembly enacted ORS 656.209, allowing the reduction of permanent total disability benefits by the worker's receipt of federal social security disability benefits. As amended by the addition of section (4) in 1979, the statute reads in its entirety:

> "(1) With the authorization of the department, the amount of any permanent total disability benefits payable to an injured worker shall be reduced by the amount of any disability benefits the worker receives from federal social security.
>
> "(a) If the benefit amount to which the worker is entitled pursuant to ORS 656.001 to 656.794 exceeds the worker's federal disability benefit limitation determined pursuant to 42 U.S.C. 424(a), the reduction in worker's compensation benefits authorized by this subsection shall not be administered in such manner as to lower the amount the worker would have received pursuant to ORS 656.001 to 656.794 had such reduction not been made.
>
> "(b) If the benefit amount to which the worker is entitled pursuant to ORS 656.001 to 656.794 is less than the worker's federal disability benefit limitation determined pursuant to 42 U.S.C. 424(a), the reduction in worker's compensation benefits authorized by this subsection shall not

> be administered in such manner as to lower the amount of combined benefits the worker receives below the federal benefit limitation.
>
> "(2) No reduction of permanent total disability benefits shall be made pursuant to this section unless authorized by the department.
>
> "(3) No reduction of benefits shall be authorized pursuant to this section except upon actual receipt of federal social security disability benefits by the injured worker.
>
> "(4) The effective date of the operation of any offset provided in this section shall be the date established in the authorization provided in subsection (1) of this section, whether the authorization was issued prior to or subsequent to May 8, 1979."

Pursuant to this legislation, the Department promulgated administrative rules providing for an offset but terminating any offset authorization at age 62. Former OAR 438-26-015(4). This rule was amended in 1983, removing the age limitation. Former OAR 436-57-001 et seq.

When the state offset law was adopted, federal law already provided for a federal offset. See former 42 U.S.C. 424a. The federal legislation provided for reduction of social security disability payments by certain state and local workers' compensation benefits, according to a formula. The offset legislation sought to assure that a beneficiary would not receive less than the highest amount he/she would receive from any one benefit but also to cap the total benefit to which the federal program would contribute.[1] The federal legislation recognized that some states had enacted offset laws of their own and some had not. It provided that no federal offset would be taken if a state statute provided for reduction of workers' compensation benefits by social security benefits. Thus, if there was no state offset law, the federal offset law would apply. If, however, a state, as Oregon, were to provide for a similar offset, no federal offset would be taken.[2] Until 1981, the federal offset was to be taken only until a worker reached 62 years of age.[3]

In August 1981, the federal offset law was changed. With respect to persons whose social security disability award was granted after the months of enactment and who had become disabled after February 1981, the federal offset was to be taken until age 65, rather than age 62.[4] At age 65 years, social security disability benefits terminate; any further social security benefits are taken under the old-age or retirement provisions of the Act. The 1981 amendments to the federal law also limited the authority of the state and local government to enact offset legislation which would displace the federal offset provision. That is, the law provided that the federal offset would be taken unless a state law or plan had been enacted prior to February 18, 1981, providing for reduction of state-mandated benefits when a beneficiary was also entitled to social security disability benefits.[5]

Each claimant herein has been awarded permanent total disability benefits pursuant to the Oregon Workers' Compensation Act. Each has been entitled to social security disability benefits since before September 1981. Pursuant to ORS 656.209 and the administrative rules promulgated by the Department based on ORS 656.209, the respective insurers and self-insured employers applied to the Department for authorization to offset each claimant's award of social

security disability benefits against each award of permanent total disability. In each case, prior to the passage of the 1981 amendments to the federal law, the Department authorized offset pursuant to the state statute and rules. Each authorization expired by its terms when claimant reached age 62. However, after the 1981 amendments to the federal offset law and the 1983 amendment to the state offset rules, the Department authorized offset of social security disability benefits payable after claimant reached 62 and before he reached 65 years of age.

The Department's authorization of offsets effective before claimants reached 65 was granted, although the 1981 amendment to the Social Security Act, allowing offsets in calculating social security disability payments to persons aged 62 to 65 did not apply to persons who, like claimants, were disabled before February 1981 and entitled to social security disability benefits before September 1981.

The question before us, as we understand it, is whether the 1983 authorizations of state offsets for claimants between age 62 and 65 violated any of the following: (1) ORS 656.202, (2) ORS 656.209, and (3) 42 U.S.C. sec. 424a.

ORS 656.202

Claimants argued at hearing, and the Referee held, that the Department applied the 1983 offset regulation retroactively, and that such retroactive application is precluded by ORS 656.202(2), which provides:

> "(2) Except as otherwise provided by law, payment of benefits for injuries or deaths under ORS 656.656.001 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 Referee held that ORS 656.202 precludes application of any offset rule to claimants that was not in effect at the time the offset rule first became applicable to them. We are perplexed by what such a notion has to do with ORS 656.202. ORS 656.202(2) simply provides that unless otherwise provided by law, the law in effect at the time of injury governs the amount of benefits to which an injured worker is entitled. In this regard, the legislature expressly provided that ORS 656.209 would apply to "benefits for injuries incurred prior to the effective date of this 1977 act, on July 1, 1978, and thereafter." Or Laws 1977, ch. 430 sec. 8. Accordingly, application of ORS 656.209 to pre-enactment injuries is expressly provided. Moreover, nothing in either ORS 656.202 or .209 provides that the offset benefit formula which the Department is required to adopt must remain static or that the formula extant when offset authorization is first granted in a particular case is fixed with respect to that claimant in perpetuity. Consequently, we reject this basis of the Referee's decision.

ORS 656.209

Claimants also argue that the 1983 offset authorization applying to them after they reach age 62 is at odds with ORS 656.209 because it provides for a retroactive offset and because ORS 656.209 must parallel the federal offset statute, which, of course, did not authorize a federal offset while they were between 62 and 65 years of age.

ORS 656.209(4) does provide that no offset authorization may permit a retroactive offset. No authorization issued by the Department may authorize

offset for benefits already received. See Fletcher v. SAIF, 48 Or App 777 (1980). However, we do not agree that the Department applied the 1983 offset regulation retroactively. To the contrary, both ORS 656.209 and the rules promulgated by the Department operate prospectively only. The new rules adopted September 1, 1983 eliminated that provision of the old rules terminating the offset at age 62. The rules provided that the offset authorization would be effective on the date established by the authorization. Former OAR 436-57-130(6) (WCD Admin. Order 4-1983). Although offset authorizations had been sent to some of the claimants prior to the adoption of the new rule, the effective dates of the offsets were after the date of the authorizations. Moreover, these prerule authorizations were withdrawn and new authorizations were issued September 1, 1983, effective September 1, 1983. There is no evidence that offsets were actually taken without authorization. Consequently, we are unable to find that any retroactive offset has been taken.

Claimants also argue that Oregon's offset scheme is controlled by federal law. They observe that when Oregon announced the 1983 rule changes providing for offset of social security disability even after age 62, the Department indicated that the change was a byproduct of the 1981 amendments to the federal offset law. From this, they reason that Oregon could not apply its 1983 rule change to persons exempt from the federal amendments. Claimants' reasoning is flawed.

Although the Department may not have understood the relationship between state and federal law, the 1983 rule clearly did apply to all persons, including those entitled to unreduced social security disability benefits between ages 62 and 65. Moreover, there is nothing in ORS 656.209 that precluded the Department from enacting such a rule. The only limitation that the legislature has imposed on the Department in its development of rules is that the offset should not be administered so as to reduce the combined benefits either below the amount provided under the workers' compensation law alone or below the federal benefit minimum determined pursuant to 42 USC sec. 424a. ORS 656.209(1). The term "federal benefit limitation" is undefined. However, the federal statute provides for an offset if the total of workers' compensation and social security benefits exceeds 80 percent of the workers' average covered earnings. This "'80 percent of average covered earnings' limitation" is repeatedly referred to in the committee report that accompanied the 1965 enactment of the offset legislation. See S. Rep. No. 404, 89 Cong., 1st Sess., reprinted in 1965 U.S. Code Cong. & Admin. News 1943, 2040-2041. We are persuaded that the Oregon statute incorporates this benefit limitation only. It cannot be read to say that an Oregon workers' compensation claimant is entitled to the same total benefit under the Oregon offset law that he would receive if Oregon had no offset law. We, therefore, reject claimants' contention that state law precludes authorization of a state offset simply because, in the absence of the state offset, there would be no federal offset.

42 U.S.C. sec. 424a

While claimants do not clearly argue that the federal statute precludes the states from taking offsets when, as here, the federal government would not, we address the issue briefly.

Without specifically saying so, claimants seem to argue that when Congress enacted a federal offset program, it intended to restrict the circumstances in which a state offset program may operate. However, application of federal preemption requires an expression of congressional intent to exclusively occupy the field. Here, we find just the opposite. Congress has enacted its own offset law while recognizing, and providing for, diverse state offset laws.

Prior to 1981, the federal law simply stated that the federal offset will not be taken if the state provides for reduction of its workers' compensation benefits when a worker is entitled to both types of benefit. The 1981 amendments to the Social Security Act changed this provision so that the federal offset would not be taken only if the state law or plan had provided for a benefit reduction prior to February 18, 1981. The amendments, just as the original provision, in no way limited the kind of offset statute that states might choose to adopt. While the federal offset would not operate to reduce the benefits of persons who had been drawing both social security disability and workers' compensation benefits while between the ages of 62 and 65 when the amendment took effect, nothing in the language of the act precluded the state from reducing benefits to such persons.

The federal government might reasonably have adopted a policy that limited the circumstances under which states might reduce workers' compensation benefits payable to persons also receiving social security disability benefits. Such a limitation would tend to equalize benefits nationwide. However, we find no indication in the legislative history of such an intention. On the contrary, the exclusive concern of Congress appears to have been to limit the total cost of disability benefits, not to regulate state disability compensation programs. Therefore, we find the authorizations issued by the Department to be permissible under federal law.

Accordingly, the Department authorizations permitting offsets of federal disability benefits against permanent total disability awards for each claimant after the age of 62 are reinstated and affirmed.

ORDER

The Referee's order dated June 30, 1987 is reversed. Weyerhaeuser Company's request for review of the Referee's order in WCB Case No. 86-04618 is dismissed. Each authorization dealing with the remaining claimants is reinstated and affirmed.

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1. "Sec. 224. (a) If for any month prior to the month in which an individual attains the age of 62--

"(1) such individual is entitled to benefits under section 223, and

"(2) such individual is entitled for such month, under a workmen's compensation law or plan of the United States or a State, to periodic benefits for a total or partial disability (whether or not permanent), and the Secretary has, in a prior month, received notice of such entitlement for such month,

the total of his benefits under section 223 for such month and of any benefits under section 202 for such month based on his wages and self-employment income shall be reduced (but not below zero) by the amount by which the sum of--

"(3) such total of benefits under sections 223 and 202 for such month, and

(4) such periodic benefits payable (and actually paid) for such month to such individual under the workmen's compensation law or plan,

exceeds the higher of--

"(5) 80 per centum of his 'average current earnings', or

"(6) the total of such individual's disability insurance benefits under section 223 for such month and of any monthly insurance benefits under section 202 for such month based on his wages and self-employment income, prior to reduction under this section.

In no case shall the reduction in the total of such benefits under sections 223 and 202 for a month (in a continuous period of months) reduce such total below the sum of--

"(7) the total of the benefits under sections 223 and 202, after reduction under this section, with respect to all persons entitled to benefits on the basis of such individual's wages and self-employment income for such month which were determined for such individual and such persons for the first month for which reduction under this section was made (or which would have been so determined if all of them had been so entitled in such first month), and

"(8) any increase in such benefits with respect to such individual and such persons, before reduction under this section, which is made effective for months after the first month for which reduction under this section is made.

PL 89-91, Sec. 224(a).

2. "(d) The reduction of benefits required by this section shall not be made if the workmen's compensation law or plan under which periodic benefit is payable provides for the reduction thereof when anyone is entitled to benefits under this title on the basis of the wage and self-employment income of an individual entitled to benefits under section 223.

PL 89-91, Sec. 224(d).

3. Compare PL 89-97, Sec. 224(a) with PL 97-35, Sec. 2208(a)(2); 42 U.S.C. 424a(a).

4. The 1981 Statute provided that:

"(a) Section 224 of the Social Security Act is amended...

(2) in subsection (a), in the matter preceding paragraph (1), by striking out 'age of 62' and inserting 'age of 65';...

(b) The amendments made by subsection (a) shall be effective with respect to individuals who first become entitled to benefits under Section 223(a) of the Social Security Act for months beginning after the month in which this Act is enacted, but only in the case of an individual who became disabled within the meaning of Section 223(d) of such Act after the sixth month in which this Act is enacted."

PL 97-35, Sec. 2208.

5. (d) **Exception.** The reduction of benefits required by this section shall not be made if the law or plan described in subsection (a)(2) under which a periodic benefit is payable provides for the reduction thereof when anyone is entitled to benefits under this title [42 USCS 401 et seq.] on the basis of the wages and self-employment income of an individual entitled to benefits under section 223 [42 USCS 423], and such law or plan so provided on February 18, 1981.

42 U.S.C. 424a(d).

In the Matter of the Compensation of
**ROBERTA F. RUSCHEINSKY, Claimant**
WCB Case No. 85-13236
ORDER ON REVIEW
Carol Wright, Claimant Attorney
Cooney, Moscato, et al., Defense Attorneys

Reviewed by Board Members Gerner and Cushing.

Claimant requests review of those portions of Referee Podnar's order which: (1) upheld HMSI's partial denial of her medical services claim for a low back injury; and (2) declined to award unscheduled permanent disability for the same condition. On review, the issues are compensability, and extent of unscheduled permanent disability. We affirm.

FINDINGS OF FACT

On April 27, 1982, claimant, a clerk for Fred Meyer, HMSI's insured, compensably injured her back. She was treated and evaluated by Dr. Buxman, her family physician; Dr. Mandiburg, orthopedic surgeon; Dr. Walker, chiropractor; and the Orthopaedic Consultants.

Claimant returned to her regular work in January 1983. She continued to work until September 1983, at which time she moved to California.

While in California, working as a clerk at Zody's, Mission Insurance's insured, claimant experienced thoracic and lumbar symptoms after lifting a cosmetic tray. She sought treatment for those symptoms, but did not return to work at Mission's insured for reasons unrelated to her work injury.

Claimant filed a claim for her 1983 injury with Mission. No formal acceptance or denial was ever issued. Mission paid medical bills and temporary disability benefits from December 13, 1983 through February 22, 1984.

On March 11, 1985, an Order Approving Compromise and Release was issued by the State of California, in which Mission agreed to pay claimant $1,500 in exchange for a release of all rights claimant had against Mission and its insured pertaining to the October 12, 1983 California injury.

On March 13, 1985, after concluding that no permanent disability resulted from claimant's April 1982 back injury, HMSI issued a Notice of Closure.

Claimant returned to Oregon in June 1985.

On July 16, 1985, claimant began treating with Dr. Hyland, chiropractor, for recurrent low back and right leg symptoms. Hyland treated her until August 31, 1985, at which time she discontinued treatment.

On July 23, 1985, while claimant was treating with Hyland, a Determination Order set aside HMSI's March 13, 1985 Notice of Closure.

On September 4, 1985, HMSI issued a partial denial of claimant's medical services rendered since July 16, 1985. Claimant requested a hearing.

On September 30, 1985, a Determination Order closed claimant's 1982 claim and awarded various periods of temporary disability through September 16, 1983. No permanent disability was awarded. Claimant again requested a hearing.

At the time of the hearing, claimant, 27 years old, was working three, 12-hour shifts per week as a wax cleaner for Precision Castparts. Her prior work experience includes clerking work and phone soliciting. She is a high school graduate with five months of college training in clerical work.

FINDINGS OF ULTIMATE FACT

Claimant's back condition, which HMSI accepted in 1982, is not a material contributing cause of her current need for treatment.

Claimant suffers no permanent impairment resulting from her compensable 1982 injury.

CONCLUSIONS OF THE LAW

After indicating that he was unclear as to the severity, contribution or noncontribution of the California claim and settlement of that claim, the Referee stated that he was unable to conclude that claimant's current treatment was the result of her compensable 1982 Oregon injury. Consequently, he upheld HMSI's denial of claimant's current treatment. We agree.

Compensability of Medical Services

Initially, to establish entitlement to compensation for medical services, a claimant must prove the reasonableness and necessity of the medical services and a causal relation between the medical services and a compensable injury or disease. ORS 656.245(1); Jordan v. SAIF, 86 OR App 29, 32 (1987); West v. SAIF, 74 Or App 317, 320 (1985). Specifically, claimant must prove that her compensable 1982 back condition was a material contributing cause of her need for her current treatment. See Grable v. Weyerhaeuser Co., 291 Or 387 (1981).

Additionally, where a claimant has suffered an on-the-job injury in another state for which she has claimed, but has not been awarded, compensation, and the medical evidence is that the original Oregon injury materially contributed to the claimant's present disability, even though the out-of-state injury contributed independently to the present disability, the Oregon employer remains responsible for the claimant's condition. Miville v. SAIF, 76 Or App 603, 607 (1985).

Under either the Grable analysis or the Miville analysis, the first crucial question is whether claimant can establish that her compensable 1982 back injury was a material contributing cause of the need for her current treatment. Van Blokland v. Oregon Health Sciences University, 87 Or App 694, 697-8 (1987).

Here, claimant contends that her need for medical treatment is causally related to her compensable 1982 back injury and then relies on a series of cases, including Smith v. Ed's Pancake House, 27 Or App 361 (1976), Boise Cascade Corp. v. Starbuck, 61 Or App 631 (1983), and Miville v. SAIF, Supra in asserting that HMSI's insured is responsible for her subsequent need for medical treatment.

HMSI contends that there is no evidence in the record to establish that claimant's treatment beginning July 16, 1985 is reasonable and necessary, nor is there evidence that such treatment is materially related to her compensable 1982 injury. We agree.

Claimant's initial 1982 injury occurred in Oregon and was compensated according to Oregon law. She had a second back injury in 1983 while working in

California. The disposition of that injury was controlled by California law. Mission paid claimant temporary disability benefits from October 13, 1983 through February 22, 1984 and also paid claimant's medical bills resulting from the 1983 injury. No formal acceptance or denial of the California claim was ever made. In March 1985, claimant and Mission entered into a compromise and release agreement, in which claimant released all rights against Mission and its insured in exchange for the sum of $1,500.

The record establishes the following: (1) claimant filed a claim in California for an incident which occurred while working there; (2) claimant's symptoms resulting from the intervening incident were similar in that they involved the same body parts as were injured in her compensable 1982 Oregon injury; and (3) no formal acceptance or denial was ever made by Mission, nor was the incident determined to be a "new injury" or an "aggravation" of claimant's compensable 1982 injury.

Under these circumstances, we find that the issue of whether the medical treatment claimant received from July 15, 1985 forward is materially related to her compensable 1982 injury is of sufficient medical complexity that we cannot decide it without expert opinion. Uris v. Compensation Department, 247 Or 420, 424-26 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985).

The medical evidence establishes that the only physicians to treat or evaluate claimant after July 16, 1985 were the Orthopaedic Consultants, Dr. Radecki, M.D., and Dr. Hyland, claimant's treating chiropractor. None of these physicians' reports establish that claimant's medical treatment after July 16, 1985 is materially related to claimant's compensable 1982 back injury.

In August 1985, the Consultants performed a second independent medical evaluation. After noting their October 1982 examination of claimant, and reviewing claimant's history, which was "essentially unchanged," the Consultants opined that claimant had "reached maximum improvement from the injury sustained in Oregon in 1982," and that claimant's current chiropractic treatments are not curative. (Ex. 28-4). The Consultants did not indicate whether claimant's treatments beginning on July 16, 1985 related to or were caused by the 1982 injury.

Dr. Radecki examined claimant in December 1985 and again in March 1986. Radecki diagnosed "persisting low back pain of unknown etiology," and concluded that her low back pain was neither radicular nor mechanical in nature. He did not determine the etiology of claimant's low back pain, but felt that claimant was most likely depressed and deconditioned. (Ex. 31A-3). Thus, Radecki did not render an opinion as to the cause of her current back treatment.

In March 1987, claimant's treating chiropractor, Dr. Hyland, authored a narrative report on claimant's back pain. In that report, he noted that claimant "presented herself to this office on July 16, 1985, for injuries due to a work-related incident on April 27, 1982." (Ex. 33-1).

After our review of that report, we find that Hyland did not independently opine that claimant's treatments beginning on July 16, 1985 were materially related to claimant's 1982 compensable injury. He noted only that claimant reported that her complaints were related to the 1982 injury.

Consequently, we find that the medical evidence relating to claimant's medical treatment beginning on July 16, 1985 fails to establish that claimant's compensable 1982 back injury is a material contributing cause of the need for her current treatment. Based on this finding, we do not proceed to determine

whether such treatments were reasonable and necessary, nor do we determine responsibility under the Miville analysis.

We conclude, therefore, that claimant has failed to establish the compensability of her medical treatment beginning on July 16, 1985.

Extent of Unscheduled Permanent Disability

The Referee affirmed the September 30, 1985 Determination Order which awarded claimant temporary disability only, noting that the preponderance of the evidence indicated no permanent impairment resulting from the compensable 1982 injury. We agree.

Disability is rated at the time of hearing. See Gettman v. SAIF, 289 Or 609, 614 (1980); Emmons v. SAIF, 34 Or App 603 (1978). It is claimant's burden to prove that she suffers permanent impairment resulting from her compensable injury. ORS 656.214(5).

In rating the extent of claimant's unscheduled permanent disability, we consider her loss of earning capacity and physical impairment attributable to the compensable injury, and all of the relevant social and vocational factors set forth in OAR 436-30-380 et seq. We apply these rules as guidelines, not as restrictive mechanical formulas. Harwell v. Argonaut Insurance Co., 296 Or 505, 510 (1984); Fraijo v. Fred N. Bay News Co., 59 Or App 260 (1982).

Considering our conclusion that claimant's medical services received beginning on July 16, 1985, are not compensably related to her accepted compensable 1982 back injury. and in light of claimant's 1983 California claim for similar back symptoms, we are not persuaded that she has suffered permanent impairment as a result of her 1982 compensable injury. Consequently, we agree with the Referee that claimant is not entitled to an unscheduled permanent disability award.

ORDER

The Referee's order dated July 15, 1987, is affirmed.

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August 31, 1990 Cite as 42 Van Natta 1918 (1990)

In the Matter of the Compensation of
**ANN M. RYAN, Claimant**
WCB Case No. 88-05053
ORDER ON REVIEW
Coons & Cole, Claimant Attorneys
Dennis Ulsted (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

Claimant requests review of Referee Seifert's order which: (1) found that her claim was not prematurely closed by Determination Order; (2) upheld the SAIF Corporation's denial of an aggravation claim; and (3) affirmed a Determination Order award of 15 percent (48 degrees) unscheduled permanent disability for an upper and mid-back injury. On review, the issues are premature closure, or in the alternative, aggravation, and extent of unscheduled permanent disability. We affirm.

FINDINGS OF FACT

The Board adopts the Referee's "Findings" with the following supplemented ultimate finding of fact.

The psychological condition for which claimant is now being treated is the same condition which was previously found noncompensable.

CONCLUSIONS OF LAW AND OPINION

The Board adopts the Referee's "Opinion" with the following comments.

Claimant argues that her new psychologist, Dr. Carter, is treating her for a different condition than that which was previously found not compensable. The previously litigated condition was termed "anxiety and depression." Now, Dr. Carter has diagnosed "psychological condition affecting physical condition--depression, anxiety, chronic pain . . . ."

We find that, although Dr. Carter has called claimant's condition by a different name, it is the same condition that the the previous order clearly found not to be compensable. Thus, because it is the same condition, regardless of cognomination, the issue cannot be relitigated. See Liberty Northwest Ins. Co. v. Bird, 99 Or App 560 (1989); Proctor v. SAIF, 68 Or App 333 (1984).

ORDER

The Referee's order dated November 22, 1988 is affirmed.

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August 31, 1990 Cite as 42 Van Natta 1919 (1990)

In the Matter of the Compensation of
**PHILIP H. SPARKS, Claimant**
WCB Case No. 89-01873
ORDER ON REVIEW
Garlock, et al., Claimant Attorneys
Roy W. Miller (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

The SAIF Corporation requests review of that portion of Referee Foster's order that awarded 20 percent (64 degrees) unscheduled permanent disability for his Legionnaires disease condition, whereas a Determination Order had awarded no permanent disability. Claimant cross-requests review of that portion of the Referee's order that declined to award a separate assessed attorney fee for expenses incurred in cross-examination of a medical expert. On review, the issues are extent of unscheduled permanent disability and attorney fees. We reverse.

FINDINGS OF FACT

In 1986, claimant attended a trade show in Reno, Nevada. After his return to Oregon, he began to have difficulty breathing. Claimant's symptoms increased and he was admitted to a hospital where Dr. Cordova, M.D., diagnosed Legionnaires disease with respiratory failure. On March 2, 1988, SAIF accepted his Legionnaires disease condition.

Claimant was medically stationary on November 28, 1988. A January 23, 1989 Determination Order awarded claimant temporary total disability but no permanent partial disability.

Claimant is 47 years old and has an eleventh grade education. For the past ten years, he has been employed as a baker and at one time he owned a bakery shop. In addition, claimant worked for the employer as a shop foreman, installer and servicer of spray equipment. At the time of hearing, claimant had returned to work as a baker for approximately 36 hours each week.

Since he contracted Legionnaires disease, claimant has a lack of energy and stamina. He experiences shortness of breath after exertion.

## CONCLUSIONS OF LAW AND OPINION

### Extent of unscheduled permanent partial disability

The Referee found clear and convincing evidence that claimant was entitled to 20 percent unscheduled permanent disability for fatigue and shortness of breath related to his compensable Legionnaires disease condition. We disagree.

In May 1988, Dr. Hansen, M.D., a specialist in pulmonary disease, reported that claimant had complete pulmonary function, was medically stationary and could perform regular work duties. In June 1988, Dr. Bryant, an infectious disease specialist, opined that there was no ongoing Legionnaires infection and no restriction from work on that basis. In November 1988, Dr. Barker, a pulmonary specialist, found no pulmonary impairment. He reported that, by the disability standards of the respiratory system, claimant would be class I, or 0 percent impairment.

On a January 11, 1989 Change of Attending Physician form, Dr. Shea, D.C., diagnosed claimant's condition as post-traumatic fatigue secondary to Legionnaires disease. On January 30, 1989, Dr. Shea reported to SAIF that, subsequent to contracting Legionnaires disease, claimant had experienced symptoms of fatigue after exercising. She noted that claimant's physical exam showed no abnormal findings and his range of motion was within normal limits. Dr. Shea reported that claimant had not exercised since he became ill, but she believed that with a gradual increase in exercise, his endurance level would improve.

On April 17, 1989, Dr. Segur, chiropractor, examined claimant and noted complaints of weakness after physical exertion. Dr. Segur opined that claimant's infection and incomplete resolution had resulted in permanent partial disability. Dr. Segur rated claimant's physical impairment at 12 percent.

When faced with conflicting medical opinions, we give greater weight to those that are well-reasoned and based on complete information. Somers v. SAIF, 77 Or App 259, 263 (1986). Under the circumstances, we do not find the opinions of Dr. Segur and Dr. Shea, chiropractors, to be persuasive. Neither has been shown to have expertise in infectious disease or pulmonary function. Rather, we are persuaded by the testimony of Dr. Schwerzler, M.D., who concluded that treatment or diagnosis of an infectious disease falls outside the realm of chiropractic medicine. Dr. Schwerzler testified that, for treatment of a disease such as that contracted by claimant, he would refer claimant to an infectious disease or pulmonary specialist. Dr. Schwerzler also reported that fatigue was not a common residual effect of the disease and he opined that claimant's disease had completely resolved without residual problems or impairment.

In the present case, we rely upon the expertise of Drs. Hansen, Bryant and Barker in addition to the testimony of Dr. Schwerzler. We therefore conclude that claimant has failed to prove a permanent loss of earning capacity due to his compensable Legionnaires disease condition.

Attorney Fees

On review, claimant contends that his counsel is entitled to an assessed fee for deposing a physician whose report was not provided until the time of hearing. We disagree. At hearing, claimant prevailed only upon the issue of extent of disability. No authority exists for an award of an assessed fee in addition to the Referee's attorney fee award of 25 percent of permanent disability.

ORDER

The Referee's order dated May 31, 1989 is reversed. The January 23, 1989 Determination Order is reinstated and affirmed.

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August 31, 1990 Cite as 42 Van Natta 1921 (1990)

In the Matter of the Compensation of
**VINCENT L. THOMPSON, Claimant**
WCB Case No. 89-02162
ORDER ON REVIEW
Coons & Cole, Claimant Attorneys
Saif Legal Department, Defense Attorney

Reviewed by Board Members Crider and Nichols.

Claimant requests review of that portion of Referee Gruber's order that declined to award temporary total disability compensation for the period commencing January 16, 1989. On review, the issue is temporary total disability compensation. We affirm.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

We adopt the Referee's Conclusions and Reasoning dealing with entitlement to temporary total disability benefits.

At hearing, claimant contended that he was entitled to a resumption of temporary total disability benefits when he left his light duty position with the employer. The Referee correctly concluded that claimant was not entitled to a resumption of temporary total disability benefits. This is so because he voluntarily left his light duty position for reasons unrelated to the compensable injury, and did not again become totally disabled. See Ricky L. Halflich, 41 Van Natta 182 (1989); compare with Carmen Gusman, 42 Van Natta 425 (1990) (claimant entitled to resumption of benefits when laid off from light duty position).

On review, claimant abandons his argument that he was entitled to a resumption of temporary total disability benefits when he left work but contends that he was entitled to a resumption of temporary partial disability benefits when he offered to return to work and was not rehired. We disagree. Once

claimant voluntarily leaves work for reasons unrelated to the compensable injury, his efforts to find suitable light work do not entitle him to a resumption of benefits.

We note, however, that we are unable to determine on this record whether or not claimant was receiving his regular wage for his light duty work at the employer. If he was, then he was entitled to temporary partial disability compensation at a rate of zero both while employed and after leaving. Safeway v. Owsley, 91 Or App 478 (1988). If his wage on the light duty work was less than his regular wage, then he was entitled to temporary partial disability benefits while working. He was entitled to continue to receive such benefits after leaving until such time as he may again become temporarily totally disabled or his time loss benefits are otherwise terminated pursuant to law. See former OAR 436-60-030(4)(a).

ORDER

The Referee's order dated June 27, 1989 is affirmed.

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In the Matter of the Compensation of
**JAN M. WILLIAMS, Claimant**
WCB Case No. 89-01499
ORDER ON REVIEW
Peter O. Hansen, Claimant Attorney
Lane, Powell, et al., Defense Attorneys
Arthur W. Stevens (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

Claimant requests review of Referee Michael Johnson's order which found that claimant's temporary disability benefits had been properly computed. On review, the issue is rate of temporary disability. We affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

The Board adopts the Referee's "Opinion" with the following comments.

Claimant sets forth several arguments in support of her position that her rate of temporary disability was improperly computed. We respond to those arguments.

Claimant argues that, "under the [Workers' Compensation] statute, one does not even have a workers' compensation claim until one seeks medical care and treatment" for the injury; i.e., that a claim is not "perfected" until that time. However, claimant cites no authority for that conclusion, and we have found none. Moreover, the plain language of the statute is clear: The benefits of a worker who incurs an injury shall be based on the wage of the worker at the time of injury. ORS 656.210(2)(b)(A).

Claimant next argues, for the first time on this appeal, that her injury is an occupational disease rather than an injury; therefore that her temporary disability benefits should be calculated as set forth in ORS 656.210(2)(b)(B). We find that the issue may not now be raised.

It is well settled that the Board will not consider new legal theories presented on Board review where prejudice would result to one of the parties. See Gunther H. Jacobi, 41 Van Natta 1031 (1989). (Because the insurer's evidentiary submissions had been directed toward an injury claim, rather than an occupational disease claim, it would be fundamentally unfair and prejudicial to the insurer to decide the case on a completely different basis on Board review). Here, claimant's claim was originally denied, litigated and ordered accepted as an injury claim. (Ex. 5). Jan Williams WCB # 88-09534 (Opinion and Order dated December 14, 1988). That order was not appealed and became final by operation of law. The issue may not be raised and argued in claimant's brief to the Board relating to a subsequent matter.

ORDER

The Referee's order dated August 2, 1989 is affirmed.

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August 31, 1990 Cite as 42 Van Natta 1923 (1990)

In the Matter of the Compensation of
**LILLIE M. WILLIS, Claimant**
WCB Case No. 87-14796
ORDER ON REVIEW
Andrew H. Josephson, Claimant Attorney
Roberts, et al., Defense Attorneys

Reviewed by Board Members Gerner and Cushing.

The insurer requests review of Referee Hoguet's order that: (1) found that the Hearings Division lacked jurisdiction to consider claimant's hearing request from the insurer's denials of claimant's chiropractic treatment because the insurer had not first submitted the matter to a medical panel pursuant to ORS 656.327; (2) set aside the aforementioned denials; and (3) assessed penalties and attorney fees for alleged unreasonable claims processing. Agreeing that the Referee had authority to address the merits of the denials, the parties seek remand for consideration of the issue. On review, the issues are remand, jurisdiction, and reasonableness and necessity of treatment. We deny the remand motion and reverse the Referee's order.

FINDINGS OF FACT

Claimant developed a compensable low back strain on December 1, 1986 while working as a dental assistant. Following treatment, claimant's treating physician, Dr. Hazel, found claimant to be medically stationary with her condition having resolved. An April 29, 1987 Determination Order awarded claimant no permanent disability. That Determination Order was affirmed pursuant to an Opinion and Order issued September 4, 1987.

Since April, 1987, claimant has treated with Dr. Kennedy, a chiropractor, at least two times per month. Between April 1987 and November 15, 1987, claimant's appointments for treatment were set by the doctor's office on a strict calendar schedule without regard for claimant's actual physical need. Claimant did not suffer any disabling effects of her 1986 injury during this time period. Often, the treatment rendered was when claimant was feeling fine and suffering no pain.

On August 27, 1987, the insurer issued a denial of future chiropractic treatment, contending that it was not reasonable or necessary. Claimant appealed this denial and continued to be treated by Dr. Kennedy.

Claimant suffered an exacerbation of her low back condition on November 15, 1987 while picking up some limbs at a friends house. Claimant continued treatment with Dr. Kennedy. Claimant's condition again resolved on January 8, 1988. Thereafter, she required her regular scheduled care with Dr. Kennedy.

On January 26, 1988, the insurer issued a denial of current chiropractic care as not being reasonable or necessary. The denial acknowledged the insurer's responsibility for the chiropractic treatment surrounding the November 1987 event, but asserting that the condition had again resolved and that claimant was primarily pain free, the insurer argued that the current treatment was not appropriate. Claimant also appealed this denial.

Claimant was examined by Dr. Howell both before and after the November 1987 exacerbation. Claimant's treatments were not reasonable and necessary.

## CONCLUSIONS OF LAW AND OPINION

### Jurisdiction

The Referee held that, under former ORS 656.327, the parties could not bring an issue of treatment frequency before the Hearings Division under ORS 656.283, but were limited solely to a review by the Director. The Referee set aside the denial of frequency, awarded an attorney fee, and dismissed the claimant's request for hearing without awarding any relief. The parties both contend that this was in error, and we agree.

Former ORS 656.327 was enacted by the Legislature in 1987 and became effective on January 1, 1988. It states in relevant part that:

> "(1)If an injured worker, an insurer or self-insured employer or the Director believes that an injured worker is receiving medical treatment that is excessive, inappropriate, ineffectual or in violation of rules regarding the performance of medical services and wishes review of that treatment by a medical panel, the injured worker, insurer, self-insured employer or Director shall so notify the parties and the Director."

The language of this former statute is discretionary upon the parties. It contains two requirements: first there has to be one or more of the types of problems listed in the statute; and second, the parties have to want the Director to act. Once the matter has been submitted by one of the parties to the Director, then the provisions of ORS 656.327(2) take effect. At that point, the Director has sole jurisdiction over the matter and the insurer can not deny the claim and the claimant cannot request a hearing. It is only at that point that the Hearings Division loses jurisdiction over the matter under ORS 656.283. Therefore, under former ORS 656.327, the matter was appropriately before the Referee because neither of the parties had invoked the provisions of ORS 656.327.[1]

### Remand

Because of the Referee's decision on the jurisdictional issue, he failed to

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[1] On May 6, 1990, the Legislature enacted new legislation that amended ORS 656.327. The Legislature also revised ORS 656.704 in a manner that could impact the jurisdictional grant under ORS 656.327. On de novo review, we are authorized to make such disposition of the case as is deemed appropriate. ORS 656.295(6); Destael v Nicolai Co., 80 Or App 596 (1986). Such disposition can include consideration of an issue on review that was raised at hearing but not addressed by the Referee's order. Bryan W. Johnston, 40 Van Natta 58 (1988) aff'd mem Johnston v. Fred Meyer, Inc., 94 Or App 343 (1988).

reach the particular merits of this case. Both parties have consequently asked for a remand so that a Referee may consider and decide the merits of this case.

The Board may also 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).

In this case there is no further evidence needed because the record on the merits was fully developed at the time of the orginal hearing. Consequently, a remand would not be appropriate and we proceed with our review.

Reasonableness and Necessity of Treatment

The insurer denied the frequency of claimant's chiropractic treatment, before and after the November 15, 1987 exacerbation, because it was not reasonable or necessary. This was done by issuing a denial on August 27, 1987 and a second denial after the resolution of claimant's symptoms on January 26, 1988. We agree in part.

It is well settled that prospective denials are impermissable. 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 "further chiropractic treatment" in its August 27, 1987 denial. Such a denial is prospective. Therefore, the denial shall be set aside. Since the record indicates that the claimant continued to receive chiropractic treatment after this denial, up to the date of the November 15, 1987 exacerbation and the nonprospective January 26, 1988 denial of chiropractic treatment, the reasonableness and necessity of the post-August 27, 1987 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 orginal denial for processing purposes and for hearing); Hollie J. Rahim, 42 Van Natta 415 (1990). We evaluate whether the treatments after the August 27, 1987 denial, as well as whether the treatments after the January 26, 1988 denial, were reasonable and necessary.

A claimant is entitled to all reasonable and necessary curative or palliative medical care required for recovery from a compensable injury or for relief of pain. See ORS 656.245(1); West v. SAIF, 74 Or App 317, 320 (1985); Wetzel v. Goodwin Bros., 50 Or App 101 (1981); McGarry v. SAIF, 24 Or App 883, 888 (1976). For example, palliative chiropractic treatment, on an as-needed basis, is compensable where it is necessary to relieve severe pain and permit claimant to work. West v. SAIF, supra at 320-21. Claimant has the burden of proving that the treatment is reasonable and necessary. McGarry v. SAIF, supra.

Claimant contends that the treatment rendered by Dr. Kennedy is both reasonable and necessary. Dr. Kennedy supports this position. Although the Board generally gives greater weight to the conclusions of a treating physician, it will not do so when there are persuasive reasons to do otherwise. Weiland v. SAIF, 64 Or App 810, 814 (1983); Nancy E. Cudaback, 37 Van Natta 1580, withdrawn on other grounds, 37 Van Natta 1596 (1985), republished 38 Van Natta 423 (1986). In this instance, there are persuasive reasons not to give Dr. Kennedy's conclusions as to the reasonableness and necessity of claimant's treatment greater weight.

First, claimant's office visits are made upon a schedule set by Dr. Kennedy's office. When claimant finishes a treatment, she receives a new office appointment before she leaves the office. The timing of these office appointments bear no relationship to any need on the part of the claimant, but merely reflect the passage of an appropriate amount of time between office visits. (Tr. 58-59).

Second, during the relevant time periods herein, claimant has been predominately pain and disability free. Claimant often went in for her prescheduled office appointment and received a treatment that did nothing for her because she was not in pain nor was she disabled. (Exs. 8 & 11). The treatment rendered during these times did not aid claimant, because at those times claimant did not have a problem or condition that needed to be aided.

Third, the treatment course that claimant was under did not afford claimant any relief, it was only to prevent exacerbations. (Tr. 62). But, whether claimant was under treatment or not, she would still have exacerbations if she overdid anything. (Tr. 60-61). The treatment did not help maintain claimant's condition in any material way because, regardless of the amount or timing of treatment, claimant's condition would react depending on her activities.

Fourth, claimant went for two months without any treatment at one point. During this time claimant continued to be able to work. (Tr. 60). Since claimant was able to continue working without treatment, there has been no showing that her treatment is necessary to maintaining her employment.

All of these reasons demonstrate that claimant's current treatments are not reasonable and necessary at any frequency, contrary to the opinion of Dr. Kennedy that they are. Therefore, we do not give much weight to Dr. Kennedy's opinion on this matter.

On the other hand, Dr. Howell offers an opinion that is both well-reasoned and consistent. Dr. Howell opined that claimant is not in need of any treatment when she is pain free. He further reports that since claimant's current condition had resolved, treatment would not be of any benefit. We find Dr. Howell's opinion on this matter to be more persuasive. In reaching this conclusion, we have considered the exhibit offered by claimant for purposes of impeaching Howell's credibility. In doing so, we do not view the Department of Human Resource's memo, which listed Howell as a physician excluded from billing Medicare, particularly relevant to the case at hand. In any event, the memo is insufficient to alter our conclusion that Howell's opinion is both well-reasoned and persuasive.

Claimant has failed to prove by a preponderence of the evidence that her treatment by Dr. Kennedy, during the relevant times herein, is reasonable and necessary.

Penalties and Attorney Fees

Considering our reasoning concerning the "Jurisdictional" issue and our "Reasonable and Necessary" finding, we do not find the insurer's denials to be unreasonable. Consequently, penalties and related attorney fees are not assessable on that basis.

However, the insurer's August 27, 1987 denial was in part prospective, and therefore the issue of a penalty on that denial must be addressed. It can be contended that because this denial was prospective, it was unreasonable. We disagree.

It was not until after the issuance of the employer's August 27, 1987 denial that the Court of Appeals decided Evanite Fiber Corp. v. Striplin, supra.

Therefore, under the circumstances, and considering the law at the time the employer issued its denial, we do not find that the denial was unreasonable. Consequently, no penalties or a related attorney fee will be assessed.

Even if we did find the denial to be unreasonable, because we have affirmed the reasonable and necessary portion of the August 27, 1987 denial, as well as the subsequent January 26, 1988 denial, there are no amounts "then due" upon which to base a penalty. Accordingly, no penalty-related attorney fee may be assessed either. Lloyd L. Cripe, 41 Van Natta 1774 (1989).

ORDER

The Referee's order dated Feburary 26, 1988 is reversed. The denial dated August 27, 1987 is set aside, in part, as prospective. For services at hearing and on review concerning the prospective denial issue, claimant's attorney is awarded $100, to be paid by the insurer. That portion of the August 27, 1987 denial that denied claimant's unpaid medical services up to the November 15, 1987 exacerbation and the January 26, 1988 denial as not reasonable and necessary, is reinstated and upheld. The January 26, 1988 denial is reinstated and upheld. The Referee's $1,000 penalty-related attorney fee is reversed.

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August 31, 1990 Cite as 42 Van Natta 1927 (1990)

In the Matter of the Compensation of
**THOMAS A. WUELLETT, Claimant**
WCB Case No. 83-03294
ORDER ON REVIEW
Pozzi, Wilson, et al., Claimant Attorneys
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Nichols and Brittingham.

The insurer requests review of Referee Tenenbaum's order that: (1) set aside its denial of claimant's left arm and neck injury claim on the basis that it was improperly issued; and (2) awarded claimant's attorney an assessed fee for overturning the denial. On review the issues are compensability and attorney fees. We reverse.

FINDINGS OF FACT

Claimant sustained a compensable injury to his left arm and neck on August 11, 1980. The claim was accepted and benefits were paid. In addition to his workers' compensation claim, claimant also filed a longshore and harbor workers' claim alleging that his injury fell within the jurisdiction of the Longshoremen's and Harbor Workers' Compensation Act.

On December 29, 1982, Administrative Law Judge Murty found that claimant fell within the jurisdiction of the Longshore and Harbor Workers' Compensation Act and ordered that benefits be paid accordingly. Thereafter, the insurer appealed the Decision and Order of the Administrative Law Judge.

On March 31, 1983, the insurer issued its denial on the basis that claimant was a non-subject worker under the Oregon Workers' Compensation system at the time of his injury.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that Bauman v. SAIF, 295 Or 788 (1983), precluded the insurer from issuing a denial of a claim it had previously accepted. We disagree.

The insurer argues that Bauman, supra is not applicable under the facts of this case because it did not deny the claim until claimant had successfully obtained an adjudication that his claim was covered under the Longshoremen's and Harbor Workers' Compensation Act. We agree that Bauman, supra, is not applicable to the facts of this case.

At the time the insurer issued its denial, it had accepted claimant's claim and was paying benefits. However, in the interim claimant also filed a longshoremen's and harbor workers' claim which was subsequently found within the jurisdiction of that act and benefits were paid accordingly.

The court recently held in Camlu Retirement Center v. Evenhus, 102 Or App 603 (1990), that Bauman, supra, does not prohibit an insurer from issuing a denial on a claim it has previously accepted where the denial was based on the fact that it did not provide coverage for the injury. The court cited its decision in Oak Crest Care Center v. Bond, 101 Or App 15, 19, rev den 310 Or 121 (1990), in which it stated "Bauman does not apply to invalidate such a denial or bind a carrier to a previous acceptance when there is a lack of coverage." Camlu, supra at 605. We analogize the facts of this case to those in Camlu.

In this case the insurer issued a denial not on the merits of the claim it had previously accepted, but on the basis that claimant was not a subject worker under Oregon's Workers' Compensation law. I:n other words, when claimant's claim was conclusively determined to be within the jurisdiction of the Longshoremen's and Harbor Workers' Act, he was simultaneously determined to be a non-subject worker under Oregon Workers' Compensation law. See ORS 656.027(4); Mann v. SAIF, 91 Or App 715 (1988). Therefore, we find that the insurer properly issued its denial. Accordingly, we reinstate the insurer's denial.

Attorney Fees

Inasmuch as we have reinstated the insurer's denial, it follows that claimant's attorney is not entitled to a fee for setting aside the insurer's denial at hearing. Accordingly, we reverse the Referee's award of an assessed attorney fee.

ORDER

The Referee's orders dated September 3, 1986 and October 2, 1987 are reversed. The insurer's denial is reinstated and upheld. The Referee's $1,000 assessed attorney fee is reversed.

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In the Matter of the Compensation of
**KATHLENE R. ZIMMERLY, Claimant**
WCB Case No. 88-09124
ORDER ON REVIEW
Francesconi & Associates, Claimant Attorneys
Bullard, Korshoj, et al., Defense Attorneys

Reviewed by Board Members Nichols and Crider.

The insurer requests review of that portion of Referee Seifert's order that set aside its denial of claimant's occupational disease claim for suicidal depression. In her brief, claimant requests review of that portion of the order

that failed to award claimant's attorney an attorney fee for services at hearing. On review, the issues are compensability and attorney fees. We affirm in part and modify in part.

FINDINGS OF FACT

Claimant, 46 years old, had been taking antidepressant medication and receiving psychotherapy since at least 1980, after she attempted suicide. (Tr. 29-30). She was diagnosed with major affective/major depressive disorder and probable underlying personality disorder. (Tr. 124, 153). She was briefly hospitalized again in 1982 for suicidal ideation, unrelated to her employment.

Claimant worked as a Service Coordinator for the employer, a federally subsidized housing program for low income persons, beginning in July 1981. (Ex. 1-3). Her job entailed evaluating applicants, inspecting housing, and completing large amounts of paperwork and reports. (Ex. 1-4).

In July 1987 claimant broke her left, dominant-hand thumb in a nonwork-related injury. The left hand was put in a cast. As a result, she was required to write with her non-dominant hand. (Tr. 27). She fell behind in her paperwork, for which she compensated by working evenings and weekends.

The program methodology changed several times between July 1987 and February 1988, when claimant took time off to have surgery on her thumb. These changes resulted in increased workloads.

As a result of a major reorganization at the employer in November 1987, claimant's office was relocated from east Portland to Columbia Villa in North Portland, an area where there is a high incidence of violent crime. Claimant's supervisor changed at the same time. He told claimant not to work late, come in early or work on weekends. Claimant nevertheless continued to work odd hours. Employees were expected to work evenings and weekends to keep up their case loads. (Tr. 385).

Claimant received a written reprimand from her supervisor in January 1988 for neglecting to follow procedures. The reprimand stated that any subsequent failures to follow procedures could result in disciplinary action up to and including termination. (Ex. 1-54). Claimant filed a grievance with her union over the reprimand. (Tr. 378-79). Claimant also received a performance evaluation on January 28, 1988 that indicated she needed improvement in a number of areas, including the area that was the subject of the reprimand. (Ex. 1-61).

After the office relocation, a memo was circulated regarding time off work for illness and injury and reinstatement rights. Theoretically, an employee who was absent because of a nonjob-related injury for more than 11 consecutive days and who could not return to his or her regular employment could be terminated, although the policy was to reinstate the employee to suitable work if possible. (Def. ex. 2).

Knowing that claimant would be off work for surgery, the employer promoted a secretary to replace claimant temporarily. (Ex. 1-55). The secretary was inexperienced and claimant became concerned that her work load would fall even further behind. As a result of being behind in her work, the reprimand, the performance evaluation, the inexperienced replacement, and the memo, claimant became afraid that she would lose her job while she was on medical leave for her surgery.

Claimant had thumb surgery on February 3, 1988. On February 16, 1988 she was released to light duty work, i.e., work that did not require her to use her left hand except as a helper. (Cl. Ex. 1).

When claimant returned to work on February 22, 1988 she found her office occupied by the secretary. The supervisor assigned claimant a desk and a chair in a storage room that had formerly been the secretary's location. It was located some distance from the cluster of service coordinator offices and had no telephone. The supervisor took claimant off her job as a service coordinator and assigned her to process property damage claims that other workers had not been able to find time for. (Tr. 47). Claimant was told she was not to talk to landlords and tenants from her former case load. (Tr. 51). The employer did not explain to claimant the reason he continued the secretary in claimant's job, nor did he tell her how long she would be reassigned to new duties. (Tr. 336-37).

As a result of the physical relocation, work reassignment and her isolation, claimant became convinced that she was completely incompetent and would never be able to do a job again. (Tr. 91). She left work at noon on February 26, 1988, intending to commit suicide. (Tr. 54). After a co-worker warned claimant's therapist, claimant was hospitalized. (Tr. 54). She was diagnosed with major depression, recurrent, and borderline personality. (Ex. 10-1). She was not released to return to work after that time.

Claimant filed a claim for work-related suicidal depression on April 14, 1988. It was denied May 9, 1988.

Claimant had further thumb surgery on May 5, 1988 and made another suicide attempt on May 26, 1988, the date she received her last paycheck.

## FINDINGS OF ULTIMATE FACT

Claimant suffers from recurrent major depression and borderline personality.

The assignment of claimant to a different desk location and different duties without complete explanation happened in a real and objective sense. These were not conditions generally inherent in every working situation, nor were they reasonable disciplinary, corrective or job performance evaluation actions by the employer. These conditions were a material contributing cause of claimant's major depression.

## CONCLUSIONS OF LAW AND OPINION

The insurer argues that: (1) the correct standard to apply to this occupational disease/mental disorder case is major contributing cause; (2) claimant's disability was caused by the natural progression of her long-standing mental disorder; (3) her assignment to a different office was not objectively stressful; (4) any stress that occurred arose solely within "the imaginary processes of claimant's impaired mind;" (5) claimant's suicide attempt of May 1988 is not compensable because stress from the cessation of employment is not compensable; and (6) the cause of claimant's mental disorder was not her job, but her thumb surgery.

Claimant argues that her claim is compensable because: (1) the employment conditions producing her disorder were real and objective; (2) she was diagnosed as having a mental disorder generally recognized in the medical community; (3) she has provided clear and convincing evidence that the mental disorder arose out of and in the course of employment; and (4) she has shown her employment was at least a material contributing cause of her mental disorder.

Compensability

Because claimant's last potential injurious exposure to working conditions involving a mental disorder was February 26, 1988, her claim is analyzed under the occupational disease law which became effective January 1, 1988. See Johnson v. SAIF, 78 Or App 143, rev den 301 Or 240 (1986); Ellen L. Crawford, 41 Van Natta 1257, recon 41 Van Natta 1362 (1989); Donna E. Aschbacher, 41 Van Natta 1242 (1989).

To establish compensability of a mental disorder under the amended occupational disease law, we must be persuaded that: (1) the employment conditions producing the mental disorder exist in a real and objective sense; (2) they are conditions other than conditions generally inherent in every working situation or reasonable disciplinary, corrective, or job performance evaluation actions by the employer, or cessation of employment; (3) there is a diagnosis of a mental disorder generally recognized in the medical or psychological community; and (4) there is clear and convincing evidence that the mental disorder arose out of and in the course of employment. ORS 656.802(2)(a)-(d).

The Referee found claimant's claim compensable after requiring claimant to prove that work-related conditions were the major contributing cause of her disorder. We affirm, but our reasoning differs. In order to establish a compensable mental disorder, an injured worker needs to prove by clear and convincing evidence that work-related conditions not otherwise excluded under ORS 656.802(2) are a material, rather than major, cause of the disorder. Donna E. Aschbacher, supra; Ellen L. Crawford, supra.

Claimant argues that the employment conditions contributing to her mental disorder existed in a real and objective sense, namely: the transfer to a new and dangerous office location, being behind in her work, the reprimand, the performance evaluation, the memo, the inexperienced replacement, and, in particular, displacement from her office to a desk and chair in an isolated storage room without a phone, and a change in duties. Although claimant's reaction to these events was subjective, the unrefuted evidence shows that these events and conditions in fact occurred. See Duran v. SAIF, 87 Or App 509 (1987). We conclude that these are real and objective events that produced claimant's mental disorder. See ORS 656.802(2)(a).

To determine whether these work-related conditions are a material cause of claimant's mental disorder, we turn to the medical evidence. Dr. Oken, claimant's treating psychiatrist, stated that claimant's condition had been relatively stable from 1982 until 1988. (Tr. 137). Claimant suffers from a borderline personality disorder that renders her more susceptible than some people to stress. Nevertheless, that characteristic remained unchanged until 1988. Dr. Oken opined that stress in the work place had been the cause of claimant's depressive episode and hospitalization in February and May 1988. (Tr. 137). He indicated that claimant had no troubles at that time aside from the deterioration in her work situation and her concern that she could not produce because of her thumb surgery. (Tr. 138-139, 58, 61, 62). No physician offered any opinion contrary to Dr. Oken's. Further, although the insurer argued that the surgery in itself was the cause of claimant's suicidal depression, it offered no evidence in support of its contention.

Under these circumstances, claimant has established by clear and convincing evidence that her major depressive disorder arose out of and in the course of her employment. However, her mental disorder is not compensable if the conditions which caused her suicidal ideation were "employment conditions generally inherent in every working situation," or "reasonable disciplinary, corrective or job performance actions by the employer," ORS 656.802(2)(b), or if there is no

"diagnosis of a mental or emotional disorder which is generally recognized in the medical or psychological community." ORS 656.802(2)(c). We turn to an examination of these exclusions.

We conclude that claimant's displacement from her office and her duty changes are claimant's primary stressors. We further conclude that these are not "conditions generally inherent in every working situation." Thus, without deciding whether claimant's other stressors are inherent in every work situation, we find that the office and duty changes, alone, were a material cause of claimant's depressive disorder. As a result, claimant's claim does not come within the scope of the exclusion for conditions generally inherent in every working situation. Furthermore, the insurer has not maintained that claimant's office and duty changes were reasonable disciplinary, corrective or job performance evaluation actions by the employer.

We next consider the requirement of a diagnosis of a mental or emotional disorder which is generally recognized in the medical or psychological community. Dr. Oken, claimant's treating psychiatrist, diagnosed claimant with major depressive disorder. Dr. Colbach, M.D., psychiatrist, who performed an independent medical examination of claimant, diagnosed her as suffering from major depression, and Dr. Keppel, M.D., diagnosed the same disorder when claimant was hospitalized for suicidal ideation in February 1988. This disorder, defined in DSM-III-R, published by the American Psychological Association, is generally recognized in the psychological community. Thus, the condition claimed satisfies the requirements of ORS 656.802(2)(c).

In summary, claimant's perception that she was going to lose her job and her perception that she was incompetent and could not work again, whether or not unreasonable, were based on her office and duty changes, which were real events, not inherent in every working situation, capable of causing stress. See Duran v. SAIF, supra; Petersen v. SAIF, 78 Or App 167, rev den 301 Or 193 (1986). Accordingly, we conclude that claimant has established, by clear and convincing evidence, that non-excluded work-related conditions were a material cause of her depressive mental disorder, which ultimately required medical services and resulted in mental disability.

Attorney Fee At Hearing

Claimant's attorney prevailed at hearing and thus deserves an attorney fee. OAR 438-15-010(6). The Referee failed to award this fee. Accordingly, we award it on review.

ORDER

The Referee's order dated March 2, 1989, as reconsidered March 20, 1989, is affirmed in part and modified in part. For services at hearing and on review regarding the compensability issue, claimant's attorney is awarded an assessed fee of $6,625, payable by the insurer. The remainder of the order is affirmed.

In the Matter of the Compensation of
**WILLIS N. WELTZ, Claimant,**
And, in the Matter of the Complying Status of
**Patrick M. Arnold, dba, Mike's Auto Sales, and, dba, P.M. Associates, Employer**
WCB Case Nos. 88-14270 & 88-14271
ORDER OF DISMISSAL
Allen, Stortz, et al., Claimant Attorneys
Winslow & Alway, Employer Attorneys

The Department of Justice, on behalf of the Department of Insurance and Finance (DIF), requests review of that portion of Referee Harri's order that found claimant's claim remained compensable and directed the SAIF Corporation to pay benefits and attorney fees. On review, the issues are jurisdiction, scope of review, and whether benefits paid from the Industrial Accident Fund by SAIF under ORS 656.054 should terminate by operation of law upon the Referee's ruling that the employer was not a subject employer and claimant was not a subject worker at the time of claimant's injury. We dismiss.

## FINDINGS OF FACT

The alleged noncomplying employer timely filed a hearing request concerning a Director's proposed order finding the employer to be noncomplying. SAIF accepted claimant's claim. The sole issue at hearing was the Director's proposed order. Both SAIF and DIF waived appearance. The Referee set aside the Director's proposed order, finding that claimant was not a subject worker and the employer was not a subject employer. The Referee then ordered SAIF to process claimant's claim, and to pay claimant benefits and an assessed attorney fee.

## CONCLUSIONS OF LAW AND OPINION

If any party requests a hearing on a proposed order regarding noncompliance or any other matter unrelated to a claim, the Board appoints a Referee to hold a hearing. ORS 656.740(3); Heinz J.U. Sauerbrey, 37 Van Natta 1512 (1985). When a Referee issues an order pursuant to a proposed order of noncompliance, it is then a final order of the Director and must be appealed directly to the Court of Appeals. ORS 656.740(4); ORS 183.480(1) and (2); ORS 183.482(1). See Stanley Wilson, 40 Van Natta 387 (1988).

Here, the sole issue raised at hearing was noncompliance; compensability was not litigated. Because a matter concerning a claim was not contested at hearing, proper review of this order is before the Court of Appeals. ORS 656.740(4). It is regrettable that the Referee's statement of appeal rights may have misled the parties. However, the Board's jurisdiction is statutory, and an incorrect statement of appeal rights cannot expand or contract this jurisdiction. Miltenberger v. Howard's Plumbing, 93 Or App 475 (1988); Larry J. Powell, 42 Van Natta 1594 (1990).

Parenthetically, we note that the Referee exceeded the proper scope of his review in addressing the compensability issue, which was not before him at hearing. As a result, that portion of the Referee's order that required SAIF to compensate claimant and to pay attorney fees would appear to be gratuitous.

In any event, because we lack jurisdiction, we dismiss the request for review without making any decision on the merits regarding claimant's continuing right to benefits.

IT IS SO ORDERED.

In the Matter of the Compensation of
**LINDA J. RAYMOND, Claimant**
WCB Case No. 88-22283
ORDER ON REVIEW
Martin J. McKeown, Claimant Attorney
H. Thomas Andersen (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

Claimant requests review of Referee Seymour's order which: (1) affirmed a Determination Order award of 30 percent (96 degrees) unscheduled permanent disability for a low back injury; (2) did not award scheduled disability for a leg condition; and (3) found that the SAIF Corporation's request for offset of overpayments was moot. In her brief, claimant argues that her claim was prematurely closed because SAIF failed to provide sufficient information to completely rate her impairment. On review, the issues are premature closure, offset, and extent of scheduled and unscheduled permanent disability. We affirm.

FINDINGS OF FACT

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

Claimant was 37 years of age at the time of hearing. She was not working. Her highest SVP over the ten years prior to the date of hearing was 4, for work as a nurse's aide. DOT 355.674-014.

Claimant has had a single level microlumbar discectomy. In the lumbar area, claimant has retained 60 degrees flexion, 10 degrees extension, 20 degrees right flexion and 30 degrees left flexion. There is no evidence by which it can be determined if claimant is entitled to an impairment value for reduced thoracolumbar rotation.

Claimant has severe, preexisting scoliosis which results in her shortened leg and L4-5 disc bulge.

CONCLUSIONS OF LAW AND OPINION

Premature Closure

Claimant argues that, because SAIF did not submit information regarding loss of rotation to the Evaluation Division, her claim was prematurely closed. We disagree.

The test for determining whether a claim was prematurely closed is whether claimant was medically stationary at the time of closure. Here, claimant was found to be medically stationary on the same date her ranges of back motion were measured. The absence of rotation information is irrelevant to a determination of claimant's medically stationary status. Moreover, we rate permanent disability at the time of hearing and claimant has the burden of proving extent of disability. ORS 656.266.

Extent of Scheduled Permanent Disability

Claimant argues that she should receive an award of scheduled disability for a shortened leg and for atrophy of her left thigh and calf. She argues that an injury to the L4-5 area of the back could create a neurological problem in the leg. However, none of the medical reports relate claimant's unoperated L4-5 disc bulge or her left leg problems to her compensable injury. Accordingly, we agree with the Referee that, because the evidence does not relate

claimant's leg problems to her compensable injury, she is not entitled to an award of scheduled permanent disability. ORS 656.214(2).

Extent of Unscheduled Permanent Disability

In determining the extent of claimant's permanent disability, the Referee applied the standards for evaluating permanent disability as adopted by the Director, pursuant to ORS 656.726(3)(f). See ORS 656.283(7). We apply the same rules, specifically, the version of OAR 436-35-001 et seq in effect at the time of the December 20, 1988 Determination Order.

Following the application of the disability standards, the Referee concluded that claimant's disability does not exceed the 30 percent unscheduled permanent disability that she has previously been awarded. We agree.

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

Age

The appropriate value for claimant's age of 37 years is 0. Former OAR 436-35-290(3).

Formal education

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

Skills

Former OAR 436-35-300(4) adopts by reference the "SVP" (specific vocational preparation time) values assigned to various occupations by the Dictionary of Occupational Titles (DOT), published by the U.S. Department of Labor. The highest SVP level demonstrated by a claimant during the ten years prior to the date of hearing is used to determine a value for skills. Former OAR 436-35-300(4). Claimant's highest SVP during the ten years prior to the date of hearing was 4, as a nurse aide. (DOT # 355.674-014). Therefore, the appropriate value for skills is 3. Former OAR 436-35-300(4).

Training

Claimant has documented training as a Certified Nursing Assistant. Therefore, the appropriate value for training is 0. Former OAR 436-35-300(5). Claimant's total education value is 3, the formal education value plus the skills value plus the value for training. Former OAR 436-35-300(6).

Adaptability

Claimant was not working at the time of hearing. We conclude that, because claimant retains the physical capacity to lift 25 pounds intermittently and 10 pounds frequently, she is able to perform jobs in the light to sedentary

Impairment

In the thoracolumbar region, claimant retains 60 degrees flexion for a value of 3. She retains 10 degrees extension for a value of 2. For retaining

20 degrees right flexion she is entitled to a value of 0. She retains 30 degrees left flexion for a value of 0 as well. Former OAR 436-35-360(6)-(8). No range of motion information was available for left or right rotation, and as discussed above, we rate without those figures. Range of motion values are added for a total value of 5. Former OAR 436-35-360(10). Additionally, claimant had a discectomy for which she receives a value of 5. Former OAR 436-35-350(2). Combining her impairment values we arrive at a total of 9.8. See former OAR 436-35-360(11).

Claimant argues that she is also entitled to a value of 4 for an unoperated disc derangement with clinically-related residual symptoms. We disagree. As previously discussed, none of the medical evidence relates claimant's unoperated disc problem to her compensable injury. Accordingly, we decline to award an additional value to the unoperated disc condition.

Computation of unscheduled disability.

Having determined each value necessary to compute claimant's permanent disability under the "standards," we proceed to that calculation. When claimant's age value, 0, is added to her education value, 3, the sum is 3. When that value is multiplied by claimant's adaptability value, 6, the product is 18. When that value is added to claimant's total impairment value of 9.8, the result is 27.8 percent unscheduled permanent partial disability. That number is rounded to the next highest whole number for a total of 28. Former OAR 436-35-280(7). Claimant's total unscheduled permanent disability under the "standards" is 28 percent.

Finally, claimant contends that she is entitled to disability in addition to that determined by the standards, because there is clear and convincing evidence that the standards do not adequately reflect her loss of earning capacity. See former ORS 656.283(7). Claimant argues that she has significant loss of strength that is not compensated under the standards.

In support of her argument, claimant notes that subsequent amendments to the disability standards provide impairment value for loss of function due to loss of strength. OAR 436-35-350(4). Claimant argues that the amended statutes constitute clear and convincing evidence that she has not been adequately compensated under the prior standards. We disagree.

We have previously rejected arguments that the current standards are clear and convincing evidence per se that claimant was undercompensated by her award under the prior standards. See e.g. Joseph Anger, 41 Van Natta 827 (1989). Moreover, we find that in the application of the disability standards, former OAR 436-35-000 et seq, which were effective at the time of the July 6, 1988 Determination Order, claimant's physical limitations have been considered. We do not find clear and convincing evidence of permanent unscheduled disability in excess of that determined by application of the "standards."

Claimant has previously been awarded 30 percent permanent disability. Because SAIF does not request that claimant's award be reduced, we affirm the Referee's order.

Offset

In the event claimant was awarded additional permanent disability, SAIF requested authorization to offset an alleged overpayment of temporary disability. Because claimant is awarded no additional permanent disability, we do not address SAIF's offset request.

ORDER

The Referee's order dated April 18, 1989 is affirmed.

In the Matter of the Compensation of
**BEVERLY A. BOND, Claimant**
WCB Case No. 86-17765
ORDER ON REMAND
Brian R. Whitehead, Claimant Attorney
Schwabe, et al.,, Defense Attorneys
Kevin L. Mannix, Attorney

This matter is before the Board on remand from the Court of Appeals. Oak Crest Care Center v. Bond, 101 Or App 15 (1990). The court has reversed our order in Beverly A. Bond, 41 Van Natta 975 (1989), which had found that Cigna's denial, based on a lack of coverage, was prohibited under Bauman v. SAIF, 295 Or 788 (1983). Specifically, the court held that Bauman does not apply to invalidate a denial based on a lack of coverage or to bind a carrier to a previous acceptance when there is a lack of coverage. Reasoning that our order did not consider the remaining issues raised by a denial issued by Crawford Risk Management, the court has remanded. We proceed with our reconsideration.

Crawford was providing coverage on January 5, 1985, the date of claimant's injury. However, Cigna, a prior carrier, initially accepted the claim. In December 1986, Cigna discovered that it was not providing coverage on the date of injury. Thereafter, it issued its denial.

In February 1987, Crawford accepted responsibility and began processing the claim. In October 1987, Crawford denied responsibility for the claim, contending that Cigna's denial was ineffective.

Crawford does not contest the fact that it was providing coverage on January 5, 1985, the date of claimant's injury. Instead, it based its denial of responsibility for the claim on the alleged "ineffectiveness" of Cigna's denial. The court has held that Cigna's denial was valid. Consequently, the basis for Crawford's denial has been eliminated.

Inasmuch as Bauman has no application to denials based on the lack of coverage and since Crawford was providing coverage on the date of claimant's injury, we hold that Crawford is responsible for the claim. Accordingly, Crawford's denial is set aside and the claim is remanded to Crawford for processing according to law. Cigna's denial is reinstated and upheld.

IT IS SO ORDERED.

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In the Matter of the Compensation of
**OPAL L. SCARRIOFFINI, Claimant**
WCB Case No. 88-07137
ORDER ON REVIEW
Imperati, et al., Claimant Attorneys
Cummins, et al., Defense Attorneys

Reviewed by Board Members Howell and Speer.

The self-insured employer requests review of Referee Thye's order which granted claimant permanent total disability, whereas a Determination Order awarded 35 percent (112 degrees) unscheduled permanent disability for a low back injury and 5 percent (7.5) scheduled permanent disability for loss of use or function of the right leg. On review, the issue is extent of permanent disability, including permanent total disability. We reverse and modify.

## FINDINGS OF FACT

Claimant, 57 years of age at hearing, has a 9th grade education and no GED. She has worked as a waitress her entire adult life.

In August 1987, claimant compensably injured her low back while attempting to move a tray from a shelf.

Claimant was first treated by Dr. Reynolds, family physician, and then referred to Dr. Wade, orthopedic surgeon. Wade released claimant from work. She has not worked since that time.

Vocational services began in November 1987, but were suspended in January 1988 because of claimant's medical condition.

Claimant's claim was closed by a February 22, 1988 Determination Order, awarding claimant 35 percent unscheduled permanent disability and 5 percent scheduled permanent disability for the loss of use or function of her right leg. Claimant requested a hearing.

In April 1988, claimant sought treatment from Dr. Wayson, M.D. (Ex. 23).

In July 1988, Dr. Zivin, M.D., performed an independent medical examination. (Ex. 26-6).

Vocational services began again in June 1988. (Ex. 24B). Claimant participated in a physical capacities evaluation, performed by Dr. Slack, M.D., but refused to attend a vocational evaluation on the advise of her attorney. (Ex. 28).

Claimant's physical capabilities include lifting 5 pounds 80 to 100 percent of the time, carrying and pushing/pulling 5 pounds 60 to 80 percent of the time, and very limited bending, squatting, stair/ladder climbing, stooping, reaching above shoulder, kneeling, twisting or crouching. She is restricted totally from unprotected heights and driving automotive equipment, moderately from exposure to marked changes in temperature/humidity and exposure to dust, fumes and gases and mildly from moving around machinery. (Ex. 26B-6).

In August 1988, Skilling conducted a vocational evaluation, based only on existing medical opinions and vocational information, including the physical capacities evaluation conducted by Dr. Slack.

## ULTIMATE FINDINGS OF FACT

Claimant is capable of intermittent sedentary work. She has transferable skills. She has not made reasonable efforts to obtain suitable and gainful employment.

Claimant suffers moderate permanent impairment resulting from her compensable injury. She has suffered severe loss of earning capacity resulting from her injury.

## CONCLUSIONS OF LAW AND OPINION

The Referee concluded that given claimant's age, low level of formal education, and lack of transferable skills without retraining, claimant was not currently employable or able to sell her services on a regular basis in a hypothetically normal labor market. We disagree.

To establish entitlement to permanent total disability benefits, claimant has the burden of proving that she is willing to seek regular and gainful employment and that she has made reasonable efforts to obtain such employment. ORS 656.206(3). Claimant has failed to meet her burden.

The record does not establish that claimant is willing to seek regular and gainful employment. She refused to participate in the vocational evaluation. Consequently, Skilling, claimant's vocational rehabilitation counselor, noted that he was "unable to complete his evaluation because [claimant] failed to participate." (Ex. 28-1). Furthermore, claimant admitted that she had made no efforts to find employment since the injury. (Tr. 35). Based on claimant's failure to participate in the vocational evaluation, which was part of her vocational assistance program, and based on claimant's admission, we conclude that she has failed to prove that she is willing to seek work, and that she has made reasonable efforts to obtain employment. See Georgia-Pacific Corp. v. Perry, 92 Or App 56 (1988); Virgil K. Comstock, 42 Van Natta 459 (1990).

Claimant's failure to make reasonable efforts to seek gainful employment may be excused if she can establish that such efforts would be futile. Butcher v. SAIF, 45 Or App 318 (1983). The record, however, is devoid of evidence to establish that it would be futile for claimant to seek work.

Because claimant has failed to establish that she is willing to seek regular gainful employment, because she has failed to show that she made reasonable efforts to obtain such employment, and because she has failed to establish that a work search would be futile, we conclude that she has failed to establish entitlement to permanent total disability. ORS 656.206(3).

Extent of Unscheduled Permanent Disability

The February 22, 1988 Determination Order awarded claimant 35 percent unscheduled permanent disability. We modify.

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 a restrictive mechanical formula. See Harwell v. Argonaut Insurance, 296 Or 505, 510 (1984).

After considering claimant's moderate impairment resulting from her compensable back injury, her limited physical capabilities, her age, her complete lack of transferable skills, and her limited education, we conclude that claimant suffers 80 percent unscheduled permanent disability resulting from her compensable injury.

Extent of Scheduled Permanent Disability

The February 22, 1988 Determination Order awarded claimant 5 percent scheduled permanent disability for the loss of use or function of her right leg. There is no evidence in the record to establish that claimant suffers loss of use or function of her right leg in excess of that already awarded by the Determination Order. Consequently, that award will be affirmed.

ORDER

The Referee's order dated November 22, 1988 is reversed. The Referee's award of permanent total disability is reversed. In addition to the Determination Order award, claimant is awarded 45 percent (144 degrees) unscheduled permanent disability, for a total award to date of 80 percent (256 degrees) unscheduled permanent disability. Claimant's attorney fee payable out of compensation shall be adjusted accordingly. However, the total fees payable by the Referee's and the Board's orders shall not exceed $3,800.

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In the Matter of the Compensation of
**DALE W. EBERLY, Claimant**
WCB Case No. 88-21003
ORDER ON RECONSIDERATION
Merrill Schneider, Claimant Attorney
Schwabe, et al., Defense Attorneys

Claimant requests reconsideration of that portion of our June 26, 1990 Order on Review which: (1) affirmed the Determination Order's medically stationary date of February 3, 1987; and (2) awarded claimant temporary total disability from the date of surgery, September 16, 1986, to claimant's medically stationary date, February 3, 1987. On July 24, 1990, we abated our order and granted the insurer an opportunity to respond within 10 days. That period having expired without a response, we have proceeded with our reconsideration.

Claimant contends that the medical evidence does not support a medically stationary date of February 3, 1987. Instead, claimant argues that he was not medically stationary until May 20, 1988, relying upon a May 20, 1988 closing report. Inasmuch as that report was rendered at the request of the insurer, and not in response to a need for treatment or follow-up examination, we decline to disturb our finding that claimant was medically stationary on February 3, 1987. Instead we rely on the medical report from Dr. Gambee dated February 3, 1987, which indicates that no further material improvement would be reasonably expected from medical treatment or the passage or time. The preponderance of the evidence establishes that claimant's condition was medically stationary on February 3, 1987.

Claimant further contends that the insurer was required to pay claimant temporary total disability from the date of surgery on September 16, 1986 through the date of closure on September 16, 1988. Moreover, claimant argues that, since he was medically stationary on May 20, 1988, the insurer is entitled to recover an overpayment for amounts due from May 20, 1988 through closure on September 16, 1988. This overpayment, claimant contends, should be used as an offset against any future awards of permanent disability from this claim.

In our prior order we found claimant was substantively entitled to temporary disability from the date of surgery until he was medically stationary on February 3, 1987. By this order we have reconfirmed our finding that claimant was medically stationary as of February 3, 1987.

Yet, claimant is procedurally entitled to the continued payment of temporary disability until he returns to regular work, is released to regular work and is medically stationary, or is medically stationary and the claim is closed. Fazzolari v. United Beer Distributors, 91 Or App 592 on recon 93 Or App 103, rev den 309 Or 236 (1988).

Here, because of claimant's March 16, 1988 retirement, his treating physician, Dr. Gambee, did not address claimant's ability to return to work until May 20, 1988. Furthermore, claimant testified that he returned to modified work on May 20, 1988. Finally, the claim was closed on September 16, 1988. Therefore, we find claimant is procedurally entitled to an increased award of temporary disability from February 4, 1987 until September 16, 1988, the date of closure.

Accordingly, our June 26, 1990 order is withdrawn. On reconsideration, we adhere to and republish our June 26, 1990 order with the following modification. Claimant is awarded temporary disability from February 4, 1987 to September 16, 1988, less wages earned during this time. Claimant's attorney is awarded an approved attorney fee of 25 percent of the increased compensation created by this order. However, the total attorney fee awarded by our prior order and this order shall not exceed $3,800. After payment of this award, the insurer is permitted to recover these temporary disability benefits against future permanent disability benefits. The parties' appeal rights shall run from the date of this order.

IT IS SO ORDERED.

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In the Matter of the Compensation of
**SHIRLEY G. HELGESON, Claimant**
WCB Case No. 88-21713
ORDER ON REVIEW
Emmons, et al., Claimant Attorneys
Saif Legal Department, Defense Attorney

Reviewed by Board Members Nichols and Brittingham.

Claimant requests review of Referee Howell's order that: (1) increased claimant's unscheduled permanent disability award for a low back injury from 21 percent (67.2 degrees), as awarded by Determination Order, to 26 percent (83.2 degrees); (2) reduced claimant's scheduled permanent disability award for the right forearm from 20 percent (30 degrees), as awarded by Determination Order, to 10 percent (15 degrees); (3) awarded 5 percent (7.5 degrees) scheduled permanent disability for the left forearm, whereas the Determination Order had awarded no permanent disability for the left forearm condition; and (4) ordered the SAIF Corporation to pay only the difference between the total dollar value of the Referee's permanent disability awards and the awards made by Determination Order. On review, the issue is extent of permanent partial disability, scheduled and unscheduled. We affirm.

## FINDINGS OF FACT

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

SAIF did not file a formal cross-request for hearing seeking reduction of claimant's permanent disability awards as granted by the Determination Order. However, at hearing, SAIF requested authorization to offset previously overpaid permanent disability if the Referee chose to reduce claimant's award on "his own motion." The Referee, by order dated April 12, 1989, reduced claimant's award for the right forearm. Claimant requested reconsideration, contending that the Referee should not have reduced the award in the absence of a formal request from SAIF. In response to the motion, SAIF expressly asked for a reduction. The Referee then issued an Order Denying Reconsideration on April 18, 1989.

CONCLUSIONS OF LAW AND OPINION

Claimant challenges the Referee's order on three grounds: First, she contends that the Referee erred in concluding that she exaggerates her difficulties and, therefore, incorrectly refused to rely on her reported loss of grip strength in rating her disability in the right forearm. Second, claimant contends that the Referee erred in reducing her award for the right forearm because SAIF had not requested a reduction. Third, she contends that the Referee erred by ordering SAIF to pay only the dollar value of the difference between the sum of the Referee's unscheduled and two scheduled awards, and the sum of the Determination Order's unscheduled and scheduled awards. Claimant argues that SAIF should have been ordered to pay her the increase in the unscheduled award and the scheduled award for the left forearm, the reduction in the scheduled award for the right forearm notwithstanding.

We conclude that the Referee correctly assessed the evidence with regard to claimant's loss of grip strength. We adopt his Conclusions, with the exception of the last three paragraphs.

We disagree with claimant's contention that the Referee improperly reduced her permanent disability award for the right forearm. Admittedly, SAIF did not file a formal hearing request seeking a reduction of claimant's permanent disability awards. Yet, at hearing, SAIF sought permission to offset any overpaid permanent disability created if the Referee chose to reduce claimant's awards "on his own motion." We interpret SAIF's action as effectively seeking reduction or elimination of claimant's awards. To do otherwise would permit a carrier to seek and receive permission to recover an overpayment created by a reduced award, while at the same time avoiding its potential liability for an attorney fee under ORS 656.382(2) should the award not be reduced or eliminated.

Finally, we disagree with claimant's contention that the Referee incorrectly ordered SAIF to pay only the difference between the sum of the Referee's awards and the sum of the Determination Order's awards. The Referee, in effect, authorized SAIF to offset overpaid scheduled disability for the right arm against his increased awards for the back and left arm in this same claim. The Referee did so pursuant to SAIF's express request for an offset in the event he reduced the permanent disability awarded in the Determination Order. ORS 656.268(10) and OAR 436-60-170 specifically allow offsets of overpayments of permanent disability benefits previously paid in the same claim. See Steven M. Ginther, 42 Van Natta 526 (1990). The offset is not limited to compensation paid for the same body part; all that is required is that the offset be against compensation paid in the same claim. Accordingly, we conclude that the Referee properly offset overpaid permanent partial disability for the right arm against the awards for the back and left arm.

ORDER

The Referee's order dated April 12, 1989 is affirmed.

In the Matter of the Compensation of
**SUSAN L. JOHNSON, Claimant**
WCB Case No. 88-04052
ORDER ON REVIEW
Bennett, Durham, et al., Claimant Attorneys
Acker, et al., Defense Attorneys

Reviewed by Board Members Cushing and Gerner.

The insurer requests review of those portions of Referee Thye's order which: (1) set aside its partial denial of claimant's claim for a psychological condition; (2) set aside a Determination Order on the basis that it had prematurely closed claimant's claim; and (3) declined to grant an offset for an alleged overpayment of temporary disability benefits. On review, the issues are compensability, premature closure and offset. We reverse in part and affirm in part.

FINDINGS OF FACT

In Decmber 1984, claimant began working for the employer, a marketing research company, as a receptionist. Prior to that time, she had worked as a receptionist at another employer, but was terminated for poor attendance. She did not work between 1978 and 1982, the time period coinciding with the beginning and ending of her first marriage.

In January 1985, she was involved in a compensable motor vehicle accident. As a result of this accident, she broke her nose, incurred a slight concussion and injured her spine from the neck to the lumbar area.

Following the injury, claimant also began experiencing headaches. She returned to work in March 1985, but was unable to perform her duties due to neck and low back pain, headaches, and an inability to concentrate. She sought treatment from Dr. Young, chiropractor, who released her from work. At that time a CT scan of the brain was negative. Thereafter, during the summer of 1985, claimant entered into her second marriage.

Vocational services were undertaken in July 1985 and claimant was released to part-time work by Dr. Young. However, after a few days, claimant again suffered headaches and Dr. Young rescinded his work release. Vocational assistance was continued, however, attempts to contact claimant were unsuccessful. In December 1985, claimant indicated to her vocational counselor that she no longer had a strong desire to return to work. Her vocational assistance was terminated in January 1986 for reasons unrelated to her compensable injury.

Claimant continued to complain of headaches, fatigue, memeory problems, confusion and depression which led Dr. Young to refer her for a neuropsychological workup. Claimant was examined by Dr. Castles, psychologist, in April 1987. Thereafter, claimant continued to treat with Dr. Castles. In February 1988, a Determination Order closed claimant's claima awarding temporary disability benefits from January 29, 1985 through January 22, 1988. Claimant was found to be medically stationary as of January 22, 1988. No permanent disability benefits were awarded.

On February 25, 1988, claimant was hospitalized for two weeks for suicide ideation resulting from depression. On February 26, 1988, the insurer denied claimant's psychological claim on the basis it was not related to her compensable injury.

Claimant is 35 years of age. She graduated from high school and attended 1 1/2 years of community college. She also completed a dental assistant training program. Her work experience includes retail sales, waitressing, and work as a receptionist/secretary.

As a result of her compensable injury, she has sustained permanent impairment in the minimal range. She also suffers from chronic headaches and chronic pain symptoms in her back.

## CONCLUSIONS OF LAW AND OPINION

### Compensability

The Referee concluded that the compensable motor vehicle accident was a material contributing cause of her current psychological condition. We disagree.

Inasmuch as there was a 2 1/2 year period between claimant's compensable accident and the onset of her psychological treatment, we find the issue of whether her psychological condition is materially related to the compensable accident to be a complex medical question. Thus, although claimant's testimony is probative, the resolution of this issue largely turns on an analysis of the medical evidence. Uris v. Compensation Department, 247 Or 420, 426 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985).

Dr. Castles opined that claimant's psychological condition was a mixed organic brain syndrome which was resultant from the 1985 compensable accident. Castles based her opinion on testing she performed which she interpreted as showing that claimant's intellectual functioning had decreased since the accident. Dr. Castles, however, offers no persuasive explanation in regards to how her testing, performed approximately 2 1/2 years after the accident could accurately measure claimant's level of intellectual functioning prior to the accident. Further, she did not take claimant's vocational history prior to the accident, although she admitted it would be relevant to her opinion. Finally, she offers no explanation in regards to how she arrived at the diagnosis of mixed organic brain syndrome, when claimant does not meet the diagnostic criterion for such a diagnosis. Therefore, we do not find Dr Castles opinion persuasive.

Dr. Lezak's corroborating opinion suffers from the same lack of explanation. She offers no explanation in regards to the conclusion that claimant's intellectual functioning was higher prior to the accident, but rather relies on Dr. Castles' testing. Moreover, she also did not have claimant's vocational history prior to the accident. Accordingly, we are not persuaded by Dr. Lezak's corroborating opinion.

By contrast, Dr. Wicher opined that claimant's psychological condition was unrelated to the motor vehicle accident. Wicher disagreed with Castle's assessment of claimant's intellectual functioning prior to the accident. She noted that claimant's past vocational history consisted of low-level clerical jobs and that claimant had been terminated from the job she held prior to the at-injury job for excessive absenteeism. She further noted that Castle's testing could also indicate a low motivation or a personality disorder. Dr. Wicher's opinion is supported by Dr. Stolzberg, a neurologist, who reported that it was unlikely that the accident caused brain damage, particularly in light of the negative CT scan and negative neurological examination.

We are persuaded by the opinion of Dr. Wicher, as supported by Dr. Stolzberg. She had claimant's vocational history and persuasively explains her conclusions. Accordingly, claimant has not established that her 1985 compensable accident is materially related to her psychological condition.

### Premature Closure

The Referee found that the issue of premature closure was moot in that he had set aside the denial of claimant's psychological condition. As we have reversed the Referee with regard to claimant's psychological condition, we now address the issue of premature closure.

In order to establish that the December 1988 Determination Order prematurely closed her claim, claimant must demonstrate that she was not medically stationary on the date of closure. Scheuning v. J.R. Simplot & Company, 84 Or App 622, 625 (1987). "Medically stationary" means that "no further improvement would reasonably be expected from medical treatment or the passage of time." ORS 656.005(17).

Dr. Young, claimant's treating chiropractor, is the only physician to opine that claimant was not medically stationary at the time her claim was closed. In support of this opinion, Young notes that claimant's symptoms have fluctuated in the past and will continue to do so in the future. Young further reported that he "hoped" that continued treatment and the passage of time would lead to improvement in claimant's condition.

We conclude that claimant has not established that further improvement of her condition could reasonably be expected from medical treatment or the passage of time. We interpret Dr. Young's opinion to mean that claimant will continue to experience fluctuations in her condition in the future of the same type she experienced prior to claim closure. Further, Dr. Young's "hope" that claimant's condition would improve does not rise to the level of reasonable expectation. Finally, Dr. McKillop opined that claimant was medically stationary prior to the issuance of the Determination Order. Accordingly the Determination Order properly closed claimant's claim.

Extent of Unscheduled Permanent Disability

The Referee did not reach the issue of extent of permanent disability inasmuch as he had set aside the Determination Order on the basis that it was premature. We have herein reinstated the Determination Order, therefore, we proceed to rate claimant's permanent disability.

In rating the extent of claimant's disability, we consider her permanent impairment and all 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 (1982).

After considering our findings as to claimant's impairment and relevant social and vocational factors in light of the aforementioned guidelines, we conclude that claimant is entitled to a 10 percent unscheduled permanent disability award for her back, neck and head injury.

Offset

We adopt the conclusions and reasoning regarding the offset issue as set forth in the Referee's order. See Dawkins v. Pacific Motor Trucking, 308 Or 254 (1989); Weyerhaeuser Co. v. Kepford, 100 Or App 410 (1990).

ORDER

The Referee's order dated September 1, 1988 is reversed in part and affirmed in part. That portion which set aside the insurer's denial of claimant's psychological condition is reversed. The denial is reinstated and upheld. Claimant's $4,500 attorney fee award is reversed. That portion which set aside the Determination Order as premature is reversed. The February 16, 1988 Determination Order is reinstated and upheld insofar as it pertains to claimant's medically stationary date. Claimant is awarded 10 percent (32 degrees) unscheduled permanent disability for her head, neck and back injury. Claimant's counsel is awarded 25 percent of the increased compensation created by this order not to exceed $3,800. The remainder of the order is affirmed.

In the Matter of the Compensation of
**DANIEL R. JORDISON, Claimant**
And, in the Matter of the Complying Status of
**DEAN T. CATES, dba CATES CONSTRUCTION, Employer**
WCB Case Nos. 89-01966 & 89-01967
ORDER OF DISMISSAL
Goldberg, et al., Claimant Attorneys
Davis & Bostwick, Defense Attorneys
Sharon R. Schooley, Assistant Attorney General

The noncomplying employer requests review of Referee Mills' order that upheld the Proposed and Final Order issued by the Compliance Section of the Department of Insurance and Finance, dated November 9, 1988.

FINDINGS OF FACT

On November 9, 1988, the Department of Insurance and Finance published a Proposed and Final Order, declaring the employer to be a noncomplying employer from September 8, 1988 to September 13, 1988.

The claim was referred to the SAIF Corporation by Compliance on November 9, 1988. SAIF accepted the claim and notified the employer on November 17, 1988. The employer requested a hearing concerning the Proposed and Final Order on November 17, 1988.

The sole issue at hearing was the Proposed and Final Order. SAIF waived appearance at hearing. Counsel for the employer stated at hearing that the only issue was the Proposed and Final Order and noncompliance.

The Referee in his "Conclusion and Opinion" portion of his order, stated that the claim was compensable.

The Referee's order provided in part:

> "IT IS HEREBY ORDERED as follows:
> The Proposed and Final Order issued by the Compliance Section of the Workers' Compensation Division, Department of Insurance and Finance, dated November 9, 1988, declaring Dean T. Cates, dba Cates Construction, a noncomplying employer from September 8, 1988 to September 13, 1988 and claimant Daniel R. Jordison to be a subject employee on September 9, 1988 is approved..."

CONCLUSIONS OF LAW AND OPINION

If any party requests a hearing on a Proposed and Final Order regarding noncompliance the Board appoints a Referee to hold a hearing. ORS 656.740(3). 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 656.740(4); ORS 183.480(2); See Stanley Wilson, 40 Van Natta 387 (1988).

The employer timely requested a hearing on the Proposed and Final Order by letter dated November 17, 1988. This letter makes no mention of compensability. At hearing, employer's counsel reconfirmed that the Proposed and Final Order and noncompliance was the sole issue to be decided at hearing. Additionally, the record reflects that compensability was not actually litigated. We also note that SAIF waived appearance.

Furthermore, the Referee did not address compensability in his order language. The Referee only ordered that the Proposed and Final Order was approved. The Referee's discussion in the "Conclusion and Opinion" section of the order that claimant's claim was compensable, we consider gratuitous and not binding. See Willis N. Weltz, 42 Van Natta 1933 (1990).

The matter before the Referee did not concern a matter concerning a claim within the scope of ORS 656.283 or ORS 656.704. Because the Referee's order solely concerned the Proposed and Final Order and noncompliance, the Board does not have jurisdiction over the employer's appeal. ORS 656.740(4). Because we lack jurisdiction to review the Referee's order, the request for review must be dismissed.

It is regrettable that the Referee's statement of appeal rights has misled the employer. However, our jurisdiction is statutory and an incorrect statement of appeal rights can not expand or contract the jurisdiction. See Larry J. Powell, 42 Van Natta 1594 (1990); Gary O. Soderstrom, 35 Van Natta 1710 (1983).

Accordingly, the request for Board review is dismissed.

IT IS SO ORDERED.

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In the Matter of the Compensation of
**DALE L. LOEFFLER (Deceased), Claimant**
WCB Case No. TP-90038
ORDER ON RECONSIDERATION
Pozzi, et al., Claimant Attorneys
Snarskis, et al., Defense Attorneys

On August 31, 1990, we dismissed without prejudice the paying agency's petition for resolution of a dispute concerning a compromise of claimant's alleged third party cause of action which was settled without approval of the paying agency. We took this action at the request of the paying agency, who announced that the parties had agreed upon a procedure to resolve their dispute which did not currently require Board intervention.

Claimant now seeks penalties and an attorney fee for efforts expended in persuading the paying agency to withdraw its petition. We deny the request.

We have previously held that the third party statutes do not provide authorization for an attorney fee award other than that disbursed from the third party recovery. Arlo W. Dunbar, 40 Van Natta 366, 491 (1988); Raymond Steiner, 40 Van Natta 381, 382 (1988). We apply the same reasoning concerning our authority to assess penalties.

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

IT IS SO ORDERED.

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In the Matter of the Compensation of
**JAMES C. BALES, (Deceased) & CHAROLLET K. BALES, Claimant**
Own Motion No. 84-0052M
OWN MOTION DETERMINATION
Burt Swanson, et al., Claimant Attorneys

The Board issued its Own Motion Order in the above-entitled matter on November 28, 1984, reopening the worker's claim for a worsened condition related to his industrial injury of April 19, 1976. The claim was reopened with temporary disability benefits to commence December 7, 1983, and to continue "until closure pursuant to ORS 656.278."

The worker died on May 17, 1989, yet his claim was never closed. When the insurer terminated temporary disability benefits, the worker's widow requested a hearing. By Opinion and Order dated June 19, 1990, the Referee ordered the insurer to submit the claim for closure by the Evaluation Section pursuant to ORS 656.268 and to resume and continue the payment of temporary disability benefits until claim closure. The Referee also assessed penalties for the insurer's unreasonable claim processing and termination of benefits.

By letter dated June 26, 1990, claimant's attorney requested that the Director assess maximum penalties for the insurer's failure to properly process this claim. There is no indication in the record of how the Director has responded to that request. However, the Evaluation Section has referred this claim to the Board for claim closure pursuant to its own motion authority under ORS 656.278.

After reviewing the record, we conclude that, inasmuch as the aggravation rights on this claim have expired, we have exclusive own motion jurisdiction of this claim. See Miltenberger v. Howard's Plumbing, 93 Or App 475, 477 (1988). Accordingly, claimant's claim is closed with an award of temporary total disability from December 7, 1983 until May 17, 1989, the day of his death. Deduction of overpaid temporary disability, if any, from unpaid permanent disability is approved.

Claimant will be awarded no further permanent disability. 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 (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 own motion authority under ORS 656.278. Id. Consequently, the Board is without authority to award claimant any further permanent disability benefits for his compensable injury.

IT IS SO ORDERED.

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In the Matter of the Compensation of
**DAVID R. BOWEN, Claimant**
WCB Case Nos. 89-01708 & 89-00167
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Kevin L. Mannix, Defense Attorney
Arthur W. Stevens, III (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

United Pacific Insurance requests review of that portion of Referee Mulder's order that: (1) set aside its denial of claimant's "new injury" claim for his current low back condition; and (2) upheld the SAIF Corporation's denial

of claimant's aggravation claim for the same condition. In its brief, United Pacific contends that SAIF's November 8, 1988 denial was an improper backup denial. On review, the issues are responsibility and the propriety of SAIF's denial. We affirm.

## FINDINGS OF FACT

The Board adopts the Referee's Findings of Fact.

## CONCLUSIONS OF LAW AND OPINION

### Propriety of denial

United Pacific contends that SAIF's November 1988 denial was improper under Bauman v. SAIF, 295 Or 788 (1983). The insurer argues that SAIF had processed a 1985 claim for a low back strain and, in a May 1988 stipulation, accepted claimant's aggravation claim. In an August 8, 1988 stipulation, SAIF agreed to pay claimant permanent partial disability. United Pacific argues that SAIF has accepted the claim and it cannot now issue a backup denial.

We agree with the Referee's conclusion and reasoning that, under the circumstances, Bauman is not applicable.

### Responsibility

The Referee concluded that claimant's work while United Pacific was on the risk independently contributed to his need for treatment in 1988. We agree.

United Pacific concedes that claimant's employment, while it was on the risk, independently contributed to a worsening of his condition. However, it argues that the evidence does not show a worsening since August 1988. We disagree.

Claimant began to have different symptoms (e.g. "giveway," left leg symptoms) in August 1988. After returning to work in August 1988 and subsequent to entering into the August stipulation, claimant experienced worse pain than he had before, and he sought treatment from Dr. Johnson. His last day of work was September 20, 1988, and he had disc surgery by Dr. Johnson in October 1988. In October 1988, Dr. Johnson opined that claimant's underlying condition had worsened and he reported that claimant's work as a loom operator contributed directly to his current herniated disc.

We conclude that claimant's underlying condition worsened since the August 1988 stipulation, which was the last award or arrangement of compensation. Claimant's work while United Pacific was on the risk contributed directly to his current herniated disc condition, therefore, United Pacific is responsible.

Claimant has requested an award of insurer-paid attorney fees for services on review. We conclude that an attorney fee is not appropriate because the only issue before the Board was responsibility. In other words, claimant's right to compensation was never at risk. See Mercer Industries v. Rose, 103 Or App 96 (1990); Howard v. Willamette Poultry, 101 Or App 584 (1990).

## ORDER

The Referee's order dated May 30, 1989 is affirmed.

In the Matter of the Compensation of
**DEBRA A. BUEL, Claimant**
WCB Case No. 88-17903
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
Terrall & Miller, Defense Attorneys

Reviewed by Board Members Howell and Speer.

The insurer requests review of Referee Shebley's order that: (1) awarded 35 percent (112 degrees) unscheduled permanent disability for a low back injury, whereas a Determination Order awarded no permanent disability; and (2) found that claimant was medically stationary on October 24, 1988. The insurer challenges that portion of the Referee's order which considered a psychological component in determining the extent of permanent disability due to claimant's injury. On review, the issues are extent of unscheduled permanent disability and medically stationary date. We reverse in part and affirm in part.

## FINDINGS OF FACT

The Board adopts the Referee's Findings of Fact.

## CONCLUSIONS OF LAW AND OPINION

### Psychological component

The Referee found that claimant's functional overlay was a compensable component of her claim. The Referee concluded that, although it was undisputed that there was no objective evidence of low back impairment, claimant was entitled to an award of 35 percent unscheduled permanent disability. We disagree.

In determining the extent of claimant's permanent disability, the Referee applied the standards for evaluating permanent disability as adopted by the Director pursuant to ORS 656.726(3)(f). See ORS 656.283(7). Specifically, the Referee applied former OAR 436-35-000 et seq, effective at the time of claimant's October 6, 1988 Determination Order. See OAR 438-10-005; 438-10-010. These are the rules which we apply as well.

Former OAR 436-35-400(1) provides that a permanent state of mental disorder must be diagnosed by a psychiatrist or psychologist. In this case, claimant's functional overlay or the psychological component alleged to be due to her injury has not been diagnosed by a psychiatrist or psychologist. On October 14, 1987, claimant was examined by Dr. Turco, psychiatrist, who opined that she had no diagnosable psychological condition. In November 1987, Dr. Turco reported that claimant had no objective psychiatric findings.

We conclude that because claimant's psychological component has not been diagnosed by a psychiatrist or psychologist, there can be no award of impairment under the standards for the condition.

The Referee found that, under the standards, claimant was entitled to an award of 35 percent unscheduled permanent disability for her neck and low back condition. In August 1988, claimant was examined by Dr. Rosenbaum, M.D. Dr. Rosenbaum reported inconsistencies in claimant's range of motion tests (e.g., loss of range of motion shown during one maneuver, but in another position, no loss of range of motion and no symptoms in the same body part). Dr. Rosenbaum reported that claimant's current loss of function is based upon subjective symptoms with no objective verification.

Under the circumstances, we are not convinced that claimant is entitled to an award of unscheduled permanent disability. We are unable to find that claimant's loss of range of motion is attributable to impairment resulting from injury to a body part. See former OAR 436-35-320(2). Finally, even if claimant's loss of range of motion was due to her functional overlay or psychological component condition, we find the evidence persuasive that that condition is noncompensable. We therefore reverse the Referee's award of unscheduled permanent disability.

Medically stationary date

The Referee found that claimant was medically stationary on October 24, 1988, rather than on September 9, 1988, as found by Determination Order. Dr. Noall's October 24 letter indicates that claimant was not medically stationary on September 9 because she was continuing to improve (in addition to participating in a work hardening program). We agree with the Referee's conclusion that, as her treating doctor, Dr. Noall was in a better position to declare her medically stationary than an independent medical examiner, who observed her on one occasion.

ORDER

The Referee's order dated February 10, 1989 is reversed in part and affirmed in part. Those portions of the Referee's order that found claimant's psychological component to be due to her compensable injury and awarded claimant 35 percent (112 degrees) unscheduled permanent disability, are reversed. That portion of the October 6, 1988 Determination Order which did not award permanent disability is reinstated and upheld. The remainder of the Referee's order is affirmed. For prevailing on review on the issue of the medically stationary date, claimant's counsel is awarded an attorney fee of $300, to be paid by the insurer.

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September 10, 1990 Cite as 42 Van Natta 1951 (1990)

In the Matter of the Compensation of
**KENNETH HOLLOWAY, Claimant**
Own Motion No. 90-0116M
CORRECTED OWN MOTION ORDER ON RECONSIDERATION
Pozzi, et al., Claimant Attorneys
Saif Legal Department, Defense Attorney

The Board issued its own Motion Order on Reconsideration in this matter on August 28, 1990. That order was incorrectly sent to the wrong parties. Accordingly we abate and withdraw that order in its entirety. We hereby issue this corrected order in its stead.

Claimant requests reconsideration of the Board's Own Motion Order on Reconsideration issued April 23, 1990, that declined to assess the SAIF Corporation with a penalty and attorney fee for its processing of his request for own motion relief. Claimant again contends that SAIF failed to properly process his own motion claim. In order to allow sufficient time to consider the motion, the above noted Board order was abated and withdrawn May 23, 1990.

In our April 23, 1990 order, we found that SAIF timely processed claimant's own motion request for temporary disability benefits. We adhere to that finding here. Claimant's attorney has submitted an attorney retainer agreement and, therefore, is entitled to an approved fee payable out of claimant's increased compensation. Claimant's attorney is awarded 25 percent of

the additional compensation granted by our April 4, 1990 order, not to exceed $400, as a reasonable attorney's fee.

On reconsideration, as supplemented and corrected herein, we adhere to and republish our April 4, 1990, and April 23, 1990, orders in their entirety. The parties' rights of reconsideration and appeal shall run from the date of this order.

IT IS SO ORDERED.

**Board Member Crider, dissenting:**

The SAIF Corporation unreasonably resisted payment of compensation; therefore, claimant's attorney is entitled to an attorney fee, payable by SAIF, for efforts to get that compensation.

Board rules require insurers to submit own motion claims to the Board with a recommendation within 60 days of receipt. OAR 438-12-025(2). Claims subject to the rule include "any written request for additional compensation for worsened conditions resulting from the original injury, signed by or on behalf of a claimant . . ." OAR 438-12-020. In this regard, the rules parallel the statutory rules governing submission of a claim for aggravation under ORS 656.273. Thus, anything that would serve as an aggravation claim, if submitted within the five-year aggravation period, must be submitted to the Board pursuant to OAR 438-12-025(2) if it is filed with an insurer after the five-year aggravation period.

On October 12, 1989, SAIF had notice that claimant had been hospitalized for an L4-5 fusion. The reports submitted by Dr. Kendrick, M.D., indicated that the need for surgery was related to a prior L4-S1 fusion performed in 1974 due to the compensable injury. It was obvious from these reports that claimant was working for a logging company at the time of hospital admission and therefore would be entitled to temporary total disability compensation upon hospitalization for surgery. See report of Dr. Kendrick dated September 7, 1989.

Such a report would clearly require processing as an aggravation claim. See Haret v. SAIF, 72 Or App 668 (1985). It was in writing and it put SAIF on notice that claimant would be off work due to the compensable injury. Nevertheless, SAIF did not submit the claim to the Board until March 29, 1990, more than a month after claimant's attorney specifically requested payment of time loss.

Claimant's compensation was delayed by several months by SAIF's failure to process. A fee should be awarded under ORS 656.382(1). Because the Board fails to treat the doctor's report as a claim, I dissent.

In the Matter of the Compensation of
**LESTER R. LEMKE, Claimant**
WCB Case No. 85-08229
ORDER ON REVIEW
Stebbins & Coffey, Claimant Attorneys
Cummins, et al., Defense Attorneys

Reviewed by Board Members Howell and Perry.

The self-insured employer requests review of those portions of Referee Bennett's order which: (1) set aside its denial of claimant's occupational disease claim for bilateral carpal tunnel syndrome; and (2) awarded claimant's counsel a $5,000 assessed attorney fee. On review, the issues are compensability and attorney fees. We affirm.

FINDINGS OF FACT

Claimant began working for the employer as a green chain puller in 1976. In this job, lumber comes down on the green chain and claimant pulls it off and puts it in bins. The employer has three different chains which carry different sizes of wood. The lumber varies between 8 feet and 24 feet. The width of the lumber also varies between 2" x 4" and 4" x 12".

Claimant used both hands to grip the wood. This activity required significant extension and flexion of the wrist joint. The degree of extension was greater than the degree of flexion. The amount of extension required was greater on the left hand than on the right. Claimant is right-handed.

Claimant spent most of his time working on the "upstairs" green chain which carried longer lengths of wood. He began to notice symptoms of carpal tunnel syndrome when he was working on the "downstairs" green chain. This chain carried a large number of shorter lengths of wood. While claimant was working on this chain, his left hand began to go numb, and then both hands began going numb. At night, his right arm hurt from the hand to the elbow. He was then shifted back to the upstairs green chain. For two weeks the work was slow and his hand symptoms improved. Then the work picked up and his hand symptoms became increasing worse.

In April 1985, he sought treatment from Dr. Bernstein, neurologist, for bilateral numbness, tingling and pain is his hands and wrists. Nerve conduction studies were consistent with a diagnosis of moderately severe carpal tunnel syndrome on the left and mild carpal tunnel syndrome on the right. Thereafter, Dr. Bernstein released claimant from work.

In July 1985, the employer denied claimant's claim for bilateral carpal tunnel syndrome. In October 1985, claimant underwent a left carpal tunnel release surgery. In November 1985, he underwent a right carpal tunnel release surgery. Both surgical procedures were performed by Dr. Bert. In January 1986, claimant was released to return to regular work.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant's work activities were the major contributing cause of his bilateral carpal tunnel syndrome. We agree.

In order to prevail on an occupational disease claim, claimant must show that the work activities either caused the condition, or in the case of a preexisting condition, that the work activities caused a worsening of the underlying condition. Wheeler v. Boise Cascade, 298 Or 452 (1985); Weller v. Union

Carbide, 288 Or 27 (1979). In addition, claimant must establish that the work activities were the major contributing cause of the condition or its worsening. Roseburg Lumber Co. v. Killmer, 72 Or App 626 (1985).

In the present case, there is no evidence that claimant's bilateral carpal tunnel syndrome preexisted his employment. Further, claimant had not experienced carpal tunnel symptoms or missed work due to such symptoms prior to his employment. His bilateral carpal tunnel symptoms commenced only after he began working for the employer, specifically on the "downstairs" green chain. Accordingly, the evidence does not establish that claimant had preexisting bilateral carpal tunnel syndrome, therefore, he must show that his work activities were the major cause of the development of the condition. See Devereaux v. North Pacific Ins. Co., 74 Or App 388, 391-92 (1985).

Dr. Bernstein opined that claimant's work activities were the major contributing cause of his development of bilateral carpal tunnel syndrome. He explained that claimant's work on the green chain involved forceable wrist flexion and extension which increased pressure in the carpal canal. He further noted that the work also involved repetitive forceful grasping which led to a thickening in the tendons from the fingers to the forearms which caused carpal tunnel syndrome. Bernstein's opinion is supported by Dr. Bert who also opined that claimant's work activities were directly causative of his bilateral carpal tunnel syndrome.

By contrast, Dr. Nathan opined that claimant's work activities had no relationship to the development of his bilateral carpal tunnel syndrome. Nathan testified that claimant's bilateral carpal tunnel syndrome was idiopathic in the sense that he had an underlying long-term carpal tunnel disease which became symptomatic in 1985. Dr. Nathan opined that, although it was possible that claimant's work activities rendered his carpal tunnel disease symptomatic, it did not worsen the underlying disease.

We are persuaded by the opinion of Dr. Bernstein and the supporting opinion of Dr. Bert. Dr. Bernstein persuasively explained how the flexion and extension involved in claimant's work activities caused the development of bilateral carpal tunnel syndrome. Moreover, his conclusion in regard to the work activities causing a thickening of the tenosynovium (a change in underlying tissue), is supported by the operative findings of Dr. Bert. Finally, his opinion regarding causation is consistent with claimant's testimony regarding his work activities, particularly with regard to the use of his left hand. By contrast, Nathan assumes that claimant's condition preexisted his employment. However, we have found no support for that assumption.

Accordingly, we conclude that claimant has established that his work activities were the major contributing cause of his bilateral carpal tunnel syndrome.

Attorney Fees

The employer contends that the Referee's award of attorney fees to claimant's counsel was excessive. We disagree. After review of claimant's counsel's statement of services at the hearing level and considering the factors set forth in OAR 438-15-010(6), we conclude that the Referee's award was appropriate. We note in this regard that this case involved a complex medical issue requiring substantial prehearing discovery and that claimant's counsel invested a significant amount of time at the hearings level.

In arriving at a reasonable assessed fee at the Board level, we consider these same factors. However, we note that a portion of claimant's counsel's efforts were expanded defending against the employer's effort to reduce

the assessed fee awarded at hearing. No assessed fee is payable for such efforts. Saxton v. SAIF, 80 Or App 631 (1986).

ORDER

The Referee's order dated January 6, 1989 is affirmed. For services on review concerning the compensability issue, claimant's counsel is awarded a reasonable assessed attorney fee of $1,000, payable by the self-insured employer.

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In the Matter of the Compensation of
**JOHNIE LOWERY, Claimant**
WCB Case No. 88-20153
ORDER ON REVIEW
Black, et al., Claimant Attorneys
Tom Dzieman (Saif), Defense Attorney

Reviewed by Board Members Crider and Nichols.

Claimant requests review of that portion of Referee Melum's order that declined to award temporary disability compensation from the date of claimant's bilateral knee and right elbow injury. On review, the issue is temporary disability compensation. We reverse.

FINDINGS OF FACT

Claimant was injured at work on August 12, 1985. At the time of his injury claimant was working setting chokers for a noncomplying employer. Claimant sustained a contusion and strain injury to both knees and the right elbow.

Claimant initially missed no work from the injury. However, a few days after the injury, he was laid off for being too slow on the job due to his physical injury. Claimant commenced work for a new employer at a less physically demanding job and for a lesser wage the same month he was fired from logging job.

The claim was accepted as nondisabling by the SAIF Corporation on December 17, 1985.

On May 17, 1988, claimant was taken off work by Dr. Wehinger, chiropractor. SAIF paid temporary disability payments in August and September of 1988.

A Determination Order issued February 16, 1989. Claimant was awarded no temporary or permanent disability benefits.

CONCLUSIONS OF LAW AND OPINION

Claimant contends he is entitled to temporary disability compensation when he first left work in August 1985. The Referee found that claimant had failed to prove that his injury of August 1985 caused any disability in performing his regular work. The Referee concluded that claimant had failed to prove he was disabled from his employment due to his compensable injury at the time he was injured. However, the Referee found that claimant was disabled from work on May 17, 1988, as indicated by Dr. Wehinger's report. Accordingly, the Referee awarded claimant temporary total disability from May 17, 1988 through September 24, 1988.

On review, claimant argues that he is entitled to temporary partial disability benefits from the date of his injury. Claimant asserts that he was unable to perform his regular work as a choker setter and was fired from this position two days after his injury because he was too slow to adequately perform the job. Claimant argues that he was slow because of his compensable injury. Accordingly, claimant concludes that because he was unable to perform his regular work due to his compensable injury and was required to take a lesser paying job, he is entitled to temporary disability dating back to this time. We agree.

We find that claimant is entitled to temporary disability benefits from the date he was terminated, August 12, 1985. Claimant credibly testified that he was unable to work efficiently as a choker setter after he sustained his injury. Claimant stated that because his injury prohibited him from working at the fast pace necessary to adequately perform his job he was fired.

Following claimant's injury, Dr. Grant diagnosed a contusion and strain to both knees and the right elbow. Furthermore, the medical evidence in July and August of 1986 indicated that claimant was partially disabled; and claimant credibly testified that his symptoms were the same in 1986 as they were following his compensable injury. Moreover, we note that following claimant's injury there is no evidence that he sustained any additional injuries and there was no abrupt worsening. Accordingly, we find that claimant was temporarily disabled from his regular work due to his compensable injury from the date he left his job at injury.

Claimant, therefore, is entitled to temporary disability benefits from that date; however, because claimant engaged in modified work for wages after he left his employer at injury, SAIF is entitled to reduce these benefits to temporary partial disability. ORS 656.212; OAR 436-60-030(3). These temporary partial disability benefits are based on the difference between his regular wage and the wage he earned working at the modified work. OAR 436-60-030(1). Claimant was entitled to resumption of temporary total disability compensation when he was taken off all work in May 1988. Accordingly, we find that claimant is entitled to temporary disability benefits pursuant to law, from the date he left his job at injury until such time as he returned to his regular employment, or was both medically stationary and able to return to his regular employment, or his claim was closed. ORS 656.212.

## ORDER

The Referee's order dated March 6, 1989 is reversed in part and affirmed in part. In addition to the temporary disability compensation awarded by the Referee's order, claimant is awarded temporary disability benefits from August 12, 1985 through May 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 directly to claimant's attorney. However, the total attorney fees awarded by the Referee and Board orders out of increased temporary disability compensation shall not exceed $3,800.

In the Matter of the Compensation of
**BEVERLY J. MARTINEZ, Claimant**
WCB Case No. 87-16874
ORDER ON REMAND
Olson, et al., Claimant Attorneys
Gary Wallmark (Saif), Defense Attorney

This matter is before the Board on remand from the Court of Appeals. Horgen v. Martinez, 101 Or App 396 (1990). The court has reversed our prior order which held that claimant was entitled to compensation because the noncomplying employer had not properly denied the claim. Beverly J. Martinez, 41 Van Natta 935 (1989). Consequently, the court has remanded with instructions to determine compensability.

FINDINGS OF FACT

Claimant began working for the noncomplying employer, a day care center, in March 1987. In addition to her teaching duties, she regularly swept floors, cleaned bathrooms and emptied trash. In April 1987, she began to experience right shoulder pain, but continued working. Her pain worsened, and on May 28, 1987, she saw Dr. Balmer, M.D. She did not inform Dr. Balmer that her right shoulder pain was related to her work. He diagnosed mild right shoulder tendinitis and instructed her to return in 7-10 days if necessary. Claimant did not return to Dr. Balmer or any other doctor until November 16, 1987.

Claimant returned to regular work until the end of the school year in early June 1987. Sometime prior to September 8, 1987, the noncomplying employer informed claimant that she would not be rehired for the 1987-88 school year. On September 8, 1987, claimant filed a claim for her right shoulder condition.

Claimant was reexamined by Dr. Balmer on November 16, 1987. At that time, she informed him that she believed her right shoulder condition was related to her janitorial duties between March and June 1987. Given that history, Dr. Balmer opined that her condition was work-related.

Claimant did not exhibit pain or other limitations while performing her job duties. She did not tell fellow workers or her employer that she had suffered a work-related injury or occupational disease.

Claimant was not a credible witness. She greatly exaggerated the extent of her janitorial duties at the day care center.

CONCLUSIONS OF LAW AND OPINION

Finding claimant not credible, the Referee concluded that claimant had not proven the compensability of her right shoulder condition. We agree.

In order to establish the compensability of an injury claim, claimant has the burden of proving that her work activity was a material contributing cause of her right shoulder disability or need for medical services. See Harris v. Albertson's, Inc., 65 Or App 254, 256-57 (1983). To prove that she suffered an occupational disease, claimant must prove that work activities were the major contributing cause of her condition. Dethlefs v. Hyster Co., 295 Or 298 (1988).

Here, there is no evidence, other than claimant's testimony and Dr. Balmer's opinion based solely on her history, that claimant's shoulder disability is related to her work. We concur with the Referee's assessment that claimant's version of events lacked credibility. To begin, we defer to the

Referee's determination of credibility based on the Referee's observation of claimant's demeanor. Humphrey v. SAIF, 58 Or App 360, 363 (1982). In addition, we agree with this determination based on our review of the record. See Coastal Farm Supply v. Hultberg, 84 Or App 282, 285 (1987).

Specifically, claimant did not inform her doctor, until over six months after first seeing him, that her shoulder problem was related to her work. Additionally, she did not file the workers' compensation claim until after she was informed that she was not going to be rehired by the employer. Finally, despite her contentions to the contrary, the credible evidence establishes that she neither exhibited pain or limitations while at work nor advised her co-workers of any work-related condition.

Considering claimant's noncredible testimony with the fact that all medical evidence relating her shoulder condition to her work was premised on the history provided by claimant, we find that claimant has not met her burden of proving that her shoulder disability is compensable. Consequently, the SAIF Corporation's acceptance of the claim on behalf of the noncomplying employer is set aside and SAIF shall terminate its processing of the claim.

Accordingly, the Referee's order dated April 11, 1988 is affirmed.

IT IS SO ORDERED.

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In the Matter of the Compensation of
**LORIE J. KELLEY, Claimant**
WCB Case No. 89-01778
ORDER ON REVIEW
Emmons, et al., Claimant Attorneys
Karen M. Werner, Attorney
Rick Dawson (Saif), Defense Attorney

Reviewed by Board Members Speer and Howell.

The SAIF Corporation requests review of Referee Seymour's order that awarded claimant an insurer-paid attorney fee when a denial was rescinded prior to hearing. On review, the issue is attorney fees. We reverse.

## FINDINGS OF FACT

Claimant's hand injury claim was denied in January 1988. Thereafter, claimant retained an attorney to appeal the denial and a hearing was requested on January 26, 1989. In February 1989, SAIF filed a response to the hearing request and during the month of March 1989 the parties engaged in settlement negotiations. On April 7, 1989, SAIF voluntarily rescinded its denial and thereafter claimant's attorney requested an insurer-paid fee pursuant to OAR 438-15-030(1). The Referee found that counsel was instrumental in obtaining compensation for claimant without the necessity of a hearing and accordingly awarded insurer-paid fees.

## CONCLUSIONS OF LAW AND OPINION

The Referee awarded an $800 insurer-paid attorney fee pursuant to OAR 438-15-030(1) which provides:

> "If an attorney is instrumental in obtaining compensation for a claimant without a hearing before a Referee, a reasonable attorney fee may be approved or assessed. The amount of the fee shall be determined by the Referee or by agreement of the parties."

Subsequent to the Referee's order, in Duane L. Jones, 42 Van Natta 875 (1990), we concluded that under ORS 656.386(1) the legislature intended that fees are awardable for services at, and prior to hearing, only if the claimant finally prevails in a hearing. 42 Van Natta at 877. Consequently, we reevaluated the propriety of OAR 438-15-030(1), which provides for carrier-paid attorney fees without a hearing and without the necessity of claimant prevailing finally before a referee. We therefore held that subsection (1) of the rule was invalid because it exceeded the scope of the governing statute, ORS 656.386(1). Duane L. Jones, supra, at 878.

Here, there was no hearing and claimant did not finally prevail before a referee, therefore, insurer-paid attorney fees were not properly awarded. We accordingly reverse the Referee's $800 insurer-paid attorney fee.

ORDER

The Referee's order dated May 23, 1989 is reversed. The $800 attorney fee award is reversed.

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In the Matter of the Compensation of
**PARASKEVI WATKINS, Claimant**
WCB Case No. 85-03792
ORDER ON REVIEW
Rasmussen & Henry, Claimant Attorneys
H. Thomas Andersen (Saif), Defense Attorney

Reviewed by Board Members Howell and Perry.

Claimant requests review of that portion of Referee Livesley's order which upheld the SAIF Corporation's denial of a psychological condition and headaches. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

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

Claimant's chronic pain due to her compensable injury has led to her depressive disorder and headaches.

CONCLUSIONS OF LAW AND OPINION

Compensability of Psychological Condition

The Referee analyzed claimant's claim as an occupational disease under former ORS 656.802(1)(b). He found that, because claimant did not have a diagnosed mental disorder, her claim was not compensable. We agree with the Referee's conclusion that claimant's claim is not compensable as an occupational disease. However, we find it compensable as a consequence of a compensable injury.

A claimant asserting the compensability of a psychological condition following an industrial injury must prove by a preponderance of the evidence that the compensable injury was a material cause of the condition, or if the mental condition predated the injury, that the injury worsened that preexisting condition. Jeld-Wen v. Page, 73 or App 136, 139 (1985); Partridge v. SAIF, 57 Or App 163, 167, rev den 293 Or 394 (1982).

Here, claimant did not have a mental condition that predated her injury, but a preponderance of the evidence proves that her compensable injury was a material cause of her psychological condition.

Claimant is from Greece and worked in a Greek restaurant with other persons from Greece. She does not speak English very well, and was drawing support from fellow workers from her native country. After her compensable injury, claimant was not able to return to work at the restaurant. Claimant developed a lack of self-worth and became increasingly depressed.

Claimant has been diagnosed as having reactive depression, or alternatively, adjustment reaction with major depressive disorder. Her treating physician, Dr. Jewell, first began treating claimant with antidepressants for chronic pain management in early 1985. In early 1986, Dr. Jewell referred claimant to Dr. Hawkins, a psychologist, who noted that claimant's feelings of self-worth were related to her ability to work and, because claimant could not work, she required help in coping with her depression and managing the chronic pain which had developed from her arm injury.

In May 1985, claimant was referred to an Injured Workers' Program for vocational assessment. The psychologist stated that claimant had had an excellent work history before her injury, and was becoming more depressed and concerned lately because she could not work.

Dr. Jewell referred claimant to a pain center in January 1987. After the initial evaluation at the pain center, the psychologist at the center stated that claimant had had a positive relationship with Dr. Hawkins in the past, and that she would probably need ongoing supportive assistance from her in order to return to some kind of functional capacity.

Virtually every examination that claimant has had since her compensable injury has noted depression and recommended that claimant continue with supportive psychotherapy. We conclude that claimant has proved by a preponderance of the evidence that her compensable injury was a material cause of her psychological condition. Jeld-Wen, supra.

Compensability of Headaches

The Referee found that there was "no clear evidence between claimant's headaches and her compensable injury." He opined that claimant's excessive use of coffee and cigarettes may be the cause of her headaches and noted that the time span between the injury and the onset of headaches was too long to indicate a connection. He also stated that there was a lack of medical evidence associating the headaches with the injury. We disagree.

Although there was nearly a five year time span between the compensable injury and the onset of claimant's headaches, the medical reports over the years after the injury continually document chronic pain and reactive depression. When the headaches began, they were immediately associated with her myofascial syndrome which was secondary to the injury and depression. (Exs. 95-4, 111-2).

Claimant's initial evaluation at the Oregon Pain Center noted that she had constant tightness in the back of her neck into her shoulder area and frequent headaches. In her discharge summary in April 1987, Dr. Holmes, medical director, noted that claimant had "myofascial involvement, cervical and shoulder girdle with muscular contraction headaches," but that techniques learned by claimant at the center had resulted in interruption of her headaches. (Ex. 95-3, 4).

A follow-up examination in August 1987 noted severe temporal and orbital pain which the doctor attributed to her myofascial syndrome, secondary to reactive depression and chronic right upper extremity dysfunction. The physician also noted frequent bruxism related to the myofascial syndrome, and that claimant's teeth were loosened because of this.

Because of the above-mentioned medical evidence, we conclude that claimant's compensable injury was also a material contributing cause of her headaches.

Claimant is entitled to a reasonable, carrier-paid attorney fee for her counsel's efforts at hearing and on Board review. In arriving at such a fee, we consider the factors set forth in OAR 438-15-010(6). Under the facts of this case, we conclude that $2,500 is a reasonable fee.

ORDER

The Referee's order dated June 8, 1989 is reversed. The SAIF Corporation's denial of claimant's psychological condition and headaches is set aside and this claim is remanded to SAIF for processing according to law. Claimant's attorney is awarded a reasonable assessed fee of $2,500, payable by SAIF.

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September 12, 1990 Cite as 42 Van Natta 1961 (1990)

In the Matter of the Compensation of
**STEPHANIE J. THOMAS, Claimant**
WCB Case No. 89-25956
ORDER DENYING MOTION TO DISMISS
Roberts, et al., Defense Attorneys

The self-insured employer has moved for an order dismissing claimant's request on the grounds that claimant did not seek Board review of Referee Mill's order. The motion is denied.

FINDINGS OF FACT

On May 7, 1990, the Referee issued an Order to Show Cause. Within 30 days from the order, claimant was requested to submit a written justification for her failure to appear at a scheduled hearing. If a timely response was not received or if good cause was not established, the Referee advised the parties that the hearing request would be dismissed.

On June 18, 1990, the Referee's Order of Dismissal issued. On July 18, 1990, the Referee received a letter from claimant in which she provided her explanation for not appearing at the hearing and described her current circumstances. The letter stated that claimant was "request[ing] a review by the Workers' Compensation Board with regard to this claim." The letter indicated that a copy had been provided to the employer's attorney. On July 23, 1990, the Board mailed a computer-generated letter to the parties acknowledging the letter as a request for review of the Referee's order.

ULTIMATE FINDINGS

Claimant requested Board review of the Referee's June 18, 1990 order within 30 days of its issuance.

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).

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). 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 unmistakeable, we have concluded that we have jurisdiction pursuant to ORS 656.295. See Rochelle M. Gordon, 40 Van Natta 1808 (1988). We have reached such a conclusion even when the request has been directed to the Referee, rather than the Board. Roy E. Speight, 41 Van Natta 2215 (1989).

Here, claimant's letter was directed to the Referee. However, claimant expressly stated that she was "request[ing] a review by the Workers' Compensation Board with regard to this claim." Under such circumstances, we conclude that the intention expressed in claimant's letter is both clear and unmistakeable. i.e., claimant wanted the Board to review the Referee's order.

Accordingly, the motion to dismiss is denied. Upon receipt of a hearing transcript, copies will be distributed to the parties and a briefing schedule implemented. In submitting their respective briefs, the parties are further requested to address the employer's "motion to strike." That motion, as well as the other issues raised by claimant's request, will be considered at the time of Board review.

IT IS SO ORDERED.

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September 12, 1990 Cite as 42 Van Natta 1962 (1990)

In the Matter of the Compensation of
**PAUL E. VOELLER, Claimant**
WCB Case No. 88-18620
ORDER ON RECONSIDERATION
Peter O. Hansen, Claimant Attorney
Schwabe, et al., Defense Attorneys

The self-insured employer requests reconsideration of the Board's Order on Review dated August 15, 1990 which affirmed the Referee order which set aside its July 13, 1988 Determination Order as premature. Specifically, the employer contends that the order does not give proper legal effect to a prior order of the Board.

The employer contends that, whether or not claimant's psychological condition was medically stationary when the claim was closed, claim closure was not premature because claimant never had the condition which we ordered the employer

to accept (reactive depression); having never had the accepted condition, the condition was appropriate for claim closure at any time.

The employer would have us read our prior order, which adopted Referee Neal's Opinion and Order as a nullity--requiring acceptance of a condition that claimant did not have. Having read the order as a nullity, the employer contends that closure was appropriate even though it is obvious that the psychological condition from which claimant suffered was not medically stationary. We decline to do so. The employer's argument is without merit.

On June 11, 1986, the employer apparently denied claimant's psychological condition. Claimant requested a hearing. Referee Neal stated the issue broadly as "compensability of claimant's mental stress claim as either an industrial injury or an occupational disease." In her opinion, she said, "I find that claimant has established the compensability of his mental stress claim for his depression or major affective disorder that took him to the hospital in February 1986 and required treatment by Dr. Pavaresch." Her order set aside the employer's denial and directed the employer to "accept responsibility for claimant's reactive depression."

Upon receipt of Referee Neal's order, the employer ascertained that no physician had diagnosed claimant's psychological condition as a "reactive depression," as opposed to a depression or major affective disorder. The employer then asked the Evaluation Section to close the claim without any award of temporary or permanent disability. The employer made this request despite the Referee's findings that claimant had been repeatedly hospitalized and had been unemployed since April 21, 1986 due to the condition that she found compensable, on the ground that claimant did not have and never had reactive depression. Evaluation did close the claim, albeit with an award of temporary total disability.

Reading Referee Neal's Opinion and Order as a whole, it is clear that the Referee found that claimant's psychological condition, which she described in the text of her opinion as depression and major affective disorder, was caused by his work and that she set aside a denial of that condition. Consequently, it was improper to close the claim until that condition became medically stationary. Having found that that condition was not medically stationary at the time of claim closure, Referee Shebley correctly set aside the Determination Order.

Assuming, however, that the employer correctly reads Referee Neal's April 15, 1988 Opinion and Order to set aside the employer's denial only to the extent that it was addressed to "reactive depression," claim closure was nonetheless premature if claimant suffered from any other compensable condition and if that compensable condition was not yet medically stationary when the Determination Order issued. Rogers v. Tri-Met, 75 Or App 470, 473 (1985). Our prior order, affirming and adopting Referee Neal's Opinion and Order, is final. By that order, we found that claimant suffers from depression and/or major affective disorder due to his work exposure. We reiterate that finding here. Consequently, having found that claimant's compensable psychological condition was not stationary when the claim was closed, we adhere to our August 15, 1990 Order on Review.

The employer's request is granted, and the Board's prior order is withdrawn. Accordingly, on reconsideration, as supplemented herein, the Board adheres to and republishes its former August 15, 1990 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
**BARRY DUNN, Claimant**
And, in the Matter of the Complying Status of
**FRANK STANLEY WOOD and MIKE HERMELING, dba HERWOOD, Noncomplying Employer**
WCB Case Nos. 89-05827, 89-05826, 89-03292 & 88-16769
ORDER ON REVIEW
Brothers, et al., Claimant Attorneys
Carl William Hopp, Jr., Defense Attorney
Bonnie Laux (Saif), Defense Attorney
Atherly, et al., Defense Attorneys

Reviewed by Board Members Perry and Howell.

The alleged noncomplying employer, Herwood, requests review of that portion of Referee Brazeau's order that set aside its denial of claimant's hand injury claim. Claimant and the Department of Justice request review of that portion of the Referee's order that found that claimant was not a subject employee of Herwood. Claimant also requests review of that portion of the Referee's order which declined to assess penalties and attorney fees for an alleged unreasonable and untimely denial. On review, the issues are subjectivity and penalties and attorney fees. 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.

### Compensability

The Referee found that claimant was an independent contractor rather than an employee. We agree. At the same time he worked for Herwood, claimant bid on other jobs in the community. Claimant had his own assistants, whom he hired, and on one occasion, fired. Claimant paid his employees and signed a statement that he would be responsible for them. Finally, Herwood did not believe that it could terminate claimant's employment at will. Under the circumstances, we conclude that claimant both held himself out as an independent contractor and acquiesced to independent contractor status.

The Referee found that, even though claimant was an independent contractor, Herwood was required to provide coverage for him because he fell within the provisions of ORS 656.029(1). The Referee concluded that Herwood had contracted with claimant to perform labor that was a normal and customary part of its trade or business. The Referee also concluded that claimant was not a sole proprietor and therefore was not exempt under that provision.

We agree with the Referee's conclusion that, under ORS 656.029(1), Herwood is responsible for claimant's injury. ORS 656.029 provides for the obligation of "persons" letting a contract to provide workers' compensation coverage. The Referee correctly concluded that under ORS 656.029(3)(a), Herwood, as a partnership, fell within the statute's definition of "person." We note, parenthetically, that ORS 656.029 does not require the "person" to be an employer. Therefore, even though claimant has been found to be an independent contractor, under ORS 656.029(1), Herwood remains responsible for his injury.

Request for hearing from SAIF's acceptance

As an employer, Herwood is not barred from challenging SAIF's acceptance of claimant's injury claim. However, ORS 656.029 requires claims to be processed as provided in the statutes pertaining to noncomplying employers. Therefore, under ORS 656.054, SAIF is the processing agent for Herwood.

In the present case, SAIF received notice of claimant's injury claim by at least August 12, 1988, the date on which its representative signed claimant's 801 form. Herwood did not request a hearing from SAIF's acceptance until February 7, 1989. We conclude that, from the time SAIF received notice of the claim, Herwood had 60 days to request a hearing and it failed to do so. See Kristi L. Chase, 42 Van Natta 1247 (1990). Accordingly, Herwood may only defeat the compensability of the claim upon a showing of fraud, misrepresentation or other illegal activity.

We conclude that, on this record Herwood has failed to show fraud, misrepresentation or other illegal activity capable of affecting claim acceptance. Herwood has not defeated the compensability of the claim accepted by SAIF.

Penalties and attorney fees

The Referee declined to assess penalties and attorney fees for an alleged unreasonable and untimely denial by Herwood. We agree that penalties and attorney fees are not appropriate. Herwood's action or inaction on the claim is not relevant since in this circumstance, the claim was processed under ORS 656.029, as for a noncomplying employer. Processing is therefore solely the responsibility of SAIF. See Clark v. Linn, 98 Or App 393 (1989).

Claimant is entitled to a reasonable assessed fee for services on Board review relating to the issues of subjectivity and compensability. In determining the amount of such a reasonable assessed fee, we consider the facotrs set forth in OAR 438-15-010(4). Here, we note, claimant's counsel expended efforts on the penalty and attorney fee issue on which he did not prevail. In light of this fact, and considering the above-mentioned factors, we concluded that $950 is reasonable.

ORDER

The Referee's order dated May 12, 1989 is affirmed. For services on review pertaining to the issues of subjectivity and compensability, claimant's counsel is awarded a reasonable assessed fee of $950, payable by the SAIF Corporation, on behalf of the noncomplying employer.

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September 13, 1990 Cite as 42 Van Natta 1965 (1990)

In the Matter of the Compensation of
**LAWRENCE H. EBERLY, Claimant**
WCB Case No. 89-00616
ORDER ON REVIEW
Vick & Gutzler, Claimant Attorneys
Williams, et al., Defense Attorneys

Reviewed by Board Members Cushing and Gerner.

Claimant requests review of those portions of Referee Shebley's order that: (1) upheld the insurer's partial denial of claimant's current cervical

condition; and (2) declined to assess penalties and related attorney fees for an alleged unreasonable denial. On review, the issues are compensability and penalties and attorney fees. We affirm.

## FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" as supplemented below.

Claimant's compensable low back condition is not materially related to claimant's current cervical condition.

## CONCLUSIONS OF LAW AND OPINION

### Compensability

The Referee upheld that portion of the insurer's partial denial which denied claimant's cervical condition. We agree with the Referee's conclusions. The Referee also set aside that portion of the partial denial that denied "degenerative disease or pre-existing conditions in claimant's low back, if any, which were actually and materially worsened by his accepted lumbar strain." The parties have not requested review of this portion of the Referee's order, and therefore, we confine our comments to the procedural and substantive validity of the partial denial as it addresses claimant's cervical condition.

An insurer's acceptance of a claim includes only those injuries or conditions specifically accepted in writing pursuant to ORS 656.262(6). Johnson v. Spectra Physics, 303 Or 49, 58 (1987). Acceptance need not meet any particular degree of specificity. The insurer will be bound by the specific condition accepted regardless of the fact that the cause of that condition may be noncompensable. Georgia-Pacific v. Piwowar, 305 Or 494, 501 (1988). An insurer's failure to respond to a claim or a separate aspect of a claim is neither acceptance nor denial. Johnson, supra, 303 Or at 55-56.

The insurer may partially deny a claim if it specifies which injuries or conditions it accepts and which it denies. It is improper to deny those conditions which are a part of the acceptance. But it is not improper to deny separate aspects, i.e., conditions/injuries arising out of the same claim. Piwowar, supra, 305 Or at 501-502; Johnson, supra, 303 Or at 58. This specificity, which promotes timely closure of accepted conditions and prompt appeals of denied conditions, is the essence of a partial denial. Johnson, supra.

Claimant compensably injured his low back on March 16, 1988 in a lifting incident. The insurer asks us to take administrative notice that the 801 claim form and a report to the Workers' Compensation Division, otherwise known as a Form 1502, constitutes a "formal acceptance" of claimant's lumbar strain. We decline, as we find that neither the 801 nor 1502 read separately or together constitutes a formal acceptance of the claim. The claim was deferred on the 801, and a Form 1502 is not an acceptance. See EBI Ins. Co. v. CNA Insurance, 95 Or App 448 (1989).

However, by a partial denial dated January 25, 1989, the insurer accepted "lumbar strain." Accordingly, we find that the insurer accepted the specific condition of "lumbar strain." As such, it was not procedurally improper for the insurer to deny a separate aspect of that claim. We find claimant's cervical condition to be a separate infirmity. Consequently, it was not procedurally improper to deny the condition.

As we find the partial denial relating to claimant's cervical condition procedurally valid, we proceed to the merits. The medical evidence persuasively

shows claimant's cervical condition is unrelated to claimant's accepted condition. Both claimant's treating physician, Dr. Misko, and the independent medical examiner, Dr. Snodgrass found that claimant's cervical condition was related to degenerative changes and not claimant's accepted low back condition. (Exs. 41, 42). Therefore, with respect to the cervical condition, we find the partial denial proper.

Penalties and Attorney Fees

In light of the above discussion, we agree with the Referee that the partial denial was not unreasonable as it refers to the cervical condition. However, claimant also contends the partial denial was unreasonable in attempting to deny "degenerative changes and pre-existing conditions." We note that the partial denial does not adequately identify the body part this language was referring to. As such, that portion of the partial denial lacked specificity as to the condition denied as required by Weyerhaeuser Co. v. Warrilow, 96 Or App 34 (1989).

Nonetheless, we note that at the time the insurer issued its partial denial the state of the law in this area was in flux. As long as the insurer had a legitimate doubt from a legal standpoint of its liability, its conduct was not unreasonable. Norgard v. Rawlinsons, 30 Or App 999, 1003 (1977). Under these circumstances, we conclude that the insurer had a legitimate doubt concerning its responsibility for claimant's "degenerative changes and pre-existing conditions" and the degree of specificity required in its denial. Accordingly, we hold that its denial was not unreasonable.

ORDER

The Referee's order dated April 17, 1989, is affirmed.

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September 13, 1990 Cite as 42 Van Natta 1967 (1990)

In the Matter of the Compensation of
**FRED W. KREAMIER, Claimant**
WCB Case No. 89-04576
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
Schwabe, 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: (1) set aside its denial of claimant's medical services claim for an air ride suspension seat; and (2) ordered the employer to install the seat in one of its work trucks. On review, the issues are medical services and jurisdiction. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact as our own, except for those findings of fact contained in the last paragraph of page two of the order and those in the third paragraph of the third page of the order.

CONCLUSIONS OF LAW AND OPINION

In this case, the employer essentially raises two questions: (1) is an air ride suspension seat a reasonable and necessary medical service for claimant under ORS 656.245(1) and OAR 436-10-040(8); and, if it is, (2) apart from ordering

the carrier to pay for the seat, does the Referee have authority to direct the employer to install the seat in one of its trucks to accommodate claimant? Inasmuch as we find that claimant has not established the compensability of the claim, we need not address the second question.

Reasonable and Necessary

In order for claimant to prove that his air ride suspension seat is compensable under ORS 656.245(1), he must meet the requirements of OAR 436-10-040(8). This rule states in relevant part that:

> "Furniture is not a medical service. Articles such as beds, hot tubs, chairs, Jacuzzis, and gravity traction devices are not compensable unless a need is clearly justified by a report which establishes that the 'nature of the injury or the process of recovery requires' that the item be furnished. The report must specifically set forth why the patient requires an item not usually considered necessary in the great majority of workers with similar impairments."

This rule sets out two requirements, both of which have to be met in order to make the claim for the air ride suspension seat compensable.

Claimant must first prove that the medical evidence clearly establishes his need for the seat because the nature of his injury and the process of his recovery requires it. Dr. King and the Western Medical Consultants address this issue. Dr. King stated that claimant needed the seat because it "would do much in relieving the stress on his back", may "reduce or prevent additional permanent impairment in the future", "may reduce his present requirement for antiinflammatories", "may reduce the frequency of chiropractic treatment", "could" prevent a worsening of his condition, and would be more beneficial to him than not. (Exs. 13B, 14A). The Western Medical Consultants stated that claimant "would benefit" from the seat and that it would be less expensive than paying for time loss. (Ex. 16).

All these statements together, with the facts of this case, are sufficient to carry claimant's burden under this section of the rule; however claimant fails to meet his burden under the second requirement of the rule.

In addition to proving that the nature of the injury or the process of recovery requires the use of the seat, claimant must also present medical evidence that establishes, with particularity, why he requires the seat where the great majority of workers with similar impairments do not. In this case, there is no evidence on this requirement. There is no report setting out the reasons with particularity. Claimant has failed to meet this requirement of the rule.

Since claimant is required to meet both requirements of the rule, and he has not, he has not established his entitlement to the air ride suspension seat under OAR 436-10-040(8).

Jurisdiction

Since we have found that the air ride suspension seat is not a reasonable and necessary medical service, we need not address the second question raised herein.

ORDER

The Referee's order dated June 23, 1989 is reversed in part. That portion of the order that set aside the denial of the air ride suspension seat is reversed. The denial is reinstated and upheld. The Referee's $1,500 assessed attorney fee award is reversed. The remainder of the order is affirmed.

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September 13, 1990 Cite as 42 Van Natta 1969 (1990)

In the Matter of the Compensation of
**MICHAEL D. MCGINNIS, Claimant**
WCB Case No. 87-04340
ORDER ON REVIEW (REMANDING)
Vick & Gutzler, Claimant Attorneys
Saif Legal Department, Defense Attorney

Reviewed by Board Members Cushing, Nichols and Perry.

The SAIF Corporation requests review of Referee Schultz's order that: (1) found that the Hearings Division had jurisdiction to rate the extent of claimant's permanent disability; (2) increased claimant's unscheduled permanent partial disability for a back injury from 10 percent (32 degrees), as awarded by a Determination Order, to 30 percent (96 degrees). SAIF also moves for remand to the Referee for introduction of a post-hearing medical report. On review, the issues are remand, jurisdiction, and extent of unscheduled permanent partial disability. We reverse and remand.

FINDINGS OF FACT AND ULTIMATE FACT

Claimant was 31 years old at the time of the hearing and was employed by SAIF's insured, as a custodian, when he was compensably injured on July 15, 1985. Claimant sustained injuries to his left hip, cervical, dorsal and lumbar spine, his left arm, wrist, fifth finger, and three front teeth, as well as a cerebral concussion, when he fell 10 to 12 feet off of a scaffolding.

Claimant was examined at the request of SAIF by the Orthopaedic Consultants on November 21, 1986. The Consultants concluded that claimant was medically stationary and not in need of further surgery for his wrist or spinal injuries.

A Determination Order issued March 2, 1987, awarding claimant 10 percent (32 degrees) unscheduled permanent partial disability (PPD) and 15 percent (28.80 degrees) scheduled PPD for loss of his left arm. Claimant requested a hearing on this Determination Order contesting the extent of his disability.

Claimant was referred to Dr. Keizer, orthopedic and fracture surgeon, on May 5, 1987. Following an examination, Dr. Keizer recommended a total bone scan, an MRI scan and a carpal tunnel release, which was performed on June 3, 1987 by Dr. Schader. Claimant's claim was reopened for an aggravation.

Claimant had returned to work in a light duty capacity in November 1986. He stopped working in June 1987 because of increasing low back pain and the wrist surgery; and he returned to work again on June 13, 1988 to a painting and lawn mowing job. At the time of the June 16, 1988, hearing claimant had worked three full days in this custodial position.

On June 14, 1988, Dr. Schader found claimant medically stationary and released him for modified work.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant was medically stationary as of June 14, 1988. Since the Evaluation Section had initially rated claimant's disability, the Referee reasoned that he had the authority to award claimant unscheduled and scheduled permanent partial disability even without formal closure by the Department. We disagree.

SAIF argues that closure of this claim by Evaluation is intended by ORS 656.268 and OAR 438-06-040. We agree. The Board's rule, OAR 438-06-040, states:

> "Except as provided in 438-08-020 issues of permanent disability shall not be adjudicated unless the claim has been once considered by Evaluation or the insurer under ORS 656.268." (Emphasis added).

Under the Board's rule, it is not appropriate for the Referee to rate the extent of claimant's permanent disability unless "the claim" has once been considered by the Evaluation Section or the claim comes within the exception for denied aggravation claims under OAR 438-08-020. We find under the circumstances of this case it was not appropriate for the Referee to proceed with such a determination.

In reaching our conclusion, we turn to the definition of a claim in ORS 656.005(6), which states:

> "Claim means a written request for compensation from a subject worker or someone on the worker's behalf, or any compensable injury of which a subject employer has notice or knowledge."

We find that when claimant's aggravation claim was opened for surgery and additional temporary disability benefits in June 1987, the reopening was a "claim" which must be properly closed pursuant to ORS 656.268(2)(a). That statute provides:

> "Unless the insurer or self-insured employer has elected to close the claim pursuant to subsection (3) of this section, when the injured worker's condition resulting from a disabling injury has become medically stationary, . . . the insurer or self-insured employer shall so notify the Department of Insurance and Finance, the worker, and the employer if any, and request the claim be examined and further compensation, if any, be determined."

In addition, we note that at the time of this hearing, there was also a request for hearing outstanding which raised the issue of the extent of disability awarded by a Determination Order of March 2, 1987, which issued before claimant's claim was reopened in June 1987. Arguably, assuming that claimant's condition was medically stationary and the record sufficiently developed, the Referee could have addressed that issue at the time of this hearing. However, since extent of permanent disability is to be rated at the time of hearing, we conclude that it would be extremely confusing, if not impossible, to rate claimant's disability, disregarding the permanent contribution, if any, which resulted from the reopening of claimant's claim.

Therefore, because this claim does not fall within the exception of OAR 438-08-020, we find that until this "claim" has been properly closed, it is inappropriate for a referee to rate claimant's permanent disability. Accordingly,

the claim that was reopened in June 1987 is remanded to SAIF for closure under ORS 656.268 if that has not been done. Claimant's request for hearing on the Determination Order of March 2, 1987 is preserved and remanded to the Hearings Division, to be placed in deferred status. In the event the closure of claimant's reopened claim results in another hearing request, that request shall be consolidated with the request on the March 1987 Determination Order. Should no subsequent hearing request materialize, the parties shall proceed to a determination concerning the extent of claimant's permanent disability based on the request for hearing filed on the March 1987 Determination Order.

SAIF has moved the Board to remand this claim to admit a report of Dr. Schader's that was not available at the time of hearing. Because we have found that the Referee did not have authority to rate claimant's permanent disability and are remanding this case for further proceedings, we do not reach the merits of SAIF's motion.

ORDER

The Referee's order dated September 7, 1988 is reversed. This case is remanded to Referee Schultz for further proceedings consistent with this order.

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In the Matter of the Compensation of
**JON C. MILLET, Claimant**
WCB Case No.88-16759
ORDER ON REVIEW
Merrill Schneider, Claimant Attorney
Stafford Hazelett, Defense Attorney

Reviewed by Board Members Gerner and Myers.

Claimant requests review of that portion of Referee Quillinan's order which allowed the insurer to offset its approved overpayment against unpaid temporary disability. On review, the issue is offset of overpayments. We reverse.

FINDINGS OF FACT

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

Claimant was not paid temporary disability from September 21, 1988, through September 30, 1988. Claimant has been paid all other temporary disability due him. (Ex. 17-2).

CONCLUSIONS OF LAW AND OPINION

The Referee allowed the insurer to offset its overpayment against unpaid temporary disability due under the Determination Order. Claimant contends that the overpayment cannot be offset against the unpaid temporary disability because overpayments can only be offset against permanent disability awards. We agree.

Recovery on an overpayment may only be made against permanent disability awards. Buddy Tillman, 41 Van Natta 239 (1989); Harold Bates, 38 Van Natta 992 (1987). Here, the offset is sought against temporary disability (the unpaid amount from September 21, 1988 through September 30, 1988), not permanent disability. That is not permissible. Claimant is entitled to have the temporary disability paid to him and not offset against the existing overpayment.

ORDER

The Referee's order dated July 19,1989 is reversed in part. That portion that authorized the insurer to offset its overpayment against the unpaid temporary disability from September 21, 1988 through September 30, 1988 is reversed. The insurer is ordered to pay claimant that temporary 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 is athorized to recover its $3,921.58 overpayment against claimant's future permanent disability awards, if any. The remainder of the order is affirmed.

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In the Matter of the Compensation of
**DEBRA M. SANSBURN, Claimant**
WCB Case No. 89-05718
ORDER ON REVIEW
Donald L. Dickerson, Claimant Attorney
Employers Defense Counsel, Defense Attorneys

Reviewed by Board Members Cushing and Gerner.

The insurer requests review of Referee Livesley's order which: (1) set aside a Compliance Section order suspending claimant's compensation for refusing to attend an independent medical examination; and (2) awarded an insurer-paid attorney fee for setting aside the suspension order. On review, the issues are suspension of compensation and attorney fees. We reverse.

FINDINGS OF FACT

Claimant compensably injured her back on August 30, 1987. During the processing of her claim, claimant has attended three independent medical examinations (IME) at the initiation and request of the insurer.

On August 3, 1988, the insurer requested a Determination Order. On October 28, 1988, the Evaluation Section notified both claimant and the insurer that the determination was deferred pending the receipt of a report from claimant's treating doctor, Dr. Helms. On November 3, 1988, the Evaluation Section directed the insurer to schedule a current examination and forward the results to Dr. Helms for comment.

On November 15, 1988, the insurer, in compliance with the Evaluation Section's request, sent claimant a notice of an IME it had scheduled with Dr. Woolpert. The notice conformed with the requirements of former OAR 436-60-090(3). Claimant did not attend that examination because she was scheduled for an MRI, CT scan and myelogram at that time with another physician.

On January 16, 1989, the insurer wrote to claimant's counsel, requesting he insure claimant's attendance at a rescheduled IME with Dr. Woolpert on February 2, 1989. On January 17, 1989, the insurer mailed claimant a notice of the new IME. Claimant did not attend that examination.

On February 3, 1989, the insurer agained rescheduled the IME with Dr. Woolpert, this time for February 23, 1989, and sent claimant notice of the examination.

On February 9, 1989, the insurer received notification from claimant's attorney that claimant was refusing to attend the rescheduled IME. The insurer,

on February 10, 1989, requested the Compliance Section to suspend claimant's compensation for failure to attend the prior examinations. Copies of this suspension request were sent to claimant and her attorney.

On February 17, 1989, the Compliance Section notified the parties that the request to suspend compensation would be deferred until after the rescheduled IME on February 23, 1989. Claimant did not attend that examination, and the insurer renewed its request for suspension of benefits.

The insurer's renewed request for suspension met all the requirements of former OAR 436-60-090, which included providing claimant notice that she must respond to the insurer's request within 10 working days. Former OAR 436-60-090 (6)(h). This request and notice was sent to claimant and her attorney.

Claimant did not respond to the insurer's request to suspend claimant's compensation. On March 16, 1989, the Compliance Section issued an order suspending claimant's compensation as of February 23, 1989. Claimant appealed the suspension order.

Claimant did not have a valid reason for refusing to attend one of the examinations scheduled with Dr. Woolpert.

## CONCLUSIONS OF LAW AND OPINION

The Referee held that the suspension of claimant's compensation was invalid because there was no legal basis to compel claimant to attend an IME requested by the Evaluation Section. The Referee also awarded claimant an insurer-paid attorney fee for overcoming the suspension order. We disagree.

ORS 656.325(1)(a) states in relevant part:

> "Any worker entitled to receive compensation under ORS 656.001 to 656.794 is required, if requested by the director, the insurer or self-insured employer, to submit to a medical examination at a time and from time to time at a place reasonably convenient for the worker and as may be provided by the rules of the director." (emphasis added)

This statute gives the Director, as well as carriers, the power to request IMEs. Further, the Director is not limited by the number of IME's that the carrier has scheduled when he decides that an IME is necessary. Finally, if claimant does not attend the IME, the Director has the power to suspend claimant's compensation. See ORS 656.325(1)(a).

In this case, the Director, through the Evaluation Section, is the entity requesting the IME. The insurer, in scheduling the examination and providing claimant notice of the examination, is acting at the Director's insistence and therefore as his agent under ORS 656.325(1)(a). This act of agency is confirmed by former OAR 436-10-100(2), which provides that a request for an examination by the Evaluation Section is not an examination that counts toward the insurer's limit of three. If it does not count against the insurer, the only other source of authority it can count against is the Director. Therefore, although the insurer was the one scheduling the IME, it was requested by the Director under ORS 656.325(1)(a) for the purpose of fulfilling the obligation to determine disability under ORS 656.268.

As noted, the Director has the power to suspend claimant's compensation if claimant fails to attend an IME scheduled pursuant to ORS 656.325(1)(a). Former

OAR 436-60-090. This suspension is usually done upon the application by the insurer. A request for suspension must follow the requirements set out in former OAR 436-60-090(6).

The Referee found that the insurer did not comply with the requirements of former OAR 436-60-090(6)(d) because it failed to state the reason that claimant refused to attend the examination. We disagree.

The rule requires a statement that claimant failed, or refused, to attend the examination. It requires a statement of why claimant failed to attend only if claimant gives a reason. If claimant does not give a reason for failing to attend the examination, it does not prevent the insurer from validly requesting a suspension under the rule. Here, claimant did not offer a reason for failing to attend the examination to the insurer or the Compliance Section. Claimant's first statements as to why she refused to attend the examination were made at the hearing. Consequently, the insurer's requests for suspension of compensation on February 10, 1989 and February 24, 1989, complied with the requirements of the rule.

On the merits of the suspension, claimant fails to provide a valid reason to set aside the suspension order. Claimant was given adequate notice of her obligation to attend the IME. Claimant was also warned, by both the insurer and her attorney, of the consequences if she failed to attend the examination. The IME was reset on three different occasions, and claimant failed to attend any of the three examinations. The reason claimant gave at hearing for refusing to attend the examination was that she felt that the insurer was trying to mentally harass her and that it had enough information already. Claimant has not shown any valid reason for refusing to attend the IME with Dr. Woolpert pursuant to ORS 656.325(1)(a) and thus the suspension order should be reinstated.

Since we have reversed the Referee on the setting aside of the suspension order, we also reverse the Referee on his award of attorney fees for having prevailed on that issue. Because of our decision on the merits of the order itself, we need not reach the issue of whether claimant's attorney is entitled to an insurer-paid attorney fee when claimant prevails on the setting aside of a suspension order.

ORDER

The Referee's order dated July 3, 1989 is reversed. The Compliance Section's order suspending claimant's compensation is reinstated and affirmed. The Referee's $1,250 attorney fee award is reversed.

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In the Matter of the Compensation of
**RONALD L. SCHILLING, Claimant**
WCB Case No. 87-09708
ORDER ON RECONSIDERATION
Peter O. Hansen, Claimant Attorney
John D. McLeod, Defense Attorney
Gary T. Wallmark (Saif), Defense Attorney

The SAIF Corporation, on behalf of Brothers Landscaping, a noncomplying employer, requests reconsideration of our May 30, 1990 order that affirmed a Referee's order that: (1) found that claimant was a subject worker; (2) found that claimant's low back claim was timely; and (3) set aside SAIF's denial of claimant's low back condition. On reconsideration, SAIF argues that, in a prior hearing convened before Referee Podnar on March 2, 1988, it reserved its right

to assert the defense of responsibility. We abated our order to allow sufficient time to consider SAIF's motion and claimant's response. Having completed our further consideration of this matter, we now proceed to our review.

We continue to agree with the Referee's conclusion that claimant's low back claim was timely and the condition is compensable. SAIF, therefore, is responsible unless it can defensively assert the last injurious exposure rule and show that claimant's subsequent employment with Sunnyside Methodist (Sunnyside) independently contributed to a 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 SAIF 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, Sunnyside, along with other employers, was a party to the prior hearing before Referee Podnar. Sunnyside and employers in addition to Brothers Landscaping (the noncomplying employer) had been made parties through consolidation of prior hearing requests (WCB Case Nos. 86-12261, 87-04350 and 87-04725). Sunnyside appeared at the proceeding before Referee Podnar. SAIF advised the referee and all parties concerned that it intended to assert the last injurious exposure rule (another employer's responsibility) as a defense. In particular, SAIF advised that it intended to argue that any responsibility it had for claimant's claim would terminate as of claimant's 1982 exposure at Sunnyside. All parties, including claimant, then agreed to excuse Sunnyside from further proceedings.

We agree with SAIF, that it is entitled to use the last injurious exposure rule defensively, because we find that claimant agreed to excuse Sunnyside from the proceeding to which it was a party and because claimant also expressly agreed that SAIF could later assert responsibility as a defense. Under these circumstances, we conclude that SAIF should not be barred from using the last injurious exposure rule defensively. See Connie A. Martin, 42 Van Natta 495 (1990) (Insurer not precluded from using rule defensively where claimant voluntarily withdraws hearing request challenging denial of other potentially responsible carrier).

We must, therefore, address whether claimant's subsequent employment with Sunnyside independently contributed to a worsening of his low back condition. If the second injury contributed even slightly to the causation of the disabling condition, the second employer is responsible. Boise Cascade Corp. v. Starbuck, 296 Or 238 (1984). Between successive accepted claims to the same body part, the last injury rule places the burden on the last employer to disprove actual contribution. Industrial Indemnity v. Kearns, 70 Or App 583 (1984).

We conclude that claimant's employment with Sunnyside independently contributed to his current condition. Both of claimant's injuries involved his low back. In September 1985, Dr. Franks, M.D., reported that claimant had developed back pain at his landscaping job in 1978 with Brothers Landscaping. Dr. Franks reported that claimant gradually improved until his 1982 injury at Sunnyside. He noted that, since his 1982 injury, claimant had been having continuing problems of his back "going out" at least once a month.

In April 1986, claimant's treating doctor, Dr. Erde, M.D., noted that claimant was rehabilitated after his 1978 injury and was able to go back to heavy lifting until his 1982 injury. At the time of Dr. Erde's examination, claimant reported that he could not stand for long periods of time and generally was unable to do any kind of lifting work.

In May 1986, claimant was examined by the Western Medical Consultants. The Consultants noted claimant's 1978 injury and reported that claimant gradually improved. They reported that, prior to April 16, 1982, claimant was "asymptomatic as far as his back." The Consultants attributed claimant's back symptoms and any treatment for his low back symptoms to his 1982 injury.

We conclude that claimant's employment with Sunnyside independently contributed to his current condition. We therefore find that following the contribution to claimant's condition by Sunnyside, SAIF (on behalf of the noncomplying employer, Brothers Landscaping) is no longer responsible for claimant's low back condition.

Accordingly, SAIF's request for reconsideration is granted. On reconsideration, we amend those portions of our order that addressed the issue of responsibility and affirmed that portion of the Referee's order which set aside SAIF's denial. SAIF's June 17, 1987 denial of compensability (as amended by its March 2, 1988 letter) on behalf of the noncomplying employer remains set aside. SAIF's denial of responsibility, made at the time of the first hearing, is reinstated and upheld. The Referee's assessed attorney fee award is modified. Claimant's attorney is awarded a $250 reasonable assessed fee for services related solely to the compensability of this claim against the noncomplying employer. In reaching this conclusion, we have considered the factors set forth in OAR 438-15-010(4). We have particularly considered the minimal value of the interest secured for claimant in light of the continual validity of SAIF's responsibility denial.

As amended herein, we adhere to and republish our May 30, 1990 order. The parties' right of appeal shall run from the date of this order.

IT IS SO ORDERED.

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In the Matter of the Compensation of
**KAREN M. TULL, Claimant**
WCB Case No. 88-17674
ORDER ON REVIEW
Lucas, et al., Claimant Attorneys
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Perry and Howell.

Claimant requests review of those portions of Referee Neal's order which: (1) found that claimant's claim was not prematurely closed; (2) declined to assess a penalty and associated attorney fee for alleged premature submission of her claim for closure; (3) found that the SAIF Corporation's denial of claimant's carpal tunnel condition was not an improper "backup" denial; and (4) found that claimant had not timely appealed SAIF's denial of her carpal tunnel condition. On review, the issues are the propriety of SAIF's denial, timely request for hearing, compensability, premature closure and penalties and associated 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 supplemented findings of fact.

On September 4, 1987, SAIF issued a Notice of Claim Acceptance formally accepting "somantic [sic] dysfunction."

On September 21, 1987, a SAIF claims representative prepared an 801 form that listed July 21, 1987 as the date of injury/onset of disease. The nature of the injury/disease indicated "tenderness/stiffness" of the neck and arms. Additionally in the comment section of the 801, the claims representative, quoting claimant's statement from a first medical report, wrote "have been having trouble with hands going to sleep, for about 1 week. L shoulder and arm hurt all the time since 7-21-87 and head ache."

The claim was accepted as disabling on the face of the 801.

On February 24, 1988, SAIF issued a partial denial. It accepted a "neck and shoulder injury" and denied claimant's "carpal tunnel syndrome."

ULTIMATE FINDING OF FACT

Claimant's hand symptoms, subsequently diagnosed as bilateral carpal tunnel syndrome, were accepted on September 21, 1987 as part of her original July 27, 1987 claim.

CONCLUSIONS OF LAW AND OPINION

Compensability

Claimant argues that SAIF is precluded from denying her carpal tunnel condition. We agree.

On the original First Medical Report form submitted to SAIF by Dr. Ackerson, D.O., claimant's treating physician, the physician noted that claimant's complaints were "pain, tenderness and stiffness low neck to upper shoulders with numbness of both arms." The condition causing the numbness was not diagnosed as carpal tunnel syndrome until October 13, 1987, after SAIF's acceptance of the claim.

SAIF accepted the claim after receiving an 801 form its claims representative had prepared and submitted on behalf of claimant. That acceptance encompassed the disease causing those symptoms, which turned out to be carpal tunnel syndrome. SAIF may not now avoid responsibility for that condition. Bauman v. SAIF, 295 Or 788 (1983); SAIF v. Abbott, 103 Or App 49 (1990).

Because we find that SAIF's denial of claimant's carpal tunnel syndrome was an invalid "backup" denial, it was not necessary for claimant to have requested a hearing from that denial. Thus, the issue of claimant's late request for hearing is moot. See Knapp v. Weyerhaeuser, 93 Or App 670 (1988).

Premature Closure

Claimant argues that her claim was prematurely closed in October 1987. We agree. Claims shall not be closed nor temporary disability compensation terminated if the worker's condition has not become medically stationary. ORS 656.268(1). An injured worker will be considered medically stationary when no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17).

Here, claimant's physician notified SAIF on August 18, 1987 that he had not seen claimant since July 10, 1987. He stated that he assumed she was working. As a matter of fact, claimant did return to work for about 2 weeks, but could not continue due to pain in her hands. Based on the physician's report, SAIF submitted the neck and shoulder claim for closure.

Subsequent to the October 14, 1987 closure in December 1987, claimant's arm and hand problems were diagnosed as carpal tunnel syndrome. Because we have found that claimant's carpal tunnel syndrome was a compensable component of her original claim and was accepted by SAIF, we conclude that SAIF's closure was premature and that the claim should have remained open for further treatment and payment of temporary disability benefits until claimant was medically stationary.

Penalty and Attorney Fee

A penalty is appropriate if we find that SAIF unreasonably delayed or resisted the payment of compensation to claimant. Here, SAIF relied on the treating physician's report stating that he believed she had returned to work and that he had not seen her since July 30, 1987. We conclude that SAIF's reliance on the treating physician's report prompting submission of the claim for closure was not unreasonable; thus, we decline to assess a penalty or associated attorney fee for unreasonable claims processing.

ORDER

The Referee's order dated April 5, 1988 is affirmed in part and reversed in part. The SAIF Corporation's denial of claimant's bilateral carpal tunnel condition is set aside. The October 14, 1987 Determination Order is set aside as premature. The claim is remanded to the SAIF Corporation for processing according to law. The remainder of the Referee's order is affirmed. Claimant's attorney is awarded a reasonable assessed fee of $2,000, payable by SAIF, for finally prevailing on Board review with regard to SAIF's denial.

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In the Matter of the Compensation of
**WILLIS N. WELTZ, Claimant**
And, in the Matter of the Complying Status of
**Patrick M. Arnold, dba Mike's Auto Sales, and, dba,P.M. Associates, Employer**
WCB Case Nos. 88-14270 & 88-14271
ORDER OF ABATEMENT
Allen, Stortz, et al., Claimant Attorneys
Winslow & Alway, Attorneys
Saif Legal Department, Defense Attorney

The Board issued an Order of Dismissal in the above-captioned matter on August 15, 1990. The Department of Justice, on behalf of the Department of Insurance and Finance (DIF), now requests that the Board reconsider its order on the grounds that the issue of whether the SAIF Corporation must continue to pay compensation is a matter concerning a claim, and thus review lies solely with the Board rather than the Court of Appeals.

In order to allow sufficient time to consider the Department's request, our August 15, 1990 order is abated and withdrawn. Claimant is requested to file a response to the motion within 10 days. Thereafter, this matter shall taken under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
**BONNIE J. SANTANGELO, Claimant**
WCB Case Nos. 88-21804 & 88-21803
ORDER ON REVIEW
Dale D. Liberty, Sr., Claimant Attorney
Kenneth P. Russell (Saif), Defense Attorney
Stafford Hazelett, Defense Attorney

Reviewed by Board Members Howell and Speer.

Liberty Northwest Insurance Corporation (Liberty) requests review of Referee Mulder's order which: (1) found that claimant had established good cause for failure to request a hearing within the statutory limit; and (2) set aside Liberty's denial of claimant's left shoulder condition. In its brief, Liberty contends that the Board should order reimbursement by the SAIF Corporation for claim costs. On review, the issues are jurisdiction, responsibility, and reimbursement. We reserve that portion of the Referee's order regarding Liberty Northwest's denial and dismiss claimant's hearing request concerning that denial.

FINDINGS OF FACT

Claimant originally filed an aggravation claim with Liberty. Liberty paid interim compensation, but subsequently denied the claim. Claimant had actual notice of Liberty's denial more than 60 days before she filed her request for hearing on December 13, 1988.

Claimant became aware, within 60 days of the date Liberty's denial was mailed, that she was entitled to request a hearing on Liberty's denial, but she did not want to request a hearing.

With time remaining in which to request a hearing with Liberty, claimant filed a claim with SAIF, asserting a new injury. SAIF paid interim compensation, but also subsequently denied the claim.

ULTIMATE FINDINGS OF FACT

Claimant did not file her request for hearing on Liberty's denial within 60 days after the denial was mailed. She did not prove good cause for failing to file her request within the 60-day time limit.

CONCLUSIONS OF LAW AND OPINION

Timely Request for Hearing

The Referee found that claimant had established good cause for her untimely request for hearing. We do not 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, confers jurisdiction 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, 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). 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 immediately request a hearing on Liberty's September 6, 1988 denial. Rather, on the day she received Liberty's denial she called its claims examiner for information about the denial. (Tr. 30). The examiner explained to her that she could request a hearing and have an attorney at no charge to her. She stated she did not want to request a hearing. (Tr. 17).

Claimant asked for further advice from Liberty's claims examiner, who told her to file a claim with SAIF. Claimant testified that she filed the claim with SAIF "right away" after speaking to Liberty's claims examiner.

Although there is no direct evidence in the file as to when Liberty mailed its denial or when claimant received it, claimant did receive actual notice of Liberty's denial. Her testimony makes it apparent that she had notice of Liberty's denial before she filed her claim with SAIF. SAIF received claimant's claim, an 827 form signed on October 7, 1988 by her physician, on October 12, 1988.

Because it is established that claimant had actual notice of Liberty's denial on or before October 7, 1988, and she did not file her request from hearing on that denial until December 16, 1988, we conclude that claimant's request for hearing was untimely.

Claimant contends that she had good cause for not filing the hearing request from Liberty's denial within 60 days. She asserts that she believed, when SAIF began paying interim compensation, that SAIF had accepted her claim.

We are not persuaded that receipt of interim compensation and claimant's assumption that her claim had been accepted constitutes good cause for not requesting a hearing from Liberty's denial. See Robert E. Derby, 41 Van Natta 405 (1989). Additionally, we do not find that Liberty's claims examiner mislead claimant. We conclude that claimant's conversation with Liberty's employee was not the cause of claimant's failure to file a timely request for hearing. Claimant's decision not to file a request for hearing sooner from Liberty's denial was not mistake, inadvertence, surprise or excusable neglect under ORCP 71B(1). Claimant has failed to establish good cause. Cogswell v. SAIF, supra; Diane T. Lindholm, 42 Van Natta 447 (1990).

Because we do not find that claimant had good cause for her untimely request for a hearing, we lack jurisdiction to reach the issue of compensability of her claim.

Liberty requests an order from the Board requiring SAIF to reimburse Liberty for payments made by Liberty. We have previously held that we do not have authority to order such 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 concerning the responsible paying party, reimbursement between 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 April 13, 1989 is reversed in part and affirmed in part. Claimant's request for hearing concerning Liberty Northwest's denial is dismissed. The remainder of the order is affirmed.

In the Matter of the Compensation of
**KATHRYN D. WAGNER, Claimant**
WCB Case Nos. 88-14544, 88-14543 & 88-19064
ORDER ON REVIEW
Callahan, et al., Claimant Attorneys
John Motley (Saif), Defense Attorney
Stafford Hazelett, Defense Attorney

Reviewed by Board Members Nichols and Crider.

Liberty Northwest Insurance Corporation (Liberty Northwest) requests review of those portions of Referee Daron's order which: (1) found that claimant timely filed an occupational disease claim for bilateral carpal tunnel syndrome with Liberty Northwest; (2) set aside Liberty Northwest's denial of that claim; and (3) upheld the SAIF Corporation's denial of claimant's occupational disease claim for the same condition. Liberty Northwest also requests that, in the event SAIF is found to be responsible for claimant's bilateral carpal tunnel syndrome, the Board order SAIF to reimburse Liberty Northwest for all claim costs to date. Claimant cross-requests review of those portions of the order which: (1) upheld Liberty Northwest's denial of her claim for a low back injury; and (2) upheld SAIF's denial of her nonspecific bilateral arm/hand overuse syndrome. On review, the issues are timeliness of claimant's bilateral carpal tunnel syndrome claim with Liberty Northwest, compensability of and responsibility for claimant's bilateral carpal tunnel syndrome, compensability of claimant's back injury and overuse syndrome, and reimbursement. We affirm in part and reverse in part.

## FINDINGS OF FACT

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

The Referee found that claimant did not receive medical treatment for her low back pain at any time while she was employed by Liberty Northwest's insured. On the other hand, we find that claimant sought medical treatment for her low back strain in February 1987, after she injured her low back at work. Claimant called the office of her treating physician, Dr. Willey, and was advised to rest.

In addition, we supplement with the following findings. Dr. Willey treated claimant's low back injury again in July 1988. Claimant had no back pain prior to the lifting incident at Liberty Northwest's insured. She has had intermittent back pain with activity since that episode.

Claimant sustained repetitive trauma to her upper extremities while working for both Liberty Northwest and SAIF's insured's as an electronic assembler. Claimant filed an occupational disease claim with SAIF's insured on June 23, 1988. On October 13, 1988, SAIF advised claimant that her carpal tunnel syndrome was work-related, that SAIF was not the responsible carrier, and that SAIF would request designation of a paying agent pursuant to ORS 656.307. On December 12, 1988, SAIF withdrew its prior notice and advised claimant that it was now denying the compensability of her bilateral carpal tunnel condition. A .307 order never issued.

Claimant was first treated for her carpal tunnel syndrome while working for Liberty Northwest's insured. Claimant first missed time from work as a result of her carpal tunnel syndrome when she left work for SAIF's insured in June 1988. Claimant's last exposure to work activity that could have affected her carpal tunnel condition occurred in June 1988 while working for SAIF's insured.

Claimant has bilateral upper extremity overuse syndrome with involvement of the extensor tendons and the wrists, separate from the median nerve involvement of her carpal tunnel syndrome. Claimant first developed and was first treated for her upper extremity overuse syndrome while working for SAIF's insured.

## FINDINGS OF ULTIMATE FACT

Claimant's February 1987 low back injury caused disability and need for medical services.

Claimant filed her occupational disease claim for carpal tunnel syndrome with Liberty Northwest's insured within one year of the date she became disabled or knew that she was suffering from an occupational disease.

Claimant's work activities were a material contributing cause of her bilateral carpal tunnel syndrome and need for treatment.

Claimant's carpal tunnel syndrome first became disabling when she left work for SAIF's insured in June 1988. Work activities with SAIF's insured could have contributed to claimant's carpal tunnel syndrome.

Claimant's repetitive work activities for SAIF's insured were a material contributing cause of claimant's overuse syndrome and need for treatment.

## CONCLUSIONS OF LAW AND OPINION

### February 1987 Low Back Injury

The Referee found claimant's low back injury was not compensable because claimant received neither medical services nor temporary total disability benefits. We disagree and reverse.

In order to establish the compensability of her low back condition, claimant must prove that her work activity was a material contributing cause of her low back injury, and that the injury resulted in disability or the need for treatment. Hutcheson v. Weyerhaeuser, 288 Or 51 (1979). Claimant has the burden of proving her contentions by a preponderance of the evidence. Id. We find that claimant has carried her burden of proof.

We adopt the Referee's conclusion that claimant sustained a low back injury from her work activities at Liberty Northwest's insured in early February 1987. In order to be compensable, then, we must find that claimant's injury required medical services or resulted in disability or death. ORS 656.005(7)(a).

Claimant testified that she called the office of Dr. Willey, her treating physician, the evening she was injured. She was told to rest and that there was no need to make an appointment. Although the Referee accepted claimant's testimony on other issues, he did not accept claimant's testimony as to this event because the call was not entered into claimant's medical chart.

When the Referee makes credibility findings based on claimant's demeanor, we generally defer to those findings. However, when, as here, the Referee's finding is based on alleged inconsistencies between claimant's testimony and the documentary record rather than the witness' demeanor, the Referee has no greater advantage than the reviewing body in determining credibility. International Paper Co. v. McElroy, 101 Or App 61 (1990); Coastal Farm Supply v. Hultberg, 84 Or App 282, 285 (1987).

Claimant's explanation of her phone conversation with Dr. Willey shortly after the injury is plausible given the nature of her injury. In addition, claimant's testimony is unrebutted. Under these circumstances, we accept claimant's testimony that she received medical advice/services in February 1987.

Additionally, Dr. Willey treated claimant in July 1988, when she experienced a flare-up of her low back condition. Dr. Willey testified via deposition that the July 1988 episode was a recurrence of claimant's initial February 1987 injury. His testimony on this point is unrebutted. Therefore, we find that claimant did receive medical services for her February 1987 injury in both February 1987 and July 1988. See Finch v. Stayton Canning Co., 93 Or App 168 (1988).

The Referee also found that, to constitute "compensable temporary disability," an injured worker must be off work more than three days unless off work continuously at least 14 days or hospitalized. He concluded, therefore, that one day off work is not sufficient disability to constitute a "compensable injury." We know of no such statutory requirement. The three-day waiting period upon which the Referee relied only applies to entitlement to disability benefits. See ORS 656.210(3).

The record establishes that claimant injured her low back at work when she lifted a tub of circuit boards. She notified her supervisor of her injury and did not work the next day. As a result of claimant's injury and pain, her supervisor temporarily modified her job so that she did not have to do any lifting. After claimant resumed lifting tubs, she sustained occasional flare-ups of her low back pain during which she required assistance in lifting the tubs. Accordingly, we further find that claimant's low back injury was disabling.

In sum, claimant's low back injury both required medical services and resulted in disability. Consequently, her injury is compensable.

Carpal Tunnel Syndrome

Timeliness of Filing

We adopt the Referee's reasoning and conclusion that claimant timely filed her claim for bilateral carpal tunnel syndrome with Liberty Northwest's insured.

Compensability of Carpal Tunnel Syndrome

When compensability and responsibility are both at issue, as here, the threshold issue is compensability. Runft v. SAIF, 303 Or 493, 498-99 (1987); Elizabeth Coomer, 41 Van Natta 2300, 2302 (1989). The Referee found that claimant has compensable bilateral carpal tunnel syndrome [CTS] and that her work activity was the major contributing cause of her condition. We agree with the Referee's conclusion that the claim is compensable; however, we base our decision on a different analysis.

Claimant has satisfied her burden if she proves that her condition was caused by work activities or exposures generally. She need not prove that her condition was caused by a particular employment. Bracke v. Baz'ar, Inc., 293 Or 239, 248-49 (1982).

The legislature amended the occupational disease statute, ORS 656.802, effective January 1, 1988. Since claimant's last exposure to work activity that could have affected her condition occurred in June 1988, we find that this case

should be analyzed under the amended statute. See Johnson v. SAIF, 78 Or App 143, rev den 301 Or 240 (1986); Donna E. Aschbacher, 41 Van Natta 1242 (1989).

To be compensable under the amended law, claimant's occupational disease must fall within one of the subsections of former ORS 656.802(1). As claimant's claim is for conditions resulting from repetitive use of the hands, it must be assessed under former ORS 656.802(1)(c). That statute defines as one type of occupational disease:

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

The Referee found Dr. Willey to be the most knowledgeable about the relationship between claimant's work activities and her carpal tunnel condition. The Referee, therefore, relied on Willey's opinion in concluding that claimant does have compensable bilateral carpal tunnel syndrome. We agree and rely on Dr. Willey's opinion.

Both claimant's treating physician, Dr. Willey, and independent examining physician, Dr. Nathan, have diagnosed CTS. However, their medical opinions on causation differ greatly. Dr. Willey attributes claimant's condition to the repetitive hand and arm movements required in electronic assembly work, while Dr. Nathan opines that her condition is "idiopathic," i.e., due to an unknown, non-work related cause. The Board generally gives greater weight to the conclusions of a treating physician unless there are persuasive reasons to do otherwise. Weiland v. SAIF, 64 Or App 810, 814 (1983). In this case, there are no such reasons.

Dr. Willey is claimant's treating physician and is familiar with her medical history. He has examined claimant on numerous occasions, sent her for special diagnostic studies, and carefully assessed both her work and off-work activities. He noted that claimant's symptoms disappeared when she was off work and increased when she returned to work. Dr. Willey explained that claimant's work required her to perform twisting and other repetitive wrist movements. Based on his analysis of both her work activities and off-work activities, he concluded that claimant's bilateral CTS was caused by her work as an assembler. We find Dr. Willey's medical opinion to be both well-reasoned and based on complete information. Somers v. SAIF, 77 Or App 259, 262 (1986); see Hammons v. Perini Corp., 43 Or App 299, 302 (1979).

In contrast, Dr. Nathan, a hand specialist, saw claimant only one time for an independent examination. Although claimant informed Dr. Nathan of her repetitive work activities, his report does not address the impact of claimant's work and non-work activities as they would relate to her condition. Dr. Nathan does not explain the basis for his opinion that claimant's CTS is not work-related nor how he concluded that her condition is "idiopathic." We do not find Dr. Nathan's opinion on causation to be well-reasoned or based on a complete and accurate history and, therefore, we do not find it to be persuasive. Miller v. Granite Construction Co., 28 Or App 473, 476 (1977); Weiland v. SAIF, supra; Somers, supra. Consequently, we conclude that claimant has established the compensability of her bilateral carpal tunnel condition.

Responsibility for Carpal Tunnel Syndrome

The Referee assigned responsibility to the first insurer, Liberty Northwest. We reverse, and find that SAIF is responsible for claimant's carpal tunnel condition under the last injurious exposure rule.

Responsibility for occupational diseases is governed by the "last injurious exposure rule." Bracke v. Baz'ar, Inc., supra at 246. See also Boise Cascade Corp. v. Starbuck, 296 Or 238, 243 (1984). The carrier on the risk when the condition becomes disabling is initially responsible if work activity for its insured could have contributed to claimant's condition. That carrier may avoid responsibility for the occupational disease by establishing that a prior employment is the sole cause of claimant's disability, or that it was impossible for employment with the carrier on the risk when the condition became disabling to have caused the condition. Starbuck, supra, at 244 n. 3; FMC Corp. v. Liberty Mutual Ins. Co., 70 Or App 370, modified 73 Or App 223 (1984).

The assignment of responsibility for claimant's carpal tunnel syndrome presents a complex medical question; therefore, resolution of this issue turns largely on the medical evidence. Uris v. Compensation Department, 247 Or 420, 426 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985), rev den 300 Or 546 (1986).

Claimant worked for Liberty Northwest's insured as an electronics assembler from October 1985 to January 1988, performing work activity which required repetitive wrist and hand movement. Claimant noticed problems with her hands and, in April 1987, Dr. Willey diagnosed CTS of the left hand. Later that month, the doctor diagnosed bilateral CTS. Nevertheless, claimant missed no time from work and asserted no claim while employed by Liberty Northwest's insured.

Later, from May to June 1988, claimant worked for SAIF's insured assembling circuit boards. After doing this job for only a few days, claimant had wrist, hand and thumb pain. Claimant ceased working for SAIF's insured on June 22, 1988 on the advise of Dr. Willey. We find claimant's CTS first became disabling when she left work for SAIF's insured in June 1988.

Dr. Willey stated that it is unclear whether claimant's work activity for SAIF's insured worsened her underlying CTS. However, he noted that the constant twisting and pulling required to assemble circuit boards for SAIF's insured caused claimant's wrist problems to recur. Further, he opined that claimant's work activity for SAIF's insured was capable of causing claimant's CTS. For the reasons enumerated above, we give great weight to Dr. Willey's well-reasoned opinion. Somers, supra. Accordingly, we conclude that work activity with SAIF's insured could have caused claimant's CTS. We further conclude that SAIF has failed to establish claimant's prior employment with Liberty Northwest's insured was the sole cause of claimant's carpal tunnel condition, and that it was not impossible for work activity with SAIF's insured to cause claimant's condition. Consequently, SAIF is the responsible insurer for claimant's compensable bilateral carpal tunnel syndrome. FMC Corp., supra.

Reimbursement

Liberty Northwest requests that the Board order SAIF to reimburse it for claim costs associated with claimant's carpal tunnel syndrome. However, 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 are not matters concerning a claim. EBI Companies v. Kemper Group Ins., 92 Or App 319 (1988); Reynolds-Croft, Inc. v. Bill Morrison Co., 55 Or App 487 (1982). Reimbursement between carriers is authorized 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).

Bilateral Upper Extremity Overuse Syndrome

Claimant filed a second occupational disease claim with SAIF's insured for overuse syndrome of the upper extremities. The Referee found that "overuse syndrome" is too vague a diagnosis for claimant's other, non-carpal tunnel syndrome upper extremity symptoms and, therefore, concluded that it could not constitute a compensable disease under former ORS 656.802. We disagree.

The medical evidence establishes that claimant developed different wrist/arm symptoms after beginning a new, heavier job for SAIF's insured. Dr. Willey testified that these symptoms were separate from the previously diagnosed CTS symptoms, and were caused by the constant turning, twisting, pushing, and pulling with the hands and wrists to which claimant was exposed while cutting bolts. He explained that the CTS specifically involved the flexor or palmar surface of the hand and swelling of the median nerve at the wrists, while claimant's new symptoms involved pain on the dorsum or top of the hands as well as symptoms up the arms along the extensor tendons.

Dr. Willey admits that it has been difficult to give a specific diagnosis to this separate overuse syndrome. He testified that claimant's symptoms represent the dynamics of two syndromes, carpal tunnel syndrome and a non-specific overuse syndrome, both of which are a part of one entity -- claimant's bilateral wrist condition. Dr. Nathan diagnosed only CTS of unknown origin. He gave no basis for his diagnosis and opinion and, thus, we find his report to be of little value in determining the cause of claimant's other wrist/arm symptoms.

On the other hand, we have found Dr. Willey, claimant's treating physician, to be knowledgeable about claimant's multiple symptoms and conditions and, therefore, give greater weight to his opinion. Weiland, supra. Similarly, we find Dr. Willey's opinion on this issue to be well-reasoned and based on complete information. See Somers, supra. Accordingly, we defer to his opinion and find that claimant does have a separate overuse syndrome of the upper extremities which coexists with her carpal tunnel syndrome.

Moreover, Dr. Willey's opinion establishes that claimant's work activities were a material contributing cause of her bilateral upper extremity overuse syndrome. Therefore, claimant has established a compensable claim under former ORS 656.802(1)(c). We reach this conclusion regardless of the diagnosis of her non-carpal tunnel syndrome wrist/arm symptoms. See Tripp v. Ridge Runner Timber Services, 89 Or App 355 (1988); Karen M. Partridge, 39 Van Natta 137 (1987).

ORDER

The Referee's order dated May 30, 1989 is affirmed in part and reversed in part. Liberty Northwest Insurance Corporation's denial of claimant's low back injury claim is set aside. The low back injury claim is remanded to Liberty Northwest for further processing according to law. Liberty Northwest's denial of claimant's bilateral carpal tunnel syndrome is reinstated and upheld. The SAIF Corporation's denials of claimant's carpal tunnel syndrome and overuse syndrome are set aside and those claims are remanded to SAIF for processing according to law. That portion of the Referee's order which directed the responsible insurer to pay temporary disability compensation beginning June 22, 1987 is corrected to read June 22, 1988. The Referee's assessed attorney fee award of $1,750 for prevailing on the compensability of claimant's carpal tunnel syndrome shall be paid by SAIF, not Liberty Northwest. For services at hearing and on review regarding the compensability of claimant's low back injury, claimant's attorney is awarded a $1,000 assessed fee, payable by Liberty Northwest. For services at hearing and on review regarding the compensability of claimant's overuse syndrome, claimant's attorney is awarded a $1,000 assessed fee, payable by SAIF. The remainder of the order is affirmed.

In the Matter of the Compensation of
**DICK A. WRIGHT, Claimant**
WCB Case No. 89-01599
ORDER ON REVIEW
Gatti & Gatti, Claimant Attorneys
Acker, et al., Defense Attorneys

Reviewed by Board Members Cushing and Myers.

Liberty Northwest Insurance Corporation requests review of those portions of Referee Nichols' order that awarded additional temporary disability. On review, the issue is temporary disability. We affirm.

We adopt the Referee's "Findings of Fact" and "Opinion and Conclusions" as well as her opinion on reconsideration as supplemented below.

By an Opinion and Order dated December 21, 1988, a prior referee found claimant's low back injury compensable as a new injury. Accordingly, the responsible insurer's denial was set aside and the claim remanded to Liberty Northwest for "processing and payment of compensation due under the Oregon Workers' Compensation Law." (Ex. 2). In response to the prior order, Liberty Northwest paid claimant temporary disability commencing from the date Argonaut Insurance had ceased making interim compensation payments on June 15, 1988. Liberty Northwest declined to pay temporary disability benefits from February 19, 1988 to June 14, 1988 because claimant had already received interim compensation for this same period of time from Argonaut. Liberty Northwest argued that to pay for this period of time would result in a double payment to claimant in contravention of ORS 656.210.

We do not agree. By an Opinion and Order, dated December 21, 1988, Liberty Northwest was found to be the responsible insurer and ordered to accept the claim and pay compensation due. Compensation due included temporary disability. The temporary disability due and owing was from the date of medical verification of claimant's inability to work on February 19, 1988 as reported by claimant's treating physician, Dr. Taylor. This duty continued unabated up to and including the day of the prior hearing subject to offset for unemployment benefits. The fact that another insurer, Argonaut, paid interim compensation payments to claimant from the date of disability up to the date of its aggravation denial is immaterial.

We note that claimant's retention of time loss benefits from both insurers for the same period of time results in compensation greater than that allowed by ORS 656.210(1). As such, the additional temporary disability constitutes an overpayment. This overpayment of temporary disability is subject to an offset against any future award of permanent disability from this claim. Thus, Liberty Northwest will be allowed to recover its overpayment of temporary disability from permanent disability when and if a Determination Order issues. See Petshow v. Ptld. Bottling Co., 62 Or App 614 (1983); Steven E. Pace, 38 Van Natta 139 (1986); William J. Snyder, 41 Van Natta 876 (1989).

ORDER

The Referee's order dated May 15, 1989, as reconsidered June 30, 1989, is affirmed. For services on Board review, claimant's counsel is awarded a reasonable assessed fee of $675, payable by Liberty Northwest.

In the Matter of the Compensation of
**JAMES A. BARRETT, Claimant**
WCB Case No. 89-02941
ORDER ON REVIEW
Jim L. Scavera, Claimant Attorney
Cowling & Heysell, Defense Attorneys

Reviewed by Board Members Cushing and Myers.

Claimant requests review of that portion of Referee Gruber's order which declined to award temporary disability benefits from March 6, 1989 through March 29, 1989. On review, the issue is entitlement to temporary disability benefits. We reverse.

## FINDINGS OF FACT

We adopt the "Findings of Fact" as set forth in the Referee's order with the following supplementation.

Following his release to work on March 29, 1989, claimant looked for work at a toy company, a beverage company and other logging mills.

## CONCLUSIONS OF LAW AND OPINION

The Referee found that due to the labor strike, claimant had voluntarily removed himself from the work force and concluded that he was not entitled to temporary disability benefits. We disagree.

Subsequent to the Referee's order, the Supreme Court stated that to receive temporary total disability benefits, a claimant must be in the work work force at the time of his disability. See Dawkins v. Pacific Motor Trucking, 308 Or 254, 258 (1989).

Claimant became disabled because of his compensable bilateral wrist condition on March 6, 1989, the date he underwent left carpal tunnel release surgery. He remained totally disabled as a result of his compensable condition until March 29, 1989, the date Dr. Holbert released him to regular work. The issue, then, is whether claimant had voluntarily removed himself from the work force prior to March 6, 1989.

The record establishes that Dr. Holbert and claimant had discussed a left carpal tunnel procedure as early as November 1988. The fact that the surgery did not occur until March 1989 was due to Dr. Holbert's schedule as he had asked for authorization to perform the surgery in mid-January 1989. Finally, the record establishes that approximately 2 to 3 weeks following his surgery, claimant began looking for work at a toy company, a beverage company, and other lumber mills.

Under these circumstances, we find that at the time of his disability, claimant had not withdrawn from the work force. Accordingly, we conclude that claimant is entitled to temporary total disability from March 6, 1989 through March 29, 1986. See Hal L. Farnworth, 42 Van Natta 1674 (1990).

## ORDER

The Referee's order dated August 10, 1989, is reversed. Claimant is awarded temporary total disability benefits from March 6, 1989 through March 29, 1989. Claimant's counsel is awarded 25 percent of the increased compensation created by this order, not to exceed $3,800.

In the Matter of the Compensation of
**LORI S. PRATT, Claimant**
WCB Case No. 88-20302
ORDER DENYING RECONSIDERATION
Rasmussen & Henry, Claimant Attorneys
Beers, et al., Defense Attorneys

Claimant has requested reconsideration of our August 21, 1990 Order on Review that declined to increase her scheduled permanent disability award because she did not request such an increase on Board review. The motion is denied.

Claimant's request is, in effect, a cross-request for review first filed after our Order on Review issued. Such a request is untimely. ORS 656.289(3); see James D. Tate, 41 Van Natta 2247, on recon 41 Van Natta 2414 (1989).

In our Order on Review, we found that, under the applicable "standards," claimant had 52 percent (78 degrees) scheduled permanent partial disability. However, we affirmed the Referee's award of 50 percent (75 degrees) permanent partial disability because claimant had not cross-requested review asking for an increased award of permanent partial disability.

We note that there are important policy reasons for not allowing a party to first request an increase or reduction in permanent partial disability after we conduct our de novo review. If we were to allow such a procedure, carriers could readily thwart the legislative intent expressed in 656.382(2). They could simply wait to see if the Board arrived at a figure lower than previously awarded and, only then, request reduction. The carrier would then never risk paying the attorney fee provided for in 656.382(2) because, it would only request a reduction in permanent partial disability after the Board had determined the extent of disability. See Kordon v. Mercer Ind., 308 Or 290 (1989).

The request for reconsideration is denied. We adhere to our August 21, 1990 order. The parties' rights of appeal shall continue to run from the date of our August 21, 1990 order.

IT IS SO ORDERED.

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In the Matter of the Compensation of
**JAMES C. CONAWAY, Claimant**
WCB Case No. 89-04568
ORDER ON REVIEW
Rex Q. Smith, Claimant Attorney
Beers, et al., Defense Attorneys

Reviewed by Board Members Speer and Howell.

The insurer requests review of Referee Quillinan's order that set aside its denial of claimant's lipid myopathy condition treatment. On review, the issue is medical services. We reverse.

FINDINGS OF FACT

The Board adopts the Referee's Findings of Fact.

## CONCLUSIONS OF LAW AND OPINION

The Referee concluded that treatment for claimant's lipid storage myopathy was related to the compensable injury and was reasonable and necessary. She therefore set aside the insurer's denial of medical services for the myopathy condition. We disagree.

Claimant's treating doctor, Dr. Sonneland, opined that his lipid storage myopathy condition caused an aggravation of his low back pain. For purposes of treating claimant's metabolic disorder, Dr. Sonneland recommended a trial of carnitine, a non-prescription dietary supplement.

ORS 656.245(1) provides that:

> "For every compensable injury, the insurer or the self-insured employer shall cause to be provided medical services for conditions resulting from the injury for such period as the nature of the injury or the process of the recovery requires, including such medical services as may be required after a determination of permanent disability."

However, ORS 656.245(4) further provides that:

> "Notwithstanding any other provision of this chapter, the director, by rule, upon the advice of the committee created by ORS 656.794 and upon the advice of the professional licensing boards of practitioners affected by the rule, may exclude from compensability any medical treatment the director finds to be unscientific, unproven, outmoded or experimental."

In the present case, the insurer contends that claimant's carnitine treatments are barred by OAR 436-10-040(7), which provides:

> "Dietary supplements - such as minerals and vitamins - are not reimbursable unless a specific compensable dietary deficiency has been clinically established in the injured worker."

See also Mary A. Thomas, 42 Van Natta 1538 (1990) (Validity of OAR 436-10-040(7) upheld.)

We agree with the insurer. Although treatment is by dietary supplement, claimant has not shown that the carnitine treatments are necessary for a specific compensable dietary deficiency. Neither does he challenge the validity of OAR 436-10-040(7) as it applies to this case. We, therefore, conclude that the dietary supplement treatments are not compensable.

## ORDER

The Referee's order dated June 27, 1989 is reversed. The insurer's January 13, 1989 denial is reinstated and upheld. The Referee's $1,200 attorney fee award is reversed.

In the Matter of the Compensation of
**DENNIS K. EASTON, Claimant**
WCB Case No. 89-01561
ORDER ON REVIEW
L. Thomas Clark, Claimant Attorney
Bonnie V. Laux (Saif), Defense Attorney

Reviewed by Board Members Perry and Howell.

Claimant requests review of that portion of Referee Nichols' order which declined to grant permanent total disability. On review the issue is permanent total disability. We affirm.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact."

CONCLUSIONS OF LAW AND OPINION

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

The Referee held that because claimant's preexisting conditions were not worsened by the 1981 injury, they should not be considered in determining entitlement to permanent total disability. We agree. Preexisting conditions are taken into consideration in rating disability only if the preexisting conditions were disabling at the time of the compensable injury. Searles v. Johnston Cement, 101 Or App 589 (1990).

In this case, claimant's preexisting conditions -- left leg, low back and mental capacity condition -- were not disabling at the time of the compensable 1981 injury; nor is there a preponderance of evidence indicating that they were caused or worsened by the compensable injury.

ORDER

The Referee's order dated June 14, 1989 is affirmed.

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In the Matter of the Compensation of
**MICHAEL J. EDWARDS, Claimant**
WCB Case No. CO-00027
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Pozzi, Wilson, et al., Claimant Attorneys
Cowling & Heysell, Defense Attorneys

Reviewed by Board Members Howell and Perry.

On August 17, 1990, the Board acknowledged receipt of the parties' claim disposition agreement, as supplemented by an August 13, 1990 addendum, in the above-captioned matter. The addendum was forwarded to the Board on August 15, 1990 by claimant's counsel and received on August 16, 1990.

Pursuant to the parties' agreement, in consideration of the payment of $162,000 by EBI Companies, claimant fully releases his right to future workers' compensation benefits, except medical services, for his compensable injury.

The agreement is in accordance with the terms and conditions prescribed by the Director. See ORS 656.236(1); OAR 436-60-145. The Board does not find any statutory basis for disapproving the agreement. See ORS 656.236(1). Accordingly, the parties' claim disposition agreement is approved, hereby fully and finally resolving this matter. An attorney fee payable to claimant's attorney according to the terms of the agreement is also approved.

Claimant's attorney argues that his client's 30-day right to request disapproval of this agreement should have commenced on the date that the agreement was submitted to the Board, rather than the mailing date of the Board's written acknowledgement of its receipt. We disagree.

When a claim disposition agreement is submitted to us, we will first determine if it meets our form, notice and filing requirements. See Louis R. Anaya, 42 Van Natta 1843 (1990). We will also review the agreement to determine if it satisfies the prerequisites established by ORS 656.236 and OAR 436-60-145 (Temp.). Anaya, supra. Filing will not be accepted, and acknowledgment will not be issued, if a claim disposition agreement fails to satisfy either our requirements or the requirements of the statute and the director's rule. See OAR 438-09-020(3); Anaya, supra.

Such a procedure is designed to insure that claimants have been fully apprised of their rights under the workers' compensation law in general and claim disposition agreement requirements in particular. After such written assurances have been provided, the Board then initiates actions to notify all parties of the date that claimant's 30-day right of revocation begins and to advise all appropriate forums that proceedings shall be stayed. Considering the gravity of such measures, it is imperative that these actions not be taken unless the agreement submitted for approval is in full compliance with statutory and administrative prerequisites.

Here, the parties' agreement expressly referred to a notice of rights that had been provided to claimant. The agreement further stated that a copy of that "document" was attached to the agreement. Because no such "document" was attached, the parties were requested to provide it. When the "document" forwarded to the Board did not comply with the "notice" provisions of OAR 436-60-145(3), the parties were again asked to satisfy statutory and administrative prerequisites.

On August 16, 1990, the Board received an "addendum" to the agreement documenting the fact that claimant had been provided with a notice of rights which complied with OAR 436-60-145(3). See OAR 438-09-023. The following day, August 17, 1990, the Board acknowledged the claim disposition agreement. See OAR 438-09-020(1). Thus, in accordance with OAR 438-09-025(2), the agreement was deemed to have been submitted as of the date of mailing of the written acknowledgement.

In conclusion, we are obligated to insure that any agreement submitted for our approval is in strict compliance with the specific standards discussed above.

IT IS SO ORDERED.

In the Matter of the Compensation of
**FREDDIE L. JONES, Claimant**
WCB Case No. 89-02956
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
Michael O. Whitty (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

Claimant requests review of Referee Foster's order which upheld the SAIF Corporation's denial of claimant's occupational disease claim for a stress-related mental disorder. On review the issue is compensability. We affirm.

## FINDINGS OF FACT

We adopt the Referee's "Findings."

## CONCLUSIONS OF LAW AND OPINION

Claimant alleges that he has been subjected to work-related stress resulting in a compensable mental condition under former ORS 656.802(1)(b).

Claimant must prove that he 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 his stress exist in "a real and objective sense." Former ORS 656.802(1)(b) and 656.802(2)(a) & (c). Moreover, he must prove by clear and convincing evidence that his condition arose out of and in the course of his employment. Former ORS 656.802(2)(d). To establish that his condition arose out of and in the course of his employment, claimant must prove by clear and convincing evidence that his work exposure was a material cause of his condition. Ronald V. Dickson, 42 Van Natta 1102 (1990); Deborah Anderson, 42 Van Natta 513 (1990); Donna E. Aschbacher, 41 Van Natta 1242 (1989); Ellen L. Crawford, 41 Van Natta 1257 (1989).

Other than an ambiguous, one-line, hand-written reference in Dr. Donald R. Rinehart, Ph.D.'s chart notes, "DSM __ 309.24 Adj.Dis order___ Anxious Mood," claimant presents no evidence that he suffers from a mental disorder with a diagnosis that is generally recognized in the medical or psychological community nor that the events which are the source of his stress exist in "a real and objective sense." (See Ex. 1B-1). Importantly, Dr. Turco, M.D., psychiatrist, in a well-reasoned and thorough report, opines that, "This is essentially an administrative problem and not a so-called stress claim." (Ex. 8-3).

Further, assuming a generally recognized psychological diagnosis and some real work-related stressors which are not exempted from consideration, the record does not constitute clear and convincing evidence that such stressors materially contribute to the claimed mental disorder.

We agree with the Referee that claimant has not sustained his burden to prove that he has a compensable mental condition.

## ORDER

The Referee's order dated May 25, 1989 is affirmed.

In the Matter of the Compensation of
**CHARLES M. KEPFORD, Claimant**
WCB Case No. 87-02846
SECOND ORDER ON REMAND
Malagon, et al., Claimant Attorneys
Acker, et al., Defense Attorneys

Claimant and the self-insured employer request reconsideration of our August 24, 1990 Order on Remand that reinstated a Referee's assessment of a penalty and an associated attorney fee for the self-insured employer's unreasonable conduct in failing to timely submit a claim for closure. Contending that our order neglected to award an employer-paid attorney fee for his counsel's services on Board review and before the Court of Appeals, claimant seeks reconsideration. The employer requests that we reduce the 25 percent penalty assessment for unreasonable claims processing.

We deny the employer's motion. However, even had we agreed with the employer's contention that it bears no responsibility for a 6 month delay between a closing evaluation report and a reply from the Evaluation Division directing the employer to process the claim to closure as an occupational disease, we would continue to assess a 25 percent penalty based on the other four grounds of unreasonable claims processing described in our order.

We turn to claimant's request. The relevant facts are as follows. A Referee awarded temporary disability benefits and assessed a 25 percent penalty and a $2,000 penalty-related employer-paid attorney fee based on several instances of unreasonable conduct. The employer requested Board review. We affirmed the Referee's order and awarded a $700 attorney fee for claimant's successful defense of the Referee's order. Charles M. Kepford, 41 Van Natta 573 (1989).

Thereafter, the employer petitioned for judicial review. The court affirmed that portion of our order that awarded temporary disability benefits. Weyerhaeuser Company v. Kepford, 100 Or App 410 (1990). However, the court reversed that portion of our order that affirmed the Referee's assessment of a penalty for the employer's failure to pay temporary disability benefits. Inasmuch as the Referee had also assessed a penalty for other alleged unreasonable conduct, the court "remanded for reconsideration of penalty excluding consideration of employer's failure to pay benefits." Weyerhaeuser Company v. Kepford, supra, at page 415.

Claimant petitioned the court for an attorney fee award for services rendered in successfully defending the Board's temporary disability award. The court denied the petition, concluding that the employer had been the prevailing party.

On remand, we found the employer's conduct in failing to timely submit the claim for closure to have been unreasonable. Consequently, we reinstated the Referee's assessment of a penalty and a $2,000 penalty-associated attorney fee.

Claimant seeks an award of a carrier-paid attorney fee for successfully defending against: (1) the employer's request for Board review of the Referee's order; and (2) the employer's petition for judicial review of the Board's order. Claimant relies upon ORS 656.382(2), which provides that if a request for Board review or appeal to the court is initiated by a carrier and the Board or court finds that the compensation awarded to a claimant should not be disallowed or reduced, claimant is entitled to a carrier-paid attorney fee.

Here, claimant has previously been granted a carrier-paid attorney fee for services on Board review in successfully defending against the employer's attempt to disallow the Referee's award of temporary disability compensation. Charles M. Kepford, supra, at page 578. Furthermore, that portion of our prior order, along with the award of temporary disability, has been affirmed by the court. Weyerhaeuser Company v. Kepford, supra, at page 415. Consequently, we conclude that claimant is entitled to no further carrier-paid attorney fee award for services previously rendered on Board review.

Moreover, on remand from the court, we received specific instructions, none of which pertained to the award of a carrier-paid attorney fee for claimant's counsel's services at either the Board or appellate level regarding the successful defense of the Referee's and/or Board's temporary disability award. Instead, we were expressly mandated to reconsider the assessment of a "penalty excluding consideration of employer's failure to pay benefits." Inasmuch as our directions on remand did not include the award of an attorney fee for the successful defense of the temporary disability award, we are without authority to consider the issue at either appellate level. See Aguiar v. J.R. Simplot Company, 94 Or App 658 (1989).

Finally, our remand order made no finding that claimant's temporary disability compensation "should not be disallowed or reduced." See ORS 656.382(2). Thus, the condition precedent to an attorney fee award pursuant to that statute was not rendered by our order. Rather, such a finding was most recently made by the Court of Appeals. Therefore, the court was the appropriate forum to have considered an attorney fee award pursuant to ORS 656.382(2) for services rendered at that appellate level. Yet, as noted above, the court has previously denied claimant's petition for attorney fees for such services.

Accordingly, our August 24, 1990 order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our August 24, 1990 order, effective this date.

IT IS SO ORDERED.

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In the Matter of the Compensation of
**THEODORE E. LANCE, Claimant**
WCB Case No. 88-14723
ORDER ON REVIEW
Brothers, Drew, et al., Claimant Attorneys
Rankin, et al., Defense Attorneys
Bonnie Laux (Saif), Defense Attorney

Reviewed by Board Members Brittingham, Nichols and Crider.

The SAIF Corporation requests review of Referee Myzak's order that granted claimant permanent total disability, whereas a Determination Order had awarded 25 percent (80 degrees) unscheduled permanent disability for a low back condition. Both SAIF and the employer filed briefs. Claimant filed a motion to strike the employer's brief. On review, the issues are: (1) the motion to strike; and (2) extent of permanent disability, including permanent total disability. We reverse the award of permanent total disability, but increase claimant's unscheduled permanent partial disability.

## FINDINGS OF FACT

We adopt the Referee's "Findings of Fact," with the exception of the fifth paragraph and the last paragraph on page two. In addition, we supplement with the following.

After he was released to regular work, claimant went to the Willamette Valley to work in order to obtain more money. (Tr. 66).

Claimant became medically stationary on February 4, 1988.

In May 1988 claimant was examined by the Western Medical Consultants.

In November 1988 Dr. Newby, neurosurgeon and claimant's attending physician, assessed claimant's physical capacity for work.

Claimant has a constant list forward of 10 degrees flexion. Range of motion (ROM) of his thoracolumbosacral spine is 55 degrees flexion; 0 degrees extension; side bending right to 10 degrees, left to 20 degrees; rotation right to 45 degrees, left to 45 degrees. Hip flexion is 110 degrees on the right and 120 degrees on the left, with low back pain. Hip extension causes marked increase in low back pain.

## FINDINGS OF ULTIMATE FACT

Claimant is not permanently and totally disabled for medical reasons alone. Nor is he permanently and totally disabled as a result of a combination of medical and nonmedical factors. Moreover, claimant has not established that he is willing to work and has made reasonable efforts to find work. Such work search efforts would not be futile.

As a result of his compensable low back injury, claimant has sustained a 50 percent loss of earning capacity.

## CONCLUSIONS OF LAW AND OPINION

### Motion to Strike

Briefs were filed by both the SAIF Corporation and the employer. Claimant filed a motion to strike the employer's brief, on the premise that SAIF and the employer are the same party in this proceeding. However, in Workers' Compensation proceedings, the employer and insurer are separate parties to the claim. ORS 656.006(19). Both briefs were timely filed. Consequently, we deny claimant's motion.

### Permanent Total Disability

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

To establish permanent total disability, claimant must prove that he is presently unable to perform any work at a gainful and suitable occupation. ORS 656.206(1). Permanent total disability may be established through 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. Bannister Pipeline, 70 Or App 699 (1984). Because application of an "odd-lot" analysis presupposes some capacity for employment, an injured worker is statutorily required to make reasonable efforts to find work, although he need not engage in job seeking activities that, in all practicality, would be futile. ORS 656.206(3); SAIF v. Orr, 101 Or App 612 (1990); Welch, supra, 70 Or App at 701. Furthermore, even if seeking such work would be futile, claimant must establish that he is or would be willing to seek regular gainful employment. SAIF V. Stephen, 308 Or 41 (1989).

Extent of Impairment

The first step in determining whether claimant is permanently and totally disabled requires an evaluation of his physical condition.

The Referee found claimant credible. She relied on claimant's assessment of his own limitations and on vocational consultant Ridenour's testimony that claimant was permanently and totally disabled, which was also based on claimant's assessment of his own limitations. On the other hand, Dr. Newby, neurosurgeon and claimant's treating physician, opined that claimant was physically capable of performing light-sedentary work. The Western Medical Consultants, independent medical examiners, concluded that claimant was physically capable of performing sedentary work.

Although the Referee found claimant credible, we give greater weight to the expert medical opinion of Dr. Newby and the Consultants than to claimant's lay opinion. See William O. Esselstrom, 42 Van Natta 1036 (1990). Similarly, we give little weight to the opinion of the vocational consultant because it is based on claimant's lay assessment of his own limitations. Furthermore, claimant did not contend at hearing that he was permanently and totally disabled on a physical basis alone. (Tr. 5).

Accordingly, on this record we are not persuaded that claimant is permanently and totally disabled solely as a result of his physical condition. Instead, we find that he is able to perform sedentary work. Consequently, we conclude that claimant is not physically incapacitated from performing any work at a gainful and suitable occupation.

Odd-Lot Doctrine

The Referee also found claimant permanently and totally disabled based on a combination of medical and nonmedical factors. In addition, she concluded that claimant had satisfied the work search requirement because he had shown some motivation to work by his unsuccessful attempts at working as a security guard, and because the employer did not have any available positions that it claimed claimant could perform. Furthermore, she found that any additional work search would be futile, given claimant's level of impairment. We disagree with the Referee's ruling.

At the time of the hearing, claimant was 53 but appeared older. He had preexisting amputations of three fingers of his left hand. He had a seventh grade education and was certified as a welder. His prior work experience includes work as a welder, a gas station attendant, a farm, sawmill and cement laborer, a security guard, and a dishwasher. He has no transferable skills for any sedentary job other than an entry-level position.

We are not persuaded that a work search would be futile. As established above, the uncontradicted medical opinions establish that claimant is capable of performing sedentary work. Furthermore, although the vocational consultant testified that claimant was unemployable based on claimant's own assessment of his physical capabilities, he also testified that there were positions available in claimant's geographical area that were within claimant's sedentary capabilities, such as ticket taker and order clerk. (Tr. 35). As noted above, to the extent that the vocational counselor's conclusion is based on claimant's own assessment of his physical capabilities, we do not find his opinion persuasive. Moreover, when presented with the medical assessment that claimant could perform sedentary work, and considering claimant's nonmedical factors, the vocational counselor did not indicate that a work search would be futile. (Tr. 17, 20, 21, 35). Based on this record, we conclude that a work search would not be futile.

Absent a showing of futility, claimant must make some effort to obtain employment. We next turn to whether claimant has made reasonable efforts to find work. After being released to regular work, claimant decided he could not return to the dishwashing job. (Tr. 99, 125). Instead, he went to the Willamette Valley to find work that would pay more. (Tr. 99). After he made two unsuccessful attempts to work as a security guard, he made no further efforts to find work. Furthermore, claimant did not apply for any other position with the at-injury employer, even though the employer had a number of part-time positions within the sedentary range that did not require other than entry-level skills, such as towel monitor at the swimming pool, checker at the golf shop, and taking golf reservations over the phone.

We acknowledge that claimant testified he was willing to work. However, his testimony is not persuasive in light of his failure to look for regular gainful employment. Therefore, based on this record, we find that claimant has not made reasonable efforts to find work.

Accordingly, we find claimant has not met his burden to establish that he is permanently totally disabled due to a combination of medical and nonmedical disabilities which have effectively foreclosed him from gainful employment.

Unscheduled Permanent Disability

The disability standards adopted by the Director pursuant to ORS 656.726(3)(f) apply only to claims "closed and evaluated by the Evaluation Section . . . on and after July 1, 1988, where claimant last became medically stationary on and after January 1, 1988." See OAR 438-10-005. Here, claimant became medically stationary after January 1, 1988. However, his claim was initially closed by Determination Order issued March 16, 1988. Although the March 1988 Determination Order was reconsidered in subsequent Determination Orders after July 1, 1988, the claim was not reopened and then reclosed after that date. Therefore, we find March 16, 1988 to be the date of closure. Accordingly, we apply the guidelines rather than the standards to this claim.

The criterion for rating unscheduled permanent partial disability is the permanent loss of earning capacity due to the compensable injury. Earning capacity means the ability to obtain and hold gainful employment in the broad field of general occupations, taking into consideration such factors as age, education, training, skills and work experience. Former ORS 656.214(5). The rules for rating unscheduled disability were set forth in former OAR 436-65-600 et seq. Although not binding on the Board, see Harwell v. Argonaut Insurance Co., 296 Or 505, 510 (1984), we apply those rules as guidelines.

Considering claimant's age of 53 and appearance older than his stated age, his seventh grade education, his lack of transferable skills, his adaptability from light to sedentary work, the labor market, and his physical impairment, we conclude that an award of 50 percent (160 degrees) unscheduled permanent disability adequately and appropriately compensates claimant for the loss of earning capacity due to the compensable injury. We increase the award granted by the Determination Order accordingly.

ORDER

The Referee's order dated December 22, 1988 is reversed. In lieu of the Referee's award of permanent total disability, and in addition to the 25 percent (80 degrees) unscheduled permanent disability awarded by Determination Order, claimant is granted an additional 25 percent (80 degrees) unscheduled permanent disability, for a total of 50 percent (160 degrees) for his low back condition. Claimant's attorney is entitled to 25 percent of the increased compensation

created by this order, not to exceed $3,800, payable directly to claimant's attorney. The SAIF Corporation is permitted to credit the attorney fee paid pursuant to the Referee's award against the attorney fee awarded herein.

**Board Member Crider, dissenting.**

Referee Myzak found claimant credible. Her credibility determination was explicitly grounded on her opportunity to observe claimant and assess his demeanor. She noted that his manner of testifying was straightforward. She concluded that his testimony was truthful.

Claimant testified to very limited physical capacities. Based on those physical capacities and other relevant factors, Richard Ridenour, a vocational expert, testified that claimant was unemployable. The Referee agreed.

The majority, however, rejects claimant's testimony giving it "little weight" because claimant's assessment is inconsistent with that of his physician. Having rejected claimant's testimony, the majority concludes that claimant is not permanently and totally disabled.

This is a tough case. Dr. Newby obviously thinks that claimant has greater residual capacity than claimant has indicated. However, it is precisely in these tough cases that the Board must rely on its referees, for it is our referees who have the best opportunity to assess the credibility of witnesses.

The majority's approach is not only unwise; it is contrary to law. We are enjoined to give the demeanor credibility findings of our referees great weight. See Anfilofieff v. SAIF, 52 Or App 127 (1981). This principle holds true not only when the referee finds a witness not credible but also when the referee finds a witness credible despite inconsistencies between his testimony and that of others or apparent inconsistencies in his own testimony. See Condon v. City of Portland, 52 Or App 1043, rev den, 291 Or 662 (1981).

The majority apparently concludes that this principle of deference to demeanor credibility findings does not apply if the Board explains its disagreement with the referee by indicating that a physician's statement is entitled to greater weight.

The majority's reliance on William O. Esselstrom, 42 Van Natta 1036 (1990) is misplaced. In Esselstrom, a referee found a claimant credible but declined to award disability compensation based on claimant's testimony that he believed he had suffered a loss of range of motion and strength. We also declined to increase claimant's award, based on our view that the physician, utilizing recognized measurement procedures, was better equipped than the worker to make the measurements required by the standards for rating disability. On the other hand, in this case the question is not what impairment claimant has sustained, but what he is able to do--how much sitting, standing, lifting and the like. Medical expertise does not place a physician in a superior position when it comes to describing the extent to which pain affects ability to carry out these daily life activities. Therefore, credible lay testimony is entitled to equal or greater weight than a physician's conclusory assessment of physical capacities on a form.

Because the Referee's credibility determination and her finding as to claimant's physical capacities were based on her observations at hearing, her credibility determination and her findings based thereon are entitled to deference. Therefore, I would affirm.

In the Matter of the Compensation of
**ROBERT E. ROY, Claimant**
WCB Case No. 89-07274
ORDER ON REVIEW
Pozzi, et al., Claimant Attorney
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Myers and Gerner.

The insurer requests review of Referee Fink's order which set aside its denial of claimant's neck and left arm injury claim. On review, the issue is compensability.

The Board affirms and adopts the order of the Referee with the following supplementation.

The insurer urges us to uphold its denial because the Referee did not find that claimant suffered a left ulnar nerve and brachial plexus injury, and those conditions are what it denied. The insurer cites William T. Lattion, 34 Van Natta 1518 (1982), as authority for the proposition that where a condition is not found to exist, the denial of that condition, though not really relevant, should be upheld rather than set aside. We might agree with the insurer had the denial of these conditions been a partial denial of an otherwise compensable claim; however, we interpret the insurer's denial in this case as being a denial of the entire claim.

In Lattion the insurer partially denied degenerative disc disease that did not exist. The claimant still had an accepted claim for a lumbar strain. Here, the insurer denied the entire claim as well as the specific diagnoses of ulnar nerve and brachial plexus injuries. The Referee found, and we agree, that the work injury materially contributed to claimant's need for medical services and disability, whatever the diagnosis of claimant's problems. If an on-the-job injury requires medical services, it is compensable, even if there is no specific diagnosis. ORS 656.005(7)(a); See Tripp v. Ridge Runner Timber Services, 89 Or App 355 (1988); Karen M. Partridge, 39 Van Natta 137 (1987).

The insurer requests that we define the diagnosis of the condition it is now ordered to accept because the diagnosis of claimant's condition is presently unknown. As noted, a diagnosis of a condition is not required to have a compensable claim under ORS 656.005(7)(a). The only requirement is medical services and/or disability that were materially caused by the work injury. In this case, the insurer is not being ordered to accept a condition, diagnosis or symptom complex, because one is not known; it is merely being ordered to accept the medical services and/or disability that were the material result of the work injury.

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed fee for claimant's counsel's services on review is $625 to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case, the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated August 7, 1989 is affirmed. For servies on review, claimant's attorney is awarded an assessed fee of $625, to be paid by the insurer.

In the Matter of the Compensation of
**DALE K. BOLLING, Claimant**
WCB Case No. 88-18626
ORDER ON REVIEW
Flaxel, Todd, et al., Claimant Attorneys
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Howell and Speer.

Claimant requests review of that portion of Referee Scavera's order which increased his award of unscheduled permanent disability for a back injury from 16 percent (51.2 degrees), as awarded by Determination Order, to 21 percent (67.2 degrees). The self-insured employer cross-requests review of the Referee's order and seeks a decrease in unscheduled permanent disability. On review the issue is extent of unscheduled permanent disability. We reverse.

FINDINGS OF FACT

On September 27, 1987, claimant sustained a compensable injury of his low back when the boom on his front-end loader fell and jarred him around in the cab. The claim was closed by Determination Order on July 25, 1988, with an award of 16 percent unscheduled permanent partial disability.

Claimant was 28 years old at the time of the hearing and has a 10th grade education. His primary job experience is that of front-end loader operator. Claimant has some skills as a welder and car mechanic, however, he has little job experience in these fields and his training in these areas is not documented.

The credibility of claimant's testimony at the hearing, as well as his complaints of pain and range of motion limitations, have all been questioned. (See e.g., O&O, p. 2; Exs. 6, 10, 16, 17, 22, 25).

Claimant was initially treated by Drs. Hearne and Smith, who prescribed pain and anti-inflammatory medications, 90/90 traction, and physical therapy. There was no objective evidence of nerve root involvement. (Exs. 6, 7, 8, 9).

Claimant was referred to orthopedic surgeon, Dr. Adams, in December 1987. Dr. Adams noticed inconsistencies in range of motion testing and significant positive nonorganic physical findings. (Ex. 10-2). X-rays showed anterior traction spur formation and narrowing of the L4-5 disc space. Claimant was given a diagnosis of industrial lumbar syndrome without radicular components. (Ex. 10-3).

Orthopedist, Dr. Whitney, reported a disc protrusion at L3-4 and a posterior-disc bulge at L4-5. (Exs. 14, 15). These derangements cause claimant mechanical pain with only occasional radicular-type pain. Claimant is permanently restricted from driving a front-end loader and work in the medium category is suggested with restrictions on bending and distance driving. Claimant also has a very mild posterior disc protrusion at L5-S1 without significant impingement on the dural sac. Similarly, there are no clinically-related residual symptoms attributed to this derangement.

In May 1988 independent medical examiners, (IME) Dr. Englander (neurologist), and Dr. Coletti (orthopedist), noted significant refusals and inconsistencies on examination. They diagnosed preexisting lumbar degenerative disc disease, and lumbar/thoracic strain with no objective residuals. Claimant

was placed under no restrictions relative to his employment. (Ex. 16). Dr. Whitney concurred with the IME findings. (Ex. 17).

In September 1988 Dr. Whitney reported that claimant suffers no significant mechanical pain and only on rare occasions does he have evidence of radicular discomfort. A radicular component is unlikely. (Ex. 22). If claimant returns to his former job, he runs the risk of repeated injury. Claimant is restricted to medium level work, lifting under 50 pounds, no lifting from the floor or twisting, no prolonged driving, or driving in bouncing type equipment. (Ex. 24).

Dr. Serbu performed a neurosurgical consult in December 1988. During the physical examination, claimant went through peculiar gyrations that were purely functional. There were no positive neurological findings and claimant was diagnosed with mild degenerative disc disease. No restrictions were placed on the type of work claimant could do.

## CONCLUSIONS OF LAW AND OPINION

### Extent of Unscheduled Permanent Disability

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

For purposes of determining injury-related permanent partial disability, ORS 656.283(7) and 656.295(5) require application of the standards for the evaluation of disabilities adopted by the director pursuant to ORS 656.726(3)(f)(A). Those "standards" in effect on the date of the Determination Order from which the hearing was requested control the evaluation of permanent partial disability. OAR 438-10-010.

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

In this case, the "standards" adopted effective July 1, 1988, former OAR 436-35-001 et seq, apply to the rating of claimant's permanent partial disability. Former OAR 436-35-270 through 436-35-440 apply to the rating of unscheduled permanent partial disabilities. Former OAR 436-35-270(1).

### Training

In the employer's cross-request for review it contends that the "standards" do not require documented training to obtain a "0" factor for training. We do not agree with this interpretation of former OAR 436-35-300(5). In Jack E. Emerald, 42 Van Natta 1161 (1990), we held that "documentation" means a certificate, diploma, degree, etc. If no such documentation is in the record and none is offered or provided pursuant to the rule, claimant's training value is +1. Emerald supra at 1163. Here, claimant's purported "training" in welding, auto mechanics, and carpentry

were not "documented" within the meaning of the rule and therefore the Referee's value of +1 was correct.

Adaptability

Next, the employer contends that the Referee should not have averaged light and medium work adaptability factors. The employer misreads the rule. We concur with the Referee's application of former OAR 436-35-310(4) which clearly states: "For those workers with physical capacity to do more than the requirements of one category, but not the full range of requirements for the next higher category, the value shall be the average of the values for the two categories." Here, claimant has the residual functional capacity to do a full range of light work and work in the medium category with restrictions in the amount of lifting. Because claimant cannot perform a full range of medium work activities, it was appropriate to average the adaptability values for light and medium work.

Impairment Rating

Claimant initially asserts that his award should be higher because the Referee did not consider chronic restrictions on repetitive use due to disabling pain. We find claimant's testimony and allegations of pain unpersuasive given the credibility findings. In addition, the amended rules, which allow a separate value for limitations on repetitive use, were not in effect when the claim closed on July 25, 1988. Accordingly, the amended rules are not applicable. Joseph Anger, 41 Van Natta 827 (1989).

Claimant also argues that his award should be increased by 4 percent because there is an inoperative disc derangement at three levels, not just two. We note that former OAR 436-35-350(2) allows a rating of 4 percent for an unoperated intervertebral disc, if there are clinically-related residuals. Here, the disc protrusion at L5-S1 is reported to be very mild with no attributable residuals. Because there were no symptoms associated with this third disc, an award is not justified. Daniel M. Alire, 41 Van Natta 752, 756 (1989).

Based upon the April 11, 1989 report of Dr. Whitney, the Referee found unoperated disc derangements with clinically-related residuals at L3-4 and at L4-5. We disagree.

We are not persuaded that the preponderance of the medical evidence establishes that claimant's unoperated discs have clinically-related residual symptoms. Dr. Whitney's April 1989 report is the only record that arguably supports a finding of residuals and it only says claimant has "significant mechanical pain with occasional radicular type pain." (Ex. 15). However, Dr. Whitney also states on another occasion that he "doubt[s] there is a radicular component." (Ex. 22). In fact, in September 1988, Dr. Whitney released claimant to his regular work. (Ex. 22A). We are less persuaded by Dr. Whitney's opinion in that he reaches inconsistent results without thorough explanation. See Marshall v. Boise Cascade, 82 Or App 130 (1986); Melody M. Schneider, 40 Van Natta 1297 (1988). We give greater weight to the the medical opinions which are both well-reasoned and based on complete information. Somers v. SAIF, 77 Or App 259 (1986). Accordingly, we hold that the combination of claimant's doubtful testimony and accounts of pain and physical restrictions, which is supported by only one isolated medical finding, is insufficient to sustain an impairment rating of 8 percent under former 436-35-350(2). Alire, supra.

We observe that the elimination of a rating for unoperated discs at L3-4 and L4-5 results in claimant receiving no impairment rating under the "standards." Pursuant to former OAR 436-35-280(1), there can be no unscheduled disability if the injury did not result in impairment. However, the employer asks for a reduction in the Referee's increased award and does not challenge the Determination Order's award of 16 percent unscheduled permanent disability. Therefore, we reverse the Referee's award and affirm the Determination Order.

ORDER

The Referee's order dated March 7, 1989 is reversed in part and affirmed in part. The Referee's increased award of permanent disability and approved attorney fee is reversed. The Determination Order dated July 25, 1988 is reinstated and upheld. The remainder of the Referee's order is affirmed.

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In the Matter of the Compensation of
**JANET V. DOLLENS, Claimant**
WCB Case No. 89-02337
ORDER ON REVIEW
Robert E. Nelson, Claimant Attorney
Roberts, et al., Defense Attorneys

Reviewed by Board Members Cushing and Gerner.

The self-insured employer requests review of Referee Leahy's order which set aside its denial of claimant's back injury claim. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

Claimant is a food service cashier/dishwasher for the self-insured employer. The employer has a food service contract with Boeing Company. This contract allows the employer to use such portions of the Boeing complex as are necessary to perform the contract. The contract also requires that all employees of the employer abide by Boeing's rules. The entire complex is owned and maintained by Boeing.

Claimant commutes to work with her husband who works at the same complex as an employee of Boeing. They park in a Boeing parking lot on the southeast side of the complex. On November 1, 1988, on her way from this parking lot to the time clock, claimant fell and suffered an injury. Claimant had not yet reported to work at the time of the injury.

CONCLUSIONS OF LAW AND OPINION

The Referee found claimant's back injury compensable. He reasoned that the employer's contract with Boeing resulted in the employer having "at least constructive control over the areas claimant was not precluded from using." We disagree that "constructive control" is sufficient employer control to find the injury work related.

Claimant has the burden to prove that her injury arose out of and in the scope of her employment. ORS 656.005(7)(a). If the injury has a sufficient relationship to work, it is compensable. Rogers v. SAIF, 289 Or 633 (1980). Injuries occurring while coming to and going from work are ordinarily not work related, and hence, not compensable, unless the employer exercises some control

over the place where the injury is sustained. Cope v. West American Ins. Co., 309 Or 232, 239 (1990), Sheri V. Hiltner, 42 Van Natta 1039 (1990). Control is manifested by employer ownership or maintenance; see Montgomery Ward v. Cutter, 64 Or App 759 (1983), Kowcun v. Bybee, 182 Or 271 (1947); employer actions; see Montgomery v. SIAC, 224 Or 380 (1960); or the presence of employer created special hazards. See Nelson v. Douglas Fir Plywood Co., 260 Or 53 (1971).

Here, claimant fell and injured herself on the way from a Boeing parking lot to clock in at her place of employment which is located within property owned by Boeing. Since claimant had not yet reported to work at the time of her injury, compensability will be determined by whether the employer had control over the place where the injury occurred. Cope, supra, 309 Or at 239.

The Referee did not address the issue of control over the place of injury. He stated that the contract relationship between the employer and Boeing resulted "in at least constructive control over the areas claimant was not precluded from using."

However, more than "constructive control" is required. In Hiltner, supra, the Board reversed a referee's finding that the insured exercised control over the lobby area of a multistory, multipurpose commercial office building in which it leased space because the insured paid rent. In Cope, the Court stated that "[w]hether the requisite control is evinced by increased, employer-created hazards . . . or by the employer's property rights to the area where the injury is sustained . . . is immaterial. Some form of employer control of the area demonstrates the work-connection necessary to make the injury compensable." Cope, supra, 309 Or at 239. Thus, actual control of the area of injury is necessary.

Claimant has not shown that the employer had the requisite control over the area of injury. Claimant argues that her employer controlled the actions of its employees while they were on Boeing property. By contract with Boeing, the employer's employees were required to follow Boeing's rules and regulations. (Ex. 18-15). Thus, claimant was required to wear a badge and safety glasses on her way to clock in. However, as the above quotation from Cope demonstrates, the requisite employer control is control of the area of injury.

The employer does not own any of the property within the Boeing complex. (Tr. 40). Furthermore, the contract with Boeing stated that the employer was not responsible for the maintenance of Boeing's real and personal property. (Ex. 18-5). The only contractual term relating to maintenance deals with sanitation in the serving and food storage areas. Moreover, claimant stipulated that Boeing was in charge of the maintenance to all of the facilities.

In Adamson v. The Dalles Cherry Growers, Inc., 54 Or App 52 (1981), the employer's facilities were on both sides of a public street and the public street was the only way that claimant could get to work. Still, the court found noncompensable an injury that occurred on the street as claimant walked from her parked car to report to work. Id. The court based its decision on the fact that the employer had no control over street traffic, use of the street or its maintenance. Id. at 59. Although the area of injury in the present case is private property, it is not owned by the employer. Therefore, Adamson is analogous in that the employer here had no control over the walkway where the injury occurred, its use, or its maintenance.

The other possible manifestations of control, employer actions and employer-created special hazards, also do not apply to this case. In Montgomery v. SIAC, supra, the Court found compensable an injury that occurred on a public street because the employer had control over the traffic signal on the street.

No such employer action is involved in the present case. The employer's requirement that employees follow Boeing rules while on Boeing property does not amount to the magnitude of control demonstrated in Montgomery. Also, claimant did not claim that there were any employer-created hazards.

In conclusion, claimant has shown none of the manifestations of employer control that would allow her to avoid the general rule that an injury incurred coming to and going from work is not work related.

ORDER

The Referee's order dated May 24, 1989, as republished on June 29, 1989, is reversed. The self-insured employer's denial is reinstated and upheld. That portion which awarded claimant a $1,000 assessed attorney fee is reversed.

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In the Matter of the Compensation of
**JAMES F. DRAKE, Claimant**
WCB Case No. 88-19054
ORDER ON RECONSIDERATION
Rankin, et al., Defense Attorneys

On August 2, 1990, we issued an Order of Abatement in this matter stating that we had decided to reconsider our Order on Review of July 25, 1990. In our initial order, we affirmed and adopted Referee Shebley's order setting aside the self-insured employer's denial of claimant's injury claim for a low back condition. On reconsideration, the employer contends the condition is not compensable because the record does not establish medical causation. Upon further reflection, we conclude our decision was incorrect, but do so for different reasons. Accordingly, we disavow our prior position, and reverse the Referee's order.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact."

ULTIMATE FINDINGS OF FACT

We reject the Referee's "Ultimate Findings of Fact," and make our own.

The medical causation of claimant's low back condition can not be determined.

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. Former ORS 656.005(8). The Supreme Court has adopted a unitary work-connection approach: "If the injury has sufficient work relationship, then it arise out of and in the course of employment and the statute is satisfied." Rogers v. SAIF, 289 Or 633, 643 (1980).

We proceed to consider claimant's claim under the unitary work-connection analysis as explained in Phil A. Livesley Co. v Russ, 296 Or 25 (1983). In Phil A. Livesley the Court adopted the "quantum" approach in regard to "arising out of" and "in the course." Phil A. Livesley Co., supra, 296 Or at 28, citing 1A Larson, Workmens' Compensation Law 29.10 at 5-355.

The "course of employment" prong of the work-connection analysis generally refers to whether the injury occurred while claimant was at work or engaged in a work-related activity. Thus, the time, place and circumstances under which the accident takes place must be considered. Phil A. Livesley Co., supra, 296 Or at 29 (1983). Here, claimant was injured while on his 15 minute break. The work break was a scheduled portion of claimant's daily work schedule. Claimant took his break on the employment premises. The evidence indicates the employer had knowledge and acquiesced in claimant's work break. Accordingly, we find the injury occurred in the course of claimant's employment.

We next consider whether the injury was "arising out of" claimant's employment. The "arising out of employment" prong of the analysis requires that claimant show a causal link between the occurrence of the injury and a risk connected with his employment. In analyzing the risk factor we now determine whether the injury had its origin in a risk connected with the employment or rationally and naturally incidental thereto. Phil A. Livesley, supra, 296 Or at 29-30.

Here, claimant experienced a back strain. He first experienced the condition while attempting to vomit during a mid-morning work break. The record suggests several potential causes for claimant's condition.

To begin, claimant credibly testified that his back pain was a cumulative result of heavy work activities between May and October 1988. Since his back muscles had "just tired out," the vomiting attempt was the "last straw." Other possibilities were that he injured his back while attempting to vomit because he was suffering from the flu or because he became nauseous after eating.

Considering the number of potential causes for claimant's vomiting attempt, and its contribution to his back strain, we conclude that the causal relationship between his back condition and his work activities presents a complex medical issue. Therefore, although claimant's credible testimony is probative, resolution of this issue largely turns on the medical evidence. Uris v. Compensation Dept., 247 Or 420, 426 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985).

Here, Dr. Perry, claimant's treating physician, concluded that it was "entirely possible" that claimant's work activities, in addition to "acute vomiting," "could have" contributed to his acute back pain. Thus, Perry neither attributes claimant's vomiting episode to work activities nor does he discuss the relative contribution of each potential cause to claimant's current back condition. Moreover, Perry's opinion is couched in terms of possibilities, not probabilities. We consider such an opinion to be unpersuasive. See Gormley v. SAIF, 52 Or App 1055 (1981).

Consequently, we are not persuaded that claimant's back condition arose from his employment. Accordingly, we conclude that the claim is not compensable. See Jimmy D. Ellis, 42 Van Natta 590 (1990).

ORDER

The Referee's order dated April 6, 1989 is reversed. The self-insured employer's denial of claimant's low back condition is reinstated and upheld.

In the Matter of the Compensation of
**KARIN E. HOECHLIN-COGBURN, Claimant**
WCB Case No. 89-01135
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Nancy Marque (Saif), Defense Attorney

Reviewed by Board Members Brittingham, Nichols and Crider.

Claimant requests review of Referee Myzak's order that upheld the SAIF Corporation's denial of claimant's claim for a psychiatric condition. On review, the issue is compensability.

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

Claimant was exposed to allegedly stressful work conditions after January 1, 1988. We, therefore, apply former ORS 656.802, as amended effective January 1, 1988 (See Oregon Laws 1987, Chapter 713, Section 4). Claimant's burden of proof under that statute includes establishing by clear and convincing evidence that her work exposure was a material cause of her adjustment disorder.

Resolution of this issue is sufficiently complex to require expert medical evidence. Claimant relies on the opinions of Drs. Gascoyne, Holland and Helfing. The opinions of Gascoyne and Helfing are entitled to little weight for the reasons given by the Referee. We, likewise, give little weight to the opinion of Dr. Holland for the following reason.

Claimant experienced a number of stressors, including stress as a result of her treatment by Ms. Boone, a coworker. We are persuaded that Boone's treatment of claimant was stressful largely because of claimant's inordinate desire to please Boone. This fact persuades us that claimant's relationship with Boone is not the type of association inseparable from the work place that is properly considered to be a risk of employment. See SAIF v. Noffsinger, 80 Or App 640 (1986).

Although Dr. Holland opined that employment activities had played a role in causing claimant's adjustment disorder, he failed to quantify the relative effect of claimant's various employment stressors. We are, therefore, unable to ascertain to what extent Dr. Holland based his opinion on stresses related to Boone's treatment of claimant. Moreover, in reviewing the chart notes of treating psychiatrist Helfing, we note that the problems claimant reported dealt mainly with off-the-job, personal difficulties, primarily related to her family and past experiences. On this record, claimant has not carried her burden of establishing, by clear and convincing evidence, that her employment materially contributed to her adjustment disorder.

ORDER

The Referee's order dated June 9, 1989 is affirmed.

**Board Member Crider, dissenting:**

The Referee apparently concluded that the cause of claimant's stress was her relationship with a coworker. The Referee said that "the interface that occurred at work between [the coworker] and claimant does not establish that the stress arose out of and in the course of her employment." O & O at p. 4. Consequently, she found claimant's mental disorder not compensable.

I believe that the Referee's reasoning is inconsistent with established law. In SAIF v. Noffsinger, 80 Or App 640 (1986), the court rejected a contention that a mental disorder caused by stress emanating from interaction with a coworker does not arise out of and is not in the scope of employment. The court rejected SAIF's contention holding that:

> "[Workers] do not work in a vacuum; they are generally involved in interpersonal relationships with other workers. As this case demonstrates, those relationships can be less than idyllic. Yet, they are as much within the scope of their employment as is the performance of assigned tasks."

SAIF v. Noffsinger, supra, 80 Or App at 647. In light of this principle, I believe that the Referee erred in refusing to treat claimant's interactions with her coworker as work-related.

That the Referee's reasoning, adopted by the Board, is erroneous does not necessarily mean that the claim is compensable. We must find that claimant suffers from a mental disorder caused or worsened by the stress of her interaction with her coworker and that her claim is not otherwise noncompensable under former ORS 656.802(2). I believe that the record demands that we find that claimant does suffer from an adjustment reaction arising out of work. As I understand the record, Dr. Helfing, the treating psychiatrist, opines that claimant suffers an adjustment disorder, one of the causes of which is working conditions. Dr. Holland, an examining psychiatrist, agrees that claimant suffers an adjustment disorder and that work played a role in causing this disorder. In addition, however, he diagnoses preexisting psychopathology--notably, chronic neurotic depression, posttraumatic stress disorder and a tendency to realize emotional distress as physical symptoms. These he does not relate to claimant's work experience. There is no expert evidence which refutes the proposition that claimant's adjustment reaction is work-related although one examiner, Dr. Klein, apparently was skeptical of claimant's history.

Claimant, having established, by clear and convincing evidence, that her adjustment disorder is work-related, has established a compensable claim unless we find it noncompensable under former ORS 656.802(2). The Referee has accepted claimant's recitation of events at work involving her coworker which claimant experienced as stressful. We have no reason to reject those findings. Consequently, those events are real. Dr. Holland, relying on claimant's report of these events, concluded that claimant was subjected to conditions objectively capable of causing stress which are not encountered in every work situation. Therefore, the claim is compensable.

I dissent because the Referee's rationale, adopted by the Board, is wanting and because I have concluded that the denial should be set aside.

In the Matter of the Compensation of
**REX A. HOWARD, Claimant**
WCB Case No. 88-08337
ORDER ON REVIEW
Quintin B. Estell, Claimant Attorney
Merrily McCabe (Saif), Defense Attorney

Reviewed by Board Members Nichols and Crider.

Claimant requests review of those portions of Referee Foster's order that upheld the SAIF Corporation's denial of claimant's neck and left shoulder, arm and hand claim, low back sacroiliac claim, left hip and knee claim, respiratory claim, and psychological claim. SAIF cross-requests review of those portions of Referee Foster's order that set aside its denial of claimant's hypertension claim, inflammatory bowel claim, and plantar fascitis claim. On review the issue is compensability. We reverse in part and affirm in part.

## FINDINGS OF FACT

Claimant was a practicing chiropractor for 19 years. In 1980, he began to notice a generalized tightness in his mid-back area. Claimant also experienced low back pain by late 1985. As his condition worsened, he reduced his work week hours from 60 down to 21 hours per week.

On November 20, 1985, claimant filed an occupational disease claim with SAIF for his back problem. Claimant was treated by Dr. Poulson, M.D., in December 1985. Pain caused claimant to leave his practice in early March 1986. SAIF accepted claimant's lumbar/thoracic fibromyositis claim on May 27, 1986.

In the summer of 1986, claimant experienced the onset of plantar fascitis, respiratory problems, pain into the left S-1 joint, cervical and left shoulder pain, and pain and numbness in the left arm and hand. By the fall of 1986, claimant was also suffering from hypertension and anxiety/depression, and complaining of pain in his hip. By March 1987, claimant was also complaining of pain and swelling in his knees.

On July 14, 1986, claimant named Dr. Isaacson, M.D., as his treating physician.

## FINDINGS OF ULTIMATE FACT

Claimant's work materially contributed to his development of osteoarthritis in the dorsolumbar spine and a related kyphosis.

Claimant's compensable kyphosis materially contributed to his neck, low back sacroiliac and left hip conditions.

Claimant's work activities and compensable back condition did not materially contribute to his hypertension condition, inflammatory bowel condition, or respiratory condition.

Claimant's compensable back condition materially contributed to his depression and anxiety condition.

## CONCLUSIONS OF LAW AND OPINION

The Referee held that claimant's hypertension, inflammatory bowel and plantar fascitis are related to claimant's compensable back condition and set aside SAIF's denial with regard to those conditions. On review, claimant argues

that the medical record establishes that his shoulder, arm and hand syndrome, low back sacroiliac and left hip condition, knee condition, respiratory condition, and psychological condition are related to his compensable back condition. Claimant argues further that SAIF accepted these conditions because it had notice of the conditions and failed to deny them.

SAIF argues that claimant has not established that his compensable back condition was a material contributing cause of his denied medical conditions.

It is well settled that a carrier is liable for the natural consequences flowing from a compensable injury. Williams. v. Gates McDonald & Co., 300 Or 278, 281 (1985); Patitucci v. Boise Cascade Corp., 8 Or App 503, 507-8 (1972). Therefore, to establish the compensability of claimant's current conditions, claimant has the burden of proving by a preponderance of the evidence that his 1985 compensable back condition is a material contributing cause of his current complaints. 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. Lobato v. SAIF, 75 Or App 488, 492 (1985).

While claimant is competent to testify about his pain, and is a skilled professional capable of determining cause and extent of spinal problems, he is not in a position to be an objective observer while acting as his own advocate. For this reason, we give little weight to claimant's opinion regarding the causation of his problems.

Neck, Shoulder, Arm and Hand Syndrome; Low Back Sacroiliac, Left Hip and Knee Conditions

The Referee upheld SAIF's denial of claimant's shoulder, arm and hand syndrome, his neck, low back sacroiliac and left hip conditions, and his knee condition. Claimant argues that these problems are attributable to postural alteration as a result of kyphosis of the spine due to work-related dorsolumbar osteoarthritis. We conclude that claimant's neck, low back sacroiliac and left hip conditions are compensable, but not his shoulder, arm and hand syndrome or left knee condition.

In reaching this decision, we rely on the opinions of Drs. Bennett and Poulson. Claimant was examined by Dr. Bennett, a specialist in arthritic and rheumatic diseases, on March 13, 1986. Bennett diagnosed osteoarthritis of the dorsolumbar junction and adjacent levels, with related kyphosis. He related this condition to claimant's work as a chiropractor. On March 26, 1986, Dr. Poulson agreed with Dr. Bennett. We are persuaded by this evidence that claimant's kyphosis condition is causally related to his compensable back condition.

We further conclude that claimant's neck, low back sacroiliac and hip complaints are materially related to his compensable kyphosis. Our decision is based on the opinion of Dr. Corrigan, orthopedist, who examined claimant at Northwest Pain Center on October 16, 1986. Dr. Corrigan noted tenderness in the neck, left lumbosacral angle and lumbar paravertebral muscles at their lower rib cage insertion. He attributed these symptoms to the secondary postural effects of the dorsolumbar kyphosis. He ruled out nerve route problems as the source of claimant's neck complaints based, in part, on x-rays of the cervical spine revealing mild degenerative disc disease involving the C3-C4 and C5-6 levels. but no significant foraminal encroachment.

In reaching this conclusion, we give little weight to the opinion of Dr. Tilden, D.C., who opined that claimant's kyphosis was unrelated to his compensable back condition. Dr. Tilden never examined claimant and failed to give an explanation for his opinion. Nor do we credit the conclusory opinion of the Western Medical Consultants' that claimant's back and neck pain is unrelated to work.

We also give little weight to the opinion of Dr. Isaacson, the treating physician. She variously diagnosed claimant's neck, shoulder, arm and hand problems as arthritis and C-6 radiculopathy, both work related. She based her opinion, in part, on the report of Dr. Stolzberg, a consulting neurologist, who diagnosed C-6 radiculopathy.

Although the Board generally gives greater weight to the conclusions of a treating physician, it will not do so when there are persuasive reasons to do otherwise. Weiland v. SAIF, 64 Or App 810, 814 (1983); Nancy E. Cudaback, 37 Van Natta 1580, withdrawn on other grounds, 37 Van Natta 1596 (1985), republished 38 Van Natta 423 (1986). Here, we find persuasive reasons not to defer to the opinion of Dr. Isaacson. She opined that the neck, shoulder, arm and hand condition was related to the compensable dorsolumbar problem because claimant had first experienced these symptoms when he turned his neck while wearing a Jewett brace for the compensable back problem. We are reluctant to infer causation from this type of temporal relationship, particularly when, as here, it appears that the physician's opinion regarding causation appears to be based on the patient's opinion rather than on an independent evaluation of the etiology of the condition. See Bradshaw v. SAIF, 69 Or App 587 (1984), Edwards v. SAIF, 30 Or App 31, rev den 279 Or 301 (1977).

Accordingly, we defer to Dr. Corrigan's opinion and conclude that claimant's neck problems, like his sacroiliac and hip problems, are mechanical in nature and the result of his altered posture. Moreover, in light of the fact that Dr. Isaacson's opinion is the only medical evidence supporting the compensability of claimant's shoulder, arm and hand symptoms, we conclude claimant has not established the requisite causal relationship between these symptoms and his work as a chiropractor.

Finally, we note that the record is devoid of any medical opinion expressly relating claimant's knee condition to his kyphosis or work activity. Therefore, claimant has not established the compensability of that condition. Accordingly, the Referee's order is affirmed with regard to claimant's shoulder, arm and hand syndrome and left knee condition, and reversed with regard to claimant's neck, low back sacroiliac and left hip conditions.

Hypertension

Dr. Coleman, consulting pulmonary disease specialist, reported on November 11, 1986 that it is probable that claimant's hypertension was exacerbated by stress related to claimant's back condition. The Referee agreed and held that claimant's hypertension condition is related to his back condition. We disagree.

Dr. Girod, a specialist in infectious diseases, reviewed claimant's records at SAIF's request. He agreed with Dr. Montanaro, allergy specialist, that acute anxiety or panic can produce transient elevations in blood pressure, but stated that there is no medical evidence that a chronic anxiety state can produce hypertension. Dr. Girod opined that since there is not sufficient medical evidence to associate hypertension with chronic anxiety, it would be inappropriate to attribute claimant's hypertension to this claim.

Dr. Lyon opined on July 12, 1988 that claimant's hypertension was not job-related.

Dr. Coleman reported that he felt that it is probable that claimant's hypertension condition was exacerbated by stress related to his back condition. However, Dr. Coleman admitted that the relationship between claimant's back condition and the hypertension was unclear because he did not have the baseline data necessary to determine the extent to which the patient's high blood pressure was exacerbated by anxiety and stress related to the injury. Because of its equivocal nature, we find Dr. Coleman's opinion unpersuasive.

We rely, instead, on the opinions of Drs. Girod and Lyon and find that claimant's compensable back condition is not a material contributing cause of his hypertension condition. Accordingly, the Referee's order is reversed with regard to claimant's hypertension condition.

Inflammatory Bowel Condition

The Referee found that claimant's inflammatory bowel condition is materially related to his compensable back condition. We disagree.

Dr. Bennett, Professor of Medicine, related claimant's irritable bowel syndrome to stress from his compensable back condition. However, Dr. Bennett failed to explain the basis for that opinion. Therefore, we find Dr. Bennett's opinion conclusory and give it little weight. Dr. Maveety, gastroenterologist, raised the possibility that claimant's irritable bowel syndrome could be related to ulcerative colitis, which in turn, could be related to claimant's ankylosing spondylitis. However, Dr. Maveety rendered no further opinion on this question. Dr. Lyon, in his internal medicine report, opined that claimant's irritable bowel syndrome is unrelated to any on-the-job injury.

On this record, we find that claimant has failed to carry his burden of showing that his compensable back condition is a material contributing cause of his irritable bowel condition. Accordingly, the Referee's order is reversed with regard to this condition.

Plantar Fascitis Condition

The Referee held that claimant's plantar fascitis condition is materially related to his back condition. We disagree.

Claimant began to treat with Dr. Isaacson on August 14, 1986. She obtained a history of bilateral plantar fascitis which had developed over the previous year. Dr. Isaacson continued to treat claimant through the date of the hearing, but in no way related claimant's plantar fascitis condition to his back condition.

The only opinion supporting compensability of the plantar fascitis is from James Heiser, L.P.T., who evaluated claimant on October 9, 1987. He felt that claimant would have trouble with his posterior leg muscles and the short flexor muscles of the feet resulting from the degenerative changes in his back. Heiser gave no explanation for the basis of this opinion. Therefore, we find it conclusory and give it little weight.

The Western Medical Consultants rendered a contrary opinion based on their examination in July 1988. They did not find any evidence which would suggest there was an industrial cause of the plantar fascitis.

On this record, claimant has failed to carry his burden of proving that his plantar fascitis condition is materially related to his back condition. Accordingly, the Referee's order is reversed with regard to this condition.

Respiratory Condition

The Referee found that claimant's respiratory complaints are not related to his compensable back condition. We agree.

Dr. Montanaro, allergy specialist, performed an independent medical examination on February 10, 1987. He completed an exercise pulmonary function study and could find no evidence that claimant suffered from any ventilatory problems.

Dr. Coleman felt that claimant's respiratory condition is the result of complications and treatment of the injury to claimant's back. However, Dr. Coleman based his opinion on his assertion that pulmonary function testing revealed evidence of a restrictive lung impairment. This directly contradicts Dr. Montanaro's findings. Further, the record does not reflect testing which indicates a finding of restrictive lung impairment. Because Dr. Coleman's opinion rests on the results of unsubstantiated testing, we find it unpersuasive. We rely on the well reasoned opinion of Dr. Montanaro and find that claimant's respiratory condition is not materially related to his compensable back condition. Accordingly, the Referee's order is affirmed with regard to this condition.

Psychological Condition

The Referee found that claimant's depression is not related to his occupational disease. We disagree.

Dr. Bennett addressed claimant's depression in his March 2, 1988 report, stating that claimant showed objective evidence of increased anxiety. Dr. Bennett opined that claimant suffered from a chronic pain syndrome resulting from his back problem which led to anxiety and depression.

Dr. Campbell, consulting clinical psychologist, administered the Beck Depression Inventory and the Minnesota Multiphasic Personality Inventory. He opined that claimant suffered from psychological distress secondary to his Fibromyalgia condition.

Dr. Isaacson also felt that claimant's depression and anxiety are related to his compensable back condition. She stated clearly on August 18, 1988, that there is a causal relationship between claimant's back pain and his depression.

Dr. Glass performed a psychiatric evaluation of claimant on July 12, 1988. Dr. Glass did not see claimant as clinically depressed, but opined that he was situationally depressed and opined that claimant had no psychiatric illness related to his injury. However, Glass's opinion is conclusory in that he failed to explain the basis of his opinion that claimant's chronic back condition does not contribute to his situational depression. Further, although he felt that claimant had no psychiatric disability, Dr. Glass prescribed antidepressant drugs. In light of these facts, we discount Dr. Glass's conclusory, ill-reasoned opinion. See Marshall v. Boise Cascade, 82 Or App 130, 133 (1986).

Claimant underwent an independent psychological evaluation with Dr. Davies, clinical psychologist, on August 27, 1987. Dr. Davies found no evidence of acute psychiatric disturbance secondary to claimant's compensable back injury.

We find no persuasive reasons not to defer to the opinions of treating physician Isaacson and consulting physicians Bennett and Campbell. Drs. Glass and Davies saw claimant only a single time, while Dr. Isaacson has treated claimant extensively and Dr. Bennett has been associated with the case for over two years. Thus, they possess the greatest familiarity with claimant's psychological condition. Therefore, we find that claimant's depression and anxiety are materially related to his compensable back condition. Accordingly, the Referee's order is reversed with regard to this condition.

"De Facto" Acceptance

Claimant argues on review that because SAIF had notice of the conditions which it later denied, it effectively accepted those conditions.

An insurer's acceptance of a claim only includes those injuries or conditions specifically or officially accepted in writing pursuant to ORS 656.262(6). Johnson v. Spectra Physics, 303 Or 49 (1987). SAIF's acceptance of claimant's claim was limited to lumbar/thoracic fibromyositis. See Sandra Branham, 40 Van Natta 1267 (1988). Therefore, SAIF did not accept the conditions which it denied.

Attorney Fee

After considering the factors set forth in OAR 439-15-010(4), and applying them to this case, we find that $2,500 is a reasonable assessed fee for claimant's counsel's efforts at hearing and on review concerning the issues of claimant's psychological condition, and neck, low back sacroiliac, and left hip conditions. In reaching this conclusion, we have particularly considered the time devoted to the issues, as represented by claimant's counsel's appellate brief and statement of services, the complexity of the issues presented, and the value of the interests. We further note that claimant is not entitled to an attorney fee for services devoted to those issues which he has not been successful in defending on review.

ORDER

The Referee's order dated January 23, 1989, as amended January 27, 1989, is reversed in part and affirmed in part. Those portions of the order that set aside the SAIF Corporation's denial of claimant's hypertension condition, irritable bowel condition and plantar fascitis condition are reversed. The Referee's $2,000 assessed attorney fee award is reversed. SAIF's denial of those conditions is reinstated and upheld. Those portions of the order that upheld SAIF's denial of claimant's psychological condition, and neck, low back sacroiliac and left hip conditions are reversed. SAIF's denial of those conditions is set aside, and those portions of the claim are remanded to SAIF for processing according to law. The remainder of the order is affirmed. For services at hearing and on Board review regarding the compensability of the psychological condition and the neck, low back sacroiliac and hip condition, claimant's attorney is awarded a $2,500 assessed fee, payable by SAIF.

In the Matter of the Compensation of
**CAP T. JESSUP, JR., Claimant**
WCB Case No. 88-22094
ORDER ON REVIEW
Don Willner & Associates, Claimant Attorneys
Tooze, et al., Defense Attorneys

Reviewed by Board Members Howell and Speer.

The insurer requests review of Referee Fink's order which: (1) increased claimant's unscheduled permanent disability award for his mid-back condition from 17 percent (54.4 degrees), as awarded by Determination Order, to 34 percent (108.8 degrees); and (2) increased claimant's scheduled permanent disability award for loss of use or function of his right knee from 14 percent (21 degrees), as awarded by Determination Order, to 18 percent (27 degrees). On review, the issue is extent of scheduled and unscheduled permanent disability. We reverse.

## FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" with the exclusion of the last two paragraphs and the "Ultimate Findings of Fact."

## CONCLUSIONS OF LAW AND OPINION

For purposes of determining injury-related permanent partial disability, ORS 656.283(7) and 656.295(5) require application of the standards for the evaluation of disabilities adopted by the director pursuant to ORS 656.726(3)(f)(A). Those "standards" in effect on the date of the Determination Order from which the hearing was requested control the evaluation of permanent partial disability. OAR 438-10-010.

In this case, claimant was medically stationary on October 11, 1988, and the Determination Order issued on November 21, 1988. Therefore, the "standards" adopted effective July 1, 1988, (former OAR 436-35-001 et seq), as amended by temporary rules effective August 19, 1988, apply to the rating of claimant's permanent partial disability.

### Unscheduled Disability

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

### Age

The appropriate value for claimant's age of 60 years is +1. Former OAR 436-35-290.

### Formal Education

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

Skills

Former OAR 436-35-300(4) adopts by reference the "SVP" (specific vocational preparation time) values assigned to various occupations by the Dictionary of Occupations Titles (DOT), published by the U.S. Department of Labor. The highest SVP level demonstrated by a claimant during the ten years prior to the date of injury is used to determine a value for skills. Former OAR 436-35-300(4). Claimant's highest SVP during the ten years prior to the date of injury was 3 as a furnace tender (DOT # 502.482-010). Therefore, the appropriate value for skills is 3. Former OAR 436-35-300(4).

Training

The insurer argues that the Referee erred in assigning an "education value" of +1. The insurer argues that the assigned value should be 0 because claimant had vocational training in criminology 20-23 years prior to claimant's accident. However, under former OR 436-35-300(5), if there is no documentation of claimant's vocational training in criminology, then a +1 value should be allowed. Claimant has no documented training. Therefore, the appropriate value for training is +1. Former OAR 436-35-300(5).

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

Adaptability

The insurer argues that the Referee erred in assigning an adaptability rating of 6. We agree.

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

The Referee relied upon the vocational counselor's evaluation of claimant's physical capacity limitations and held that claimant was restricted to sedentary/light employment. We reject the conclusions of the vocational counselor as to claimant's physical capacity limitations. The vocational counselor was not shown to be a competent expert to make physical capacity evaluations. The persuasive medical evidence indicates that claimant's physical capacity falls between the light and medium categories as defined in former OAR 436-35-310(4). (Ex. 53-7). In this case, the values for the two categories are averaged to obtain the appropriate adaptability value. Former OAR 436-35-310(4). The average of 4, the value for light physical capacity, and 1, the value for medium physical capacity, is 2.5.

Standards Disability Computation

The Age and Education sum is 5. This value is multiplied by the adaptability factor of 2.5 to yield the product 12.5. To this product is added the impairment value. The Referee assigned an impairment value of 4, and we agree. The total sum is 16.5 percent disability. This result is rounded to the next higher whole percentage. Former OAR 436-35-280(7). Claimant's permanent unscheduled disability under the standards is, therefore, 17 percent, as awarded by the Determination Order.

Scheduled Disability - Knee

The Referee increased claimant's scheduled disability award 4 percent over that awarded by the Determination Order. The insurer first argues that the Referee erred by comparing claimant's injured leg to a perfect leg rather than to claimant's uninjured leg to establish the basis from which to find loss of range of motion. The value given for claimant's lost range of motion in his right knee is based upon active degrees of motion. "It is compared to the degrees of motion possible in the contralateral normal joint, or to ranges of motion established by the American Medical Association." Former OAR 436-35-010(3); Don G. Cysewski, 42 Van Natta 890 (1990).

Claimant was able to flex his uninjured left knee 135 degrees, which establishes his normal range of flexion, and was able to flex his injured right knee 125 degrees. (Ex. 53-5). The 10 degree difference (10/135) is utilized to determine the proportional loss of the maximum value for loss of flexion in the knee. Here the value is 3.9 percent. Former OAR 436-35-220(1).

The insurer also argues that the Referee erred by assigning a value for a partial removal of the meniscus. Former OAR 436-35-230(4)(c) allows proportionate losses for less than a complete removal. The operation report indicates the "medial meniscus was trimmed using basket biters and a shaver." (Ex. 12-1). A trim is a partial removal and the Referee correctly assigned a value of 5 percent. Former OAR 436-35-230(4)(c).

The Referee incorrectly assigned a 5 degree (1 percent) value for loss of extension of claimant's right knee. The medical evidence indicates that claimant "hyperextends 5 degrees bilaterally." (Ex. 53.5). Hyperextension is overextension and claimant has not lost any motion.

Additionally, the Referee assigned a 5 percent value for atrophy pursuant to former OAR 436-35-230(5). However, the medical evidence indicates that claimant's "[m]uscle strength is good in the lower extremities. There is no evidence of weakness...muscle strength is felt to be good at the quadriceps and hamstrings." (Ex. 53-4, 53-5). The evidence does not establish atrophy and there should be no value assigned for loss of strength or atrophy.

We find the total rating for the knee by combining (not adding) the rating for decreased motion, 3.9 percent, with the value for the partial removal of the meniscus, 5 percent, for a total of 8.7 percent which is rounded up to 9 percent. Former OAR 436-35-220(4).

The Determination Order awarded 14 percent (21 degrees). Because the insurer has not requested a reduction of the Determination Order, we affirm the Determination Order.

ORDER

The Referee's order dated March 30, 1989 is reversed. The November 21, 1988 Determination Order is reinstated and affirmed.

In the Matter of the Compensation of
**RICHARD JOHNSON, Claimant**
WCB Case No. 88-20093
ORDER ON REVIEW
Hampson, et al., Claimant Attorneys
Rankin, et al., Defense Attorneys

Reviewed by Board Members Howell and Speer.

Claimant requests review of Referee Nichols' order which: (1) declined to grant permanent total disability; (2) increased claimant's unscheduled permanent disability for a hip injury from 59 percent (188.8 degrees), as awarded by prior Determination Orders, to 80 percent (256 degrees); and (3) affirmed prior Determination Order awards totalling 50 percent (75 degrees) scheduled permanent disability for loss of use or function of his left leg. In the alternative, claimant requests remand for further evidence taking and reconsideration. On review the issues are remand, extent of unscheduled and scheduled permanent disability, including permanent total disability. We reverse.

FINDINGS OF FACT

Claimant, who was 44 years old at the time of the hearing, injured his left hip and left lower extremity when his horse reared and fell on him. Claimant was working as a ranch hand at the time.

Subsequent to the compensable injury, claimant has had two complete hip arthroplasties which caused numerous, adverse side effects precipitating several subsequent surgeries including bone grafting and aspiration of septic organisms--a total of at least six surgical procedures on claimant's hip. (Ex. 99). Claimant had arthroscopic surgery on his left knee in 1982 and again in 1984, followed by complications requiring a third procedure when Staph epidermitis was found, leaving claimant with degenerative joint disease, secondary to the surgeries. (Ex. 99; Voc. Ex. 45).

At the time of injury, claimant also sustained a fractured left ankle which left residual problems and a fractured great toe which left a loss of function considered to be moderately severe. (Ex. 1, 4, 28, 58, 99). Claimant sustained a shortening of the left leg and significant loss of muscle mass in his left hip. (Ex. 99).

In 1988, the Orthopaedic Consultants found claimant to be over 82 percent disabled on his lower left side according to AMA Guidelines. (Ex. 99-7).

Until the accident, claimant had been a cowboy/ranch hand most of his employable years although he worked for a few months in a meat packing plant on the kill floor and a few months as a construction laborer. (Ex. 45). Claimant, due to his compensable injury, cannot return to work in these areas.

Subsequent to his compensable injury, vocational assistance began in 1979. (Voc. Ex. 1-13). Claimant consistently indicated to his vocational counselors that he was willing to seek employment and willing to relocate if necessary. As a vocational assistee, claimant was "above average on attendance/punctuality ... very willing and could probably best be described as 'steady.'" (Ex. 21). After the accident, claimant relocated and completed training as a bootmaker. Because of his physical limitations, claimant is not able to work fast enough making boots to make enough money to live on. Not from a lack of effort, claimant was unable to find work as a shoe repairman in communities within his geographical area (Eastern Oregon). (Ex. 42-2).

Although a high school graduate, claimant tested low in academic skills, especially in math and reading. (Ex. 43-10). Claimant, on his own volition after the accident, enrolled in adult educational classes to improve his reading and math skills which he followed through on for several years, only interrupted by surgeries. (Ex. 50) Claimant worked consistently to improve his English and mathematical skills. (Ex. 51-2).

To become employable, claimant would require substantial vocational rehabilitation because he possesses minimal residual transferable skills appropriate for training/employment within his physical capacity. (Ex. 45). Aptitude tests indicate that claimant would work best in an occupation dealing with objects rather than one which would require extensive work with people and/or large groups of people. (Ex. 43-6). In 1981 an aptitude test specifically indicated that claimant would not be an appropriate candidate for ortholist/prothetist training. (Ex. 43). To train as an ortholist/prothetist, claimant would have to take a basic anatomy class, which given his low academic scores, would have been too difficult for claimant. (Tr. 68 & 69). Dr. Fitch, M.D., reconstructive orthopedist, explained in 1988, that claimant could not physically meet the requirements of a copy machine repair person because claimant would not even be able to carry his tools. (Ex. 66-1). Other than the boot-making course, no other vocational training has been provided. At the time of the hearing, no suitable employment or training had been found for claimant. (Ex. 68; Tr. 63-72).

Claimant made reasonable efforts to seek regular, gainful employment. Additional efforts would have been futile. But for his compensable injury, claimant would be willing to make additional work search efforts.

## CONCLUSIONS OF LAW AND OPINION

### Remand

Claimant requests remand for "proper development" of vocational evidence. We may remand to the Referee if we find that the record has been "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(5). We find the evidence in the present case sufficient to review on the merits.

### Extent of Disability

The Referee found that claimant was not permanently and totally disabled. In making her determination, the Referee found that no medical report indicates that claimant is permanently and totally disabled and that claimant's efforts towards getting back into the work force have been less than optimal.

Claimant must prove by a preponderance of the evidence that he is permanently totally disabled. Harris v. SAIF, 292 Or 683 (1982). Although severely disabled, claimant is not totally incapacitated on a physical or medical basis alone. 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 be permanently and totally disabled due to a combination of his physical condition and certain nonmedical factors, such as age, education, work experiences, adaptability to nonphysical labor, mental capacity and emotional conditions. Clark v. Boise Cascade Co., 72 Or App 397 (1985).

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 be futile. See Butcher v. SAIF, 45 Or App 318 (1983). However, even if a work search would be futile, such a claimant must establish that he or she, but for the compensable injury, would have been willing to seek regular gainful employment. SAIF v. Stephen, 303 Or 41 (1989).

The medical evidence indicates that claimant is severely disabled as a consequence of the cumulative effect of his injuries and surgeries. Claimant cannot return to the work he had done for the 15 years prior to his injury, and is limited to sedentary work. The Orthopaedic Consultants wrote,

> "...(claimant) has a combination of problems which we choose to rate as impairment of the entire left lower extremity rather than rating each joint separately.... It is obvious that vocational placement will be quite difficult. He is only qualified for a sedentary position where he is able to control how much sitting and standing he does.... The prognosis for problems with the left hip and knee in the future are not good...." (Ex. 99-7, 99-8).

Claimant has minimal transferable skills appropriate for work within his physical capacities. During the ten years of vocational assistance, claimant has been willing and cooperative. However, vocational assistance has been unsuccessful. Vocational counselors have repeatedly ignored claimant's abilities and limitations and concentrated on inappropriate employment possibilities and training such as training to be an ortholist/prothetist, as a supervisor of mentally retarded adults, as a dental lab technician, and as a copy machine repair person (Ex. 43-7; 53-2; 55-2; 56-2, 66-1). Although a vocational counselor opined that claimant needed to improve his attitude towards looking for employment (Ex. 53-2), and at hearing speculated as to job availability for claimant, we conclude that claimant's attitude justifiably deteriorated and that his failure to continue to look for work was reasonable because further attempts would be futile. (Ex. 53-2, 53-4). Furthermore, job availability cannot be based on speculation. We are persuaded that claimant would be willing to seek regular, gainful employment, but for his compensable injury.

Taking into consideration claimant's age, education, work experience, adaptability to nonphysical labor and mental capacity, we conclude that claimant is permanently and totally disabled as a result of his compensable 1979 injury.

## ORDER

The Referee's order dated March 13, 1989 is reversed. In lieu of the Referee's increased award of unscheduled permanent disability, claimant is granted permanent total disability effective March 13, 1989, the date the hearing record closed. The insurer is permitted to offset permanent disability payments paid subsequent to that date against claimant's permanent total disability benefits. Claimant's attorney is awarded a fee equal to 25 percent of the increased disability compensation created by this order, payable by the insurer directly to claimant's attorney, except that total out-of-compensation fees awarded by the Referee and the Board shall not exceed $6,000.

In the Matter of the Compensation of
**GREGORY D. MARSHALL, Claimant**
WCB Case No. 88-18154
ORDER ON REVIEW
Francesconi & Associates, Claimant Attorneys
Cooney, et al., Defense Attorneys

Reviewed by Board Members Howell and Speer.

Claimant requests review of that portion of Referee Shebley's order that increased his award of unscheduled permanent disability for a low back condition from 6 percent (19.2 degrees), as awarded by Determination Order, to 12 percent (38.4 degrees). On review the issue is extent of unscheduled permanent disability. We affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

The Board adopts the Referee's "Conclusions of Law and Opinion," as supplemented by the following comments.

On review, claimant does not contest his award under the standards, but instead argues that there is clear and convincing evidence that he is entitled to a greater award of disability than contemplated by the standards. First, claimant contends that the Referee failed to give credence to vocational expert opinion that he is precluded from performing 84 percent of the jobs, in the two categories of laborer and marketing, for which he previously qualified. (Ex. 50). Claimant asserts that his occupational history of: warehouseman, painter, and bus driver, may be classified in the medium work range, however, these jobs require bending, stooping, and/or continuous sitting and thus he is precluded from performing them.

Next, claimant argues that the jobs he currently qualifies for would result in a loss in wages of about $4,000 per year. This figure is based on the highest paying job claimant has been offered since his injury. Finally, claimant asserts that his three years of college are misleading because his grades are so low. Consequently, even if he got his teaching degree, it is doubtful he would be employable in an academic area.

The Referee addressed all of claimant's "clear and convincing" arguments and concluded that it was not highly probable, nor had claimant produced extraordinarily persuasive evidence, that the standards yielded an inadequate award. We concur with this determination.

We conclude that claimant's age, education, training, adaptability and skills have all been taken into consideration under the Referee's application of the standards. Therefore, those factors do not necessarily constitute clear and convincing evidence under ORS 656.283(7) that claimant was not adequately compensated. See Henry H. Stinnett, 42 Van Natta 1187 (1990).

In Richard L. Sproul, 42 Van Natta 1516, 1518 (1990), we recently held that a claimant's physical capacity to do certain work and the corresponding limitations caused by the compensable injury are already considered under a standards analysis and "do not equate to additional disability." Here, claimant's residual functional capacity restrictions were already rated and thus

do not, in and of themselves, constitute clear and convincing evidence of additional impairment.

We are also not convinced by claimant's contention that he is precluded from performing 84 percent of two categories of jobs for which he was previously qualified. In determining disability, we consider the broad range of occupations available in the labor market. Earning capacity is based upon not only the number of jobs a worker can perform, but also upon such factors as wages, number of hours/days worked, availability of jobs in the worker's hypothetical labor market, etc. See Goldie M. Ames, 42 Van Natta 1657 (1990). Furthermore, a private rehabilitation consultant stated that it is not accurate to assume claimant will experience a long term or permanent loss of earning capacity as he makes the adjustment to light and modified medium work. (Ex. 51). There are in fact jobs with claimant's current employer that could be performed by claimant without violating his medical restrictions. (Tr. 24).

Finally, we fail to see how claimant's poor college grades and arguably low prospects for teaching academic subjects in elementary school is clear and convincing evidence that claimant has additional disability outside the standards. The Referee did not find claimant more adaptable because of this additional schooling. In fact, the Referee agrees that claimant would probably only qualify for physical education instruction and should concentrate his job search in warehouse work in the light to medium range. (Order, p. 4).

Furthermore, claimant's "standards" rating is not affected one way or the other by the fact that he has completed three years toward an elementary school teaching degree. Under OAR 436-35-300(3)(a), claimant would not get a value for formal education anyway because he has a high school degree. Also, the Referee did not consider the college work as additional "training" under OAR 436-35-300(5), because he concluded "[t]here is no documentation demonstrating competence in any specific vocational pursuit." (Order, p. 5). Accordingly, we are not persuaded that claimant's poor college grades and speculative low prospects for obtaining a teaching job in the future yield an inadequate award of current disability under the standards.

ORDER

The Referee's order dated May 17, 1989 is affirmed.

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September 19, 1990 Cite as 42 Van Natta 2023 (1990)

In the Matter of the Compensation of
**ALLEN C. MOORE, Claimant**
WCB Case Nos. 88-06009, 88-06008, 88-04898 & 88-04897
ORDER ON REVIEW
Brian R. Whitehead, Claimant Attorney
Stafford Hazelett, Defense Attorney
Garrett, et al., Defense Attorneys

Reviewed by Board Members Howell and Perry.

Country Companies Northwest requests review of that portion of Arbitrator Michael Johnson's order that awarded an insurer-paid attorney fee for services rendered in this responsibility case. On review, the issue is attorney fees. We affirm.

FINDINGS OF FACT

Claimant compensably injured his right knee in October 1981 while working for Country Companies' insured. Sometime thereafter, the employer changed its workers' compensation coverage from Country Companies to Liberty Northwest Insurance Corporation. Subsequent to this change in coverage, claimant was involved in an industrial accident in December 1987 and he filed an aggravation claim against Country Companies, as well as a "new injury" claim against Liberty Northwest.

In February 1988, Country Companies issued a denial of responsibility for an aggravation of a right knee injury. In March 1988, Liberty Northwest also denied responsibility. An order issued designating a paying agent pursuant to ORS 656.307 on March 28, 1988. Subsequently, the present arbitration proceeding was held before Referee/Arbitrator Johnson who issued an order setting aside Country Companies' denial and upholding Liberty Northwest's denial. The Arbitrator also ordered Country Companies to pay claimant's attorney fees. On reconsideration, the Arbitrator adhered to his original decision pertaining to the attorney fee award.

Claimant's attorney participated in extensive prehearing preparation, as well as a moderately lengthy hearing and two post-hearing depositions. Counsel also submitted written closing arguments and responded to evidentiary objections arising out of both depositions. Through claimant's direct examination at the arbitration proceeding, claimant's attorney presented factual evidence necessary for the determination of the responsibility issue. Claimant's attorney developed and submitted medical evidence which was relied on at hearing and during the deposition. Throughout the appeal, claimant's attorney took the position that Country Companies' responsibility denial should be overturned, as this was an aggravation of the old injury.

CONCLUSIONS OF LAW AND OPINION

The sole issue on review is whether claimant's attorney "actively and meaningfully" participated in the responsibility arbitration proceeding under ORS 656.307(5), so as to entitle him to an attorney fee. Subsection (5) provides that:

> "[t]he claimant shall be joined in any proceeding under this section as a necessary party, but may elect to be treated as a nominal party. If the claimant appears at any such proceeding and actively and meaningfully participates through an attorney, the arbitrator may require that a reasonable fee for the claimant's attorney be paid by the employer or insurer determined by the arbitrator to be the party responsible for paying the claim."

In a recent case, Daniel J. Bergman, 42 Van Natta 946 (1990), we interpreted subsection (5) and found "active and meaningful" participation in an arbitration proceeding where the claimant's attorney filed a new injury claim, requested a hearing, prepared for hearing, and submitted exhibits.

Here, the Arbitrator concluded that, "[c]laimant actively and meaningfully participated through his attorney. * * * Said attorney participated in an extensive pretrial preparation, a moderately lengthy hearing, two post-hearing depositions, submission of written closing arguments, and responded to evidentiary objections arising out of each deposition." (Arb. Decision, 6). We concur that the participation described is active and meaningful within the meaning of the statute.

Country Companies argues that because this was a responsibility arbitration, with neither insurer denying compensability, the claimant's entitlement to benefits was not in jeopardy. Also, because there was a paying agent pursuant to ORS 656.307, claimant's attorney's participation was not required or necessary for claimant to have continuation of benefits. Finally, Country Companies asserts that claimant's attorney "pointed the finger" at the employer who had the lower rate of temporary disability benefits and thus "[c]laimant's attorney can hardly be found to have 'actively participated' in procuring or even protecting something of value to the claimant." (Appellant's Brief, p. 7). "If anything, claimant's attorney's participation in the responsibility case between Country Companies and Liberty Northwest actually resulted in a disservice to the claimant, as the claimant received a lower time loss benefit." (Reply Brief, p. 2). We are not persuaded by this analysis.

Recently, in Jean Novotny, 42 Van Natta 1060 (1990), we acknowledged that the questioning of a witness at hearing was active participation; however, such participation was not found "meaningful" because the attorney had not contended that any particular insurer was the responsible party. Thus, the attorney participation in Novotny was not "meaningful" because it did not go to the ultimate issue of the hearing. Id. Unlike Novotny, here, claimant's attorney did successfully argue that a particular insurer (Country Companies) was responsible and he actively participated in resolving the ultimate "responsibility" question. In fact, Country Companies asserts that claimant's attorney, by "pointing the finger at them," was instrumental in claimant getting a lower temporary disability rate. This assertion implies that the insurer believes claimant's attorney contributed to the ultimate decision of the arbitration hearing.

The participation of claimant's attorney was not nominal. His involvement in the resolution of the arbitration proceeding was more extensive than the attorney participation found in either Bergman, supra, or Novotny, supra. We hold that claimant's attorney's participation was "active and meaningful" and accordingly, we affirm the Arbitrator's order.

Claimant's counsel seeks the award of an assessed attorney fee for services on Board review. However, claimant is not entitled to an attorney fee for defending against the attorney fee issue. Saxton v. SAIF, 80 Or App 631 (1986); Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The Referee's order dated January 19, 1989, as reconsidered February 9, 1989, is affirmed.

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In the Matter of the Compensation of
**PABLO C. PACHECO, Claimant**
WCB Case No. 88-22492
ORDER ON REVIEW
Black, et al., Claimant Attorneys
Tom Dzieman (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

Claimant requests review of Referee Brown's order which affirmed a Determination Order that awarded no unscheduled permanent disability for a low

back injury. On review the issue is extent of unscheduled permanent disability, if any. We affirm.

## FINDINGS OF FACT

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

Dr. Kho, neurologist, concluded that claimant's signs and symptoms of pain were probably attributable to a conversion disorder. Claimant has never had a psychological work-up and the diagnosis of conversion disorder was not made by either a psychologist or psychiatrist.

Dr. Pederson, chiropractor, observed that claimant's extreme complaints of soft tissue pain (myalgia, myofibrositis, or myofascial pain syndrome) were very exaggerated and not supported by anatomical evidence.

## CONCLUSIONS OF LAW AND OPINION

The Board adopts the Referee's "Opinion" with the following comments.

The Referee made a finding that claimant had "disabling pain due to conversion disorder." However, the Referee did not give a permanent disability award for pain because he felt the pain did not result in measurable impairment. We concur that claimant has not proven he has a measurable impairment due to pain.

Disabling pain is ratable where it results in permanent loss of use or function. Former OAR 436-35-320(1)(a); Daniel M. Alire, 41 Van Natta 752 (1989). Here, the diagnosis of a pain disorder is made by a neurologist who attributes claimant's pain to a conversion reaction which, under OAR 436-35-400(4), is a form of psychoneurosis. Under OAR 436-35-400(4), a permanent state of psychoneurosis must be diagnosed by a psychologist or psychiatrist and claimant has never had a psychological evaluation. The only other evidence of claimant's pain is a report by a chiropractor who describes an exaggerated soft tissue pain that is unsupported by any anatomical findings. We hold that there is no medical basis for measuring or rating claimant's alleged disabling pain because the diagnosis of "conversion reaction" is not established by psychological evidence. Furthermore, claimant has not proven a physical cause for his alleged disabling pain. Accordingly, we affirm the Referee's determination that claimant has proven no permanent impairment due to low his back injury.

## ORDER

The Referee's order dated May 18, 1989 is affirmed.

In the Matter of the Compensation of
**ORVILLE F. PARKER, Claimant**
WCB Case Nos. 88-13368 & 87-04318
ORDER ON REVIEW
Burt, et al., Claimant Attorneys
Gail M. Gage (Saif), Defense Attorney
Gary Jones, Defense Attorney

Reviewed by Board Members Howell and Perry.

Claimant requests review of Referee Higashi's order that: (1) affirmed a March 26, 1986 Determination Order award of 40 percent (128 degrees) unscheduled permanent disability for a low back injury; and (2) affirmed a September 13, 1988 Determination Order award of 40 percent (128 degrees) unscheduled permanent disability for a low back injury. On review, the issue is extent of permanent disability, up to and including permanent total disability. We affirm.

FINDINGS OF FACT

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

Claimant is 60 years old. He has a high school degree but has no documented training in a specific vocation. For the past ten years, claimant has been employed as a safety supervisor and a long-haul truck driver. Claimant's highest SVP for the past ten years is 4 as a long-haul truck driver.

Before his 1987 injury, claimant was performing work in the heavy category. Claimant was released to light work but has not returned to work.

CONCLUSIONS OF LAW AND OPINION

The Board adopts the Referee's "Opinions and Conclusions," with the following supplementation.

Permanent Total Disability

The Referee concluded that, under the odd lot doctrine, claimant was not permanently and totally disabled. The Referee found that claimant had not sought work and that there would be jobs that claimant could perform. The Referee relied upon the testimony of a vocational expert, Mr. McNaught, who attended the hearing and viewed the surveillance tapes offered by the SAIF Corporation. Based upon his observation of the tapes and the testimony at hearing, Mr. McNaught testified that there would be a number of unskilled jobs available to claimant.

Although we agree that claimant has not sought work and that it would not be futile for him to do so, we do not rely upon that portion of the Referee's order which incorporated Mr. McNaught's opinion. We conclude that, as there is no evidence that the surveillance tapes were disclosed to claimant in advance of the hearing, the tapes may be considered only for purposes of impeachment. See OAR 438-07-017.

Because we agree with the Referee's conclusion that claimant was impeached by the surveillance tapes, we are not persuaded by the opinion of his vocational counselor who concluded that "assuming claimant is credible," he believed that claimant's limitations would preclude him from working. Additionally, we do not rely on the opinions of Drs. Buza and Renholds, who relied upon claimant's complaints of pain in their assessment of his physical impairment.

We conclude that claimant has not shown that, under the odd-lot doctrine, his physical impairment has combined with his age, education and training to render him permanently and totally disabled.

1986 Determination Order

The Referee concluded that, because he had found that claimant was not credible, he could not rate claimant's impairment or rely upon his reports of pain and limitations. For purposes of the 1986 Determination Order, in rating the extent of claimant's unscheduled permanent disability, we consider his loss of earning capacity and physical impairment attributable to the compensable injury, along with the relevant social and vocational factors set forth in OAR 436-30-380 et seq. We apply these rules as guidelines, not as restrictive mechanical formulas. Harwell v. Argonaut Insurance Co., 296 Or 5050, 510(1984).

As we have accepted the Referee's finding that claimant is not credible, we are unable to rely on the reports of claimant's doctors who have based their opinions on his history and complaints of pain and limitations. For example, Dr. Buza reports that "because of his complaints of back pain, claimant's activity is limited to at least 25 percent of the whole person." Dr. Renholds has reported that claimant is severely debilitated, i.e., that he is only able to walk with a walker.

After considering that portion of claimant's impairment established by the record and the relevant social and vocational factors set forth in OAR 436-30-380, et seq, we conclude that claimant has failed to prove that the extent of his disability is greater than the 40 percent awarded by the 1986 Determination Order.

1988 Determination Order

The Referee also declined to increase the amount of unscheduled permanent disability awarded by the 1988 Determination Order. We agree for the following reasons.

The Determination Order issued September 13, 1988. Therefore, the "standards" adopted effective July 1, 1988 (former OAR 436-35-001 et seq), as amended by temporary rules effective August 19, 1988, apply to the rating of claimant's permanent partial disability. Former OAR 436-35-270 through 436-35-440 apply to the rating of unscheduled permanent partial disabilities. Former OAR 436-35-270(1). Accordingly, on review, these are the standards which we apply.

The standards provide that "there shall be no unscheduled disability if the injury did not result in impairment." Former OAR 436-35-280(1). In the present case, Dr. Holmes, M.D., opined that claimant's functional overlay inhibited his examination. Claimant's other doctors relied upon his subjective reports of pain and limitations in rating his disability. As explained above, due to claimant's lack of credibility, we are unable to rely upon the impairment findings in the record. We also agree that a value for pain cannot be assigned, based upon claimant's testimony. Claimant is, therefore, entitled to no impairment value under the "standards" and no permanent disability may be awarded. However, because SAIF has not requested the reduction of claimant's award, the Referee's order shall not be disturbed.

ORDER

The Referee's order dated May 22, 1989, as amended by his May 26, 1989 order, is affirmed.

In the Matter of the Compensation of
**CHARLES L. PRATT, Claimant**
WCB Case No. 89-01048
ORDER ON REVIEW
Vick & Gutzler, Claimant Attorneys
Employers Defense Counsel, Defense Attorneys

Reviewed by Board Members Myers and Gerner.

The insurer requests review of that portion of Referee Baker's order which required it to pay for medical services. Claimant cross-requested review of that portion of the Referee's order which found a seizure disorder not compensable. However, in his respondent's brief, claimant withdrew his cross-request. Claimant also moves to strike the insurer's reply brief on the basis that it raised new issues not raised in the opening brief. On review, the issues are medical services and appellate procedure. We deny the motion to strike and reverse on the merits.

MOTION TO STRIKE

Claimant seeks to have the insurer's reply brief stricken from the record because it raises new issues not raised in the opening brief. If a reply brief raises issues that have not been raised before that time, those issues will not be considered. See Richard C. Centeno, 41 Van Natta 619, 620 (1989). In this case, the reply brief merely makes a different factual argument on the same issue raised in its opening brief. The reply is in response to claimant's respondent's brief. Since no new issues were raised, the motion to strike will be denied.

FINDINGS OF FACT

Claimant suffered a compensable disabling injury to his neck on November 6, 1986. He has undergone two surgeries on his neck. Claimant has had episodes of severe spasms and pain in his neck.

On October 16, 1988, claimant had a loss of consciousness episode for which he was taken to the hospital by ambulance. Tests were run, treatment rendered, and claimant was hospitalized on account of this loss of consciousness episode.

Claimant's loss of consciousness was due to a seizure disorder that was not caused by or related to his compensable injury. The medical services rendered in connection with the October 16, 1988 loss of consciousness episode were for the evaluation and treatment of the seizure disorder.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant had not proven that his seizure disorder was materially related to his compensable injury. We agree and claimant does not contest this. The Referee, however, found that because claimant had neck pain at the time of his loss of consciousness, and it could have been a fainting spell due to his neck pain, he was entitled to have his medical bills paid on a diagnostic basis. We disagree.

Diagnostic services are compensable when claimant can show that they are necessary to determine if a causal relationship exists between a compensable injury and a condition that requires treatment. Clifford D. Howerton, 38 Van

Natta 1425 (1986). Claimant must show reasonable necessity of diagnostic treatment by a preponderance of the evidence. Myrtle L. Thomas, 35 Van Natta 1093 (1983).

In this case, a diagnosis of a seizure disorder was made at the time of the first treatment for the loss of consciousness episode. The diagnosis did not change. The testing undertaken was not to determine the diagnosis of a seizure disorder, the causation of the diagnosed seizure disorder, nor the disorder's relationship to claimant's compensable injury. Rather, the testing was merely to determine the extent of the seizure disorder so that it could be effectively treated. The remainder of the medical services rendered as a sequela of the loss of consciousness episode were for the treatment of the seizure disorder, and would have had to have been rendered for that disorder regardless of the existence of the compensable injury. Accordingly, we conclude that the services rendered for the October 16, 1988 loss of consciousness episode were for the unrelated seizure disorder and not diagnostic medical services related to claimant's compensable injury.

ORDER

The Referee's order dated July 31, 1989 is affirmed in part and reversed in part. That portion of the order that required the insurer to pay for claimant's medical services on a diagnostic basis is reversed. The Referee's award of a $900 assessed attorney fee is reversed. The remainder of the order is affirmed.

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In the Matter of the Compensation of
**KATHY J. RICHARD, Claimant**
WCB Case No. 89-02363
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Stafford Hazelett, Defense Attorney

Reviewed by Board Members Brittingham, Nichols and Crider.

Claimant requests review of Referee Thye's order that: (1) dismissed claimant's hearing request concerning a November 10, 1988 denial of acupuncture treatments as untimely; (2) upheld the insurer's December 14, 1988 denial of claimant's medical services claim for acupuncture treatment; and (3) declined to assess penalties and attorney fees for an alleged unreasonable denial. On review the issues are timeliness of hearing request, 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".

FINDINGS OF ULTIMATE FACT

Claimant's hearing request was not filed within 60 days of the November 10, 1988 denial. She did not have good cause for the delay in filing the request.

The insurer's December 14, 1988 denial prospectively denied future treatment for an accepted condition.

There are no amounts due for the period covered by the December 14, 1988 denial. The denial was not a resistance to the payment of compensation.

## CONCLUSIONS OF LAW AND OPINION

### Timeliness of Hearing Request

The Referee found that claimant had not shown "good cause" for her failure to request a hearing within 60 days of the November 10, 1988 denial. We agree.

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 she has shown "good cause" for late filing because, after receiving the November 10, 1988 denial by regular mail, she phoned the insurer's claims examiner in the belief that she had to receive a denial by certified mail. In response to that call, the examiner sent and claimant received the December 14, 1988 denial, which she interpreted to be a supplement to the November 10, 1988 denial, which allowed her 60 days from December 14, 1988 to file a request for hearing.

There is neither an allegation nor any evidence that claimant was misled by the insurer to believe that the 60-day appeal period from the November 10, 1988 denial would be extended by the December 14, 1988 denial. Although claimant's illness prevented her from picking up the certified letter, we are unpersuaded that the illness or any other event interfered with her timely filing of a request for hearing. To begin, claimant admits that she received a copy of the November 10, 1988 denial by direct mail. Moreover, claimant appears to have merely relied on her interpretation, which proved incorrect. This lack of diligence did not constitute "good cause." See Cogswell v. SAIF, 74 Or App 234 (1985); Cary O. Miller, 42 Van Natta 618 (1990).

### Medical Services

The Referee considered the December 14, 1988 denial to be invalid insofar as it purported to deny future treatment, yet found that it could be construed to deny payment of any acupuncture treatments between November 10, 1988 and December 14, 1988. He concluded the denial was valid insofar as it denied compensability of acupuncture treatment rendered prior to its date. Inasmuch as there were no unpaid billings between November 10, 1988 and the date of hearing, we disagree.

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 this case, the December 14, 1988 denial stated that pursuant to OAR 436-10-040(4)(a), Dr. Hung had failed to provide a completed written treatment plan, and continued: "Therefore, without waiving any further questions of compensability, we must deny your request for further treatment from Dr. Hung."

Such a denial is an impermissible denial of future treatments. Accordingly, it shall be set aside.

Penalty and Attorney Fee

Claimant argues that a penalty and attorney fee should be assessed on the basis that the insurer's denial of December 14, 1988 was unreasonable. Assuming for the sake of argument that the denial was unreasonable, there are no outstanding billings for the period covered by the denial. Therefore, there are no "amounts due" on which to base a penalty. Ellis v. McCall Insulation, 308 Or 74 (1989); Lloyd L. Cripe, 41 Van Natta 1774 (1989). Moreover, since there was no unreasonable resistance to the payment of compensation, an attorney fee is not assessable. Ellis, supra, and Cripe, supra.

ORDER

The Referee's order dated May 17, 1989 is affirmed in part and reversed in part. Claimant's request for a hearing on the November 10, 1988 denial is dismissed. The insurer's denial of December 14, 1988 is set aside. For services at hearing and on review concerning the prospective denial, claimant's attorney is awarded an assessed fee of $1,000, to be paid by the insurer.

**Board Member Crider, dissenting:**

I agree with the majority's ruling regarding claimant's untimely hearing request and the insurer's prospective denial of acupuncture treatment for claimant's compensable face, neck and jaw injury. I also agree there are no amounts due on which to base a penalty for the insurer's prospective denial. However, unlike the majority, I conclude the insurer's denial was an unreasonable resistance to the payment of compensation so that claimant is entitled to a penalty-related attorney fee under ORS 656.382. See Ellis v. McCall Insulation, 308 Or 74 (1989).

The denial was issued before the decision in Evanite Fiber Corporation v. Striplin, 99 Or App 353 (1989), on which the majority relies in finding the denial improper. However, the denial was equally improper under existing case law at the time of the denial. See Bowser v. Evans Product Company, 270 Or 841 (1974); Wait v. Montgomery Ward, Inc., 10 Or App 333, 338 (1972); Thomas A. Beasley, 37 Van Natta 1514 (1985). In light of this case law, the denial was unreasonable.

The denial was a resistance to the payment of compensation. The condition for which claimant receives acupuncture treatment is compensable. The insurer's prospective denial purported to cut off compensation for the condition. Even if a prospective denial is not a bar to future services, the denial effectively discourages claimant from filing future claims for such treatment that may well be compensable. This constitutes resistance to the payment of compensation.

Accordingly, claimant is entitled to a penalty-related attorney fee for establishing the unreasonableness of the prospective denial. I, therefore, dissent from the majority's contrary holding.

In the Matter of the Compensation of
**LUZ E. RODRIGUEZ, Claimant**
WCB Case No. 89-04776
ORDER ON REVIEW
Dahn & Morrison, Claimant Attorneys
Kenneth Russell (Saif), Defense Attorney

Reviewed by Board Members Crider and Nichols.

The SAIF Corporation requests review of Referee Mills' order that granted claimant permanent total disability, whereas a Determination Order had awarded 81 percent (259.2 degrees) unscheduled permanent disability for a right shoulder and back condition. On review, the issue is extent of permanent disability, including permanent total disability. We reverse.

## FINDINGS OF FACT

Claimant, 41 years of age at the time of hearing, compensably injured her right shoulder on September 9, 1985 when attempting to lift plants. She subsequently underwent a Neer acromioplasty. Claimant has been diagnosed as suffering from adhesive capsulitis in her right shoulder.

After the surgery, claimant continued to have shoulder pain. On October 23, 1985, Dr. Neitling, M.D., reported that claimant complained of pain in the base of her neck. In April 1986, Dr. Neitling reported that claimant complained of pain in the low thoracic region. On August 11, 1986, Dr. Neitling noted that claimant complained of pain in her right arm, and, on September 15, 1986, noted that this pain radiated into claimant's right hand. On January 30, 1987, the Orthopaedic Consultants noted that claimant complained of pain in her right leg.

A Determination Order issued on November 12, 1987, awarding 50 percent unscheduled permanent disability. A March 1, 1988 Stipulation affirmed this award.

A second Determination Order issued on December 15, 1988, increasing claimant's award to 81 percent unscheduled permanent disability.

## FINDINGS OF ULTIMATE FACT

Claimant's condition has not permanently worsened since March 1, 1988.

## CONCLUSIONS OF LAW AND OPINION

The Referee found that SAIF had conceded that claimant's condition worsened since November 12, 1987 when it reopened claimant's claim by stipulation of August 3, 1988. The Referee then found that claimant's physical impairment, together with other factors relevant under the "odd lot" doctrine, prevent her from selling her services in a competitive labor market. He held that claimant is therefore permanently and totally disabled. On review, SAIF argues that claimant has not proved a permanent worsening of her condition and is therefore not entitled to an award of unscheduled permanent partial disability greater than the 50 percent awarded by the November 12, 1987 Determination Order.

In order to receive an increased award of permanent disability, claimant must establish that her compensable condition has permanently worsened since the last arrangement of compensation, which in this case is the March 1, 1988 stipulation which affirmed the 50 percent permanent disability awarded by the November 12, 1987 Determination Order. Stepp v. SAIF, 304 Or 375 (1987).

We agree with SAIF's contention that claimant's condition has not permanently worsened since the last arrangement of compensation on March 1, 1988. After examining claimant on March 21, 1988, the Orthopaedic Consultants found extreme oversomatization of claimant's symptoms. The Consultants diagnosed psychological pain factors blocking claimant's recovery. They did not relate claimant's psychological factors to her compensable injury.

Claimant argues that a worsening of her condition is established by a comparison of the Consultants' range of motion findings of claimant's right shoulder in their September 1987 and March 1988 examinations. While claimant appeared to have less range of motion of her right shoulder in the Consultants' second examination, they reported severe interference in the second examination to the point of making it unreliable. We therefore are not persuaded that claimant's ability to move her shoulder has diminished since the last arrangement of compensation.

It would appear that claimant's ability to work has not changed. She was able to do light work both before and after the last arrangement of compensation. Claimant was evaluated at the Northwest Pain Center on June 3, 1987. She could sit for one hour, stand for 10 to 15 minutes, stand and move for three hours at a time and lift 5 to 10 pounds. After the last arrangement of compensation, on January 18, 1989, Dr. Gray opined that claimant's symptoms were subjective and she could do light work.

Claimant's physical capacities were evaluated on September 15 and 16, 1988, at the Tuality Work Return Program. Ms. Pappagianis, O.T.R., included a physical capacities and restrictions form in her report with hesitancy because she felt that it was not a true reflection of claimant's maximum capacities. She stated that ascertaining claimant's true capacities was not possible based on claimant's inability to complete an evaluation thoroughly secondary to her pain complaints.

For these reasons, we are unpersuaded that claimant's physical condition has permanently worsened or her ability to work has been permanently diminished since March 1, 1988. Assuming, however, that claimant is less able to work, we are not persuaded that the worsening is due to the compensable injury.

Dr. Thompson, orthopedic surgeon, opined on September 28, 1988 that claimant's condition had not worsened since the time he last saw her in November 1986. Thompson stated that claimant's subjective complaints far exceed her objective findings and that those complaints are totally unrelated to the industrial injury. He concluded that claimant's inability to work was due to psychosocial factors. Drs. Gray and Berkeley concurred with Dr. Thompson's conclusions.

This evidence convinces us that the source of claimant's increased complaints is psychological in nature. There is no evidence that claimant's psychological problems are related to her compensable industrial injury. Therefore, we find that claimant has not shown that her compensable condition has permanently worsened since the last arrangement of compensation. Accordingly, the Referee's order and the December 15, 1988 Determination Order are reversed to award claimant no additional permanent disability and her total award shall remain at 50 percent unscheduled permanent disability.

The Referee concluded SAIF had conceded to a permanent worsening of claimant's condition when it reopened his claim. In her brief, claimant makes a similar argument that, under Bauman v. SAIF, 295 OR 788 (1983), SAIF's reopening of her claim by stipulation of August 3, 1988, precluded it from denying that her condition has permanently worsened. We disagree.

By the stipulation, the parties simply agreed that the claim would be reopened. A claim must be reopened for aggravation whenever there is a worsening of a workers' compensable condition making him less able to work--either temporarily or permanently. Smith v. SAIF, 302 Or 396 (1986). Thus, SAIF's agreement to reopen did not necessarily amount to a concession that the worsening was permanent. Moreover, there is nothing in the language of the stipulation to support the conclusion that SAIF stipulated a permanent worsening of claimant's condition. Since SAIF did not deny a previously accepted condition, claimant's citation to Bauman, supra, is irrelevant.

ORDER

The Referee's order dated July 30, 1989 is reversed. The Determination Order dated December 15, 1988 is modified to award no permanent disability in addition to the 50 percent (160 degrees) unscheduled permanent disability awarded by the November 12, 1987 Determination Order and agreed to by the March 1, 1988 stipulation. The Referee's award of a $500 assessed attorney fee is reversed.

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September 20, 1990 Cite as 42 Van Natta 2035 (1990)

In the Matter of the Compensation of
**RICHARD R. BOATSMAN, Claimant**
WCB Case Nos. 89-03776 & 89-03775
ORDER ON REVIEW
Robert J. Guarrasi, Claimant Attorney
Kevin L. Mannix, Defense Attorney

Reviewed by Board Members Cushing and Gerner.

Claimant requests review of that portion of Referee Myzak's order that increased claimant's unscheduled permanent disability award for a low back injury from 10 percent (32 degrees) to 11 percent (35.2 degrees). The self-insured employer cross-requested review of that portion of the Referee's order that denied its motion to suspend the issuance of the Referee's Opinion and Order and reopen the hearing record for the taking of additional evidence. However, in its respondent's brief, the employer withdrew its cross-request for review. Consequently, in conducting our review and reaching a decision on the merits, the cross-request has not been considered and is dismissed. On review, the sole issue is extent of unscheduled permanent disability. We modify.

Motion to Strike - Attorney Fee

The employer moves to strike that portion of claimant's reply brief, which responded to the employer's cross-request and requested a carrier-paid attorney fee for prevailing on an "abandoned" issue. The motion to strike is granted.

The employer withdrew its cross-request for review in its respondent's brief. Therefore, claimant improperly responded to the withdrawn issue in his reply brief. Consequently, we grant the motion to strike that portion of the reply brief responding to the issue withdrawn from Board review.

Claimant seeks an attorney fee for prevailing on the withdrawn cross-request. However, when a request for review is dismissed prior to a decision on the merits, there is no entitlement to an attorney fee under ORS 656.382(2). Terlouw v. Jesuit Seminary, 101 Or App 493 (1990).

Here, the issue was properly withdrawn from Board consideration by the employer's respondent's brief. Moreover, the withdrawn issue did not address claimant's right to compensation. Finally, claimant did not finally prevail on the issue on Board review. Consequently, no carrier-paid fee is awarded under ORS 656.382(2).

## FINDINGS OF FACT

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

Claimant was awarded 10 percent unscheduled permanent disability for a prior compensable 1982 low back injury by a December 28, 1984 Opinion and Order. That order was not appealed. At the time of the October 1984 hearing, claimant credibly testified that even though he had returned to his regular work, his performance of that position was modified to accommodate his ongoing pain associated with lifting and bending. (Ex. 16). Since the date of hearing, and monthly through September 1985, claimant continued to be treated for ongoing low back pain, the severity of which remained constant. (Ex. 1A).

There is no medical evidence in the record regarding claimant's physical condition between September 1985 and claimant's subsequent 1987 compensable low back injury.

## CONCLUSIONS OF LAW AND OPINION

### Extent of Unscheduled Permanent Disability

The Board adopts the Referee's "Opinion and Conclusions of Law" with the following supplementation.

Claimant has failed to establish that he has regained any of his lost earning capacity resulting from his previous compensable 1982 low back injury. The mere fact that claimant returned to his regular work is not sufficient to conclude that by doing so, claimant regained any of his lost earning capacity. In fact, at the time of claimant's subsequent compensable 1987 low back injury, claimant was still working for the same employer in the same position with the same restrictions due to the earlier low back injury. Consequently, we conclude that claimant has failed to establish that he regained some of his lost earning capacity prior to his June 1987 injury. Under such circumstances, claimant's prior award has been considered in determining this award for this injury. ORS 656.222; Thomason v. SAIF, 73 Or App 319, 322 (1985).

## ORDER

The Referee's order dated June 23, 1989 is affirmed.

In the Matter of the Compensation of
**JAMES B. LAKE, Claimant**
WCB Case Nos. 89-02408, 89-02407, 89-02455 & 89-02454
ORDER ON RECONSIDERATION
Malagon, et al., Claimant Attorneys
Employers Defense Counsel, Defense Attorney
Merrily McCabe (Saif), Defense Attorney

Claimant has requested reconsideration of that portion of our August 27, 1990 order that declined to award an assessed fee for services rendered on review. In our order, we set aside Liberty Northwest's denial of claimant's new injury claim for his low back condition, and upheld the SAIF Corporation's denial of claimant's aggravation claim for the same condition. Claimant contends he is entitled to an assessed fee because he submitted a brief on review supporting the ultimately prevailing position on the responsibility issue. We disagree.

Claimant is not entitled to a fee under ORS 656.382(2) or ORS 656.386(1). Neither the right to compensation nor the amount of compensation was at risk on review. A ".307 order" had issued in the matter, and the sole issue on review was responsibility. See Howard v. Willamette Poultry, 101 Or App 584 (1990). Moreover, the party that sought review, Liberty Northwest, had the lower temporary disability rate. Had it prevailed in establishing that SAIF was responsible, claimant's compensation would have been increased, not disallowed or reduced. Under these circumstances, claimant's attorney is not entitled to a carrier-paid fee for services on Board review. Mercer Industries v. Rose, on recon 103 Or App 96 (1990); Curtis R. Key, 42 Van Natta 183 (1990).

Accordingly, our August 27, 1990 order is abated and withdrawn. On reconsideration, the Board adheres to and republishes its former order, effective this date.

IT IS SO ORDERED.

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In the Matter of the Compensation of
**DALE A. MILLER, Claimant**
WCB Case No. 89-02445
ORDER ON REVIEW
Vick & Gutzler, Claimant Attorneys
Shelly McIntyre (Saif), Defense Attorney

Reviewed by Board Members Crider and Brittingham.

Claimant requests review of Referee Neal's order that: (1) found that claimant's 1987 right ankle injury claim was not prematurely closed; and (2) upheld the SAIF Corporation's denial of further responsibility for claimant's right ankle condition. On review, the issues are premature claim closure and responsibility. We reverse.

FINDINGS OF FACT

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

On March 29, 1989, SAIF denied responsibility for further medical care and disability for claimant's right ankle condition on the ground that claimant's employment at Big O Tires had independently contributed to a worsening of the compensable ankle condition.

Claimant's compensable 1987 right ankle injury is symptomatically aggravated with activity and relieved by rest. Claimant's activity in January 1989 caused a symptomatic worsening of the ankle injury to the point that he was unable to work as of January 14, 1989.

FINDINGS OF ULTIMATE FACT

At the time the claim was closed, claimant's right ankle disability was expected to improve with time and rest.

Claimant's work activities with Big O Tire did not independently contribute to a worsening of claimant's compensable right ankle injury.

CONCLUSIONS OF LAW AND OPINION

Big O Tire has accepted claimant's worsened ankle condition as a new injury. Claimant, however, contended at hearing that his work activities at Big O Tire did not independently contribute to a worsening of his condition and, thus, that responsibility should remain with SAIF, as the insurer responsible for the 1987 injury. If that is true, then claimant's preclosure worsening also requires that we set aside the closure as premature.

The Referee found that claimant's work activity at Big O Tire independently contributed to the January 14, 1989 worsening of claimant's underlying ankle condition. Like the Referee, we rely solely on the reports of Dr. Rusch. He has treated claimant since July 1987, and he is the only physician who has rendered an opinion relevant to the responsibility issue.

Dr. Rusch's efforts to respond to the parties' demands for opinions cast in language carrying precise meaning in the legal context are not entirely clear. Thus, SAIF, as insurer responsible for the 1987 injury, relies on Dr. Rusch's January 23, 1989 letter which states that claimant's work with Big O Tires independently contributed to his increased symptomatology and his May 22, 1989 letter which concludes that his work with Big O Tires symptomatically worsened his underlying pathological condition. Ex. 36 and Ex. 47. Claimant, on the other hand, notes that while Dr. Rusch has used the phrases "independent contribution" and "worsening of the underlying condition," he has always indicated that claimant's worsenings have been symptomatic.

Reading Dr. Rusch's letters together with his chart notes, we are persuaded that Dr. Rusch believes that claimant's underlying condition has remained fundamentally unchanged for some time. We note, in particular, that on May 22, 1989, Dr. Rusch opined that "claimant had suffered a worsening of symptoms with the new employment activities but that there was no significant pathological change in the condition itself."

The Referee concluded that because Dr. Rusch said that there was no significant pathological change, we should infer that he believed that there was some pathological change. Any independent contribution, no matter how slight, is sufficient to shift responsibility. Mission Insurance Co. v. Dundon, 86 Or App 470 (1987). However, we are unwilling to infer that Dr. Rusch believes that claimant's work for Big O Tires contributed at all to a worsening of claimant's underlying condition.

It would appear that Dr. Rusch was repeatedly asked by SAIF's claims examiner whether work activities had contributed in any way to the worsening of the underlying condition. He never said that the underlying condition has worsened except symptomatically. He has consistently opined that claimant's condition was essentially stable--becoming symptomatically worse with activity. On March 9, 1989, he indicated that claimant's ankle continued to be symptomatic with activity, that there had been no particular status change. Each of the letters relied on by SAIF indicate that claimant has suffered a symptomatic worsening due to work activity. As early as February 1989 Dr. Rusch advised SAIF that it would be "most difficult to indicate that his employment at Big O Tires worsened this underlying condition." He has never so indicated. Indeed, the tenor of the record as a whole persuades us that he believed that the underlying condition had not changed.

Therefore, we conclude that SAIF, as insurer responsible for the 1987 injury, remains responsible. Hensel Phelps v. Mirich, 81 Or App 290 (1986). Consequently, we reverse.

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counselor's efforts at hearing and on review is $2,400, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case, as represented by claimant's briefs and statement of services, the complexity of the issues, and the value of the interest involved.

ORDER

The Referee's order dated June 20, 1989 is reversed. The SAIF Corporation's denial of March 29, 1989 is set aside. The Determination Order is set aside and the claim remanded to SAIF for processing according to law. For services at hearing and on Board review, claimant's attorney is awarded $2,400, payable by SAIF.

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September 21, 1990 Cite as 42 Van Natta 2039 (1990)

In the Matter of the Compensation of
**CATHY J. RISER, Claimant**
WCB Case No. 86-13112
ORDER ON REVIEW
Zafiratos & Roman, Claimant Attorneys
Carroll Smith (Saif), Defense Attorney

Reviewed by Board Members Howell and Perry.

The SAIF Corporation requests review of those portions of Referee Schultz's order which awarded 8 percent (12 degrees) scheduled permanent disability in addition to 25 percent (37.5 degrees) awarded by Determination Order for loss of use or function of claimant's left leg; and (2) awarded 52 percent (78 degrees) unscheduled permanent disability in addition to 35 percent (112 degrees) awarded by Determination Order for a left hip, low back, and psychological injury. On review, the issue is extent of scheduled and unscheduled permanent disability. We reverse.

FINDINGS OF FACT

Claimant was 36 years old on the date the hearing record closed. She has 11 years of formal education and has not obtained a GED (Ex. 15 & Tr. 15).

Her work experience from 1974 until October 1984 included work as a cook, waitress, bartender and shrimp picker. (Exs. 1, 8, 15, 67A, & 78). Of those jobs, the one requiring the most vocational preparation was that of cook (DOT #313.361-014), assigned an SVP of 7. (Ex. 116, p.2).

On October 1, 1984, while working for the employer as a cook, claimant compensably sprained her left ankle. (Exs. 1 & 16). During the one and one half years following her injury, claimant treated with Dr. Orwick. She was also seen by a number of specialists and participated in a pain program. By February 1986, claimant's left ankle sprain was medically stationary. An April 4, 1986 Determination Order closed the claim and awarded 25 percent scheduled permanent disability for loss of the left leg. (Exs. 2, 4, 7, & 9-52).

In June 1986, claimant's claim was reopened for treatment of low back pain and symptoms of left trochanteric bursitis, both of which were due to the altered gait caused by her ankle sprain. As a result of her left hip and low back pain, claimant rotated her left leg outward and developed left knee pain. (Exs. 42, 56, 58, 60-62, 69A, 85, & 113).

Over the next year, Dr. Orwick provided additional medical treatment without significant change in claimant's condition. (Exs. 58-60, 62A, 82, & 90). In May and June of 1987, claimant was evaluated at a pain center. A diagnosis of reflex sympathetic distrophy of the left foot was made. Psychologically, she was found to be greatly focused on her physical complaints and somewhat depressed. (Ex. 86).

In October 1987, claimant was examined by an orthopedist, a neurologist, and a neurosurgeon for the Orthopaedic Consultants. Claimant then demonstrated severe functional interference, making detailed examination findings difficult. Psychiatric evaluation was recommended. (Ex. 95).

Dr. Porter, a professor of surgery at the Oregon Health Sciences University, also examined claimant in October 1987. He could not find clear evidence of sympathetic dystrophy but did find a significant functional component to claimant's pain complaints. Claimant was referred for EMG and nerve conduction studies, which were abnormal but indicative of a diffuse sensorimotor polyneuropathy. Dr. Paxton performed a neurosurgical evaluation in November 1987. Claimant demonstrated inconsistent posture, inconsistent responses to testing of sensation in her feet, and inconsistent pain behavior with respect to her low back. Dr. Paxton felt that a great deal of claimant's difficulty was functional. (Exs. 95A-95C, 96A & 96C).

On November 18, 1987, claimant was examined by Dr. Turco, a psychiatrist. He found some situational depression but no psychiatric diagnosis or need for psychiatric treatment. Claimant's problems were found to be motivational and due to her personality structure. (Ex. 97). Dr. Steinman, claimant's then treating physician, concurred with Dr. Turco. (Exs. 99, 100, & 101).

On April 13, 1988, claimant was examined by Dr. Duff, an orthopedic surgeon. Claimant had mild atrophy of the soft tissue around her left ankle, normal sensation in her feet, no left knee instability, and no left calf or thigh atrophy. Claimant was then medically stationary. She had minimal injury-related impairment and marked functional overlay. (Ex. 105). Dr. Steinman agreed with Dr. Duff's opinion to that effect. (Ex. 112).

In May 1988, claimant was evaluated by Providence Disability Prevention Services. Her left leg reflexes were normal. Left leg strength was normal. Dorsiflexion was 10 degrees; left ankle plantar flexion 30 degrees. Left

knee extension was -10 degrees, with no instability. Left hip flexion was to 90 degrees. Claimant had 30 degrees thoracolumbar flexion, 0 degrees extension, 20 degrees right lateral flexion, and 10 degrees left lateral flexion. (Ex. 109, p. 4, 5, & 11). Psychological examination and testing by Psychologist Ballering demonstrated claimant's strong somatic focus, moderate depression, and the presence of secondary gain operating to reinforce her assumed role as a severely disable person. (Ex. 109, p. 9 & Ex. 110).

An August 9, 1988 Determination Order closed claimant's claim and awarded 35 percent unscheduled permanent disability compensation. (Ex. 113).

At the time of hearing, claimant was unable to return to her usual and customary work as a cook and had not returned to or been offered, modified work. She was able to perform work in the sedentary category.

## CONCLUSIONS OF LAW AND OPINION

In determining the degree of claimant's permanent injury-related impairment, we rely primarily upon the objective findings of the Providence Disability Prevention Service. Those reports are the most recent and detailed, and are generally consistent with other medical evidence.

It appears that the Referee relied upon claimant's testimony as to her limitations. We did not observe claimant's testimony at hearing and are unable to rely on it for this review. For example, she described her foot movement in various directions such as "left", "right", "up", and "down". We cannot determine which, if any, of those directions represent subtalar motion, including, inversion, eversion, plantar flexion, and dorsiflexion. Claimant testified to the degree of various movements as "none", "very minimal", "slight", "a little bit", and "an inch". While some of those terms have established meanings in the medical community, claimant's testimony is wholly inadequate to prove the extent or degree of impairment so as to permit a determination of the appropriate impairment values under the "standards." In that regard claimant has failed in her burden of proof. ORS 656.266. Finally, the overwhelming medical evidence is that claimant's presentation of her symptoms and limitations is substantially distorted by functional factors not related to her ankle sprain injury.

Pain may be disabling and, when it is, it may be considered under the "standards" in effect before January 1, 1989. Former OAR 436-35-010(2)(a); 436-35-320(1)(a); Daniel M. Alire, 41 Van Natta 752 (1989). However, in this case, each of the numerous medical experts, including her attending physician, who has seen claimant since late 1987, has found severe functional overlay which affected her subjective complaints, limitations, and examination findings. For that reason, and despite the Referee's general finding that claimant was credible, we are unwilling to rely on her testimony regarding any disabling pain she may experience.

### Scheduled Permanent Partial Disability

For purposes of determining injury-related permanent partial disability, ORS 656.283(7) and 656.295(5) require application of the standards for the evaluation of disabilities adopted by the director pursuant to ORS 656.726(3)(f)(A). Those "standards" in effect on the date of the Determination Order from which the hearing was requested control the evaluation of permanent partial disability. OAR 438-10-010.

The Referee applied the "standards" effective January 1, 1989. However, the "standards" adopted effective July 1, 1988, former OAR 436-35-001 et

seq, apply to the rating of claimant's permanent partial disability. OAR 438-10-010. Former OAR 436-35-010 through 436-35-260 apply to the rating of scheduled permanent partial disabilities. Former OAR 436-35-010(1). It is those standards which we apply.

Claimant suffers limited left foot dorsiflexion of 10 degrees for which an impairment value of 4 percent is assigned. Former OAR 436-35-190(8). Plantar flexion is limited to 30 degrees for a value of 4 percent. Former OAR 436-35-190(8). There is no reliable evidence of the degree of any other permanent, injury-related limitations in claimant's left ankle motion. Ranges of motion in claimant's ankle are added (not combined). Former OAR 436-35-190(11). The total value for loss of ankle motion is 8 percent.

Dr. Duff found sensation in claimant's foot to be normal. Dr. Paxton found claimant's reports on testing to be inconsistent. We conclude that claimant has failed to prove entitlement to an impairment value for loss of sensation under former OAR 436-35-200(1). Neither has claimant proven ankle joint instability. Former OAR 436-35-200(2).

Claimant has mild left ankle dorsiflexion weakness. For that weakness, a 2 percent impairment value of the foot is assigned by former OAR 436-35-230(5)(a). The values for impairment of claimant's left foot are combined (not added) for a value of 9.8 percent. Former 436-35-190(12). That value is converted to an impairment value for the leg. Former OAR 436-35-240(4). Here, that value is 8.9 percent. Former OAR 436-35-210.

Claimant has a 10 degree loss of left knee extension. She is entitled to a 1 percent impairment for loss of the leg. Former OAR 436-35-220(2).

Because claimant's left hip condition results from bursitis of the greater trochantor of the left femur, impairment is properly rated as part of the leg. See former OAR 436-35-130(1). (Claimant has not proven unscheduled impairment to the hip.) For the limitation of the left hip flexion to 90 degrees, claimant is assigned an impairment value of 2 percent of the leg. Former OAR 436-35-220(5).

The Referee awarded values for chronic conditions limiting repetitive use. However, the "standards" which apply in this case do not provide for an impairment value for chronic conditions limiting repetitive use of a body part. But see OAR 436-35-230(7).

The values for claimant's foot impairment, left knee impairment and left hip impairment are combined to obtain a single impairment value for claimant's left leg. Former OAR 436-35-240. Here 8.9 percent, 1 percent, and 2 percent combine to a value of 11.6 percent. That value is rounded to the next higher whole percent and represents claimant's scheduled permanent disability. Former OAR 436-35-010(6). Claimant's scheduled permanent disability is 12 percent.

We do not find clear and convincing evidence of scheduled disability in excess of the "standards." The medical evidence indicates that claimant's physical injury-related impairment is minimal.

Unscheduled Permanent Partial Disability

In this case, the "standards" adopted effective July 1, 1988, former OAR 436-35-001 et seq, apply to the rating of claimant's unscheduled permanent partial disability. Former OAR 436-35-270 through 436-35-440 apply to the rating of unscheduled permanent partial disabilities. Former OAR 436-35-270(1).

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

The appropriate value for claimant's age of 36 years is 0. Former OAR 436-35-290.

The appropriate value for claimant's 11 years of formal education is 1. Former OAR 436-35-300(3).

Former OAR 436-35-300(4) adopts by reference the "SVP" (specific vocational preparation time) values assigned to various occupations by the Dictionary of Occupational Titles (DOT), published by the U.S. Department of Labor. The highest SVP level demonstrated by a claimant during the ten years prior to the date of injury is used to determine a value for skills. Former OAR 436-35-300(4). Claimant's highest SVP during the ten years prior to the date of injury was 7 as a cook (DOT # 313.361-014). Therefore, the appropriate value for skills is 1. Former OAR 436-35-300(4).

Claimant has no documented training. Therefore, the appropriate value for training is 1. Former OAR 436-35-300(5). Claimant's total education value is 3, the formal education value plus the skills value plus the value for training. Former OAR 436-35-300(6).

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

Claimant is unable to return to her usual and customary work and has not returned to, or been offered, regular, modified work since she became medically stationary . Claimant's physical capacity falls within the sedentary category. Thus, the appropriate adaptability value is 8. Former OAR 436-35-310(4)(d).

The final factor necessary to determine claimant's unscheduled permanent disability is a value for her permanent injury-related impairment.

Claimant has limited low back motion as a consequence of her injury. For reduced thoracolumbar flexion (30 degrees retained) she is entitled to an impairment value of 6 percent. Former OAR 436-35-360(7). For reduced right lateral flexion (20 degrees retained), she is entitled to no value. Former OAR 436-35-360(8). For reduced left lateral flexion, (10 degrees retained), she is entitled to a value of 2 percent. Former OAR 436-35-360(8). Claimant has proven no other permanent injury-related limitations in low back motion. The values for reduced range of low back motion are added (not combined) to obtain a single range of motion value. Former OAR 436-35-360(10). In this case, that value is 11 percent.

The Referee assigned a 25 percent value for claimant's functional overlay and pain syndrome. Claimant is entitled to no value for "mental illness" under the "standards."

Dr. Turco, with the concurrence of claimant's attending physician, diagnosed some situational depression. Psychologist Ballering also diagnosed depression. However, there is no evidence that claimant's depression is disabling. Neither does the record contain evidence to establish as a matter of complex medical causation, that claimant's pain syndrome is a permanent, injury-related mental disorder. To the contrary, claimant's so-called functional overlay is not, according to Dr. Turco's unrebutted and persuasive opinion, a true psychiatric disorder but represents a lack of motivation due to claimant's personality makeup. Furthermore, because no psychologist or psychiatrist has diagnosed either claimant's pain syndrome or functional overlay as a permanent mental disorder, no value may be assigned for those conditions under the "standards." Former OAR 436-35-400(1).

Claimant's total unscheduled injury-related impairment is 11 percent.

Having determined each value necessary to compute claimant's permanent disability under the "standards," we proceed to that calculation. When claimant's age value 0 is added to his education value 3 the sum is 3. When that value is multiplied by claimant's adaptability value 8 the product is 24. When that value is added to claimant's impairment value 11 the result is 35 percent. Former OAR 436-35-280(7). Claimant's permanent disability under the "standards" is, therefore, 35 percent.

We do not find clear and convincing evidence that claimant's unscheduled permanent disability is greater than 35 percent. The unrebutted medical evidence is that claimant's permanent injury-related impairment is minimal. Considering that, with other relevant factors and with the fact that claimant's symptoms and complaints are primarily attributable to a functional condition which has not been shown to be due to claimant's ankle sprain injury, we conclude that claimant has failed to prove permanent unscheduled disability greater than 35 percent.

Because SAIF requested review of the Referee's order but did not request or cross-request a hearing from the Determination Orders, we reverse the Referee and reinstate the awards made by the Determination Orders.

## ORDER

The Referee's order dated January 18, 1989 is reversed. The Determination Orders issued April 4, 1986 and August 9, 1988 are reinstated and affirmed.

In the Matter of the Compensation of
**DAVID M. NELSON, Claimant**
WCB Case No. 89-02897
ORDER ON REVIEW
Patrick Lavis, Claimant Attorney
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Myers and Gerner.

Claimant requests review of Referee Mulder's order which: (1) awarded claimant 10 percent (32 degrees) unscheduled permanent disability in addition to the 8 percent (25.6 degrees) unscheduled permanent disability previously awarded by Determination Order; and (2) declined to order the self-insured employer to pay for a report from claimant's chiropractor. On review, the issues are extent of unscheduled permanent disability and medical reports. We modify and affirm.

FINDINGS OF FACT

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

Claimant's prior work as a Sherman edger operator was medium/heavy work. That job required some occasional heavy pulling and heavy shoveling, but this was not a constant requirement of performing that job.

Claimant's current work as a COE edger operator is light/medium work. This job is automated but does require occasional heavier lifting or pulling. Claimant has the capabilities to lift 30 pounds occasionally and 10 pounds frequently.

Claimant has a herniated disc at the L4-5 level, which was caused by the injury. The disc herniation causes clinical symptoms in claimant's left hip and lower extremity. Claimant has a disc bulge at the L2-3 level, which is documented by CT Scan. That bulge has no clinical or residual effect upon claimant's symptoms or his disability, in that the bulge is on the right side and claimant has no right sided symptoms.

The March 22, 1989 report by Dr. Sherman was requested by claimant's attorney for the purposes of litigation. The report does not address claimant's treatment or need therefore and was not written in connection with any treatment.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant had suffered a permanent loss of earning capacity in the amount of 18 percent and that there was insufficient information to decide whether the cost of Dr. Sherman's March 22, 1989 report should be borne by claimant or the employer. We modify the permanent disability award and affirm that portion of the Referee's order which concerned the medical report.

Permanent Disability

The determination of permanent partial disability under the "standards" is made by determining the appropriate values assigned by the "standards" to the claimant's age, education, adaptability and impairment. Once established, the values for age and education are added and the sum is multiplied by the appropriate value for adaptability. The product of those two figures is then added to the appropriate value for impairment to yield the percentage of unscheduled permanent partial disability. OAR 436-35-280. In this case, the "standards" adopted effective January 1, 1989, OAR 436-35-001 et seq, apply to the rating of claimant's disability.

Age

The appropriate value for claimant's age of 34 years is zero. OAR 436-35-290.

Education

The appropriate value for claimant's 10 years of formal education is +1. OAR 436-35-300(3).

OAR 436-35-300(4) adopts by reference the "SVP" (specific vocational preparation time) values assigned to various occupations by the Dictionary of Occupational Titles (DOT), published by the U.S. Department of Labor. The highest SVP level demonstrated by a claimant during the ten years prior to the date of injury is used to determine a value for skills. OAR 436-35-300(4). Claimant's highest SVP during the ten years prior to the date of injury was 5 as an edger operator (DOT # 667.682-026). Therefore, the appropriate value for skills is +2. OAR 436-35-300(4).

Claimant has no documented training. Therefore, the appropriate value for training is +1. OAR 436-35-300(5). Claimant's total education value is +4, the formal education value plus the skills value plus the value for training. OAR 436-35-300(6).

Adaptability

An adaptability value for a claimant who is unable to return to his or her usual and customary work, (See OAR 436-35-270(3)(a)), but who has returned to modified work is determined from a matrix of values at OAR 436-35-310(3)(a). That matrix compares the physical capacity of the claimant's usual and customary work with the physical capacity required by the modified work. This is true even though claimant may have the physical capacity to do heavier work than is required by the modified employment. Physical capacities are not defined by the "standards" generally. We utilize those definitions contained in OAR 436-35-310(4)(a)-(d).

In this case, claimant's usual and customary work required the physical capacity to do medium/heavy work. Claimant's modified work required a light/medium physical capacity. Therefore, the appropriate adaptability value is +1.5. OAR 436-35-310(3)(a).

Impairment

Claimant has 65 degrees of flexion, which is assigned a value of 2.5 percent. OAR 436-35-360(6). He has 10 degrees of extension, which is assigned a value of 2 percent. OAR 436-35-360(7). He also has 10 degrees of left lateral flexion and 12 degrees of right lateral flexion, which are assigned values of 4 percent and 3.6 percent respectively. OAR 436-35-360(8). Claimant has no loss of rotation. These values are added to reach a value of 12.1 percent.

Claimant has an unoperated disc herniation at the L4-5 level which is due to the injury and contributes to his disability. This herniation is assigned a value of 4 percent. OAR 436-35-350(2). The value for the loss of range of motion is combined with the value for claimant's herniated disc for a total impairment value of 15.61 percent.

Calculation of Standards Disability

The Age and Education sum is +4. This value is multiplied by the Adaptability factor of +1.5 to yield the product +6. To this product is added the

Impairment value of 15.61 percent to yield the total sum of 21.61 percent disability. See generally OAR 436-35-280. This percentage is rounded up to the next higher whole number for a total of 22 percent unscheduled permanent disability. OAR 436-35-280(7).

Payment of Physician's Report

A doctor's fee for writing a report is the responsibility of the carrier if the report is written in connection with compensable treatment. Clara M. Peoples, 31 Van Natta 134 (1981). If the report, or the services upon which the report is based, is not for the purpose of treatment, but for the purpose of litigation, then the requester of the report/service must bear the cost of it. Clara M. Peoples, supra.; Welch v. Bannister Pipeline, 82 Or App 23 (1986).

In this case, claimant's attorney requested a report from claimant's doctor. The request was made after the Determination Order had issued and while a request for hearing on extent of permanent impairment was pending. The report was addressed to claimant's attorney and mailed only to him. The report did not address any facet of claimant's treatment, it merely reported claimant's impairment factors under the standards. This information on claimant's impairment was necessary to the preparation of his case to gain an increase in his disability award over that awarded by his Determination Order, and not in connection with any treatment for claimant.

Under these facts, it appears that the report was not procured to assist in claimant's treatment, but soley for the purpose of litigating the extent of claimant's permanent disability. The cost of the report should be borne by claimant.

ORDER

The Referee's order dated July 27, 1989 is modified in part and affirmed in part. In addition to the 18 percent (57.6 degrees) unscheduled permanent partial disability awarded by the Referee, claimant is awarded 4 percent (12.8 degrees), for a total award to date of 22 percent (70.4 degrees). Claimant's attorney is awarded 25 percent of the additional compensation granted by this order, payable directly to claimant's attorney. However, the total attorney fee approved by the Referee and Board orders shall not exceed $3,800. The remainder of the order is affirmed.

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May 30, 1990 Cite as 42 Van Natta 2047 (1990)

In the Matter of the Compensation of
**JAN C. LEECH, Claimant**
WCB Case Nos. 88-11939, 88-12567, 88-18223 & 88-18224
ORDER ON REVIEW
S. David Eves, Claimant Attorney
Saif Legal Department, Defense Attorney
Stafford Hazelett, Defense Attorney

Reviewed by Board Members Crider and Brittingham.

Liberty Northwest Insurance Corporation requests review of Referee Baker's order that: (1) set aside its denial of claimant's low back condition; (2) upheld the SAIF Corporation's aggravation denial of the same condition; (3) awarded a penalty for Liberty Northwest's unreasonable denial; and (4) awarded an assessed fee of $2,000. On review, the issues are responsibility, penalties and attorney fees. We affirm.

## FINDINGS OF FACT

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

Claimant's weekly temporary total disability rate at SAIF's insured was $50 and it was $163.92 at Liberty Northwest's insured.

SAIF denied claimant's claim on the basis of responsibility only. However, Liberty Northwest issued a denial of both compensability and responsibility. On September 30, 1988, Liberty Northwest issued a denial which conceded compensability but continued to challenge responsibility. No ".307 order" issued until October 18, 1988, after the hearing commenced.

## CONCLUSIONS OF LAW AND OPINION

We adopt the Referee's "Opinions and Conclusions" with the following supplementation.

On review, Liberty Northwest challenges the Referee's assessment of a $2,000 fee as excessive for either prevailing on the denial of for prevailing on the penalty issue.

Claimant's attorney is entitled to a penalty-related attorney fee for the unreasonable denial. ORS 656.382(1). Moreover, although compensability was conceded at hearing, because no ".307 order" had issued, claimant's compensation remained at risk. Consequently, an attorney fee is authorized by ORS 656.386(1) for overcoming the denial also. Theresa L. Howard, 41 Van Natta 338 (1989); Ronald L. Warner, 40 Van Natta 1082, on recon, 1194 (1988). Finally, even if a ".307 order" had been issued prior to hearing, claimant would have been entitled to a fee for actively and meaningfully participating at hearing as his efforts were directed at placing responsibility with Liberty Northwest, a result which gained him the higher rate of temporary disability compensation. ORS 656.307(5); Richard H. Church, 42 Van Natta 367 (1990). Considering the factors established by OAR 438-15-010(6), the fee awarded by the Referee appropriately compensates claimant's counsel for services at hearing.

The amount of claimant's compensation was at issue on Board review because Liberty Northwest sought review and it had the higher temporary disability rate. Had it prevailed in establishing that SAIF was responsible, claimant's compensation would have been decreased. Under these circumstances, claimant's attorney is entitled to a carrier-paid fee for services on review. Dale S. Matsen, 41 Van Natta 163 (1989).

## ORDER

The Referee's order dated January 26, 1989 is affirmed. For services on Board review, claimant's attorney is awarded an assessed fee of $1,000, to be paid by Liberty Northwest Insurance Corporation.

In the Matter of the Compensation of
**MONTY G. PITTAM, Claimant**
WCB Case No. 89-06965
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Davis & Bostwick, Defense Attorneys

Reviewed by Board Members Myers and Gerner.

The self-insured employer requests review of those portions of Referee Livesley's order which assessed a penalty and associated attorney fee for the employer's allegedly late payment of mileage reimbursement. On review, the issue is whether the employer was late in paying mileage reimbursement. We reverse.

## FINDINGS OF FACT

Claimant has an accepted claim for a right hand injury which occurred on May 11, 1987. Claimant treated with Dr. Teal, a hand surgeon, who performed surgery on November 28, 1988.

In late December 1988 claimant handed his supervisor a form with Dr. Teal's letterhead. That form states: "dates seen in office:" and then lists 22 dates from September 2, 1987 through December 12, 1988. It also lists three "dates of surgery." Claimant did not tell the supervisor that the form was a request for mileage reimbursement. He assumed the supervisor knew that was the purpose of the form. There are no allegations that the employer was late in paying for any medical services.

Claimant submitted a request for mileage reimbursement in May 1989 which was timely paid.

## CONCLUSIONS OF LAW AND OPINION

The issue in this case is whether the form claimant gave to his supervisor in December 1988 is sufficient to constitute a claim for compensation which would subject the employer to a penalty for unreasonable delay in the payment of compensation under former ORS 656.262(10).

ORS 656.005(6) states:

> "'Claim' means a written request for compensation from a subject worker or someone on the worker's behalf, or any compensable injury of which a subject employer has notice or knowledge."

Claimant argues that his submission of the form to his supervisor in December 1988 constitutes a claim which requires processing it under ORS 656.262(2). We disagree. The form which claimant submitted to the supervisor gives no indication of what claimant is requesting. It is merely a listing of treatment dates. There is no allegation that the employer was late in paying for the treatments themselves. We conclude that the mere submission of a list of treatment dates is insufficient to put the employer on notice that claimant is requesting anything, let alone requesting mileage reimbursement. Furthermore, there is no proof that the employer knew, or should have known, that this form was a request for mileage reimbursement. Accordingly, we hold that the employer did not unreasonably delay compensation by not responding to the form submitted by claimant to his supervisor in December 1988.

ORDER

The Referee's order dated August 11, 1989 is affirmed in part and reversed in part. Those portions of the Referee's order which assessed a penalty and $350 associated attorney fee are reversed. The balance of the Referee's order is affirmed.

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In the Matter of the Compensation of
**FRANCISCA GARCIA, Claimant**
WCB Case Nos. 88-09391, 88-09392, 88-15097 & 88-15098
ORDER ON REVIEW
Gregory Perkins, Claimant Attorney
Schwabe, et al., Defense Attorneys
Rankin, et al., Defense Attorneys
Chelsea Mohnike (Saif), Defense Attorney
Acker, et al., Defense Attorneys

Reviewed by Board Members Speer and Howell.

EBI Companies requests review of those portions of Referee Harri's order that: (1) set aside its denial of claimant's aggravation claim for her right ankle condition; (2) upheld United Employers' denial of claimant's aggravation claim for the same condition; and (3) upheld Liberty Northwest Insurance Corporation's and the SAIF Corporation's denials of claimant's "new injury" claim for the same condition. On review, the issue is responsibility. We affirm.

FINDINGS OF FACT

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

From 1980 to May 1988, claimant worked as a nurse's aide for the same employer. On June 6, 1982, claimant sustained a right ankle injury at work. Her right ankle condition was accepted by United Employers/Fremont Indemnity (United).

On April 15, 1984, claimant re-injured her right ankle at work. EBI, the insurer on the risk at the time, accepted her right ankle claim. After her 1984 injury, claimant's ankle symptoms continued. She left work May 1988 as a result of disabling right ankle pain.

CONCLUSIONS OF LAW AND OPINION

The Board adopts the Referee's "Conclusions and Opinion," with the following supplementation.

Responsibility between EBI and earlier insurers

The present case involves a series of work-related injuries to the same body part. Where successive injuries are to the same body part, a rebuttable presumption exists that the last compensable injury contributed to the worsened condition and that the insurer on the risk at the time is responsible. Industrial Indemnity Co. v. Kearns, 70 Or App 583 (1984); Linda L. Wise, 42 Van Natta 115 (1990).

Here, EBI has the burden to prove that the 1984 accepted injury did not independently contribute to the worsened underlying condition which gives rise

to the claim for compensation. Claimant testified that, after her 1984 injury, her ankle pain was worse than it had previously been. Dr. Schader, claimant's treating doctor, agreed that it was possible that claimant's employment (after her 1982 injury), contributed to a worsening of the underlying condition. Dr. Schader acknowledged that claimant's repeated injuries at work (ankle sprains) could have worsened her symptoms and made the meniscoid lesion larger and more symptomatic.

We agree with the Referee's conclusion that EBI has not shown that the 1984 injury did not independently contribute to a worsening of claimant's underlying condition. Therefore, between EBI and the employer's insurers before EBI came on the risk, we conclude that EBI is responsible.

Responsibility between EBI and subsequent insurers

To shift responsibility to a subsequent insurer, EBI must prove an actual independent contribution to claimant's underlying condition by her work activities during the time the subsequent insurer was on the risk. Dr. Schader opined that, from the time he began treating claimant again (1985) until the time of her surgery in 1988, claimant's employment activities had not worsened her underlying condition.

EBI has failed to prove an independent contribution by claimant's work activities, subsequent to the time it went off the risk. We therefore conclude that EBI is responsible for claimant's current right ankle condition.

Attorney Fees

Claimant's counsel has requested an attorney fee for services provided on review. We conclude that, because responsibility was the only issue on review, claimant's compensation was never at risk and ORS 656.382(2) does not provide a basis for an assessed attorney fee. See Howard v. Willamette Poultry, 101 Or App 584 (1990).

ORDER

The Referee's order dated May 8, 1989, as reconsidered July 7, 1989, is affirmed.

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September 25, 1990 Cite as 42 Van Natta 2051 (1990)

In the Matter of the Compensation of
**EARL HAGY, Claimant**
WCB Case Nos. 88-12422, 88-16772 & 89-04213
ORDER ON REVIEW
Olson, et al., Claimant Attorneys
Cummins, et al., Defense Attorneys
Atherly, et al., Defense Attorneys
David Schieber (Saif), Defense Attorney

Reviewed by Board Members Crider and Nichols.

Claimant requests review of Referee Mirassou's order that upheld denials of an occupational disease claim for hearing loss issued by the SAIF Corporation on behalf of C & D Lumber Company, by Liberty Northwest Insurance Corporation on behalf of Willamina Lumber Company, and by SAIF on behalf of Blue Mountain Forest Products. On review, the issues are compensability and responsibility. We reverse.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact. We make the following additional finding: Claimant began work for Blue Mountain in July, 1984.

FINDINGS OF ULTIMATE FACT

Claimant's work activity as a saw filer is the major contributing cause of his noise-induced, high frequency neurosensory hearing loss which has required medical services and resulted in disability.

Claimant has not missed work owing to his hearing loss. He first sought treatment for his hearing loss on March 1, 1988, while working for Willamina Lumber.

Claimant's work activity while employed by Blue Mountain, Willamina Lumber and C & D Lumber was capable of causing his noise-induced hearing loss.

CONCLUSIONS OF LAW AND OPINION

Compensability

The Referee observed that, "The expert evidence in this case uniformly establishes that claimant suffers from job-related slow, progressive, noise-induced hearing loss...". Nevertheless, she upheld the denials because the evidence does not establish that noise exposure at Blue Mountain, Willamina or C & D Lumber was the major contributing cause of this hearing loss.

The Referee applied the wrong legal standard. The question, in an occupational disease case, is not whether the disease was caused by work activities for any particular employer. Rather, it is whether the disease was caused by employment exposure generally.

The Supreme Court first so held in Inkley v. Forest Fiber Co., 288 Or 337 (1980). The Court reversed a decision by the Court of Appeals which, affirming the Board, denied compensation to a worker who had suffered work-related hearing loss because the worker failed to prove that the hearing loss was caused by employment with a particular employer:

> "There, the claimant suffered incremental hearing loss caused over a period of time when claimant was subjected to conditions which could cause the disability. During that period, however, his employment was insured by successive insurers. It could not be determined whether employment under the last insurer actually caused any additional hearing loss. This court held that the last insurer would be liable for the entire disability if the conditions of employment were of a nature which could have contributed to the disability. In such a case, the last injurious exposure rule was applied not only as a substitute for allocation ... but also for an altogether different purpose: to relieve the claimant of the 'burden of proving medical causation,' as to any specific insurer, 288 Or at 345."

Bracke v. Baza'r, 293 Or 239, 246 (1982). See also Runft v. SAIF, 303 Or 493, 500 (1987).

Following Inkley and Bracke, we conclude that claimant has satisfied his burden of proof on the compensability issue if he has established that his hearing loss was caused by work place noise exposure.

Counsel for claimant correctly observes that claimant, who continued to work as a saw filer at the time of hearing, was last exposed to potentially causal conditions after January 1, 1988. Moreover, the claim was filed and the hearing held prior to the effective date of the 1990 amendments to the occupational disease law. Consequently, the 1987 amendments to the occupational disease law control this case. The Board has not yet decided whether noise exposure should be treated as an exposure to a substance, in which case this dispute is governed by former ORS 656.802(1)(a), or an exposure to repetitive trauma, in which case the dispute is governed by former ORS 656.802(1)(c). Compensability under the former is established by proving that the work exposure was the major cause of the disease and under the latter by proving that the work exposure was a material cause of the disease. We need not decide the question in this case, for it is clear that work place noise exposure is the major cause of claimant's hearing loss. Both Mr. Frink, the treating audiologist, and Dr. Scott, M.D., IME, have concluded that it is probable that claimant's hearing loss is due to occupational noise exposure. Coupled with the lay evidence, which indicates that claimant is exposed to very little nonoccupational noise, these opinions establish the requisite legal causation no matter which rule applies.

Responsibility

Having determined that claimant's hearing loss is compensable, we must assign responsibility.

In occupational disease cases, responsibility is assigned to the insurer that was on the risk when the disease resulted in disability. Bracke v. Baza'r, supra. That insurer may avoid responsibility only if the record demonstrates either that employment while it was on the risk was not of the type that is capable of causing the disease (Inkley v. Forest Fiber Products Co., supra) or that exposure while a later insurer was on the risk independently contributed to a worsening of the disease. Spurlock v. International Paper Co., 89 Or App 461 (1988).

In determining which insurer has the burden of proof on the responsibility issue, we rely on the Court's opinion in Inkley, supra. Evidence in that case indicated that claimant had experienced disability during an earlier employment, when he tested positive for hearing loss. However, claimant lost no time from work during that employment, and he first filed a claim for his hearing loss during a subsequent employment. The Court initially assigned responsibility to the insurer on the risk during the later employment.

Here, claimant tested positive for hearing loss while working for Blue Mountain, but he did not experience time loss during that employment. He first sought treatment and filed a claim for hearing loss during a subsequent employment with Willamina. We rely on Inkley and assign responsibility in the first instance to Willamina. See also SAIF v. Carey, 63 Or App 68 (1986) (onset of disability is date of first treatment where claimant has not lost time from work).

We note that holdings in other cases may suggest that responsibility should rest in the first instance with Blue Mountain because claimant tested positively for hearing loss during that employment. See SAIF v. Baer, 60 Or App 133 (1982); Robert A. Lusk, 42 Van Natta 1584 (1990). However, because the facts in Inkley are so similar to the facts in this case, we rely on its analytic approach.

Consequently, Willamina is responsible unless it demonstrates either that employment while it was on the risk was not of the type that is capable of causing the disease, or that exposure while a later insurer was on the risk independently contributed to a worsening of the disease. Inkley, supra; Spurlock v. International Paper Co., 89 Or App 461 (1988).

Willamina's insurer vigorously contends that it is not responsible because claimant's hearing loss was not actually caused by exposure while in its employ. The insurer points to audiometric evidence that claimant's hearing loss did not significantly worsen between October, 1984 (before claimant went to work for Willamina) and March, 1988.

We are not persuaded by the insurer's argument. In Inkley v. Forest Fiber Products Co., supra, the Court rejected virtually identical evidence in avoidance of responsibility: Audiometric evidence showed that claimant's hearing had actually improved between the time the employer was insured by SAIF and the date, following claimant's retirement, when the claim was filed. Between those dates, the employer had been a direct responsibility employer. The Board absolved the employer of liability because there was no medical evidence to show that claimant's employment after the employer assumed direct responsibility contributed to his hearing loss. The Court remanded for a finding as to whether the employment was capable of causing the hearing loss.

We are aware that under the rule set forth in FMC Corp. v. Liberty Mutual Insurance Co., 70 Or App 370 (1984), clarified, 73 Or App 223 (1985), Willamina could avoid responsibility by demonstrating that it was impossible for claimant's employment with Willamina to have contributed to his disability. However, Willamina has not established that its employment actually made no contribution to the disability. Although both medical experts have opined that claimant did not suffer a "significant threshold shift" since he began work for Willamina and therefore that claimant did not suffer "significant" change in his hearing during that period, both audiometric tests performed in 1988 show some additional loss. Moreover, claimant himself complained of additional subjective hearing loss during his employment with Willamina. For these reasons, we would be reluctant to find that it was impossible that exposure at Willamina contributed to the disability.

Moreover, Inkley does not allow an insurer to avoid responsibility if employment while the insurer was on the risk was capable of causing the disease. Here, claimant was engaged in the same type of work for Willamina that we have found caused the hearing loss. The Willamina mill, according to claimant, was very noisy. Although he wore hearing protectors most of the time, there were circumstances when it was impossible to do so consistent with his job responsibilities. For these reasons, we find that claimant's work was capable of causing hearing loss. We are reinforced in this finding by Dr. Smith's recommendation that claimant undergo audiometric testing every six months while employed in a sawmill. This suggests that the physician believed that sawmill work was capable of causing hearing loss even when protective devices were used.

For these reasons, Willamina is responsible for the hearing loss unless it has established that work exposure at C & D Lumber, for whom claimant subsequently worked, independently contributed to claimant's disability. As Willamina recognizes, independent contribution cannot be established by proof that a later employment exposure could have contributed; it requires proof of actual contribution. There is no such evidence in this record. Consequently, Willamina is responsible.

After considering the factors set forth in OAR 438-15-010(4) and applying

them to this case, we find that a reasonable fee for claimant's counsel's services on review concerning the denial issue is $5,500, to be paid by Liberty Northwest. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's appellant's brief and statement of services), the significant complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated May 3, 1989 is reversed. Liberty Northwest Insurance Company's denial is set aside, and the claim is remanded to Liberty Northwest for processing according to law. For services at hearing and on Board review regarding the denial issue, claimant's attorney is awarded an assessed fee of $5,500, payable by Liberty Northwest.

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September 25, 1990 Cite as 42 Van Natta 2055 (1990)

In the Matter of the Compensation of
**GWENETH M. JOHNSON, Claimant**
WCB Case No. 89-09609
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Nancy Marque (Saif), Defense Attorney

Reviewed by Board Members Crider and Nichols.

Claimant requests review of Referee Livesley's order that upheld the SAIF Corporation's "de facto" denial of a mammogram and associated mileage. On review, the issue is medical services.

We affirm and adopt the Referee's order except that we do not adopt the Referee's comments concerning his own experience in the Optifast program. The record establishes that a mammogram is not medically necessary as a prerequisite to participation in the weight loss program. The mere fact that a physical examination is required prior to commencement of the program does not establish that a mammogram, appropriately recommended for general health reasons, is compensable, in the absence of evidence that the Optifast program required that an individual in claimant's position undergo a mammogram. There is no such evidence.

ORDER

The Referee's order dated September 8, 1989 is affirmed.

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September 25, 1990 Cite as 42 Van Natta 2055 (1990)

In the Matter of the Compensation of
**NORMAN L. MURRAY, Claimant**
WCB Case No. 89-12634
ORDER OF DISMISSAL
Breathouwer, et al., Claimant Attorneys
Daryll E. Klein, Defense Attorney

Claimant requests review of Referee Mulder's order which reversed the Director's Proposed and Final order that denied the insurer a fourth independent medical examination (IME). Because we lack subject matter jurisdiction, we dismiss.

## FINDINGS OF FACT

Claimant was injured on December 27, 1983. The claim was accepted. During the life of this claim, the insurer has requested and obtained three IME's. On May 30, 1989, the insurer requested a fourth IME. Claimant objected and the insurer sought permission from the Director, under ORS 656.325(1), for the fourth IME.

The Director issued a Proposed and Final Order dated June 22, 1989 denying the fourth IME. The Director's order provided notice that the Proposed Order could be challenged under the provisions of ORS 656.702(2) and OAR 436-10-110(5). The Director's order was appealed to the Hearings Division under the procedure set forth in OAR 436-10-110(5).

On August 1, 1989, a hearing was held solely on the issue of the Proposed and Final Order. The Referee reversed the Director's order and granted the insurer permission for the fourth IME. The Referee's order provided notice that the Opinion and Order could be appealed to the Board. Claimant appealed the Referee's decision to the Board.

## CONCLUSIONS OF LAW AND OPINION

Claimant requests that the Director's Proposed and Final Order, which denied the insurer a fourth IME, be reinstated and the Referee reversed. We lack jurisdiction to entertain this request for review and consequently dismiss it.

The Director has jurisdiction over matters arising under ORS 656.001 to 656.794, that are "not matters concerning a claim." ORS 656.704(2). The Director may issue orders and conduct hearings under this authority. The Director may use the services of the Hearings Division to conduct hearings and issue final orders. ORS 656.704(2); OAR 436-10-110(5). Appeals from a Director's final order, as issued by a Referee under OAR 436-10-110(5), are reviewable only pursuant to ORS 183.310 to 183.550. ORS 656.704(2). These matters are not subject to review by the Board under ORS 656.295.

The Board, and its Hearing Division, have jurisdiction over "matters concerning a claim." ORS 656.283; 656.295; 656.704(1)&(3). This jurisdiction includes actions and orders of the Director when they involve matters concerning a claim.

The determination as to which is the appropriate jurisdiction for review depends on whether the matter in controversy is a "matter concerning a claim." "A matter concerning a claim" 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). Here, the only issue was whether a fourth IME was allowable under the discretion granted the Director by ORS 656.325(1). The Referee decided that issue on behalf of the Director pursuant to ORS 656.704(2) and OAR 436-10-110(5). Since there was no compensation directly at issue, only the Director's discretion to grant an additional IME, this case does not involve a matter concerning a claim. Thus, the only avenue of review of the Director's order, as issued by the Referee, is to the Court of Appeals under ORS 183.310 to 183.550. The Board lacks jurisdiction to review this matter.

We are mindful that the Referee's statement of appeal rights may have misled the parties to appeal to the Board instead of the Court of Appeals; however, the Board's jurisdiction is statutory and an incorrect statement of appeals rights cannot expand or contract that jurisdiction. Donald C. Rosacker, 41 Van Natta 2405 (1989). We note that the Director did state the correct appeals

rights (except for the typographical error of ORS 656.702(2) instead of the correct ORS 656.704(2)) in his order, indicating that this case did not involve a matter concerning a claim.

Accordingly, claimant's request for review is dismissed.

IT IS SO ORDERED.

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In the Matter of the Compensation of
**LELA NYSETH, Claimant**
WCB Case No. TP-90041
THIRD PARTY DISTRIBUTION ORDER
Brownstein, et al., Claimant Attorneys
J. David Thurber (Saif), Defense Attorney

Claimant has petitioned the Board for the allowance of an extraordinary attorney fee for services rendered in connection with a third party judgment. Specifically, claimant seeks approval of an attorney fee equal to 40 percent of the $17,909.50 judgment. The SAIF Corporation, as paying agency, objects to claimant's request. Noting that it would receive $800 less if the requested fee was approved, SAIF contends that this case was not extraordinary. We find that extraordinary circumstances do not exist to justify the requested fee.

FINDINGS OF FACT

Claimant sustained a compensable injury arising from a September 1988 motor vehicle accident with a third party. SAIF has accepted the claim and provided benefits.

Claimant engaged legal counsel to explore the possibility of bringing suit against the third party for her injury. She had previously retained this counsel's services concerning a March 1987 motor vehicle accident. At that time, claimant had executed a retainer agreement which provided that claimant's counsel would receive 33-1/3 percent of an "after suit files" settlement and 40 percent of the recovery "immediately prior to or during trial."

Claimant orally agreed to an identical arrangement regarding the September 1988 motor vehicle accident. A retainer agreement documenting this understanding was not executed until after the third party judgment was secured.

Prior to trial, the third party insurer offered to settle the case for $25,000. However, SAIF declined to compromise its "third party lien" of $14,911.60. Furthermore, claimant's counsel felt there was a "good chance" of recovering a judgment "two or three" times larger. Consequently, the pre-trial offer was rejected.

Following a three-day trial, the third party was found to be 77.5 percent contributorily negligent. Since claimant's damages were found to be $23,269, claimant was awarded a judgment against the third party totalling $17,909.50. Claimant's counsel devoted in excess of 132 hours of time while representing claimant during this third party case. Counsel estimates the value of such efforts at more than $15,000. Relying upon these efforts and claimant's retainer agreement, counsel seeks an extraordinary fee equal to 40 percent of the $17,909.50 judgment; i.e., $7,163.80.

SAIF opposes claimant's counsel's request, contending that the case involved a "simple automobile accident with not unique questions of law or fact." SAIF further notes that the third party was willing to settle the case for $25,000 prior to the trial. Finally, SAIF argues that the approval of an extraordinary fee will reduce its portion of the recovery by $800, as well as reduce claimant's share of the judgment.

CONCLUSIONS OF LAW

ORS 656.593(1) provides in exact detail how, and in what order, the proceeds of any damages from a third party judgment shall be distributed.

Costs and attorney fees shall be initially disbursed. ORS 656.593(1)(a). The attorney fees in no event shall exceed the advisory schedule of fees established by the Board for third party actions. ORS 656.593(1)(a); Shipley v. SAIF, 79 Or App 149, 152-53 (1986).

The Board's advisory schedule concerning attorney fees in third party cases is set forth in OAR 438-15-095. The rule provides as follows:

> "Unless otherwise ordered by the Board after a finding of extraordinary circumstances, an attorney fee not to exceed 33-1/3 percent of the gross recovery obtained by the plaintiff in an action maintained under the provisions of ORS 656.576 and 656.595 is authorized."

Extraordinary attorney fees have been allowed in the past. In Leonard F. Kisor, 35 Van Natta 282 (1983), a 40 percent share of the proceeds was allowed where the third party litigation involved a complex asbestosis issue and the paying agency did not object to the fee. An extraordinary fee of 40 percent has also been allowed where claimant's counsel expended nearly three full months in preparation for a 5-day malpractice trial and obtained an extremely favorable result. See John Galanopoulos, 35 Van Natta 548 (1983). Finally, in John P. Christensen, 38 Van Natta 613 (1986), claimant's counsel was granted an extraordinary fee of 50 percent where the case had been litigated over a 10-year period, including two presentations on procedural issues before the Oregon Supreme Court and one mistrial, and the paying agency had raised no objection to the request.

However, an extraordinary attorney fee was not allowed in David S. Holcomb, 41 Van Natta 195 (1989). In Holcomb, a $20,000 settlement of a third party action was achieved while claimant's appeal from a summary judgment order was pending. Although claimant's counsel had undoubtedly expended many hours in case preparation, the Board did not consider the case to be particularly complex nor did it find the litigation to have been lengthy as in Galanopoulos and Christensen. Finally, the Board noted that the paying agency objected to the allowance of an extraordinary attorney fee.

Here, claimant is requesting an extraordinary attorney fee equal to 40 percent of the third party judgment. We do not consider the circumstances present in this case to be extraordinary.

In reaching this conclusion, we find this case to be remarkably similar to Holcomb. Claimant's counsel has unquestionably devoted a significant amount of time in preparing and presenting claimant's case through a 3-day trial. However, there is no contention that the case, either legally or factually, was particularly complex. In addition, notwithstanding the extensive hours devoted to the case, claimant's counsel's efforts do not favorably compare to those expended in Galanopoulos or Christensen. Moreover, considering the size of the

pre-trial offer, the result cannot be characterized as "extremely favorable." Finally, the paying agency objects to the request.

Accordingly, for the reasons expressed herein, we find that this case does not constitute extraordinary circumstances justifying the allowance of an extraordinary attorney fee. Consequently, claimant's attorney is not entitled to an extraordinary attorney fee equal to 40 percent of claimant's third party recovery. Rather, claimant's attorney shall receive 33-1/3 percent of the third party judgment as prescribed in OAR 438-15-095. Thereafter, the remainder of the recovery shall be distributed in accordance with ORS 656.593(1).

IT IS SO ORDERED.

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In the Matter of the Compensation of
**KATHLEEN M. PAYNE, Claimant**
WCB Case No. 88-14535
ORDER ON RECONSIDERATION
Victor Calzaretta, Claimant Attorney
David Jorling, Defense Attorney

The self-insured employer requests reconsideration of that portion of our August 31, 1990 Order on Review that reversed the Referee's order which upheld the employer's denial of her occupational disease claim for a mental disorder. The employer asserts that: (1) there is no evidence in the record that demonstrates that the stressful conditions to which claimant was exposed in her position with the employer were not generally inherent in every working situation; and (2) the Board made no findings as to what conditions caused claimant's illness and whether those conditions were generally inherent in every working situation. We disagree.

There is ample evidence in the record to support a finding that the stressful conditions to which claimant was exposed as an ECO are not generally inherent in every working situation.

First, a number of witnesses testified, without contradiction, that the job of an emergency communications officer (ECO) was particularly stressful. Dr. Turco described the job as difficult and indicated that it was without question a stressful job. (Tr. 505, 551, 559 & 560). After claimant's mental disorder became disabling, he reported that she could not perform the job of ECO but that she was ". . . capable of working at any other department in the city." (Ex. 10, p.5). Dr. Hicks noted that claimant's job was highly stressful and that when she came under increasing stress she sought less stressful positions. (Tr. 170 and Ex. 12, p. 1). He reported several stressors common to ECOs including forced overtime, lack of rest and lunch breaks and the burden of being responsible for, at times simultaneous, emergency calls. (Tr. 146). Captain Davis, commander of the employer's Bureau of Emergency Communications, agreed that an ECO's job can be "pretty stressful" and involved "high pressure." (Tr. 86 & 130). Claimant's supervisor agreed that the Bureau was "a damn tough place to work." (Tr. 305). A former ECO of 14 years described the job as involving "terrific stress." (Tr. 367). It is also noteworthy that the employer's counsel made a point, when questioning claimant, to establish that she knew in advance the kind of stress with which she would have to deal, once she transferred from her former position as a secretary to the position of ECO. (Tr. 440).

Second, testimony makes clear that specific stressful conditions under which claimant worked were not generally inherent in every working situation.

One condition claimant found stressful was being responsible for the safety of police officers. Not only is such a condition not inherent in every working situation, it is not even required of ECOs in lower classifications. (Tr. 254). Forced overtime was another condition stressful to claimant. However, from 20 to 40 percent of all ECOs were not required to work any or as much overtime as claimant. (Ex. 24, Tr. 270, 291, 294, 388 & 415).

As to the employer's assertion that we made no findings as to what work conditions contributed to claimant's mental disorder and whether those conditions were generally inherent in every working situation, we direct the employer to the following portion of our order, labeled "ULTIMATE FINDINGS":

> "Claimant suffered a mental disorder, an adjustment disorder with mixed emotional features, the cause or worsening of which arose out of and in the course of her employment as an ECO for the employer. That mental disorder required medical treatment and resulted in disability.
>
> "Employment conditions, which existed in a real and objective sense, including answering emergency calls, dealing with irate and anxious people, working extra hours, often without a lunch break, having difficulty getting restroom breaks and being responsible for the safety of others contributed in material part to claimant's worsened mental disorder.
>
> "The conditions which resulted in claimant's disabling mental disorder were not conditions generally inherent in every working situation; they were not disciplinary, corrective or job performance evaluation actions; and they were not associated with the cessation of employment." (Emphasis supplied).

Accordingly, our August 31, 1990 order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our August 31, 1990 order effective this date. The parties' rights of appeal shall run from the date of this order. In addition to the attorney fee granted in our prior order, claimant's attorney is awarded an assessed attorney fee of $330 for services on reconsideration.

IT IS SO ORDERED.

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In the Matter of the Compensation of
**JOSEPH J. SEARING, Claimant**
WCB Case No. 88-21214
ORDER ON REVIEW
Vick & Gutzler, Claimant Attorneys
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Myers and Gerner.

The insurer requests review of Referee Howell's order which granted permanent total disability, whereas a Determination Order awarded 62 percent (198.4 degrees) unscheduled permanent disability for an inner ear dysfunction and 18 percent (10.8 degrees) scheduled permanent disability for the loss of hearing in claimant's right ear. On review, the issue is permanent total disability. We reverse.

## FINDINGS OF FACT

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

## CONCLUSIONS OF LAW AND OPINION

### Permanent Total Disability

The Referee found that claimant was capable of performing certain part-time jobs which paid minimum wage. He noted that this would net claimant less than one quarter of his pre-injury wage and less than one third of his TTD rate. He then stated:

> "The question is whether such employment is 'gainful' as that term is used in ORS 656.206(1)(a). The term 'gainful' is not defined by statute or administrative rule. A determination of what is gainful employment is left to be made on a case by case basis.
>
> "Based upon the facts of this case, I conclude that the 'suitable' work which is available to claimant does not constitute 'gainful' employment under ORS 656.206(1)(a)."

We disagree with the Referee's conclusion. In Walter R. Searles, 41 Van Natta 627, 629 (1989), aff'd 101 Or App 589 (1990), we reasoned as follows:

> "[T]he purpose of awarding permanent total disability benefits is to maintain claimant, not to restore him to pre-injury wage status (as is the purpose of vocational rehabilitation, for example). Steven E. Puttie, 40 Van Natta 1069, 1072 (1988); Walter R. LaChappelle, 36 Van Natta 1565, 1566 (1984). Given that purpose, 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."

Accordingly, based on the Referee's findings of fact and the aforementioned reasoning, we conclude that claimant is capable of performing suitable gainful employment. Therefore, claimant is not permanently and totally disabled.

### Extent of Permanent Disability - Scheduled and Unscheduled

Claimant makes no argument for an increase in his scheduled or unscheduled permanent partial disability awards, except for an award of permanent total disability. Likewise, the insurer makes no argument for reduction. Therefore, we decline to adjust the award where neither party requests us to do so. Lyndia M. Bristol, 42 Van Natta 1069 (1990); Jimmie C. Ward, 42 Van Natta 1265 (1990).

Therefore, the September 26, 1988 Determination Order shall be affirmed.

## ORDER

The Referee's order dated June 2, 1989, as reconsidered on June 13, 1989, is reversed. The Referee's award of permanent total disability is reversed. The September 26, 1988 Determination Order is reinstated and affirmed.

In the Matter of the Compensation of
**SPIROS J. VERGIS, Claimant**
WCB Case No. 89-05497
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Stafford Hazelett, Defense Attorney

Reviewed by Board Members Nichols and Brittingham.

Claimant requests review of Referee Quillinan's order which: (1) affirmed a Determination Order awarding 20 percent (64 degrees) unscheduled permanent disability for a low back injury; and (2) awarded 5 percent (7.5 degrees) scheduled permanent disability for loss of use or function of the left leg, whereas a Determination Order had awarded no permanent disability. On review, the issue is extent of scheduled and unscheduled permanent partial disability. We affirm.

## FINDINGS OF FACT

We adopt the Referee's "Findings of Facts" with the following supplementation. Claimant became medically stationary as of October 12, 1988. Claimant retains the following low back ranges of motion in degrees: forward flexion - 65; extension - 25; right and left flexion - 15; right rotation - 20; and left rotation - 30. Claimant walks without a limp. He has good muscle strength, no atrophy, and normal reflexes.

Claimant has constant L4-5 radicular pain which is disabling and radiates into the low back and the left buttocks. He cannot do repetitive bending, twisting, or stooping without pain. He cannot sit or stand for prolonged periods without pain. Claimant has leg muscle cramps after working all day.

## FINDINGS OF ULTIMATE FACT

Claimant has sustained a 19 percent permanent loss of earning capacity as a result of his compensable low back injury.

Claimant has suffered no loss of use or function of his left leg as a result of his compensable low back injury.

## CONCLUSIONS OF LAW AND OPINION

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

For purposes of determining injury-related permanent partial disability, ORS 656.283(7) and 656.295(5) require application of the standards for the evaluation of disabilities adopted by the Director pursuant to ORS 656.726(3)(f)(A). Those "standards" in effect on the date of the Determination Order from which the hearing was requested control the evaluation of permanent partial disability. OAR 438-10-010.

In this case, the claim was closed by a November 16, 1988 Determination Order. Consequently, the "standards" adopted effective July 1, 1988, (former OAR 436-35-001 et seq), as amended by temporary rules effective August 19, 1988, apply to the rating of claimant's permanent partial disability. Former OAR 436-35-270 through 436-35-440 apply to the rating of unscheduled permanent partial disabilities. Former OAR 436-35-270(1). Former OAR 436-35-010 through 436-35-260 apply to the rating of scheduled permanent partial disabilities. Former OAR 436-35-010(1).

Unscheduled Disability

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

Age, Education and Adaptability

The Referee found that claimant was working full-time at his at-injury job performing his former job duties to the satisfaction of his employer. On that basis, she found that the age, education and adaptability factors were not applicable to this worker.

Claimant contends that, although he has returned to work for the same employer, he has a 25 pound lifting restriction which modifies his working abilities. Consequently, he argues that the Referee erred in failing to apply the factors of age, education and adaptability. We disagree.

Workers who return to their "usual and customary work" are allowed no values for age, education or adaptability. Former OAR 436-35-290(2)(b); OAR 436-35-300(2)(b); OAR 436-35-310(2)(b). "Usual and customary work" as used in OAR 436-35-290 through 436-35-310 means the job held at the time of injury, or the same job for a different employer. Former OAR 436-35-270(3)(a).

Claimant concedes that his job duties as a journeyman painter are the same as prior to his injury. He testified that he lifts 50 pound buckets of paint and 35 to 45 pound extension ladders. Furthermore, since returning to work, claimant has missed no time from work due to his back condition and works overtime as available. On this basis, we conclude that clamant has returned to his usual and customary work. Accordingly, we assign no values for age, education and adaptability.

Impairment

Relying on the Orthopaedic Consultants' report of September 1, 1988, the Referee found that claimant has 8 percent impairment for lost ranges of low back motion. On review, we also rely on their report; however, we calculate a different impairment value. For 25 degrees loss of forward flexion, claimant is awarded a value of 2.5 percent, under former OAR 436-35-360(6); for 5 degrees loss of extension, claimant is awarded a value of .5 percent, under former OAR 436-35-360(7); for 5 degrees loss of right and left flexion, claimant is awarded a value of 1 percent each under former OAR 436-35-360(8); for 10 degrees loss of right rotation, claimant is awarded a value of 2 percent under former OAR 436-35-360(9). The values for loss of range of motion in each area of the thoracolumbar spine are added (not combined) for a total impairment value of 7 percent. Former OAR 436-35-360(10).

The Referee awarded a 5 percent impairment value for laminectomy with single discectomy and 3 percent for facetectomy. We affirm these awards. However, we disagree with the award of 4 percent for an unoperated L3-4 disc. The MRI performed prior to the L4-5 surgery only noted L3-4 findings of questionable significance. Further, claimant has never had any symptoms consistent with an L3-4 disc; his "clinically-related symptoms" have all been consistent with the L4-5 disc which has now been surgically excised. Therefore, claimant is entitled to no value for an unoperated disc.

Claimant also contends that the Referee erred in not assigning a value under the standards for disabling low back pain. We agree.

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

Here, we find that the preponderance of the evidence demonstrates that claimant has a loss of use or function in his low back attributable to disabling pain. The Orthopaedic Consultants noted that as a consequence of his impairment, claimant might not be able to return to a full eight-hour day. However, claimant has returned to his at-injury job, performing his former job duties, which includes repetitive bending. After working all day, claimant has L4-5 radicular pain into his low back and left buttocks and leg muscle cramps. We consider a value of 5 percent to be reasonable in this particular case.

Computation of Unscheduled Disability

Having determined each value necessary to compute claimant's permanent disability under the "standards," we proceed to that calculation. Claimant's age, education, and adaptability values are a nullity. When the total value for loss of low back motion (7 percent), the value for surgeries (8 percent) and the value for disabling pain (5 percent) are combined, the result is 18.7 percent unscheduled permanent partial disability. Former OAR 436-35-280(7). That disability figure is rounded to the next higher whole percentage. Id. Claimant's permanent disability under the "standards" is, therefore, 19 percent.

Scheduled Disability

The Referee found that claimant has some questionable loss of strength in the left great toe, and on this basis, awarded claimant 5 percent for loss of use or function of the left leg. We, on the other hand, find no evidence of muscle weakness or loss of use or function of the left leg. Dr. Nelson, claimant's treating physician, noted some mild, residual left radiculopathy in early and mid 1988. Pertinent findings from the Orthopaedic Consultants' September 1, 1988 closing exam, with which Nelson concurred, indicate that claimant walks without a limp, that he can specifically toe and heel walk, has good lower extremity muscle strength, and no anatomical sensory loss.

Moreover, if claimant has any toe/leg impairment, it is to be rated under former OAR 436-35-010(2)(a) and former OAR 436-35-130 et seq, not under former OAR 436-35-350(4). Nevertheless, we find no loss of use or function of the left leg or foot due to disabling pain and, therefore, decline to grant an award on this basis.

The insurer has not requested a reduction in either the unscheduled or scheduled disability awards. Therefore, we do not disturb the Determination Order award of 20 percent unscheduled permanent disability and the Referee's award of 5 percent scheduled permanent disability.

ORDER

The Referee's order dated July 19, 1989 is affirmed.

In the Matter of the Compensation of
**GILBERTO T. ZAPATA, Claimant**
WCB Case No. 88-22009
ORDER ON REVIEW
Olson, et al., Claimant Attorney
Roberts, et al., Defense Attorneys
Alice M. Bartelt, Defense Attorney

Reviewed by Board Members Gerner and Myers.

Claimant requests review of Referee Daron's order which affirmed Determination Orders awarding claimant a total of 35 percent (112 degrees) unscheduled permanent disability previously awarded in this claim. On review, claimant contends that he is permanently and totally disabled. We vacate the Referee's order and dismiss claimant's hearing request.

FINDINGS OF FACT

Claimant has a compensable injury dating from February 27, 1985. The claim was originally closed by Determination Order of December 11, 1985 which awarded claimant 15 percent unscheduled disability.[1]

Claimant filed an aggravation claim in 1987. The insurer denied the claim on October 13, 1987. Claimant requested a hearing on that denial. By Opinion and Order of January 20, 1988 as amended by an Order on Reconsideration of April 22, 1988, (both of which we take administrative notice) Referee Borchers set aside the denial of the aggravation claim. As a result of the reopening occasioned by Referee Borchers' order, a Determination Order dated June 24, 1988 awarded claimant an additional 20 percent unscheduled disability. The Evaluation Section amended the June 24, 1988 Determination Order by a Determination Order dated July 25, 1988, reducing the total award of unscheduled disability to 25 percent. Claimant requested a hearing to protest both 1988 Determination Orders, thereby giving rise to this case.

In the meantime, the insurer requested review of Referee Borchers' orders. On January 18, 1990, the Board reversed that portion of Referee Borchers' order which set aside the aggravation denial. Our order (of which we take administrative notice) stated: "That portion which set aside Liberty Northwest's denial of October 13, 1987 is reversed, and the denial is reinstated and upheld." Our order has now become final as a matter of law.

The effect of our earlier order is to nullify the two Determination Orders at issue in this case because the aggravation claim which gave rise to those Determination Orders is now not a compensable claim as a matter of law. Thus, under ORS 656.273, there is no basis for awarding claimant additional permanent disability because as a matter of law claimant's compensable condition is no worse than at the time of the December 11, 1985 Determination Order. Accordingly, this case is moot and claimant's request for hearing will be dismissed.

ORDER

The Referee's order dated June 21, 1989 is vacated. Claimant's hearing request is dismissed.

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[1] We note that the Referee's order purports to affirm this Determination Order; however, the request for hearing which gave rise to this case, does not purport to request review of this Determination Order. Furthermore, this Determination Order became final as a matter of law long before the hearing was requested in this case. Accordingly, that portion of the Referee's order which purports to affirm the Determination Order of December 11, 1985 is without effect.

In the Matter of the Compensation of
**RICHARD H. LONG, Claimant**
WCB Case Nos. 88-15939 & 88-17007
ORDER ON REVIEW (REMANDING)
Francesconi & Associates, Claimant Attorneys
Roberts, et al., Defense Attorneys
Scheminske, et al., Claimant Attorneys

Reviewed by Board Members Nichols, Brittingham and Crider.

Aetna Casualty Company requests review of those portions of Arbitrator Galton's order that: (1) set aside its denial of claimant's bilateral carpal tunnel syndrome; (2) upheld Alexsis Risk Management's denial, as processing agent for Western Employers Insurance, of claimant's aggravation claim for the same condition; (3) ordered Aetna to pay temporary disability compensation commencing May 4, 1988; (4) awarded claimant's attorney an assessed fee for prevailing against Aetna's denial; (5) assessed a penalty and attorney fee against Aetna for an alleged unreasonable denial; and (6) reduced the attorney fee requested by Aetna's counsel. On review, the issues are scope of review, responsibility, temporary disability benefits, penalties and attorney fees. We remand.

On July 2, 1985, claimant filed a claim for bilateral carpal tunnel syndrome with the employer. At that time Western Employers was on the risk. The claim was accepted and closed by Determination Order on May 26, 1986. In late 1987 claimant's condition began to deteriorate; his hands were "going to sleep." Aetna was on the risk at that time. In May 1988 claimant filed an aggravation claim with Western Employers, which was denied on September 7, 1988. Claimant also filed a new occupational disease claim with Aetna, which was denied on October 3, 1988. The Arbitrator, applying FMC Corp. v. Liberty Mutual Insurance Co., 70 Or App 370 (1984), modified 73 Or App 223, rev den 299 Or 223 (1985), and Champion International v. Castilleja, 91 Or App 556 (1988), placed the burden of proof on Aetna to demonstrate that it was not responsible. The Arbitrator assigned ultimate responsibility to Aetna because: 1) work activity while it was on the risk could have and did, in fact, contribute to the disability; 2) Aetna did not prove the claim with Western Employers was the sole cause of claimant's condition; and 3) Aetna did not prove it was impossible for work during its coverage to have caused the condition.

We review the Arbitrator's order solely on questions of law. ORS 656.307(2); Timothy R. Schroeder, 41 Van Natta 568 (1989). We conclude that the Arbitrator did not apply the correct standard of law.

This case involves an accepted occupational disease with Western Employers, followed by an increase in disability during subsequent employment while Aetna was on the risk. Responsibility is, therefore, initially fixed with Western Employers, as the insurer on the accepted claim. In order to avoid responsibility, Western Employers must prove affirmatively that the later employment during Aetna's coverage independently contributed to claimant's pathology, as distinct from mere symptoms, or that the accepted injury did not contribute to the current condition. Spurlock v. International Paper Co., 89 Or App 461 (1988); Fred Meyer v. Benjamin Franklin Savings & Loan, 73 Or App 795 (1985); Linda L. Wise, 42 Van Natta 115 (1990).

Accordingly, the Referee should have charged Western Employers--not Aetna--with the burden of proving it was not the responsible carrier. Moreover, the Referee did not determine whether the work activity during Aetna's coverage independently contributed to claimant's pathology, as distinct from mere symptomatology.

The Board may remand a case if it determines that the record has been improperly, incompletely or otherwise insufficiently developed. ORS 656.295(5). Here, remand is appropriate because the Arbitrator did not make necessary findings nor apply the correct standard of law as discussed above. Inez Horsey, 42 Van Natta 331 (1990).

Accordingly, the Referee's order is vacated and this matter is remanded to Arbitrator Galton for further proceedings consistent with this order in any manner which will achieve substantial justice.

IT IS SO ORDERED.

**Board Member Crider dissenting.**

The Referee found that claimant's work while Aetna was on this risk, which involved repetitive fine bilateral hand movements, "actually and in a major way contributed to and caused the disability for which claimant now seeks compensation." He adopted Dr. Silver's finding that claimant's work while Aetna was on the risk was the major contributing cause of his worsened condition. The Referee did not use the word "independent." Nevertheless, given the findings he did make, and his citation to Eleanor M. Thurston, 40 Van Natta 1191 (1988), in which the Board applied the independent contribution test, it would appear that he applied the proper legal test. Given his findings, the Referee correctly concluded that responsibility for the worsened condition rests with Aetna. Spurlock v. International Paper Co., 89 Or App 461 (1988).

The Board apparently disagrees with the Referee's understanding of the law with regard to allocation of the burden of proof in responsibility cases: The Referee would allocate the burden to the last employer, the Board to the first. That disagreement is of no consequence, however, because the outcome of this case does not depend on which employer has the burden.

The Referee has made the findings necessary to apply the relevant legal principles and discussed the appropriate case law. There is no reason for remanding this case for additional findings.

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In the Matter of the Compensation of
**BECKY L. SCHMIDT, Claimant**
WCB Case No. 89-05984
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Davis & Bostwick, Defense Attorneys

Reviewed by Board Members Howell and Speer.

Claimant requests review of that portion of Referee Mongrain's order that declined to award temporary total disability benefits from March 29, 1989 to May 15, 1989. The self-insured employer cross-requests review of that portion of the Referee's order that awarded temporary total disability benefits after May 15, 1989. On review, the issue is temporary disability benefits. We reverse in part and affirm in part.

FINDINGS OF FACT

Claimant developed bilateral carpal tunnel condition in 1988, as a result of her work activities. She first sought treatment for her carpal tunnel

condition on May 4, 1988. Claimant was released to light work on May 9, 1988. The employer accepted her claim and claimant remained at modified work until January 11, 1989, when she stopped work due to a strike called by her union. At that time, claimant was not medically stationary and her claim had not been closed.

On March 29, 1989, claimant's treating physician, Dr. Whitney, performed right carpal tunnel surgery and claimant became unable to work. The union's strike ended on May 15, 1989, but claimant remained unable to work because of her disability. Claimant would have returned to work if she had not been disabled.

On April 3, 1989, the employer authorized claimant's carpal tunnel surgery but denied temporary total disability benefits on and after March 29, 1989 on the grounds that claimant had voluntarily removed herself from the labor market on January 10.

CONCLUSIONS OF LAW AND OPINION

The Referee found that, because she was out on a strike called by her union at the time she underwent surgery and became unable to work, claimant was not a "worker" on March 29. The Referee concluded that claimant was not entitled to temporary disability benefits until the time the strike ended. We disagree.

A claimant who has withdrawn from the work force is not entitled to temporary total disability benefits. Dawkins v. Pacific Motor Trucking, 308 Or 254 (1989). The critical time for determining whether a claimant has withdrawn from the work force is at the time of the disability. Weyerhaeuser v. Kepford, 100 Or App 410, 414 (1990).

In Kepford, the court found that the claimant was working and was, therefore, a member of the work force at the time he became disabled by his occupational disease. The court stated that it did not matter whether the claimant had retired or withdrawn from the work force after that time, and claimant need not show that he remained in the work force. The court held that, because the claimant 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. Kepford, supra. See also, ORS 656.325(5); Fazzolari v. United Beer Distributors, 91 Or App 592, rev den 307 Or 236 (1988).

In the present case, we conclude that claimant's status as a worker was determined at the time she became disabled by her occupational disease, rather than at the time she underwent surgery. Here, claimant became temporarily disabled and was performing modified work before the beginning of the strike on March 29, 1989. We therefore conclude that, even if claimant had withdrawn from the work force by going on strike, she was entitled to temporary partial disability compensation (even though the amount may have been zero; see former OAR 436-60-030(2)) before the strike commenced; and she became entitled to temporary total disability benefits on March 29, 1989 when she underwent surgery and became totally disabled. Former OAR 436-60-030(4)(a). She remained entitled to temporary disability compensation until she became medically stationary and was released for work. Fazzolari, supra.

We adopt that portion of the Referee's order which found that claimant was entitled to temporary disability benefits after the strike ended on May 15, 1989.

Finally, after considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that $750 is a reasonable fee for claimant's counsel's efforts in defending against the employer's cross-request. In reaching this conclusion, we have particularly considered the time devoted to the issue, as represented by claimant's cross-respondent/reply brief, the complexity of the issue, and the value of the interest involved. We further note that claimant's counsel is also receiving an approved fee for efforts in increasing claimant's award of temporary disability.

ORDER

The Referee's order dated July 14, 1989 is reversed in part and affirmed in part. That portion of the Referee's order that upheld the employer's denial of temporary total disability benefits from March 29, 1989 to May 15, 1989 is reversed. Claimant is awarded temporary total disability beginning March 29, 1989 and continuing until such compensation may be terminated pursuant to ORS 656.268. Claimant's counsel is awarded 25 percent of the increased compensation created by this order, not to exceed $1,050. For services on review concerning the employer's cross-request, claimant's attorney is awarded a reasonable fee of $750, to be paid by the employer.

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In the Matter of the Compensation of
**WILLIAM STANLEY, JR., Claimant**
WCB Case No. 89-03135
ORDER ON REVIEW
Black, Chapman & Webber, Claimant Attorneys
David Schieber (Saif), Defense Attorney

Reviewed by Board Members Brittingham and Nichols.

Claimant requests review of Referee Higashi's order which upheld the SAIF Corporation's denial of his injury claim for a myocardial infarction. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

Claimant, 51 years old as of the date of the hearing, has been a painter most of his life. He worked as an industrial painter for SAIF's insured for five years prior to his myocardial infarction. This job involved traveling to industrial sites to paint as contracted by the insured.

Claimant was painting atop an anhydrous ammonia tank on September 8, 1988, when he inhaled ammonia fumes from a leak. He experienced burning eyes and chest, and had problems breathing deeply for which he went to the local hospital emergency room. No treatment was deemed necessary.

He was again exposed to ammonia fumes for about 45 seconds on October 28, 1988, and experienced the same symptoms. Claimant and his coworkers left that job site and he drove, by himself, 100 miles to the next job site. Claimant continued to experience chest discomfort. Sometime after going to bed around 10 p.m. that night, claimant began experiencing pain radiating down his left arm. Finally, around 2 a.m., claimant drove himself to the local emergency room. Eventually, he was diagnosed as having a anteroseptal subendocardial myocardial infarction--cause unknown.

Claimant has a 30 year history of heavy smoking. He has preexisting chronic obstructive pulmonary disease, and has sought treatment for previous episodes of chest pain, some due to pulmonary problems and some of undetermined origin.

Claimant returned to work. However, his symptoms continued and coronary angiography was performed. Claimant has significant coronary artery disease involving two major arteries.

FINDINGS OF ULTIMATE FACT

Claimant's work activity was not a material contributing cause of his myocardial infarction.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant's myocardial infarction is not compensable. We agree.

To establish the compensability of his heart attack, as an injury claim, claimant must show that his work activity as an industrial painter materially contributed to that injury. See e.g. Somers v. SAIF, 77 Or App 259 (1986); Hurst v. SAIF, 76 Or App 532 (1985). On review, claimant argues that he is not alleging that his heart attack is compensable--he is alleging only that the exposure to ammonia is compensable as an injury, because it required medical services and led to disability. His argument is misplaced. See ORS 656.005(7)(a). Claimant was treated for a heart attack on October 29, 1988; he filed a claim for a heart attack; SAIF denied the compensability of his heart attack; the Referee upheld the denial of claimant's heart attack. That is the issue before this Board.

The question of medical causation in this case requires expert medical analysis. Thurston v. Mitchell Bros. Contractors, 58 Or App (1982). The issue which must be addressed by the experts is: What role, if any, did the inhalation of ammonia have in causing claimant's heart attack. At the outset, we disregard the opinion of Dr. Hites, claimant's treating family physician, because he did not address this critical issue.

We find the opinion of Dr. Gross, claimant's expert cardiologist, to be tentative, at best. First, he seems to infer a relationship between claimant's heart attack and the ammonia exposure--twice pointing out the close temporal sequence of these two events. The establishment of causation due to a chronological sequence of events is discouraged. Allie v. SAIF, 79 Or App 284, 288 (1986). Next he mistakenly noted that claimant had no prior history of coronary ischemia. However, the record establishes otherwise and, therefore, we give little weight to an opinion based on an inaccurate history. Finally, Dr. Gross proposes the theory that the ammonia exposure promoted an aggravated emotional state by preventing claimant from completing his job, thus, indirectly causing claimant's heart attack. He offers no support or explanation for this theory.

On the other hand, we find the opinion of Dr. Mots, examining cardiologist, to be most persuasive. The doctor explained that ammonia has no direct effect on the heart and could only lead to a myocardial infarction by causing severe oxygen deprivation, which would require greater exposure to ammonia and a greater reaction than claimant experienced. The doctor also noted that claimant's heart attack was due to an obstruction of a coronary artery which in turn was due to the chronic buildup of plaque over years in the coronary arteries. This has been confirmed by angiography which shows significant occlusion of two major coronary arteries. Thus, we find that Mots' opinion is based on a

complete and accurate history and is consistent with the diagnostic coronary studies that have been performed.

Consequently, we conclude that claimant has failed to prove that his work materially contributed to his myocardial infarction.

ORDER

The Referee's order dated August 1, 1989 is affirmed.

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September 26, 1990 Cite as 42 Van Natta 2071 (1990)

In the Matter of the Compensation of
**KAREN A. VEARRIER, Claimant**
WCB Case No. C0-00034
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Pozzi, et al., Claimant Attorneys
Acker, et al., Defense Attorneys

On August 23, 1990, the Board acknowledged receipt of the parties' claim disposition agreement in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of $110,000 by First Interstate Bank of Oregon, N.A., claimant agrees to release her right to future workers' compensation benefits, except medical services, for her compensable injury. She also agrees to release her right to reemployment with the employer. We set aside the proposed disposition.

ORS 656.236(1) permits parties, by agreement, to make "such disposition of any or all matters regarding a claim, except for medical services, as the parties consider reasonable," subject to the terms and conditions prescribed by the Director. The Director's rules define a "claim disposition agreement" as a written agreement in which a "claimant agrees to release rights, or agrees to release an insurer or self-insured employer from obligations, under ORS 656.001 to 656.794 except for medical services, in an accepted claim." OAR 436-60-005(9). See also OAR 438-09-001(1). The underscored portion of the rule makes clear that only rights and/or obligations under ORS Chapter 656 may be released by a claim disposition agreement.

Here, the proposed disposition releases rights and obligations under ORS Chapter 656, but also purports to release claimant's right to reemployment under ORS Chapter 659. See ORS 659.415. The latter release, because it concerns a matter outside of ORS Chapter 656, is not a proper matter for disposition under ORS 656.236 and the rules promulgated thereunder. Indeed, there is no authority which permits us to approve a release of reemployment rights. For those reasons, the proposed disposition is not a "claim disposition agreement" as defined by OAR 438-09-001(1). Furthermore, we are mindful that the offensive portion of the disposition agreement cannot be excised without substantially altering the bargain underlying the exchange of consideration. Accordingly, we are without authority to approve any portion of the proposed disposition.

Following our standard procedures, we would be willing to consider a revised agreement which does not contain provisions exceeding our authority under ORS 656.236 and OAR 438-09.

IT IS SO ORDERED.

In the Matter of the Compensation of
**JOSE ARISQUETA-MARTINEZ, Claimant**
WCB Case No. 89-06673
ORDER ON REVIEW (REMANDING)
Burt, et al., Claimant Attorneys
Merrily McCabe (Saif), Defense Attorney

Reviewed by Board Members Howell and Speer.

Claimant requests review of Referee Myers' order that dismissed claimant's request for hearing because claimant failed to appear at hearing. Claimant seeks to have the dismissal set aside, and an order remanding the case to the Hearings Division for a hearing on the merits. On review, the issue is jurisdiction. We remand.

FINDINGS OF FACT

Claimant requested a hearing on compensability of his knee injury. The hearing was set for June 14, 1989.

Claimant failed to appear for the hearing, asserting that he had not received notice of the time set for hearing.

CONCLUSIONS OF LAW AND OPINION

The Referee entered an Order of Dismissal and a subsequent order denying reconsideration, finding that claimant failed to appear at the June 14, 1989 hearing, and concluding that claimant did not prove extraordinary circumstances beyond his control which would have justified a postponement. Pursuant to former OAR 438-06-071 and former 438-06-081, the Referee issued the Order of Dismissal. Claimant filed a request for reconsideration, which the Referee properly construed as a request for postponement. We also review claimant's request as a request to review the ruling on the motion for postponement. We reverse and remand.

The Referee relied on former OAR 438-06-071 which authorizes the referee to dismiss a request for hearing for "failure of a party, or the party's representative to appear at the time and place scheduled for a hearing." Claimant personally failed to appear. However, claimant did appear by counsel. In Williams v. SAIF, 99 Or App 367 (1989), the Court of Appeals held that former OAR 438-06-071 does not provide authority for dismissal for failure of a claimant to appear at hearing if claimant's attorney appears on his behalf. On review, the Supreme Court reversed and remanded. 310 OR 320 (September 20, 1990). The Court concluded that the Referee and the Board had relied on former OAR 438-06-085, rather than former OAR 438-06-071, in dismissing claimant's hearing request. The Court affirmatively noted that it expressed no opinion regarding the Court of Appeals' interpretation of former OAR 438-06-071. Consequently, the Court of Appeals' discussion of former OAR 438-06-071 was dicta.

Nevertheless, we are persuaded that the Court of Appeals' dicta in Williams v. SAIF, supra, regarding the application of former OAR 438-06-071 is correct and we continue to apply that interpretation to cases involving the rule. See Mark A. Wiitala, 42 Van Natta 196 (1990); Denette D. Dale, 41 Van Natta 2179 (1989). Accordingly, we find the Referee was without authority to dismiss.

We therefore proceed to consider claimant's counsel's motion for postponement. The Referee considered claimant's counsel's motion to postpone and found claimant had failed to establish "good cause" which would justify a postponement. Under former OAR 438-06-081 claimant must demonstrate that extraordinary circumstances beyond his control existed that prevented his appearance at

hearing in order to obtain a postponement. Claimant contends that he did not receive notice of the June 14, 1989 hearing date. However, his attorney mailed a total of four letters to claimant's old and new addresses. Claimant knew that a request for hearing had been made. However, he failed to maintain contact with the Hearings Division and his attorney. See Anthony E. Beardslee, 42 Van Natta 965 (1990). Accordingly, we conclude claimant has failed to establish extraordinary circumstances beyond his control which would justify postponement. Therefore the motion to postpone was properly denied. Additionally, because claimant failed to appear at the first hearing he has waived his right to appear at a subsequent hearing. Dale, supra at 2181.

We remand this matter to the Hearings Division for a hearing on the merits. At hearing, the assigned Referee shall determine what evidence may be received, however, no exhibits shall be received which were not submitted in connection with the prior hearing, nor shall any witness, including claimant, be permitted to testify who was not available to and planning on testifying at the prior hearing or under subpoena to testify at that hearing.

ORDER

The Referee's Order of Dismissal dated June 15, 1989, as reconsidered on August 22, 1989, is vacated and the case is remanded to the Presiding Referee to reassign the case for further proceedings consistent with this order.

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September 27, 1990 Cite as 42 Van Natta 2073 (1990)

In the Matter of the Compensation of
**STANLEY R. BARG, JR, Claimant**
WCB Case No. 89-02280
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Cowling & Heysell, Defense Attorneys

Reviewed by Board Members Myers and Cushing.

Claimant requests review of that portion of Referee Mirassou's order that upheld the self-insured employer's denial of temporary total disability benefits. The employer cross-requests review of that portion of the order that assessed attorney fees for an alleged unreasonable denial. On review, the issues are temporary disability benefits and attorney fees. We reverse.

FINDINGS OF FACT

On August 22, 1988, claimant sustained a compensable left shoulder injury. The claim was accepted as a nondisabling injury. On September 20, 1988, claimant consulted Dr. Peterson, who provided conservative treatment while claimant continued regular work. During treatment, Dr. Peterson discussed the possibility of surgery if claimant's condition did not improve. (Tr. 5).

Claimant left work on January 10, 1989, incident to a labor dispute. On January 13, 1989, Dr. Peterson referred claimant to Dr. Singer for consideration of surgery. (Ex. 4). On January 24, 1989, the employer authorized surgery, but denied temporary total disability on the ground that claimant had voluntarily removed himself from the work force. The employer did not inquire into claimant's current employment status.

On January 27, 1989, claimant became disabled as a result of his compensable injury when Dr. Singer performed shoulder surgery. Dr. Singer released claimant to regular work on April 11, 1989.

Claimant did not seek work between January 10, 1989 and January 27, 1989 in anticipation of his upcoming examination and surgery. Claimant did, however, receive strike pay during that period. Since his release to work, claimant has received wages for three days of part-time work performed for friends. As of the hearing, he had started a job search.

## CONCLUSION OF LAW AND OPINION

### Temporary Total Disability Benefits

The Referee found that claimant was not entitled to temporary total disability benefits because, at the time he became disabled, he was not a "worker." We disagree.

It is undisputed that claimant's surgery was related to his compensable injury. The question is whether claimant had withdrawn from the work force at the time he became disabled. A claimant is considered to be in the work force if the claimant, although not employed at the time, is willing to work and is making reasonable efforts to obtain employment. Dawkins v. Pacific Motor Trucking, 308 Or 254, 258, 778 P2d 497 (1989).

Subsequent to the Referee's order, the Board issued Hal L. Farnworth, 42 Van Natta 1674 (1990). In that factually similar case, the claimant sustained an injury but continued to work, later went on strike and subsequently became disabled after surgery. The Board concluded that, although he had left the job, the claimant was entitled to temporary total disability. The Board reasoned that the claimant's actions, including the scheduling of surgery prior to the strike date, his work search after surgery, and the fact that he would have been required to take time off work regardless of the strike indicated that he had not voluntarily withdrawn himself from the work force.

We conclude that the same reasoning applies here. Claimant testified that, after the commencement of the labor dispute, he intended to "get a job somewhere else." (Tr. 6). He underwent surgery shortly after he left work and, while not scheduled prior to the strike date, the operation was contemplated before the strike was called. Moreover, at the time of the hearing, claimant had worked part time and had begun a job search. Considering the totality of the circumstances, we conclude that, at the time of his disability, claimant had not withdrawn from the work force.

Therefore, claimant is entitled to temporary total disability benefits from the date of his surgery, January 27, 1989, until the date he was released to return to regular work, April 11, 1989.

### Attorney Fees

The Referee found that, although claimant was not entitled to temporary total disability benefits, the employer had acted unreasonably in failing to inquire into claimant's employment status before issuing the denial. The Referee did not assess a penalty, because she determined that there were no "amounts then due," but determined that claimant was entitled to attorney fees. We disagree.

Attorney fees may be assessed whether or not there are "amounts then due" so long as there is "unreasonable resistance to the payment of compensation." Lloyd L. Cripe, 41 Van Natta 1774 (1989). Here, the employer failed to ascertain whether claimant had withdrawn from the work force after the commencement of the labor dispute. Evidently, it was believed that claimant necessarily had withdrawn from the work force when he went on strike. Given the recent changes

in this area of law, we find that the employer's belief was not unreasonable. Therefore, the denial does not constitute an unreasonable resistance to the payment of compensation. Consequently, claimant is not entitled to attorney fees.

ORDER

The Referee's order dated May 31, 1989 is reversed. The employer is ordered to pay claimant temporary total disability benefits for the period between January 27, 1989 and April 11, 1989, less strike pay or wages received during this period. Claimant's attorney is granted 25 percent of the increased compensation created by this order, not to exceed $1,050. That portion of the Referee's order which awarded claimant's attorney a penalty-related fee of $500, is reversed.

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In the Matter of the Compensation of
**TORIA S. BENSON, Claimant**
WCB Case Nos. 85-14056 & 84-01712
ORDER ON REMAND
Roberts, et al., Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Benson v. Multnomah County School District #1, 101 Or App 122 (1990). The court has reversed that portion of our order in Toria S. Benson, 40 Van Natta 580 (1988), which had set aside a denial of claimant's neck, shoulders, and back condition, as well as resulting psychological disability. Noting that claimant's description of events at work, as implicitly found not credible by the Referee, was the only direct evidence connecting these conditions to her work activities, the court has remanded for reconsideration.

FINDINGS OF FACT

Claimant worked as a school teacher for the employer from 1965 through 1983. In November 1983, she filed a claim alleging that in three separate incidents with students at school in early October 1983 she had sustained injuries to her neck, shoulders and back. In addition, she contended that these episodes contributed to a preexisting psychological disability.

These altercations were alleged to have occurred approximately one week before claimant was placed on a work plan, which included monitoring of claimant's classroom by the school principal. Despite several meetings with claimant and with students' parents during the weeks following the alleged incidents, the principal was unaware of either the alleged incidents or claimant's alleged injuries until the investigation concerning claimant's claim ensued in November 1983. Furthermore, except for a voice problem on one occasion, the principal did not notice any physical change in claimant's appearance or manner.

Claimant had previously sought medical attention for neck, shoulder, back, anxiety, and psychological stress prior to the alleged October 1983 events. Also, at the time of these events, claimant was receiving medical treatment. Despite these ongoing treatments, claimant's treating physicians were unaware of the alleged incidents and their alleged relationship to her conditions until around the time she filed her November 1983 claim.

CONCLUSIONS OF LAW

To establish the compensability of her neck, shoulder, back, and psychological disabilities, claimant must establish that the alleged work incidents were a material contributing cause of her existing disability or need for medical services. Harris v. Albertson's Inc., 65 Or App 254, 257 (1983). She need not establish that the alleged incidents caused a pathological worsening of her preexisting conditions. Jameson v. SAIF, 63 Or App 553, 555 (1983). Instead, she must prove that the incidents caused her conditions to become symptomatic, causing disability or requiring medical services. Grace v. SAIF, 76 Or App 511, 517 (1985).

Considering the extent of claimant's prior medical history, particularly concerning her preexisting conditions, and in light of the complexity of the causal relationship between the alleged incidents and her current disability, we conclude that resolution of the compensability issues largely turns on an analysis of the medical evidence. Uris v. Compensation Department, 247 Or 420, 426 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985).

Here, the medical opinions are divided as to whether claimant's current complaints are related to her work activities. However, the opinions that support a causal relationship between claimant's work activities and her current disabilities are based on the assumption that claimant suffered bodily injury resulting from the alleged October 1983 incidents at school. In finding that claimant had not established the requisite causal link between her work and the disabilities, the Referee implicitly found that claimant's description of the incidents and her resulting injuries lacked credibility.

When a Referee's credibility finding is made on the basis of demeanor, deference is given to the Referee's determination. International Paper Co. v. McElroy, 101 Or App 61 (1990). Yet, when the determination is implicit or based on the substance of the witness' testimony or record, we are equally capable of assessing credibility. International Paper Co. v. McElroy, supra; Coastal Farm Supply v. Hultberg, 84 Or App 282, 285 (1987).

Here, because the Referee's credibility finding was implicit, there is no determination to which we can defer. Therefore, we are equally capable of making a credibility assessment. After conducting our independent assessment, we find it particularly noteworthy, as the Referee did before us, that, despite the alleged severity of claimant's complaints arising from the alleged October 1983 incidents, neither her treating physicians nor her school principal were apparently aware of these events until her claim was filed approximately one month later.

Under such circumstances, we find claimant's contention that she suffered bodily injury as a result of the alleged October 1983 physical confrontations at school to be unpersuasive. Inasmuch as we do not rely upon claimant's contention that her complaints are attributable to the alleged work incidents, it follows that we question her reliability as a medical historian. Consequently, we likewise do not rely upon the medical opinions based upon these histories. Miller v. Granite Construction Co., 28 Or App 473 (1977).

In conclusion, because the record lacks persuasive medical evidence supporting a causal relationship between claimant's current disabilities and the alleged work incidents, and particularly considering claimant's extensive history of preexisting conditions, we hold that her claims for neck, shoulders, back and psychological conditions are not compensable. Accordingly, the employer's denial of claimant's claim for the aforementioned conditions is reinstated and upheld.

IT IS SO ORDERED.

In the Matter of the Compensation of
**RONALD L. DAVIS, Claimant**
WCB Case Nos. 88-20542, 88-20543, 89-03968 & 89-03969
ORDER ON REVIEW
John Mayfield, Claimant Attorney
Schuyler Wallace, Defense Attorney
Roberts, et al., Defense Attorneys

Reviewed by Board Members Crider and Nichols.

CNA Insurance Companies requests review of those portions of Referee Mills' order that: (1) set aside its denial of an aggravation claim for a low back condition; and (2) upheld Town & Country Chrysler-Plymouth's denial of a new injury claim for the same condition. On review, the issues are standard of review and responsibility. We affirm.

On de novo review, we affirm and adopt the Referee's order. Town & Country Chrysler-Plymouth contends that because the Referee's order was issued pursuant to a .307 order, we review only for questions of law. We disagree. At the time this hearing was convened, no .307 order had issued. Although compensability was conceded at hearing and a .307 order issued before the Referee's order issued, we have held that the special provisions of ORS 656.307 do not apply to cases in which a .307 order does not issue before hearing. Thus, in Jan C. Leech, 42 Van Natta 2047 (1990), in which a .307 order issued after hearing but before the Referee's order issued, we awarded an attorney fee under ORS 656.386(1) rather than ORS 656.307(5). We adhere to that approach in interpreting the applicability of ORS 656.307(2).

ORDER

The Referee's order dated July 20, 1989 is affirmed.

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In the Matter of the Compensation of
**IVAN E. GIBSON, Claimant**
WCB Case No. 88-20112
ORDER ON REVIEW
Coons & Cole, Claimant Attorneys
Employers Defense Counsel, Defense Attorneys

Reviewed by Board Members Crider and Brittingham.

Liberty Northwest Insurance Corporation requests review of Referee Livesley's order that set aside its denial of claimant's herniated lumbar disc. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

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

Claimant reported the malfunctioning air seat. It was immediately repaired.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant suffered a compensable injury when an air hose malfunction caused him to drive employer's dump truck off the road in

July 1988, and that the injury became symptomatic and was worsened by the repetitive trauma he experienced driving a dump truck after that time. We disagree.

In order to prove a compensable injury, claimant must prove by a preponderance of the evidence that an industrial injury materially contributed to his disability. Olson v. State Ind. Acc. Comm., 222 Or 407 (1960). Claimant credibly testified that he had no pain until August 20, 1988. Because one cannot easily infer a relationship between the July incident and the August onset of symptoms, medical evidence is required to establish a causal relationship. See Volk v. Birdseye Division, 16 Or App 349 (1974).

Dr. Williams, M.D., general practitioner, in response to a hypothetical involving the July incident followed by pain at an unspecified time, said that claimant's work, including the July incident, was a material cause of claimant's disc herniation. Dr. Serbu, neurosurgeon, to whom Dr. Williams referred claimant for surgery, responded to the same hypothetical, finding causation "if [claimant] truly did have an injury when his airbrakes went out." Serbu noted that claimant had given him no such history. Furthermore, he would not say that claimant's work driving on rough roads and jostling in his seat caused his disc herniation and said he would be very surprised if a disc herniated and no pain occurred for 3 weeks. He indicated that a disc herniation may occur without injury. Under these circumstances, we find that Dr. Serbu does not support compensability. Given Serbu's expertise and the history given him by claimant, we defer to his opinion, which we find more persuasive than that of Dr. Williams. See Earl M. Brown, 41 Van Natta 287, 291 (1989). Claimant has failed to carry his burden of proof.

ORDER

The Referee's order dated July 7, 1989 is reversed. Liberty Northwest Insurance Corporation's denial is reinstated and upheld. The assessed fee of $2,000 awarded to claimant's attorney is reversed.

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In the Matter of the Compensation of
**LISA M. GILCREASE, Claimant**
WCB Case No. 89-06794
ORDER ON REVIEW
Merrill Schneider, Claimant Attorney
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Cushing and Myers.

Claimant requests review of Referee Quillinan's order which upheld the insurer's denial of claimant's back injury claim.

ISSUES

Claimant contends that the Referee erred in her order on reconsideration by concluding that claimant had made only a claim for an industrial injury, not a claim for an occupational disease. Claimant further contends that claimant has proven that she sustained either a compensable industrial injury or a compensable occupational disease while working for the employer in December 1988.

The insurer contends that the Referee was correct in concluding that claimant had made only a claim for an industrial injury, and, therefore, that

she had waived any claim for an occupational disease. The insurer further contends that claimant has failed to prove the compensability of either an industrial injury or an occupational disease. We agree with the insurer's last contention and affirm.

## FINDINGS OF FACT

Claimant allegedly injured her back in 1986 while working for another employer. The claim was ultimately resolved under a disputed claim settlement. Claimant continued to receive chiropractic treatment between 1986 and December 1988. In December 1988, claimant began working as a nurse's aide for this employer.

Claimant quit work on January 6, 1989 for reasons unrelated to any injury or occupational disease. On January 6, 1989, claimant saw Dr. Woodham, her treating chiropractor, complaining of gradually worsening back symptoms over the month she worked for the employer. Dr. Woodham believed that claimant left work due to her back pain. Dr. Woodham opined that claimant had suffered an aggravation of her earlier injury. Dr. Woodham's form 827, the "First Medical Report" lists December 9, 1988 as "date of injury."

On March 16, 1989, the insurer denied "your cervical and thracic (sic) complaints." On April 7, 1989, claimant requested a hearing. The request referred to the denial; in the specification of issues, claimant listed compensability of both an industrial injury and an occupational disease. In its response, the insurer again denied that claimant had sustained either a compensable injury or occupational disease.

In a June 27, 1989 report, Dr. Woodham first mentions an incident during claimant's first two weeks at work in which she experienced a sudden increase in symptoms. He opined that claimant had suffered a soft tissue injury of the thoracic spine. During an independent medical examination on June 26, 1989, claimant also reported the history of an incident. Claimant did not report the incident to her employer in December 1988 or January 1989.

Claimant is not a reliable witness.

At hearing, claimant's attorney stated the issue as follows:

> "The issue is appeal of a denial, which is exhibit 4, which denies claimant's 12-9-88 injury. We're asking that the claim be accepted, the denial be overturned."

## CONCLUSIONS OF LAW AND OPINION

### The Issues at Hearing

In her original Opinion and Order, the Referee concluded that claimant was not a reliable witness; nonetheless, she concluded that claimant had sustained a new back strain as a result of her work activities and that the work activities were the major cause of the back strain and need for treatment. The insurer requested reconsideration, arguing that the sole issue before the Referee was compensability of an industrial injury. It contended that it had been prevented from responding to an occupational disease claim by claimant's statement of the issues. On reconsideration, the Referee stated: "The insurer's point that this was not an occupational disease claim is well-taken." Accordingly, she reversed her original decision and found that claimant had failed to prove an injury. She, therefore, upheld the insurer's denial.

We conclude that the issue of compensability of either an occupational disease or an industrial injury was properly before the Referee. Dr. Woodham's form 827 indicates that claimant's work activities caused claimant's problems; however, he listed as the date of injury December 9, 1988, claimant's first day of work. The insurer's denial merely denies the compensability of claimant's alleged condition. It does not specify whether the claim is for an industrial injury, an occupational disease, or both. Claimant's specification of issues indicates that she understood the denial as denying both an injury and an occupational disease, as does the insurer's response to the request for hearing.

It is true that in his statement of the issues at hearing that claimant's attorney stated that the issue was an appeal of the denial of an injury of December 9, 1988. While the attorney's statement of the issues might have been more artfully worded, we do not believe that the fact that he mentioned an injury and a particular date is sufficient to establish that he was only pursuing an injury claim. Given the fact that Dr. Woodham described an occupational disease and gave a date of injury and the fact that the insurer denied only a condition and the fact that both claimant's and the insurer's pleadings refer to both an injury and a disease, we conclude that both issues were properly before the Referee.

The Merits

On de novo review of both the industrial injury and occupational disease claims, we conclude that claimant has failed to sustain her burden of proof. Accordingly, we agree with the Referee that the denial should be upheld.

Both the injury claim and the occupational disease claim are based primarily on claimant's history. Dr. Woodham's opinions are based on what claimant told him about the alleged onset of increased pain, either as a result of the alleged incident or as a result of claimant's work activities. We discount Dr. Woodham's opinion because it is based on claimant's history. We agree with the Referee's original opinion that claimant is not reliable. The record is full of inconsistencies such as claimant's failure to mention the alleged incident for several months after it allegedly occurred. Consequently, we are unable to rely on claimant's testimony or the medical opinions based on her history.

ORDER

The Referee's order dated July 31, 1989, as modified August 17, 1989, is affirmed.

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September 27, 1990 Cite as 42 Van Natta 2080 (1990)

In the Matter of the Compensation of
**ROGER L. GREENMAN, Claimant**
WCB Case No. 89-05156
ORDER ON REVIEW
Francesconi & Associates, Claimant Attorneys
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Brittingham and Nichols.

Claimant requests review of that portion of Referee Fink's order that upheld the self-insured employer's denial of claimant's occupational disease claim for degenerative joint disease. On review, the issue is compensability. We reverse.

## FINDINGS OF FACT

We adopt the Referee's "FINDINGS OF FACT" as our own, with the exception of the last paragraph on page 2.

## FINDINGS OF ULTIMATE FACT

Claimant's work activities materially contributed to the increased symptoms of his degenerative joint disease.

## CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant's degenerative joint disease preexisted his industrial injury of May 1988, and that the medical evidence was insufficient to prove that claimant's work was either the major or the material contributing cause of his degenerative condition. Claimant contends that his work was the major contributing cause of his disease, and, in the alternative, contends that if the degenerative disease preexisted his work at the employer, his work activities worsened that disease. The insurer argues: (1) that "overuse syndrome" is not included by the words "series of traumatic events" of former ORS 656.802(1)(c), and thus claimant's condition is excluded from coverage; (2) that even if the statute applies, there is no evidence that claimant's degenerative condition preexisted his employment; and (3) that claimant failed to prove that his work materially contributed to the degenerative joint disease itself, i.e., the underlying condition.

Scope of former ORS 656.802(1)(c).

We first address the scope of the statute. According to the legislative history, the phrase "series of traumatic events or occurrences" was intended to cover "overuse" of a body part as well as other physical traumatic events. Ronald V. Dickson, 42 Van Natta 1102, 1107 (1990). Claimant's work activity of repetitive heavy lifting qualifies as overuse of a body part. The statute thus applies to claimant's condition.

Standard of Proof

As to claimant's standard of proof, he need not prove a worsening of a preexisting condition in order to establish a compensable claim. Rather, he must prove that his work exposure was a material contributing cause of either increased symptoms or a worsening of his underlying condition requiring medical services or resulting in disability. Donna E. Aschbacher, 41 Van Natta 1242, recon den 41 Van Natta 1334 (1989).

Turning to the facts of this case, we are persuaded based on the medical record that claimant's work activities of heavy lifting over his 31 years in the produce department were a material contributing cause of the increased symptoms from his degenerative joint condition. There is no evidence that claimant's condition preexisted his employment. (We note parenthetically that the Referee found that the condition preexisted his 1988 compensable injury, not his employment, at the employer.) Dr. Cunard, chiropractor and claimant's attending physician, stated that claimant's many years of lifting caused the degenerative joint disease. Dr. Simpson, chiropractor, opined that claimant's heavy physical work and his May 1988 injury symptomatically aggravated his underlying condition. The Western Medical Consultants stated that claimant's work made his condition more symptomatic, as did Dr. Kho, M.D., neurologist. Dr. Brett, M.D., neurological surgeon, stated that claimant's 35 years of work activity was the major contributing cause of his underlying degenerative joint disease. Although Cunard and Brett found claimant's work caused the underlying condition, while

the others found symptomatic worsening, there is no evidence that claimant's work had no effect on his condition. Consequently, we find that claimant's work activities materially contributed to the symptoms of his degenerative joint disease and his need for medical treatment or disability.

Attorney Fees

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services at hearing and on review concerning the compensability issue is $2,500, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the case as represented by claimant's brief and the length of hearing, the complexity of the issues, and the value of the interest involved.

ORDER

The Referee's order dated June 23, 1989 is reversed in part and affirmed in part. The self-insured employer's compensability denial is set aside. The claim is remanded to the employer for further processing according to law. For services at hearing and on Board review regarding the compensability issue, claimant's attorney is awarded an assessed fee of $2,500, payable by the employer. The remainder of the order is affirmed.

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In the Matter of the Compensation of
**VERNA M. LOGSDON, Claimant**
WCB Case No. 88-07102
ORDER ON REVIEW
Brown & Tarlow, Claimant Attorney
Meyers & Radler, Defense Attorney

Reviewed by Board Members Gerner and Cushing.

Claimant requests review of those portions of Referee Seifert's order which: (1) upheld the self-insured employer's denial of claimant's occupational disease claim for a respiratory condition; (2) declined to award an assessed attorney fee for prevailing on a denial of an eye condition which was rescinded by the employer prior to hearing; and (3) declined to assess penalties and attorney fees for an alleged unreasonable denial of the eye condition. In its brief, the employer cross-requests review of that portion of the Referee's order which awarded an attorney fee for the late denial of the claim. On review, the issues are compensability, 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 with the following supplementation.

Claimant did not suffer an injury, but sustained a prolonged exposure to cherry brine in the nature of an occupational disease. Claimant's prolonged cigarette smoking and exposure to cherry brine caused her underlying respiratory condition to become symptomatic. The concentration of the cherry brine on January 29, 1988 was no different than on any other day that claimant worked with the cherry brine.

The employer rescinded its denial of the eye irritation condition prior to the hearing. The employer's denial of the eye condition was unreasonable. There are no "amounts then due" upon which to base a penalty.

## CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant had failed to prove a compensable occupational disease claim, was not entitled to an assessed attorney fee when the employer rescinded its eye condition denial prior to the hearing, but was entitled to an attorney fee for the employer's late denial of the claim. The Referee also found that the employer's eye condition denial was not unreasonable. We agree in part and disagree in part.

### Compensability

The Referee found that claimant had not met her burden of proving a compensable occupational disease claim. We agree.

Because claimant's last exposure to working conditions involving the fumes and vapors of cherry brine was in 1988, we analyze her claim under the occupational disease law, former ORS 656.802 (1)(a), that became effective January 1, 1988. See Johnson v. SAIF, 78 Or App 143, rev den 301 Or 240 (1986); Donna E. Aschbacher, 41 Van Natta 1242 (1989).

To prove a compensable occupational disease under former ORS 656.802(1)(a), claimant must meet the burden of showing that her work exposure to the cherry brine was the major contributing cause of the onset or the pathological worsening of her condition. A symptomatic worsening of an underlying condition is insufficient to meet claimant's burden. Priscilla O. Dean, 42 Van Natta 1573 (1990). This is a complex medical question. The resolution of this issue turns largely on an analysis of the medical evidence. Kassahn v. Publishers Paper Co., 76 Or App 105, rev den 300 Or 546 (1986).

We adopt the Referee's "conclusions of law and opinion" on this issue as our own.

### Attorney Fees on Rescinded Denial

The Referee found that claimant was not entitled to an assessed fee when the denial of the eye condition was rescinded prior to the hearing because the eye condition had resolved. We agree with the Referee's conclusion, but not with his rationale.

Claimant alleges entitlement to an assessed attorney fee under OAR 438-15-030. The statutory basis for OAR 438-15-030 is ORS 656.386, and therefore to qualify for an assessed fee under OAR 438-15-030, claimant must qualify for an assessed fee under ORS 656.386(1). That statute provides for an assessed attorney fee only where claimant finally prevails in a hearing before a Referee. See ORS 656.386(1); Duane L. Jones, 42 Van Natta 875 (1990).

In this case, claimant did not finally prevail in a hearing before a Referee. Under such circumstances, claimant is not entitled to an assessed fee pursuant to ORS 656.386(1). See Duane L. Jones, supra; Ernest C. Richter, 42 Van Natta 955 (1990).

Penalties and Attorney Fees

A. Unreasonable Eye Condition Denial

Claimant contends that the denial of the eye condition was unreasonable. We agree.

The reasonableness of a denial is judged as of the date the denial only, and not by hindsight. Ginter v. Woodburn United Methodist Church, 62 Or App 118 (1983); Christena L. Lupian, 38 Van Natta 987 (1986). In this case, on the date of the denial, the employer had a chart note from Dr. Scoltock that indicated claimant had eye problems due to her exposure to the brine. The employer did not at that time have any information indicating that the eye condition was not compensable. Consequently, we find that the denial of the eye condition was unreasonable.

We are unable to assess a penalty for this unreasonable denial because claimant has failed to prove that there were any sums then due solely on the eye condition claim. We are however able to assess an attorney fee under ORS 656.382(1) due to the employer's unreasonable resistance to the payment of compensation. To award an attorney fee in this circumstance, claimant need not prove that sums were then due, but merely that compensation was resisted by the employer. Ellis v. McCall Insulation, 308 Or 74 (1989); Lloyd L. Cripe, 41 Van Natta 1774 (1989). Since there was a medical service performed, and the claim for the eye condition is now compensable, there was compensation, though not due, that was resisted. After considering the factors set forth in OAR 438-15-010(4) and applying them to this issue, we accordingly award a reasonable attorney fee of $300.

B. Late Denial

We adopt the Referee's conclusion of law and opinion on this issue as our own. After considering the aforementioned factors and applying them to this issue, we agree with the Referee that a $100 assessed fee is reasonable.

ORDER

The Referee's order dated July 28, 1989 is affirmed in part and reversed in part. That portion of the order that failed to award an attorney fee for an unreasonable denial of the eye condition is reversed. In addition to the Referee's $100 attorney fee award for a late denial, claimant's attorney is awarded an assessed fee of $300, also to be paid by the employer for its unreasonable denial. The remainder of the order is affirmed.

In the Matter of the Compensation of
**DONALD G. MESSER, Claimant**
WCB Case No. 89-00284
ORDER ON REVIEW
Kengla, et al., Claimant Attorneys
Cowling & Heysell, Defense Attorneys

Reviewed by Board Members Cushing and Myers.

The insurer requests review of Referee Mongrain's order which set aside its denial of claimant's right knee injury claim. In his brief, claimant cross-requests review, seeking entitlement to a penalty and related attorney fee for the insurer's alleged filing of a frivolous appeal. On review, the issues are compensability, penalties and attorney fees.

The Board affirms and adopts the order of the Referee. We have found no support for claimant's contention that the board has authority to assess penalties and attorney fees for a frivolous request for Board review. Rather, there is authority for the assessment of a penalty for a vexations or unreasonable hearing request or a frivolous petition for judicial review or motion. See ORS 656.382(3); 656,390. In any event, we do not consider the insurer's appeal to be frivolous.

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services on review concerning the compensability issue is $750, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case, the complexity of the issue, and the value of the interest involved. In addition, claimant is not entitled to an attorney fee for services devoted to his unsuccessful cross-request.

ORDER

The Referee's order dated May 12, 1989 is affirmed. For services on Board review concerning the compensability issue, claimant's attorney is awarded an assessed fee of $750, to be paid by the insurer.

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In the Matter of the Compensation of
**JOSEPH N. MURPHY, Claimant**
WCB Case No. 89-00950
ORDER ON REVIEW
Peter O. Hansen, Claimant Attorney
Bullard, et al., Defense Attorneys

Reviewed by Board Members Cushing and Gerner.

Claimant requests review of Referee Podnar's order that affirmed a Determination Order award of 10 percent (32 degrees) unscheduled permanent disability for tinnitus. On review, the issue is extent of unscheduled permanent disability. We affirm.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" with the following correction. The Referee found that a USAFI certificate is the military equivalent of a GED. We find that claimant has no GED.

CONCLUSIONS OF LAW AND OPINION

The Referee found that under the standards pursuant to OAR 436-35-270 through 436-35-440, claimant has a permanent unscheduled disability equal to 10 percent. Specifically, the Referee applied former OAR 436-35-000 et seq, which was effective at the time of claimant's December 13, 1988 Determination Order. See OAR 438-10-005; 438-10-010. These are the rules which we apply as well. ORS 656.295(5); OAR 438-10-010.

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

Age

The appropriate value for claimant's age of 60 years is 1. Former OAR 436-35-290.

Formal Education

The Referee found that a USAFI certificate claimant received in the military about 1943 is the military equivalent of a GED. However, claimant's undisputed testimony stated that neither Portland State University nor the high school consider a USAFI certificate to be the equivalent of a GED. No evidence was presented that would show that the certificate is accepted as a substitute for a GED.

Furthermore, former OAR 436-35-300(3)(b) states that "[f]or workers who do not have a high school diploma or a GED certificate, a value of +1 shall be allowed." This rule does not expand the definition of a GED to include any possible equivalents. Therefore, since claimant does not have a high school diploma or a GED, we assign a value for formal education of +1. But see William R. Wright, 42 Van Natta 1816 (1990) (Vocational high school diploma is equivalent to a high school diploma).

Skills

Former OAR 436-35-300(4) adopts by reference the "SVP" (specific vocational preparation time) values assigned to various occupations by the Dictionary of Occupational Titles (DOT), published by the U.S. Department of Labor. The highest SVP level demonstrated by a claimant during the ten years prior to the date of injury is used to determine a value for skills. Former OAR 436-35-300(4). Claimant's highest SVP during the ten years prior to the date of injury was 4 as a truck driver (DOT # 904.383-010). Therefore, the appropriate value for skills is 3. Former OAR 436-35-300(4).

Training

Claimant has no documented training. Therefore, the appropriate value for training is 1. Former OAR 436-35-300(5). Claimant's total education value is 5, the formal education value plus the skills value plus the value for training. Former OAR 436-35-300(6).

Adaptability

The adaptability value is determined by applying former OAR 436-35-310(2), (3) or (4). Under former OAR 436-35-310(2)(a), an attending physician's release to usual and customary work is proof that a worker is completely adaptable to perform that given job. In this case, Dr. Smith, M.D., stated that claimant's tinnitus condition would not prevent him from performing his regular job duties. (Ex. 3).

Even if Dr. Smith is not considered claimant's treating physician, claimant's tinnitus condition would not have an adaptability value under former OAR 436-35-310(3)(a) because that rule applies only to workers who have returned to modified work. Claimant has not returned to work. (Tr. 8). Also, former OAR 436-35-310(4) would not apply because claimant's tinnitus is not the cause of his inability to work. Claimant testified that injuries to his back, leg and shoulder prevent him from working. (Tr. 8). In order for former OAR 436-35-310(4) to apply, the worker's unemployment must be a result of the injury at issue and claimant's unemployment is not the result of his tinnitus. Therefore, the adaptability value is 0.

Impairment

Former OAR 436-35-390(7)(b) rates tinnitus which interferes with a worker's ability to perform work at 5 percent. Therefore, claimant's tinnitus condition entitles him to a 5 percent impairment value.

Computation of unscheduled disability

Having determined each value necessary to compute claimant's permanent disability under the "standards," we proceed to that calculation. When claimant's age value 1 is added to his education value 5 the sum is 6. When that value is multiplied by claimant's adaptability value 0 the product is 0. When that value is added to claimant's impairment value 5 the result is 5 percent unscheduled permanent partial disability. Former OAR 436-35-280(7). Claimant's permanent disability under the "standards" is, therefore, 5 percent.

Disability outside the standards

Claimant contends that his loss of earning capacity is greater than that provided for under a strict application of the standards. Claimant asserts that his tinnitus condition limits his ability to work in quiet areas and to use a telephone.

However, we have already considered these limitations in assigning claimant a value of 5 percent under the standards for tinnitus impairment. To be clear and convincing, evidence must establish that the truth of the asserted fact is "highly probable." Riley Hill General Contractor, Inc. v. Tandy Corp., 303 Or 390, 402 (1987). On this record, we do not find that claimant has proven by clear and convincing evidence that he suffers permanent disability greater than that awarded under the standards.

The insurer has not sought a reduction in claimant's 10 percent unscheduled permanent disability award. Therefore, we affirm the Referee's order.

ORDER

The Referee's order dated May 4, 1989 is affirmed.

In the Matter of the Compensation of
**TARNA D. PALMER, Claimant**
WCB Case Nos. 88-06722, 88-06723 & 88-22498
ORDER ON REVIEW
Quintin B. Estell, Claimant Attorney
Roberts, et al., Defense Attorneys
John Motley (Saif), Defense Attorney
Gary Jones, Defense Attorney

Reviewed by Board Members Crider and Nichols.

Claimant requests review of those portions of Referee Myers' order that: (1) affirmed a Determination Order which awarded 5 percent (16 degrees) unscheduled permanent disability for injury to the low back, left shoulder and chest; (2) affirmed a Determination Order which awarded no unscheduled permanent disability for a ribcage contusion; (3) upheld the SAIF Corporation's denial, on behalf of Colonial Arms, of an aggravation claim for a back condition; (4) upheld SAIF's denial, on behalf of Sid's Video, of an aggravation claim for the same condition; and (5) upheld Liberty Northwest Insurance Corporation's denial, on behalf of Cascade Pine, of a "new injury" claim for the same condition. On review, the issues are compensability, responsibility, and extent of permanent disability. We reverse.

## FINDINGS OF FACT

Claimant compensably injured her low back on June 25, 1986 when she slipped and fell while working for Colonial Arms. SAIF accepted a low back strain. By October 1986, claimant was complaining of left shoulder and chest problems which she attributed to the fall at Colonial Arms. The fall did cause those problems. Claimant treated with Dr. Young, M.D. In addition, she received osteopathic manipulations from Dr. Eschtruth.

Claimant was unable to return to her former job in view of restrictions established by Dr. Eschtruth relating to lifting and use of the left arm and shoulder. She commenced work for Sid's.

On May 17, 1987, before claimant was recovered from the 1986 injury, she was struck between the shoulder blades by the elbow of a coworker at Sid's. She suffered a ribcage contusion which was accepted by SAIF. The incident also worsened claimant's spinal dysfunction which arose out of the earlier injury.

The claim for the 1987 injury was closed by Determination Order dated November 11, 1987, without an award for permanent disability.

The claim for the 1986 injury was closed by Determination Order dated February 17, 1988 with an award of 5 percent unscheduled disability.

When claimant was medically stationary from both injuries, she had recovered full cervical and lumbar range of motion. However, on June 21, 1988, when she was last examined prior to her August 1988 exacerbation, she suffered recurrent spasm in the thoracic and lumbar areas and residual pain, particularly with overhead work, which limited her ability to work to sedentary or light work. These difficulties were caused by the 1986 injury. She also had some minimal dysfunction of the rib cage which had little affect on her ability to function which was related to the 1987 injury.

Claimant returned to work in August 1988 as a stacker at Cascade Pine. She developed back pain within a few hours. After four days of work, she was

off work pursuant to authorization by Dr. Benson, D.C., from August 22, 1988 until September 6, 1988. She worked one day, after which time loss was again authorized. She again was unable to work for more than 14 days.

No discrete injurious incident occurred at Cascade Pine. No pathological change occurred in claimant's condition following this work. However, she did experience an exacerbation of her pain and, as a result, was unable to work.

Dr. Benson submitted a claim on claimant's behalf for aggravation of the 1986 injury, noting mid-back, chest, low back, and hip pain.

A new injury claim was also filed with Cascade Pine.

Liberty Northwest, insurer of Cascade Pine, denied the new injury claim on a compensability basis.

SAIF conceded compensability but denied responsibility on an aggravation basis for both Sid's and Colonial Arms. SAIF sought a .307 order. None issued.

## FINDINGS OF ULTIMATE FACT

Sid's and Colonial Arms have conceded that claimant's claim is compensable.

Claimant's work exposure at Cascade Pine did not independently contribute to claimant's disability and need for treatment.

Liberty Northwest, as insurer of Cascade Pine, denied the claim on the basis of compensability thereby preventing issuance of a .307 order.

Immediately prior to the August 1988 exacerbation, claimant had suffered a 15 percent loss of earning capacity as a result of the 1986 compensable injury.

## CONCLUSIONS OF LAW AND OPINION

At hearing, claimant sought to establish that she was entitled to additional compensation for her inability to work commencing in August 1988 on either an aggravation or new injury basis. The aggravation employers, Colonial Arms and Sid's, conceded compensability but denied responsibility. Cascade Pine maintained that no compensable injury occurred in 1988. In addition, claimant sought additional permanent disability compensation to that she had been granted by determination orders issued in the 1986 and 1987 claims.

The Referee concluded that claimant was not a credible witness. His conclusion was based on his conviction that claimant intended to mislead him with regard to her examination by Dr. Poulson, M.D., and the confusing nature of her testimony concerning her symptomatic history. Having found claimant not credible, he rejected not only her arguments in support of her request for additional temporary disability compensation, but also her aggravation/new injury claim. Because the Referee's credibility finding is based on the substance of the witness' testimony, rather than the witness' demeanor, we are equally capable of assessing credibility. Coastal Farm Supply v. Hultberg, 84 Or App 282 (1987); Andrew Simer, 37 Van Natta 118 (1985). Based on the record as a whole, we find claimant credible. Moreover, SAIF has conceded the compensability of claimant's aggravation/new injury claim. Consequently, the issue, at least as to Sid's and Colonial Arms, is simply responsibility. On the responsibility issue, claimant does not have the

burden of proof. Consequently, even if we believed her not to be credible, we would not deny her compensation.

Credibility

We reject the Referee's credibility finding. There is no indication, as we read the record, that claimant intended to mislead the Referee with respect to her examination by Dr. Poulson on March 20, 1989. At hearing, during redirect examination of claimant, a dispute arose among counsel about the relationship of Dr. Poulson's March 16, 1989 opinion letter and his March 20, 1989 examination. During this debate, counsel for Sid's and SAIF asked leave to question claimant about the nature of the March 20, 1989 physical examination. The following colloquy ensued:

"Mr. Jones: Did Dr. Poulson examine you? Was there a physical examination that occurred yesterday by Dr. Poulson?

Witness: He just checked my pulses on my legs.

Mr. Jones: He checked your pulse and what?

Witness: My pulse on my legs and on my wrist, and that was it.

Mr. Jones: Did he visit with you at all about what you'd been doing?

Witness: He asked me who referee--why I was back to see him, and I said I was referred by [counsel for SAIF].

Mr. Jones: Was that the extent of your talk with Dr. Poulson?

Witness: Yeah.

Mr. Jones: That lasted five minutes or less?

Witness: Yes."

On further examination, Mr. Roberts, counsel for Liberty Northwest, asked if Dr. Poulson had asked her where she hurt; she replied that no, the nurse had asked. Asked if he had tested her range of motion, she denied that he had. Asked if he had tested her knee and ankle jerk, she said that he had. She agreed that the doctor had bent her legs. She agreed that the doctor had done more than "test your pulse in your arm and your leg" and that he did do "a physical examination."

There is no indication anywhere in this record that Dr. Poulson did a lengthy examination. The only March 1989 report from him in the file was based on a file review and not on an examination. Thus, there is no report from him describing the nature and extent of the examination. Although claimant apparently did not fully describe the examination when questioned by Mr. Jones, and testified more fully when her recollection was jogged by Mr. Roberts' questions, we are not persuaded that claimant intended to mislead. At the very most, her recollection was poor.

Similarly, while we agree that her testimony with respect to her symptomatic history is difficult to follow, we are convinced that this is a function of the nature of the questions to which she responded and the difficulty of describing one's physical condition at specific points in time and that it is not a reflection of lack of credibility. For these reasons, we reject the Referee's

finding that claimant is not credible and review the case giving weight to her testimony and to the medical opinion rendered based on her reported symptoms.

Compensability and Responsibility

The compensability of claimant's 1988 claim has been conceded by Sid's and Colonial Arms. Therefore, we are faced with the problem of assigning responsibility for a period of additional disability following two successive accepted injuries affecting the back. We note, parenthetically, that although the 1987 injury was accepted as a rib contusion, Dr. Young opined, and we have found, that the injury affected the spine as well. In such cases, there is a presumption that the insurer who accepted the most recent injury remains responsible. That insurer may rebut the presumption by establishing that the prior injury last independently contributed to claimant's worsened condition. Industrial Indemnity v. Kearns, 70 Or App 583 (1984).

Dr. Poulson has opined that claimant's condition in 1988, which rendered her more disabled following her work with Cascade Pine, was simply a continuation of the earlier injury for which he had treated her. He did not separately discuss the 1986 and 1987 injuries. However, he began treating claimant on referral from Dr. Young after the 1987 injury. Dr. Benson, while he felt that the 1988 exposure at Cascade Pine "worsened claimant's underlying condition," did not discuss the causal role of the 1987 injury. While it is clear that the 1986 injury was more severe than the 1987 injury, we are not prepared to assume, based on the absence of evidence addressing the contribution of the 1987 injury, that it did not independently contribute. This reluctance is reinforced by Dr. Young's August 1987 report which indicates that claimant suffered some muscle spasm in the thoracic spine as a residual of the 1987 injury, coupled with the fact that claimant's exacerbation involved the thoracic as well as the lumbar spine. Sid's as the last employer with an accepted claim has the burden of proof. It has failed to meet it.

Sid's may nonetheless avoid responsibility for the worsening if work activities at Cascade Pine independently contributed to a worsening of claimant's condition.

We are faced with conflicting medical opinion in this regard. Dr. Poulson has opined that claimant's condition did not objectively change after the work at Cascade Pine, and that claimant's exacerbation simply reflected a continuance of the problems for which he had previously treated her. We give Dr. Poulson's opinion great weight because he treated claimant before the 1988 exacerbation. Dr. Benson, on the other hand, began treating claimant after the exacerbation. He opined that exposure at Cascade Pine did "materially worsen the underlying condition." We are more persuaded by Dr. Poulson's opinion because of his longitudinal experience with claimant, and because his opinion appears more consistent with the fact that, while claimant suffers pain, she demonstrates little in the way of objectively identifiable pathology, and the fact that the worsening was over a very brief period of time but without discrete incident. For these reasons we find that claimant's underlying condition was not affected by the 1988 exposure. The worsening is the responsibility of Sid's.

Extent of Permanent Disability Due to the 1987 Injury

We are setting aside SAIF's denial of the claim for aggravation of the 1987 injury. There is no indication in the record that claimant's condition has become medically stationary. Therefore, it is premature to rate permanent disability in the 1987 claim. Andrew Simer, 37 Van Natta 154 (1985).

Extent of Permanent Disability Due to the 1986 Injury

We may rate disability in the 1986 injury, however. When, following the closure of a claim, claimant is injured again in a separate claim and is not medically stationary at the time of hearing, claimant is entitled to a rating of permanent disability in the first claim. We rate disability as of the time immediately prior to the aggravation. See e.g., Refugio Guzman, 39 Van Natta 808 (1987).

The 1986 injury claim was closed by determination order dated February 17, 1988. Claimant was medically stationary as it relates to that injury prior to January 1, 1988. Therefore, the "standards for rating permanent disability" do not apply. See 1987 Or Laws Chapter 884, section 62d; OAR 436-35-003. Claimant's injury affected her back, chest and shoulder. Therefore, provided that her condition caused permanent impairment, she is entitled to an award of unscheduled permanent disability. ORS 656.214(5).

In his July 26, 1988 report, Dr. Young, claimant's treating physician, indicated that claimant continued to exhibit spasm in the low and mid back which he attributed primarily to the 1986 injury. He also concluded that claimant was limited to sedentary or light work. This report is corroborated by Dr. Poulson's December 1987 report which had indicated that claimant suffered permanent disability caused by pain although she had full range of motion in the neck and back. He also believed claimant could perform, at best, light work. Claimant was 22 years of age at hearing. She has attended school through the 11th grade but does not have a high school diploma. Given claimant's residual physical difficulties, her limitation to light work, her youth, and her education, we find that claimant has suffered a 15 percent loss of earning capacity as a result of the 1986 injury.

Attorney Fee

Claimant is entitled to an assessed fee, payable by Liberty Northwest, for prevailing over its denial of compensability. ORS 656.386(1). Although SAIF/Sid's Video is responsible, it did not deny compensability and requested a ".307" order. The Department did not issue a ".307" order because Liberty Northwest denied compensability. Consequently, as a result of Liberty Northwest's denial, claimant's entitlement to compensation was at risk at hearing and on Board review. Under these circumstances, Liberty Northwest is responsible for claimant's attorney's fees at hearing and before the Board concerning its denial. See Karen J. Bates, 39 Van Natta 42 (1987); rev'd on other grounds, 94 Or App 666 (1989).

ORDER

The Referee's order dated April 17, 1989 is reversed in part, modified in part, and affirmed in part. The SAIF Corporation's denial on behalf of Sid's Video is set aside, and the claim is remanded to SAIF for processing according to law. For services at hearing and on Board review concerning the denial issue, claimant's attorney is awarded an assessed fee of $3,000, payable by Liberty Northwest Insurance Corporation. In addition to the 5 percent (16 degrees) unscheduled permanent disability awarded by Determination Order, claimant is awarded 10 percent (32 degrees) unscheduled permanent disability for a total award of 15 percent (48 degrees) for her mid and low back, concerning the 1986 injury claim, payable by SAIF, as insurer of Colonial Arms. Claimant's attorney is awarded 25 percent of the increased compensation created by this order, payable directly to claimant's attorney by SAIF, as insurer of Colonial Arms. The Referee's ruling regarding the November 11, 1987 Determination Order is vacated. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
**KAREN M. TULL, Claimant**
WCB Case No. 88-17674
ORDER OF ABATEMENT
Lucas, et al., Claimant Attorneys
Jerome P. Larkin (Saif), Defense Attorney

The SAIF Corporation requests reconsideration of those portions of our September 13, 1990 order that: (1) set aside its denial of claimant's claim for carpal tunnel syndrome; and (2) set aside, as premature, a Determination Order dated October 14, 1987. Contending that the Board lacked jurisdiction, SAIF seeks withdrawal of our order and reinstatement of the Referee's order.

Before addressing the motion, we request a response from claimant within 10 days from the date of this order. Consequently, our September 13, 1990 order is abated and withdrawn. At the conclusion of the aforementioned period, we shall take this matter under advisement.

IT IS SO ORDERED.

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In the Matter of the Compensation of
**SHARON WATKINS-AUBERT, Claimant**
WCB Case No. CO-00059
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Westmoreland & Shebley, Claimant Attorneys
Cooney, et al., Defense Attorneys

Reviewed by Board Members Crider and Brittingham.

On September 5, 1990, the Board acknowledged receipt of the parties' claim disposition agreement in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of lifetime annuity benefits in the amount of $750 per month by Fred Meyer, Inc., claimant agrees to release her right to future workers' compensation benefits for her compensable injury. In part of that proposed disposition, claimant agrees to release her right to "palliative medical care" yet purports to retain the "right to medical treatment pursuant to ORS 656.245" (Page 2, lines 1-2). We set aside the proposed disposition.

We shall not approve a proposed disposition if we find that it is "unreasonable as a matter of law." ORS 656.236(1)(a). A proposed disposition is unreasonable as a matter of law if, inter alia, it exceeds the bounds of existing statutes or rules. Louis R. Anaya, 42 Van Natta 1843, 1844 (1990). The lifetime right to medical services under ORS 656.245 is specifically excluded from matters which may be disposed under ORS 656.236 and rules promulgated thereunder. See OAR 436-60-145(1), 438-09-001(1). Under ORS 656.245, palliative care is compensable, even after claimant becomes medically stationary, when necessary to monitor administration of prescription medication required to maintain claimant in a medically stationary condition or when appropriate to enable claimant to continue current employment, upon approval of the responsible carrier or the Director. See 1990 Or Law (Special Session), 10(1)(b).

Here, the proposed disposition purports to release the right to palliative care while retaining the right to medical services under ORS 656.245. However, in the light of our discussion above, the release of palliative care

amounts to a partial release of claimant's statutory right to medical services for her compensable injury. The release of that right, whether complete or partial, exceeds the bounds of ORS 656.236 and OAR 436-60-145(1) and 438-09-001(1). Accordingly, we find that the proposed disposition is unreasonable as a matter of law and set it aside. See ORS 656.236(2).

Following our standard acknowledgment procedures, we would be willing to consider a revised agreement which does not contain provisions exceeding the bounds of the statute and rules.

IT IS SO ORDERED.

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September 28, 1990 Cite as 42 Van Natta 2094 (1990)

In the Matter of the Compensation of
**TANYA L. BAKER, Claimant**
WCB Case Nos. 88-18028 & 88-19615
ORDER OF ABATEMENT
Black, Chapman & Webber, Claimant Attorneys
Cowling & Heysell, Defense Attorneys
Roberts, et al., Defense Attorneys

The Board has received claimant's motion for reconsideration of our Order on Review dated August 31, 1990.

In order to allow sufficient time to consider the motion, the above noted Board order is abated and withdrawn. Royal Insurance of America and Liberty Northwest Insurance Corporation are requested to file responses to the motion within ten days. Thereafter, this matter will be taken under advisement.

IT IS SO ORDERED.

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September 28, 1990 Cite as 42 Van Natta 2094 (1990)

In the Matter of the Compensation of
**MICHELE A. BORTON, Claimant**
WCB Case No. 88-16744
ORDER ON REVIEW
S. David Eves, Claimant Attorney
Stafford Hazelett, Defense Attorney

Reviewed by Board Members Howell and Perry.

The insurer requests review, and claimant cross-requests review, of Referee Daron's order which: (1) increased claimant's unscheduled permanent disability award for a low back injury from 12 percent (38.4 degrees), as awarded by a Determination Order, to 17 percent (54.4 degrees); (2) increased claimant's scheduled permanent disability award for a left leg condition from 3 percent (4.5 degrees), as awarded by a Determination Order, to 5 percent (7.5 degrees); and (3) declined to assess a penalty and related attorney fee for the insurer's alleged unreasonable failure to pay an assessed attorney fee previously awarded. In its brief, the insurer argues that the disability rating standards in effect at the time of the August 8, 1988, and the August 25, 1988 Determination Orders are not the proper standards to apply. On review, the issues are extent of scheduled and unscheduled disability, and penalties and attorney fees. We affirm in part and modify in part.

## FINDINGS OF FACT

The Board adopts the Referee's "Findings of Fact" through the second full paragraph of the Opinion and Order, with the following supplementation.

Claimant was 44 years of age at the time of hearing. She has a high school education, but has no documented training demonstrating competence in a specific vocational pursuit. Claimant's original job duties required heavy physical capacity. She now has the physical capacity to perform in the light/medium range. Claimant has returned to light/medium modified work.

Claimant has worked as a grocery store clerk, hand sprayer (agric.) and school bus driver. There is no evidence in the record to verify the fact that claimant had worked as a school bus driver during the ten years preceding the date of injury.

## CONCLUSIONS OF LAW AND OPINION

### Permanent Disability

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

For purposes of determining injury-related permanent partial disability, ORS 656.283(7) and 656.295(5) require application of the standards for the evaluation of disabilities adopted by the Director pursuant to ORS 656.726(3)(f)(A). Those "standards" in effect on the date of the Determination Order from which the hearing was requested control the evaluation of permanent partial disability. OAR 438-10-010. (Emphasis added).

In this case, because the Determination Order was issued on August 8, 1988 and modified on August 25, 1988, the "standards" adopted effective July 1, 1988, (former OAR 436-35-001 et seq), as amended by temporary rules effective August 19, 1988, apply to the rating of claimant's permanent partial disability. Former OAR 436-35-270 through 436-35-440 apply to the rating of unscheduled permanent partial disabilities. Former OAR 436-35-270(1). Former OAR 436-35-010 through 436-35-260 apply to the rating of scheduled permanent partial disabilities. Former OAR 436-35-010(1).

### Unscheduled Permanent Disability

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

### Age

The appropriate value for claimant's age of 44 years is 1. Former OAR 436-35-290(1).

Formal education

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

Skills

Former OAR 436-35-300(4) adopts by reference the "SVP" (specific vocational preparation time) values assigned to various occupations by the Dictionary of Occupational Titles (DOT), published by the U.S. Department of Labor. The highest SVP level demonstrated by a claimant during the ten years prior to the date of injury is used to determine a value for skills. Former OAR 436-35-300(4). Claimant's highest SVP during the ten years prior to the date of injury was 4 as a hand sprayer (agric.) (DOT # 408.684-014). Therefore, the appropriate value for skills is 3. Former OAR 436-35-300(4).

Training

Claimant has no documented training. The insurer argues that, because claimant has a license to spray certain herbicides, she has received training demonstrating competence in a specific vocational pursuit. We do not agree. See Jack E. Emerald, 42 Van Natta 1161 (1990) ("documentation" means certificate, diploma, degree, etc.). A license is not necessarily equivalent to documented training. In this case, we do not find claimant's license equivalent to documented training and, therefore, the appropriate value for training is 1. Former OAR 436-35-300(5). Claimant's total education value is 4, the formal education value plus the skills value plus the value for training. Former OAR 436-35-300(6).

Adaptability where claimant has returned to modified work

An adaptability value for a claimant who is unable to return to his or her usual and customary work [See former OAR 436-35-270(3)(a)] but who has returned to modified work is determined from a matrix of values at former OAR 436-35-310(3)(a). That matrix compares the physical capacity of the claimant's usual and customary work with the physical capacity required by the modified work. This is true even though claimant may have the physical capacity to do heavier work than is required by the modified employment. Physical capacities are not defined by the "standards" generally. We utilize those definitions contained in former OAR 436-35-310(4)(a)-(d).

In this case, claimant's usual and customary work required the physical capacity to do heavy work. Claimant's modified work requires a light/medium physical capacity. Therefore, the appropriate adaptability value is 2.5. Former OAR 436-35-310(3)(a).

Impairment

The medical evidence is sufficient to prove that claimant has an injury-related loss of 15 degrees of flexion in her thoracolumbar region and is therefore entitled to a 1.5 percent impairment value. Former OAR 436-35-360(2). There is no evidence of additional impairment in the lower back.

After de novo review of the medical evidence and consideration of claimant's credible testimony, we conclude that claimant has an additional 5 percent impairment in her lower back because of loss of use or function due to disabling pain. The value for lost range of motion in claimant's low back is combined with the value for disabling pain for a total impairment value of 6.4.

Computation of unscheduled disability.

Having determined each value necessary to compute claimant's permanent disability under the "standards," we proceed to that calculation. When claimant's age value, 1, is added to her education value, 4, the sum is 5. When that value is multiplied by claimant's adaptability value, 2.5, the product is 12.5. When that value is added to claimant's impairment value, 6.4, the result is 18.9 percent unscheduled permanent partial disability. Former OAR 436-35-280(7). That disability figure is rounded to the next higher whole percentage. Former OAR 436-35-280(7). Claimant's unscheduled permanent disability under the "standards" is, therefore, 19 percent.

Scheduled Permanent Disability

Claimant argues that she has atrophy of her left leg, resulting in impairment, due to her compensable injury. She bases her argument on one measurement found in the report of Dr. Martens, a physician who performed an IME. The report gave a measurement of claimant's right thigh as 21 inches and the left 20 1/4 inches. However, there is nothing in that report to indicate whether claimant is right or left leg dominant, or that relates the 3/4 inch difference in leg measurement to atrophy resulting from claimant's compensable injury. Accordingly, we do not find that claimant has proven an impairment rating for atrophy in the left thigh. Former OAR 436-35-230(5)(b).

Claimant next argues that she is entitled to an award for impairment due to weakness in the left thigh. Claimant's treating physician Dr. Rung and Dr. Martens both noted weakness or decreased strength in claimant's left ankle and foot. Dr Rung also noted left leg weakness secondary to radiculopathy. Neither physician indicated the extent of claimant's leg or foot impairment due to weakness.

The Referee found that claimant was entitled to 5 percent disability for atrophy and weakness. We have found that claimant has not met her burden of proving that she has left leg atrophy due to her compensable injury, but does demonstrate some weakness. In the absence of contradictory evidence, we agree with the Referee's conclusion that claimant has 5 percent scheduled permanent disability due to weakness of her left leg.

Penalties and Attorney Fees

The Board adopts the Referee's "Opinion and Conclusions" in relation to the issue of penalties and attorney fees. See Saxton v. SAIF, 80 Or App 631, rev den 302 Or 159 (1987); James C. Ingram, 41 Van Natta 2417, 2418 (1989).

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel'e services on review for prevailing over the insurer's appeal of the extent issue is $600. We have particularly considered the complexity of the issues and the value of the interests involved.

ORDER

The Referee's order dated January 9, 1989 is modified in part and affirmed in part. In addition to the 17 percent (54.4 degrees) unscheduled permanent disability previously awarded, claimant is awarded an additional 2 percent (6.4 degrees) for a total award of 19 percent (60.8 degrees) unscheduled

permanent disability. A fee of 25 percent of the increased compensation due as a result of this order is approved, payable directly to claimant's counsel. However, the total of the fees approved by the Referee and Board shall not exceed $3,800. The remainder of the Referee's order is affirmed. For services on review concerning claimant's successful defense against the insurer's request for review on the extent issues, claimant's attorney is awarded a reasonable assessed fee of $600, payable by the insurer.

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In the Matter of the Compensation of
**MARK A. CRAWFORD, Claimant**
WCB Case No. 88-06777
ORDER ON REVIEW
Rasmussen & Henry, Claimant Attorneys
Brian L. Popock, Defense Attorney

Reviewed by Board Members Myers and Gerner.

Claimant requests review of Referee Leahy's order that: (1) upheld the self-insured employer's partial denial of claimant's current right middle finger condition; (2) declined to award temporary disability; and (3) declined to assess penalties and attorney fees for an alleged unreasonable partial denial. On review, the issues are compensability, temporary disability, and penalties and attorney fees. We reverse.

## FINDINGS OF FACT

On July 2, 1987, claimant cut his right middle finger with a trim saw during the course and scope of his employment. Claimant submitted an 801 claim form on July 13, 1987. Per the 801, the employer accepted a right hand injury on July 16, 1987.

Claimant did not seek immediate medical attention. Consequently, the laceration developed a severe infection.

On September 4, 1987, claimant reported to the emergency room, where Dr. Balme performed a surgical procedure, debridement, on the infected finger. Dr. Balme diagnosed "Status post saw injury to the dorsum of the long finger PIP joint with disruption of the central slip; fracture of the distal proximal phalanx, all of the above complicated by infection and osteomyelitis." He noted the presence of a boutonniere deformity. Dr. Balme concluded that claimant's PIP joint was effectively ruined and noted the possibility of amputation.

Dr. Balme authorized temporary total disability from the date of surgery, September 4, 1987.

On October 7, 1987, the employer issued a denial which denied claimant's current condition concerning the right middle finger. This denial was rescinded by stipulated order dated February 18, 1988.

Claimant continued to have difficulties with his right middle finger. On April 14, 1988, Dr. Casey scheduled claimant for surgical correction of the boutonniere deformity on May 10, 1988.

On May 5, 1988, the employer issued a partial denial of claimant's current right middle finger condition.

## ULTIMATE FINDINGS OF FACT

Claimant's current right middle finger condition is materially related to the compensable 1987 injury.

## CONCLUSIONS OF LAW AND OPINION

### Compensability

The Referee concluded that the employer's acceptance of the 1987 compensable injury did not preclude the employer from denying claimant's current right middle finger condition. We disagree.

Where there is an accepted claim, the employer/insurer may not issue a denial which attempts to terminate future responsibility for that accepted condition where the extent of claimant's disability has not yet been determined. Roller v. Weyerhaeuser Co., 67 Or App 583 (1984).

On the 801 claim form the employer accepted a nondisabling right hand injury. Within the descriptive portion of the 801 the injury was described as a laceration to the knuckle of claimant's right middle finger. On October 7, 1987, upon receipt of prescriptions, billings, and request for time loss, the employer denied claimant's current condition. The denial was rescinded, however, by stipulated order dated February 18, 1987. Thus, the effect of the October 1987 denial is a nullity, and had no legal effect on the employer's original acceptance. Accordingly, we find that the employer's acceptance included the injury to the right middle finger. We further note that this right middle finger claim has never been closed, nor has extent of permanent disability been determined.

Claimant's current condition is diagnosed as a boutonniere deformity. The surgery scheduled by Dr. Casey in May 1988 was intended to correct the deformity, and preclude amputation. The May 5, 1988, partial denial stated:

> ""(We) have received information from Dr. Casey that a surgery has been scheduled for correction to your right longer finger. This is to notify you we are denying responsibility for this condition as we do not believe it is compensable under your July 2, 1987 work related claim." (Ex. 16).

We find the current condition is not a new condition. It was previously identified when claimant first presented himself for treatment on September 4, 1987. At that time, Dr. Balme diagnosed a boutonniere deformity condition. It was also noted on October 7, 1987 by Dr. Balme, who suggested further treatment, and referred claimant to Dr. Casey. We therefore find that claimant's current condition in May 1988 is no different than the condition of September 1987. Accordingly, we further find that the partial denial is denying claimant's current condition, and as such, is an attempt to deny future benefits for an accepted condition prior to closure. We therefore find the employer has issued an improper partial denial.

However, we further note, notwithstanding our finding concerning the procedural impropriety of the employer's partial denial, that on the merits claimant has established a compensable condition. When claimant initially injured himself, he did not seek immediate medical care for the finger. As a consequence, the delayed treatment of the wound resulted in severe infection. This infection, in turn, developed into the boutonniere deformity condition. Thus,

the boutonniere deformity is materially related to the accepted July 1987 right hand injury claim.

It is the employer's position that claimant's current condition of the boutonniere deformity resulted from claimant's negligence in failing to seek and obtain immediate medical treatment. As such, the employer argues, the current condition is not compensable. We find the applicable statute is ORS 656.325(2). This statutes provides:

> "For any period of time during which any worker commits unsanitary or injurious practices which tend to either imperial or retard recovery of the worker, or refuses to submit to such medical or surgical treatment as is reasonably essential to promote recovery....the right of the worker to compensation shall be suspended with the consent of the director and no payment shall be made for such period. The period during which such worker would otherwise be entitled to compensation may be reduced with the consent of the director to such an extent as the disability has been increased by such refusal."

The compensability of the July 1987 injury is not in issue. In light of the previous discussion, finding the insurer's current condition denial invalid both procedurally and on the merits, we conclude the employer's mitigation of damages argument is not properly before us.

Even assuming that claimant has engaged in unsanitary practices, injurious practices, or has refused to submit to medical services, the employer's remedy for an accepted claim was to seek a suspension of benefits or to request a reduction of benefits at claim closure with the Director in accordance with statute and administrative rule. See ORS 656.325(2); OAR 436-60-105.

Entitlement to temporary disability

Because we find claimant's current condition compensable, we reach the temporary disability issue, whereas the Referee did not.

The employer argues claimant is entitled to no additional temporary disability because claimant quit his employment on July 13, 1987 for reasons unrelated to the compensable injury. And secondly, that claimant's current condition is unrelated to the compensable July 1987 injury due to claimant's failure to mitigate damages. Therefore, the employer argues, claimant is entitled to no additional temporary disability. We conclude otherwise.

The medical evidence indicates, and his physicians verify, that claimant was temporarily totally disabled on September 4, 1987, the date of surgery, due to the compensable injury. The employer paid temporary disability for the period of time claimant was hospitalized for surgery in September 1987, but then unilaterally terminated payments. On November 12, 1987, claimant was released for regular work by Dr. Casey. (Ex. 10A). There is conflicting evidence of a release only to light work, on October 23, 1987, by Dr. Balme. However, in any event, claimant was not medically stationary. Accordingly, his temporary total disability should not have been terminated. Fazzolari v. United Beer Distributors, 91 Or App 592 (1988).

Claimant testified he had engaged in some minimal wage earning activity. He further testified that he began receiving unemployment benefits in December

1987 through June 1988. (Tr. 78). When a worker is receiving unemployment benefits by representing an ability to work, those benefits may be treated as receipt of "post-injury wages." That is, temporary total disability payments could be reduced by "earnings" in the form of unemployment benefits. Wells v. Pete Walker's Auto Body, 86 Or App 739 (1987). Claimant was only entitled to temporary partial disability after December 1987. See ORS 656.212; OAR 436-60-030.

Penalties and related attorney fees

We find the conduct of the employer in issuing the May 5, 1988 partial denial to be unreasonable. Medical evidence conclusively establishes that claimant's current condition was materially related to the compensable July 1987 injury. The October 1987 denial had been rescinded and made a nullity. The employer had no contrary medical evidence before it at the time of denial to conclude otherwise. Accordingly, we find the employer had no legitimate basis from either a medical or legal standpoint by which to issue the denial. Norgard v. Rawlinsons, 30 Or App 999 (1977).

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services at hearing and on Board review concerning the compensability and the unreasonable denial issues is $2,500 and $300 respectively, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the case, the complexity of the issues, and the value of the interests involved.

ORDER

The Referee's order dated September 30, 1988 is reversed. The employer's partial denial is set aside and the claim is remanded to the employer for processing according to law. Claimant is awarded temporary total disability from September 4, 1987, until terminated in accordance with law, subject to offset for any unemployment benefits, temporary disability, or wages received. Claimant's attorney is awarded an approved fee of 25 percent of the increased temporary disability compensation created by this order, not to exceed $3,800, payable by the employer directly to claimant's attorney. For its unreasonable denial, the employer shall pay to claimant a penalty equal to 25 percent of the compensation due at the time of hearing. Claimant's attorney is also awarded a penalty-related assessed fee of $300, payable by the employer directly to claimant's attorney. For services at hearing and on Board review concerning the partial denial, claimant's attorney is awarded an assessed fee of $2,500, to be paid by the employer.

In the Matter of the Compensation of
**LINDA D. DIXON, Claimant**
WCB Case No. 88-20125
ORDER ON REVIEW
Callahan, et al., Claimant Attorneys
Gail Gage (Saif), Defense Attorney

Reviewed by Board Members Nichols and Brittingham.

Claimant requests review of Referee Danner's order that upheld the SAIF Corporation's denials of claimant's psychological condition claim. On review, the issue is compensability. We affirm.

## FINDINGS OF FACT

The Board adopts the Referee's findings, with the exception of the finding that the events complained of by claimant were conditions generally inherent in any job situation.

## FINDINGS OF ULTIMATE FACT

Claimant's mental disorder did not arise out of and in the course of her employment.

## CONCLUSIONS OF LAW AND OPINION

The Referee found that the events complained of by claimant were conditions generally inherent in any job situation within the meaning of former ORS 656.802(2)(b). He further found that claimant had not shown by clear and convincing evidence that her mental condition arose out of and in the course of her employment under former ORS 656.802(2)(d).

We conclude that the folowing events complained of by claimant are not generally inherent in every working situation. Claimant's supervisor verbally complained about her work, yet she was given favorable written reviews. In this regard claimant was given no work to do, rather than being trained to do it properly. Management failed to respond to claimant's memos concerning her treatment in the department, yet continued to complain about her. See Kathleen M. Payne, 42 Van Natta (1990). Dr. Lowery causally related these events to claimant's psychological condition.

Although not all of the events complained of by claimant were inherent in every working situation, former ORS.802(2)(d) requires that the evidence be clear and convincing that the mental disorder arose out of and in the course of employment.

Here, there were significant events in claimant's life outside the work place which placed stress on her: the death of claimant's sister, a sick child at the time she left work, and an admitted PMS problem. Myron Lee, M.D., and claimant's treating physician, noted the off-work stressors and opined that there was no one contributing cause to the development of claimant's condition. Dr. Turco, psychiatrist, also noted the off-work stressors. He felt that if claimant was not able to do her job effectively, her difficulties were not work related.

Dr. Lowrey testified that the on-the-job stressors were the major cause of claimant's condition. He based this opinion on the sum of claimant's complaints of job stressors, many of which we have discounted as inherent in every job situation, reasonable disciplinary, corrective or job performance evaluation actions, or as nonexistent from a real and objective standpoint. We are not persuaded that what remains would be sufficient to cause claimant's psychological condition. Therefore, we give Dr. Lowrey's opinion little weight. The opinions of Drs. Lee and Turco persuade us that the presence of these off-work stressful events renders the evidence less than clear and convincing that claimant's psychological condition arose out of her work.

In sum, while claimant was subjected to conditions which were not generally inherent in every working situation, claimant has not shown by clear and convincing evidence that these conditions were the cause of her mental condition. Therefore, the Referee's order is affirmed.

ORDER

The Referee's order dated March 8, 1989 is affirmed.

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In the Matter of the Compensation of
**NORBERTO FIGUEROA, Claimant**
Own Motion No. 90-0290M
OWN MOTION ORDER
Borneman & Rossi, Claimant Attorneys
Industrial Indemnity, Insurance Carrier

The insurer has submitted to the Board claimant's claim for an alleged worsening of his March 30, 1981, industrial injury. Claimant's aggravation rights have expired. The insurer has accepted responsibility for claimant's condition. However, it opposes reopening of his claim for payment of temporary total disability benefits, contending that claimant did not sustain a worsening of his condition or, alternatively, that he has removed himself from the work force.

In order to receive temporary disability benefits for a worsening of a compensable injury, claimant must have been in the work force at the time of the worsening. Dawkins v. Pacific Motor Trucking, 308 Or 254, 258 (1989); Cutright v. Weyerhaeuser, 299 Or 290 (1985). Here, claimant alleges that his compensable injury worsened in April, 1990, when he was hospitalized three days for chronic low back and bilateral leg pain. We need not decide whether claimant's compensable injury had indeed worsened, because we do not find that he was in the work force at the time of the alleged worsening. The record shows that claimant has not worked since 1987. Therefore, in order to prove that he was in the work force at the time of the alleged worsening, claimant must prove that he has been willing to work and that either: (1) he has been making reasonable efforts to obtain employment; or (2) such efforts would have been futile due to the compensable injury. See id.

The record is devoid of any persuasive evidence that claimant is willing to work or has made reasonable efforts to obtain work. By chart note dated February 16, 1990, Dr. Altrocchi wrote that he did not think claimant will perform any type of useful work again. However, the doctor blamed claimant's "general behavioral attitude" in addition to his chronic pain, thereby suggesting that claimant's lack of employment may be due at least in equal part to his lack of motivation as well as the residuals of his compensable injury. Based on

this record, therefore, we do not find that claimant was in the work force at the time of his alleged worsening. See id.

Accordingly, we deny claimant's request for own motion reopening.

Entitlement to medical expenses pursuant to ORS 656.245 is not affected by this order.

IT IS SO ORDERED.

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September 28, 1990 Cite as 42 Van Natta 2104 (1990)

In the Matter of the Compensation of
**LIELA L. HAUGEN, Claimant**
WCB Case No. 89-08644
ORDER ON REVIEW
Robert G. Dolton, Claimant Attorney
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Howell and Speer.

Claimant requests review of Referee Bennett's order that declined to assess penalties and attorney fees for an alleged unreasonable failure to authorize surgery. On review, the issue is penalties and attorney fees. We affirm.

The Board affirms and adopts the Referee's Order with the following supplementation.

The Referee found that the insurer's failure to accept or deny claimant's claim (request for authorization of surgery) was unreasonable. However, the Referee found that, because the surgery had never been performed, there were no amounts due upon which to base a penalty. The Referee also concluded that because there was no resistance to the payment of compensation, an attorney fee was not appropriate.

We agree with the Referee's conclusion and we note that claimant has not shown that the surgery was compensable. Moreover, because Dr. Higgins withdrew the request for surgery and the surgery was never performed, we conclude that there was no unreasonable resistance to the payment of compensation.

ORDER

The Referee's order dated September 1, 1989 is affirmed.

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September 28, 1990 Cite as 42 Van Natta 2104 (1990)

In the Matter of the Compensation of
**DAVE E. HERMAN, Claimant**
WCB Case No. 88-22454
ORDER ON REVIEW (REMANDING)
Aspell, et al., Claimant Attorneys
Terrall & Miller, Defense Attorneys

Reviewed by Board Members Howell and Speer.

Claimant requests review of those portions of Referee Higashi's order that upheld the self-insured employer's denial of his medical services and

aggravation claim on the grounds that they were barred by a prior disputed claim settlement under the doctrine of res judicata. In addition, claimant seeks remand for the admission of evidence regarding post-hearing surgery. The issues on review are res judicata and remand. We reverse and remand.

## FINDINGS OF FACT

Claimant sustained a compensable low back injury in April 1986. The claim was closed by Determination Order in February 1988 with a 20 percent unscheduled permanent disability award. Claimant appealed the extent of permanent disability and later sought payment for vocational assistance, medical services, and time loss.

While the extent issue was awaiting a hearing, claimant was enrolled in a work-hardening program and attempted to return to medium duty work which he had to terminate due to suspected nerve root damage. (Exs. 49, 52-2). Immediately prior to issuance of the February 1988 Determination Order, claimant was being treated for thrombophlebitis, which was a second reason for his termination of the work-hardening program. This deep venous insufficiency is not related to the compensable back injury. (Exs. 44-8, 47).

Throughout the period between February 1988 and June 1988, claimant continued to have significant symptoms associated with his low back and was referred by his attending physician to physiatrist, Dr. Ryan. (Tr. 18). In June 1988, Dr. Ryan reported that claimant's condition had been misdiagnosed and claimant should receive a work-up for possible herniated disc at L5-S1. (Exs. 51, 52). Dr. Ryan based his conclusions on a June 1987 myelogram with CT scanning that revealed bulging at L5-S1, and incomplete filling of the L5 nerve root sleeves bilaterally. In addition, there was an October 1987 MRI scan consistent with herniated disc at L5-S1. A consultation with neurosurgeon, Dr. Rosenbaum, was scheduled. (Ex. 50).

When Dr. Rosenbaum did not recommend surgical intervention, despite his diagnosis of "probable right lumbosacral disk herniation" (Ex. 54-3), Dr. Ryan sought authorization for a physical therapy program which stressed reduction of disc and prevention of further injury (a treatment program he had alternatively recommended in June 1988). (Ex. 52-4). Authorization for these medical services was not granted. It was the issue of physical therapy and work-hardening program that led to negotiations between the parties. The discussions focused on the employer's expressed desire that claimant not pursue these medical treatments with Dr. Ryan because they were viewed as neither palliative nor curative of the underlying disability. (Tr. 59-62).

In September 1988, claimant entered into two agreements with the employer. Claimant received an additional 5 percent unscheduled permanent disability, and $2,400 to give up his claims for vocational assistance and current medical treatment with Dr. Ryan. Claimant also agreed that: "all other treatment which claimant may seek on and after July 20, 1988, for the current or foreseeable future shall remain in a denied status...." (Ex. 58-6).

The significance of the July 20th date and the reference to future treatments is that claimant had an appointment with Dr. Ryan on or about July 19th and several more scheduled. The employer agreed to pay for claimant's earlier treatments, but no visits with Dr. Ryan on or after July 20, 1988. (Tr. 66). Claimant expressly asked for settlement language that preserved his rights under ORS 656.245, 656.273 and 656.278 to protect his entitlement to future medical services. (Tr. 66-67; Ex. 58-7).

After the Disputed Claim Settlement, claimant returned to work; however, he had constant radiating low back pain. He was unable to sit or sleep due to pain. He therefore sought consultation and treatment from a neurologist at Stanford University, Dr. Schuer. Dr. Schuer's tentative findings revealed herniated disc and he recommended surgical intervention.

Pursuant to Dr. Schuer's recommendations, claimant requested payment for medical treatments which the employer denied in December 1988, on the grounds that claimant's condition was unchanged from the September 1988 settlement and that claimant had bargained away the issues of medical treatment and aggravation for a herniated disc.

Claimant appealed the December 1988 denial and Referee Higashi upheld the employer's denial in a May 1989 Order. This order was appealed and, on September 25, 1989, claimant underwent disc surgery. The operative and post-surgical reports establish that claimant had a protruding disc at L5-S1 and since the surgery he has had a complete resolution of symptoms, including the radiating pain.

The hearing record is replete with medical reports discussing a possible herniated disc in the lumbar region associated with claimant's industrial injury. A small thecal sac at the L5-S1 level was thought to explain the inability to definitively demonstrate an abnormal disc. (e.g., Exs. 7, 10, 11, 18, 20, 21, 26, 29, 44, 51, 52, 54).

## ULTIMATE FINDINGS OF FACT

The reasonableness and necessity of surgery due to a herniated disc was not a claim or issue in the disputed claim settlement.

The causal relationship between claimant's compensable low back injury and his need for surgical intervention due to a herniated disc was not an issue in the disputed claim settlement.

## CONCLUSIONS OF LAW AND OPINION

### Res Judicata

The Referee concluded that claimant had agreed in the disputed claim settlement that his condition of herniated disc was not related to his accepted low back injury. The Referee therefore decided that this was the law of the case and claimant was barred by principles of res judicata from seeking surgical treatment for his herniated disc. We do not agree.

The doctrine of res judicata precludes litigation of claims and issues previously adjudicated. North Clackamas School District v. White, 305 Or 38, 50, modified 305 Or 468 (1988). Both issue and claim preclusion apply to worker's compensation proceedings. Drews v. EBI Companies, 310 Or 134 (1990). 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. Carr v. Allied Plating Co., 81 Or App 306, 309 (1986); See also Restatement (Second) of Judgments, Secs. 17-19, 24 (1982). A Referee's order approving a disputed claim settlement is a final "judgment" within the meaning of this rule. See Patricia S. Thompson, 42 Van Natta 648 (1990), citing Proctor v. SAIF, 68 Or App 333 (1984).

Claimant appealed a February 1988 Determination Order of 20 percent unscheduled permanent disability and also sought vocational assistance and medical treatments. After February 1988, the "dispute" between the parties related to extent of permanent disability, and whether outstanding claims for medical services and vocational assistance were reasonable and a result of the accepted low back condition. The employer argued that claimant's current condition was the result of unrelated venous insufficiency and therefore denied services. That was the status of the controversy going into the disputed claims settlement.

We find no language in the settlement agreement that expressly "bargains away" the right to current or future medical services for surgical treatments related to claimant's accepted low back condition. The only express language deals with medical treatments for venous insufficiency. The record itself contains a number of conflicting medical reports from a variety of experts dating from the injury to the September 1988 disputed claim settlement that indicate disc herniation is a possibility and surgery may be necessary in the future. However, we find nothing in the settlement agreement where claimant either specifically requests or employer expressly denies surgery as treatment for the low back condition. Accordingly, we conclude that the disputed claim settlement did not litigate to final judgment the issue of surgical removal of a herniated disc.

Furthermore, it would have been a violation of former ORS 656.236 to bargain away future claims for medical services for claimant's compensable low back condition. Claimant's low back condition was not, nor legally could it have been, subject to settlement, except as pertaining to the permanent disability issue. The only potential bona fide disputes were whether or not the claims for time loss and/or additional permanent disability were a result of the low back injury; and, whether the then claimed and outstanding medical/vocational services were reasonable and necessary, and related to the low back. The employer asserted that both the time loss and medical services were the result of the thrombophlebitis. In any case, claimant was only pursuing payment of medical expenses for physical therapy and work-hardening directly. The settlement agreement was supposed to discontinue those medical treatments that were viewed as neither palliative nor curative of the underlying disability.

Based on this record, we do not find that claimant either validly bargained away his right to pursue payments for surgical treatments resulting from his low back injury or that he is barred from asserting such a claim. Accordingly, the disputed claim settlement agreement is not res judicata (either issue or claim preclusion), as to the claim for surgery as a compensable medical service.

The employer contends that, at the time of the settlement agreement, claimant's general condition included his symptoms of low back injury. The employer therefore argues that principles of res judicata prevent a relitigation of all treatments contemplated at the time of settlement, unless claimant can demonstrate a worsening. We find this argument without merit because the extent to which claimant's "general" condition may have been considered for purposes of determining the time loss issue, does not represent a full litigation or determination of the causal relationship between the 1986 compensable injury and claimant's need for disc surgery. See Rush v. Argonaut Ins. Co., 98 Or App 730 (1989).

Claimant's surgical intervention for herniated disc is compensable, if the need for surgery results from the compensable back injury, rather than from the noncompensable venous insufficiency. The compensable injury does not have to be the sole or most significant cause of the current need for treatment.

Rush, supra, at 733. In Rush, the employer also argued that the condition claimant was currently receiving treatment for was the same condition found unrelated to a compensable work injury in an earlier aggravation hearing. Rush, supra, at 733-34. The Court of Appeals concluded that res judicata did not bar the claim for services because the Board properly determined that part of claimant's current need for services was causally related to the compensable injury. Id. at 734.

Here, the hearing record contains medical opinions since the date of injury that disc herniation was possible and surgical intervention was a future treatment option for the compensable injury. However, the settlement does not address the causal link between the compensable injury and disc surgery and the Referee never reached this issue. Thus, the causal relationship between the 1986 back injury and claimant's medical need for disc surgery was not fully litigated in settling the aggravation claim for time loss. If it is determined that part of claimant's December 1988 need for surgery was causally related to the 1986 compensable injury, res judicata does not bar the claim for services. Rush, supra, at 734.

Remand

Having determined that the doctrine of res judicata does not bar claimant's claim for surgical expenses, we next decide whether the surgical reports are sufficiently relevant so as to justify remand. Here, the surgical and post-surgical reports could be highly probative on the issue of the reasonableness and necessity of the disc surgery. Thus, we find that the surgical and follow-up reports are relevant evidence, without which the record would be incomplete. We conclude that the case should be remanded to the Hearings Division for further development. See Palmer v. Plaid Pantry #54, 76 Or App 405 (1985); Duckett v. SAIF, 79 Or App 749 (1986). Accordingly, this case shall be remanded to the Presiding Referee to appoint a referee to further reopen the record for additional evidence regarding claimant's post-hearing surgery. The appointed referee is instructed to proceed in any manner that will achieve substantial justice. ORS 656.283(7).

Those reports were not available at the time of the hearing in this matter.

ORDER

The Referee's order dated May 15, 1989 is reversed. The case is remanded to the Presiding Referee for further proceedings consistent with this order.

In the Matter of the Compensation of
**ROBERT C. KILLION, Claimant**
WCB Case No. 89-04208
ORDER ON REVIEW
Patrick Lavis, Claimant Attorney
Nelson, et al., Defense Attorneys

Reviewed by Board Members Brittingham and Nichols.

Claimant requests review of Referee Knapp's order that: (1) increased claimant's scheduled permanent disability award for loss of use or function of the left arm from 6 percent (11.52 degrees), as awarded by a Determination Order, to 18 percent (34.56 degrees); and (2) increased claimant's scheduled permanent disability award for loss of use or function of the left leg from 5 percent (7.5 degrees), as awarded by a Determination Order, to 18 percent (27 degrees). On review, the issue is extent of scheduled permanent disability. We affirm in part and modify in part.

## FINDINGS OF FACT

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

## FINDINGS OF ULTIMATE FACT

Claimant has an 18 percent loss of use of function of his left arm.

Claimant has a 33 percent loss of use or function of his left leg.

## CONCLUSIONS OF LAW AND OPINION

In determining the extent of claimant's permanent disability, we apply the standards for evaluating permanent disability as adopted by the Director, pursuant to ORS 656.726(3)(f). See ORS 656.283(7). Specifically, we apply the current version of OAR 436-35-001 et seq, the rules in effect at the time of the February 21, 1989 Determination Order.

Left Arm

The Referee awarded claimant a total impairment value of 18 percent for loss of use or function of the left arm. We affirm the Referee's award; however, we reach our conclusion on a different basis.

The Referee assigned claimant a value of 5 percent for lost range of motion of the left wrist/forearm. We disagree and assign claimant the following values. For 55 degrees of dorsiflexion claimant receives a value of 1 percent of the wrist. OAR 436-35-080(1). For 55 degrees of palmar flexion claimant receives a value of 2.5 percent of the wrist/forearm. OAR 436-35-080(3). These values are added (not combined) to arrive at a total value for lost range of motion of 3.5 percent. OAR 436-35-080(9). This value (3.5 percent) is converted into a value for the arm of 2.5 percent. OAR 436-35-090(1).

The Referee found that claimant had a normal range of motion in the left elbow. We disagree. We find that claimant is entitled to a value of 3 percent of the arm for 135 degrees of extension. OAR 436-35-100(2).

In addition, the Referee found that claimant was not entitled to a value for the surgeries performed on claimant's left arm. We agree. OAR 436-35-110(4). However, we disagree with the Referee's award of 10 percent for loss of grip strength. OAR 436-35-005(1) requires that loss of grip strength be measured by a physician. Dr. Swanson did not measure claimant's grip strength. Nor did any other physician. accordingly, we find that claimant is entitled to no value for loss of grip strength.

Finally, the Referee awarded claimant a value of 5 percent for a chronic condition limiting repetitive use. OAR 436-35-010(7). We agree. Claimant's left arm injury has resulted in limitations on endurance and stamina. Accordingly, claimant is assigned a value of 5 percent for loss of repetitive use of his left forearm. Id.

To arrive at a total impairment value for claimant's loss of use or function of the left arm, the value assigned for lost range of motion of the left wrist/forearm (2.5) is combined with the value for lost range of motion of the left arm (3) to arrive at a value of 5.5 percent. OAR 436-35-120(2). This value (5.5) is then combined with the value for loss of repetitive use of the left forearm (5) to arrive at a total impairment value of 10.5. OAR 436-35-080(11). This is rounded to the next highest value for a total value of 11 percent for loss of use or function of the left arm. OAR 436-35-010(6). The insurer has not requested a reduction in claimant's left arm award. Accordingly, we affirm the Referee's award of 18 percent scheduled permanent disability for loss of use or function of the left arm.

Claimant argues that he is entitled to a greater permanent disability award than evidenced by the standards. There may be clear and convincing evidence of a greater loss of use or function, based upon lack of strength in claimant's left arm, than the 11 percent value awarded under the standards. However, we are not persuaded that claimant has greater than the 18 percent loss of use or function awarded by the Referee. Accordingly, we affirm the Referee's award.

Left Leg

The Referee assigned claimant a total impairment value of 18 percent for loss of use or function of the left leg. We disagree.

The Referee assigned claimant a value of 5 percent for lost range of motion. We agree. For a 50 percent loss of inversion or 15 degrees claimant is entitled to a value of 3 percent. OAR 436-35-190(2). For a 50 percent loss of eversion or 10 degrees claimant is entitled to a value of 2 percent. OAR 436-35-190(4). These values are added (not combined) for a total lost range of motion of the left foot of 5 percent. OAR 436-35-190(11). This value (5) is converted to a value for the leg of 4.5 percent. OAR 436-35-210.

In addition, the Referee assigned claimant a value of 10 percent for loss of use or function of the left leg that is the result of limitations from a vascular disease. OAR 436-35-230(6)(b). We disagree. We find no medical evidence that claimant's limping is the result of a vascular disease. Accordingly, we find claimant is not entitled to a value for a loss of use or function which is the result of a vascular disease.

Finally, the Referee awarded claimant 5 percent for a chronic condition limiting repetitive use. OAR 436-35-010(7). We agree. As a result of chronic swelling claimant has a limp when he walks which limits the repetitive use of his left leg. Therefore, we find claimant is entitled to a value of 5 percent for a chronic condition limiting repetitive use.

To arrive at a total impairment rating for the loss of use of function of claimant's left leg we combine the value for lost range of motion (4.5) with the value for loss of repetitive use (5), for a total value of 9.275 percent. OAR 436-35-190(11). This is rounded to the next highest value for a total of 10 percent under the standards for loss of use or function of the left leg. OAR 436-35-010(6).

We find the evidence as a whole establishes that claimant has a greater loss of use or function than the value awarded under the standards. Claimant experiences swelling and pain in his tendon, calf and heel. Claimant limps and has trouble walking on uneven surfaces. He cannot operate a fork lift that is equipped with a standard transmission. Dr. Swanson, claimant's treating physician, characterized claimant's disability as moderate to severe and limited him from prolonged walking or standing. Based on Dr. Swanson's opinion and claimant's testimony regarding his total limitations, claimant has established by clear and convincing evidence that his permanent loss of use of function of his left leg is 33 percent.

ORDER

The Referee's order dated June 15, 1989 is affirmed in part and modified in part. In addition to the Referee's and Determination Order awards of 18 percent (27 degrees) scheduled permanent disability for loss of use of function of the left leg, claimant is awarded 15 percent (22.5 degrees), giving him a total award to date of 33 percent (49.5 degrees) scheduled permanent disability for loss of use or function of the left leg. The remainder of the Referee's order is affirmed. Claimant's attorney is awarded 25 percent of the increased compensation created by this order, payable directly to claimant's attorney. However, the total out-of-compensation fees awarded under the Referee and Board orders shall not exceed $3,800.

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In the Matter of the Compensation of
**DANELL R. LUX, Claimant**
WCB Case No. TP-90052
THIRD PARTY ORDER DISAPPROVING SETTLEMENT
Sellers & Jacobs, Claimant Attorneys
Roberts, et al., Defense Attorneys

The parties have submitted a "Settlement and Release Pursuant to ORS 656.587" for Board approval. The agreement purports to release all of claimant's rights to workers' compensation benefits in return for the paying agency's approval of her third party settlement and the reduction of its third party lien. Inasmuch as we lack authority to approve such an agreement, it is disapproved.

FINDINGS OF FACT

In August 1988 claimant sustained a compensable injury as a result of a motor vehicle accident with a third party. The claim was accepted and the insurer provided compensation.

Claimant engaged legal counsel and instituted a civil action against the third party. The third party and claimant have agreed to settle this action for an undisclosed sum. The insurer, as paying agency, has approved the settlement offer and agreed to reduce its lien for claim costs from $10,735.15 to

$6,610.52. Finally, in return for the paying agency's approval, claimant agrees to release all of her rights to future workers' compensation benefits.

On July 17, 1990, the parties' submitted a proposed "Settlement and Release Pursuant to ORS 656.587" to the Board, seeking approval of their agreement. On July 25, 1990, the parties were advised by the Board through its counsel that the agreement could not be approved because it was contrary to revised ORS 656.236 and 656.587, which had become effective July 1, 1990. On September 10, 1990, the parties resubmitted the agreement, requesting that their settlement be approved "nunc pro tunc" to June 30, 1990.

CONCLUSIONS OF LAW

Pursuant to the proposed agreement, in return for the paying agency's approval of claimant's third party settlement and the reduction of its lien, claimant agrees to release her rights to "future benefits under the Workers' Compensation Act in connection with her August 31, 1988 workers' compensation claim." Page 2, Lines 11 - 14. As support for this "release" the parties rely on ORS 656.587, as interpreted by the Board in Roger Riepe, 37 Van Natta 3 (1985), and Robert M. Pilczynski, 37 Van Natta 39 (1985). Page 2, Lines 1 - 7.

Prior to July 1, 1990, ORS 656.587 provided that "ORS 656.236 does not apply to compromises and settlements under ORS 656.578 to 656.595." Thus, under prior law, the prohibition against the release of a worker's benefits, as contained in then existing ORS 656.236, was not applicable to the third party statutes. As held in Riepe and Pilczynski, such a statutory exclusion made it possible for workers to release any and all of their rights in exchange for a paying agency's approval of a third party compromise.

However, effective July 1, 1990, the aforementioned exclusion from the requirements of ORS 656.236 was removed from ORS 656.587. See Senate Bill 1197, Section 34. Consequently, ORS 656.236 is now applicable to third party compromises and settlements.

Current ORS 656.236 permits the "disposition of any or all matters regarding a claim, except for medical services." See Senate Bill 1197, Section 9 (Emphasis added). Inasmuch as ORS 656.236 prohibits the disposition of medical services and since ORS 656.236 is applicable to third party settlements, the proposed agreement (which attempts to release all of claimant's future benefits) is contrary to law and cannot be approved.

In response to our refusal to approve their agreement, the parties have raised two arguments. One, they contend that the agreement should be considered under the prior law because "this case was initially scheduled for hearing on May 10, 1990." Secondly, the parties assert that the agreement can be approved "nunc pro tunc to June 30, 1990."

We disagree with both assertions. The parties' first contention is apparently based on Section 54(2) of Senate Bill 1197, which provides that any matter regarding a claim which is in litigation before the Hearings Division, Board or appellate courts under Chapter 656, and regarding which matter a request for hearing was filed before May 1, 1990 and a hearing was convened before July 1, 1990, shall be determined pursuant to the law in effect before July 1, 1990.

To begin, there has been no assertion that the scheduled hearing, initially scheduled for May 10, 1990, was actually convened. Thus, Section 54(2) would not apply.

Furthermore, third party disputes are not subject to the jurisdiction of the Hearings Division. Rather, such issues are solely within the province of the Board. ORS 656.587; 656.593(3). Therefore, assuming that a hearing had been scheduled and convened prior to July 1, 1990, such circumstances would be irrelevant insofar as the third party matter was concerned because the Referee would lack authority to consider such issues.

We also disagree with the parties' second assertion that we have authority to approve their agreement "nunc pro tunc to June 30, 1990." "Nunc pro tunc" is a phrase applied to acts allowed to be done after the time when they should be done, with a retroactive effect, i.e., with the same effect as if regularly done. Black's Law Dictionary, abr. 5th Ed, p. 553-54 (1983).

Here, the parties seek our approval of an agreement "nunc pro tunc" to a date, June 30, 1990, which was some 17 days before they submitted the agreement for our consideration. Were we to accede to the parties' wishes and approve the agreement under such circumstances, we would effectively be circumventing the intent of the legislature that, effective July 1, 1990, the statutory prohibition against a worker's release of rights to future medical services be applied to third party settlements. Accordingly, we decline to approve the parties' agreement "nunc pro tunc" to June 30, 1990, particularly where we did not approve the agreement prior to July 1, 1990.

In conclusion, based on the reasoning expressed above, we are without authority to approve the parties' agreement. Consequently, the settlement shall not be approved.

Accordingly, the proposed agreement is disapproved as contrary to law.

IT IS SO ORDERED.

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In the Matter of the Compensation of
**GARY O. TARPLEY, Claimant**
WCB Case Nos. 89-05526 & 89-05525
ORDER ON REVIEW
Coons & Cole, Claimant Attorneys
Karen Werner, Associate Attorney
James Dodge (Saif), Defense Attorney
Employers Defense Counsel, Defense Attorneys

Reviewed by Board Members Nichols and Brittingham.

Liberty Northwest Insurance Corporation requests review of Referee Myzak's order that: (1) set aside its denial of claimant's current back condition as a "new injury" or aggravation; (2) upheld the SAIF Corporation's denial of claimant's aggravation claim for the same condition; and (3) declined to continue the hearing. On review, the issues are remand and responsibility. We reverse.

## FINDINGS OF FACT

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

## FINDINGS OF ULTIMATE FACT

Dr. Hayes' deposition was obtainable with due diligence prior to hearing.

Claimant's 1974 injury and related 1985 surgery independently contributed to his current low back pathology. The November 1987 work injury and the work activity on October 11, 1988 did not independently contribute to a worsening of claimant's underlying pathology.

## CONCLUSIONS OF LAW AND OPINION

### Remand

At hearing, the Referee denied Liberty Northwest's motion to leave the record open so that it could obtain the deposition of the treating physician, Dr. Hayes. In its brief, Liberty Northwest requests that we remand the case to the Referee for the purpose of taking Dr. Hayes' deposition.

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(3). To merit remand for consideration of additional evidence it must be clearly shown that material evidence was not obtainable with due diligence at the time of the hearing. Kienow's Food Stores v. Lyster, 79 Or App 416 (1986); Delfina P. Lopez, 37 Van Natta 164, 170 (1985).

Here, Liberty Northwest solicited Dr. Hayes' opinion in November 1988, and again in January and February 1989. It then waited until June 9, 1989, twelve days before the hearing, to request further clarification from Dr. Hayes. If Liberty Northwest had requested clarification sooner, it would have realized the need for a deposition in time to schedule one prior to hearing. Therefore, we find that the deposition was available with due diligence at the time of hearing. Accordingly, we decline to remand this case.

### Responsibility

On October 11, 1988, claimant experienced a disabling flare-up of low back pain following an incident at work for the employer. Liberty Northwest was on the risk at the time. Claimant has two prior accepted low back injury claims with the same employer, one in September 1974 and the other in November 1987. SAIF was on the risk for the 1974 injury; Liberty Northwest was on the risk for the 1987 claim.

Responsibility is fixed with Liberty Northwest as the insurer with the most recent accepted claim. In order to shift responsibility, Liberty Northwest must prove affirmatively that the September 1974 injury with SAIF last independently contributed to claimant's low back pathology, as distinct from his symptoms.

The Referee assigned responsibility to Liberty Northwest, based on her conclusion that the October 11, 1988 incident independently contributed to claimant's need for medical treatment and disability. On review, Liberty Northwest argues that SAIF is responsible because Dr. Hayes' opinion establishes that claimant's October 1988 flare-up was a consequence of his September 1974 injury and related surgery in March 1985. We agree that SAIF is responsible.

Claimant's September 1974 injury occurred when he was hit in the low back and pelvis with a 30-inch diameter log. As a result of this injury, claimant seriously damaged his lumbar spine and underwent low back surgery in March 1985, including a laminectomy and discectomy at L5-S1 and a decompression at L4-L5 and L5-S1. Claimant's low back symptoms improved somewhat after the surgery, but he has experienced daily low back discomfort since the 1974 injury. The claim with SAIF was last closed with an award of 40 percent unscheduled permanent disability for the low back, and 20 percent scheduled disability for the left leg.

The November 1987 incident occurred when claimant was performing a pulling and twisting maneuver at work. Medical records at the time document increased symptoms, but no objective medical evidence of a worsening of claimant's prior back injury. On January 8, 1988, Dr. Donahoo reported that the November 1987 incident had resolved without additional permanent impairment, and that there had been no "essential worsening overall" as a result of the 1987 incident.

At the time of the most recent incident in October 1988, claimant felt a snap in his low back while helping an employee lift a saw at work. He developed pain in his low back, right hip and legs and was unable to continue working. On November 8, 1988, claimant's current treating physician, Dr. Hayes, orthopedic surgeon, characterized the October 1988 incident as an "exacerbation of [claimant's] back pain." He opined that claimant's continuing back problems were the result of the 1974 injury and unrelated to the November 1987 injury. On January 18, 1989, Dr. Hayes opined that the October 1988 incident did not significantly worsen claimant's underlying back condition. On February 9, 1989, Dr. Hayes opined that the October 1988 incident did not independently contribute to a worsening of claimant's underlying condition. Finally, On June 9, 1989, Dr. Hayes explained that because of claimant's altered back mechanics after his 1985 surgery, the 1988 flare-up followed as a result or consequence of the surgery.

There is no medical opinion in the record contrary to the opinions of Drs. Hayes and Donahoo. We are persuaded by this medical record that claimant's 1974 injury continues to independently contribute to his current low back pathology. The opinions of Drs. Hayes and Donahoo further persuade us that the work injury in 1987 and the work activity in October 1988 contributed to increased symptoms, but did not worsen claimant's underlying pathology. Accordingly, we conclude that claimant's 1974 injury last independently contributed to his low back pathology. As a result, SAIF is responsible for claimant's current condition, and we reverse the Referee on this issue.

ORDER

The Referee's order dated July 17, 1989 is reversed. Liberty Northwest Insurance Corporation's denial is reinstated and upheld. The SAIF Corporation's denial is set aside, and the claim is remanded to SAIF for further processing according to law.

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In the Matter of the Compensation of
**JAMES D. TATE, Claimant**
WCB Case No. C0-00040
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Gary Wallmark (Saif), Defense Attorney

Reviewed by Board Members Nichols and Brittingham.

On August 28, 1990, the Board acknowledged receipt of the parties' claim disposition agreement, as supplemented by the addendum, in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of $50,000 by the SAIF Corporation, claimant fully releases his right to future workers' compensation benefits, except medical services, for his compensable injury.

The agreement and addendum are in accordance with the terms and conditions prescribed by the Director. See ORS 656.236(1); OAR 436-60-145. The Board does

not find any statutory basis for disapproving the agreement. See ORS 656.236(1). Accordingly, the parties' claim disposition agreement and addendum are approved, hereby fully and finally resolving this matter.

Parenthetically, we note that, in the addendum, SAIF agreed to advance claimant $2,500 pending Board review of the agreement. The addendum further provides that, if the Board disapproves the agreement, the advance payment will be deducted as an overpayment from any temporary disability benefits, as well as permanent disability benefits, that may be awarded in the future. The agreement to deduct the advance payment from any future temporary disability benefits is contrary to law. See, e.g., Milton D. Forell, 41 Van Natta 2194 (1989); Buddy Tillman, 41 Van Natta 239 (1989); William J. Dale, 39 Van Natta 632 (1987); Harold D. Bates, 38 Van Natta 992 (1986). Because we are approving this agreement, however, the offensive portion of the addendum is of no legal effect.

IT IS SO ORDERED.

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In the Matter of the Compensation of
**PATTI L. WILSON, Claimant**
WCB Case No. 89-08089
ORDER ON REVIEW
Merrill Schneider, Claimant Attorney
Roy Miller (Saif), Defense Attorney

Reviewed by Board Members Nichols and Brittingham.

Claimant requests review of Referee Quillinan's order that awarded an attorney fee out of compensation rather than awarding an assessed fee. The issue on review is attorney fees.

The Board affirms and adopts the order of the Referee with this additional comment. Claimant argues she is entitled to an assessed fee because the aggravation denial was rescinded immediately before the hearing. Since the Referee's order has been issued, the Board has issued Duane L. Jones, 42 Van Natta 875 (1990), in which it held that a claimant's attorney would not be entitled to an assessed fee when the insurer reasonably issues and then reasonably rescinds a denial before a hearing. We find the Jones holding applicable in this matter.

ORDER

The Referee's order dated August 7, 1989 is affirmed.

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In the Matter of the Compensation of
**KEVIN C. HOFFMAN, Claimant**
WCB Case No. 89-01764
ORDER ON REVIEW
Starr & Vinson, Claimant Attorneys
Employers Defense Counsel, Defense Attorneys

Reviewed by Board Members Cushing and Myers.

Claimant requests review of those portions of Referee (Mirassou) McWilliams' order that: (1) increased claimant's scheduled permanent disability award for loss of use or function of his bilateral foot condition from 26 percent (35.1 degrees) for the right foot and 28 percent (37.8 degrees) for the left foot as awarded by a Determination order, to 37 percent (49.5 degrees) for each foot; and (2) granted the insurer's offset request for overpaid temporary disability. The insurer cross-requests review of that portion of the order that: (1) increased claimant's scheduled permanent disability award for his bilateral foot condition from 26 percent for the right foot and 28 percent for the left foot to 37 percent for each foot; and (2) declined to grant its request to offset overpaid permanent disability benefits. On review, the issues are extent of permanent disability and offset. We affirm in part, and reverse in part.

## FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" with the exception that the "Dr. Butters" referred to in the last paragraph of page 2, was Dr. Jones who performed the closing examination, we further supplement:

There was not a November 15, 1988 Determination Order issued.

The February 24, 1987 Determination Order was not appealed by claimant.

## CONCLUSIONS OF LAW AND OPINION

### Extent of permanent disability

Because the Determination Order in issue here was published on December 20, 1988, the "standards" adopted effective July 1, 1988, (former 436-35-001 et seq), as amended by temporary rules effective August 19, 1988, apply to the rating of claimant's permanent partial disability. Former OAR 436-35-010 through 436-35-260 apply to the rating of scheduled permanent partial disabilities. Former OAR 436-35-010(1).

### Disability under the standards

We adopt the Referee's conclusions concerning the extent of claimant's permanent disability with the exception of the findings which give claimant 15 percent per foot for impairment resulting from a "fracture of the calcaneus bone which limits the ability to stand, walk, or run."

In calculating the extent of claimant's disability we refer to the range of motion measurements, atrophy of the heel pads, and hypersensitivity of the heel pads as reported by Dr. Jones in his November 15, 1988 closing examination. Claimant has loss of subtalar inversion and eversion in each foot for a rating of 5 percent and 4 percent respectively. In the right foot claimant's retained dorsiflexion is 15 degrees for 2 percent, and retained plantar flexion is 20 degrees for 7 percent. In the left foot claimant's retained dorsiflexion is 10

degrees for 4 percent, and retained plantar flexion is 25 degrees for 5.5 percent. Dr. Jones also reported atrophy of the heel pads which we rate at 5 percent each, as well as hypersensitivity in the heel pads which we rate at 5 percent each.

Having determined each value necessary to compute claimant's disability under the standards we proceed to that calculation. When the total loss of range of motion in the right foot is 18 percent, combined with 5 percent for atrophy, and 5 percent for hypersensitivity, the result is 26 percent. When the total range of motion in the left foot is 18.5 percent, combined with 5 percent for atrophy, and 5 percent for hypersensitivity, the result it 27 percent. Claimant's disability, therefore, under the standards is 26 percent for the right foot and 27 percent for the left foot.

Disability outside the standards

Either party may establish that the record, as a whole, constitutes clear and convincing evidence that the degree of permanent partial disability suffered by claimant is more or less than the entitlement indicated by the "standards". ORS 656.283(7) and 656.295(5). To be clear and convincing, evidence must establish that the truth of the asserted fact is "highly probable." Riley Hill General Contractor, Inc. v. Tandy Corp., 303 Or 390, 302 (1987).

The Referee found by clear and convincing evidence that claimant was entitled to an additional 15 percent impairment rating for a "fracture of the calcaneus bone which limits the ability to stand, walk, or run" for each foot. For support, the Referee relied on OAR 436-35-240(1) which was not in effect at the time claimant was rated.

We have previously held that amendments to the standards merely establish that the disability standards were amended at a time following closure of claimant's injury claim, and do not constitute clear and convincing evidence that the claimant's loss of use or function is greater than previously awarded. Joseph Anger, 41 Van Natta 827 (1989).

Proceeding to the merits, we do not find that the lay and medical record establishes that it is "highly probable" that the fracture of the calcaneus bone in both feet limited claimant's ability to stand, walk, or run. The November 15, 1988 closing examination by Dr. Jones was rendered after claimant had recovered from his surgery. The report does not indicate that the fractured calcaneus bone has restricted claimant's ability to perform these movements. Likewise, we also conclude that claimant has not proved by clear and convincing evidence a loss of foot pads beyond the 5 percent already awarded for atrophy, nor a loss of endurance resulting from the bilateral foot condition.

Accordingly, claimant has not presented clear and convincing evidence that his award under the standards does not adequately reflect his loss use or function of his bilateral foot condition. Accordingly, we conclude that claimant's permanent disability was 26 percent for the right foot and 28 percent for the left foot. Inasmuch as the insurer requested a reduction of the Referee's award of permanent disability, and not a reduction of the award per the Determination Order, we will not further reduce the disability as awarded under the December 20, 1988 Determination Order.

Offset of temporary disability

Relying partly on the belief that claimant did not contest the propriety of an offset of overpaid temporary disability benefits, the Referee found that

an offset was appropriate and accordingly authorized an offset from October 10, 1988 through November 7, 1988. We disagree.

Claimant contends that he was not released to regular work and medically stationary until November 15, 1988. An insurer must pay a worker temporary disability until the worker is released to regular work and is medically stationary, or the worker becomes medically stationary and the claim is closed. Fazzolari v. United Beer Distributors, 91 Or App 592 (1988). The record shows claimant was given a regular work release on October 10, 1988, but did not return to work because none was available. Dr. Jones found claimant medically stationary on November 15, 1988. Thus, claimant was entitled to temporary disability from October 10, 1988 through November 7, 1988. Accordingly, the insurer was not entitled to an overpayment for this period of time. The insurer provides no argument otherwise.

Offset of permanent disability

The Referee concluded that the absence in the record of an alleged November 15, 1988 Determination Order amounted to a failure of proof, and declined to grant an offset of permanent disability benefits to the insurer. Because we have concluded there is no November 15, 1988 Determination Order, we proceed to consider the merits of the insurer's request.

The insurer contends that it should be allowed to offset the difference between the February 24, 1987 Determination Order award of 40 percent per foot, and his current disability rating of 26 percent for the right foot and 28 percent for the left foot as awarded by the December 20, 1988 Determination Order.

The Evaluation Section had authority to rate a claimant's permanent disability at the time it last closed the claim on December 20, 1988. However, it had no authority to alter the prior award of February 24, 1987, which had become final by operation of law. Romilda Williams, 41 Van Natta 1887 (1989). Thus, the Evaluation Section's reduction of claimant's prior award was invalid. Therefore, since the Evaluation Section had authority to determine claimant's permanent disability at the time of closure, the December 20, 1988 Determination Order, in effect, declined to award permanent disability beyond the 40 percent per foot that claimant had previously been awarded. Consequently, since we have found above that claimant's permanent disability does not exceed 40 percent for each foot, no overpayment of compensation exists. See Randy Strazi, 42 Van Natta 1116 (1990).

ORDER

The Referee's order dated May 24, 1989 is affirmed in part and reversed in part. That portion of the Referee's order that increased claimant's permanent disability award beyond the December 20, 1988 Determination Order is reversed. The award granted by the aforementioned Determination Order is reinstated and affirmed, with the exception of that part of the order which attempts to reduce the previous awards of 40 percent (54 degrees) scheduled permanent disability granted by the February 24, 1987 Determination Order. That portion of the Referee's order that authorized the insurer an offset of temporary disability is reversed. The remainder of the order is affirmed.

In the Matter of the Compensation of
**MACK T. EUBANKS, Claimant**
WCB Case No. 89-06087
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Davis & Bostwick, Defense Attorneys

Reviewed by Board Members Perry and Howell.

Claimant requests review of Referee Mongrain's order which: (1) declined to award temporary total disability benefits between March 21, 1989 and April 17, 1989; (2) declined to assess a penalty and associated attorney fee for alleged unreasonable failure to pay temporary disability benefits; and (3) awarded 2 percent (3 degrees) scheduled permanent disability for loss of use or function of each hand for carpal tunnel syndrome, whereas a Determination Order awarded no scheduled disability. On review, the issues are temporary disability benefits, extent of scheduled permanent disability, and penalties and associated attorney fees. We affirm in part and modify in part.

## FINDINGS OF FACT

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

## CONCLUSIONS OF LAW AND OPINION

### Temporary Disability

The Board adopts the Referee's "Opinion" and "Conclusions of Law" with respect to the issue of temporary disability. Because we conclude that the self-insured employer properly terminated claimant's temporary disability benefits, we conclude that a penalty and associated attorney fee for refusal to pay those benefits is not due.

### Extent of Scheduled Disability

The Board adopts the Referee's "Opinion" and "Conclusions of Law" with respect to the issue of extent of scheduled permanent disability with the following modification.

OAR 436-35-010(7) does not allow for an award higher or lower than the stated 5 percent for each body part. See Larry L. McDougal, 42 Van Natta 1544 (1990) (under OAR 436-35-320(4), more than one 5 percent impairment value for loss of repetitive use of a body part may be awarded if more than one "body part" had limited use due to compensable injury or disease.) We agree with the Referee that claimant suffers chronic conditions limiting repetitive use of his hands. Accordingly, claimant is awarded 5 percent (7.5 degrees) for limitations of repetitive use of each hand due to his carpal tunnel condition.

On the record as a whole, we are not persuaded that claimant has shown by clear and convincing evidence that he suffers additional impairments that are not adequately described by the standards.

## ORDER

The Referee's order dated July 28, 1989 is affirmed in part and modified in part. That portion which awarded 2 percent (3 degrees) scheduled disability for the right forearm and 2 percent (3 degrees) scheduled disability for the left forearm, whereas a Determination Order awarded no scheduled disability, is modified to award 5 percent (7.5 degrees) scheduled disability for each forearm.

The remainder of the order is affirmed. Claimant's attorney is awarded 25 percent of the increased compensation created by this order, payable directly to claimant's attorney. However, the total attorney fees awarded by the Referee and Board orders shall not exceed $3,800.

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In the Matter of the Compensation of
**ROGER F. OMAN, Claimant**
WCB Case Nos. 89-09332, 89-09331, 89-09330, 89-09329, 88-020888, 88-20887, 88-20886, 88-14663, 88-14662, 88-14661, 88-12960, 88-12300 & 88-12299
ORDER ON REVIEW
Parker & Bush, Claimant Attorneys
Kenneth L. Kleinsmith, Defense Attorney
Waggoner, et al., Defense Attorneys
Scheminske & Lyons, Defense Attorneys
Randolph Harris (Saif), Defense Attorney
Stafford Hazelett, Defense Attorney

Reviewed by Board Members Howell and Speer.

Liberty Northwest Insurance Corporation requests review of that portion of Referee Neal's order that required it, as the ultimately responsible party, to reimburse the SAIF Corporation, paying agent under an ORS 656.307 order. On review, the issue is jurisdiction to order reimbursement. We vacate in part and affirm in part.

FINDINGS OF FACT

In this responsibility case, the SAIF Corporation was designated paying agent by an ORS 656.307 order. The Referee found Liberty Northwest Insurance Corporation responsible. The Referee also ordered Liberty Northwest to "make the necessary adjustments" with SAIF, under the ORS 656.307 order.

CONCLUSIONS OF LAW AND OPINION

The issue of reimbursement between carriers is not a matter concerning a claim under ORS 656.704(3) and ORS 656.726(2). EBI Companies v. Kemper Group Insurance, 92 Or App 319 (1988). "Neither the Hearings Division nor the Board has jurisdiction over matters that do not concern a claim." Ashley v. University of Oregon, 100 Or App 588, 589 (1990). ORS 656.307(3) provides that once a determination of responsibility is made, the director shall order necessary adjustments. Consequently, the Referee lacked jurisdiction to order reimbursement. Nellie D. Reinsch, 42 Van Natta 488 (1990).

ORDER

The Referee's July 17, 1989 order is affirmed in part and vacated in part. That portion of the order that directed Liberty Northwest Insurance Corporation to reimburse the SAIF Corporation is vacated. The remainder of the Referee's order is affirmed.

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IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
James G. Adams, Claimant.
GIUSTI WINE CO.
and EBI Companies,
*Petitioners,*
*v.*
James G. ADAMS,
United Pacific Insurance, Western Employers Insurance
and Royal Insurance,
*Respondents.*

(86-08747, 85-15626, 86-01876, 86-08746; CA A61582)

Judicial Review from Workers' Compensation Board.

Argued and submitted January 12, 1990.

Patric J. Doherty, Portland, argued the cause for petitioners. With him on the brief were Karli L. Olson and Rankin, VavRosky, Doherty, MacColl & Mersereau, Portland.

James L. Edmunson, Eugene, argued the cause for respondent James G. Adams. With him on the brief was Malagon, Moore & Johnson, Eugene.

Daryll E. Klein, Portland, waived appearance for respondent Royal Insurance.

Craig A. Staples and Roberts, Reinisch & Klor, P.C., Portland, waived appearance for respondent Western Employers Insurance.

O. R. Skopil, III and Cooney, Moscato & Crew, Portland, waived appearance for respondent United Pacific Insurance.

Before Graber, Presiding Judge pro tempore, and Riggs and Edmonds, Judges.

RIGGS, J.

Graber, P. J. pro tempore, concurring.



**RIGGS, J.**

Employer seeks review of an order of the Workers' Compensation Board after remand. In *Giusti Wine Co. v. Adams,* 94 Or App 175, 764 P2d 620 (1988), we remanded the case to the Board for a determination of whether claimant had "good cause" under ORS 656.319(1)(b) for failure to file a request for a hearing within the statutory period.[1] The Board

[1] ORS 656.319(1) provides:

"With respect to objection by a claimant to denial of a claim for compensation under ORS 656.262, a hearing thereon shall not be granted and the claim shall not be enforceable unless:

"(a) A request for hearing is filed not later than the 60th day after the claimant was notified of the denial; or

"(b) The request is filed not later than the 180th day after notification of denial and the claimant establishes at a hearing that there was good cause for failure to file the request by the 60th day after notification of denial."

concluded that claimant had good cause, and employer assigns error to that holding. We affirm.

We recite the facts from our first opinion:

> "On August 19, 1985, [employer] issued a denial of responsibility for claimant's aggravation claim. It sent the letter by certified mail, return receipt requested, to claimant's correct address. Claimant did not claim the letter, despite notices left by the post office on August 21 and 27. On October 29, 1985, employer sent a copy of the notice of denial through the regular mail. Claimant received it on November 4, 1985. He filed a request for hearing on December 18, 1985." 94 Or App at 176.

The referee concluded that claimant had good cause for the late filing, because there was no evidence that he received notification of the August 19, 1985, denial until he received the copy on November 4. He reversed the denial.

On remand, the Board concluded:

> "Claimant testified that he never received the post office's notices regarding the certified denial letter of August 19, 1985. The Referee found claimant to be credible, and we find no reason to disturb that finding on review. Accordingly, we find that, despite reasonable diligence, claimant did not receive actual notification of the denial until he received the second letter on November 4, 1985. Because claimant could not be expected to file a request for hearing on the denial prior to



> that date of notification, we find good cause for his delay in filing the hearing request. The hearing request is not barred. *See* ORS 656.319(1)(b)."

Employer argues that the Board's determination of good cause is not supported by substantial evidence and that the order is "legally erroneous because it equates 'notification' under ORS 656.319(1)(b) with receipt, not mailing."

We review the Board's determination of good cause for substantial evidence and errors of law. ORS 656.298(6); *Cowart v. SAIF,* 94 Or App 288, 290, 765 P2d 226 (1988). "Good cause in this context means 'mistake, inadvertence, surprise or excusable neglect,' as those terms are used in ORCP 71B(1)." *Hempel v. SAIF,* 100 Or App 68, 70, 784 P2d 1111 (1990). Claimant testified that he did not receive the denial letter of August 19, 1985, or any of the notices regarding that letter left at his address by the post office. The referee found that claimant's testimony regarding his back pain was credible, and he gave no indication that claimant's testimony regarding notification of the denial was not credible. Therefore, there was substantial evidence to support the Board's finding that claimant did not receive actual notification of the denial until November 4, 1985, despite reasonable diligence. The Board's finding to that effect supports its conclusion that claimant had good cause for filing a request for a hearing after the 60-day statutory period had run, because this claimant could not be expected or required to file a request for a hearing until he had actually been notified of the denial.

Employer argues that the Board's conclusion on good cause is inconsistent with *Norton v. Compensation Depart-*

*ment,* 252 Or 75, 448 P2d 382 (1968), and urges us to adopt the analysis of the dissenting Board member:

> "I do not consider claimant's alleged failure to receive post office notices of the certified letter as good cause because, if it is, the 60 day statutory period would in effect begin to run from the date that a claimant *received* notice. The *Wright* court has recently reasoned that such a principle is directly contrary to the Supreme Court's interpretation of ORS 656.319(1) in *Norton v. Compensation Department,* [*supra*]. [*Wright v. Bekins Moving & Storage Co.*, 97 Or App 45, 775 P2d 857, *rev den* 308 Or 466 (1989).]" (Emphasis in original.)

In *Norton,* the Supreme Court held that the 60-day



period in ORS 656.319(1) "after the claimant was notified of the denial" begins to run the date that notice of the denial is mailed, not the date that it is received, because mailing notice to the correct address "is presumed to bring knowledge to the addressee of the notice." 252 Or at 78. In *Wright,* we held that a hearing request filed more than 180 days after the denial was mailed could not be timely. 97 Or App at 49. The issue in that case was whether there were "extenuating circumstances" that could be the basis for relief from the 180-day time limitation of ORS 656.319(1). 97 Or App at 48-49.

Here, the 60-day period in ORS 656.319(1) began running on August 19, 1985, when employer mailed the denial to claimant. *See Norton v. Compensation Department, supra,* 252 Or at 78. Accordingly, the hearing request was filed more than 60 days, but less than 180 days, after notification of the denial. Claimant is required to show good cause for failure to file by the 60th day after the denial was mailed to overcome the presumption that he had knowledge of the denial within the 60-day period. *See* ORS 656.319(1)(b). Claimant demonstrated good cause under the statute. The Board did not grant any relief from the statutory time limitation that is not provided by the statute, and it did not change the date that the statutory period effectively began to run.[2]

Affirmed.

**GRABER, P. J.** pro tempore, concurring.

I agree that we should affirm, but I write separately to state more precisely the issue and my view of its proper resolution.

The majority correctly notes that we review the Board's determination of good cause for substantial evidence and errors of law. ORS 656.298(6). There is only one material finding of fact that we must review for substantial evidence: "[T]hat, despite reasonable diligence, claimant did not receive actual notification of the denial until he received the second letter on November 4, 1985." I agree with the majority that substantial evidence in the record supports that finding.

The Board concluded that nonreceipt was good cause

[2] Employer's other arguments require no discussion.

for claimant's delay in filing the hearing request, reasoning that he could not be expected to file a request for hearing on a denial that he had not yet received. *See Hempel v. SAIF*, 100 Or App 68, 70, 784 P2d 1111 (1990). The sole legal issue is whether the Board's conclusion erroneously interpreted a provision of law. Employer contends that the finding of non-receipt is insufficient, as a matter of law, to constitute "good cause" under ORS 656.319(1)(b).

More specifically, employer asserts that *Norton v. Compensation Department*, 252 Or 75, 448 P2d 382 (1968), precludes the Board's interpretation of good cause. Employer is wrong, because *Norton* did not answer the question here: whether nonreceipt of the notice of denial can be good cause. *Norton* held that the 60-day period for measuring the timeliness of a claimant's request for hearing runs from the mailing of the notice. It also held that mailing creates a presumption of receipt. The Board's conclusion in the present case is not inconsistent with either of those principles.

*Norton* did *not* contain either of the holdings that employer ascribes to it. It did not make the presumption of receipt conclusive, as distinct from rebuttable, and it did not decide what the result would be if a particular claimant overcomes the presumption of receipt. The strongest evidence that the Board was correct on those two points is found in *Norton* itself:

> "It is, of course, conceivable that the mailing of the notice of denial will not bring notice of the denial to the workman within 60 days after the denial or will not bring notice within a reasonably substantial time after the mailing, all through no fault of the workman. What relief can be granted to the workman in such event will have to depend upon the particular circumstances of each case." 252 Or at 78.

The majority cleanly disposes of employer's final argument, which rests on *Wright v. Bekins Moving & Storage Co.*, 97 Or App 45, 775 P2d 857, *rev den* 308 Or 466 (1989). There, we held that a request for hearing filed more than 180 days after the mailing of the denial could not be timely. Because the present request was filed more than 60, but less than 180, days after employer mailed the denial, *Wright* does not apply.

Accordingly, the Board's conclusion that claimant demonstrated good cause under the statute is consistent with the governing statutes and cases. We must affirm.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Robert M. Bryant, Claimant.
WEYERHAEUSER COMPANY,
*Petitioner,*
*v.*
Robert M. BRYANT,
*Respondent.*
(WCB 86-01731; CA A60254)

Judicial Review from Workers' Compensation Board.

Argued and submitted November 15, 1989.

Brian L. Pocock, Eugene, argued the cause and filed the brief for petitioner.

Lynne W. McNutt, Coos Bay, argued the cause and filed the brief for respondent.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

RICHARDSON, P. J.

Reversed and remanded for reconsideration.



**RICHARDSON, P. J.**

Employer seeks review of an order of the Workers' Compensation Board that set aside a denial on the ground that employer had improperly denied future medical benefits. We reverse and remand.

Claimant, a timber faller, suffered a compensable low back strain in August, 1979. He received intermittent chiropractic treatments until July, 1980, when the claim was closed as non-disabling. In February, 1983, he briefly received therapy from Dr. Cohen, a chiropractor.

In August, 1984, claimant received treatment for low back pain from Dr. Mang, a chiropractor. He returned to Mang in November, 1984, and, when the pain did not resolve, Mang referred him to Dr. Hockey, an orthopedic surgeon. Hockey concluded that claimant had a herniated disc and should have no further chiropractic treatments.

Employer referred claimant to Dr. Howell, an osteopath, for examination in January, 1986. Howell found no objective basis for claimant's complaints of low back pain and concluded that the 1979 back strain had resolved. In his opinion, claimant's 1986 condition was not related to the industrial injury of 1979. He recommended that claimant receive no further chiropractic treatments.

On January 30, 1986, employer wrote to claimant:

> "As a result of the recent medical examination done by Richard K. Howell, D.O., it has been determined that further chiropractic treatment is not reasonable or necessary as it relates

to your industrial injury of August 28, 1979. Therefore, Weyerhaeuser Company will not be responsible for any treatment rendered after January 30, 1986."

Claimant sought a hearing. The referee concluded that chiropractic treatment for claimant's condition was not reasonable and necessary. The Board adopted the findings of the referee but concluded that employer's letter was a denial of future medical benefits and therefore was not appropriate under ORS 656.245(1). It set aside the denial.

Whether or not the Board was correct, the resolution of that issue does not dispose of this review. Because employer had medical evidence that claimant's current condition is not



related to the compensable injury, employer was entitled to deny the compensability of the condition for which treatment was sought. The *letter* was not sufficient to do that. *Johnson v. Spectra Physics,* 303 Or 49, 58, 733 P2d 1367 (1987). It is apparent from the record, however, that the parties *tried* the case by *agreement* with that issue in mind.

Accordingly, the referee should have decided the issue of compensability; however, he did not. Instead, he held only that "claimant has failed in his burden of proof to establish that further chiropractic treatment is reasonable and necessary." The Board decided that that was not a proper basis on which to deny claimant's entitlement to all future chiropractic treatments. It should also have decided the additional issue of whether the condition for which claimant seeks treatment is compensable. We remand the case to the Board for reconsideration of that issue.

Reversed and remanded for reconsideration.

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IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Sharon S. Rager, Claimant.

Sharon S. RAGER,
*Petitioner,*

*v.*

EBI COMPANIES
and Lincoln County School District,
*Respondents.*

(85-11532; CA A60485)

Judicial Review from Workers' Compensation Board.

Argued and submitted December 18, 1989.

Martin J. McKeown, Eugene, argued the cause for petitioner. With him on the brief was Martin J. McKeown, P.C., Eugene.

Randy G. Rice, Portland, argued the cause for respondents. With him on the brief was Beers Zimmerman Rice & Isaacs, Portland.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

NEWMAN, J.

Affirmed.



**NEWMAN, J.**

Claimant seeks review of an order of the Workers' Compensation Board that reversed the referee's order and denied payment for a home whirlpool unit. We affirm.

The Board adopted, but also supplemented, the referee's findings of fact. Claimant sustained compensable back and right hip injuries when she slipped and fell at work in March, 1983. In October, 1984, her treating chiropractor, Dr. Ray, declared her medically stationary but permanently impaired, and he released her for work. She continued to receive chiropractic treatment. Although claimant was able to return to work, her pain continued, primarily in the right hip and right buttock areas. The pain was worse when she was lying down, and it interfered with her sleep at night.

In July, 1985, Orthopaedic Consultants evaluated claimant, on behalf of employer's insurer, EBI, and recommended a steroid injection or use of a non-steroidal anti-inflammatory drug. Claimant refused those therapies. Ray disagreed with Orthopaedic Consultants' recommendations and stated that claimant should be allowed to continue with the chiropractic treatment that he provided, because he believed it was effective in keeping her discomfort to a minimum.

Claimant's pain continued and, in September, 1986, Ray prescribed the purchase of a home whirlpool unit to reduce claimant's pain and to allow her to sleep. Nonetheless, in January, 1987, Ray stated again that claimant was responding well to his chiropractic treatments. In May, 1987, Orthopaedic Consultants reevaluated claimant and concluded that a whirlpool was unnecessary. The Board also found:

> "Claimant's physical discomfort responds well to chiropractic treatment, including a regimen of specific spinal adjustments, myofascial trigger point therapy, pulsed ultrasound, positive galvanic stimulation, moist hydrotherapy and the use of prescribed exercises. This treatment is effective in relieving her chronic pain, allowing her to remain actively employed and function on a daily basis."

The Board concluded:

> "In the present case, Dr. Ray, claimant's treating chiropractor, had treated claimant with specific chiropractic spinal adjustments, myofascial trigger point therapy, ultrasound,



> cryotherapy, orthopedic support and prescribed exercise. Although the treatments had been quite effective in reducing the intensity, duration, severity and frequency of claimant's chronic pain, it had not been eliminated. Therefore, Dr. Ray prescribed a full-size Jacuzzi whirlpool.

"Dr. Ray believed that the $4,000 home hot tub unit was quite justified since: (1) whirlpool type applications of moist heat are far more effective than a simple tub bath or heating pad; (2) claimant lived almost 25 miles from the nearest city that would have public hot tub facilities; and (3) claimant's modesty created a reluctance to frequent such public bathing facilities. He believed that the therapy was necessary so that claimant's chronic muscular spasms and pain were reduced prior to her retiring for the evening, thereby allowing her to sleep more fully and with less pain.

"Although claimant has shown that a hot tub would provide effective palliative treatment for her pain syndrome, *she has not shown with particularity why she needs the service when the majority of workers with similar injuries do not.* Dr. Ray repeatedly stated that his various chiropractic treatments were quite effective in controlling claimant's pain syndrome. In fact, it is undisputed that chiropractic treatments have provided claimant with effective, short-term relief. *Therefore, claimant has not shown a special need for the hot tub due to any ineffectiveness of traditional palliative medical treatment.* Neither do we believe that her modesty or 25 mile distance from public hot tub facilities prove claimant's entitlement to an item not usually considered necessary in the great majority of workers with similar impairments." (Emphasis supplied.)

Claimant contends Board's denial of the compensability of the whirlpool unit is not based on substantial evidence. She asserts that chiropractic treatments provide her some relief from pain, but they do not solve the problem of sleeplessness. She asserts that whirlpool treatments would solve that problem and that her distance from a public hot tub facility, her modesty and her concerns about drug therapy are circumstances that set her apart from the majority of workers with similar injuries.

The Board did not err. ORS 656.245(1) *(since amended by* Or Laws 1990 (Special Session), ch 2, § 10) provided in part:

"For every compensable injury, the insurer or the self-insured employer shall cause to be provided medical services



for conditions resulting from the injury for such period as the nature of the injury or the process of the recovery requires[.] * * * 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."

*Former* OAR 436-10-040(7)[1] provided in part:

"Articles such as beds, hot tubs, chairs, [J]acuzzis, and gravity traction devices are not compensable unless a need is clearly justified by a report which establishes that the 'nature of the injury and the process of recovery requires' that the item be furnished. The report must set forth with particularity why the patient requires an item not usually considered necessary in the great majority of workers with similar impairments."

[1] OAR 436-10-040(7) was amended and renumbered OAR 436-10-040(8) as of February 1, 1988. It remains the same in substance.

Benefits for articles such as whirlpools are appropriate, whether they are palliative or curative, if they are reasonable and necessary as a result of a compensable injury and if the claimant has established with particularity why she needs the service, even though the majority of workers with similar injuries do not.[2] In *Elixir Industries v. Lange,* 100 Or App 492, 786 P2d 1301 (1990), the Board had concluded that the claimant had satisfied the criteria of *former* OAR 436-10-040(7), and it held that a hot tub was appropriate. We affirmed, because there was substantial evidence to support the Board's findings that the claimant's surgery did not successfully alleviate her pain, that she had an intolerance for standard nonaddictive pain medications, that she lived 30 miles from other sources of hydrotherapy and that daily use of a hot tub was necessary to control the effects of post-surgical impairment of the lumbosacral spine.

Here, although claimant has shown that home whirlpool treatments would be beneficial to her, there is substantial evidence to support the Board's findings that claimant responds well to palliative chiropractic treatments, that they



are effective in controlling her pain and that they allow her to remain actively employed and to function on a daily basis. On the basis of those findings, the Board rationally concluded that claimant did not satisfy the criteria of *former* OAR 436-10-040(7), because she had failed to show with particularity why she required a service that the majority of workers with similar injuries do not. The Board did not err.

Claimant also assigns as error that the Board relied on *former* OAR 436-10-040(7), because the director exceeded his delegated authority in promulgating that rule. ORS 656.245(4) provides that the director "may exclude from compensability any medical treatment the director finds to be unscientific, unproven, outmoded or experimental." Claimant asserts that hydrotherapy treatment is not "unscientific, unproven, outmoded or experimental." Consequently, she argues that *former* OAR 436-10-040(7) is contrary to legislative intent, ORS 656.012(2)(a), because it limits an injured worker's right to receive prompt and complete medical treatment.

Contrary to the thrust of claimant's argument, *former* OAR 436-10-040(7) does not exclude hydrotherapy treatment. Rather, it recognizes that a whirlpool can be appropriate, and it imposes reasonable conditions that an injured worker must satisfy to receive payment for that item. Therefore we do not reach claimant's argument that the director exceeded his authority.

Affirmed.

[2] In view of our disposition in this case, we do not decide whether the Legislature's 1990 amendments to ORS 656.245(1) affect claimant's claim for a whirlpool. *See* Or Laws 1990 (Special Session), ch 2, §§ 10, 54.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
James E. Tennant, Claimant.

James E. TENNANT,
*Petitioner,*

*v.*

LYMAN SLACK CHEVROLET
and SAIF Corporation,
*Respondents.*

(WCB No. 87-00760; CA A50926)

In Banc*

Judicial Review from Workers' Compensation Board.

Argued and submitted October 18, 1989; resubmitted in banc April 11, 1990.

Charles Robinowitz, Portland, 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.

NEWMAN, J.

Affirmed.

Joseph, C. J., dissenting.

* Graber, J. pro tempore, participated in this opinion; DeMuniz, J., did not participate.



**NEWMAN, J.**

Claimant seeks review of an order of the Workers' Compensation Board that denied his claim for his first three days of temporary total disability. We affirm.

Claimant, an auto mechanic, sustained a compensable injury to his neck on September 25, 1985. As a result of the injury, he left work during that work day and was absent from work on September 26 and 27, on October 23 and 24 and on November 18 and 27. On January 6, 1986, his treating doctor ordered him off work on account of the injury, and he was unable to return to work as an auto mechanic thereafter. After January 6, 1986, he missed at least 14 consecutive days of work as a result of the injury. He was not declared medically stationary until October 28, 1986. The referee awarded him 30 percent unscheduled permanent partial disability.

ORS 656.210(3) provides:

"No disability payment is recoverable for temporary total disability suffered during the first three calendar days after

the worker leaves work as a result of the compensable injury unless the total disability continues for a period of 14 days or the worker is an inpatient in a hospital. If the worker leaves work the day of the injury, that day shall be considered the first day of the three-day period."

The referee held:

"The next issue concerns the claimant's entitlement to three days of time loss. The claimant argues that the time loss should have been paid as soon as he missed 14 days of work. ORS 656.210(3) provides that 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.* The claimant was not off work for 14 consecutive days until January 6, 1986. The claimant's request for time loss prior to missing 14 consecutive days is denied." (Emphasis supplied.)

The Board affirmed and adopted the order of the referee.

Claimant assigns as error that the Board denied him

"payment for the first three days of his total disability [September 25, 26 and 27] where his disability continued for



more than 14 consecutive days, although this did not occur from the date of injury."

He argues that ORS 656.210(3) requires payment of temporary total disability for the first 3 days as soon as an injured worker misses a total of 14 days of work as a result of the injury. Alternatively, he argues that, even if the statute requires that a claimant must miss 14 consecutive days as a result of the injury, that 14-day period need not begin with the date of the injury. He asserts that, if the legislature had meant to require that the 14-day period run consecutively from the date of the injury, the statute would have said so.

The Board correctly interpreted ORS 656.210(3), which says that temporary total disability benefits are not recoverable for 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." We interpret the word "continues" to mean "to maintain without interruption a condition, course or action." *Websters Ninth New Collegiate Dictionary* 284 (1985 ed). As did the Board, we interpret the statute to mean that claimant must miss a continuous period of 14 days, without interruption, from the first day of being off work by reason of a compensable injury in order to receive temporary total disability for the first three days.[1]

Affirmed.

[1] All that the legislative history shows is that the legislature intended to adopt a 3-day waiting period to save money in benefits and administrative costs in smaller claims. *See* Minutes, Senate Committee on Labor and Industries, March 8, 1965, 2.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Richard L. Short, Claimant.
LIBERTY NORTHWEST
INSURANCE CORPORATION
and Mead Corporation,
*Petitioners - Cross-Respondents,*
*v.*
Richard L. SHORT,
*Respondent - Cross-Petitioner,*
*and*
KEMPER GROUP INSURANCE,
*Respondent - Cross-Respondent.*
(85-15198, 85-15197, 85-12701; CA A51178)

In Banc

Judicial Review from Workers' Compensation Board.

Argued and submitted November 13, 1989; resubmitted in banc February 7, 1990.

Stafford J. Hazelett, Portland, argued the cause and filed the briefs for petitioners - cross-respondents.

Brian R. Whitehead, Salem, argued the cause and filed the brief for respondent - cross-petitioner.

Jerry Keene, Portland, argued the cause for respondent cross-respondent. With him on the brief was Roberts, Reinish & Klor, P.C., Portland.

EDMONDS, J.

Affirmed on petition and on cross-petition.

Buttler, J., specially concurring.



**EDMONDS, J.**

Employer seeks review of a Workers' Compensation Board order awarding compensation to claimant on his aggravation claim and assessing penalties and attorney fees for employer's failure to pay compensation. We affirm.[1]

Claimant filed an occupational disease claim for "tennis elbow" in his right arm on February 7, 1980. Temporary disability benefits were paid, and the condition was declared stationary on April 4, 1980. In 1984, claimant suffered an aggravation and was off work for three days.[2]

[1] Claimant cross-petitions for review of the Board's denial of temporary disability benefits. There is substantial evidence to support the Board's findings, and we affirm on the cross-petition.

[2] The report of claimant's doctor indicated a three-day release from work. Claimant testified that he could not remember exactly how many days he was off, but he thought that it was five to seven days. There is substantial evidence to support the Board's finding that claimant was off work for three days.

Employer paid claimant's medical expenses, but denied payment of temporary disability benefits. The referee upheld the employer's denial and claimant sought Board review. The Board awarded temporary disability benefits and assessed penalties and attorney fees against employer, pursuant to ORS 656.262(10), holding that, "because claimant had previously received time loss benefits for this condition, he had already satisfied the three-day waiting period set forth in *former* ORS 656.210(3)."[3] Employer seeks review, arguing that the Board erred in awarding benefits for the three-day time loss.

ORS 656.210(3) provides:

> "No disability payment is recoverable for temporary total disability suffered during the *first three calendar days* after the worker leaves work as a result of the *compensable injury* unless the total disability continues for a period of 14 days or the worker is an inpatient in a hospital." (Emphasis supplied.)

ORS 656.005(7)(a) defines "compensable injury" as

> "an accidental injury, * * * arising out of and in the course of employment requiring medical services resulting in disability or death * * *."

ORS 656.273(1) provides:



> "After the last award or arrangement of compensation, an injured worker is entitled to additional compensation, including medical services, for worsened conditions resulting from the original injury."

"Aggravation" is defined in OAR 436-60-005(1) as

> "the worsened condition of an injured worker which is a medically verified increase in seriousness or severity of a condition arising from an industrial injury to the worker since the last award or arrangement of compensation for that industrial injury."

Employer argues that an injured worker's absence from work must exceed three days before he is entitled to temporary disability benefits by reason of an aggravation because, under ORS 656.263(6), an aggravation claim is processed in accordance with the provisions of ORS 656.262 that apply to an original claim. However, ORS 656.210(3) can also be reasonably interpreted, when read with ORS 656.273(1), to limit the three-day waiting period only to original injury claims, because (1) the statute refers only to a compensable injury and (2) the legislature could have easily added the words "or aggravation" after "compensable injury" had it intended a broader application.

When statutory language lends itself to more than one interpretation, we can look to legislative history to identify the context in which it was adopted as an aid to resolving the ambiguity, *City of Portland v. Rice,* 94 Or App 292, 296, 765 P2d 228 (1988), *aff'd* 308 Or 118 (1989) However, the legislative history of ORS 656.210(3) is not dispositive. There is an

[3] ORS 656.210(3) is still in effect in its original version.

indication that the three-day period was added to reduce the cost of administering the workers' compensation system by excluding coverage for a large number of insignificant temporary injuries. *See* Minutes, House Committee on Labor and Management, January 18, 1965, pp 2-3. That purpose may apply to insignificant aggravations as well as to insignificant initial injuries. However, the history also indicates strong opposition to the adoption of any three-day waiting period. Before adding the three-day waiting period in 1965, Oregon was the only state requiring a one-cent employee contribution and allowing claims of disability without a waiting period. Both the House Labor and Management and Senate Labor and Industries Committees discussed whether to add any



waiting period at all, because the unique provisions were thought to offset each other. There was also testimony supporting elimination of the three-day waiting period from the bill altogether.[4] It can be inferred from the history that the legislature intended that "compensable injury" meant only the original injury.

Our inquiry, then, is to determine how the legislature would have intended the statute to be applied, had it considered the question. *Security State Bank v. Luebke,* 303 Or 418, 737 P2d 586 (1987). To answer that inquiry, we look to the language used, the statutory objective and any other evidence of the intended meaning. ORS 174.010. *State v. Parker,* 299 Or 534, 704 P2d 1144 (1985).

Generally, the Workers' Compensation Law should be interpreted in a light most favorable to the worker. *SAIF v. Bond,* 64 Or App 505, 506, 669 P2d 332 (1983). Looking at the

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[4] Jim Marr, AFL-CIO secretary, spoke to the House Labor and Management Committee and pointed out:

> "We are the only state which does not have a waiting period, but we are also the only state where the employees make a contribution. Half the employees contribution goes to a retroactive relief fund. The other half goes to for general administration.
>
> "The cost of the three-day waiting period to employers in Oregon is about $450,000, about half of the amount the employees are contributing."

*See* Minutes House Committee on Labor and Management, January 18, 1965.

On February 25, 1965, the Committee Chair moved to eliminate the three-day waiting from the bill altogether, but the motion failed. *See* Minutes, House Committee on Labor and Management, February 25, 1965. Later, the Senate Committee on Labor and Industries struggled with the same issue:

> "Mr. Marr stated he would like subsection 14 removed completely, which would eliminate the three-day waiting period. Mr. Marr said he realized Oregon is the only state that does not have a waiting period, but Oregon is the only state where the employee makes a one cent contribution for the purpose of not having a waiting period, which amounts to about $850,000 a year. But the employers want to use this for pre-existing disabilities.
>
> "* * * * *
>
> "Mr. Marr objected to the half cent that is being used for pre-existing disability and second injury. He feels it should be used to offset the three-day waiting period.
>
> "Senator Hallock asked Mr. Gill if this half cent would cover the time loss costs for the three-day waiting period and Mr. Gill said it would. Approximately $353,000 a year would be saved administratively by having a three-day waiting period. And a large amount of these is retroactive, that is, a lot of the people hurt will be paid for these first three days anyway, if they go into the hospital or if they are unable to return to work within 14 days." Minutes, Senate Committee on Labor and Industries, March 18, 1965.

language of ORS 656.210(3), its statutory companion, and its legislative history in the light most favorable to the worker, we conclude that had the legislature intended to require a worker to incur more than one three-day waiting period without compensation relating to the same injury, it would have expressly said so.

Affirmed on petition and on cross-petition.

**BUTTLER, J.,** specially concurring.

Although I concur with the majority's result, I do so for very different reasons, and the reasons are important ones. The majority affirms the Board, because it concludes that ORS 656.210(3) does not apply to aggravation claims.

Clearly, it does. It provides that no temporary total disability payment is recoverable during the first three 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." An aggravation is a worsened condition "resulting from the original injury[,]" ORS 656.273(1), rather than a new injury. If a worker leaves work as a result of a worsening, he "leaves work as a result of the compensable injury." ORS 656.210(3). In other words, the worsening is a continuation of the original compensable injury, *see Drews v. EBI Companies,* 102 Or 134, ___ P2d ___ (1990), and, for that reason, the five-year aggravation period is not extended. Therefore, ORS 656.210(3) is applicable.

The only real question presented by the parties and by the Board's decision is whether a worker who leaves work as a result of an aggravation of a compensable injury is entitled to temporary total disability compensation for the first three days if the total disability does not continue for a period of 14 days or he is not an inpatient in a hospital. The answer is no, unless the worker fulfills one of those requirements either following the original compensable injury or following an aggravation of that injury. In either case, the severity of the injury will have been established for the purposes of the statute.

In this case, claimant was totally disabled for more than 14 days as a result of his original compensable injury and received total disability compensation for all days during



which he was off work at that time. Therefore, he has fulfilled the literal requirements of the statute and is entitled to temporary total disability compensation for all of the days that he was totally disabled as a result of his compensable injury, including those that resulted from the aggravation. That is what the Board held, and it is right.

Accordingly, I would affirm for those reasons.

Joseph, C. J., and Newman and Riggs, JJ., join in this concurring opinion.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Isabel David Hernandez, Claimant.

Isabel David HERNANDEZ,
*Petitioner,*

*v.*

SAIF CORPORATION
and Martinez General Construction,
*Respondents.*

(89-0581M; CA A63091)

Judicial Review from Workers' Compensation Board.

Argued and submitted June 8, 1990.

Darris K. Rowell, Salem, argued the cause for petitioner. With him on the brief was Olson, Rowell & Walsh, Salem.

Jerome Lidz, Assistant Attorney General, Salem, waived appearance for respondents.

Before Buttler, Presiding Judge, and Rossman and De Muniz, Judges.

PER CURIAM

Petition dismissed.



**PER CURIAM**

Claimant petitions for review of an Own Motion order of the Workers' Compensation Board, assigning error to the Board's award of attorney fees.[1] ORS 656.278(3) provides, in part:

> "The claimant has no right to appeal any order or award made by the board on its own motion, except when the order diminishes or terminates a former award."

The Board's order increased claimant's former award of compensation. Therefore, claimant has no right to seek review of the order.

Petition dismissed.

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[1] OAR 438-15-080 provides:

> "If the Board orders increased compensation for temporary disability, the Board shall approve a fee of 25 percent of the increased compensation, not to exceed $1,050."

The Board approved "a reasonable attorney fee of 25 percent of the additional compensation awarded by the Board's order, not to exceed $150." Claimant assures us that the amount of the fee award was deliberate, not merely a typographical error.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Marvin H. Allen, Claimant.

Marvin H. ALLEN,
*Petitioner,*

*v.*

AMERICAN HARDWOODS
and SAIF Corporation,
*Respondents.*

(TP-87028; CA A61751 (Control))

In the Matter of the Compensation of
Hanlon Dodgion (Deceased), Claimant.

Judy DODGION,
Beneficiary of Hanlon Dodgion, Deceased,
*Petitioner,*

*v.*

AMERICAN HARDWOODS
and SAIF Corporation,
*Respondents.*

(TP-87027; CA A61754)
(Cases Consolidated)

Judicial Review from Workers' Compensation Board.

Argued and submitted April 16, 1990.

James L. Francesconi and Francesconi & Associates, Portland, filed the brief for petitioners.

Jas. Adams, Assistant Attorney General, Salem, argued the cause for respondents. With him on the brief were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

Before Graber, Presiding Judge pro tempore, and Riggs and Edmonds, Judges.

RIGGS, J.

Affirmed.



**RIGGS, J.**

The issue in this case is whether the Workers' Compensation Board erred in holding that, under Oregon law, SAIF has a valid lien against the proceeds of claimants'[1] third-party settlements after an accident that occurred in Michigan. We affirm.

Claimants Dodgion and Allen were long haul truck

[1] "Claimants" refers both to Allen and to Dodgion's surviving spouse, the beneficiary of his estate. The Board issued two third-party distribution orders, and the cases were consolidated on review.

drivers for American Hardwoods, an Oregon employer covered by SAIF. In June, 1984, they were involved in a head-on collision with another truck in Michigan. Dodgion was killed, and Allen was seriously injured. Allen and Dodgion's surviving spouse, the beneficiary of his estate, filed workers' compensation claims in Oregon. SAIF accepted the claims and paid Allen $137,741 and anticipated paying him another $20,596, for a total of $158,337. SAIF also paid $31,568 to Dodgion's beneficiary, and anticipated paying an additional $136,561, for a total of $168,130.

In March, 1986, claimants brought actions against the other truck driver's estate and Twin Ports Grocery Company, the owner of the other truck.[2] Both claims were eventually settled. Allen's "Settlement Agreement" provided that the settlement was for non-economic loss only and contained an express choice of laws clause adopting Michigan law. Under Michigan law, a workers' compensation carrier cannot reach the proceeds of a claimant's third-party settlement that are for noneconomic loss.[3] *Great American Ins. Co. v. Queen,*



410 Mich 73, 300 NW2d 895 (1980). Dodgion's "Release of All Claims" does not include a choice of laws clause.[4]

SAIF asserted that it had valid liens against all of Dodgion's settlement proceeds and against Allen's proceeds for the smaller of $158,337 or its statutory distributional share. In November, 1987, SAIF petitioned the Board for a third-party distribution order declaring its lien against the settlement proceeds valid and distributing them in accordance with ORS 656.593(1) and (3).[5]

Relying on sections 6 and 145 of the *Restatement*



*(Second) Conflict of Laws* (1971), the Board concluded that "claimant's right of tort recovery against the third parties and the third parties' liabilities to claimant were determined by Michigan law." It reasoned that, with respect to those issues, Michigan had the "most significant contacts" with the parties and the subject matter of their dispute. However, the Board

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[2] Under Michigan law, tort liability for motor vehicle accidents has been generally abolished and replaced with a no-fault system of personal protection benefits that limit recovery to certain categories of loss. One of those categories is noneconomic loss. Although the other truck driver and Twin Ports Grocery were Minnesota residents, they were covered insured under a policy that contained a written certification that provided them with the rights and immunities of Michigan's no-fault law.

[3] In Michigan, a workers' compensation carrier is not entitled to reimbursement for the type of expenses that SAIF paid. *Great American Ins. Co. v. Queen, supra.* Under that state's law, a carrier's right to reimbursement from a third-party settlement is restricted to only those proceeds that are compensation for types of damages that are common to both the tort action and to benefits that it has paid on the compensation claim.

[4] The record contains two copies of what purports to be Dodgion's release. One copy has a paragraph that states: "It is further agreed to by the parties that all of the consideration paid to the plaintiff * * * is consideration for non-economic loss. The parties agree that no portion of the settlement is consideration for economic loss." That provision is below the signature line and in a different typeface than the rest of the document. The other copy has no such paragraph. No explanation of the discrepancy is in the record.

concluded that Oregon law governs the issue of SAIF's rights to share in the settlement proceeds:

> "That issue concerns the relationship of an Oregon worker, and an Oregon workers' compensation carrier and, indirectly at least, an Oregon employer. The state of Michigan had no substantial interest in whether SAIF is able to recover all, some or none of its compensation payments from claimant's proceeds. The financial, social and legal impacts of that determination are centered in Oregon. Under these circumstances, Oregon has the most significant relationship to the parties and the subject matter of their dispute and its law should control. *See* Restatement (Second) of Conflict of Laws §§ 6, 145(2). The law of Michigan, like the law of any other foreign jurisdiction, is advisory only."

The Board then concluded that the liens are valid and ordered distribution.

Claimants assign error first to the Board's conclusion that Oregon, rather than Michigan, law applies and, second, to the conclusion that SAIF's lien may be satisfied out of the settlement proceeds. They argue that, under general choice of law principles, because Michigan has the most significant contacts with the parties and the subject matter of the dispute, its law controls. *Restatement (Second) Conflict of Laws* §§ 6, 145. Therefore, claimants contend that, under Michigan law, SAIF's lien is invalid, because their recovery was for non-economic loss only.

We conclude that the Board correctly held that Oregon law governs the validity of SAIF's liens on the third-party settlement proceeds. Although the Board relied on general choice of law principles, enumerated in sections 6 and 145, section 185 of the *Restatement* is directly on point. It provides:

> "The local law of the state under whose workman's compensation statute an employee has received an award for an injury determines what interest the person who paid the award has in any recovery for tort or wrongful death that the employee

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[5] ORS 656.593(1) and (3) provide:

"(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 * * *. 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.

"* * * * *

"(3) A claimant may settle any third party case with the approval of the paying agency, in which event the paying agency is authorized to accept such a share of the proceeds as may be just and proper and the worker or the beneficiaries of the worker shall receive the amount to which the worker would be entitled for a recovery under 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."

> may obtain against a third person on account of the same injury."

Section 185 is in accord with Larson, who states:

> "As to third party actions, if compensation has been paid in a foreign state and suit is brought against a third party in the state of injury, the substantive rights of the employee, the subrogated insurance company and the employer are ordinarily held governed by the law of the foreign state." 4 Larson, *Workmen's Compensation Law* 16-171, § 88.00 (1989).

Oregon has a vital interest in applying its law to determine the interest of an Oregon workers' compensation carrier in settlement proceeds that are obtained by Oregon workers. Claimants obtained workers' compensation in Oregon. Under Oregon law, SAIF, as the paying agency, is entitled to reimbursement from the proceeds of any settlement for the amounts that it paid on behalf of the injured and deceased workers. ORS 656.580(2); ORS 656.593(1) and (3). The provision in the agreement that the settlement was for noneconomic loss only is irrelevant. Although that limitation would apparently protect the settlement proceeds from the reach of workers' compensation carriers under Michigan law, *see Great American Ins. Co. v. Queen, supra,* the Oregon legislature has made no such exception.

We also reject claimants' suggestions that the express choice of laws provision in Allen's settlement agreement, adopting Michigan law, is evidence of the parties' recognition of that state's greater interest in the enforcement of the agreement. SAIF was not a party to the agreement, and the parties may not contract to circumvent a fundamental policy of Oregon law by choosing the law of another jurisdiction. *See Young v. Mobil Oil Corp.,* 85 Or App 64, 67-73, 735 P2d 654 (1987). The underlying public policy of the third-party distribution statutes and the purpose of the statutory liens

> "is to allocate *whatever* the claimant recovers between him and the paying agency and to provide reimbursement to those responsible for statutory compensation of injured workers when damages for settlements are obtained against the persons whose act caused the injuries." *Schlect v. SAIF,* 60 Or App 449, 456, 653 P2d 1284 (1982). (Emphasis in original.)

Affirmed.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Marvin C. Wright, Claimant.
SAIF CORPORATION,
*Petitioner,*
*v.*
Marvin C. WRIGHT,
*Respondent.*
(WCB TP-88016; CA A51030)

Judicial Review from Workers' Compensation Board.

Argued and submitted November 22, 1989.

John A. Reuling, Jr., Assistant Attorney General, Salem, argued the cause for petitioner. With him on the brief were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

David C. Force, Eugene, argued the cause for respondent. On the brief were Randy M. Elmer and Vick & Gutzler, Salem.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

RICHARDSON, P. J.

Motion to dismiss petition for judicial review denied; motion for attorney fees denied; reversed and remanded with instructions to dismiss motion.



**RICHARDSON, P. J.**

SAIF moved the Workers' Compensation Board for an

> "order requiring [claimant] and his attorney * * * to distribute to SAIF Corporation the sum of $36,324.24 as its [ORS 656.593] share of the (unapproved) third party settlement made in this matter."

The Board denied the motion on the ground that, because SAIF had denied the underlying claim, it was not the "paying agency" and therefore is not entitled to share in the settlement under ORS 656.593(3). SAIF seeks review of the order. We conclude that the Board had no authority to rule on the motion.

Claimant was injured in an automobile accident with another vehicle on August 27, 1984. For the facts of the injury and claims, see *Bernards v. Wright,* 93 Or App 192, 760 P2d 1388 (1988). He filed claims with four employers, contending that he was injured in the course and scope of employment. Because three of the claims involved non-complying employers, SAIF received and processed those claims. ORS 656.054(1). SAIF denied the claims in June, 1985, on the

ground that claimant was not a subject worker of any of the three employers. Sometime in 1985, claimant filed an action against the other driver involved in the accident; on January 20, 1986, that case was settled for $81,960.75. SAIF was not aware of the lawsuit or the settlement and did not consent to the settlement. ORS 656.593(3).

Claimant appealed the denials and the referee upheld them on January 30, 1986. The Board found that claimant was a subject worker, and SAIF began processing the claim on behalf of a non-complying employer. We affirmed the decision. *Bernards v. Wright, supra.* On April 20, 1986, claimant requested that SAIF reimburse him for medical bills that had been paid to the providers from the settlement proceeds. That was the first time that SAIF knew about the lawsuit or the settlement. In response, SAIF filed the motion that is the subject of this review.

At oral argument, claimant moved to dismiss the petition for judicial review on the ground that we do not have jurisdiction, because the Board did not have jurisdiction to



rule on the motion.[1] An order of the Board regarding distribution of a third-party settlement under ORS 656.593(3) is an order on a matter "concerning a claim," and it is therefore reviewable by us under ORS 656.298. *Schlecht v. SAIF,* 60 Or App 449, 653 P2d 1284 (1982). Whether the Board erred in addressing the issue does not effect *our* jurisdiction to review the order.

However, we agree with claimant that the Board did not have authority to rule on SAIF's motion. When a claimant prosecutes a third-party action under ORS 656.578, a paying agency has a lien against the cause of action. ORS 656.580(2). If the claimant settles the tort action, the paying agency or the Board must approve the settlement, ORS 656.587, and the paying agency is entitled to share in the proceeds. ORS 656.593(3).

In the settlement of a third-party action and the distribution of the proceeds, the Board has authority to do only two things. First, it may order written approval of the settlement by the paying agency, if there is a dispute between the parties regarding it. ORS 656.587. Second, if the settlement is approved,

> "the paying agency is authorized to accept such a share of the proceeds as may be just and proper * * *. Any conflict as to what may be a just and proper distribution shall be resolved by the board." ORS 656.593(3).

SAIF argues that the Board has authority to rule on its motion under ORS 656.593(3), because the motion sought a just and proper distribution of a settlement. There appeared to be no disagreement as to the amount to which SAIF would be entitled if it had approved the settlement. The issues raised by SAIF's motion were, *inter alia,* whether the settlement of the case in the circuit court was void under ORS 656.587;

[1] Claimant subsequently filed a written motion to dismiss the petition for judicial review.

whether SAIF could reach proceeds of the settlement after they had been distributed to medical providers, claimant's attorney and claimant; and whether either SAIF or claimant was estopped to assert the position that they did. Whatever tribunal might have authority to adjudicate the issues leading to a final resolution of the dispute, it is not the Board. *See*



*SAIF v. Cowart,* 65 Or App 733, 672 P2d 389 (1983). The Board's authority in matters concerning settlement of third-party actions is defined by statute. The statutes do not give it authority to rule on SAIF's motion. It should have dismissed the motion.[2]

Motion to dismiss petition for judicial review denied; motion for attorney fees denied; reversed and remanded with instructions to dismiss motion.

[2] Claimant moved for an award of attorney fees on review pursuant to ORS 656.390. The motion is denied.



IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of
Nancy C. Evenhus, Claimant.

CAMLU RETIREMENT CENTER
and Liberty Northwest Insurance Corporation,
*Petitioners,*

*v.*

Nancy C. EVENHUS,
Norpac Foods, Inc., Industrial Indemnity
and CIGNA Insurance,
*Respondents.*

(WCB 87-04881, 87-03084, 87-03085; CA A61213)

Judicial Review from Workers' Compensation Board.

Argued and submitted March 21, 1990.

Paul L. Roess, Portland, argued the cause for petitioners. With him on the brief was Acker, Underwood, Norwood & Hiefield, Portland.

Brian R. Whitehead, Salem, waived appearance for respondent Nancy C. Evenhus.

John E. Snarskis, Portland, argued the cause and filed the brief for respondents Norpac Foods, Inc., and Industrial Indemnity.

Jerald P. Keene, Portland, argued the cause for respondent Cigna Insurance. With him on the brief was Roberts, Reinisch & Klor, P.C., Portland.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

RICHARDSON, P. J.

Reversed and remanded for further proceedings not inconsistent with this opinion.



**RICHARDSON, P. J.**

Liberty Northwest Insurance Corporation (Liberty) seeks review of an order of the Workers' Compensation Board that Liberty was responsible for claimant's left knee injury, because it had accepted the claim and could not issue a backup denial under *Bauman v. SAIF,* 295 Or 788, 670 P2d 1027 (1983). We reverse and remand.

Claimant suffered a compensable injury to her left knee while employed at Norpac Foods, Inc. (Norpac). On September 15, 1986, she sustained a second left knee injury while working for Camlu Retirement Center (Camlu). She filed an aggravation claim with Norpac's insurer, Industrial Indemnity, which denied it, and a new injury claim with Camlu, which sent it to Liberty, its insurer. Liberty accepted the claim and began paying medical benefits. Liberty subsequently discovered that its coverage for Camlu did not begin until September 16, a day after the injury, and that the claim should have been sent to CIGNA Insurance Companies as the responsible carrier on the date of the injury. Liberty therefore issued a denial of responsibility. No claim was filed with CIGNA.

At a consolidated hearing on both denials, the referee found that Liberty did not provide coverage on the date of the injury, but that it was nonetheless responsible, because the claim could not be denied once it had been accepted. The Board affirmed, because

> "Liberty Northwest's 'backup' denial was invalid. Therefore, Liberty Northwest's acceptance continued in force and was legally binding, and the duty to pay benefits continued to run."

Both the referee and the Board relied on *Bauman v. SAIF, supra,* which prohibits a denial on the merits of a claim once it has been accepted. Here, Liberty's denial was based on the fact that it did not provide coverage for the injury. As we said in *Oak Crest Care Center v. Bond,* 101 Or App 15, 19, 789 P2d 6, *rev den* 310 Or 121 (1990), "*Bauman* does not apply to invalidate such a denial or bind a carrier to a previous acceptance when there is a lack of coverage." The Board erred in holding Liberty's denial invalid.

The Board only considered whether Liberty could



deny the claim under *Bauman.* We therefore remand so that it may review the remaining issues raised by the denials.

Reversed and remanded for further proceedings not inconsistent with this opinion.

IN THE COURT OF APPEALS OF THE STATE OF OREGON

Gerald R. McCOY,
*Appellant - Cross-Respondent,*
*v.*
UNION PACIFIC RAILROAD COMPANY,
*Respondent - Cross-Appellant.*
(A8610-06049; CA A50380)

Appeal from Circuit Court, Multnomah County.

Harl H. Haas, Judge (Order dated April 15, 1988).

William C. Snouffer, Judge (Judgment dated October 26, 1988).

Argued and submitted March 14, 1990.

James N. Westwood, Portland, argued the cause for appellant - cross-respondent. With him on the briefs were Miller, Nash, Wiener, Hager & Carlsen, Portland, and Thomas M. Schneiger and Bricker, Zakovics & Querin, P.C., Portland.

Thomas W. Brown, Portland, argued the cause for respondent - cross-appellant. With him on the briefs was Cosgrave, Kester, Crowe, Gidley & Lagesen, Portland.

Before Buttler, Presiding Judge, and Warren and Rossman, Judges.

BUTTLER, P. J.

Affirmed on appeal and on cross-appeal.



**BUTTLER, P. J.**

Plaintiff appeals from the judgment in this personal injury action under the Federal Employers' Liability Act (FELA), 45 USC §§ 51 *et seq,* assigning error to the trial court's granting, in part, defendant's motion for summary judgment. Defendant cross-appeals, assigning error to the court's failure to grant its motion for summary judgment in its entirety.

Plaintiff filed his complaint on October 8, 1986, alleging that he has suffered hearing loss and tinnitus arising out of his employment as a locomotive fireman and engineer as a result of defendant's negligence in failing to provide plaintiff with

> "a safe place in which to work and safe tools and equipment in one or more of the following particulars:
>
> "(a) Defendant failed to warn plaintiff of the danger caused by exposure to loud noises emitted from its equipment;
>
> "(b) Defendant required plaintiff to work around retarders when it knew or should have known that the noise would cause damage to his ears;

"(c) Defendant failed to inspect, discover and remedy the condition of the retarders which caused extremely loud noises to be emitted;

"(d) Defendant failed to provide plaintiff with devices to protect his ears;

"(e) Defendant failed to test plaintiff's hearing on a regular basis.

"(f) Defendant ordered plaintiff not to wear hearing protection when it knew it [*sic*] he would be exposed to injurious noises on the job."

As an affirmative defense, defendant alleged that plaintiff had failed to bring this action within the time permitted by 45 USC § 56, which provides:

"No action shall be maintained under this chapter unless commenced within three years from the day the cause of action accrued."

Defendant filed a motion for summary judgment, asserting that the entire claim is barred by the statute. Plaintiff contended that no part of his claim is time-barred. The court granted the motion in substantial part, ruling that



"any and all of plaintiff's causes of action for tinnitus and hearing loss which accrued more than three years prior to the time of filing of plaintiff's complaint are barred * * *. It is further ordered any and all causes of action for tinnitus and hearing loss which accrued within three years prior to the time of filing of the complaint are allowed."

The case proceeded to trial on "causes of action that accrued within three years prior to the filing of the complaint." The jury returned a verdict for plaintiff, awarding general damages of $12,500 for aggravation of his condition.

Federal law controls the determination of when a claim "accrues" under 45 USC § 56. *Bailey v. Central Vermont R. Co.*, 319 US 350, 63 S Ct 1062, 87 L Ed 1444 (1943). In *Urie v. Thompson*, 337 US 163, 69 S Ct 1018, 93 L Ed 1282 (1949), the plaintiff had contended that his claim did not accrue until he became incapacitated; the defendant argued that it accrued when plaintiff was first exposed to the deleterious substance. The United States Supreme Court held that a claim under FELA accrues on discovery, which occurs when the employee is aware, or should be aware, of his injury. *Urie v. Thompson, supra*, 337 US at 170. In the case of an occupational disease, when the injurious consequences of the exposure occur over time rather than at a particular point in time and the exact moment of initial exposure is unknown or unknowable, the claim accrues when the accumulated effects of the deleterious substance manifest themselves.

In *United States v. Kubrick*, 444 US 1111, 100 S Ct 352, 62 L Ed 2d 259 (1979), in deciding the meaning of "accrue" as used in the Federal Tort Claims Act, 28 USC § 2401(b), the Court rejected the argument that the discovery rule requires knowledge that the acts causing the injury might constitute legally actionable conduct. 444 US at 1113. It concluded that it was unnecessary, for limitations purposes, that the plaintiff know that the defendant is legally blameworthy

before an action accrues. It held that a claim accrues when the plaintiff knows both the existence and the cause of his injury, not at a later time when he also knows that the defendant's conduct constituted negligence.

Recently, federal courts have stated that a claim accrues under FELA when the plaintiff possesses sufficient critical facts from which the injury and its cause, including its



work-relatedness, should be plainly known. *DuBose v. Kansas City Southern Ry. Co.*, 729 F2d 1026 (5th Cir), *cert den* 469 US 854 (1984); *Jones v. Maine Cent. R. Co.*, 690 F Supp 73 (D Me 1988). Certain factors, such as whether the plaintiff had experienced disability, whether his condition had been medically diagnosed and whether off-the-job exposures could have contributed to the condition, are relevant to the question of whether the plaintiff had knowledge of the condition and its cause, *DuBose v. Kansas City Southern Ry. Co., supra,* 729 F2d at 1031, but none of those factors, alone, is determinative.

Ordinarily, the question of whether and when an employee knew or should have known that he had an occupational disease is one of fact for the jury. However, when the evidence is such that a reasonable factfinder could only answer the question one way, it is for the court to decide. Plaintiff contends that the evidence creates questions of fact as to when he first became aware that he had an "actionable disability" and when he first connected that condition with his work place. On review of a summary judgment, we view the evidence and all reasonable inferences that may be drawn therefrom in the light most favorable to plaintiff.

In August, 1981, plaintiff was examined for defendant by Dr. Minogue as part of a routine medical examination. He reported at that time that he had no hearing difficulties, ringing or buzzing. Minogue reported that plaintiff's hearing was normal. When deposed, plaintiff testified that he was exposed to loud noises at work, including engine noise, whistles and radios. He testified that he went to see Dr. Petrusek in 1986 regarding his hearing. He further testified:

"Q: Had you noticed any problems with your hearing before going to see Dr. Petrusek?

"A: Yes.

"Q: When did you notice that problem?

"A: Six or seven — well, the last five, six or seven years it's been bothering me, yes.

"Q: And what did you relate that to?

"* * * * *

"A: * * * Loud noises.

"* * * * *



"Q: You relate the ringing and the hearing loss to the noise that you have been exposed to?

"A: Yes.

"Q: And did you think about consulting with some doctor related to that?

"A: Until I went to Dr. Petrusek, no.

"Q: Why is that?

"A: I didn't think it was that bad."

Questions and testimony followed concerning plaintiff's off-the-job use of rifles, shotguns and chain saws. On further questioning, he testified:

"Q: So, prior to six or seven years ago, whenever you would operate a rifle or shotgun you never noticed a ringing after that?

"A: No.

"Q: But six or seven years ago you started noticing a ringing?

"A: Yes.

"Q: And that would be after gun use?

"A: I had it all the time when I first noticed the ringing.

"* * * * *

"Q: What loud noises did you think were causing the problem back then?

"A: Six or seven years ago?

"Q: Yes.

"A: The ones I have already stated. The loud radios, the loud engines, loud whistles.

"Q: So six or seven years you related loud noises at work to your hearing problem; is that correct?

"A: When it first started coming on, yes.

"* * * * *

"Q: You mentioned earlier that you had this ringing about six or seven years ago and you also had the hearing problem about that same time and at that time you related it to loud noises; right?

"A: Right.

"Q: And the loud noises that you related it to were the loud noises at work?



"A: Yes.

"Q: And that is still your opinion?

"A: Yes."

Plaintiff's testimony is clear that he first noticed hearing problems five to seven years before the August, 1987, hearing and that, when he first noticed the problems, he believed that they were caused by loud noises at his employment. His contention that his testimony is ambiguous or that he was confused or forced by defendant's counsel to answer questions one way is not well taken.

Plaintiff contends that, in any event, a question of fact remains, because his testimony is contradicted by Minogue's examination report of August 19, 1981, which reveals that he did not complain of hearing problems and that he had no hearing problems at that time. That report, how-

ever, does not create a *material* question of fact. Even assuming that it is correct that plaintiff had no hearing difficulties in August, 1981, that evidence is not inconsistent with plaintiff's testimony that his problems developed five to seven years before August, 1987, or sometime between August, 1980, and August, 1982. Although the report might create a question of fact as to whether plaintiff's problems developed before August, 1981, it does not create a question of fact as to whether they developed before October, 1983, three years before he commenced this action.

Plaintiff contends, additionally, that there is an issue of fact as to when his condition was serious enough to cause a claim to accrue. Plaintiff testified that he did not go to a doctor for his hearing problems until February, 1986, because, before that time, his condition simply was not "bad enough." He likens his claim to one for workers' compensation in which a claim arises when a claimant experiences disability or seeks medical attention. *See Weller v. Union Carbide Corporation,* 288 Or 27, 602 P2d 259 (1979). The accrual of a claim under FELA, however, does not require that the plaintiff be disabled, according to the federal cases discussed above. Similarly, whether or not plaintiff's condition was bad enough to cause him to go to the doctor is irrelevant, if, as the evidence here shows, he knew of his condition and its cause.

Plaintiff also contends that a question of fact remains



as to when he became aware that the condition was work-related. The evidence shows that plaintiff was also exposed to off-the-job noises, including firearms and chain saws. When he first testified during his deposition regarding the cause of the hearing loss, he attributed it to "loud noises" and not specifically to loud noises at work. Later, however, he testified that work was the source of the hearing loss and that he was aware of that at the time he first became aware of the problems. Plaintiff's testimony, read in its entirety, is neither internally inconsistent nor inconsistent with any other evidence, and shows that plaintiff was aware no later than August, 1982, that he had a hearing problem that was caused by loud noises related to his employment. His failure to file his complaint within three years of that date is fatal to his claim.

Plaintiff argues that his claim is one for "negligent assignment to hazardous work" and that he is entitled to recover for damages sustained while he was working in an unsafe environment until he was relieved of the injurious work exposure. He argues that the Statute of Limitations was tolled during the entire time when he was exposed to the unsafe conditions. Even assuming the validity of the concept of "negligent assignment," we conclude that neither the complaint nor the evidence supports recovery on that theory. It appears, in those cases that have discussed the question, that a material component of a claim for negligent assignment is that the defendant either made or continued the worker's injurious job assignment with knowledge of the worker's injury and its relationship to the employment. *See Kichline v. Consolidated Rail Corp.,* 800 F2d 356, 361 (3rd Cir 1986); *Emmons v. Southern Pacific Transportation Co.,* 701 F2d 1112 (5th Cir 1983);

*Fletcher v. Union Pac. R. Co.*, 621 F2d 902 (8th Cir 1980) *cert den* 449 US 1110 (1981); *Fowkes v. Pennsylvania Railroad Company*, 264 F2d 397 (3rd Cir 1959); *Corrigan v. Burlington Northern R.R., Inc.*, 612 F Supp 665 (D Minn 1985). That is not the case here. The trial court properly rejected plaintiff's contention that he is entitled to recover on a theory of negligent assignment.

The trial court denied defendant's motion for summary judgment in part, concluding that "any and all causes of action for tinnitus and hearing loss which accrued within three years prior to the time of filing of the complaint are allowed." In its cross-appeal, defendant contends that the



trial court erred in failing to grant its motion for summary judgment in its entirety and in ruling that plaintiff could recover damages for the worsening of his condition after October, 1983.[1]

The apparent theory of the trial court, although not articulated, is that, if plaintiff could show that his condition worsened as a result of the loud noises to which he continued to be exposed at work during the three years immediately before he filed his complaint, he would be entitled to damages for the worsening that occurred during that limited period. That was how the case was tried, and defendant does not contend that plaintiff's evidence was insufficient or that the instructions were erroneous. It contends, simply, that, once the Statute of Limitations had run on plaintiff's original claim, he was barred from *all* relief, even though defendant's continuing negligence caused him additional harm.

We perceive no reason why plaintiff must be denied all relief if his hearing loss became worse because of his work exposure during the three years preceding the filing of this action. If, for example, hearing loss had originated before he commenced work for defendant, and he then worked for defendant for three years, during which time loud noises at work increased his loss, we believe that plaintiff would be entitled to recover for the aggravation of his condition, if he filed his action timely. That situation would be analogous to a plaintiff who had a preexisting back problem that was aggravated as a result of an automobile accident.

Defendant relies on language in *Urie v. Thompson, supra,* that, taken at face value, might preclude plaintiff's recovery for the worsening. The context in which that language was used, however, persuades us that the Court did not intend to preclude this kind of a claim. In *Urie,* the plaintiff filed his FELA complaint in November, 1941, alleging that he had contracted silicosis as a result of his exposure to silica dust at work since about 1910. The defendant argued that the plaintiff must have contracted the disease long before the

[1] Defendant does not argue that plaintiff could not proceed to trial on the worsening of his condition during the three years before filing his complaint because plaintiff had not pleaded a claim on that theory.

Statute of Limitations had run, so his claim was barred. Alternatively, the defendant argued that each inhalation of dust was a separate tort giving rise to a "fresh" cause of action; therefore, the plaintiff was limited to a claim for inhalation between November, 1938, and May, 1940, when he became incapacitated and ceased work.

The Court said that "neither of the outlined constructions of the Statute of Limitations can be sustained." 337 US at 169. It explained:

> "For, if we assume that Congress intended to include occupational diseases in the category of injuries compensable under the Federal Employers' Liability and Boiler Inspection Acts, such mechanical analysis of the 'accrual' of petitioner's injury—whether breath by breath, or at one unrecorded moment in the progress of the disease—can only serve to thwart the congressional purpose.
>
> "If Urie were held barred from prosecuting this action because he must be said, as a matter of law, to have contracted silicosis prior to November 25, 1938, it would be clear that the federal legislation afforded Urie only a delusive remedy. It would mean that at some past moment in time, unknown and inherently unknowable even in retrospect, Urie was charged with knowledge of the slow and tragic disintegration of his lungs; under this view Urie's failure to diagnose within the applicable statute of limitations a disease whose symptoms had not yet obtruded on his consciousness would constitute waiver of his right to compensation at the ultimate day of discovery and disability." *Urie v. Thompson, supra,* 337 US at 169.

It went on to say:

> "Nor can we accept the theory that each intake of dusty breath is a fresh 'cause of action.' In the present case, for example, application of such a rule would, arguably, limit petitioner's damages to that aggravation of his progressive injury traceable to the last eighteen months of his employment. Moreover, petitioner would have been wholly barred from suit had he left the railroad, or merely been transferred to work involving no exposure to silica dust, more than three years before discovering the disease with which he was afflicted." 337 US at 170.

Instead, the Court held that the plaintiff's claim accrued when he discovered his problem and its cause, which, in that case, the evidence showed was not until he became



incapacitated within the three year Statute of Limitations period. It seems clear that the Court rejected the proposition that each intake of dust created a fresh cause of action for the purpose of the limitation, because it would have imposed an unintended *restriction* on the relief to which the plaintiff was entitled when he did not discover his illness until May, 1940.

That is not this case. Here, plaintiff discovered his problem and its cause no later than 1982 but failed to file his action within the limitation period; nevertheless, he continued to be damaged until he filed this action. Although he is not entitled to recover for all of his hearing loss, there is no reason why he should be barred from recovering for the loss

that occurred within the three years preceding his commencement of this action. The court in *Kichline v. Consolidated Rail Corp., supra,* reached the same conclusion.

Affirmed on appeal and on cross-appeal.

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IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of
Hun J. Kim, Claimant.

MT. HOOD COMMUNITY COLLEGE
and Liberty Northwest Insurance Corporation,
*Petitioners,*

*v.*

Hun J. KIM,
*Respondent.*

(86-09851; CA A62516)

Judicial Review from Workers' Compensation Board.

Argued and submitted June 13, 1990.

Paul L. Roess, Portland, argued the cause for petitioners. With him on the brief was Acker, Underwood, Norwood & Hiefield, Portland.

Robert Wollheim, Portland, argued the cause for respondent. With him on the brief was Welch, Bruun and Green, Portland.

Before Rossman, Presiding Judge, and Riggs and Edmonds, Judges.

ROSSMAN, P. J.

Affirmed.



**ROSSMAN, P. J.**

Employer seeks review of the Workers' Compensation Board's order on remand. In the earlier review, we remanded, because the referee's order, which the Board adopted, was inadequate for review. *Kim v. Mt. Hood Community College,* 95 Or App 406, 769 P2d 239 (1989). We affirm.

The facts are set out in our earlier opinion. On remand, the Board correctly stated that the issue is whether claimant's injury arose out of and in the course of his employment. It then identified seven factors to consider in determining whether there is a sufficient relationship between the injury and the employment so that the injury should be compensable. *See, e.g., Mellis v. McEwen, Hanna, Gisvold,* 74 Or App 571, 574, 703 P2d 255, *rev den* 300 Or 249 (1985). It considered each of the factors and concluded that the injury is compensable.

Employer does not challenge the application of those factors. It acknowledges that "[t]he question * * * really comes down to whether the activity performed by [claimant] when he

was hurt was '. . . for the benefit of the employer.' " It argues that, because it provides an educational service to the community at large, it is the community, rather than the employer, that directly benefits from the fund-raising activities in which claimant participated.

Although claimant's characterization of employer's argument as "sophistic nonsense" may be somewhat harsh, it comes very close to the mark. The funds raised by claimant's activities went to the Mt. Hood Community College Foundation. The sole purpose of the foundation is to raise money for the benefit of the college and its students, and all proceeds from its fundraising activities go to that. Clearly, the fact that employer may serve the public does not mean that employer cannot receive a direct benefit from donations made to it.[1]

Affirmed.

[1] Petitioners also argue that we should adopt the "good citizen rule" that

"acts that are nothing more than the discharge of a person's duties as good citizen or member of the community are not within the course of employment, even if they take place on the employment premises and may have been requested by the employer." 1A Larson, *Workmen's Compensation Law* 5-383, § 27.34 (1985). (Footnote omitted.)

Employer did not specifically rely on the good citizen rule in its argument to the Board. At oral argument in this court, however, claimant's counsel indicated that he understood the argument and responded to it. We need not decide whether to adopt the good citizen rule, because the facts of this case could not fit within it.



## IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of
David R. Abbott, Claimant.

SAIF CORPORATION
and Olympic Forest Products,
*Petitioners,*

*v.*

David R. ABBOTT,
Liberty Northwest Ins. and Pinkertons, Inc.,
*Respondents.*

(WCB 87-13095, 87-13096, 87-13097; CA A50887)

Judicial Review from Workers' Compensation Board.

Argued and submitted November 22, 1989.

John A. Reuling, Jr., Assistant Attorney General, Salem, argued the cause for petitioners. With him on the brief were Dave Frohnmayer, Attorney General, Virginia L. Linder, Solicitor General, Salem, and Scott P. Monfils and Jeffrey Stewart Love, Portland.

Craig A. Staples, Portland, argued the cause for respondents Liberty Northwest Ins. and Pinkertons, Inc. With him on the brief was Roberts, Reinisch & Klor, P.C., Portland.

No appearance for respondent David R. Abbott.

Before Richardson, Presiding Judge, and Newman and Deits, Judges.

DEITS, J.

Reversed with respect to basis for temporary total disability benefits and remanded with instructions to modify order in accordance with this opinion; otherwise affirmed.



**DEITS, J.**

Petitioners seek review of an order of the Workers' Compensation Board that set aside SAIF's backup denials of responsibility for claimant's back injury and carpal tunnel syndrome.

Claimant was an employee of Pinkertons Detective Agency, which was hired by Olympic Forest Products to investigate the unusual number of worker's compensation claims that were being filed at one of its sawmills, as well as suspected drug use by employees at that mill. Pinkertons placed an undercover detective, claimant, in the mill to do the investigation. He worked as an entry level mill worker and received a paycheck from Olympic. Olympic paid him its usual hourly rate, and Pinkertons supplemented that to make up his Pinkertons' salary. Olympic made its usual payroll deductions from claimant's checks and paid premiums to SAIF for him. Pinkertons directed his investigative activities. Only the owner and the plant superintendent, Meek, knew of claimant's identity. Meek believed that claimant was using an assumed name for the investigation.

On November 7, 1986, a week after he began work at the mill, claimant was hit in the chest by a log. He filed an injury claim on November 18, claiming right wrist and right shoulder strain. A plant manager verified the injury and signed the claim. Claimant listed Olympic as his employer on the form and showed his wages as the amount that he was being paid by Olympic. As part of the claim filing process, claimant was required to talk with Meek, whose job it was to investigate compensation claims. Claimant told Meek not to worry about the claim, because it was just a ruse to allow him to talk to Meek about the investigation. Meek knew that the claim had been filed, but took no further action to delay or prevent it from going to SAIF and being approved. On December 15, 1986, SAIF accepted the claim as a non-disabling injury.

On January 6, 1987, claimant was injured again when another employee at the mill threw a 2 × 4 at him. He experienced back pain and numbness on his right side and filed a second injury claim, listing only back pain. He met with Meek concerning the claim. Meek assumed that it was not a real claim, but that claimant was again using it as an excuse to talk



with him about the investigation. Again, he knew that the claim had been filed, but did not investigate or take action to delay it from going to SAIF, because he did not think that claimant was really hurt. SAIF accepted the claim on February 5, 1987, as a back strain. Claimant left Olympic in January, 1987. In February, his neurosurgeon informed SAIF that

he had a carpal tunnel syndrome and that he might need to have surgery, which he underwent on May 22, 1987. SAIF paid claimant compensation for the time he lost due to the surgery. Claimant filed a claim against Pinkertons on May 29, 1987, for the carpal tunnel damage resulting from the November 7, 1986, injury.

In early 1987, shortly after claimant left the mill, Meek discovered that claimant was receiving compensation for the two injuries. On June 22, 1987, SAIF denied responsibility for both previously accepted claims on the ground that claimant was not Olympic's employee. Liberty Northwest, Pinkertons' insurer, denied compensability on June 25 on the ground the injury did not result from claimant's employment at Pinkertons.

A hearing was held on SAIF's and Liberty's denials on December 22, 1987. The hearings officer approved Liberty's denial and disapproved SAIF's denials under *Bauman v. SAIF,* 295 Or 788, 670 P2d 1027 (1983). The hearings officer held that any misrepresentations that claimant had made were not sufficient to allow SAIF's backup denials, because Meek knew that claimant had filed claims and should have followed up on them, even if he had misunderstood why they were filed. The hearings officer also awarded increased time loss payments, based on claimant's entire wages, including the amount paid by Pinkertons, rather than just on the wages from Olympic. The Board affirmed.

Petitioners argue that the Board erred in setting aside SAIF's denial. An insurer may not deny a previously accepted claim more than 60 days after receiving notice of the claim, without a showing of fraud, misrepresentation or other illegal activity. *Ebbtide Enterprises v. Tucker,* 303 Or 459, 738 P2d 194 (1987). In order to justify a backup denial, a misrepresentation must have been sufficiently material that the



insurer's decision "could reasonably have been affected." *Ebbtide Enterprises v. Tucker, supra,* 303 Or at 464.[1]

Petitioners contend that claimant misrepresented his employment status when he listed Olympic as his employer on the claim form and that his statement to Meek that the claims were not real was a misrepresentation. Although claimant's statement to Meek that the claims were ruses were misrepresentations, they were not sufficiently material to justify SAIF's backup denial. Meek knew what claimant's status at the mill was and that he had filed the claims. That knowledge was attributable to Olympic as well as to its insurer, SAIF. *Colvin v. Industrial Indemnity,* 301 Or 743, 725 P2d 356 (1986); *Nix v. SAIF,* 80 Or App 656, 660, 723 P2d 366, *rev den* 302 Or 158 (1986). Meek did not follow up on the claims or take any action to see that they were not sent to SAIF. In view of Olympic's knowledge and its inaction, we conclude that claimant's misrepresentations were not sufficiently material to affect SAIF's decision on the claim.

[1] The so called "*Bauman* rule" on retroactive denials was repealed effective July 1, 1990, by Or Laws 1990 (Special Session), ch 2, § 15. The change does not affect this case.

Petitioners argue that, even if SAIF is not entitled to deny the claims, the Board should have held that employer is not responsible for the carpal tunnel syndrome. Claimant's condition was diagnosed at the time of injury as wrist sprain and arm strain. It was described on the claim form as involving swelling, aching and hand numbness. It was not diagnosed as carpal tunnel syndrome until after the November injury was accepted. Petitioners argue, relying on *Johnson v. Spectra Physics,* 303 Or 49, 733 P2d 1367 (1987), that SAIF accepted the November 7 injury as "right wrist strain and right shoulder strain" and that that was not an acceptance of the carpal tunnel syndrome. *Johnson* held that, when a single claim encompasses two separate conditions, acceptance of one of the conditions does not constitute acceptance of the other. Here, however, the claim did not involve two conditions, but rather involved the question of whether acceptance of the compensability of specific symptoms included acceptance of the disease that was later found to cause the symptoms. In *Georgia-Pacific v. Piowar,* 305 Or 494, 753 P2d 948 (1988), the court held that an acceptance of the compensability of specific



symptoms includes acceptance of the compensability of the disease causing those symptoms. As the court stated:

> "Allowing an insurer to deny compensation for a previously-accepted condition once it learns that the condition is attributable to a specific noncompensable disease opens the door to instability, uncertainty and delay. This is precisely the kind of vacillation which this court found unacceptable in *Bauman,* 295 Or at 793-794." 305 Or at 501.

SAIF accepted claimant's condition involving upper extremity swelling, aching and hand numbness. That acceptance encompassed the disease causing those symptoms, which turned out to be a carpal tunnel syndrome. SAIF may not avoid responsibility for that condition.

Petitioners also assert that the Board erred in affirming the increase of the time loss benefits by including the wages paid by Pinkertons. We agree. Generally, when a claimant who is working for two employers is injured, benefits are measured by the wages from both jobs, but each employer bears its proportionate share of the burden of paying benefits. *Bolton v. Oregonian Publishing Co.,* 93 Or App 289, 761 P2d 1135 (1988). Whether or not this is a case of dual employment, because claimant's work activities were all part of the performance of one job, only Olympic's liability is involved in this review. We conclude that Olympic is only responsible for benefits based on the wages that it paid to claimant.

Reversed with respect to the basis for temporary total disability benefits and remanded with instructions to modify order in accordance with this opinion; otherwise affirmed.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Maria R. Porras, Claimant.
CASTLE & COOK, INC.,
*Petitioner,*
*v.*
Maria R. PORRAS,
*Respondent.*
(84-11249; CA A60731)

Judicial Review from Workers' Compensation Board.

Argued and submitted January 12, 1990.

Peter A. Ozanne, Portland, argued the cause for petitioner. With him on the brief were Delbert J. Brenneman and Schwabe, Williamson & Wyatt, Portland.

Richard M. Walsh, Salem, argued the cause for respondent. With him on the brief was Olson, Rowell & Walsh, Salem.

Before Graber, Presiding Judge pro tempore, and Riggs and Edmonds, Judges.

RIGGS, J.

Reversed and remanded for reconsideration of penalty and attorney fees; otherwise affirmed.



**RIGGS, J.**

In this Workers' Compensation case, the Board granted claimant permanent total disability (PTD), concluded that employer's unilateral reclassification of certain payments was improper and assessed attorneys fees and a penalty against employer. Employer petitions for review. We reverse and remand for reconsideration of the penalty and attorney fees and otherwise affirm.[1]

Claimant suffered a compensable injury at employer's plant on June 16, 1982. A determination order on January 21, 1983, awarded her temporary total disability (TTD) but deferred a finding on permanent disability until more medical evidence was available. After undergoing tests in June, 1983, related to the 1982 injury, claimant suffered a cerebral vascular accident (CVA) while in the hospital. After the CVA, claimant had a series of colonic seizures. Medication brought those under control, but claimant continued to have what she described as seizure activity. Employer denied compensability of the CVA, the seizures and a related psychological condition. On July 23, 1984, a second determination order

[1] Claimant asks that we change the date on which she became medically stationary for purposes of PTD. There is no record of claimant making the request below, nor did she cross-petition for review. ORAP 5.45(2). Accordingly, we do not address the issue.

was issued awarding additional TTD and 45 percent unscheduled permanent partial disability (PPD) for the 1982 injury. The determination order did not include the CVA.

On February 25, 1985, a referee found the CVA compensable. In May, 1985, employer unilaterally decided to redesignate PPD previously paid on the June 16 injury as TTD and stopped paying PPD. A third determination order was issued on November 19, 1985, which included both the 1982 injury and the CVA. The order awarded additional TTD and 50 percent PPD. Both parties appealed that order. A referee found 85 percent PPD and that claimant had become medically stationary on July 8, 1985. The referee also held that employer's unilateral redesignation of benefits was proper. Both parties requested Board review, and the Board affirmed the referee, except that it determined that the medically stationary date was June 4, 1985. On claimant's petition for review, we remanded to the Board for reconsideration in



the light of the substantial evidence standard of review. *Porras v. Castle & Cook, Inc.*, 91 Or App 526, 755 P2d 154 (1988). On reconsideration, the Board awarded PTD under the "odd lot" doctrine.[2] It also held that employer's unilateral redesignation of benefits was improper and awarded attorney fees and a penalty.

Employer does not contest compensability of the CVA, only of the subsequent seizures. It claims that the Board's findings that the seizures were compensably related to the June 16, 1982, injury and the CVA were unreasonable and contrary to the overwhelming weight of the evidence. We understand employer's argument to mean that the Board's finding is not supported by substantial evidence.

No doctor was able to find an organic explanation for the seizures. The Board concluded that claimant was not faking them, and that finding is supported by substantial evidence in the record in the opinions of claimant's treating internist, neurologist, neurosurgeon and a consulting neuropsychiatrist.[3]

The Board also found that claimant's psychological

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[2] Except when designated otherwise hereafter, when we refer to the Board's "order," we mean the order on reconsideration after our remand.

[3] Employer contends that the Board's discounting of Dr. Pavaresh's opinion with regard to the voluntariness of the seizures was erroneous. However, if there is substantial evidence to support a finding of fact, the Board need not find in accordance with every expert opinion. It is sufficient for the Board to find, as it did here, that the treating doctors had a better opportunity to assess the particular condition in this case.

Employer also contends that the Board erred in accepting Pavaresh's opinion on one aspect of a case but in rejecting it on another aspect. Claimant correctly points out that the Board

> "is free to analyze each question and medical issue separately and to fully consider all rationales, arguments, and proof on each issue before reaching a decision. The fact that the [B]oard found [a doctor's] opinions * * * persuasive on some issues does not bind the referee from considering all the evidence on [the] remaining issues." (Emphasis deleted.)

That would not be so if a subsequent finding could only flow from factors necessarily rejected by the initial finding, which is not the case here.

condition, to which the seizures could be attributed, was compensably related to the CVA and, hence, to the industrial injury. There was conflicting testimony from doctors on both sides. In concluding that the psychological disorder was related to the industrial injury, the Board relied on testimony



by a doctor who had been seeing claimant for an extended period and the consulting neuropsychiatrist. That evidence supports the Board's conclusion that the psychological condition is related to the CVA and is, therefore, compensable.

Employer next contends that the Board erred when it ruled that employer could not unilaterally redesignate previously paid PPD as TTD. We agree with the Board. After the first determination order, employer was required to pay 45 percent PPD. That determination did not include the CVA. Employer claims that the referee's determination that the CVA was compensable reopened the claim, thus changing the medically stationary date. Employer reasons that that change created an obligation to pay TTD, rather than PPD.

Initially, we note that the order finding the CVA compensable did not address the effect on the July 23, 1984, determination order directing employer to pay PPD. The Board correctly pointed out that "[t]he issue here is not whether the employer may recover an overpayment of PPD by offsetting it against current or future compensation benefits due. Rather, the issue is whether the employer may do so without prior approval * * *." Generally, an employer "may not recoup overpayments without prior authorization from the Board, the referee or the Workers' Compensation Department." *Spivey v. SAIF,* 79 Or App 568, 571, 720 P2d 755 (1986). When unilateral action on the part of the employer is permitted, it is clearly spelled out in the statute. *See, e.g.,* ORS 656.268(3)(a). There is no statutory permission for an employer to act unilaterally in this situation.

Because of the invalid unilateral reclassification of payments, the Board assessed a penalty, ORS 656.262(10), and attorneys fees. ORS 656.382(1). The levying of a penalty depends on whether the employer had a legitimate doubt as to its liability for the payments. Under that legal standard, the Board made a factual finding, which we review for substantial evidence support. *Brown v. Argonaut Insurance Company,* 93 Or App 588, 591, 763 P2d 408 (1988).

Employer contends that it relied on rules governing unilateral reclassification of PPD in the *aggravation* context. *Former* OAR 436-54-232(1). Additionally, after the reclassification had been made, employer conferred with the Compliance Division, which agreed that the action was appropriate. The Board concluded that employer "offered no reasonable explanation for its unauthorized, unilateral offset against TTD compensation awarded by the prior Referee's Opinion and Order." The Board based its conclusion on the fact that employer consulted with the division only *after* it had acted unilaterally. While that adequately explains why the Board rejected that explanation, it does not explain why the

Board rejected employer's explanation that it had relied on *former* OAR 436-54-232(1). Therefore, we remand for the Board to consider that argument.[4]

Reversed and remanded for reconsideration of penalty and attorney fees; otherwise affirmed.

[4] Employer's remaining assignment of error is without merit.



IN THE COURT OF APPEALS OF THE STATE OF OREGON

Wanda L. DRYDEN
*Appellant,*
*v.*
STATE ACCIDENT INSURANCE FUND CORPORATION,
*Defendant,*
James William GORDON,
*Respondent.*
(85-1807; CA A61014)

Appeal from Circuit Court, Marion County.

Richard D. Barber, Judge.

Argued and submitted June 13, 1990.

William B. Wyllie, Salem, argued the cause and filed the brief for appellant.

James C. Edmonds, Salem, argued the cause for respondent. With him on the brief were Michael C. McClinton and Clark, Lindauer, McClinton, Krueger, Fetherston & Edmonds, Salem.

Before Warren, Presiding Judge, and Riggs and Edmonds, Judges.

EDMONDS, J.

Reversed and remanded.



**EDMONDS, J.**

This case is before us for the second time. In our first opinion, we held that, because plaintiff's punitive damages claim alleged an intentional tort against Dryden (defendant) personally, outside the scope of the Oregon Tort Claims Act (OTCA), ORS 30.260 *et seq,* the trial court erred in striking the claim on the ground that punitive damages are not recoverable under OTCA. *Dryden v. SAIF,* 88 Or App 542, 746 P2d 240 (1987).[1] On remand, the trial court, relying on *Brungardt v. Barton,* 69 Or App 440, 685 P2d 1021 (1984), granted defendant's motion for a directed verdict at the close

[1] We also held that the court did not err in entering judgment in favor of defendant State Accident Insurance Fund Corporation.

of plaintiff's case, ruling that the jury was not entitled to conclude from the evidence that defendant was acting outside the scope of his employment or that plaintiff had complied with the notice requirements of the OTCA.

Plaintiff appeals and argues that there was testimony at trial from which the jury could have concluded that defendant was acting outside the scope of his employment, that as a result plaintiff did not have to comply with the notice requirements of OTCA and that the trial court, therefore, erred in granting defendant's motion. Viewing the evidence in the light most favorable to plaintiff, *Brown v. J.C. Penney Co.*, 297 Or 695, 705, 688 P2d 811 (1984), we agree and reverse.

Defendant had plaintiff under surveillance as part of his job as an investigator employed by SAIF. As plaintiff was driving her car, she and her daughter, who was a passenger, noticed that defendant was following them in another car. After both cars pulled off the road and parked, plaintiff confronted defendant. Plaintiff's daughter testified:

"A: * * * And my mom got out. She was upset and angry, scared. I was scared. Didn't know who this guy was. And she asked him what he was going, [*sic*] why he was following us, and I guess he didn't answer. I don't know. I was in the car.

"Q: You didn't hear any answer, anyway?

"A: No.

"Q: What did he do then?

"A: Well, after she asked him all that, she went around to



the front of the car and yelled to me to get his license plate, and she did have her hands on the car, and *evidently he panicked or something, 'cause he did go forward before he went back and went around her then after he went backwards,* and it did hurt her, her shins.

"Q: And —

"A: And she went up over the car and held herself up by her hands.

"Q: In other words, she was sort of spread-eagled over the hood of the car?

"A: Just — yeah.

"Q: Did she get herself off there?

"A: Yeah.

"Q: And then he left?

"A: Well, he backed up and then went around, yeah.

"* * * * *

"Q. And when your mother got out, you remained in the car?

"A. Yes.

"Q. She was loud?

"A. Very.

"Q. She was swearing?

"A. Yes.

"Q. She was threatening?

"A. I didn't hear her threaten nothing. She just wanted to know who he was.

"Q. Waving her fists around?

"A. Well, she was upset, yeah.

"Q. And you indicated to me before that he looked scared inside his car —

"A. Yes.

"Q. — Isn't that correct?

"A. Yes.

"Q. In fact, you told me he was actually cowering in his seat?

"A. Well, he looked scared, yes, nervous." (Emphasis supplied.)

Plaintiff testified:

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"Q. You claim that [defendant] ran into you with his car?

"A. Yes. He did."

Defendant testified:

"Q. * * * how did you feel?

"A. *Well, at first I knew that [plaintiff] knew that I was following her, that my, might say, cover was blown, that — and I was first mad at myself that I got caught, I guess, for following her, and I knew that it would be very difficult then to find out what her activities would be at that point forward.*

"Q. When she got out of her car, was she loud?

"A. Very, very excited, very, might say, irrational.

"Q. Was she swearing?

"A. Yes, she was.

"Q. Was she threatening?

"A. Yes, she was.

"Q. Did she appear angry?

"A. Yes.

"Q. How did you feel?

"A. Well, I was very nervous and, you might say, almost scared. My past experience as a police officer coming into contact with people like this, I didn't know what to expect from her at that point forward.

"* * * * *

"Q: You said that you were told to avoid contact with these people that you were — that you had under surveillance; am I correct about that?

"A: That's correct. I knew that since [plaintiff's] workers' comp claim was coming to a hearing in a month or so, I knew she was represented by an attorney, and we were not to have any physical or verbal type of contact with her.

"* * * * *

"Q: * * * I'm not sure that you answered that correct — that question the way you meant to. [The question was:] 'Was there no way possible that you could leave without hitting [plaintiff]?'

"A: *Oh, if I would have put my car in drive and drove forward, sure, I would have hit her, but I didn't do that.*

"Q: What did you do?

"A: I put my car in reverse and backed up and then tried to drive around to the left to go around her, and then she — I was driving at approximately one or two miles per hour. *As I start — I backed up, then started to pull forward around her. As I did that, she stepped in front of my vehicle again, causing me to stop.*

"Q: You had to repeat the process, then?

"A: Had to repeat the process. She finally left, moving back over to her vehicle, and that enabled me to — I still swung out a little bit to leave the area.

"Q: Ever come into contact with her at all?

"A: Never." (Emphasis supplied.)

In *Brungardt v. Barton, supra,* we stated:

"In order to determine whether [a] defendant's actions fall within the scope of his employment, we consider whether the act in question is of a kind he was hired to perform, whether the act occurred within the authorized time and space and whether the employe was motivated, at least in part, by a purpose to serve the employer." 69 Or App at 443, *citing Stanfield v. Laccoarce,* 284 Or 651, 655, 588 P2d 1271 (1978).

As a general rule, whether a particular act is within the scope of employment is to be decided by the trier of fact. Not every intentional tort by an employee is outside the scope of employment. The intentional use of force may be authorized expressly or by the circumstances. However, an intentional tort may also be a private act outside the scope of employment if the employee is motivated by other than an intention to serve the employer. *See Thomas v. Parker Refrigerated Services, Inc.,* 61 Or App 234, 239-40, 657 P2d 692, *rev den* 294 Or 792 (1983).

A motion for a directed verdict may be granted if there is only one reasonable conclusion that can be drawn from the evidence. *James v. Carnation Co.,* 278 Or 65, 69, 562 P2d 1192 (1977). Here, the jury could have found from the testimony that defendant drove forward and hit plaintiff with his car. The jury could have inferred that that act was either intentional or negligent. If it was intentional, it may have been outside defendant's scope of employment, depending on his motivation. The jury was entitled to draw an inference that defendant intentionally struck plaintiff and acted out of anger, because his "cover had been blown," and without



intending to benefit his employer. The trial court erred in granting his motion for a directed verdict.

Reversed and remanded.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Larry K. Rose, Claimant.

MERCER INDUSTRIES
and Lumbermen's Underwriting Alliance,
*Petitioners - Cross-Respondents,*

*v.*

Larry K. ROSE,
*Respondent - Cross-Petitioner,*
*and*

AMERICAN BUILDING MAINTENANCE,
EBI Companies and EBI Services, Inc.,
*Respondents - Cross-Respondents.*

(88-16120, 88-03158; CA A51112)

Judicial Review from Worker's Compensation Board.

On petitioners - cross-respondents' petition for reconsideration filed May 22, 1990. Former opinion filed January 17, 1990, 100 Or App 252, 785 P2d 385.

Patric J. Doherty, E. Kimbark MacColl, Jr., and Rankin, VavRosky, Doherty, MacColl & Mersereau, Portland, for petition.

No appearance *contra.*

Before Graber, Presiding Judge pro tempore, and Riggs and Edmonds, Judges.

EDMONDS, J.

Petition for reconsideration allowed; former opinion modified to affirm on cross-petition and adhered to as modified.



**EDMONDS, J.**

Petitioner moves for reconsideration of our opinion in *Mercer Industries v. Rose,* 100 Or App 252, 785 P2d 385 (1990). We held that the Board erred when it refused to award attorney fees to claimant after claimant actively litigated the issue of responsibility. Petitioner argues that claimant is not entitled to an employer-paid attorney fee, because his right to compensation was never in jeopardy.

Claimant's entitlement to receive compensation was resolved before the hearing when an order of responsibility under *former* ORS 656.307,[1] was issued. 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. In such

[1] ORS 656.307 was amended in 1987, after the hearing in this case, to include a provision for award of attorney fees in responsibility hearings. *See* ORS 656.307(5).

rejected cases where the claimant prevails finally in a hearing before the referee or in a review by the board itself, then the referee or board shall allow a reasonable attorney fee." (Emphasis supplied.)

Because claimant did not seek review from an order denying compensation, he is not entitled to attorney fees under ORS 656.386(1). *Shoulders v. SAIF,* 300 Or 606, 611, 716 P2d 751 (1986). To the extent that *SAIF v. Phipps,* 85 Or App 436, 737 P2d 131 (1987), is inconsistent with this opinion, it is overruled.

Motion for reconsideration allowed; former opinion modified to affirm on cross-petition and adhered to as modified.

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270 September 5, 1990 No. 424

## IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of
Arthur R. Morris, Claimant.
WAUSAU INSURANCE COMPANIES,
*Petitioner,*
*v.*
Arthur R. MORRIS,
*Respondent.*
(89-0063M; CA A62580)

Judicial Review from Workers' Compensation Board.

Argued and submitted July 6, 1990.

David Horne, Beaverton, argued the cause and filed the brief for petitioner.

Douglas L. Minson, Hillsboro, argued the cause and filed the brief for respondent.

Before Buttler, Presiding Judge, and Rossman and De Muniz, Judges.

BUTTLER, P. J.

Award of benefits for temporary total disability reversed; remanded for reconsideration.

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**BUTTLER, P. J.**

The Workers' Compensation Board reopened claimant's claim on its own motion pursuant to ORS 656.278(1)(a).[1]

[1] ORS 656.278 provides, in part:

"(1) 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 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 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[.]"

It is undisputed that claimant has experienced a worsening of his compensable condition and that he needs surgery. Employer's insurer seeks review of the Board's decision that he is also entitled to benefits for temporary total disability until he becomes medically stationary or is released for work.

The Board relied on *Dawkins v. Pacific Motor Trucking*, 308 Or 254, 258, 778 P2d 497 (1989), in which the Supreme Court held:

> "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*, [299 Or 290, 702 P2d 403 (1985)]. 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, *Cutwright v. Wyerhaeuser, 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).
>
> "A claimant who is not employed, is not willing to be employed, or although willing to be employed is not making reasonable efforts to find employment (unless such efforts



> would be futile because of the work-related injury) has withdrawn from the work force. A claimant who, at the time of the aggravation of the work-related injury, has withdrawn from the work force is not entitled to temporary total disability."

Claimant has not worked since he was injured in 1983. There is substantial evidence to support the Board's finding that he has been totally disabled since 1986. The record shows, additionally, that claimant has had little motivation to return to work and that he has twice been denied benefits for permanent total disability on that ground. Despite that, the Board found that claimant is now willing to work, and on that basis it held that he was in the work force when his condition worsened and is entitled to benefits for temporary total disability.

Contrary to claimant's contention, although the Board is permitted in certain cases to award additional benefits on its own motion "if in its opinion such action is justified," ORS 656.278(1), the Board's decision is not completely discretionary; a claimant must qualify for those benefits. Claimant was not entitled to benefits for temporary total disability simply because the Board decided to award them. OAR 438-12-035 provides that temporary total disability benefits awarded by the Board on its own motion "shall continue to be paid under the relevant statutory provisions and regulations established by the Director for all other claims[.]" Claimant is entitled to benefits for temporary total disability only if he qualifies for those benefits under the relevant statutory provi-

sions. We review the Board's own motion order pursuant to ORS 183.482(7) and (8) for substantial evidence and errors of law. ORS 656.298(6).

Employer contends that, in finding that claimant is willing to work, the Board has disregarded its previous rulings regarding his lack of motivation to seek work. We agree with the Board that it is claimant's willingness to seek work *at the time of the aggravation* that is relevant to whether he is in the work force. Although claimant may have withdrawn from the work force at one time, and the Board may have made a finding to that effect, that decision does not irrevocably commit him to retirement for purposes of workers' compensation benefits. If he is willing to seek work at the time of the aggravation, he is a member of the work force at that time.



We conclude, however, that the Board has not adequately explained its finding that claimant is willing to work. The Board did not hold a hearing, as it could have, *see* OAR 438-12-040, or consider any evidence other than the medical report submitted to support the need for surgery and a letter from claimant's attorney stating that claimant "is adamant that he has wanted to work throughout this entire period of time" and "has never voluntarily removed himself from the labor market."[2] The letter does not separately state that claimant's attitude toward work has changed or that he is presently willing to work. In the light of the Board's two previous determinations that are directly contrary to claimant's assertion that he has never withdrawn from the work force,[3] it needs to explain its conclusion.

Award of benefits for temporary total disability reversed; remanded for reconsideration.

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[2] Although the letter is hearsay and would not be admissible under the evidence code, those rules do not apply to the Board. *See* ORS 656.283(7).

[3] In its opinion of July, 1984, the Board, in affirming the referee, found:

"As has been observed by most of the physicians who have examined claimant over the past several years, he clearly lacks any motivation to return to work. Not only does he lack motivation to return to work, but he is strongly motivated to preserve his disability status and to convince others that he is unable to work. It appears that claimant determined several years ago that he would never return to work and he has proceeded to insure that that decision becomes a self-fulfilling prophecy. That is unfortunate, because claimant is undoubtedly quite disabled. His unwillingness to consider a return to work, however, makes any rehabilitation efforts futile and hampers a determination of the extent to which he is precluded from the general labor market."

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Gale J. Warren, Claimant.

GEORGIA-PACIFIC CORPORATION,
*Petitioner,*

*v.*

Gale J. WARREN,
*Respondent.*

(87-15662; CA A63134)

Judicial Review from Workers' Compensation Board.

Argued and submitted July 30, 1990.

Jerry K. Brown, McMinnville, argued the cause for petitioner. With him on the brief was Cummins, Brown, Goodman, Fish & Peterson, P.C., McMinnville.

David C. Force, Salem, filed the brief for respondent.

Before Buttler, Presiding Judge, and Rossman and De Muniz, Judges.

BUTTLER, P. J.

Affirmed.



**BUTTLER, P. J.**

Employer seeks review of an order of the Workers' Compensation Board affirming the referee's decision that claimant's carpal tunnel syndrome is compensable.

The Board's opinion explains the issue in this case:

> "The record contains relevant medical opinions from treating orthopedic surgeon Schachner and Dr. Nathan, hand surgeon. The opinions of both medical experts support the following findings and conclusions. First, claimant experienced no difficulties with her hands or wrists before she began working for the employer. Second, claimant's work with the employer was the major contributing cause of her current bilateral wrist and hand *symptoms.* Third, those symptoms are attributable to 'carpal tunnel syndrome,' defined as a complex of symptoms resulting from compression and oxygen deprivation of the median nerve in the carpal tunnel.
>
> "Accordingly, if 'carpal tunnel syndrome' is the 'occupational disease' in this case, claimant has demonstrated a compensable disease. However, the employer disagrees with this characterization of claimant's disease. It relies, instead, on an alternative definition put forth by Dr. Nathan, who performed an independent medical examination in September 1987. If we accept Dr. Nathan's opinion, claimant has not demonstrated a compensable occupational disease. He defined claimant's disease as the slowing of the median nerve identified in electrodiagnostic tests. He further opined that this nerve slowing was entirely ideopathic in origin and was not worsened by claimant's work activity.

"The Referee rejected Dr. Nathan's opinion and concluded that claimant's carpal tunnel syndrome was a compensable occupational disease. We agree. In order to be compensable, an occupational disease must require treatment or result in disability or death. ORS 656.804 and *former* 656.005(8)(a). Claimant is not seeking treatment for a slowing of the median nerve but for her clinical condition, characterized as carpal tunnel syndrome. Dr. Nathan concedes that treatment of claimant's median nerve slowing would be inappropriate in the absence of symptoms, *i.e.*, until the onset of carpal tunnel syndrome. Furthermore, when treatment is provided, it does nothing to correct the underlying slowing of the median nerve but merely relieves symptoms by allowing more blood and oxygen to reach the nerve. Finally, claimant's condition is disabling because of her symptom complex, not the slowing of her median nerve.

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"After considering these factors, we conclude that claimant's carpal tunnel syndrome is a compensable occupational disease." (Emphasis in Board's.)

Employer contends, essentially, that the Board had no choice but to accept Nathan's opinion that claimant's underlying condition is ideopathic and has not been affected by her employment. According to Nathan, his research shows that, with carpal tunnel disease, there is a distinction between the underlying condition, which Nathan described as "entrapment neuropathy," and the syndrome, which occurs when the condition becomes symptomatic. Nathan testified that he determined, from the location of claimant's nerve lesion, that, although claimant's symptoms probably were caused by her work activity, her underlying neuropathy was ideopathic. Dr. Schachner, claimant's treating neurosurgeon, was of the opinion that claimant's employment was the cause of her carpal tunnel syndrome.

Employer argues that, in the light of Nathan's extensive research, experience and explanation concerning the nature of carpal tunnel syndrome and claimant's condition, the Board's finding that Schachner's opinion is more persuasive is not supported by substantial evidence. Additionally, it contends that, in the light of Nathan's uncontroverted opinion that the underlying condition is separate from its symptoms and that it was not caused or made worse by the employment, the Board erred as a matter of law in concluding that the syndrome is the disease and that it is compensable. *See Weller v. Union Carbide Corp.*, 288 Or 27, 602 P2d 259 (1979).

As the Supreme Court suggested in *Weller*, 288 Or at 33, sometimes the medical evidence will support the conclusion that the symptoms for which compensation is sought *are* the disease. Here, even accepting Nathan's testimony that claimant has an underlying condition, "entrapment neuropathy," that is ideopathic in origin, claimant seeks compensation for carpal tunnel syndrome, a complex of symptoms resulting from compression and oxygen deprivation of the median nerve in the carpal tunnel. In the opinion of both Nathan and Schachner, the syndrome was brought on by claimant's work activity with employer. Schachner stated that claimant's work is the etiologic source of her syndrome. He

attributed no part of it to a preexisting condition and made no distinction between carpal tunnel syndrome and an underlying carpal tunnel disease. We conclude that the Board's finding that the syndrome is the compensable disease is supported by substantial evidence and that its conclusion is supported by its findings.

Affirmed.



IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Kenneth Davies, Claimant.

DIAMOND FRUIT GROWERS,
*Petitioner - Cross-Respondent,*

*v.*

Kenneth DAVIES,
*Respondent - Cross-Petitioner.*

(87-16765; CA A62692)

Judicial Review from Workers' Compensation Board.

Argued and submitted July 30, 1990.

Scott H. Terrall, Portland, argued the cause for petitioner - cross-respondent. With him on the briefs were G. Joseph Gorciak and Terrall & Miller, Portland.

William H. Skalak, Portland, argued the cause and filed the brief for respondent - cross-petitioner.

Before Buttler, Presiding Judge, and Rossman and De Muniz, Judges.

BUTTLER, P. J.

Affirmed on petition; reversed and remanded on cross-petition for reconsideration of attorney fees.



**BUTTLER, P. J.**

Employer seeks review of an order of the Workers' Compensation Board affirming the referee's decision that claimant's back, neck and shoulder injuries are compensable. Claimant cross-petitions, contending that the Board's award of attorney fees was inadequate. We affirm without discussion on the petition and reverse and remand on the cross-petition.

Claimant prevailed before the Board on employer's appeal of the referee's order setting aside employer's denial of the claim. He was entitled to an award of employer-paid attorney fees under ORS 656.382(2). Claimant's counsel submitted a statement of services requesting attorney fees of $1,562.50 for 12.5 hours of service at a rate of $125 per hour. The Board awarded $600, without any explanation for its decision.

In *Weyerhaeuser Co. v. Fillmore*, 98 Or App 567, 779 P2d 1102 (1989), we held that, although the Board is not required in making an award of attorney fees to make findings as to each of the factors described in OAR 438-15-010(6),[1] the Board's explanation must be detailed enough to inform us that it has considered all of the factors and that there is a reasonable basis for the award. 98 Or App at 571. Although the Board did not necessarily need to explain why it awarded less than the amount requested, it had to say enough to permit us to determine that there is a reasonable basis for the amount awarded. The Board gave no explanation. Therefore, we remand for reconsideration of attorney fees.

Affirmed on petition; reversed and remanded on cross-petition for reconsideration of attorney fees.

[1] OAR 438-15-010(6) provides:

"(6) In any case where a referee or the Board is required to determine a reasonable attorney fee, the following factors shall be considered:

"(a) The time devoted to the case;

"(b) The complexity of the issue(s) involved;

"(c) The value of the interest involved;

"(d) The skill of the attorneys;

"(e) The nature of the proceedings;

"(f) The benefit secured for the represented party;

"(g) The risk in a particular case that an attorney's efforts may go uncompensated; and

"(h) The assertion of frivolous issues or defenses."

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IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Frank L. Stoddard, Claimant.

Frank L. STODDARD,
*Petitioner,*

*v.*

CREDIT-THRIFT CORPORATION and Standard Fire Insurance,
*Respondents.*

(84-10872; CA A63057)

Judicial Review from Workers' Compensation Board.

Argued and submitted July 6, 1990.

Karen M. Werner, Eugene, argued the cause for petitioner. With her on the brief were Richard T. Kroff and Emmons, Kropp, Kryger, Alexander & Egan, P.C., Albany.

No appearance for respondents.

Before Buttler, Presiding Judge, and Rossman and De Muniz, Judges.

BUTTLER, P. J.

Reversed and remanded for reconsideration.

**BUTTLER, P. J.**

Claimant petitions for review of an order of the Workers' Compensation Board affirming the referee's order denying funds for the modification of his home and the removal of architectural barriers. We reverse and remand.

In 1971, claimant became quadriplegic as a result of a work-related injury. He was granted permanent total disability and has attendants to care for his needs 24 hours a day. Until recently, he lived in a home in Corvallis, which he had paid to have remodelled to accommodate his wheelchair and other needs. Employer had paid for installation of an air conditioner, which had been prescribed by claimant's doctor.

As the result of a divorce, claimant could no longer afford to live in his Corvallis home, and he sold it and move to a new home in Salem. Employer denied his request for funds for the remodelling of his new home, including the widening of the doors to his bedrooms and one bathroom so that he can enter those rooms in his wheelchair; the replacement of his bedroom window with a patio door as an emergency exit; the remodelling of one bathroom so that he can more readily use the shower and the toilet; replacing the wooden ramp to his front door with a concrete ramp with railings, and a cover from the house to the garage, to make access to the house more convenient. Employer also denied his request for an air conditioner, modifications to his van and payment for certain items prescribed by his doctor, including a stand-up table, a Hoyer lift, a commode shower, a trapeze sling and a digital stimulator.

The referee and the Board allowed claimant to be reimbursed for all of the prescribed items. They denied the compensability of the modifications to his house. The referee held that remodelling of a home is not the type of service for which compensation is allowed under ORS 656.245(1), relying on *Lorenzen v. SAIF*, 79 Or App 751, 719 P2d 1336 (1986). ORS 656.245(1) provides:

> "For every compensable injury, the insurer or the self-insured employer shall cause to be provided medical services for conditions resulting from the injury for such period as the nature of the injury or the process of the recovery requires, including such medical services as may be required after a determination of permanent disability. Such medical services



> shall include medical, surgical, hospital, nursing, ambulances and other related services, and drugs, medicine, crutches and prosthetic appliances, braces and supports and where necessary, physical restorative services. The duty to provide such medical services continues for the life of the worker."

The Board did not reach the issue of whether the remodelling was a covered service under ORS 656.245(1). Instead, it held:

> "Although we agree that the use of shower facilities would provide some degree of independence for claimant, the record does not show that claimant would be able to perform this or other tasks without the assistance of caregivers. Thus, there is no need to decide whether such a service is covered under ORS 656.245(1), since even if it were covered, the service would not be reasonable and necessary in this case."

The Board did not discuss the requested architectural changes separately; we assume, therefore, that it intended its conclusion to apply to all of the proposed modifications.

In order to be compensated for the requested services, claimant must show that they are necessary for the "nature of the injury or the process of recovery." ORS 656.245(1). There is no medical evidence to that effect; however, a specialist in providing equipment for people with physical disabilities testified that doctors recommend that quadriplegics be as independent as possible. Both that witness and claimant testified that the requested changes would enable claimant to be more self-sufficient.

The Board's reason for concluding that the services are not reasonable and necessary is not clear. It apparently relied on the fact that, even with the changes, claimant would still need the assistance of caregivers. If that is a test for whether a requested service is reasonable and necessary, we are not aware of the authority for it, and many services that are authorized and were authorized here would not come within the statute. If, as the Board acknowledges, the requested changes would make claimant more independent, that is at least some evidence that the changes are necessary because of the nature of claimant's injury and the process of recovery. The Board should explain why the fact that claimant will continue to need caregivers makes the services not compensable under ORS 656.245(1).

Additionally, the Board's denial of claimant's request



for the widening of his bathroom door to permit his entering without assistance appears to be inconsistent with its allowing reimbursement for the commode shower, which can only be used in the bathroom and which he can use only with assistance. On reconsideration, the Board should explain that apparent inconsistency.

Reversed and remanded for reconsideration.

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Terry L. Turcotte, Claimant.
CATLIN GABEL SCHOOL
and EBI Companies,
*Petitioners,*
*v.*
Terry L. TURCOTTE,
*Respondent.*
(WCB 87-09629; CA A63055)

Judicial Review from Workers' Compensation Board on petitioners' motion to determine jurisdiction filed March 8, 1990.

Patric J. Doherty and Rankin, Vavrosky, Doherty, MacColl & Mersereau, Portland, for motion.

David C. Force and Vick & Gutzler, Salem, *contra.*

Before Rossman, Presiding Judge, and Newman and Edmonds, Judges.

PER CURIAM

Judicial review dismissed.



**PER CURIAM**

Employer has moved for a determination of whether we have jurisdiction to review a November 14, 1989, order. We hold that we do not have jurisdiction.

After the Board issued its order, claimant requested reconsideration of the attorney fee portion of that order. The Board issued an order on reconsideration on December 8, 1989, in which it withdrew the November 14 order, assessed an additional $300 in attorney fees and republished the rest of the original order.

The order on reconsideration states that it was mailed to all parties on December 8, 1989. By the time that employer filed a petition for judicial review of the November 14 order, on December 13, 1989, that order had been withdrawn.

Because employer never filed a petition for judicial review of the December 8 order, as required by ORS 656.295,[1] there is nothing over which we have jurisdiction.[2] *Armstrong v. SAIF, supra* n 2.

Judicial review dismissed.

[1] ORS 656.295(8) provides, in part:

"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."

Employer never received a copy of the order on reconsideration, but it was mailed.

[2] Because petitioners have not shown that their failure to receive the order was caused by the Board, the order cannot be considered a nullity on due process grounds. *Armstrong v. SAIF,* 58 Or App 602, 604, 649 P2d 818, *rev den* 293 Or 801 (1982).

IN THE COURT OF APPEALS OF THE
STATE OF OREGON

In the Matter of the Compensation of
Ralph Johnson, Claimant.
V. W. JOHNSON & SONS
and Wausau Insurance Company,
*Petitioners,*
*v.*
Ralph JOHNSON,
*Respondent.*
(87-01078; CA A62247)

Judicial Review from Workers' Compensation Board.

Argued and submitted April 4, 1990.

David O. Horne, Beaverton, argued the cause and filed the brief for petitioners.

John Paul Graff, Portland, argued the cause for respondent. With him on the brief was Graff & O'Neil, Portland.

Before Graber, Presiding Judge pro tempore, and Joseph, Chief Judge, and Edmonds, Judge.

JOSEPH, C. J.

Reversed and remanded for reconsideration.



**JOSEPH, C. J.**

Employer petitions for review of a Workers' Compensation Board order that denied it the right to offset against claimant's permanent total disability benefits the amount that it had previously paid claimant on a permanent partial disability award. We reverse.

In October, 1987, the referee found that claimant was permanently and totally disabled as of the date of the hearing. Employer appealed to the Board, and claimant filed a cross-appeal, contending that the award should have been retroactive. In its brief to the Board, employer argued that, in the event that the Board awarded PTD retroactively, it should be allowed an offset for any benefits that it had already paid on the claim. The Board found claimant permanently and totally disabled as of August 19, 1986, but denied employer's request for an offset on the basis of a purported waiver.

Employer first argues that the Board did not have "jurisdiction" to consider claimant's cross-appeal, because he did not contend at the referee's hearing that the date of disability should be other than the date of the hearing. Therefore, employer argues, it did not have notice that that date was in issue. Claimant's request for a hearing put employer on notice that PTD was in issue. A claimant is entitled to benefits from the earliest date on which the disability is proved to have

existed. *See Adams v. Edwards Heavy Equipment, Inc.*, 90 Or App 365, 752 P2d 340 (1988). Thus, the date of disability is necessarily one aspect of the issue of PTD, *see Freres Lumber Co., Inc. v. Murphy*, 101 Or App 92, 789 P2d 674, *rev den* 310 Or 195 (1990), and the Board properly considered it.

Employer next argues that the Board erred in holding that employer had waived the issue of offset, because it did not raise it at the referee's hearing. Claimant counters that, by holding that employer had waived the issue, the Board adhered to the policy of maintaining an orderly compensation process by requiring that the right to an offset be raised at the hearing. *See Spivey v. SAIF*, 79 Or App 568, 720 P2d 755 (1986); *Wilson v. SAIF*, 48 Or App 993, 618 P2d 473 (1980); *Horn v. Timber Products, Inc.*, 12 Or App 365, 507 P2d 36 (1973). Claimant argues that employer knew that PTD was an issue, could have foreseen the risk of an overpayment and took the gamble in the hope that the referee would not award PTD



or that claimant would not challenge the date of the award. As a result, employer failed to make a record on which the Board could have decided whether an overpayment existed or the amount of the overpayment.

Requiring a claim of offset to be raised or waived encourages parties to litigate all issues in a single hearing. *Wilson v. SAIF, supra*, 48 Or App at 998. However, the Supreme Court's recent opinion in *Drews v. EBI Companies*, 310 Or 134, ___ P2d ___ (1990), leads us to conclude that failure to raise an issue may not constitute a waiver in the workers' compensation context. In *Drews*, the court primarily discussed whether claim and issue preclusion apply in workers' compensation litigation. However, the court also addressed the issue of waiver. The referee's opinion there, which the Board adopted, had denied the claimant the right to raise the issue of the correct rate of payment on the ground that the claimant could have done so " 'in the prior * * * hearing and, since [claimant did] not, it was then waived.' " *Drews v. EBI Companies, supra*, 310 Or at 137. The court held that there had been no waiver, because the version of ORS 656.262(9) then in effect provided that accepting compensation did not constitute a waiver of the right to question the amount and because waiver must be the intentional relinquishment of a known right. *Drews v. EBI Companies, supra*, 310 Or at 150.

The same rationale applies here. ORS 656.268(10) creates a right to an offset.[1] In its brief to the Board, employer claimed that right in the event that the Board accepted claimant's position regarding the PTD date. Employer clearly never intended to relinquish its right. The Board erred in failing to remand to the referee for a determination of the offset issue. ORS 656.295(5).

Reversed and remanded for reconsideration.

[1] In the 1990 Special Session, the legislature renumbered this section ORS 656.268(13).

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IN THE SUPREME COURT OF THE
STATE OF OREGON

In the Matter of the Compensation of
Walter F. Drews II, Claimant.

Walter F. DREWS II,
*Respondent on Review,*

*v.*

EBI COMPANIES
and Unity Construction,
*Petitioners on Review.*

(WCB 85-12763; CA A43657; SC S36174)

On review from the Court of Appeals*

Argued and submitted September 29, 1989.

Craig A. Staples, Portland, argued the cause and filed the petition for petitioners on review.

James L. Edmunson, Eugene, argued the cause for respondent on review.

Before Peterson, Chief Justice, and Linde, Carson, Jones, Gillette, Van Hoomissen and Fadeley, Justices.**

FADELEY, J.

The decision of the Court of Appeals is affirmed, and the order of the Workers' Compensation Board is remanded to the Board for further proceedings consistent with this opinion.

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* Judicial review of Order of Workers' Compensation Board. 96 Or App 1, 771 P2d 285 (1989).

** Linde, J., retired January 31, 1990; Jones, J., resigned April 30, 1990.



**FADELEY, J.**

The issue is whether either issue or claim preclusion applies in this case. An injured worker seeks correction of the amount of temporary total disability benefits (TTD) payable for periods when he was unable to work as a result of an injury. He also seeks a penalty and attorney fees because EBI Companies (EBI), the employer's insurer, did not correct the amount of TTD payments within a reasonable time after EBI was notified of an error in the calculation of the amount of TTD due the worker. EBI asserts that claim preclusion prevents any recovery on account of the incorrect amount of TTD and, perforce, no penalty or attorney fees. We affirm, for different reasons, the Court of Appeals decision which reversed and remanded an Order of the Workers' Compensation Board.

In 1980, a ladder fell on the worker's neck, causing injury, surgery, and time loss in 1981. The employer's report of injury listed $8.50 per hour when $10.50 was the correct hourly wage rate for the injured worker, as the employer later acknowledged. EBI calculated and paid TTD based on the

lower rate. A determination order issued in 1981 ordering TTD for a specified time period, "less time worked." No appeal was taken. The worker returned to work.

In 1984, the worker claimed aggravation and need for further surgery. EBI denied the claim but, following a June 13 hearing, on July 24, 1984, a referee allowed it to permit surgery.

When the aggravation claim was allowed to permit further surgery, the referee expressly found that the shoulder condition requiring surgery was related to the industrial accident and that the condition had worsened since the 1981 closure order. The referee in 1984 also ordered future TTD payments as follows:

> "ORDERED that EBI Companies, in connection with the aggravation claim remanded to it by the Referee, shall pay claimant temporary total disability benefits [for unspecified future periods] as authorized by [doctor], claimant's treating physician."

Temporary total disability benefits eventually were paid in 1984-85 under that order, but at an erroneously low rate. It is



not contended that the worker knew of the error in 1984 but, in any event, he failed to raise the erroneously listed TTD rate at the 1984 hearing which allowed or opened the aggravation claim.

An evaluation of the aggravation claim produced a determination order of October 7, 1985, which allowed temporary total disability for the period starting with the time of surgery and ending June 28, 1985. On October 17, 1985, the worker filed a timely request for hearing, seeking increased permanent partial disability and payment of TTD beyond June 28, 1985. The wage-rate error was discovered by the worker's vocational counselor in the fall of 1985. The injured worker's attorney advised EBI, in writing, of that error and demanded that the correct wage rate be used to recompute the amount of weekly TTD resulting from surgeries in 1984-85. EBI denied that the rate of TTD was incorrect and refused to pay additional amounts of TTD to correct the underpayments for any period. The attorney then added to the hearing request in the aggravation claim proceeding a request for correction of the TTD rate for 1984-85 and for penalty and attorney fees.

A hearing was held in March of 1986 to review requests concerning the 1985 determination order and the TTD requests. The referee found both that the TTD rate was in error for the 1984-85 period and that EBI should be ordered to pay additional TTD for a number of weeks beyond the ending date provided in the determination order. The referee also found that the insurer had unreasonably delayed correction of the rate.[1] The referee ordered EBI to pay an attorney fee and penalty of 25 percent of the TTD compensation that the worker had not received in regard to the aggravation claim due to the wage-rate error.

[1] ORS 656.262(4) provides that compensation "shall be paid no later than the 14th day after the subject employer has notice or knowledge of the claim."

However, on reconsideration requested by EBI following an unrecorded telephone conference argument, the referee concluded and ordered as follows:

> "I would have to agree with [insurer's attorney] that the incorrect wage rate was an issue that could have been raised in the prior [June 13, 1984,] hearing and, since it was not, it was



> then waived. Consequently, the opinion and Order will be amended as follows:
>
> "IT IS HEREBY ORDERED that the Opinion and Order dated April 21, 1986, shall be amended to remove the penalty and attorney fee awarded because the insurer had paid the claimant time loss at an incorrect rate.
>
> IT IS FURTHER ORDERED that the remainder of the Opinion and Order is republished and remain in full force and effect."

In March 1987, the Workers' Compensation Board, without opinion, affirmed the referee's order.

The Court of Appeals reversed and remanded to the Board because a wage rate dispute presents an issue of fact, not a separate "claim" for preclusion purposes. *Drews v. EBI Companies,* 96 Or App 1, 771 P2d 285 (1989). We affirm the Court of Appeals' reversal of the Board's order because the finality required for preclusion has not yet attached to the aggravation claim.

It is by no means clear from the record that claim or issue preclusion rules are the reason why the referee or the Board denied claimant's request for the penalty and attorney fees. The referee held only that "the incorrect wage rate was an issue which could have been raised in the prior hearing and, since it was not, it was then waived." The Board merely affirmed the referee's order. However, both parties argued to the Board and the Court of Appeals whether the wage-rate error was covered by claim preclusion rules. *Drews v. EBI Companies, supra,* 96 Or App at 3-4.

The Court of Appeals stated the issue before it in preclusion terms and held that the case involved issue preclusion, but explained its decision by stating that a question of correct wage rate "is an issue of fact, not a claim." Whether preclusion by former adjudication applies to the issue of incorrect TTD rate is properly before this court for decision.



## DISCUSSION OF CLAIM AND ISSUE PRECLUSION

Because decisions use the term *"res judicata"* inconsistently, it is important to clarify the terminology used here. "Preclusion by former adjudication" is a doctrine of rules and principles governing the binding effect on a subsequent proceeding of a final judgment previously entered in a claim. The

term comprises two doctrines: claim preclusion,[2] also known as *res judicata,* and issue preclusion,[3] also known as collateral estoppel. Some authors use the term *res judicata* to refer to both subdivisions of former adjudication doctrine. *See* 1 Restatement (Second) of Judgments 131 (1982) (Introductory Note beginning chapter 3, Former Adjudication: The Effects of a Judicial Judgment).

However, in this opinion and henceforth, we will use the more exact terms "claim preclusion" or "issue preclusion" to denote the respective branches of preclusion by former adjudication. This is merely a choice of nomenclature, not a law change.

*A. Issue Preclusion*

The issue preclusion branch of preclusion by former adjudication, formerly called collateral estoppel, precludes future litigation on a subject issue only if the issue was "actually litigated and determined" in a setting where "its determination was essential to" the final decision reached.[4] *North Clackamas School Dist. v. White,* 305 Or 48, 53, 750 P2d 485, *modified* 305 Or 468, 752 P2d 1210 (1988); Restatement (Second) of Judgments § 17(3) (1982); *see also id.* at § 27. This court has previously explained issue preclusion as follows:

> "If a claim is litigated to final judgment, the decision on a particular issue or determinative fact is conclusive in a later or different action between the same parties if the determination



> was essential to the judgment." *North Clackamas School Dist. v. White, supra,* 305 Or at 53.

Issue preclusion applies to an issue of either fact or law. Restatement (Second) of Judgments § 27 ("[w]hen an issue of fact or law is actually litigated and determined by a valid and final judgment, and the determination is essential to the judgment, the determination is conclusive"). *Compare Heller v. Ebb Auto Co.,* 308 Or 1, 6, 774 P2d 1082 (1989) ("[w]ithout any reason to think that the referee was aware of that legal issue, no decision on that issue can be implied from the denial of compensation") *with* § 27.

The preclusive effect of the rule is subject to exceptions, of which those listed in section 28 of Restatement (Second) of Judgments are illustrative.

*B. Claim Preclusion*

The claim preclusion branch of preclusion by former adjudication may be stated:

> "[A] plaintiff who has prosecuted one action against a defendant through to a final judgment * * * is barred [*i.e.*, precluded] * * * from prosecuting another action against the same defendant where the claim in the second action is one which is

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[2] *See, e.g., Taylor v. Baker,* 279 Or 139, 144, 566 P2d 884 (1977); *Dean v. Exotic Veneers, Inc.,* 271 Or 188, 194, 531 P2d 266 (1975).

[3] *See, e.g., North Clackamas School Dist. v. White,* 305 Or 48, 50, 750 P2d 485, *modified,* 305 Or 468, 752 P2d 1210 (1988); *Jones v. Flannigan,* 270 Or 121, 124, 526 P2d 543 (1974); *Gaul v. Tourtellotte,* 260 Or 14, 17, 488 P2d 416 (1971).

[4] The decision in *Chavez v. Boise Cascade,* 307 Or 632, 637, 772 P2d 409 (1989), turns on whether an issue was essential to a final decision.

based on the same factual transaction that was at issue in the first, seeks a remedy additional or alternative to the one sought earlier, and is of such a nature as could have been joined in the first action." *Rennie v. Freeway Transport,* 294 Or 319, 323, 656 P2d 919 (1982).

Claim preclusion applies equally to a defendant's defense. *See* Restatement (Second) of Judgments § 18. Claim preclusion does not require actual litigation of an issue of fact or law, as does issue preclusion. Nor does it require that the determination of the issue be essential to the final or end result reached in the action, claim, or proceeding. However, claim preclusion requires that specified characteristics be present in the former action or proceeding before the determination is conclusive on the parties in the future. The opportunity to litigate is required, whether or not it is used. Finality is also required. *See id.* at § 18, comment a, and § 19, comment a. Where there is an opportunity to litigate the question along the road to the final determination of the action or proceeding, neither party may later litigate the subject or question.



The policies upon which court-made claim preclusion law is based include (1) achieving finality to a conclusion of a dispute, and (2) preventing splitting of that dispute into separate controversies. Both policies protect limited dispute-resolution resources from repeated expenditure upon the same overall dispute. Thus, "[a] valid and final personal judgment is conclusive between the parties, except on appeal or other direct review." See Restatement (Second) of Judgments §§ 17, 18, 19, and 27 (1982).

To prevent splitting of the dispute or controversy, courts employ a broad definition of what could have been litigated. Claim preclusion conclusiveness between the parties applies "with respect to all or any part of the transaction, or series of connected transactions," out of which the action or proceeding arose. *Id.* at § 24(1); *see Rennie v. Freeway Transport, supra,* 294 Or at 324.[5]

Claim and issue preclusion rules are subject to a number of exceptions. One is relevant here. A final determination is not conclusive when, by provision of a statute or valid rule of the body making the final determination, that determination does not bar another action or proceeding on the same transactional claim. Restatement (Second) of Judgments § 20(1)(c) (1982).[6]

Rules fostering the policy against splitting the dispute also recognize exceptions. Where the decision maker

[5] An earlier formulation of the definition of what could have been litigated was stated in *Dean v. Exotic Veneers, Inc., supra* note 2, at 193-94, as every claim which could have been alleged under the same aggregate of operative facts giving rise to judicial relief. The two descriptions of what is a claim are not far apart because any transaction is proved as an aggregate of facts showing it and its nature. Section 24(2) of Restatement (Second) of Judgments states some criteria for limiting factual groupings as separate transactions.

[6] Further, Restatement section 20(1)(c) provides that a judgment for a defendant does not bar a plaintiff's claim "[w]hen by statute * * * the judgment does not operate as a bar to another action on the same claim."

expressly reserves for a party the right to maintain a second action or proceeding at the time the first determination is made, there is no preclusive effect. *Id.* at § 26(1)(b). Where a statutory scheme contemplates that the contentions arising from a transaction or series of connected transactions may be split, splitting as contemplated by the statutory scheme is not



merged in or barred by a former adjudication concerning the overall transaction. *See id.* at § 26(1)(d).

## CLAIM AND ISSUE PRECLUSION APPLY TO ADMINISTRATIVE PROCEEDINGS

Both issue preclusion and claim preclusion apply to administrative proceedings, provided that the tribunal's decision-making processes include certain requisite characteristics.[7] Both branches of preclusion by adjudication apply to workers' compensation proceedings. *North Clackamas School Dist. v. White, supra,* 305 Or at 52 (issue preclusion rules apply where they "facilitate prompt, orderly and fair problem resolution"); *Million v. SAIF,* 45 Or App 1097, 610 P2d 285 (1980) [hereafter cited as *Million II*] (claim preclusion applied, splitting of claim prevented). *See also Kepford v. Weyerhaeuser Co.,* 77 Or App 363, 713 P2d 625 (1986) (claim preclusion rules against splitting a claim do not apply where basis for later claim did not yet exist at time of earlier decision).

Section 83(1) of Restatement (Second) of Judgments provides, with exceptions, that final administrative adjudication "has the same effects under the rules of res judicata, subject to the same exceptions and qualifications, as a judgment of a court." Comment f to section 83 states:

> "*Claim and issue preclusion: general rules.* The rules of res judicata referred to in Subsection (1) include the rules of claim preclusion stated in §§ 17-24 and the qualifications and exceptions thereto stated in §§ 20-26, and the rules of issue preclusion and the qualifications and exceptions thereto stated in §§ 27-28. * * *" *Id.* § 83, *comment f* at 274.

The policies undergirding court-made rules of claim preclusion — protecting finality and preventing splitting — apply to administrative claim or issue preclusion questions.

*A. Finality*

The point at which finality attaches to a statutory administrative proceeding for preclusion purposes will usually



be governed by statutory provisions. Indeed, a statutory scheme of remedies may expressly contemplate that successive proceedings may be brought, notwithstanding the finality of the first proceeding. But the statutory scheme will usually spell out the situations where a second proceeding is

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[7] *Compare State v. Ratliff,* 304 Or 254, 258, 744 P2d 247 (1987), *with Bandy v. Norris, Beggs & Simpson,* 222 Or 1, 23-24, 342 P2d 839, 351 P2d 445 (1959); *see generally* 4 Davis, Administrative Law Treatise 49-51, § 21.2 (1983) ("*Res Judicata* Applies to Administrative Adjudication").

not precluded by finality of a first proceeding.[8] *See North Clackamas School Dist. v. White, supra,* 305 Or at 57-58. The statutes applicable to this case are discussed in the analysis section of this opinion.

*B. Splitting*

A worker who is aware that it is possible that her physical condition is the product of either an occupational disease or a job-related traumatic injury may not bring two successive compensation claims seeking the same relief for the same condition. The failure to assert both theories or contentions for recovery in the first compensation claim precludes the second claim on the second theory, where finality has attached to the proceeding on the first claim and where there was an opportunity to litigate both claims at the time of the first claim. *Million II, supra* 45 Or App at 1103. *Compare*



*Million v. SAIF,* 35 Or App 269, 581 P2d 136 (1978) [hereafter *Million I*], *with Million II, supra.*

In *Million I,* the Court of Appeals affirmed a denial of compensation on the ground that the worker's shoulder condition was not caused by an on-the-job traumatic injury. The facts in the *Million* cases are as follows. Claimant suffered a compensable injury to her hand in 1972 when she was struck there by a piece of wood. The claimant first complained of pain in her shoulder in 1973. In 1975, the claimant sought compensation for a shoulder operation as an aggravation of the 1972 injury but was rebuffed by the Board and on appeal for lack of evidence that the shoulder condition was due to the trauma of the 1972 industrial injury. *Million I, supra.* The claimant later sought compensation for the shoulder operation on the previously unstated and unlitigated theory that the condition was caused by occupational disease. In *Million II,* the Court of Appeals concluded that *res judicata* barred a second claim for workers' compensation for the shoulder con-

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[8] The requirement of finality, before preclusion applies, is expressly stated in Restatement (Second) of Judgments § 83 (1982), in part, as follows:

"(2) An adjudicative determination by an administrative tribunal is conclusive under the rules of res judicata only insofar as the proceeding resulting in the determination entailed the essential elements of adjudication, including:

"* * * * *

"(d) A rule of finality, specifying a point in the proceeding when presentations are terminated and a final decision is rendered * * *."

But where the statutory scheme of remedies contemplates assertion of a second claim, finality of the first is not preclusive of the second. Section 83 continues:

"(3) An adjudicative determination of a claim by an administrative tribunal does not preclude relitigation in another tribunal of the same or a related claim based on the same transaction if the scheme of remedies permits assertion of the second claim notwithstanding the adjudication of the first claim."

Among the exceptions to the general rule specifically cross-referenced by comment f to section 83(1) is section 26 of Restatement (Second) of Judgments, which in part provides:

"(1) When any of the following circumstances exists, the general rule of § 24 does not apply to extinguish the claim, and part or all of the claim subsists as a possible basis for a second action by the plaintiff against the defendant:

"* * * * *

"(d) The judgment in the first action was plainly inconsistent with the fair and equitable implementation of a statutory * * * scheme, or it is the sense of the scheme that the plaintiff should be permitted to split his claim."

dition based on an occupational disease theory, 45 Or App at 1102-03. The Court of Appeals concluded:

> "We think the evidence shows that claimant and her attorney were, at the time of filing of her aggravation claim in 1975, aware that it was also possible that her shoulder condition was, in whole or part, the product of an occupational disease. Under the circumstances, a claim on this theory should have been made in 1975." 45 Or App at 1103.

The first *Million* decision determined only that a shoulder condition did not result from the traumatic injury to the worker's hand. That was the question litigated, decided, essential to the decision, and embodied in an order final after appeal, thereby precluding that *issue* from being relitigated. But, because there was also an opportunity, before the first decision became final, to litigate whether the shoulder injury or condition was due to some other aspect of the worker's job, the first final decision that the shoulder injury was not work related (*Million I*) precluded further litigation on any other job-causation theory, *Million II*. That conclusion — that the shoulder condition was not job related — could not be relitigated because of *claim* preclusion rules.

Conversely, in *North Clackamas School Dist. v. White, supra,* the first litigation and decision established that



the hip-girdle injury occurred when a worker slipped on some steps at work. The first decision also established that the injury did not produce a loss of earnings at the time of the first final decision because the worker remained able to work, although the need for medical treatment continued and pain arising from the time of injury persisted.

Thereafter the worker pressed an aggravation claim. The referee and the Board found that there was no worsening because the injury did not deprive the worker of earnings but also found that medical treatment should be continued because needed treatment was for the work injury. This is the second decision referred to herein.

The Court of Appeals reversed, invoking *res judicata,* holding that the compensability of claimant's hip condition had already been determined, *i.e.,* it was not compensable.[9] This court reversed and reinstated the entitlement to medical treatment for the hip-girdle condition, as ordered by the Board. The first decision established that slipping on the steps produced a hip-girdle injury. The second decision was in agreement on that issue. *Million I,* 305 Or at 57. Both decisions established that there was a continuing need for medical care which was job related. No preclusion attached to the worker's request for continuing medical care for the job injury.

## ANALYSIS

The threshold issue tendered by EBI is whether the statutory entitlement to TTD, in the correct amount, involves a separate claim distinct from the claim for enforcement of various future rights to which the worker became entitled by reason of the initial allowance of the aggravation claim in 1984.[10] Those future rights included TTD whenever, as the

[9] *See North Clackamas School Dist. v. White,* 85 Or App 560, 737 P2d 649 (1987).

[10] It bears repeating that this order opened an aggravation claim, it did not finally determine any issue nor close any claim.

referee ordered, the treating doctor authorized them. In its issue preclusion analysis, the Court of Appeals stated:

> "We do not agree that the issue that claimant now seeks to litigate is a claim as that term is used in *res judicata* parlance. EBI had been paying temporary total disability and, consequently, there was no need to raise an issue of entitlement to it. The narrow issue involved is the amount of temporary total



> disability. More particularly, the question is what was the correct wage rate; that is an issue of fact, not a claim." 96 Or App at 4.

We agree with the first sentence of the Court of Appeals' analysis — that the TTD was not by itself the claim for preclusion by former adjudication purposes. However, stating that a subject in controversy is an issue of fact, not a claim, fails to properly explain why issue or claim preclusion does not apply.

EBI contends that the worker is impermissibly splitting his claim for compensation for a single injury. In support of that argument, EBI first urges that "claim" should be defined for preclusion purposes the same way it is defined in the workers' compensation statutes. Under ORS 656.005(6), " '[c]laim' means a written request for compensation from a subject worker or someone on the worker's behalf, or any compensable injury of which a subject employer has notice or knowledge." The definition of the term "claim" provided in ORS 656.005(6) governs the construction of ORS chapter 656, unless the context requires otherwise. ORS 656.003.

A statutory definition of "claim" is for use in interpreting the statutory scheme to which the definition expressly relates. *Chapman Bros. v. Miles-Hyatt Investments,* 282 Or 643, 646, 580 P2d 540 (1978). It does not govern claim or issue preclusion rules made by judges, *State ex rel Huntington v. Sulmonetti,* 276 Or 967, 970-71, 557 P2d 641 (1976), unless the legislature manifests its intent that the definition do so. Such an intent is not present here.

The meaning of "claim" for purposes of claim preclusion was considered in *Troutman v. Erlandson,* 287 Or 187, 598 P2d 1211 (1979). This court stated:

> "For res judicata purposes a 'claim' * * * does not mean the particular form or proceeding by which a certain kind of relief is sought but, rather, a group of facts which entitled plaintiff to relief." 287 Or at 201.

This court quoted at length "a fresh approach to determining what is a 'claim' * * * [in] the American Law Institute's Draft No. 5 of March 10, 1978, Restatement (Second) of the Law of Judgments, § 61." *Id.* at 205. The court endorsed an expanded definition of claim to include all rights or remedies between



the parties with respect to all or any part of a transaction, or series of connected transactions, out of which the action arose. Thereafter, this court has continued use of the transactional definition of claim. *See Rennie v. Freeway Transport, supra,* 294 Or at 327; *see also supra* note 5.

EBI relies upon *Dean v. Exotic Veneers, Inc.*, 271 Or 188, 531 P2d 266 (1975), to buttress its argument that the worker is splitting the claim. That case holds that, where a previous claim for money due on an express contract to pay for services is denied by the circuit court and the denial is final, a second claim in a separate action based on *quantum meruit* for the reasonable value of the same services is precluded. 271 Or at 200.

The claim for value of the same services could not be split by founding the single contention concerning payment for the services involved on one theory in one action and on a different legal theory in a second action. *Cf. Million II, supra,* 45 Or App at 1102 (first decision, that shoulder condition was not related to traumatic injury to worker's hand, final on appeal before filing of second claim that same shoulder condition resulted from occupational disease); *Kepford v. Weyerhaeuser Co., supra* (finding entered in 1979 that preexisting disc disease was not permanently worsened by a 1974 back injury did not preclude a 1983 finding that work as a logger after 1979, together with the back injury, were the major causes of an occupational disease aggravating the preexisting disc condition and necessitating post-1979 surgery).

In *Kepford,* the Court of Appeals explained that:

> "There is no evidence, however, that in 1979 claimant's back condition had reached the point that it necessitated additional treatment. The evidence presented at the 1983 hearing, including the post-surgical findings regarding the cause of the worsened condition, constituted a new set of facts that could not have been litigated in 1979." 77 Or App at 366.

*A. The Statutory Scheme.*

The legislature enacted workers' compensation changes in 1990. We generally refer, in our following discussion, to the statutes as they were before that change.

The workers' compensation statutes, in effect at the time of referee and Board orders, assist in determining what



are separate claims to which claim preclusion applies. Those statutes described when more than one proceeding could be instituted to recover for a single injury at work. The statutes also implicitly provided when the finality requisite for claim or issue preclusion attached to a given decision on various issues.

ORS 656.273 provided in part:

> "After the last award or arrangement of compensation, an injured worker is entitled to additional compensation, including medical services, for worsened conditions resulting from the original injury.
>
> "* * * * *
>
> "(3) A physician's report indicating a need for further medical services or additional compensation is a claim for aggravation."

ORS 656.268(2)(a) provided in part:

> "[W]hen the injured worker's condition resulting from a dis-

abling injury has become medically stationary * * * the insurer * * * shall * * * request the claim be examined and further compensation, if any, be determined."

Amounts of compensation are subject to adjustment until final closure. ORS 656.268(10) stated:

"Any determination or notice of closure made under subsection (3), (4) or (5) of this section may include necessary adjustments in compensation paid or payable prior to the determination or notice of closure * * *."

Medical benefits, including treatment temporarily incapacitating a worker from working, may continue even after claim closure, provided that the medical need was connected to a job-related injury. ORS 656.245(1) in part provided:

"For every compensable injury, the insurer or self-insured employer shall cause to be provided medical services for conditions resulting from the injury for such period as the nature of the injury or the process of the recovery requires. * * * The duty to provide such medical services [except for palliative care in certain circumstances] continues for the life of the worker."[11]

ORS 656.283(1) in part provided: "Subject to * * * ORS



656.319, any party or the director may at any time request a hearing on any question concerning a claim." ORS 656.283(1). An aggravation claim, for preclusion purposes and by statute, is a separate claim which is not precluded by the fact that an original claim for the work-related injury has been finally determined.

A claim determination is not final until hearing and judicial review rights are barred or exhausted. The statutory scheme indicates that the finality requisite for claim or issue preclusion, against the worker, occurs only when a worker fails to timely request a hearing after a claim denial, a determination order, or a notice of claim closure, ORS 656.319, or by failure to file a timely appeal to the Board, ORS 656.289(3), or the courts. ORS 656.295(8).[12]

*B. Applying the Statutory Scheme to This Case*

The 1984 hearing order allowed and opened an aggravation claim, reversing a denial by EBI. The claim was opened to provide additional medical treatment and to consider permanent disability following that treatment. The order expressly provided that future TTD be paid "as authorized by * * * claimant's treating physician." When the aggravation claim was allowed, the statutory right to TTD compensation arose, applicable to any future period during which the worker was disabled by the 1984 surgery related to the work injury. ORS 656.210(1). This court is not authorized to modify that statute by reading it to not apply to an aggravation or worsening claim. The 1984 aggravation claim is presently before this court, following a determination order on

[11] The material in brackets reflects amendments adopted at the 1990 special legislative session. Or Laws 1990 (Special Session), ch 2 [SB 1197 A-Engrossed], § 10.

[12] Oregon Laws 1990 (Special Session), chapter 2, [SB 1197 A-Engrossed] section 9, may describe another category of final and unreviewable orders — where the Board approves lump-sum settlements.

October 7, 1985, a timely request for hearing, the 1986 referee's hearing and order, and the subsequent, statutorily provided, reviews by the Board, the Court of Appeals, and this court. The 1984 order and the 1986 order are but separate parts of the same aggravation claim, *i.e.*, the orders were entered in the same administrative proceeding now before us on judicial review. The finality required to invoke claim preclusion has not yet attached to the compensation proceeding of which the 1984 hearing was a part.



Like *Kepford v. Weyerhaeuser Co., supra,* the TTD entitlement in controversy here is for periods and amounts arising after the original claim was determined and after the 1984 hearing was concluded. Like *North Clackamas School Dist. v. White, supra,* the first hearing on the aggravation claim in 1984 established that the work injury produced the need for treatment. Treatment thereafter caused the time loss which triggered TTD entitlement. Only when the doctor later authorized TTD periods did the statutory entitlement to TTD take effect. And, at that point, the right to TTD arose anew as part of the aggravation claim, which is still open and now before this court.

The question of the proper rate of TTD payment is but one of many issues involved in that ongoing claim for aggravation. No finality has yet been accorded the aggravation claim opened in 1984, and no splitting of that claim occurred. We conclude that neither issue nor claim preclusion applies to the TTD rate issue.[13]

But could the Board have properly affirmed on the referee's theory that the contention was "waived"? No, the conditions required to bar a contention by waiver are not met in this case. First, ORS 656.262(9), in effect at that time, provided:

> "[N]or shall mere acceptance of such compensation be considered a waiver of the right to question the amount thereof."

Second, our cases hold that waiver is "the intentional relinquishment of a known right." *Brown v. Portland School Dist. #1,* 291 Or 77, 84, 628 P2d 1183 (1981); *see also Waterway Terminals v. P.S. Lord,* 242 Or 1, 26-27, 406 P2d 556 (1965) (quoting a description of the rule of waiver in *McMillan v.*

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[13] However, the original claim was closed and final in 1981. Correction of TTD amounts paid before that closure is barred by claim preclusion even though the subject was not litigated. The administrative proceeding related to the original 1981 claim for compensation is final in all respects which are not inconsistent with the statutory scheme authorizing additional claims when and if the effects of an injury worsen in the future.

Neither the 1981 nor the 1984 order stated what rate should be paid. Both orders simply required that TTD benefits be paid. The insurer, based upon information previously furnished by the employer, paid TTD benefits at an erroneously low rate. There was no finding in either order concerning the rate of payment to be made. Therefore, neither order provides a basis for any conclusion that the claim for higher TTD benefits was barred because of issue preclusion.

*Montgomery,* 121 Or 28, 32, 253 P 879 (1927)). The record before us provides no basis for concluding that claimant intentionally relinquished — *i.e.,* waived — his right to seek the correct amount of temporary total disability by his silence on the subject in 1984. Payments would accrue, if ever, after the time of the hearing. In 1981 and 1984, the worker did not know of the mistake and, thus, could not have intentionally waived the right to correct it. The referee erred when she found that the right to seek a correction was waived. The Board erred when it affirmed the referee.

The decision of the Court of Appeals is affirmed, and the order of the Workers' Compensation Board is remanded to the Board for further proceedings consistent with this opinion.

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